NHS
Dartford and Gravesham
NHS Trust

2017

2018

ANNUAL REPORT

Care with compassion | Respect and dignity | Striving to excel | Professional standards | Working together

70 YEARS OF THE NHS 1948 - 2018


70
YEARS
OF THE NHS
1948 - 2018

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Performance Report

OVERVIEW

About Dartford and Gravesham NHS Trust and its Legal Establishment

The purpose of the overview is to give a short summary that provides sufficient information to understand the organisation, its purpose, the key risks to the achievement of its objectives and how it has performed during the year.

Dartford and Gravesham NHS Trust (the Trust) came into force as a legal entity on 1st November 1993. Its headquarters is at Darent Valley Hospital in Dartford, Kent.

In October 2013, the Trust took on a number of services at Queen Mary's Hospital, Sidcup, and Erith and District Hospital as part of the dissolution of the South London Healthcare Trust. In addition, the Trust also provides services in Gravesham Community Hospital in Gravesend as well as a number of community locations across our population. The Trust offers a comprehensive range of acute services, with a bed-base of 544, to around 400,000 people in North Kent and South East London.

Darent Valley Hospital (DVH) opened in September 2000. The hospital building is run as part of a Private Finance Initiative (PFI). This means the building is owned by a private sector company, The Hospital Company (Dartford) Limited, and the Trust leases the building. DVH has inpatient beds and specialties that include day-care surgery, general surgery, trauma, orthopaedics, cardiology, maternity and general medicine. The hospital also functions at Elm Court, which is located in Priory Mews Nursing Home in Dartford. This provides over 30 beds for patients from Darent Valley Hospital who have completed their acute phase of care but still need some rehabilitation, assessment or mobilisation or who are waiting for longer term care arrangements to be finalised.
The services provided by the Trust at Queen Mary's Hospital (QMH) include elective inpatient and day surgery and outpatient services in general surgery, urology, orthopaedics, gynaecology, medicine and paediatrics, in addition to diagnostic and therapies. Erith and District Hospital provides X-ray and outpatient services. Oxleas NHS Foundation Trust is responsible for the buildings at Queen Mary's and Erith hospitals and the Trust works closely with them and the other provider organisations operating from the sites.

The Trust's priorities are as follows:

- Provide high quality safe patient services
- Deliver financial sustainability and efficiency
- Strengthen operational efficiency and effectiveness
- Promote excellent education and personal development
- Proactive partner engagement

The Trust Board regularly receives the Board Assurance Framework (BAF) which outlines the significant risks to the achievement of the organisation's strategic objectives. Each of the risks in the BAF has an Executive Director to whom they are assigned. Each designated risk handler regularly reviews their respective BAF risks before they are presented to the Trust Board for its overall and collective review.

There were eight key risks identified in the BAF against the achievement of the Trust's strategic objective of providing high quality safe patient services. The Care Quality Commission (CQC) rated the Trust as requiring improvement and, to which, it has responded by putting in place an Improvement Plan that will help to ensure that a comprehensive approach is taken to bringing about the required change.

The BAF also contains ten key risks against the achievement of the Trust's strategic objective of delivering financial sustainability and efficiency. The Trust put a Financial Recovery Programme in place, through which it is addressing these key risks, with a view to reducing its overall financial deficit position.

Six key risks identified in the BAF as threats to the achievement of the Trust's strategic objective of strengthening operational efficiency and effectiveness. The Trust has shown strong performance against key national performance indicators but with some challenges with A&E performance as a result of the

unprecedented winter pressures that the organisation had to contend with.

The Trust works successfully in partnership with the Dartford, Gravesham and Swanley, and Bexley Clinical Commissioning Groups (CCGs), the Community and Mental Health Trust, other acute trusts, Kent County Council, Social Services (in Kent and Bexley) and its PFI Partners to ensure that the best possible care is provided.

The Trust actively supports both the South East London and the Kent and Medway Sustainability and Transformation Partnerships (STP) and works closely with partners to agree strategic priorities not just within this Trust but also throughout the whole local health economy.

This year also sees the end of the Acute Care Collaboration Vanguard with Guys and St. Thomas' Foundation Trust which has enabled partnership working to bring specialist care closer to patients' homes. The Alliance formed will now move into business as usual.

The Trust Board meets monthly in public, and its agenda is focused around the key aspects of quality, productivity and innovation, assurance and strategy. A dynamic programme of agenda items is actively managed throughout the year to ensure the Trust Board receives the information, and considers the matters it requires to perform its duties efficiently and effectively.

The Trust Board has established a number of committees, to support it in delivering its duties and responsibilities. Each sub-committee receives a set of regular reports, as outlined within their terms of reference and provides a summary to the Trust Board after each meeting. The importance of the triangulation of understanding, challenge and assurance between committees is recognised and reflected through cross membership and reporting mechanisms.

An executive management team supports the Chief Executive in managing the Trust, with each director holding a portfolio of responsibilities. The organisation is structured into a number of corporate and clinical directorates.

Chief Executive's Report

The Trust continues with its strong proud record of collaborative working and has seen some real achievements in the last year.

Following their introduction across the NHS last year the Trust continues to be a contributor to both the South East London and the Kent and Medway Sustainability and Transformation Partnerships.

The Trust has also been in a partnership for two years with Guy's and St Thomas' NHS Foundation Trust as one of thirteen acute care collaborations within NHS England's New Care Models programme. It has seen patient care enhanced in a number of clinical areas, including Vascular Surgery, Paediatrics and Cardiology which have led to innovative ways of working being adopted within these specialties, such as the Proactive Care for Older People Undergoing Surgery (POPS) programme. The two trusts also plan to continue to develop their partnership into a new form of a sustainable group model in the next year.

We continually strive to provide the right care in the right place and have worked on a number of activities so that the Trust provides professional care to patients of all ages, backgrounds and needs in a variety of settings and with a variety of partners. There have been a number of initiatives and projects that have included representatives from other organisations which have helped to ensure that patients are only in an acute hospital setting whilst they need to be. One of these activities, our Rapid Improvement Programme, was shortlisted for the prestigious Health Service Journal Awards in the Improved Partnerships between Health and Social Care and Staff engagement categories. The Trust also helped celebrate the centenary year of Queen Mary's Hospital and continues to develop a Planned Care Centre on the site for non-complex elective operations, diagnostic and outpatient activity.

Our staff continue to be dedicated to providing patients with excellent care. The strong positive culture within the Trust was shown in the 2017 Staff Survey results. Response to the survey show that on a significant number of key findings, we remain amongst the very best acute Trusts in England and received the most positive staff feedback within Kent and Medway. The Trust was positioned in the top 20% of all acute trusts in 20 out of 32 key indicators. This included the highest (best) 20% of staff recommending the Trust as a place to work or receive treatment and the staff's ability to contribute towards improvements at work.

The 2017/18 year has been another particularly challenging financial year for this organisation and for the NHS as a whole. The Trust delivered £6.5m of savings in 2017/18 through its normal savings programme and Financial Recovery Programme, but ended the 2017/18 financial year with a £15.8m deficit and has urgently developed plans to address this shortfall in 2018/19.

The Trust remains committed to delivering the key operational standards and we successfully achieved the 18 week referral to treatment and diagnostic standards, met the 62 day cancer target in nine out of twelve months. But, we were unable to consistently meet the A&E four hour wait standard due to unprecedented winter pressures, but have continued to work hard to adopt national best practice initiatives such as managing patients in an ambulatory setting. The A&E target over the year achieved 90% of patients being treated and discharged or admitted within four hours and the Trust had 125,914 attendances in the Darent Valley Emergency Department.

In November 2017 the Care Quality Commission (CQC) visited the Trust to carry out their inspection of our Trust. The overall assessment of the Trust was rated as 'Requires Improvement', but I was pleased that the inspectors found a number of areas throughout the Trust where outstanding practice was taking place. Moreover, services were rated as good for caring and the CQC observed patients being treated with

compassion, by kind and professional staff who put patients at the heart of the service they delivered. The CQC also rated services provided by the Trust at Queen Mary's Hospital, Sidcup as 'Good' overall. The rating of 'Requires Improvement' does mean that we need to change the way we work and, whilst we have already made a number of changes to address some immediate issues, further work has gone on to develop a Quality Improvement Plan to ensure we have a comprehensive approach to embedding change.

Our context continues to be one of exceptional population growth. The brown field site of Ebbsfleet has been identified as a new Garden City and a 'Healthy Town' and is now a rapidly expanding building site with the plans aiming to deliver 12,000 new homes. The population increase from 2015 to 2031 is anticipated to be in the region of 85,000 which will increase the current population of 390,000 by 22% due to various planned housing developments. Limited capital and an increasing workload are leading to a pressurised situation, urgently requiring a significant step change in healthcare provision.

We have also reported on the outcomes and achievements of the last year and the priorities we set ourselves for 2017/18.

Finally, I would wish to congratulate Susan Acott on her appointment as Chief Executive of East Kent Hospitals Foundation Trust. Susan had been a member of the Trust Board since 2005 and led the Trust, as Chief Executive, from April 2010. I would like to thank her for the commitment and significant contribution that she gave the Trust and the local population it serves during this time.

I hope that you will find this is a balanced report for the year and that you will welcome the opportunity to share in our successes. At times it has been incredibly tough and on behalf of the Trust Board, I would offer my sincere thanks to all staff and remind them of our appreciation of the importance and genuine value of the work they do in support of our patients.

To the best of my knowledge, the information in this report is accurate.

Signed.....
Acting Chief Executive

Date: 18 May 2018

A year at Dartford and Gravesham NHS Trust 2017/18 Highlights

April

New Chairman

Dartford and Gravesham NHS Trust announced the appointment of Peter Coles to the position of Chairman. Peter had been a Non-executive Director of Dartford and Gravesham NHS Trust since 2013. He has over 27 years' experience working within the NHS.

Peter took up his post on 1st April 2017 for a four year period. He succeeded Janardan Sofat, who had been Chairman since January 2014.

May

A Planned Care Centre - Queen Mary's Hospital

To meet an increase in demand for elective procedures in the short and longer term, the Trust designated Queen Mary's Hospital, Sidcup (QMH) as a Planned Care Centre. It is used for routine elective surgery to maximise use of additional operating theatres and ward space.

June

International nurse recruitment

The Trust made good progress with a range of overseas nurse recruitment activities in order to address current nursing vacancies and future resourcing requirements. The first groups from Italy and the Philippines went on to complete their Nursing and Midwifery Council (NMC) registration which included preparing for a skills based practical test. They were supported by the clinical education team.

July

Showcasing our Vanguard and Celebrating Success

In July the Foundation Healthcare Group (FHG) Vanguard hosted a Celebration and Showcase event in Robens Suite, Guy's Tower. The event was attended by over 100 healthcare leaders who have contributed to the Vanguard programme,

including Chief Executives of both partner trusts, as well as representatives from NHS England and the clinical teams who are delivering the improvements for patients.

Roald Dahl Specialist Nurse

Emily Bell started at the Trust as its new Roald Dahl Paediatric Epilepsy/Neurology Specialist Nurse. Emily is the first Roald Dahl nurse in Kent, and the first to work with one of NHS England's 50 Vanguard sites – The Foundation Healthcare Group.

Emily has an honorary contract with the Evelina as part of the Trust's alliance with Guy's and St Thomas's NHS Trust and has access to their expertise. Roald Dahl's Marvellous Children's Charity also provides ongoing training and support to all its nurses. She works with children and young people with epilepsy, and their family, at all stages of their diagnosis.

August

Increased Bed Capacity

To accommodate the increasing demand on the Trust's beds, twelve additional medical beds were opened. This is to ensure that medically stable for discharge patients were placed in a central location and receive the care required including regular reviews.

September

Secretary of State for Health Jeremy Hunt visits the Trust

On Thursday 14 September the Secretary of State for Health, Jeremy Hunt, visited Darent Valley Hospital. During his visit Medical Director, Steve Fenlon gave a presentation on the Trust's performance and successes. The Secretary of State then spoke about the importance of patient safety and praised the staff for their hard work and dedication to patient care. He was later shown around Accident and Emergency (A&E) and Acute Care Unit (ACU).

Ride 4 Life

The Ride 4 Life cycle to Paris took place with 32 intrepid cyclists raising over £54,000 for the Trust's cancer charities. This made all the riders very pleased and proud, especially as some of them had lost partners recently or were now facing that prospect.

October

Emergency Department Streaming Service

In October the co-located Primary Care Streaming Service in the Emergency Department (ED) started. The Service provides expert care for patients presenting to ED with primary care presentations or minor illnesses. The new system is designed to reduce waiting time and improve flow through ED by allowing staff in the main department to focus on patients with more acute/complex conditions leading to an improvement in the overall quality of care.

This development was funded through a successful bid by the Trust for additional funds that also included a senior nurse seeing patients on arrival to ensure they are seen as quickly as possible by the most appropriate person, which could mean a referral back to his/her GP, and redesign of the ED waiting area.

Smoke free Darent Valley Hospital

Darent Valley Hospital became a Smoke free Site. The

Hospital's total ban on smoking was announced on the front pages of both the Dartford and Gravesend editions of the Messenger on 10 August. On Monday 2nd October 2017, smoking and vaping became prohibited at Darent Valley Hospital.

November

Additional Beds at Darent Valley Hospital

A further ten beds opened on Mulberry ward in November 2017 when it became a 25-bed unit designated as the medically stable for discharge unit.

Care Quality Commission Inspection

The Trust received and supported an Inspection by the Care Quality Commission.

December

Dartford MP Gareth Johnson visits Darent Valley Hospital

Dartford MP Gareth Johnson visited the site to meet staff and learn about developments at the Trust.
Mr Johnson said: "I have always been impressed with how Darent Valley recognises that having a successful A&E department requires the whole of the hospital to play its part and they also take a very multi-agency approach."

January

Carillion liquidation

Carillion, the company that provides Facilities Management services at the Trust, received significant coverage in the national news when it was announced that it would go into liquidation. The Trust had been aware of the emerging circumstances for some time and had planned extensively for that eventuality. The Trust had a strong relationship with its Carillion colleagues and worked side by side as one organisation, always putting the patient first. Services to patients continued with minimal disruption and facilities opened as normal ensuring patient appointments remain unaffected.

February

Kent and Medway Review of Urgent Stroke Services

Significant changes to the urgent stroke care currently provided in six hospitals across Kent and Medway were proposed in February 2018 by Kent and Medway Sustainability and Transformation Partnership.

The proposed three new hyper acute stroke units aim to ensure that all residents get consistently high-quality hospital-based stroke care regardless of where they live or what time of day or night a stroke occurs. Darent Valley Hospital was proposed as a site in three of the five options.

March

New Gamma Camera

A new Gamma Camera offers patients faster and more

accurate results. The Trust commissioned the state-of-the art hybrid Gamma Camera at Darent Valley Hospital to provide specialist imaging care for patients using the latest technology. This means a faster and more accurate diagnosis for patients.

New automated track in the blood sciences laboratory

Dartford and Gravesham NHS Trust and Medway NHS Foundation Trust integrated their blood science and microbiology services to form the North Kent Pathology Service (NKPS) on 1 March 2018.

Focus on our volunteers

Volunteers play a vital role in the daily running of the Darent Valley Hospital, are very much a part of the Trust family. The Meet and Greeters offer a welcoming friendly face as they direct patients to their appointments, and our Valley Park Radio volunteers entertain patients at their bedside. There are a number of roles that volunteers carry out on the wards: helping at meal times, providing spiritual support through our chaplaincy service, and our Dementia Buddies help support nursing staff care for patients with cognitive impairment. In clerical areas volunteers provide vital admin support to staff. Volunteers are extremely valued at the Trust; with over 200 volunteers giving around 30,000 hours of their time for free each year. Some of our Volunteers, such as Elizabeth Wells, have been with the Hospital since it opened in 2000. At a Volunteers event on 16th January 2018 Peter Coles, Trust Chairman, and Siobhan Callanan, Director of Nursing and Quality presented our Volunteer Long Service Awards badges, and Elizabeth with flowers to celebrate her 90th birthday!

Elizabeth Wells, Meet and Greet and Clerical Volunteer reflected on her time in the Trust.

"I started volunteer work in 1989 following the death of my husband John and have been volunteering at the hospital in a 'Meet and Greet' role since it opened in 2000. I work every Friday helping to meet and greet people and also volunteer for any emergency. I also do two days in the Children's Resource Centre helping the medical secretaries deal with the vast amount of work needed in that department.

Being a Meet and Greet Volunteer is such a pleasure and I enjoy helping people coming though the hospital doors. Some require physical help into a wheelchair, or if blind, escorting to wherever they want to go. It is also necessary to help the deaf and people not understanding English. The types of questions I am asked range from 'Where do I get a bus/taxi?' and 'How do I claim my fare?' to 'Where is this ward/clinic/patient?' and 'How do I donate?' The nicest part is when someone says thank you.

On one occasion, I was holding a paper-cup of tea and a gentleman put all his loose change into the cup. He was mortified when he learned I was not collecting and offered me a new drink, which I declined. The money was dried and went into the charity box.

I have had the pleasure now, for many years, of working with a host of delightful people such as all the staff in the Children's Resource Centre, the Carillion staff, receptionists, security men, porters and cleaners, all the staff in all the clinics and those on the wards.

A big thank you goes to Stephen and the Philip Farrant staff, plus a big thank you to the Chief Executive Susan Acott, who is always ready to listen and say hello. Last, but not least, the Volunteer and Fundraising office staff and colleagues who try their best to keep DVH a helpful and welcoming place to visit."

The local community; grateful patients and relatives, local businesses, schools, religious/community groups, continue to show their support for the Hospital through their support of Valley Hospital Charity, and its special

funds. The Charity aims to improve patient experience by enhancing the Hospital environment, and helping the Trust to continue to invest in new equipment, brought about by medical research and technical advances, despite the tightening NHS purse strings. Our flagship fundraising event, Stride4Life, is set to hit the £500,000 fundraising milestone through its sponsored walks, fun day and associated events. Our thanks go to the Stride4Life Committee, and to everyone who has supported the event over the last 13 years, raising money for the Cancer Fighting Fund that has introduced some of the cutting edge cancer treatments at our Trust. We hope this year's event on Sunday 8th July will be the best yet.

A team of 32 determined riders took part in our inaugural Ride4Life cycling event, from the Hospital to Paris, in September 2017. They raised a fantastic £54,000 between them. We hope to recruit an even bigger team to take on our new cycling challenge in June 2019, from Darent Valley to Amsterdam, 4 countries in 4 days!

Performance Summary

The Trust ended the 2017/18 financial year with a £15.8m deficit against the control total set of a £1.6m surplus. Clinical income reduced significantly in the year and cost pressures around capacity and safety generated overspends against the plan.

Trust staff fed back positively about their experience of working in the Trust in the 2017 national staff survey, placing the Trust in i.e. the top 10 acute trusts in the NHS. Feedback showed the Trust in the best 20% of acute trusts on 20 of 32 measures. The Trust was also rated in the best 20% for quality of appraisals and non-mandatory training.

The Trust has been involved in a number of collaborations in the past year including being part of two Sustainability and Transformation Partnerships, one for Kent and Medway and the other in South East London. The Trust is actively engaged with the community, primarily through social media and our volunteers.

The Trust was inspected by the Care Quality Commission in November and December 2017 and a number of issues were identified for improvement. In response to this we have developed a Trust Wide Improvement Plan.

Performance Analysis

Performance against our 2017/18 plans the Trust's annual objectives for 2017/18 were based on five themes, listed below, with a number of sub-objectives being identified for each theme:

1. **Provide high quality, safe patient services**
2. **Deliver financial sustainability and efficiency**
3. **Strengthen operational efficiency and effectiveness**
4. **Promote excellent education and personal development**
5. **Proactive partner engagement**

Directors identified the risks to the achievement of each of these objectives and reported on how these were being managed via the Board Assurance Framework (BAF). During 2017/18 the BAF was reviewed at each meeting of the Audit Committee, and by the Trust Board every 2 months. In addition, the Quality and Safety Committee, Finance Committee and Workforce Committee have reviewed the strategic risks from the BAF which were relevant to their committees.
The Trust Board receive monthly performance reports that set out the performance against national and local key performance indicators (KPIs) for a rolling 12 month period as well as a trend analysis and year to date performance summary, this report identifies risks and actions in progress to manage them and is RAG rated (Red, Amber, Green). Detailed analysis on actions taken and performance is reported to and monitored by the Trust Board and sub-committees on specific KPIs of national and local priority. In addition, the Trust maintains live clinical and business information systems accessible to all staff via the Trust intranet with key performance metrics presented in summary dashboards. There are also intranet links to specialty reports associated with the dashboard data.

Provide high quality, safe patient services

The Trust's latest Hospital Standardised Mortality Rate (HSMR) was 97.7 for the 12 month period January 2017 to December 2017. The HSMR figure is based on average mortality rates across England with a figure of 100 being used to represent that average.

There were 15 cases of C.difficile occurring more than 72 hours post admission to hospital against a Trust objective of 24 cases; this is a further decrease on last year's outturn (20 cases against an objective of 24

cases). There were six cases of Trust-assigned MRSA bacteraemia, one of which was a contaminated blood culture. This is an increase on last year's outturn of five cases.

The Trust has regular interaction with its stakeholder group and healthcare partners, listening to the needs of the local community. The Trust also has patients attend its Trust Board to learn from their experiences.

The Trust was inspected by the Care Quality Commission in November and December 2017 and was rated as 'Requires Improvement' with a number of issues that were identified for improvement. In response to this we have developed a Trust Wide Improvement Plan.

Deliver financial sustainability and efficiency

The Trust ended the 2017/18 financial year with a £15.8m deficit. The plan was to achieve a £1.6m surplus however clinical income reduced significantly in the year and cost pressures around capacity and safety generated overspends against the plan. The Trust plan included receipt of £7.3m of Sustainability and Transformation Funds (STF) – unfortunately because of the adverse variance to plan the Trust only secured £1.1m of STF income and £1.7m share of the general distribution – making the deficit even larger. Excluding the planned and actual STF income the Trust had a plan of a £5.7m deficit and an actual deficit of £18.6m therefore a variance of £12.9m.

The Trust delivered £6.5m of savings in 2017/18 through its normal savings programme and Financial Recovery Programme without affecting patient care or quality.

Strengthen operational efficiency and effectiveness

Further LEAN workshops were delivered within 2017/18 – with 79 staff now having received this training. In order to continually improve the patient experience. The Trust implemented two patient flow initiatives, the first being Red2Green days. This scheme involves identifying delays within individual patient's pathways and addressing those variations to enable efficient movement within individual patient's pathways. The second initiative has been the implementation of Multi-disciplinary Accelerated Discharge Events (MADE). These also improve patient flow through early escalation and improved

communications. Both initiatives have delivered significant improvements to the patient's experience.

The Trust maintained good performance against referral to treatment targets and Cancer targets. However, pressures within the system reflected the national position in regards to the A&E 4 hour target and the Trust did not meet its trajectory in that area.

Promote excellent staff development

Trust staff fed back positively about their experience of working in the Trust in the 2017 national staff survey, placing the Trust in the top 10 acute trusts in the NHS. Feedback showed the Trust be to in the best 20% of acute trusts on 20 of 32 measures including communication between senior management and staff, effective team working, witnessing potential harmful errors and fairness of procedures for reporting incidents – all of which improved significantly in 2017/18.
The Trust was also rated in the best 20% for quality of appraisals and non-mandatory training.

The Trust Board agreed a new clinical education strategy in February 2018, which will be used to support the future education of staff. Our alliance with Guy's and St Thomas' NHS Foundation Trust has also supported education by enabling us to access opportunities, and will develop in future years as the Trust is a founding member of GSTT Healthcare Alliance.

The Trust's mandatory training rates have continued to improve throughout the year, and the Trust has been above its target of 85% compliance throughout 2017/18.

Proactive partner engagement

The Trust has been involved in a number of collaborations in the past year including being part of two Sustainability and Transformation Partnerships, one for Kent and Medway and the other in South East London.

2017/18 was also the second full year of the Trust examining new models of care through one of only 13 NHS England funded acute care collaborative programmes. The success of the development of a new model of care has led to the Trust becoming a founding member of the GSTT Healthcare Alliance, which will see further collaboration between the Trust and Guy's and St Thomas' NHS Foundation Trust over the coming years.

The Trust is actively engaged with the community, primarily through social media and our volunteers. The Trust regularly visits charities, schools and sports clubs to promote the work of the Trust, listen to their stories and highlight how the community can be involved in supporting the organisation through fundraising, volunteering and future career opportunities.

The Trust is committed to responding to all comments received through Facebook, Twitter, NHS Choices and Patient Opinion and has over 9,515 followers on Facebook. The Trust engages with local MPs and media as well as patient groups. Information to promote the activities of the Trust is made available in Outpatients' Clinics, through news in brief publications and via the website.

This year the Trust led a multi-agency approach to the issue of admissions and discharges. This involved community providers, the ambulance service and representatives from social care. This was a novel approach to resolving a cross organisational/ cross sector challenge which could be repeated for other such complex issues.

We continue to participate in the Health and Wellbeing Board in Dartford, Gravesham and Swanley, which reports to the Health and Wellbeing Board in Kent, and the Chief Executive regularly attends both the Health Overview and Scrutiny Committees in the boroughs of Bexley and Dartford.

The Trust has established a Stakeholder Council whose purpose is to ensure local accountability for the services that the Trust provides; to demonstrate good stewardship; to support delivery of high quality services and to influence service developments.

Presided over by the Trust Chair, the core membership of the Council includes representatives from the four local councils of Bexley, Sevenoaks, Gravesham and Dartford as well as representation from local charities for health; Health and Wellbeing Board; Social Services; University of Greenwich; Staff representatives and the chair of the Trust's Volunteers.

The Council holds quarterly meetings, the first of which took place in October 2017.

Summary of Quality Account

A Quality Account is intended to aid public understanding of what the organisation is doing well, where improvements in service quality are required, what the priorities for improvement are in the coming year and how the organisation has involved service users, staff and others with an interest in the organisation in determining those priorities for improvement. A summary of the Trust's Quality Account for 2017-18 is contained below. The full Quality Account for 2017-18, will be posted on the Trust's website (www.dvh.nhs.uk) and the Trust's pages on the NHS Choices website (www.nhs.uk).

The priorities set out in the Quality Account have continued to develop the standards of patient care provided by the Trust. The Trust has continued work to reduce the number of Methicillin-Resistant Staphylococcus Aureus (MRSA) bloodstream infections in 2017/18. The Trust has had six cases this year and one case where the blood culture was contaminated. For C.difficile cases the Trust has also achieved the national target with 15 cases against a target of 24. Health care acquired infections will continue to be a priority for 2018/19 and the Trust will work to reduce Gram negative bacteraemia by 50% by 2020/21.

The adoption of National Safety Standards for Invasive Procedures (NatSSIPs) has also been a Trust priority for 2017/18. This standard recognises that surgical 'never events' may occur in clinical settings where invasive procedures take place and seeks to broaden safeguards by introducing standards which build on the approach of the World Health Organisation (WHO) Surgical Safety Checklist. The Trust is close to declaring compliance and will then have achieved this priority.

The Trust has achieved the objective of being able to demonstrate effective learning from patient safety incidents. The implementation of action plans developed following an incident are monitored by the Trust's Patient Safety Committee and changes have included a new emergency call system in the birth centre, revisions to the handover process for the medical team on the Acute Medicine Unit and new

pre-operative guidance for patients taking anticoagulation medication.

We have focussed on improving patient experience in 2017/18 with three priorities which seek to understand what it is like to be a patient using our Trust services. We said we would improve patients' awareness of the discharge planning process and that we would make better use of responses to the Friends and Family survey. Themes for action would then form part of the information included on ward boards. All Trust wards and many departments in the Trust now have display boards making this information accessible to patients and their families.

In 2016/17 the Trust had a priority about including patient input in designing the care pathways in our Vanguard project working with Guy's and St Thomas' NHS Foundation Trust. We have continued this priority seeking feedback from patients about their experiences when using those pathways. In July 2017, the two trusts held a Celebration and Showcase event at which patients described the benefits of having specialist care closer to home. We have committed to work with Guy's and St Thomas' NHS Foundation Trust in the GSTT Alliance in identifying and developing models of care and better ways of working together.

For our three clinical effectiveness priorities, we said we would, (a) improve the management of sepsis in the Emergency Department; (b) audit the effectiveness of adoption of the National Early Warning System (NEWS) in the Trust wide Vital Signs Nursing Audit; and (c) improve mandatory training rates across the Trust using the Trust metric of an 85% compliance rate in directorates and departments. The Trust has seen improvements in each of these areas and expects to achieve the sepsis priority and the mandatory training priority. The response in the 2017 Vital Signs audit was disappointing in the improvement shown and whilst actions have been put in place to improve the audit outcomes we do not anticipate achieving this priority. The Quality Account lists all of the national audits in which Trust staff and departments have participated. These national audits are important because the audit outcomes provide a picture of clinical care, both locally and across the NHS. When each National Clinical Audit Report is produced, the outcomes are reviewed within the Trust to see how we benchmark against the national picture and to identify any improvements which can be made.

The Trust Board takes a direct interest in the experiences of patients who use our services. Every other month, a patient attends the Trust Board and tells us about their experiences at one of our hospitals. These patient stories are both positive and negative and we continue to learn from both.

The Quality Account also details the priorities the Trust has set for 2018/19. To agree these priorities the Trust Board takes into account feedback on the experience of service users, including complaints received. In addition, whilst the outcomes of clinical audits identify areas where the Trust is doing well, audit also flags up areas where improvement is required and this is reflected in the priorities set for next year.

The Trust has set the following priorities for 2018/19 under the headings: Patient Safety, Patient Experience and Clinical Effectiveness.

Patient Safety

- Reduce the numbers of Health Care Associated Infections (HCAI) and agree a trajectory for reductions in gram negative bacteraemia
- Increase levels of training for Safeguarding and Mental Capacity Act
- Replace Midwives in obstetric theatres

Patient Experience

- Privacy and Dignity - reducing the numbers of mixed sex breaches
- Improving response times to patient calls to appointments in the Outpatient Department
- Increasing use of the Birth Centre in line with our patient experience and engagement strategy

Clinical Effectiveness

- Evaluating patient outcomes from Proactive Care for Older People Undergoing Surgery (POPS) project
- Reduce mortality for fractured neck of femur
- Workforce – Engage with our staff about our governance and structures to enable better engagement and understanding

Safer Staffing reviews will continue to take place annually and together with e-rostering, the Trust is better able to scrutinise and plan its workforce, reducing reliance on agency staff. The Trust reports daily staffing levels on Ward Quality Boards and monthly reports on the website.

Financial Performance 2017/18

The Trust ended the year with a £15.8m deficit against the control total plan of £1.6m surplus.

The Trust's Statutory and Department of Health Financial Duties

As an NHS Trust, the organisation has a number of statutory and Department of Health financial duties, which are explained below.

Breakeven duty

The statutory breakeven duty is formally measured over a three year period or a five year period, if agreed with NHS Improvement. The Trust has agreed a 5 year period. The requirement is to achieve breakeven on an Income and Expenditure basis within an allowable tolerance of 0.5% of turnover. In 2017/18, the Trust reported a £12.1m deficit against the breakeven duty. This resulted in a cumulative deficit position of £14.3m, 5.6% of turnover. The in-year breakeven duty deficit is different to the deficit reported against the control total for CQUIN risk reserve of £1.0m and the IFRS impact of reporting PFI "on balance sheet" of £2.7m.

Capital Cost Absorption Duty

The Trust is required to achieve a Department of Health target rate of return on capital employed of 3.5%. The Trust achieved this target in 2017/18.

External Finance Limit (EFL)

The Trust is required to demonstrate that it has managed its cash resources effectively by staying below an agreed limit on the amount of cash drawn from the Department of Health. The Trust delivered its £16.5m EFL.

Capital Resource Limit (CRL)

The Trust is expected to manage its capital expenditure within its agreed CRL. The Trust delivered £8.2m of capital expenditure, which equals its agreed internal capital programme as reported to the Trust Board and NHS Improvement. The CRL of £8.4m was undershot by £0.4m after adjustments for donated assets and asset disposals were taken into account. The undershoot has occurred as the CRL limit set was not adjusted for lower than planned depreciation funding in year.

Better Payment Practice Code (BPPC)

The Trust is required to pay its suppliers promptly in accordance with the Confederation of British Industry's BPPC and has also signed up to the Prompt Payments code. This requires the Trust to aim to pay all undisputed invoices by the due date or within 30 days of receipt of goods or a valid invoice, whichever is later. The Trust performance, against the BPPC target by value of 95%, was 73%, compared to last financial year of 75%. 81% of its trade suppliers were paid within terms this year, compared to 82% last year.

Emergency Preparedness

The Emergency Preparedness, Resilience and Response (EPRR) landscape in 2017 was dominated by the terrorist incidents in London and Manchester as well as the fire at Grenfell Towers. Whilst, the Trust did not respond to these incidents, the rise in the UK Terror Threat Level and learning from these incidents has driven work streams within EPRR and have been incorporated into resilience planning.

Alongside this the normal regime of training and exercising has been maintained. This year the Trust has carried out a variety of exercises including cyber security, missing vulnerable persons, lockdown and infant abduction, as well as taking part in multi-agency exercises in Kent and Bexley.

Emergency Resilience training is now mandatory for senior nursing, midwifery and allied health professionals, as well as for Consultants.

In June 2017 Darent Valley Hospital was stood up to receive casualties from a fire in a local care facility. Whilst the number of casualties was relatively low, the act of declaring a live major incident allowed staff to activate protocols and plans which have not been used in anger for some years. The learning from this incident was identified and incorporated into training and delivery plans.

Challenges through the year have been predominantly involving business continuity impacted by telecommunications failures, inclement weather and burst water pipes.

NHS England annual EPRR Assurance outcome for 2017 rated the Trust as “Fully Compliant” against the Core Standards for EPRR.

Looking forward to 2018/2019, there will be a continued focus on business continuity contingencies particularly in relation to estates and critical infrastructure as well as exercises in fire, medical gas failure and decontamination.

Sustainability Report

Introduction

Sustainability at the Dartford and Gravesham NHS Trust has continued to be driven at the Trust in 2017/18 through life-cycle projects and developing the energy centre asset utilisation.

The team’s efforts for 2016/17 earned the Trust nationwide recognition with a 2016 NHS Sustainability Award. It has been a year of further planning and consolidation on last year’s efforts, seeking funding for further energy saving schemes and activities.

All NHS organisations have an obligation to work in a way that has a positive effect on the communities they serve. Sustainability means spending public money well, the smart and efficient use of natural resources and building healthy, resilient communities. By making the most of social, environmental and economic assets, we can improve health, both in the immediate and long term even in the context of rising cost of natural resources. We can reduce these costs and effects by using environmentally friendly solutions. Demonstrating that we consider the social and environmental impacts ensures that the legal requirements in the Public Services (Social Value) Act (2012) are met.

In order to fulfil our responsibilities for the role we play, Dartford and Gravesham NHS Trust continues to have the following sustainability mission statement set out in our Sustainability Policy.

Dartford and Gravesham NHS Trust is focused on improving environmental sustainability including:

- Carbon emissions reduction
- Minimising usage of natural resources
- Preparing the Trust for extreme weather events
- Preparing communities for extreme weather events
- Promoting healthy lifestyles and environments
- QIPP efficiency savings which don’t relate to in scope activities
- Clinical and care models.

As a part of the NHS, public health and social care system, we recognise our duty to contribute towards the ambition set in 2014 of reducing the carbon footprint of the NHS, public health and social care system by 34% (from a 1990 baseline). This is equivalent to a 28% reduction from a 2013 baseline by 2020.

In 2017/18 the Trust continued to achieve this goal by further reducing our CO2 by 1000 tonnes and our aim is to supersede this target by reducing our carbon emissions by 47% by 2025 using 2010/11 as the baseline year.

Policies

One of the ways in which an organisation can embed sustainability is through the use of a Sustainable Development Management Plan (SDMP) The SDMP for the Trust is in the process of being updated and will be completed in mid-2018.

The Trust will re-establish the Sustainability Group through 2018, engaging staff and arranging appropriate events to ensure all teams in the Trust work together to achieve our sustainability plan.

Climate change brings new challenges in relation to the healthcare estate, but also to patient health. Examples of recent years include the effects of heat waves, extreme temperatures and prolonged periods of cold, floods, droughts etc.

The Trust recognises its responsibility in this area and continues to invest in sustainability schemes with the improvement of the Combined Heat and Power Plant (CHP) to enable it to run more efficiently through best practice. In addition, the Trust is investing in low energy lighting in all capital schemes. The Trust has also allocated separate funds for LED lighting in existing areas to push the low energy lighting project forward in 2018/19. In 2018/19 it is planned to investigate the use of absorption chilling systems in the Trust, which could use the waste heat from the CHP plant during the late spring, summer and early autumn seasons, and its funding.

In relation to behavioural change, the Trust is engaging the company Low Carbon Europe Ltd again after tendering for the support the Trust feels it needs to keep the strategy on track and enhance the work done in the previous year.

Partnerships

The NHS policy framework requires commissioners and providers to operate in a sustainable manner. To support the Trust in meeting its commitment, the following partnerships are in place with the following organisations: Low Carbon Europe Ltd, The Carbon Energy Fund, Carbon Architecture, Energ, Centrica and Salix.

Overall Strategy

The Carbon Management Plan (CMP) and Sustainable Development Management Plan (SDMP) together with the Green Travel Plan will all be reviewed and refreshed throughout 2018. Together these plans have helped form an overall sustainability strategy for the Trust, known as the Sustainability Policy and we will look now to further develop the Policy based on current initiatives and our future plans.
To achieve our sustainability commitments, we have developed and implemented a high level plan which has seven strategic objectives to deliver the emissions reductions. This high level plan table summarises how the seven strategic projects will impact specific carbon emissions of the site (kgCO2/m2 of floor area) over the next 2 years and for the estates capital build programme over a ten year period. The projects can be split into those which reduce emissions in energy supply and those which reduce the end usage of energy.

Trust size

To provide some organisational context, the table below for floor space and staff numbers, may help explain how both the organisation and its performance on sustainability has changed over time.

Energy

The section below looks at the Trust's overall carbon emissions and total energy spent. This provides a high level view of how the Trust is performing in relation to carbon emissions.

The Trust has spent £1,026k on energy in 2017/18. This represents an increase of approximately 20% on the previous year. The primary reason for this change is due to a price increase in the tariff and the energy centre using more gas due to the boilers being used more due to the very cold winter.

As is evident from the Carbon Emission table below, there has been a saving of 2,209 tonnes CO2 in carbon emissions, annually since the CHP was commissioned in 2015/16, resulting from this change in primary energy sourcing (i.e. from Grid to local, CHP generated electricity).

Figure 1: Carbon reduction plan

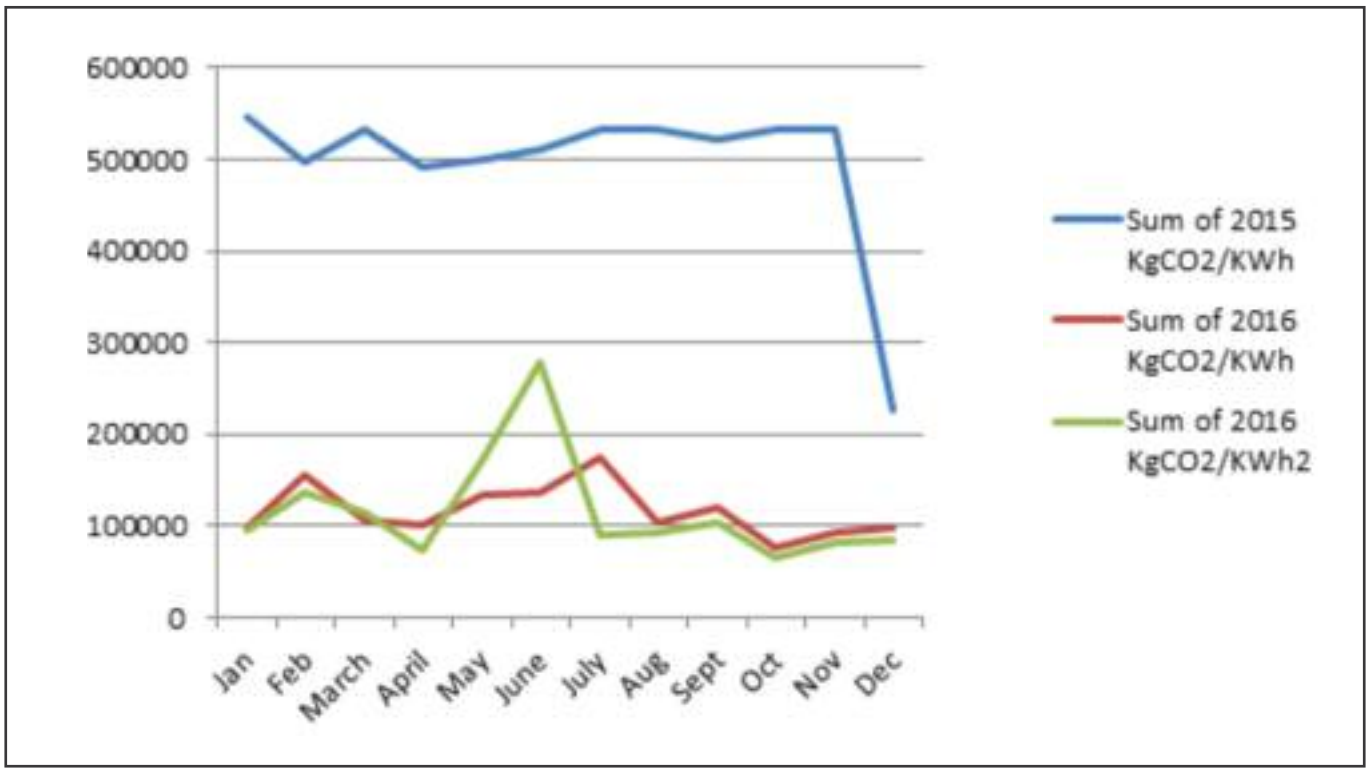
Action	Benefit %CO2 /m2	2014/15	2015/16	2016/17	2017/18	2018/19	6-10 Yrs
Estate Capital Building	0.8%		-0.5%	0%	0%	0.9%	0.4%
CHP	27%		25.0%		2%		
Staff Engagement	3%		1.5%		1.5%		
Air Handling	3%		3.0%				
Lighting Upgrade	4%			2.5%	1.5%		
Renewable Energy sources	6%					6%	
Work stream Annual Plans	5.2%		1.3%	1.3%	1.3%	1.3%	
Total	49%	0%	30.3%	3.8%	6.3%	8.2%	0.4%

Context info	2013/14	2014/15	2015/16	2016/17	2017/18
Floor Space (m^2)	59,238	59,238	63,932	64,319	64,319
Number of Staff	2,911	3,036	3,156	3,2281	3367

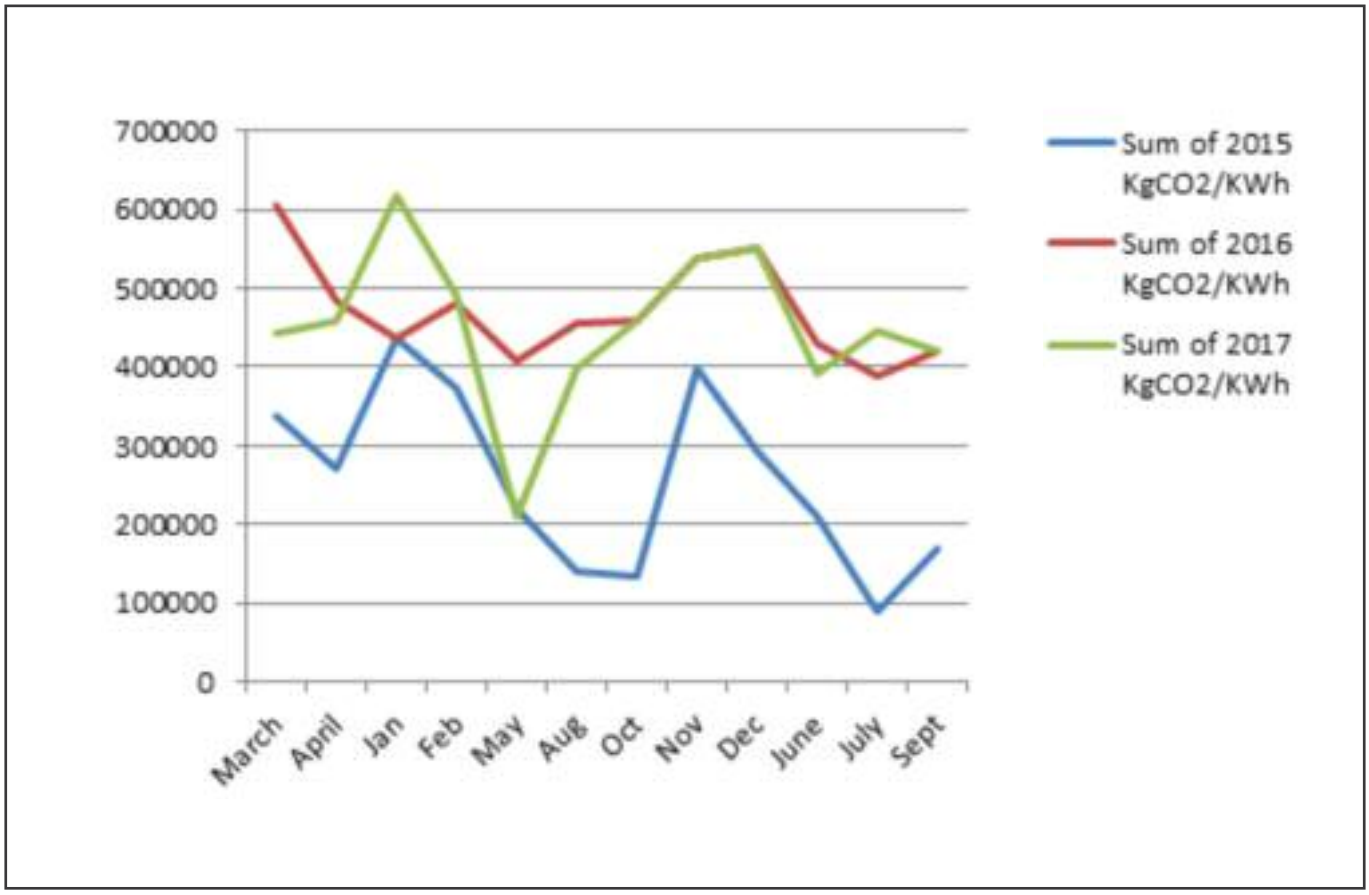
The following 2 graphs represent the changes since the CHP was commissioned in December 2015.

The table shows the detail on the usage and expenditure of each energy type. The Trust will continue to focus on improving its energy consumption, and consequential carbon emissions production through the active investment in the energy savings schemes and in working with staff to encourage behavioural change.

Reflects number of staff on payroll at month 12



Site carbon for mains electricity KgCO2/KWh



Resource		2013/14	2014/15	2015/16	2016/17	2017/18
Gas	Use (kWh)	16,685,620	15,226,049	19,670,516	31,872,195	29560442
	tCO_2e	3,540	3,194	4,117	6,661	5427
Oil	Use (kWh)	584,500	1,385,779	876,750	844,676	768642
	tCO_2e	187	443	280	268	245
Coal	Use (kWh)	0	0	0	0	0
	tCO_2e	0	0	0	0	0
	Use (kWh)	11,965,067	12,102,143	9,327,303	2,747,343	2655007
	tCO_2e	6,699	7,495	5,362	1,420	1392
Green Electricity	Use (kWh)	0	0	0	0	0
	tCO_2e	0	0	0	0	0
Total Energy CO_2e		10,425	11,133	9,759	8,349	7064
Total Energy Spend		£1,463,092	£1,433,889	£1,196,166	£850,172	£1,026,416

Travel

The Trust supports a culture for active travel to improve staff well-being and reduce sickness. Air pollution, accidents and noise all cause health problems for our local population, patients, staff and visitors and are caused by cars, as well as other forms of transport.

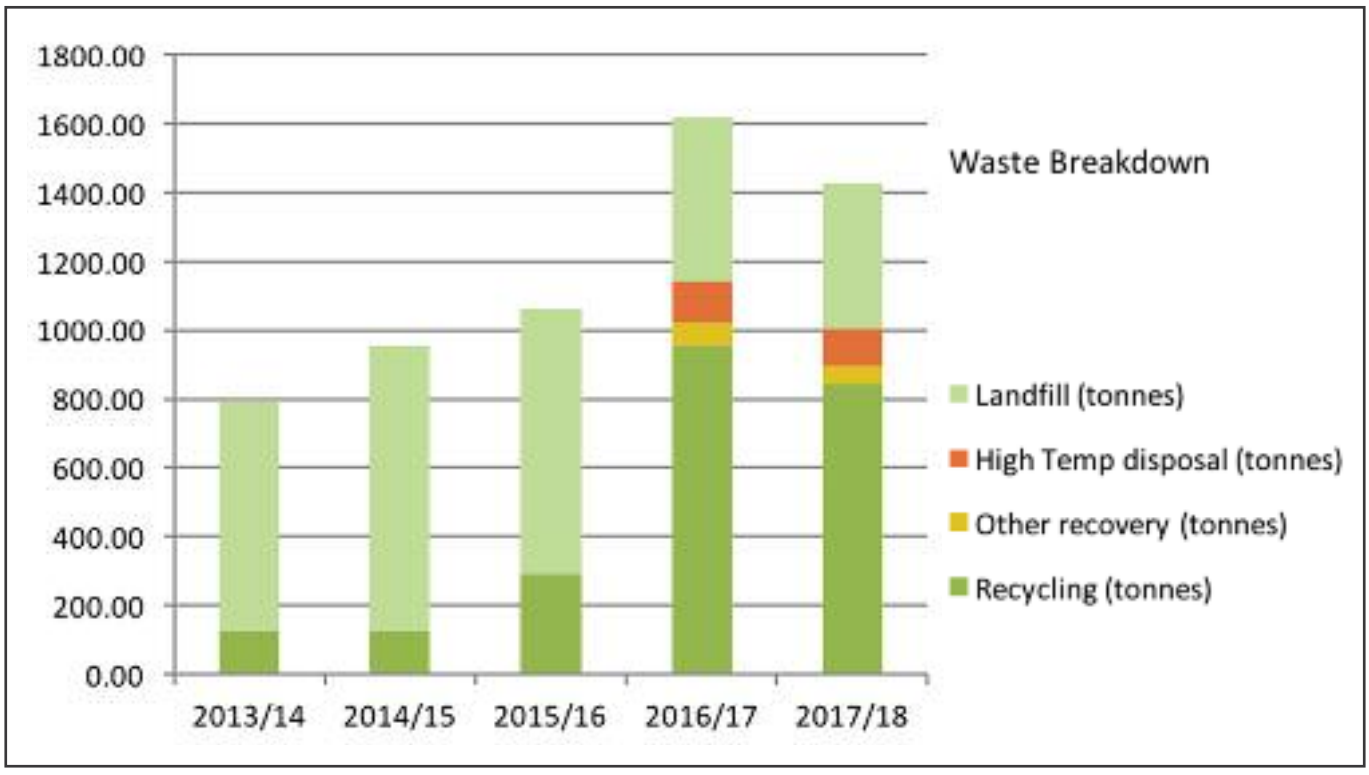
To promote alternate access options to the site, the Trust is actively working with the local bus company and is looking to agree a travel permit for staff. This will both reduce the impact of cars on the road but also benefit the site from less congestion and improving access for patients.

Category	Mode	2013/14	2014/15	2015/16	2016/17	2017/18
Business Travel and fleet	miles	361,349	0	0	1,000	436,199
	tCO_2e	133.51	745.79	762.56	0.36	136.81
Staff commute	miles	2,672,669	2,916,435	3,031,709	3,073,976	3,222,872
	tCO_2e	987.48	1,071.58	1,096.37	1,110.97	1,148.00

Waste

The Trust is aware of the importance of reducing waste. The treatment and classification of waste within the NHS monitoring process has been updated and therefore comparison to previous years is difficult.

However, considering the updated reporting process, as is evident from the graph below, the Trust is continuing to promote and ensure the use of the recycling stream, which is now more clearly separated and reported in the information returns.



Waste		2013/14	2014/15	2015/16	2016/17	2017/18
Recycling	(tonnes)	127.00	126.00	288.50	955.00	840.90
	tCO_2e	2.67	2.65	5.77	20.06	16.82
Other recovery	(tonnes)	0.00	0.00	0.00	65.00	53.8
	tCO_2e	0.00	0.00	0.00	1.37	1.08
High Temp disposal	(tonnes)	0.00	0.00	0.00	121.00	107.8
	tCO_2e	0.00	0.00	0.00	26.50	23.61
Landfill	(tonnes)	661.00	827.00	773.50	476.00	425.00
	tCO_2e	161.56	202.13	189.06	147.56	103.88
Total Waste (tonnes)		788.00	953.00	1062.00	1617.00	1427.50
% Recycled or Re-used		16%	13%	27%	59%	59%
Total Waste tCO_2e		164.23	204.78	194.83	195.48	145.38

Water Consumption

The table below shows the volume of water the Trust used compared to previous years. The Trust is committed to reducing its overall water spend and will continue to investigate saving opportunities. There is of course a balance to be maintained as the increase in water usage reflects the focus on ensuring water-borne pathogens are flushed.

Water		2013/14	2014/15	2015/16	2016/17	2017/18
Mains	m^3	109,274	83,687	105,729	87,4921	164,941
	tCO_2e	100	76	96	80	150
Water and Sewage Spend		£250,634	£1,665,455	£234,437	£203,415	£233,312

Conclusion

As noted, the Trust is committed to implementing a sustainable agenda in all areas of the Trust's operations. This has been evidenced in the awards won and short-listed for in previous years.

The Trust continues to commit capital resources to the sustainability agenda as well as encourage the Sustainability Group to influence behavioural change.

Annual Plan

The Annual Plan for 2018/19 continues the focus on the need to deliver safe patient care both in terms of human resource and physical capacity, whilst supporting the ambition for more local care.

The plan supports the delivery of modern care in the right setting enabled by partnership working, digital innovations and a sustainable workforce.

To ensure the services can be delivered in line with the NHS's constitutional standards and meet the needs of existing and future clinical capacity requirements we will be continuing with initiatives begun in 2017/18 and commencing the following:

- Implementation of the CQC Improvement Plan which includes holding ourselves and others to account and a review of our Governance
- Stroke - strategic aim for Darent Valley Hospital to become one of three Kent HASU/ASU stroke centres
- Alliance Model (with GSTT) – from April 2018 the Trust becomes a founding member of the Alliance model, taking forward aspects of the Vanguard work as business as usual
- Ebbsfleet Health Education and Innovation Quarter (HEIQ) – development of the strategic feasibility case to deliver a Health and Well-Being Hub, a Regional Diagnostic Centre, a health focussed Multi-Professional Education Centre and an Innovation Centre.
  All co-located directly adjacent to Ebbsfleet International Station
- Ebbsfleet Healthy New Town 5G Test Bed Bid to explore benefits of 5G technology in healthcare to keep patients healthier and in their own homes for longer
- Work towards a Primary and Acute Collaboration with local GP federation
- Transformational Plans to deliver financial balance

Annual Plan on a Page

2018/19

NHS
Dartford and Gravesham
NHS Trust

OUR VALUES

Care with compassion | Respect and dignity | Striving to excel | Professional standards | Working together

'Our Family, Caring For Yours'

OUR OBJECTIVES

Excellent Quality and Safety of Care for Patients

- Keeping the patient at the heart of all we do
- Use patient experience and feedback to transform services
- CQC Improvement Plan for sustainable and continuous improvements
- Measure what we do, reduce variation and share best practice
- Learn without blame to drive down healthcare-related harm and deliver high quality key access and performance targets
- Deliver key access and performance targets

Embedding Clinical and Organisational Strategy

- Delivering care to patients in the right, at the right time, by the right person
- Become one of the three Stroke HASU/ASU in Kent
- Support delivery of Local Care
- Champion health needs in Ebbsfleet Garden City
- Embed digital and other technology to transform patient experience and staff working
- Support and promote research and innovation
- Evolve the Group Model as part of the GSTT Alliance
- Develop a Primary Acute Care System
- Planned Care and QMH as preferred choice for elective

Promoting Excellent Workforce

- Living Trust values and behaviors
- Balance workforce demand with supply, adopting innovative solutions where required
- Improved recruitment and retention in hard to fill areas
- Provide an excellent education experience
- Encourage clinical staff to take on senior leadership roles
- Continue to develop multi-disciplinary learning
- Encourage leadership through training and support
- All staff receive appraisals, a PDF and eductional support

Living within our Budget

- Meet our board-approved Financial Plan
- Contribute to the achievement of financial requirements in Sustainability and Transformation Plans (STPs)
- Harness opportunities for joint working with partners to make best use of resources
- Maximise productivity and efficency in line with National and Local benchmarks

Section B:

Accountability Report

CORPORATE GOVERNANCE REPORT

Directors' Report

The Trust Board and Sub-Committees

The Trust Board meets on a monthly basis. The role of the Trust Board is to determine the strategic direction of the Trust, to monitor in-year performance against its plans and ensure that the affairs of the Trust are well-managed. The Trust Board operates in accordance with Standing Orders, Standing Financial Instructions, Scheme of Matters Reserved for the Board and Scheme of Delegation.

The Trust Board comprises a Chairman and five Non-Executive Directors, appointed by the Secretary of State via NHS Improvement, and seven Executive Directors (only five of whom have voting rights), led by the Chief Executive. The Non-Executive Directors bring a range of skills and expertise from outside the Trust. Their role is to hold Executive Directors to account.

The Trust Board meets monthly, in public. The dates, times and venues are advertised in the Trust's main offices at Darent Valley Hospital and on the Trust's website (www.dvh.nhs.uk). The agenda and papers for the public sessions are also made available on the Trust's website.

Trust Board membership as at year-end is shown on the page 29 along with Trust Board attendance.

	APR	MAY	JUNE	JULY	AUG	SEPT	OCT	NOV	DEC	JAN	FEB	MAR
Susan Acott (left 16/10/17)	✓	✓	✓	✓		✓						
Gerard Sammon	✓	✓	✓	✓		✓	✓	✓	✓	✓	✓	✓
Steve Fenlon	✓	✓	✓	✓		✓	A	✓	✓	✓	✓	✓
Lorraine Clegg	✓	✓	✓	✓		✓	A	✓	✓	✓	✓	✓
Pam Dhesi	✓	✓	✓	✓		✓	✓	✓	✓	✓	✓	✓
Vikki Leivers-Carruth (left 30/9/17)	✓	✓	✓	✓		A						
Siobhan Callanan (joined 1/10/17)							✓	✓	✓	✓	✓	✓
Andy Brown	✓	✓	✓	✓		✓	A	✓	✓	✓	✓	✓
Leslieann Osborne (Joined 1/10/17)	-	-	-	-		-	✓	✓	A	✓	A	✓
Steve Wilmshurst	✓	✓	A	✓		✓	A	✓	✓	✓	✓	✓
David Warwick	✓	✓	✓	✓		✓	✓	✓	✓	✓	✓	✓
David Findley (left 31/12/17)	✓	✓	✓	A		✓	✓	✓	✓			
Karen Taylor	✓	✓	A	A		✓	✓	✓ Chair	✓	A	✓	✓
Peter Coles	✓ Chair	✓ Chair	✓ Chair	✓ Chair		✓ Chair	✓ Chair	A	✓ Chair	✓ Chair	✓ Chair	✓ Chair
Gill Jenner (joined 1/9/17)						✓	✓	✓	✓	A	✓	✓
Lynn Gladwell (joined 1/9/17)						✓	✓	✓	A	✓	✓	A

Note 'A' in the table above denotes apologies for absence.

During the year 2017/18 there were a number of changes to membership of the Trust Board. The changes are detailed below:

Chief Executive Officer

Susan Acott was seconded to East Kent Hospital Trust on 16th October 2017 and continues to be replaced by Gerard Sammon in an interim position.

Deputy Chief Executive Officer

Gerard Sammon assumed the role of Interim Chief Executive Officer on 16th October 2018 and Dr Stephen Fenlon acts as Deputy Chief Executive in addition to his position as Medical Director

Director of Strategy and Planning

Gerard Sammon assumed the role of Interim Chief Executive Officer on 16th October 2017 and Leslieann Osborn continues to act as an interim in this position. She also continues with the performance monitoring.

Director of Nursing and Quality

Vikki Leivers-Carruth left the Trust on 1st October 2017 and was replaced by Siobhan Callanan on 2nd October 2017.

Non-Executive Directors

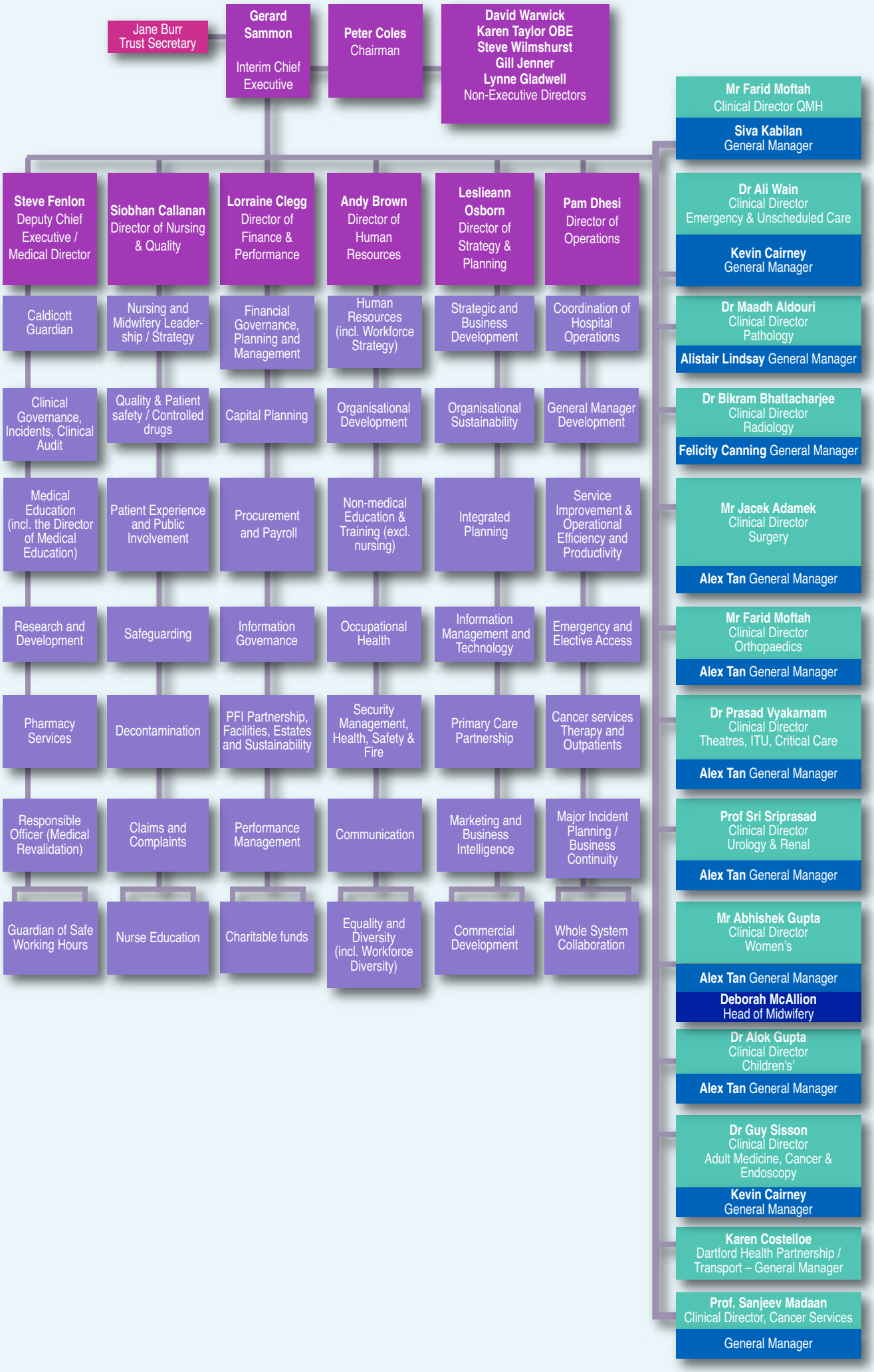
David Findley retired from his position on 31st December 2017 and was replaced by Dr Gill Jenner, who was previously an associate Non-Executive Director.

Lynn Gladwell was appointed as Non-Executive Director on 1st September 2017 as a replacement for Peter Coles who assumed position as Trust Chairman on 1st April 2017, there was no interim appointment for this position.

Management Structure

An executive management team supports the Chief Executive in managing the Trust, with each director holding a portfolio of responsibilities. The organisation is structured into a number of corporate and clinical directorates. Corporate departments are each responsible to an Executive Director and each clinical area has a designated Clinical Director and General Manager, accountable to the Chief Executive and Director of Operations respectively.

The organisational chart is on page 31.


Jane Burr
Trust Secretary
Gerard Sammon
Interim Chief Executive
Peter Coles
Chairman
David Warwick
Karen Taylor OBE
Steve Wilmshurst
Gill Jenner
Lynne Gladwell
Non-Executive Directors
Steve Fenlon
Deputy Chief Executive / Medical Director
Siobhan Callanan
Director of Nursing & Quality
Lorraine Clegg
Director of Finance & Performance
Andy Brown
Director of Human Resources
Leslieann Osborn
Director of Strategy & Planning
Pam Dhesi
Director of Operations
Caldicott Guardian
Nursing and Midwifery Leader-ship / Strategy
Financial Governance, Planning and Management
Human Resources (incl. Workforce Strategy)
Strategic and Business Development
Coordination of Hospital Operations
Clinical Governance, Incidents, Clinical Audit
Quality & Patient safety / Controlled drugs
Capital Planning
Organisational Development
Organisational Sustainability
General Manager Development
Medical Education (incl. the Director of Medical Education)
Patient Experience and Public Involvement
Procurement and Payroll
Non-medical Education & Training (excl. nursing)
Integrated Planning
Service Improvement & Operational Efficiency and Productivity
Research and Development
Safeguarding
Information Governance
Occupational Health
Information Management and Technology
Emergency and Elective Access
Pharmacy Services
Decontamination
PFI Partnership, Facilities, Estates and Sustainability
Security Management, Health, Safety & Fire
Primary Care Partnership
Cancer services Therapy and Outpatients
Responsible Officer (Medical Revalidation)
Claims and Complaints
Performance Management
Communication
Marketing and Business Intelligence
Major Incident Planning / Business Continuity
Guardian of Safe Working Hours
Nurse Education
Charitable funds
Equality and Diversity (incl. Workforce Diversity)
Commercial Development
Whole System Collaboration
Mr Farid Moftah
Clinical Director QMH
Siva Kabilan
General Manager
Dr Ali Wain
Clinical Director
Emergency & Unscheduled Care
Kevin Cairney
General Manager
Dr Maadh Aldouri
Clinical Director
Pathology
Alistair Lindsay General Manager
Dr Bikram Bhattacharjee
Clinical Director
Radiology
Felicity Canning General Manager
Mr Jacek Adamek
Clinical Director
Surgery
Alex Tan General Manager
Mr Farid Moftah
Clinical Director
Orthopaedics
Alex Tan General Manager
Dr Prasad Vyakarnam
Clinical Director
Theatres, ITU, Critical Care
Alex Tan General Manager
Prof Sri Sriprasad
Clinical Director
Urology & Renal
Alex Tan General Manager
Mr Abhishek Gupta
Clinical Director
Women's
Alex Tan General Manager
Deborah McAllion
Head of Midwifery
Dr Alok Gupta
Clinical Director
Children's'
Alex Tan General Manager
Dr Guy Sisson
Clinical Director
Adult Medicine, Cancer & Endoscopy
Kevin Cairney
General Manager
Karen Costelloe
Dartford Health Partnership / Transport – General Manager
Prof. Sanjeev Madaan
Clinical Director, Cancer Services
General Manager

The Trust Board has established seven sub-committees to assist it in meeting its role and duties. The functions of the committees are outlined below:

The Audit Committee - supports the Trust Board in its responsibility to maintain the highest standards of conduct and accountability for its use of public funds by providing assurance on the Trust's internal financial controls and compliance with accounting and statutory standards. The Audit Committee meets every two months and membership consists of five Non-Executive Directors. The members during 2017/18 were:

- Karen Taylor (Committee Chairman)
- David Warwick
- Steve Wilmshurst
- David Findley (Until 31st December 2017)
- Dr Gill Jenner (From 1st January 2018)
- Lynn Gladwell (From 1st September 2017)

The Director of Finance and the Trust Secretary attend meetings, together with Internal and External Auditors and other executive directors of the Trust as required. The Chairman of the Committee presents the minutes of each Audit Committee meeting to the Trust Board. The Trust Board also receives an Annual Report of the Committee's activities, ahead of the Trust Board's consideration of the Annual Report and Accounts.

The Quality and Safety Committee - is accountable to the Trust Board for the consistent implementation of good systems of clinical governance, clinical effectiveness and risk within the Trust. It is the overarching Committee providing the Trust Board with assurance on all aspects of clinical practice. The Committee meets monthly and is chaired by a Non-Executive Director. Its membership includes a Non-Executive Director Chair, the Trust Chairman and officers ensuring a range of clinical and managerial expertise.

The Finance Committee - is responsible for ensuring the Trust has an appropriate financial strategy that monitors and scrutinises financial performance against plan. The Finance Committee is chaired by a Non-Executive Director and meets monthly. Membership comprises Non-Executive Directors, the Chief Executive and Director of Finance.

The Workforce Committee – the Workforce Committee oversees all aspects of the Trust's approach to its workforce – in particular workforce planning, organisational development, resourcing, deployment and talent development – ensuring these are aligned with the Trust's strategy and business plans. Membership of the Committee includes Non-Executive Directors, the Director of Human Resources and officers of the Trust, with the Chair being a Non-Executive Director.

The Partnership Board - is the forum where representatives from the Trust and its PFI partners (The Hospital Company [Dartford] Limited and Carillion Health) meet to discuss the strategic and operational development of the site and its services together with PFI contractual issues. The Partnership Board has a rolling chair between the Trust Chairman and the Chairman of The Hospital Company.

The Remuneration Committee - the Chairman and all Non-Executive Directors form the Remuneration Committee, which determines the rates of pay and contracts of the Executive Directors against a Department of Health framework. The Remuneration Committee is chaired by a Non-Executive Director of the Trust Board.

The Charitable Funds Committee - oversees the governance of Dartford and Gravesham NHS Trust Charitable Fund (working name Valley Hospital Charity) on behalf of the Trust Board (in accordance with the Trust's duties as sole Trustee of the Fund). The Committee is chaired by a Non-Executive Director. Membership comprises a Non-Executive Director Chair, the Chief Executive, Director of Finance and officers of the Trust.

Additional Disclosures

Pension Liabilities

The treatment of pension liabilities is as noted in the accounting policy note in the accounts and the remuneration report.

Directors' Interests

The Trust has a proactive process requiring directors to make an annual Declaration of Interests, which is recorded in the Register of Interests. The Trust Board and its sub-committees (as listed above) routinely ask for any conflicts of interests to be declared at the outset of each meeting, to capture any interests in respect of matters on the agenda. The Register of Interests is maintained by the Trust Secretary and is open to public inspection.

Cost allocation and charges for information

The Trust has complied with HM Treasury's guidance on setting charges for information, as set out in Appendix 6.2 to Treasury's 'Managing Public Money' guidance.

Serious untoward incidents involving data loss or confidentiality breaches

The Trust has undertaken a more positive and pro-active approach to information governance incidents and the shared learning from such. As a result, the Trust has had six (with a potential further one) Information Governance Serious Incidents Requiring Investigation (IG SIRIs) that have been reported to the Information Commissioner's Office (ICO) during 2017/18.

The notifiable interests of Trust Board members in 2017/18 are set out below:

Director	Details of notifiable interest
Peter Coles	• Managing Director, Peter Coles Consulting Ltd (provides consultancy services to the NHS). • His wife has her own consultancy business, Sara Coles Ltd, which provides services to the NHS
Karen Taylor OBE	• Director of the Centre for Health Solutions at Deloitte LLP, since November 2011.
David Warwick	• Joint owner of Warwicks Ltd, a management and financial consultancy company.
Steve Wilmshurst	• Co-Director, Aviemore Associates Ltd, a quality assurance consultancy.
Lynn Gladwell	• Director UBB Waste (Essex) Ltd • Director UBB Waste (Essex) Holdings Ltd • Director UBB Waste (Essex) Intermediate Ltd • Director UK Power Networks Services Ltd • Director Power Asset Development Co Ltd • Director Consort Healthcare (Birmingham) Finding PLC • Director Consort Healthcare (Birmingham) Holdings Ltd • Director Consort Healthcare (Birmingham) Intermediate Ltd • Director Consort Healthcare (Birmingham) Ltd

Statement of the Directors' Responsibilities

Each Director confirms that as far as they are aware, there is no relevant audit information of which the Trust auditors are unaware, and they have taken all the steps they ought to have taken as a Director in order to make themselves aware of any relevant audit information and to establish that the Trust's auditors are aware of that information.

The ICO have not taken any further action for five of the incidents and the Trust is currently corresponding over one incident with the last incident still under investigation.

All incidents are regularly reported to the Trust's Information Governance Committee and the Trust has introduced an IG newsletter which is available to all staff. Details of the reported incidents are documented to improve the shared learning from the incidents across the Trust.

Summary of serious incidents requiring investigation involving personal data as reported to the Information Commissioner's Office in 2017-18				
Date of incident (month)	Nature of incident	Nature of data involved	Number of data subjects potentially affected	Notification steps
Jun-2017	Non-secure disposal of paperwork	Ward handover sheet found on the stairs of the main hospital building by a member of staff	32	Information Commissioner's Office (ICO)
Further action on information risk	Raised staff awareness of the need to dispose of such documentation in the confidential waste.			
Jun-2017	Non-secure disposal of paperwork	Ward handover sheet found in the hospital corridor by a member of staff	7	Information Commissioner's Office (ICO)
Further action on information risk	Raised staff awareness of the need to dispose of such documentation in the confidential waste.			
Jun-2017	Non-secure disposal of paperwork	An operating theatre list found within the hospital building by a member of the public	3	Information Commissioner's Office (ICO)
Further action on information risk	Communications plan to all staff in relation to secure transportation of patient details whilst within the hospital grounds.			
Jun-2017	Unauthorised Access/Disclosure	Email between staff where both parties were not using NHSmail	142	Information Commissioner's Office (ICO)
Further action on information risk	Urgent migration of all DVH email accounts to NHSmail; Policy review on Intranet and Email Usage Policy.			
Aug-2017	Non-secure disposal of paperwork	Ward handover sheet found in the hospital grounds by a member of staff	22	Information Commissioner's Office (ICO)
Further action on information risk	Communications plan to all staff in relation to secure and appropriate destruction of ward handover sheets.			
Aug-2017	Disclosed in error	Encounter report found on ward photocopier by a member of staff	1	Information Commissioner's Office

Continued

Summary of serious incidents requiring investigation involving personal data as reported to the Information Commissioner's Office in 2017-18				
Date of incident (month)	Nature of incident	Nature of data involved	Number of data subjects potentially affected	Notification steps
Further action on information risk	Review training staff awareness of 'locked print' functionality.			
Feb-2018	Disclosed in error	Ward handover sheet document left open on PC. Another staff member using PC saw the name of their friend and cancer diagnosis.	1	Information Commissioner's Office (ICO)
Further action on information risk	Incident still under investigation with the Information Commissioner's Office.			

Summary of other personal data related incidents in 2017/18		
Category	**Breach Type**	**Total**
A	Corruption or inability to recover electronic data	0
B	Disclosed in Error	24
C	Lost in Transit	0
D	Lost or stolen hardware	0
E	Lost or stolen paperwork	3
F	Non-secure Disposal – hardware	0
G	Non-secure Disposal – paperwork	8
H	Uploaded to website in error	1
I	Technical security failing (including hacking)	0
J	Unauthorised Access/Disclosure	5
K	Other	3

Fraud

The Trust has an Anti-fraud, Bribery and Corruption Policy and response plan to ensure that these matters are dealt with in a consistent and proper manner. This policy has been developed to take into account the requirements of the Bribery Act. The Director of Finance is the executive lead. As indicated in the Governance Statement the Trust engages external expertise in relation to counter fraud and the Audit Committee agrees an annual work plan and receives regular updates from the Counter Fraud Manager. The Audit Committee and Trust Board have also agreed a Bribery Statement setting out the Trust's position on this matter.

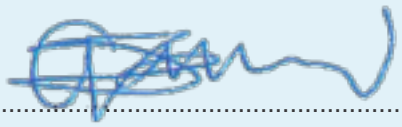
Statement of the Chief Executive's Responsibilities as The Accountable Officer for the Trust

The Trust Board is accountable for internal control. As Accountable Officer and Chief Executive, I have responsibility for maintaining a sound system of internal control and governance that supports the achievement of the organisation's policies, aims and objectives whilst safeguarding quality standards. I also have responsibility for safeguarding the public funds and the organisation's assets for which I am personally responsible, as set out in the Accountable Officer Memorandum.

To the best of my knowledge, there is no relevant audit information of which the auditors are unaware and I have taken all the steps that I ought to have in order to make myself aware of any relevant audit information and to establish that the auditors are aware of that information. I can confirm that the Annual Report and Accounts as a whole are fair, balanced and understandable. I take personal responsibility for the Annual Report and Accounts and the judgements required for determining that it is fair, balanced and understandable.

The financial statements have, to the best of my knowledge, been prepared appropriately.

To the best of my knowledge and belief, I have properly discharged the responsibilities set out in my letter of appointment as an Accountable Officer.

Signed:  Date: 18 May 2018

Gerard Sammon
Interim Chief Executive

Annual Governance Statement

Scope of responsibility

As Accountable Officer, I have responsibility for maintaining a sound system of internal control that supports the achievement of the NHS 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 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 Trust Accountable 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 Dartford and Gravesham NHS 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 Dartford and Gravesham NHS Trust for the year ended 31 March 2018 and up to the date of approval of the annual report and accounts.

Capacity to handle risk

All senior managers have risk management as a defined responsibility within their job descriptions and are active components of the risk and control framework. In addition, directorates and sub-specialities have identified clinical governance and risk leads. There is a forum for clinical governance and risk management within each directorate and the majority of clinical sub-specialties.

Staff receive training on the management of risk in the core induction (for new starters) and 'core skills', which is a two-yearly refresher that is mandatory for all staff. The Risk Management Strategy is available to staff via the Trust's intranet, together with a comprehensive range of other policies and guidance. This includes the procedures for incident reporting, managing complaints, risk assessment, investigation of incidents, health and safety, and 'being open' with staff and patients.

Additional advice on good practice can be obtained from a range of professional and specialist staff. The Trust has a Governance team whose remit includes clinical risk management, clinical governance (including clinical audit and effectiveness), complaints, the Patient Advice and Liaison Service (PALS) contacts, claims handling, and the management of all clinical and non-clinical incident reporting.

The risk and control framework

Risk assessment is a core aspect of the Trust's Risk Management Strategy. A comprehensive Risk Register is in place and consists of risks identified from across the organisation, at both corporate and directorate level. Within the Risk Register, an assessment is made of the level of current risk (based on a 5x5, likelihood x impact matrix), alongside details of the control measures required to mitigate the risk to the lowest practicable and/or acceptable level.

The management of corporate risks and/or those rated as 'high' is overseen by the Risk Register Committee which, in 2017/18, was initially chaired by the Trust Secretary and, from November 2017 onwards, by the Medical Director. All Executive Directors are members of the Risk Register Committee. The Committee meets monthly to consider progress with actions to mitigate existing risks, and consider the rating of newly-identified risks. The output of the Risk Register Committee's oversight is then received at both the Quality and Safety Committee and the Audit Committee, whose task is to consider whether the mitigating actions being taken are sufficient, in relation to the level of risk.

A number of new risks were identified in-year, but mitigated to an acceptable level. The risks rated as 'high' at the end of the 2017/18 year are described above.

Risk Identifer	Risk Title	Risk Score
1376	Insufficient Nursing Staff	4x4=16
1757	Performance of the ED - ability to manage the 4 hour target	4x4=16
1867	Medical staffing vacancy	4x4=16
1901	High bed occupancy	4x5=20
1986	Clinical coding	4x4=16
1978	Unsustainability of the GI bleed service	4x4=16

In addition to the Risk Register, the Trust has a Board Assurance Framework (BAF), which captures strategic risks to the achievement of the Trust's objectives. Each objective is led by an Executive Director, who has responsibility for managing the risks to its delivery. The BAF is maintained by the Trust Secretary and is updated regularly through detailed reviews with each lead director, prior to it being reported to the Audit Committee. The Audit Committee reviews the BAF at every meeting and also selects risks for detailed scrutiny. Directors attend the Audit Committee to explain in detail how the risks to the achievement of the relevant objective are being managed. The BAF is also reviewed by the Quality and Safety Committee and the Trust Board on a bi-monthly basis.

In March 2018 the Trust Board received a BAF report that outlined the areas where there are significant risks to achieving the organisation's objectives:

- The inability to maintain an appropriate level of admissions and discharges
- The achievement of the A&E performance trajectory
- Failure to deliver the financial plan
- Failure to achieve financial sustainability and meet statutory financial targets
- Capital resources not sufficient to meet Trust requirements
- Plans do not sufficiently reflect the required capacity to manage changes in population growth in housing
- Inability to maintain an appropriate level of infection controls and prevention of MRSA bacteraemia and other infections
- Current endoscopy suite lacks capacity to effectively meet demand
- CCGs may be unable to deliver their demand and capacity plans
- Financial uncertainty around Carillion
- The threat of cyber attacks
- CCGs continue to tender for services contrary to STP thinking
- CCGs do not align their plans for community services to the STP
- Failure to meet targets to improve access to and reporting in diagnostics
- Capacity in the health economy is insufficient to maintain and improve patient flows

The BAF was reviewed by internal audit in 2017/18 and was given a substantial assurance rating. Actions on the recommendations made by internal audit have already been put in place to ensure the assurance offered by the BAF is robust.

Reported incidents, including complaints, are managed via directorate governance meetings. More significant incidents are discussed and monitored at a corporate level by the Serious Incident Declaration Group held on a weekly basis and the Trust's Patient Safety Committee, which is accountable to the Quality and Safety Committee which ultimately reports to the Trust Board.

The Audit Committee receives a regular report on the outcome of external assessments and keeps a detailed log of these assessments. This includes inspections by regulatory bodies such as the Care Quality Commission, the Medicines and Healthcare Products Regulatory Agency, and the Health and Safety Executive, as well as accreditation and certification agencies such as the Clinical Pathology Accreditation. The report also includes details on the state of readiness for any upcoming external assessments. All assessments are available upon request from the Trust Secretary. This report is also submitted to the Quality and Safety Committee on a six-monthly basis.

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.

The Trust has undertaken risk assessments and Carbon Reduction Delivery Plans are in place in accordance with emergency preparedness and civil contingency requirements, as based on UKCIP 2009 weather projects, to ensure that this organisation's obligations under the Climate Change Act and the Adaptation Reporting requirements are complied with.

The governance framework is designed to manage risk to a reasonable level rather than to eliminate all risk of failure to achieve policies, aims and objectives, therefore the framework can only provide reasonable and not absolute assurance of effectiveness.

Governance and internal control of the organisation is an ongoing process designed to:

- Identify and prioritise the risks to the achievement of the policies, aims and objectives of Dartford and Gravesham NHS Trust.
- Evaluate the likelihood of those risks being realised and the impact should they be realised, and to manage them efficiently, effectively and economically.

The Trust Board meets monthly in public, and its agenda is focused around the key aspects of quality, productivity and innovation, assurance and strategy. A dynamic programme of agenda items is actively managed throughout the year to ensure the

Trust Board receives the information, and considers the matters it requires to perform its duties efficiently and effectively. A key tenet of the information the Trust Board receives each month is a comprehensive performance report, which contains up to date details of performance across a range of indicators. The Trust Board also undertook an assessment of its performance against the CQC well-led framework.

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

The Trust Board has established a number of sub-committees, outlined below, to support it in delivering its duties and responsibilities. Each sub-committee receives a set of regular reports, as outlined within their terms of reference and provides a summary to the Trust Board after each meeting. The importance of the triangulation of understanding, challenge and assurance between sub-committees is recognised and reflected through cross membership and reporting mechanisms. Attendance records are maintained for the Trust Board and its main sub-committees. The attendance record for the Trust Board is reported within the body of the Trust's Annual Report.

The Trust Board has agreed Terms of Reference of each of the sub-committees to ensure that the scope and coverage of each sub-committee is in accordance with the Trust Board's requirements. The Terms of Reference are reviewed and re-approved by the Trust Board annually.

- The Audit Committee provides assurance to the Trust Board in relation to the effectiveness of controls to minimise or mitigate the principal risks to the Trust and its regulatory compliance obligations.
- The Quality and Safety Committee has delegated authority to ensure the ongoing development and delivery of the Trust's objectives as they pertain to quality and safety.
- The Partnership Board, where representatives from the Trust, The Hospital Company (Dartford) Limited and Carillion Health (for 2017/18 – now Serco for 2018/19) meet to discuss the strategic and operational development of the site and its services together with PFI Contractual issues.
- The Finance Committee oversees the financial planning, monitoring and effective use of exchequer funds and to ensure there are appropriate policies and procedures in place.
- The Workforce Committee, established to oversee all aspects of the Trust's approach to its workforce.
- The Charitable Funds Committee oversees the governance of Dartford and Gravesham NHS Trust Charitable Fund on behalf of the Trust Board.
- The Remuneration Committee sets appropriate remuneration and terms of service for the Chief Executive, other Executive Directors, and other senior employees.

The Board receives the minutes and/or a report from each meeting of the aforementioned sub-committees in a timely manner, from the Chairman of each sub-committee. This ensures that any issues of concern requiring escalation to the Trust Board are highlighted. The scheduling of key meetings enables

Board/ Sub-Committee	Average Attendance of Members 2017/18
Trust Board	86%
Audit Committee	70%
Quality and Safety Committee	77%
Partnership Board	82%
Finance Committee	82%
Workforce Committee	73%
Charitable Funds Committee	78%
Remuneration Committee	72%

escalation to take place promptly, if required. For example, the Finance Committee is scheduled to meet two days before the Trust Board; the Quality and Safety Committee one week before the Trust Board; and the Audit Committee two weeks before the Trust Board. In accordance with national guidance, the Audit Committee produces an annual report of its activities, which it also submits to the Trust Board. In addition, the Audit Committee undergoes a full self-assessment and the Trust Board uses the Audit Committee Annual Report as part of its assurances prior to it approving the Trust's Annual Report and Accounts.

In addition to the above sub-committees, there are a range of other committees, structures and processes in place to oversee and manage any issues relevant to particular aspects of risk and governance. In this respect the Trust has, for example, an Infection Control Committee, a Patient Safety Committee, a Health and Safety Committee, a Resuscitation Committee, a Medicines Management Committee, a Safeguarding Committee and a Patient Experience Committee. Details of the Trust's full committee structure can be obtained from the Trust's website (www.dvh.nhs.uk).

The Trust has in place Regulation 5 – Fit and Proper Persons Requirement; Directors and Regulation 20 - Duty of Candour. A self-declaration of being Fit and Proper, plus extensive disclosure and barring scheme searches (DBS), Insolvency and Bankruptcy Register searches will be reported to the June Trust Board. Additionally, the Trust Board undertakes an annual evaluation of its effectiveness, in accordance with corporate governance best practice.

The Trust continued with its joint proposal with GSTT via the Vanguard Programme. The programme has its own governance and control structure and updates on progress are submitted to the Finance Committee and Trust Board.

The Trust Secretary supports the Trust Board in the discharge of its statutory functions and duties, and ensures that any issues regarding legal compliance, as well as best practice in corporate governance are drawn to the Trust Board's attention. To the best of my knowledge, the Trust Board, and the wider organisation, has complied with its legal obligations during 2017/18.

Changes to Executive and Non-Executive roles during 2017/18 are as reported within the Annual Report and Accounts.

Review of economy efficiency and effectiveness of the use of resources

The Trust reviews economy, efficiency and effectiveness through the review of finance and performance at budget manager, directorate and overall Trust level.

In addition to a system of devolved budget management, the Trust has strengthened its Directorate Performance Review process this year where achievement of performance, quality standards and financial targets is considered.

There is also a system of reporting finance and performance to the Trust Board, supported by detailed performance and financial reporting through the sub-committees of the Trust Board.

For an indication of economy and efficiency in the organisation, the Trust has developed Service Line Reporting using patient level costing which is benchmarked against other organisations. In addition to showing profitability and contribution by service lines the system enables comparison between patients and between clinicians.
Reference costs are also used to benchmark the Trust. The Trust reference cost score for 2016/17 was 99 which is below the average and therefore overall the Trust costs were less than the national average.

The Carter Model Hospital information and benchmarking is also being used to evaluate the Trust's services both at a national level and against peers of like trusts. This information is being used to drive efficiencies throughout the Trust and is included in the savings programme where applicable. Get it Right First Time (GIRFT) reviews are also being used to identify savings opportunities.

The Trust has also strengthened the Programme Management Office (PMO) function in order to identify opportunities, undertake quality impact assessments on schemes and monitor/challenge directorate performance against schemes on an at least a monthly basis. The overall savings programme was overseen this financial year by the Financial Recovery Plan Steering Group.

Information governance

The Trust has undertaken a more positive and pro-active approach to information governance incidents and the shared learning from such. The Trust has had seven Information Governance Serious Incidents Requiring Investigation (IG SIRIs) that have been reported to the Information Commissioner's Office (ICO) during 2017/18. The ICO have not taken any further action for six of the incidents and the Trust is currently corresponding over one incident with the last incident still under investigation.

All incidents are regularly reported to the Trust's Information Governance Committee and the Trust has introduced an IG newsletter which is available to all staff. Details of the reported incidents are documented to improve the shared learning from the incidents across the Trust.

Annual Quality Account

The directors are required under the Health Act 2009 and the National Health Service (Quality Accounts) Regulations 2010 (as amended) to prepare Quality Accounts for each financial year.

The Trust's Quality Account for 2017/18 is summarised in the main body of the annual report and demonstrates Trust achievements, some of the challenges and the focus for the coming year. The Quality Account is subject to assurance arrangements which internally include executive input, draft and final submissions to the Quality and Safety Committee and final approval by the Trust Board. Externally the Quality Account is shared with Dartford, Gravesham and Swanley CCG, who are our most significant Commissioner, the Kent Health Overview and Scrutiny Committee and Healthwatch.

The Audit Committee receives the Auditor's report on the Trust's Quality Account. This report assesses whether the performance information reported in the Quality Account is reliable and accurate, and the lead director and officer responsible for the production of the Quality Account attend the Audit Committee to respond to the findings of the audit. For 2017/18 the Quality Account was presented to both the Quality and Safety Committee and the Trust Board. The External Auditor's report was presented to the Audit Committee.

The Trust has taken measures to assure itself regarding the quality and accuracy of elective waiting time data and the risks to the quality and accuracy of this data. Elective activity and waiting times are reviewed in detail at a weekly Access Meeting, chaired by a senior General Manager with at least one Executive Director in attendance (either Director of Operations or the Director of Strategic Development and Performance). Waiting times and backlogs for outpatients, diagnostics and elective PTL are all reviewed to ensure patients are dated by clinical need and chronologically. Data is produced to monitor trends to support this.

Review of effectiveness

As Accountable 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 Trust who have responsibility for the development and maintenance of the internal control framework. I have drawn on the information provided in this annual report and other performance information available to me. My review is also informed by comments made by the external auditors in their management letter and other reports. I have been advised on the implications of the result of my review of the effectiveness of the system of internal control by the Trust Board, the Audit Committee 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 BAF and on the controls reviewed as part of the internal audit work. The Head of Internal Audit opinion for 2017/18 states that Reasonable Assurance can be given that there is a generally sound system of internal control, designed to meet the organisation's objectives, and that controls are generally being applied consistently.

Executive Directors and senior managers within the organisation who have responsibility for the development and maintenance of the system of internal control also provide me with assurance via regular meetings and submission of reports to the aforementioned committees. The BAF and Risk Register processes provide me with evidence that the effectiveness of controls to manage the risks to the organisation have been reviewed, and scrutinised appropriately.

Further evidence is provided by a range of reports including clinical audit (which is referenced in the BAF where relevant), and reports from external agencies, following inspections and/or accreditation visits. Additionally, where required independent consultants are engaged to review particular areas of risk and make recommendations for improvement. The Audit Committee approves the Internal Audit Plan

Review of Admission and Discharge Planning	Limited
Review of Processes for Policy Compliance Arrangements	Limited
Data Quality Audit - Fractured Neck of Femur	Substantial
Infection Prevention and Control	Reasonable
Assurance review of Agency Staffing	Reasonable
Governance Review of Business Continuity and Emergency Resilience	Reasonable
Assurance Review of Directorate Performance Reporting Processes	Substantial
Assurance Review of Risk Management and Assurance Framework	Substantial
Review of Critical Financial Assurance	Reasonable
Information Governance Toolkit V14.1 Part 2	Substantial

for the year and receives details of the findings from each of the Internal Audit reviews that are undertaken. The Internal Audit reviews undertaken in 2017/18, are detailed above and the assurance conclusion was reached.

The Trust has received Reasonable Assurance on the core area of Critical Financial Assurance and Substantial Assurance on Risk Management. The Internal Audit 2017/18 annual report was provided in May 2018 with a Final Head of Internal Audit Opinion.

The purpose of the Head of Internal Audit Opinion is to contribute to the assurances available to the Accountable Officer and the Trust Board which underpin the Trust Board's own assessment of the effectiveness of the organisation's system of internal control. There is no outstanding internal audit work to be carried into the next year although some reviews are subject to completion.

The Trust applies appropriate controls to the Board Assurance Framework (BAF) to help ensure it remains an integrated, dynamic document. A Trust Board approved Risk Management Strategy (RMS) is in place, last updated in March 2017. There is some further scope for improving the BAF and these suggested alterations have now been incorporated into the 2018/19 BAF.

Counter Fraud are invited to the Audit Committee to report on both the reactive and proactive work that they undertake on behalf of the Trust. Investigation days are agreed as and when a referral warrants a formal investigation. The LCFS will seek approval from the Finance Director before commencing the investigation. Referrals which are raised as investigations are reported to the Finance Director and progress is discussed on a regular basis at the Audit Committee.

'Core' assurance areas continued to be well controlled during 2017/18, including the main financial systems, risk management and assurance. Through the Assistant Director of Finance, who acts as audit liaison, the implementation of agreed actions arising from audit reports is robust. Trust managers have agreed action plans in response to all recommendations, and we have noted the generally good progress made with their implementation.

The Trust also received Joint Advisory Group (JAG) re-accreditation for the Trust's Endoscopy Unit during February 2018. The assessment visit involved giving a presentation on the Unit, interviews with key staff and a document review.

Feedback from staff in the Annual NHS Staff Survey was overall very positive with the Trust ranked in the best 20% of acute trusts in 20 measures; above average in six; average in three, and; below average in three. Listening into Action rated the Trust as the sixth best acute trust in the NHS. The Trust has a plan to address areas for improvement, which is overseen by the Workforce Committee, as are action plans to address any issues at a directorate and corporate level.

The findings of all audit reports issued to date from the Annual Plan, as well as progress against any outstanding at this time, have been reported to the Audit Committee through interim reports during the year.

Significant internal control issues have been identified as follows:

MRSA

There have been seven Trust-assigned cases of MRSA bacteraemia during 2017/18 pending assignment of one additional case. This is an increase against the five cases that occurred during 2016/17. The Director of Infection and Prevention Control and the Infection and Control Specialist Team has been engaged with directorates to strengthen engagement and ownership. The Infection Control Committee, which reports to the Quality and Safety Committee, has met monthly during the year, and an in depth report from the DIPC, along with the an MRSA report, is submitted monthly to the Quality and Safety Committee, reporting on directorate compliance, mandatory surveillance, audit and any areas of concern.

A MRSA report is submitted by the Chief Executive to the Trust Board on a monthly basis.

Financial Deficit

The Trust reported a deficit of £15.8m at year end 2017/18. This is £17.4m adverse to the Control Total set for 2017/18 of a £1.6m surplus.

The variance reflected both income and cost pressures. There was a reduction in clinical income compared to the planned growth, QIPP was not fully delivered and there were other overspends relating to patient care and capacity. As a result of these pressures the Trust did not meet its Control Total and therefore did not receive £4.5m of Sustainability and Transformational Funding which further increased the deficit.

The Trust had a range of controls in place during the financial year including:

- Monthly forecasting and reporting on a run rate basis
- Scrutiny at the Finance Committee of the financial position and potential recovery plans
- Establishment of a Financial Recovery Plan Steering Group in year
- Robust contract monitoring
- Performance reviews with all directorates to agree and monitor recovery plans
- Pay and non pay controls – with reduced authorisation limits introduced within year.

A&E 4 Hour Wait

Despite robust winter planning, which saw more senior clinical and managerial leadership on site and consistent engagement with partners, due to system constraints and increased demand the Trust was unable to meet either the constitutional target for A&E 4 hour waits, or the nationally set target for Q3 and Q4.

Bed Occupancy

The Trust has consistently had occupancy above 100% during the last year. This has created pressure on the Trust and a number of internal actions and initiatives were undertaken to mitigate the situation.

The Trust continues to fully engage with other health and social care providers during the year to champion a whole system approach to resolving the issues through the A&E Delivery Board.

The Trust also continues with its programme of increasing bed space within the footprint of the Darent Valley site though a number of initiatives including:

- a new model of care in Adult Medicine

- fully utilising the bed availability at its Planned Care Centre on the Queen Mary's Hospital site in Sidcup
- Use of CHS to maximise potential of early discharge for patients needing placements
- Use of Hilton Nurses to facilitate discharge to assess
- Embedded improvement methodology such as red and green days, MADE events, focus on stranded and super stranded patients, home before lunch to reduce length of stay
- Physical build for new beds when possible.

The Trust continues to work with the local health economy system to address this through 2018/19.

Never Events

In the year 2017/18 the Trust reported three never events

- Incorrect operation
- Incorrect implant
- Unintended connection of oxygen tube to wall mounted air flowmeter

The first two have been subject to Executive led Root Causes Analyses and resulted in an extensive action plan around theatre practice and use of the WHO checklist at all Trust sites with ongoing monitoring reported by the Medical Director into the Quality and Safety Committee.

The last never event occurred just before the year end. The Executive led Root Cause Analysis is underway and some immediate checks and audits have begun to assure current practice is safe.

All never events have been reported openly, all patients are informed of the event and have been supported and managed with further treatment where needed.

CQC Review

The Trust was inspected by the Care Quality Commission in November and December 2017 and a number of issues were identified for improvement. In response to this we have developed a Trust Wide Improvement Plan.

Mixed Sex Breaches

The Trust had breaches in Mixed Sex Accommodation, and in response to this now has in place a Privacy and Dignity policy which clearly identifies the standards for Mixed Sex Accommodation. This includes the requirement for any breaches of privacy and dignity to be reported as incidents and escalated as part of the weekly review. We are working towards full compliance, concentrating on training, awareness, and escalation. We have also agreed a trajectory of improvement with our commissioners.

Conclusion

Significant control issues have been identified and action taken or proposed to deal with these issues and gaps in control as referred to above.

Signed……

Chief Executive Date: 16 March 2018

REMUNERATION AND STAFF REPORT

Remuneration

'Senior managers' are defined as 'those persons in senior positions having authority or responsibility for directing or controlling the major activities of the NHS body. This means those who influence the decisions of the entity as a whole rather than the decisions of individual directorates or departments.' The Chief Executive of the Trust confirms that this definition only applies to the members of the Trust Board as listed in the table below.

The table below shows details of salaries, allowances and any other remuneration and pension entitlements of senior managers. No significant awards have been made in the past to senior managers. No compensation is payable to former senior managers and no amounts included in the above are payable to third parties for the services of senior managers.

Name and Title	2017/18							2016/17					
	Salary (bands of £5000) £000	Other Remuneration (bands of £5000) £000	Expense payments (taxable) to the nearest £100	Performance Pay and bonuses (bands of £5000) £000	Long term performance pay and bonuses (bands of £5000) £000	All pension-related benefits (bands of £2,500) £000	Total (bands of £5000) £000	Salary (bands of £5000) £000	Other Remuneration (bands of £5000) £000	Expense payments (taxable) to the nearest £100	Performance Pay and bonuses (bands of £5000) £000	All pension-related benefits (bands of £2,500) £000	Total (bands of £5000) £000
Acott S. - Chief Executive *	75-80	0	0	0	0	260.0-262.5	335-340	145-150	0	0	0	32.5-35.0	175-180
Draysner S. - Director of Strategic Development *	55-60	0	0	0	0	0	55-60	N/A	N/A	N/A	N/A	N/A	N/A
Brown A. - Director of Human Resources	95-100	0	0	0	0	40.0-42.5	135-140	90-95	0	0	0	27.5-30.0	120-125
Bull M. - Director of Finance & Performance	N/A	N/A	N/A	N/A	N/A	N/A	N/A	30-35	0	0	0	0	30-35
Burnett L. - Director of Estates & Facilities/Director of Strategic Estates & Capital *	95-100	0	0	0	0	67.5-70.0	160-170	85-90	0	0	0	-	85-90
Cellerier S. - Director of Nursing & Quality *	45-50	0	0	0	0	-	45-50	N/A	N/A	N/A	N/A	N/A	N/A
Clegg L. - Director of Finance	115-120	0	0	0	0	-	115-120	85-90	0	0	0	0	85-90
Dhoi P. - Director of Operations	100-105	0	0	0	0	60.0-62.5	160-165	80-85	0	0	0	15.0-17.5	95-100
Fenlon S. - Medical Director	120-125	45-50	0	0	0	47.5-50.0	215-220	70-75	10-15	0	0	-	80-85
Fenton C. - Director of Estates	N/A	N/A	N/A	N/A	N/A	N/A	N/A	35-40	0	0	0	10.0-12.5	45-50
Jeffery S. - Director of Information & Performance	N/A	N/A	N/A	N/A	N/A	N/A	N/A	90-95	0	0	0	65.0-67.5	160-165
Juett L. - Director of Estates & Facilities *	5-10	0	0	0	0	0.0-2.5	5-10	N/A	N/A	N/A	N/A	N/A	N/A
Lovers-Carruth Y. - Director of Nursing & Quality *	55-60	0	0	0	0	25.0-27.5	75-80	90-95	0	0	0	32.5-35.0	125-130
Osborn L. - Director of Strategic Development & Performance/Director of Strategy & Planning (Interim) *	90-95	0	0	0	0	27.5-30.0	120-125	85-90				40.0-42.5	160-165
Samson S. - Deputy Chief Executive-Director of Strategy & Planning/Interim Chief Executive *	125-130	0	0	0	0	57.5-60.0	185-190	135-140	0	0	0	55.0-57.5	185-195
Schreiner A. - Medical Director	N/A	N/A	N/A	N/A	N/A	N/A	N/A	30-35	55-60	0	0	7.5-10.0	95-100
Broomes S. - Acting Director of Operations	N/A	N/A	N/A	N/A	N/A	N/A	N/A	70-75	0	0	0	-	70-75
Chamberlain M. - Acting Director of Finance	N/A	N/A	N/A	N/A	N/A	N/A	N/A	0-5	0	0	0	-	0-5
McAllister D. - Acting Director of Nursing	N/A	N/A	N/A	N/A	N/A	N/A	N/A	10-15	0	0	0	7.5-10.0	30-35
Stoverson A. - Acting Director of Nursing	N/A	N/A	N/A	N/A	N/A	N/A	N/A	25-30	0	0	0	-	25-30
Bobat J. - Chairman *	0-5	0	0	0	0	0	0-5	30-35	0	0	0	0	30-35
Coles P. - Non Executive Director/Chairman *	30-35	0	0	0	0	0	30-35	5-10	0	0	0	0	5-10
Findlay D. - Non Executive Director *	0-5	0	0	0	0	0	0-5	5-10	0	0	0	0	5-10
Bidwell L. - Non Executive Director *	0-5	0	0	0	0	0	0-5	N/A	N/A	N/A	N/A	N/A	N/A
Jarvis D. - Non Executive Director *	0-5	0	0	0	0	0	0-5	N/A	N/A	N/A	N/A	N/A	N/A
Taylor K. - Non Executive Director	5-10	0	0	0	0	0	5-10	5-10	0	0	0	0	5-10
Warwick D. - Non Executive Director	5-10	0	0	0	0	0	5-10	5-10	0	0	0	0	5-10
Wilmshurst S. - Non Executive Director	5-10	0	0	0	0	0	5-10	5-10	0	0	0	0	5-10

The all pension-related benefits column represents an estimate of the increase in pension benefits accrued in year, adjusted for inflation, multiplied by a representative 20 years and reduced by employee pension contributions. Therefore this does not reflect any payments made to the individual.

- in the Pension benefit column denotes 2017/18 or 2016/17 figures not available to calculate Pension related benefits.

N/A in the 2016/17 columns denotes that the Director commenced in 2017/18 or were not a Director in the previous year.

0 on the Pension benefit column denotes either that the Director is not part of the pension scheme or the benefit calculated is negative.

A. Schreiner & S. Fenlon figures relate to both their posts as Medical Director and clinical roles.

*Director changes 2016/17-2017/18

Acott S. -	went on secondment from 16th October 2017
Braysher S. -	commenced 30th October 2017
Bunnett L. -	changed role to Director of Strategic Estates & Capital on 28th February 2018
Callanan S. -	became Director of Nursing & Quality on 2nd October 2017
Juett L. -	commenced 28th February 2018
Leivers-Carruth V. -	left the Trust on 1st October 2018
Sammon G. -	Interim Chief Executive from 16th October 2017
Osborn L. -	changed role to Director of Strategy & Planning (Interim) on 16th October 2017
Sofat J. -	left the Trust on 3rd April 2017
Coles P. -	became the Chairman on 4th April 2017
Findley D. -	left the Trust on 31st December 2017
Gladwell L. -	commenced on 1st September 2017
Jenner G. -	commenced on 1st September 2017 as Associate Non- Executive Director and from 1st January 2018 as Non-Executive Director

Remuneration Committee

The Trust has an established Remuneration Committee to advise and assist the Board in meeting its responsibilities to ensure appropriate remuneration, allowances and terms of service for the Chief Executive and Executive Directors. Membership of the committee consists of Trust Chair and all Non-Executive Directors. The Chief Executive and Directors remuneration is determined on the basis of reports to the Remuneration Committee taking account of any independent evaluation of the post, national guidance on pay rates and market rates. The Trust has had in place a Policy for Determining the Remuneration of the Chief Executive and Executive Directors since January 2015 and was reviewed in June 2017. The policy is reviewed annually by the Remuneration Committee however there is provision for the policy to be reviewed earlier in the event of change in guidance or to meet any legal requirements.

Pay rates for the Chair and Non-Executive Directors of the Trust is determined in accordance with national guidance.

The Trust does not operate any system of performance-related pay for pay which is overseen by the Remuneration Committee, and no proportion of remuneration is dependent on performance conditions. The performance of Non-Executive Directors is appraised by the Chair. The performance of the Chief Executive is appraised by the Chair. The performance of Trust Executive Directors is appraised by the Chief Executive. Annual pay increases are implemented in accordance with national pay awards for all other NHS staff.

The Chief Executive and all substantive Directors are on permanent contracts as at 31st March 2018, and subject to a maximum six-month notice period. Termination arrangements are applied in accordance with statutory regulations as modified by national NHS conditions of service agreements (specified in Whitley Council/Agenda for Change), and the NHS pension scheme. The Remuneration Committee will agree any severance arrangements for senior managers within Department of Health guidelines.

Pension Benefits

The table below shows the pension benefits of the Executive Directors. As Non-Executive members do not receive pensionable remuneration, there will be no entries in respect of pensions for Non-Executive members.

Name and title	Real increase in pension at pension age (bands of £2500) £000	Real increase in pension lump sum at pension age (bands of £2500) £000	Total accrued pension at pension age at 31 March 2018 (bands of £5000) £000	Lump sum at pension age related to accrued pension at 31 March 2018 (bands of £5000) £000	Cash Equivalent Transfer Value at 1 April 2017 £000	Real increase in Cash Equivalent Transfer Value £000	Cash Equivalent Transfer Value at 31 March 2018 £000	Employers Contribution to Stakeholder Pension £000
Acott S. - Chief Executive	5.0-7.5	15.0-17.5	65-70	180-185	986	276	1,262	0
Brayshaw S. - Director of Strategic Development	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Brown A. - Director of Human Resources	2.5-5.0	2.5-5.0	30-35	80-85	476	50	530	0
Bunnett L. - Director of Estates & Facilities/Director of Strategic Estates & Capital	2.5-5.0	10.0-12.5	25-30	80-85	461	85	551	-
Callanan S. - Director of Nursing & Quality	-	-	-	-	-	-	-	-
Clegg L. - Director of Finance	-	-	-	-	-	-	-	-
Dhesi P. - Director of Operations	2.5-5.0	7.5-10.0	40-45	120-125	699	106	811	0
Fenton S. - Medical Director	2.5-5.0	0.0-2.5	50-55	130-135	856	64	928	0
Juett L. - Director of Estates & Facilities	0.0-2.5	0	0-5	0	0	0	823	0
Leivers-Carruth V. - Director of Nursing & Quality	0.0-2.5	(0.0)-(2.5)	25-30	65-70	402	43	449	0
Osborn L. - Director of Strategic Development & Performance/Director of Strategy & Planning (interim)*	0.0-2.5	5.0-7.5	25-30	75-80	474	63	542	0
Sammon G. - Deputy Chief Executive-Director of Strategy & Planning/Interim Chief Executive *	2.5-5.0	2.5-5.0	35-40	85-90	490	59	549	0

- denotes figures not available in order to calculate the increases

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 valued are the member's accrued benefits and any contingent spouse's pension payable from the scheme. A CETV is a payment made by a pension scheme, or arrangement to secure pension benefits in another pension scheme or arrangement when the member leaves a scheme and chooses to transfer the benefits accrued in their former scheme.

The pension figures shown relate to the benefits that the individual has accrued as a consequence of their total membership of the pension scheme, not just their service in a senior capacity to which the disclosure applies. The CETV figures, and from 2005/06 the other pension details, include the value of any pension benefits in another scheme or arrangement which the individual has transferred to the NHS pension scheme. They also include any additional pension benefit accrued to the member as a result of their purchasing additional years of pension service in the scheme at their own cost. CETVs are calculated within the guidelines and framework prescribed by the Institute and Faculty of Actuaries.

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

Pay Multiples

Reporting bodies are required to disclose the relationship between the remuneration of the highest-paid director/Member in their organisation and the median remuneration of the organisation's workforce.

The banded remuneration of the highest paid Director/Member in Dartford and Gravesham NHS Trust in the financial year 2017/18 was £170,000 to £175,000 (2016/17, £165,000 to £170,000). This was 5.7 times (2016/17, 5.5 times) the median remuneration of the workforce, which was £30,183 (2016/17 was £30,992).

In 2017/18, 11 employees received remuneration in

excess of the highest paid director/ member (2016/17, there were 11 employees). Remuneration ranged from £16,375 to £265,079 (in 2016/17 the range was £15,251 to £225,249).

The calculated remuneration (annualised month 12) top end of the range has increased by £40k, this is due to additional locum payments received in month 12 for one Medical Consultant and not wholly representative of the financial year.

Total remuneration includes salary, non-consolidated performance related pay, benefits-in-kind, but not severance payments. It does not include employer pension contributions and the cash equivalent transfer value of pensions. Temporary staffing has been included, based upon the current rates of pay for each staffing group.

The above information includes the annualised value of additional sessions and overtime paid. Staff that are recharged out have been excluded from the above calculations.

Signed: .....

Chief Executive
Date: 18 May 2018

Staff Report

The Trust is committed to equality and diversity, but is currently reshaping its approach by assessing its compliance with the NHS Equality Delivery System 2 and Workforce Race Equality Standard. The Trust will also start to assess compliance against some new indicators, namely the Workforce Disability Equality Standard and Gender Pay Gap report.

The Trust has incorporated equality and diversity principles within policies, for example People with Disability in Employment Policy, Equality, Diversity and Human Rights Policy, Dignity and Respect at Work Policy, Recruitment Policy etc.

The Workforce Committee review the profile of the Trust's workforce by protected characteristics annually. This report also examines recruitment and access to training by protected characteristics. Staff surveys are reviewed by protected characteristics where these are requested in the national staff survey. The Trust publishes its workforce diversity report annually.

The table below sets out the staff numbers in 2016/17 and 2017/18.

Below is an account from our 2018 workforce diversity report, providing an overview of how the Trust responds to the equality agenda (data as of 31st January 2018):

- **Age** - The working age of the Trust's workforce profile is broadly consistent with the population of Dartford and Gravesham. There are less employees under the age of 25 within the Trust (7.54%) compared with the national working population (assumed age 16 plus), which in part is likely due to the frequent requirement for graduates and higher qualifications / advanced training within our healthcare professions. This is a national norm for the NHS. Further recruitment to apprentice posts will further address this gap.
- **Disability** - The proportion of staff disclosing a disability through full equal opportunities monitoring has remained at 3.3% in line with the previous year. This however remains significantly different to the population of Dartford and Gravesham (those who state their day-to-day activities are limited a little / a lot) at 16.1%. The Trust has a disability policy which demonstrates the Trust's commitment to equal opportunities to people with disabilities for those applying for roles, existing employees and previous employees. This includes providing appropriate training and a duty to make reasonable adjustments for employees. The Trust continues to guarantee disabled applicants an interview as part of its commitment as a Disability Confident Employer – and prior to the creation of the Disability Confident scheme, held status as a Two Ticks, Positive about Disability employer since 2007, and continues to champion this. The Trust also has a People with Disability in Employment Policy. This policy has been in place since September 2010 and is due for its next formal review in June 2017. The policy demonstrate the Trust's commitment to equality of opportunity for people with disabilities who are applying for employment or work placements with the Trust, during an employee's employment and

ex-employees where internal processes apply (eg references).

- **Ethnicity** - The ethnicity profile remains relatively consistent with previous years, with significantly more workers from non-'White' backgrounds (29.98%) compared to the local population (15.25%).

- **Gender** - The profile of the local population is a 49% male, 51% female split, whereas the current workforce gender profile shows that 17.28% staff are male and 82.72% of staff female. The table below provides additional information in relation to our workforce and gender as at February 2018.

- **Religious belief** - The proportion of staff disclosing their religious belief through full equal opportunities monitoring has decreased non-disclosure from 24.41% to 22.95%. There have broadly been proportionate increases in all disclosed religious beliefs with the exception of Judaism and 'other' that have seen a small decrease. There is a significantly broader range of religions within the medical and dental staff group.

- **Sexual orientation** - the Trust has seen a small increase in the number of staff disclosing their sexual orientation, and this has resulted in a small increase to the reported orientation results.

The Trust initiated ESR Employee Self Service in 2016 and this has allowed our staff to access elements of their own ESR record and update personal information including religion and sexual orientation; this has supported the increase in disclosure of staff information re-protected characteristics as outlined.

	Male	Female	Total	Male %	Female %
Directors (Exec and Non Exec)	5	9	14	35.71%	64.29%
Total Senior Managers (8a-8d)	38	124	162	23.46%	76.54%
Band 8A	16	86	102	15.69%	84.31%
Band 8B	10	21	31	32.26%	67.74%
Band 8C	5	8	13	38.46%	61.54%
Band 8D	7	9	16	43.75%	56.25%
All other staff (non-medical)	301	2,457	2,758	10.91%	89.09%
Consultants	115	30	145	79.31%	20.69%
FY1 FY2	16	33	49	32.65%	67.35%
All other M&D	98	90	188	52.13%	47.87%
Total	573	2743	3316	17.28%	82.72%

Staff sickness, absence and ill health retirements

The Trust had the following sickness absence and ill health retirements for 2017/18 (2016/17) is also shown.

There has been one severance payment/ exit package made in 2017/18 and no severance payments /exit packages were made in 2016/17.

Note: Redundancy and other departure costs have been paid in accordance with the provisions of the NHS Agenda for Change Scheme. Exit costs in this note are accounted for in full in the year of departure. Where the Trust has agreed early retirements, the additional costs are met by the Trust and not by the NHS Pension scheme. Ill-health retirement costs are met by the NHS pensions scheme and are not included in the table.

	17/18	16/17
Total days lost	24,522	23,484
Total staff years	2,864	2,797
Average working days lost	9	8
Number of persons retired early on ill health grounds	1	4
Total additional pensions liabilities accrued in the year (£000s)	16	294

Off-Payroll Engagements

The Trust is required to report arrangements where individuals are paid through their own companies. Since April 2017 the Trust has assessed the employment status for all intermediaries. Any engagements which are assessed to fall under IR35 are processed through payroll.

The tables below outline the Trust position regarding off-payroll engagements.

Table 1: Off-payroll engagements longer than 6 months	
For all off-payroll engagements as of 31st March 2018, for more than £245 per day and that last longer than six months:	Number
Number of existing engagements as of 31 March 2018	12
Of which, the number that have existed:	
for less than one year at the time of reporting	1
for between one and two years at the time of reporting	4
for between 2 and 3 years at the time of reporting	1
for between 3 and 4 years at the time of reporting	2
for 4 or more year at the time of reporting	4

Table 2: New Off-payroll engagements	
For all new off-payroll engagements, or those reaching six months duration between 1 April 2017 and 31 March 2018, for more than £245 per day and that last for more than six months	Number
Number of new engagements, or those that reached six months in duration, between 1 April 2017 and 31 March 2018	2
Of which…	
No. assessed as caught by IR35	0
No. assessed as not caught by IR35	2
No. engaged directly (via PSC contracted to Department) and are on the departmental payroll	6
No. of engagements reassessed for consistency/assurance purposes during the year	0
No. engagements that saw a change to IR35 status following the consistency review	0

Table 3: Off-payroll board member/senior official engagements	
For any off-payroll engagements of board members, and/or, senior officials with significant financial responsibility, between 1 April 2017 and 31 March 2018	Number
Number of off-payroll engagements of board members, and/or senior officers with significant financial responsibility, during the year	0
Number of individuals that have been deemed "board members, and/or senior officers with significant financial responsibility" during the financial year.	
This figure includes both off-payroll and on-payroll engagements	12

Trade union facility time reporting

In line with regulation, all employers must publish information on facility time, which is agreed time off from an individual's job to carry out a trade union role, before 31 July.

The trade union (facility time publication requirements) regulations 2017 came in to force on 1 April 2017. Employers have been recording facility time for the period 1 April 2017 to 31 March 2018. There is a legal requirement to publish this information. The Trust data for the financial year April 2017 to March 2018 is outlined on the right, and this is also published in both our Annual Report and on our website, in line with the regulation requirements.

a) **TU representative** – the total number of employees who were TU representatives during the relevant period.

Number of employees who were relevant union officials during the relevant period	FTE employee number
22	19.81

b) **Percentage of time spent on facility time** - How many employees who were TU representatives officials employed during the relevant period spent a) 0%, b) 1%-50%, c) 51%-99% or d) 100% of their working hours on facility time.

Percentage of time	Number of employees
0%	4
1-50%	18
51%-99%	
100%	

c) **Percentage of pay bill spent on facility time** - The figures in the table below determine the percentage of the total pay bill spent on paying employees who were TU representatives for facility time during the relevant period.

The total cost of facility time	£68,245
The total pay bill	£129,347,000
The percentage of the total pay bill spent on facility time, calculated as: (total cost of facility time ÷ total pay bill) x 100	0.053%

d) **Paid TU activities** - As a percentage of total paid facility time hours, how many hours were spent by employees who were TU representatives during the relevant period on paid TU activities.

Time spent on paid TU activities as a percentage of total paid facility time hours calculated as: (total hours spent on paid TU activities by TU representatives during the relevant period ÷ total paid facility time hours) x 100	11%

Section C:

Financial Statements

Statement of the chief executive's responsibilities for the Trust

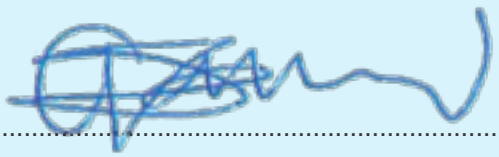
The Chief Executive of NHS Improvement has designated that the Chief Executive should be the Accountable Officer to the Trust. The relevant responsibilities of Accountable Officers are set out in the Accountable Officers Memorandum issued by the Chief Executive of NHS Improvement. These include ensuring that:

- there are effective management systems in place to safeguard public funds and assets and assist in the implementation of corporate governance;
- value for money is achieved from the resources available to the trust;
- the expenditure and income of the trust has been applied to the purposes intended by Parliament and conform to the authorities which govern them;
- effective and sound financial management systems are in place; and
- annual statutory accounts are prepared in a format directed by the Secretary of State with the approval of the Treasury to give a true and fair view of the state of affairs as at the end of the financial year and the income and expenditure, recognised gains and losses and cash flows for the year.

To the best of my knowledge and belief, I have properly discharged the responsibilities set out in my letter of appointment as an Accountable Officer.

I confirm that, 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 trust's auditors are aware of that information.

I confirm that the annual report and accounts as a whole is fair, balanced and understandable and that I take personal responsibility for the annual report and accounts and the judgments required for determining that it is fair, balanced and understandable.

Signed.....  .....Interim Chief Executive

Date 24th May 2018

Statement of directors' responsibilities in repect of the accounts

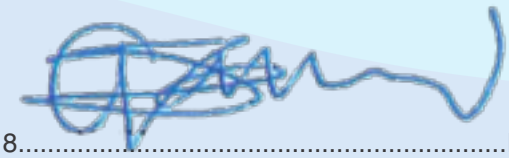
The directors are required under the National Health Service Act 2006 to prepare accounts for each financial year. The Secretary of State, with the approval of the Treasury, directs that these accounts give a true and fair view of the state of affairs of the trust and of the income and expenditure, recognised gains and losses and cash flows for the year. In preparing those accounts, directors are required to:

- apply on a consistent basis accounting policies laid down by the Secretary of State with the approval of the Treasury;
- make judgements and estimates which are reasonable and prudent;
- state whether applicable accounting standards have been followed, subject to any material departures disclosed and explained in the accounts.

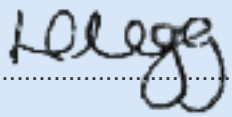
The directors are responsible for keeping proper accounting records which disclose with reasonable accuracy at any time the financial position of the trust and to enable them to ensure that the accounts comply with requirements outlined in the above mentioned direction of the Secretary of State. They are also responsible for safeguarding the assets of the trust and hence for taking reasonable steps for the prevention and detection of fraud and other irregularities.

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

By order of the Board



Date 24th May 2018.....Interim Chief Executive



Date 24th May 2018.....Finance Director

Independent auditor's report to the board of directors of Dartford and Gravesham NHS Trust

Opinion

We have audited the financial statements of Dartford and Gravesham NHS Trust ("the Trust") for the year ended 31 March 2018 which comprise the Statement of Comprehensive Income, Statement of Financial Position, Statement of Changes in Taxpayers Equity and Statement of Cash Flows, and the related notes, including the accounting policies in Note 1.
In our opinion the financial statements:

- give a true and fair view of the state of the Trust's affairs as at 31 March 2018 and of its income and expenditure for the year then ended; and
- have been properly prepared in accordance with the accounting policies directed by the Secretary of State with the consent of the Treasury as being relevant to NHS Trusts in England and included in the Department of Health Group Accounting Manual 2017/18.

Material uncertainty relating to going concern

We draw attention to note 1.1.2 to the financial statements which indicates that the Trust has incurred a deficit in 2017/18 of £20.3 million. After technical adjustments it has a cumulative deficit of £14.3 million against the breakeven duty. The financial plan set for 2018/19 is based on a deficit of £10.4 million and the Trust anticipates requiring revenue loan support during the year of £14.0 million to fund its revenue plans. These events and conditions, along with the other matters explained in note 1.1.2, constitute a material uncertainty that may cast significant doubt on the Trust's ability to continue as a going concern. Our opinion is not modified in respect of this matter.

Basis for opinion

We conducted our audit in accordance with International Standards on Auditing (UK) ("ISAs (UK)") and applicable law. Our responsibilities are described below. We have fulfilled our ethical responsibilities under and are independent of the Trust in accordance with UK ethical requirements including the FRC Ethical Standard. We believe that the audit evidence we have obtained is a sufficient and appropriate basis for our opinion.

Other information in the Annual Report

The Accountable Officer is responsible for the other information presented in the Annual Report together with the financial statements. Our opinion on the financial statements does not cover the other information and, accordingly, we do not express an audit opinion or, except as explicitly stated below, any form of assurance conclusion thereon.

Our responsibility is to read the other information and, in doing so, consider whether, based on our financial statements audit work, the information therein is materially misstated or inconsistent with the financial statements or our audit knowledge. Based solely on that work we have not identified material misstatements in the other information. In our opinion the other information included in the Annual Report for the financial year is consistent with the financial statements.

Annual Governance Statement

We are required to report to you if the Annual Governance Statement has not been prepared in accordance with the requirements of the Department of Health Group Accounting Manual 2017/18. We have nothing to report in this respect.

Remuneration and Staff Report

In our opinion the parts of the Remuneration and Staff Report subject to audit have been properly prepared in accordance with the Department of Health Group Accounting Manual 2017/18.

Directors' and Accountable Officer's responsibilities

As explained more fully in the statement set out on page 57, the directors are responsible for: the preparation of financial statements that give a true and fair view; such internal control as they determine is necessary to enable the preparation of financial statements that are free from material misstatement, whether due to fraud or error; assessing the Trust's ability to continue as a going concern, disclosing, as applicable, matters related to going concern; and using the going concern basis of accounting unless they have been informed by the relevant national body of the intention to dissolve the Trust without the transfer of its services to another public sector entity. As explained more fully in the statement of the Chief Executive's responsibilities, as the Accountable Officer of the Trust, on page 56, the Accountable Officer is responsible for ensuring that annual statutory accounts are prepared in a format directed by the Secretary of State.

Auditor's responsibilities

Our objectives are to obtain reasonable assurance about whether the financial statements as a whole are free from material misstatement, whether due to fraud or error, and to issue our opinion in an auditor's report. Reasonable assurance is a high level of assurance, but does not guarantee that an audit conducted in accordance with ISAs (UK) will always detect a material misstatement when it exists. Misstatements can arise from fraud or error and are considered material if, individually or in aggregate, they could reasonably be expected to influence the economic decisions of users taken on the basis of the financial statements.

A fuller description of our responsibilities is provided on the FRC's website at
www.frc.org.uk/auditorsresponsibilities

Report on other legal and regulatory matters

Report on the Trust's arrangements for securing economy, efficiency and effectiveness in its use of resources

Under the Code of Audit Practice we are required to report to you if the Trust has not made proper arrangement for securing economy, efficiency and effectiveness in its use of resources.

Qualified conclusion

Subject to the matters outlined in the basis for qualified conclusion paragraph below we are satisfied that in all significant respects Dartford and Gravesham NHS Trust put in place proper arrangements for securing economy, efficiency and effectiveness in the use of resources for the year ended 31 March 2018.

Basis for qualification

In assessing the controls in place to secure the Trust's financial resilience we identified that the Trust has recorded an IFRS deficit of £20.3 million for the 2017/18 financial year, an adjusted deficit of £15.8m on a control total basis. Compared against the original £1.6m surplus control total gives an adjusted £17.4m variance against plan. During the year the Trust has increased borrowings drawn down of £13.5 million to support it in meeting its working capital obligations. At the end of the 2017/18 the Trust had a cumulative deficit of £14.3 million against the Breakeven Duty.

The Trust has not agreed its control total for 2018/19 and is budgeting to record a £10.1 million deficit for 2018/19. It anticipates requiring a further £14 million of working capital support during 2018/19 in order to continue meeting its working capital obligations.

Respective responsibilities in respect of our review of arrangements for securing economy, efficiency and effectiveness in the use of resources

As explained in the statement set out on page 56, the Chief Executive, as the Accountable Officer, is responsible for ensuring that value for money is achieved from the resources available to the Trust. We are required under section 21(3)(c), as amended by schedule 13 paragraph 10(a), of the Local Audit and Accountability Act 2014 to be satisfied that the Trust has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources. We are not required to consider, nor have we considered, whether all aspects of the Trust's arrangements for securing economy, efficiency and effectiveness in the use of resources are operating effectively.

We have undertaken our review in accordance with the Code of Audit Practice, having regard to the specified criterion issued by the Comptroller and Auditor General (C&AG) in November 2017, as to whether the Trust had proper arrangements to ensure it took properly informed decisions and deployed resources to achieve planned and sustainable outcomes for taxpayers and local people. We planned our work in accordance with the Code of Audit Practice and related guidance. Based on our risk assessment, we undertook such work as we considered necessary.

Statutory reporting matters

We are required by Schedule 2 to the Code of Audit Practice issued by the Comptroller and Auditor General ('the Code of Audit Practice') to report to you if:

- we refer a matter to the Secretary of State under section 30 of the Local Audit and Accountability Act 2014 because we have reason to believe that the Trust, or an officer of the Trust, is about to make, or has made, a decision which involves or would involve the body incurring unlawful expenditure, or is about to take, or has begun to take a course of action which, if followed to its conclusion, would be unlawful and likely to cause a loss or deficiency; or
- we issue a report in the public interest under section 24 of the Local Audit and Accountability Act 2014; or
- we make a written recommendation to the Trust under section 24 of the Local Audit and Accountability Act 2014.

We have nothing to report in these respects.

The purpose of our audit work to whom we owe our responsibilities

This report is made solely to the Board of Directors of Dartford and Gravesham NHS Trust, as a body, in accordance with Part 5 of the Local Audit and Accountability Act 2014. Our audit work has been undertaken so that we might state to the Board of the Trust, as a body, those matters we are required to state to them in an auditor's report and for no other purpose. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the Board of the Trust, as a body, for our audit work, for this report or for the opinions we have formed.

Certificate of completion of the audit

We certify that we have completed the audit of the accounts of Dartford and Gravesham NHS Trust in accordance with the requirements of the Local Audit and Accountability Act 2014 and the Code of Audit Practice.

Fleur Nieboer
for and on behalf of KPMG LLP, Statutory Auditor
Chartered Accountants

15 Canada Square, Canary Wharf, London, E14 5GL
24 May 2018

Statement of Comprehensive Income

	Note	2017/18 £000	2016/17 £000
Operating income from patient care activities	2	224,194	216,483
Other operating income	3	28,874	32,063
Employee benefits	4	(150,587)	(142,810)
Other operating expenses	4	(106,055)	(94,457)
Net operating surplus/(deficit)		(3,574)	11,279
Finance income	9	19	14
Finance costs	10	(15,194)	(14,603)
PDC dividends payable		(1,518)	(2,065)
Net finance costs		(16,693)	(16,654)
Other gains / (losses)	11	7	(111)
Surplus / (deficit) for the year from continuing operations		(20,260)	(5,486)
Deficit for the year		(20,260)	(5,486)
Other comprehensive income			
Impairments	5	(1,097)	(9,997)
Revaluations	12	6,239	2,395
Other reserve movements		-	95
Total comprehensive income / (expense) for the period		(15,118)	(12,993)
Financial performance for the year			
Retained deficit for the year		(20,260)	(5,486)
IFRIC 12 adjustment (including IFRIC 12 impairments)		-	3,920
Add back all I&E impairments / (reversals)		5,518	1,239
Remove capital donations / grants I&E impact		(55)	(55)
Adjusted financial performance deficit		(14,797)	(382)

1. The impairment relates to non current assets (property) impaired as part of the valuation as at 31/03/2018. In line with the Treasury Financial Reporting manual (FREM) impairments are not considered to be part of the organisation's operating position.

The notes on pages 64 to 94 form part of these accounts.

Statement of Financial Position

	Note	31 March 2018 £000	31 March 2017 £000
Non-current assets			
Property, plant and equipment	12	142,631	142,585
Total non-current assets		142,631	142,585
Current assets			
Inventories	16	2,941	3,032
Trade and other receivables	17	21,083	14,291
Cash and cash equivalents	18	4,827	7,780
Total current assets		28,851	25, 103
Current liabilities			
Trade and other payables	19	(31,468)	(28,718)
Borrowings	21	(5,324)	(2,016)
Provisions	22	(135)	(102)
Other liabilities	20	(2,721)	(53)
Total current liabilities		(39,648)	(30,889)
Total assets less current liabilities		131,834	136,799
Non-current liabilities			
Borrowings	21	(84,915)	(75,785)
Other liabilities	20	(685)	(737)
Total non-current liabilities		(85,600)	(76,522)
Total assets employed		46,234	60,277
Financed by			
Public dividend capital		57,989	56,914
Revaluation reserve		52,657	47,515
Income and expenditure reserve		(64,412)	(44,152)
Total taxpayers' equity		46,234	60,277

The notes on pages 64 to 94 form part of these accounts.

The financial statements on pages 61 to 94 were approved by the Board on18 May 2018 and signed on its behalf by

Signed
Date 24th May 2018

Interim Chief Executive

Statement of Changes in Equity for the year ended 31 March 2018

	Public dividend capital £000	Revaluation reserve £000	Income and expenditure reserve £000	Total £000
Taxpayers' equity at 1April 2017 - brought forward	56,914	47,515	(44,152)	60,277
Surplus/(deficit) for the year	-	-	(20,260)	(20,260)
Impairments	-	(1,097)	-	(1,097)
Revaluations	-	6,239	-	6,239
Public dividend capital received	1,075	-	-	1,075
Taxpayers' equity at 31 March 2018	57,989	52,657	(64,412)	46,234

Statement of Changes in Equity for the year ended 31 March 2017

	Public dividend capital £000	Revaluation reserve £000	Income and expenditure reserve £000	Total £000
Taxpayers' equity at 1April 2016 - brought forward	56,914	55,117	(38,761)	73,270
Surplus/(deficit) for the year	-	-	(5,486)	(5,486)
Impairments	-	(9,997)	-	(9,997)
Revaluations	-	2,395	-	2,395
Other reserve movements		-	95	95
Taxpayers' equity at 31 March 2017	56,914	47,515	(44,152)	60,277

Statement of Cash Flows

	Note	2017/18 £000	2016/17 £000
Cash flows from operating activities			
Operating surplus / (deficit)		(3,574)	11,279
Non-cash income and expense:			
Depreciation and amortisation	12	7,711	7,937
Net impairments	5	5,518	1,648
Income recognised in respect of capital donations	3	(129)	(116)
Amortisation of PFI deferred credit		(53)	-
(Increase) / decrease in receivables and other assets		(7,000)	863
(Increase) / decrease in inventories		91	(285)
Increase / (decrease) in payables and other liabilties		5,174	2,868
Increase / (decrease) in provisions		33	(132)
Net cash generated from / (used in) operating activities		7,771	24,062
Cash flows from investing activities			
Interest received		19	14
Purchase of property, plant, equipment and investment property		(8,004)	(5,123)
Sales of property, plant, equipment and investment property		71	12
Receipt of cash donations to purchase capital assets		129	-
Net cash generated from / (used in) investing activities		(7,785)	(5,097)
Cash flows from financing activities			
Public dividend capital received		1,075	-
Movement on loans from the Department of Health and Social Care		14,261	5,106
Movement on other loans		(16)	46
Capital element of PFI, LIFT and other service concession payments		(1,807)	(1,621)
Interest paid on PFI, LIFT and other service concession obligations		(14,896)	(14,530)
Other interest paid		(246)	(73)
PDC dividend (paid) / refunded		(1,310)	(2,454)
Net cash generated from / (used in) financing activities		(2,939)	(13,526)
Increase / (decrease) in cash and cash equivalents		(2,953)	5,439
Cash and cash equivalents at 1 April - brought forward		7,780	2,341
Cash and cash equivalents at 1 April - restated		7,780	2,341
Cash and cash equivalents at 31 March	18	4,827	7,780

Notes to the Accounts

Note 1 Accounting policies and other information Note

1.1 Basis of preparation

The Department of Health and Social Care 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 2017/18 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 accounts.

Note 1.1.1 Accounting convention

These accounts have been prepared under the historical cost convention modified to account for the revaluation of property, plant and equipment, intangible assets, inventories and certain financial assets and financial liabilities.

Note 1.1.2 Going concern

The financial statements are prepared on a going concern basis which the directors believe to be appropriate for the following reasons:

- the FReM (financial reporting manual) states that: "The anticipated continuation of a service in the future, as evidenced by inclusion of financial provision for that service in published documents, is normally sufficient evidence of going concern"
- having considered relevant conditions and performed appropriate assessments (following the preparation and provision of 2018/19 plans to NHS Improvement)
- in the public sector an organisation is considered to remain a going concern if it is anticipated that services will continue to be delivered from the same location by a public sector organisation. Following the submission of a financial plan to NHS Improvement and the agreement of contracts with CCGs and NHS England there is sufficient certainty of the intention to continue providing services through the public sector in this location for the foreseeable future
- contracts have been agreed with the Commissioners for the provision of healthcare services for 2018/19
- the Trust is part of Kent and Medway STP which is planning as a system to achieve financial balance by 2021.

The Trust 2018/19 plan does not achieve the control total and there are the following risks to the Trust financial plan:

- level of savings required by the Trust
- Commissioner QIPP
- emerging cost pressures above contingencies
- further contractual penalties due to not being able to accept control totals.

The submitted plans include revenue support and the Trust has already drawn amounts included for April and May.

Based on these indications the directors believe that it remains appropriate to prepare the financial statements on a going concern basis. However, the matters referred to above represent a material uncertainty that may cast significant doubt on the Trust's ability to continue as a going concern. The financial statements do not include any adjustments that would result from the basis of preparation being inappropriate.

Note 1.2 Critical judgements in applying accounting policies

The following are the judgements, apart from those involving estimations (see below) that management has made in the process of applying the Trust accounting policies and that have the most significant effect on the amounts recognised in the financial statements:

Critical judgements have been applied in areas of accounting to PFI (note 25) and Pensions (note 7)

Note 1.2.1 Sources of estimation uncertainty

Estimates and judgements are continually evaluated and are based on historical experience and other factors, including expectations of future events that are believed to be reasonable under the circumstances.

The Trust makes estimates and assumptions concerning the future. The resulting accounting estimates will, by definition, seldom equal the related actual results. The estimates and assumptions that have a significant risk of causing a material adjustment to the carrying amounts of assets and liabilities within the next financial year are discussed on the following page.

The following are the key assumptions concerning the future, and other key sources of estimation uncertainty at the end of the reporting period, that have a

significant risk of causing a material adjustment to the carrying amounts of assets and liabilities within the next financial year.

Note 1.2.2 Provisions and Contingencies

In considering the amounts to be accounted for under provisions and contingent liabilities the Trust makes a judgement on the likelihood of liabilities arising in respect of pensions, public and employers liability and injury benefit.

Note 1.2.3 Assets and liabilities

The preparation of the accounts requires management to make judgements, estimates and assumptions that affect the application of policies and reported amounts of assets and liabilities, income and expenses. The estimates and associated assumptions are based on historical experience and various other factors that are believed to be reasonable under the circumstances, the results of which form the basis of making judgments about carrying values of assets and liabilities that are not readily apparent from other sources. Actual results may differ from these estimates.

Note 1.2.4 Impairment of inventories

Where necessary, the difference between the cost of the stock and its estimated market value, based upon stock turn rates, market conditions and trends in consumer demand. Due to the nature of the inventory balances held and the write off performed by the Trust at year end, no provision was deemed necessary.

Note 1.2.5 Allowances for doubtful receivables

Allowances are made for doubtful receivables in respect of non NHS balances for estimated losses resulting from the subsequent inability of customers to make required payments. If the financial conditions of customers were to deteriorate, resulting in an impairment of their ability to make payments, additional allowances may be required in future periods.

Note 1.3 Income

Revenue in respect of services provided is recognised when, and to the extent that, performance occurs, and is measured at the fair value of the consideration receivable. The main source of revenue for the Trust is from commissioners for healthcare services. Once a patient is admitted to hospital and treatment begins, income for that treatment or spell (the period over which treatment/care is provided) should be recognised from that point. Treatment may span two financial years, therefore the term 'partially completed spells' refers to patients who have not finished their treatment at the financial year end. Income relating to those spells, which are partially completed at the

financial year end, should be apportioned across the financial years on a pro-rata basis.

Where income is received for a specific activity that is to be delivered in the following year, that income is deferred.

The NHS 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 e.g. by an insurer. The NHS Trust recognises the income when it receives notification from the Department of Work and Pension's Compensation Recovery Unit that the individual has lodged a compensation claim. The income is measured at the agreed tariff for the treatments provided to the injured individual, less a provision for unsuccessful compensation claims and doubtful debts.

Revenue grants and other contributions to expenditure

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.

The value of the benefit received when accessing funds from the 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, 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.

Pension costs

NHS Pension Scheme

Past and present employees are covered by the provisions of the NHS Pension Scheme. The scheme is an unfunded, defined benefit scheme that covers NHS employers, general practices and other bodies, allowed under the direction of Secretary of State, 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. There, the schemes are accounted for as though they are defined contribution schemes.

Employer's pension cost contributions are charged to operating expenses as and when they become due.

Additional pension liabilities arising from early retirements are not funded by the scheme except where the retirement is due to ill-health. The full amount of the liability for the additional costs is charged to the operating expenses at the time the Trust commits itself to the retirement, regardless of the method of payment.

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.

Where a large asset, for example a building, includes a number of components with significantly different asset lives, then these components are treated as separate assets and depreciated over their own useful economic lives.

Note 1.6.2 Measurement

Valuation

All property, plant and equipment assets are measured initially at cost, representing the costs directly attributable to acquiring or constructing the asset and bringing it to the location and condition necessary for it to be capable of operating in the manner intended by management.

All assets are measured subsequently at valuation.

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

HM Treasury has adopted a standard approach to depreciated replacement cost valuations based on modern equivalent assets and, where it would meet the location requirements of the service being provided, an alternative site can be valued.
The valuation assumes the modern equivalent asset will be funding via a private finance initiative and therefore costs do not include VAT.

Properties in the course of construction for service or administration purposes are carried at cost, less any impairment loss. Cost includes professional fees and, where capitalised in accordance with IAS 23, borrowing costs. Assets are revalued and depreciation commences when they are brought into use.

Non current assets have been revalued by Montagu Evans Chartered Surveyors. The valuations provide an estimate of value as at 31/03/2018 based on the published indices available at the date of valuation.

Fixtures and equipment are carried at depreciated historic cost as this is not considered to be materially different from fair value. Long life equipment has been valued by Hilditch Ltd at market value.

An increase arising on revaluation is taken to the revaluation reserve except when it reverses an impairment for the same asset previously recognised in expenditure, in which case it is credited to expenditure to the extent of the decrease previously charged there. A revaluation decrease that does not result from a loss of economic value or service potential is recognised as an impairment charged to the revaluation reserve to the extent that there is a balance on the reserve for the asset and, thereafter, to expenditure. Impairment losses that arise from a clear consumption of economic benefit should be taken to expenditure. Gains and losses recognised in the revaluation reserve are reported as other comprehensive income in the Statement of Comprehensive Income.

An item of property, plant and equipment which is surplus with no plan to bring it back into use is valued at fair value under IFRS 13, if it does not meet the requirements of IAS 40 of IFRS 5.

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.

Depreciation

Items of property, plant and equipment are depreciated over their remaining useful economic lives in a manner consistent with the consumption of economic or service delivery benefits. Freehold land is considered to have an infinite life and is not depreciated.

Property, plant and equipment which has been reclassified as 'held for sale' ceases to be depreciated upon the reclassification. Assets in the course of construction and residual interests in off-Statement of

Financial Position PFI contract assets are not depreciated until the asset is brought into use or reverts to the Trust, respectively.

Revaluation gains and losses

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

Revaluation losses are charged to the revaluation reserve to the extent that there is an available balance for the asset concerned, and thereafter are charged to operating expenses.

Gains and losses recognised in the revaluation reserve are reported in the Statement of Comprehensive Income as an item of 'other comprehensive income'.

Impairments

In accordance with the 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.

Impairments are analysed between Departmental Expenditure Limits (DEL) and Annually Managed Expenditure (AME). This is necessary to comply with Treasury's budgeting guidance. DEL limits are set in the Spending Review and Departments may not exceed the limits that they have been set.

AME budgets are set by the Treasury and may be reviewed with Departments in the run-up to the Budget. Departments need to monitor AME closely and inform Treasury if they expect AME spending to rise above forecast. Whilst Treasury accepts that in some areas of AME inherent volatility may mean Departments do not have the ability to manage the spending within budgets in that financial year, any expected increases in AME require Treasury approval.

Note 1.6.3 Derecognition

Assets intended for disposal are reclassified as 'held for sale' once all of the following criteria are met:

- the asset is available for immediate sale in its present condition subject only to terms which are usual and customary for such sales;
- the sale must be highly probable i.e.:
  - management are committed to a plan to sell the asset
  - an active programme has begun to find a buyer and complete the sale
  - the asset is being actively marketed at a easonable price
  - the sale is expected to be completed within 12 months of the date of classification as 'held for sale'
  - the actions needed to complete the plan indicate it is unlikely that the plan will be dropped or significant changes made to it.

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

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

Note 1.6.4 Donated and grant funded assets

Donated 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.

Note 1.6.5 Private Finance Initiative (PFI)

HM Treasury has determined that government bodies shall account for infrastructure PFI schemes where the government body controls the use of the infrastructure and the residual interest in the infrastructure at the end of the arrangement as service concession arrangements, following the principles of the requirements of IFRIC 12. The NHS Trust therefore recognises the PFI asset as an item of property, plant and equipment together with a liability to pay for it. The services received under the contract are recorded as operating expenses.

The annual unitary payment is separated into the following component parts, using appropriate estimation techniques where necessary:

a) Payment for the fair value of services received;
b) Payment for the PFI asset, including finance costs; and Services received

PFI Asset

The PFI assets are recognised as property, plant and equipment, when they come into use. The assets are measured initially at fair value or, if lower, at the present value of the minimum lease payments, in accordance with the principles of IAS 17. Subsequently the assets are measured by valuation as outlines in note 12.

PFI liability

A PFI liability is recognised at the same time as the PFI assets are recognised. It is measured initially at the same amount as the initial value of the PFI assets and is subsequently measured as a finance lease liability in accordance with IAS 17.

An annual finance cost is calculated by applying the implicit interest rate in the lease to the opening lease liability for the period, and is charged to 'Finance Costs' within the Statement of Comprehensive Income.

The element of the annual unitary payment that is allocated as a finance lease rental is applied to meet the annual finance cost and to repay the lease liability over the contract term.

An element of the annual unitary payment increase due to cumulative indexation is allocated to the finance lease. In accordance with IAS 17, this amount is not included in the minimum lease payments, but is instead treated as contingent rent and is expensed as incurred. In substance, this amount is a finance cost in respect of the liability and the expense is presented as a contingent finance cost in the Statement of Comprehensive Income.

Lifecycle replacement

Under the contract the Trust is not provided with adequate lifecycle plan or historic details. This prevents the Trust from being able to make appropriate adjustments where the lifecycle component is provided earlier or later than the operators planned programme of life cycle replacement.

Assets contributed by the NHS Trust to the operator for use in the scheme

Assets contributed for use in the scheme continue to be recognised as items of property, plant and equipment in the NHS Trust's Statement of Financial Position.

Other assets contributed by the NHS Trust to the operator

Assets contributed (surplus property) by the NHS Trust to the operator before the asset is brought into use, which are intended to defray the operator's capital costs, are recognised initially as prepayments during the construction phase of the contract. Subsequently, when the asset is made available to the NHS Trust, the prepayment is treated as an initial payment towards the finance lease liability and is set against the carrying value of the liability.

Note 1.6.6 Useful economic lives of property, plant and equipment

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

Finance-leased assets (including land) are depreciated over the shorter of the useful economic life or the lease term, unless the Trust expects to acquire the asset at the end of the lease term in which case the assets are depreciated in the same manner as owned assets above.

Note 1.7 Inventories

Inventories are valued at the lower of cost and net realisable value using the first-in first-out cost formula. This is considered to be a reasonable approximation to fair value due to the high turnover of stocks.

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 Dartford & Gravesham NHS Trust's cash management. Cash, bank and overdraft balances are recorded at current values.

	Min life Years	Max life Years
Land	99	99
Buildings, excluding dwellings	18	58
Dwellings	63	63
Plant & machinery	5	15
Transport equipment	7	7
Information technology	5	8
Furniture & fittings	5	10

Note 1.9 Charitable Funds

Having considered the materialty of Charitable Funds the Trust adopted policy of non consolidation of Charitable Funds.

Note 1.10 Financial assets

Financial assets are recognised when the NHS Trust becomes party to the financial instrument contract or, in the case of trade receivables, when the goods or services have been delivered. Financial assets are derecognised when the contractual rights have expired or the asset has been transferred.

Financial assets are classified into the following categories: financial assets at fair value through profit and loss; held to maturity investments; available for sale financial assets, and loans and receivables. The classification depends on the nature and purpose of the financial assets and is determined at the time of initial recognition.

Loans and receivables

Loans and receivables are non-derivative financial assets with fixed or determinable payments which are not quoted in an active market. After initial recognition, they are measured at amortised cost using the effective interest method, less any impairment. Interest is recognised using the effective interest method.

The effective interest rate is the rate that exactly discounts estimated future cash receipts through the expected life of the financial asset, to the initial fair value of the financial asset.

At the end of the reporting period, the NHS Trust assesses whether any financial assets, other than those held at 'fair value through profit and loss' are impaired. Financial assets are impaired and impairment losses recognised if there is objective evidence of impairment as a result of one or more events that occurred after the initial recognition of the asset and that have an impact on the estimated future cash flows of the asset.

For financial assets carried at amortised cost, the amount of the impairment loss is measured as the difference between the asset's carrying amount and the present value of the revised future cash flows discounted at the asset's original effective interest rate. The loss is recognised in expenditure through a provision for impairment of receivables.

If, in a subsequent period, the amount of the impairment loss decreases and the decrease can be related objectively to an event occurring after the impairment was recognised, the previously recognised impairment loss is reversed through expenditure to the extent that the carrying amount of the receivable at the date of the impairment is reversed does not exceed what the amortised cost would have been had the impairment not been recognised.

Note 1.11 Financial liabilities

Financial liabilities are recognised on the statement of financial position when the NHS Trust becomes party to the contractual provisions of the financial instrument or, in the case of trade payables, when the goods or services have been received. Financial liabilities are de-recognised when the liability has been discharged, that is, the liability has been paid or has expired.

Loans from the Department of Health are recognised at historic cost. Otherwise, financial liabilities are initially recognised at fair value.

Other financial liabilities

After initial recognition, all other financial liabilities are measured at amortised cost using the effective interest method, except for loans from Department of Health, which are carried at historic cost. The effective interest rate is the rate that exactly discounts estimated future cash payments through the life of the asset, to the net carrying amount of the financial liability. Interest is recognised using the effective interest method.

They are included in current liabilities except for amounts payable more than 12 months after the Statement of Financial Position date, which are classified as long-term liabilities.

Interest on financial liabilities carried at amortised cost is calculated using the effective interest method and charged to finance costs. Interest on financial liabilities taken out to finance property, plant and equipment or intangible assets is not capitalised as part of the cost of those assets.

Note 1.12 Leases

Leases are classified as finance leases when substantially all the risks and rewards of ownership are transferred to the lessee.All other leases are classified as operating leases.

The Trust as a Lessee

Finance leases

Where substantially all risks and rewards of ownership of a leased asset are borne by the Trust, the asset is recorded as property, plant and equipment and a corresponding liability is recorded. The value at which both are recognised is the lower of the fair value of the asset or the present value of the minimum lease payments, discounted using the interest rate implicit in the lease.

The asset and liability are recognised at the commencement of the lease. Thereafter the asset is accounted for an item of property plant and equipment.

The annual rental is split between the repayment of the liability and a finance cost so as to achieve a constant rate of finance over the life of the lease. The annual finance cost is charged to Finance Costs in the Statement of Comprehensive Income. The lease liability, is de-recognised when the liability is discharged, cancelled or expires.

Operating leases

Operating lease payments are recognised as an expense on a straight-line basis over the lease term. Lease incentives are recognised initially as a liability and subsequently as a reduction of rentals on a straight-line basis over the lease term.

Contingent rentals are recognised as an expense in the period in which they are incurred.

Leases of land and buildings

Where a lease is for land and buildings, the land component is separated from the building component and the classification for each is assessed separately.

Note 1.13 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.

When some or all of the economic benefits required to settle a provision are expected to be recovered from a third party, the receivable is recognised as an asset if it is virtually certain that reimbursements will be received and the amount of the receivable can be measured reliably.

A restructuring provision is recognised when the NHS Trust has developed a detailed formal plan for the restructuring and has raised a valid expectation in those affected that it will carry out the restructuring by starting to implement the plan or announcing its main features to those affected by it. The measurement of a restructuring provision includes only the direct expenditures arising from the restructuring, which are those amounts that are both necessarily entailed by the restructuring and not associated with ongoing activities of the entity.

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 22 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 1.14 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 23 where an inflow of economic benefits is probable.
Contingent liabilities are not recognised, but are disclosed in note 23, 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.

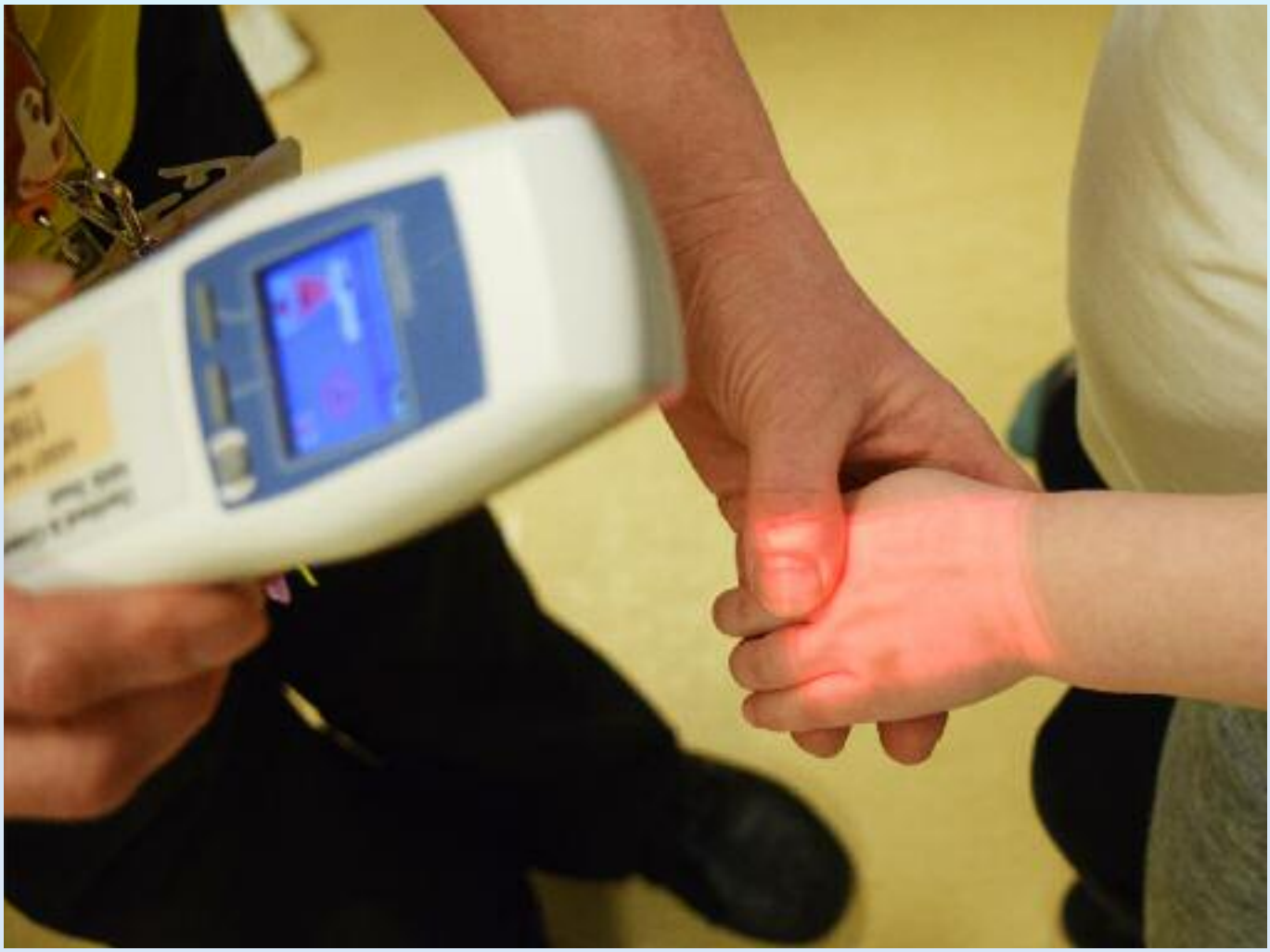
Note 1.15 Public dividend capital

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.

At any time, 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, except for

(i) donated assets (including lottery funded assets),



(ii) average daily cash balances held with the Government Banking Services (GBS) and National Loans Fund (NLF) deposits, excluding cash balances held in GBS accounts that relate to a short-term working capital facility, and

(iii) any PDC dividend balance receivable or payable.

In accordance with the requirements laid down by the Department of Health 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 thus calculated is not revised should any adjustment to net assets occur as a result the audit of the annual accounts.

Note 1.16 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 1.17 Third party assets

Assets belonging to third parties (such as money held on behalf of patients) are not recognised in the accounts since the Trust has no beneficial interest in them. However, they are disclosed in a separate note to the accounts in accordance with the requirements of HM Treasury's FReM .

Note 1.18 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, including

losses which would have been made good through insurance cover had the Trust not been bearing their own risks (with insurance premiums then being included as normal revenue expenditure).

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

Note 1.19 Standards, amendments and interpretations in issue but not yet effective or adopted

As required by IAS 8, Trusts should disclose any standards, amendments and interpretations that have been issued but are not yet effective or adopted for the public sector and an assessment subsequent application will have on the financial statements.

IFRS 9 Financial Instruments

Application required for accounting periods beginning on or after 1 January 2018, but not yet adopted by the FReM: early adoption is not therefore permitted.

IAS 39 follows an incurred losses approach to impairment, under which impairments are only recognised where there is objective evidence that a financial asset is impaired. IFRS 9 changes this to an expected losses model, under which entities need to consider the potential for impairment over the lifetime of the asset. This should reflect the credit risk associated with the financial assets held.

On recognising a financial asset, it will therefore immediately be necessary to recognise a loss allowance, based on the weighted average of future credit losses with the respective risks of a default occurring being used as the weights.

For amounts receivable from other DH group organisations, or indeed the wider public sector, it would be expected that credit risk will be low. This should limit the extent of any loss allowances required. However, amounts receivable from other organisations may be subject to higher credit risk. This will have significant impact on overseas receivables.

IFRS 15 Revenue from Contracts with Customers

Application required for accounting periods beginning on or after 1 January 2018, but not yet adopted by the FReM: early adoption is not therefore permitted.

The core principle in IFRS 15 is that entities should recognise revenue to depict the transfer of promised goods or services to the customer at an amount that reflects the consideration to which the entity expects to be entitled in exchange for those goods or services.

IFRS 15 introduces the need for additional data, to support both methodology and disclosure requirements, and the implications for systems needs to be considered, including the ability to run the existing IAS 18/IAS 11 and IFRS 15 models over the transition period.

The overall impact in the Trust could be limited given that healthcare: obligations are short term in nature;

- transactions not that complex;
- penalties and sanctions are low in value and rarely cross year ends; and
- services that are bundled tend to be over the same time period.

IFRS 15 is more prescriptive than IAS 18 and income is either recognised at a point in time or over time. Healthcare is mostly consumed as provided so recognition over time will mostly be applicable, and the tariff system provides a clear allocation of prices to obligations. Where other income is at a point in time then it is recognised when the obligation is completed, which in some long term contracts could delay recognition.

Under IFRS 15 prices are to be allocated to each performance obligation, which will generally align with a spell of care under tariff. There may be some complex 6 spell cases with distinct elements that could involve multiple performance obligations. However some local block contracts may need further examination as there might be some obligations that need to be separately identified, being subject to different pricing under contract - particularly if they cross year ends.

IFRS 15 revenue is to be recorded at expected value, being what the Trust is expected to be entitled to, so

will incorporate penalties, deductions and discounts, etc. The care that involves readmissions would probably be affected, with the income to be apportioned across the original treatment and the re-admission treatment.

IFRS 16 Leases

IFRS 16 requires that all leases are reflected on the statement of financial position (SOFP) as assets reflecting the right to use an asset and a liability to pay for that right. Currently, only finance leases are reflected on the SOFP and these leases are counted as capital expenditure which scores against capital resource limits set by HM Treasury.

Clearly, a change in the classification of leases from off-SOFP to on-SOFP will have an impact on the level of capital resource limits and how expenditure is scored against those limits.

The new standard will affect both the statement of comprehensive income (SOCI) and the cash flow statement. Under the current arrangements, operating lease rentals are an operating expense but these will be replaced under IFRS 16 by depreciation and interest charges. In the cash flow statement the cost of leases will be shown as financing costs rather than operating costs.

Metrics such as EBITDA will also be affected as, currently, operating lease rentals are included in this calculation but under the new standard they will be excluded

The total cost of the lease over its life will not change as it will be the total amount paid to the lessor but rather than the current straight line rental charge the new interest costs will be higher at the start of the lease period than the end. Depreciation will probably continue to be calculated on a straight line basis but, overall, the impact of lease arrangements will be higher at the start of the lease period than at the end.
The standard includes new disclosure requirements. Some of these will require judgement because the standard requires disclosures to be made to provide users of the accounts sufficient information to assess the effect that leases have on the entity's financial position.

A table will be included when new standards are adopted in the notes to the accounts which will include:

Depreciation charge for right-of-use assets by class of underlying asset
Interest expense on lease liabilities

- The expense relating to short-term leases and leases of low-value assets which are not taken onto the SOFP
- The expense relating to variable lease payments not included in the measurement of lease liabilities
- Income from subleasing right-of-use assets
- Total cash outflow for leases
- Additions to right-of-use assets
- Gains or losses arising from sale and leaseback transactions

The carrying amount of right-of-use assets at the end of the reporting period by class of underlying asset

Note 1.20 Operating Segments

The Trust operates as a single operating segment. The board of directors, led by the Chief Executive is the chief operating decision maker within the Trust. It is only at this level that revenues are fully reported and the overall financial and operational performance of the Trust is assessed. The chief mechanism for financial management and control is the monthly finance report presented by the Finance Director to the Board of Directors. This report is made public at the meeting and via the Trusts website.

Note 2 Operating income from patient care activities

Note 2.1 Income from patient care activities (by nature)

	2017/18 £000	2016/17 £000
Elective income	42,418	45,141
Non elective income	79,515	70,985
First outpatient income	18,864	18,647
Follow up outpatient income	14,689	17,595
A & E income	17,279	15,275
High cost drugs income from commissioners (excluding pass-through costs)	11,477	10,909
Other NHS clinical income	37,513	36,340
Private patient income	555	482
Other clinical income	1,884	1,109
Total income from activities	224,194	216,483

Note 2.2 Income from patient care activities (by source)

Income from patient care activities received from:	2017/18 £000	2016/17 £000
NHS England	24,847	23,876
Clinical commissioning groups	195,153	186,890
Other NHS providers	1,755	4,125
NHS other		1
Non-NHS: private patients	555	482
Non-NHS: overseas patients (chargeable to patient)	346	220
NHS injury scheme	788	885
Non NHS: other	750	4
Total income from activities	224,194	216,483
Of which:		

Note 2.3 Overseas visitors (relating to patients charged directly by the provider)

	2017/18 £000	2016/17 £000
Income recognised this year	346	220
Cash payments received in-year	184	67
Amounts added to provision for impairment of receivables	104	72
Amounts written off in-year	53	51

Note 3 Other operating income

	2017/18	2016/17
	£000	£000
Research and development	372	424
Education and training	5,295	5,331
Receipt of capital grants and donations	129	116
Non-patient care services to other bodies	11,650	12,109
Sustainability and transformation fund income	2,838	6,750
Other income	8,590	7,333
Total other operating income	28,874	32,063
Of which:		
Related to continuing operations	28,874	32,063

	2017/18	2016/17
	£000	£000
*The main areas of other income are:		
Income from provision of mortuary services	143	122
Funding income for stoma/colorectal services	71	99
Sale of films	52	66
Radiology Income (non NHS bodies)	509	545
Income from medical notes	34	38
Occupational Health income	129	125
PFI Support (previously within NHS England revenue from patient care)	4,500	4,723
Staff accommodation rental	543	579
Winter funding	1,653	-
Other	956	1,036
Total	8,590	7,333

Note 4 Operating expenses

	2017/18 £000	2016/17 £000
Purchase of healthcare from NHS and DHSC bodies*	6,946	6,348
Purchase of healthcare from non-NHS and non-DHSC bodies	1,034	1,570
Staff and executive directors costs	150,587	142,810
Remuneration of non-executive directors	64	54
Supplies and services - clinical (excluding drugs costs)	25,799	25,518
Supplies and services - general	404	565
Drug costs (drugs inventory consumed and purchase of non-inventory drugs)	17,717	15,875
Consultancy costs	1,138	778
Establishment	1,215	1,555
Premises	11,259	9,393
Transport (including patient travel)	497	414
Depreciation on property, plant and equipment	7,711	7,937
Net impairments	5,518	1,648
Increase/(decrease) in provision for impairment of receivables	104	115
audit services- statutory audit	52	64
other auditor remuneration (external auditor only)***	12	12
Internal audit costs **	97	178
Clinical negligence	10,863	7,794
Legal fees	192	146
Insurance	106	99
Research and development	440	455
Education and training	1,890	1,771
Rentals under operating leases	233	186
Redundancy	43	-
Charges to operating expenditure for on-SoFP IFRIC 12 schemes (e.g. PFI/ LIFT) on IFRS basis	11,774	11,447
Hospitality	16	2
Other****	931	533
Total	256,642	237,267
Of which:		
Related to continuing operations	256,642	237,267

*Services from NHS bodies does not include expenditure which falls into a category elsewhere within operating expenses.
**Internal audit fees are now shown separately, previously included under other.
*** Other auditor's remuneration relates to audit fees for work carried out on the quality accounts.

**** The main areas of other expenditure are;

	2017/18 £000	2016/17 £000
Nuclear medicine outsourcing	452	204
Radiology remote access	229	267
Other	250	62
	931	533

Note 4.1 Other auditor remuneration

	2017/18 £000	2016/17 £000
Fee of auditor financial statements	43	53
Other auditor remuneration paid to the external auditor:		
All assurance services not falling within items 1 to 5	12	12
Total	12	12

Note 5 Impairment of assets

	2017/18 £000	2016/17 £000
Net impairments charged to operating surplus / deficit resulting from:		
Abandonment of assets in course of construction	-	823
Unforeseen obsolescence	35	-
Changes in market price	5,483	825
Total net impairments charged to operating surplus / deficit	5,518	1,648
Impairments charged to the revaluation reserve	1,097	9,997
Total net impairments	6,615	11,645
* Impairments		
Estate valuation by Montagu Evans	1,295	825
Equipment valuation by Hilditch Ltd	4,188	-
	5,483	825

Note 6 Employee benefits

	2017/18 Total £000	2016/17 Total £000
Salaries and wages	116,563	110,771
Social security costs	12,191	11,084
Apprenticeship levy	592	-
Employer's contributions to NHS pensions	13,352	12,535
Termination benefits	43	-
Temporary staff (including agency)	9,514	10,056
Total gross staff costs	152,255	144.446
Recoveries in respect of seconded staff		
Total staff costs	152,255	144.446
Of which		
Costs capitalised as part of assets	267	295

Average number of employees (WTE basis)

	2017/18 Total no	2017/18 Permanent	2017/18 Other	2016/17 Total no	2016/17 Permanent	2016/17 Other
Medical and dental	410	369	41	397	355	42
Ambulance staff	5	5	-	-	-	-
Administration and estates	608	585	23	613	588	25
Healthcare assistants and other support staff	762	635	127	724	595	129
Nursing,midwifery and health visiting staff	1,143	985	158	1,135	986	149
Scientific,therapeutic and technical staff	281	256	25	277	251	26
Healthcare science staff	55	55		51	51	
Total average numbers	3264	2 890	374	3197	2 826	371
Of which:						
Number of employees (WTE) engaged on capital projects	7	7		11	11	

Note 7 Pension costs

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

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

a) Accounting valuation

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 last published actuarial valuation undertaken for the NHS Pension Scheme was completed for the year ending 31 March 2012. The Scheme Regulations allow for the level of contribution rates to be changed by the Secretary of State for Health, with the consent of HM Treasury, and consideration of the advice of the Scheme Actuary and employee and employer representatives as deemed appropriate.

The Trust operates a National Employment Savings Scheme (NEST) defined contribution workplace pension scheme. It was set up to facilitate automatic enrolment as part of Government workplace reforms.

Note 8 Operating leases

Note 8.1 Dartford & Gravesham NHS Trust as a lessee

This note discloses costs and commitments incurred in operating lease arrangements where Dartford and Gravesham NHS Trust is the lessee.
Operating Leases

The Trust has a number of operating leases for specific medical equipment. All new leases are made on the basis of the standard.

PASA Master Lease agreement (MLA) terms. There is no contingent rent for these items.
Renewals are made on an individual lease by lease basis and determined by business case assessment. There is no provision for the lessee to enter into any arrangement for a secondary lease period.
Lease equipment includes;

Triple Point Leasing Gamma Camera - terminates Nov 2024
Siemens - MRI Scanner - terminates March 2019
CHG Meridian - Lithotripsy Machine - terminates May 2023.

	2017/18 £000	2016/17 £000
Operating lease expense		
Minimum lease payments	233	186
Total	233	186

	2017/18 £000	2016/17 £000
Future minimum lease payments due:		
- not later than one year;	278	59
- later than one year and not later than five years;	510	236
- later than five years.	19	74
Total	984	196

Note 9 Finance income

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

	2017/18 £000	2016/17 £000
Interest on bank accounts	19	14

Note 10 Interest expense

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

	2017/18 £000	2016/17 £000
Loans from the Department of Health and Social Care	297	73
Main finance costs on PFI and LIFT schemes obligations	7,776	7,833
Contingent finance costs on PFI and LIFT scheme obligations	7,121	6,697
Total interest expense	15,194	14,603
Total finance costs	15,194	14,603

Note 11 Other gains / (losses)

	2017/18 £000	2016/17 £000
Gains on disposal of assets	71	11
Losses on disposal of assets	(64)	(122)
Total gains / (losses) on disposal of assets	7	(111)
Total other gains / (losses)	7	(111)

Note 12 Property, plant and equipment

	Land £000	Buildings excluding dwellings £000	Dwellings £000	Assets under construction £000	Plant & machinery £000	Transport equipment £000	Information technology £000	Furniture & fittings £000	Total £000
Valuation/gross at 1 April 2017 - brought forward	13,853	116,898	159	149	28,013	-	5,978	7,154	172,204
Additions	-	3,390	-	69	2,878	12	1,815	33	8,197
Impairments	-	(3,697)	-	-	(4,222)	-	-	-	(7,919)
Reversals of impairments	-	1,304	-	-	-	-	-	-	1,304
Revaluations	992	(3,629)	2	-	(7,650)	-	-	-	(10,285)
Disposals / derecognition	-	-	-	-	(562)	-	(56)	-	(618)
Valuation/gross cost at 31 March 2018	14,845	114,266	161	218	18,457	12	7,737	7,187	162,883
Accumulated depreciation at 1April 2017 - brought forward	-	4,657	-	-	17,959	-	2,237	4,766	29,619
Provided during the year	-	4,217	-	-	1,946	-	724	824	7,711
Revaluations	-	(8,874)	-	-	(7,650)	-	-	-	(16,524)
Disposals / derecognition	-	-	-	-	(498)	-	(56)	-	(554)
Accumulated depreciation at 31 March 2018	-	-	-	-	11,757	-	2,905	5,590	20,252
Net book value at 31 March 2018	14,845	114,266	161	218	6,700	12	4,832	1,597	142,631
Net book value at 1 April 2017	13,853	112,241	159	149	10,054	-	3,741	2,388	142,585

Note 12.1 Property, plant and equipment - 2016/17

	Land £000	Buildings excluding dwellings £000	Dwellings £000	Assets under construction £000	Plant & machinery £000	Transport equipment £000	Information technology £000	Furniture & fittings £000	Total £000
Valuation / gross cost at 1 April 2016	12,739	123,992	222	1,341	27,339	-	4,907	6,426	176,966
Additions	-	1,919	-	96	2,120	-	1,071	771	5,977
Impairments	-	(10,759)	(63)	(823)	-	-	-	-	(11,645)
Revaluations	1,114	1,281	-	-	-	-	-	-	2,395
Reclassifications	-	465	-	(465)					
Disposals / derecognition	-	-	-	-	{1,446}	-	-	(43)	{1,489}
Valuation/gross cost at 31 March 2017	13,853	116,898	159	149	28,013	-	5,978	7,154	172,204
Accumulated depreciation at 1 April 2016	-	-	-	-	17,375	-	1,650	4,023	23,048
Transfers by absorption									
Provided during the year	-	4,657	-	-	1,908	-	587	785	7,937
Disposals/ derecognition	-	-	-	-	(1,324}	-	-	{42)	{ 1,366)
Accumulated depreciation at 31 March 2017	-	4,657	-	-	17,959	-	2,237	4,766	29,619
Net book value at 31 March 2017	13,853	112,241	159	149	10,054	-	3,741	2,388	142,585
Net book value at 1 April 2016	12,739	123,992	222	1,341	9,964	-	3,257	2,403	153,918

Note 12.2 Property, plant and equipment financing

	Land £000	Buildings excluding dwellings £000	Dwellings £000	Assets under construction £000	Plant & machinery £000	Transport equipment £000	Information technology £000	Furniture & fittings £000	Total £000
Net book value at 31 March 2018									
Owned - purchased	14,845	3,797	161	218	6,221	12	4,832	1,597	31,683
On-SoFP PFI contracts and other service concession arrangements	-	110,469	-	-	-	-	-	-	110,469
Owned - donated	-	-	-	-	479	-	-	-	479
NBV total at 31 March 2018	14,845	114,266	161	218	6,700	12	4,832	1,597	142,631

Note 12.3 Property, plant and equipment financing

	Land £000	Buildings excluding dwellings £000	Dwellings £000	Assets under construction £000	Plant & machinery £000	Transport equipment £000	Information technology £000	Furniture & fittings £000	Total £000
Net book value at 31 March 2017									
Owned - purchased	13,853	4,418	159	149	9,630	-	3,741	2,385	34,335
On - SoFP PFI contracts and other service concession arrangements	-	107,823	-	-	-	-	-	-	107,823
Owned - donated	-	-	-	-	424	-	-	3	427
NBV total at 31 March 2017	13,853	112,241	159	149	10,054	-	3,741	2,388	142,585

Net book value at 31 March 2017
Owned - purchased

On-SoFP PFI contracts and other service concession arrangements

Note 13 Donations of property, plant and equipment

The following donations were received for the purchase of property, plant and equipment during the year, there were no restriction or conditions imposed by the donor. There was no difference between the cash provided and the fair value of the assets acquired.

	2017/18
i-Stat Analyser (ex-demo)	7
i-Stat Analyser full accessories	13
Laptop (7x GRA001) for Cancer nurses	6
Reclining Relax Chair (8x GRA003)	13
Bladder Scanner QMH OPD	7
Rafaela RF Ablation Device	17
Alphascope/Hysteroscope (6x GRA002)	14
Typhoon Plasma Unit	17
Mammotone Resolve System	6
Ambiturns (38x) & Sara Steady (20x)	29
	129

Note 14 Revaluations of property, plant and equipment

Land and buildings were valued by an independent valuer Montagu Evans (RICS registered valuers) as at 31st March 2018. The valuation was prepared under International Financial Reporting Standards (IFRS) which requires the statement of assets at Fair Value. Within this broad definition, assets should be valued at Market Value or, if no market exists for a property, which may be rarely sold or it is a specialised asset, an income or depreciated replacement cost (DRC) approach should be adopted. The DRC approach is based on a Modern Equivalent Asset (MEA) with the same floor area as the existing buildings and offering the same service potential. Gross valuation was £129m.

The valuation requirements of IAS 16 were applied together with regard to Department of Health Group Accounting Manual 2017/18 which sets out the accounting policies to be followed by NHS Trusts and also relied on RICS Valuation Global Standards 2017.

Equipment (long life high value) category equipment were valued by independent specialist equipment valuers Hilditch Ltd to market value as at 31st March 2018 resulting in impairment of the assets by £4.2m.

Note 15 Disclosure of interests in other entities

The Trust does not have any interest in other entities.

Note 16 Inventories

	31 March 2018 £000	31March 2017 £000
Drugs	1,264	1,605
Consumables	1,665	1,408
Energy	12	19
Tota inventories	2,941	3,032

Inventories recognised in expenses for the year were £17,383k (2016/17:£14,924k). There were no writedown of inventories recognised as expenses for the year or in the previous year.

Note 17 Trade receivables and other receivables

	31 March 2018 £000	31 March 2017 £000
Current		
Trade receivables	12,502	9,723
Accrued income	6,004	3,302
Provision for impaired receivables	(282)	(264)
Prepayments (non-PFI)	1,869	580
PDC dividend receivable	39	247
VAT receivable	951	703
Total current trade and other receivables	21,083	14,291

The great majority of trade is with Clinical Commissioning Groups as commissioners NHS patient care are funded by Government to buy NHS patients care services, no credit scoring is considered necessary. The Trust does wherever possible take deposits for private patient care or ensure that insurance is available Receivables are considered for impairment on a case by case basis.

Of which receivables from NHS and DHSC group bodies:		
Current	15,135	9,622

Note 17.1 Provision for impairment of receivables

	2017/18 £000	2016/17 £000
At 1April as previously stated	264	214
Increase in provision	104	100
Amounts utilised	(86)	(65)
Unused amounts reversed	-	15
At 31 March	282	264

Note 17.2 Credit quality of financial assets

	31 March 2018 Trade and other receivables £000	31 March 2017 Trade and other receivables £000
Ageing of impaired financial assets		
Over 180 days	282	264
Total	282	264
Ageing of non-impaired financial assets past their due date		
0 - 30 days	8,654	3,246
30-60 Days	563	1,800
60-90 days	997	686
90- 180 days	1,330	2,609
Over 180 days	677	1,118
Total	12,221	9,459

All receivables are reviewed during the year and provisions for doubtful debts are made on an invoice by invoice basis.

Note 18 Cash and cash equivalents movements

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.

	2017/18 £000	2016/17 £000
At 1 April	7,780	2,341
Net change in year	(2,953)	5,439
At 31 March	4,827	7,780
Broken down into:		
Cash at commercial banks and in hand	3	9
Cash with the Government Banking Service	4,824	7,771
Total cash and cash equivalents as in SoFP	4,827	7,780
Total cash and cash equivalents as in SoCF	4,827	7,780

Note 19 Trade and other payables

	31 March 2018 £000	31 March 2017 £000
Current		
Trade payables	8,190	8,348
Capital payables	2,784	2,589
Accruals	12,987	11,694
Receipts in advance (including payments on account)	-	67
Social security costs	1,580	1,641
Other taxes payable	1,764	1,450
Accrued interest on loans	57	7
Other payables	4,106	2,922
Total current trade and other payables	31,468	28,718
Of which payables from NHS and DHSC group bodies:		
Current	8,026	6,188

Note 19.1 Early retirements in NHS payables above

The payables note above includes amounts in relation to early retirements as set out below:

	31 March 2018 £000	31 March 2017 £000
- outstanding pension contributions	1,906	1,795

Note 20 Other liabilities

	31 March 2018 £000	31 March 2017 £000
Current		
Deferred income	2,668	-
PFI deferred income / credits	53	53
Total other current liabilities	2,721	53
Non-current		
PFI deferred income / credits	685	737
Total other non-current liabilities	685	737

Note 21 Borrowings

	31 March 2018 £000	31 March 2017 £000
Current		
Loans from the Department of Health and Scoial Care	3,294	194
Other loans	15	15
Obligations under PFI, LIFT or other service concession contracts (excl. lifecycle)	2,015	1,807
Total current borrowings	5,324	2,016
Non-current		
Loans from the Department of Health and Scoial Care	21,011	9,850
Other loans	15	31
Obligations under PFI, LIFT or other service concession contracts	63,889	65,904
Total non-current borrowings	84,915	75,785

Note 22 Provisions for liabilities and charges analysis

	Pensions - early departure costs £000	Legal claims £000	Other £000	Total £000
At 1April 2017	8	34	60	102
Arising during the year	-	85	-	85
Utilised during the year	(8)	(34)	-	(42)
Reversed unused	-	-	(10)	(10)
At 31 March 2018	-	85	50	135
Expected timing of cash flows:				
- not later than one year;	-	85	50	135
Total	-	85	50	135

Legal claims are in respect of Employment Tribunal costs including legal fees; other costs are in respect of CNST claims excess element only

Note 22.1 Clinical negligence liabilities

At 31 March 2018, £206,393k was included in provisions of NHS Resolution in respect of clinical negligence liabilities of Dartford and Gravesham NHS Trust (31 March 2017: £174,788k).

Note 23 Contingent assets and liabilities

	31 March 2018 £000	31 March 2017 £000
Value of contingent liabilities		
Employment tribunal and other employee related litigation	(115)	-
Gross value of contingent liabilities	(115)	-
Net value of contingent liabilities	(115)	-
Net value of contingent assets		

Contingent liability is in respect of Employment Tribunal case with low probability of successful claim

Note 24 Contractual capital commitments

	31 March 2018 £000	31 March 2017 £000
Property, plant and equipment	69	423
Total	69	423

Note 25 On-SoFP PFI, LIFT or other service concession arrangements

The contract provides for the construction and operation of a new hospital, which was fully operational from 11th September 2000. Although the total length of the project is 67 years, the Trust has the option to terminate the contract after 32 years and every 5 years thereafter. The PFI arrangement was refinanced on 31 March 2003, which provided a cash benefit of £1,527k for which the gain will be spread over the remainder of the 32 years and on-going annual benefit (at current prices) of £2,187k. At the end of the contract term the assets transfer to the Trust in full. Under IFRIC12, the asset is treated as an asset of the Trust. The substance of the contract is that the Trust has a finance lease and the payments comprise two elements, inputted finance lease charges and service charges. Within the operating expenditure future commitments, a judgement is made on inflation to arrive at future costs.

Note 25.1 Imputed finance lease obligations

Statement of Financial Position PFI and LIFT schemes:

	31 March 2018 £000	31 March 2017 £000
Gross PFI, LIFT or other service concession liabilities	137,632	147,215
Of which liabilities are due		
- not later than one year;	9,584	9,584
- later than one year and not later than five years;	38,336	38,336
- later than five years.	89,712	99,295
Finance charges allocated to future periods	(71,728)	(79,504)
Net PFI, LIFT or other service concession arrangement obligation	65,904	67,711
- not later than one year;	2,015	1,807
- later than one year and not later than five years;	10,651	9,554
- later than five years.	53,238	56,350

Note 25.2 Total on-SoFP PFI, LIFT and other service concession arrangement commitments

Total future obligations under these on-SoFP schemes are as follows:

	31 March 2018 £000	31 March 2017 £000
Total future payments committed in respect of the PFI, LIFT or other service concession arrangements	525,448	554,925
Of which liabilities are due:		
- not later than one year;	29,593	28,478
- later than one year and not later than five years;	126,827	123,397
- later than five years.	369,028	403,050

Note 25.3 Analysis of amounts payable to service concession operator

This note provides an analysis of the Trust's payments in 2017/18:

	2017/18 £000	2016/17 £000
Unitary payment payable to service concession operator	28,478	27,598
- Interest charge	7,776	7,833
- Repayment of finance lease liability	1,807	1,621
- Service element and other charges to operating expenditure	11,774	11,447
- Contingent rent	7,121	6,697
Total amount paid to service concession operator	28,478	27,598

Note 25.4 Impact of IFRS treatment - current year

The information below is required by the Department of Heath for budget reconciliation purposes

	2017/18 £000	2016/17 £000
Revenue consequences of IFRS: PFI and other items under IFRIC12		
Depreciation charge	4,073	4,531
Interest expense	14,897	14,530
Impairment charge / reversal - AME	80	409
other expenditure (from UP)	11,774	11,447
Other income - amortisation of PFI deferred income / credits	(53)	-
Impact on PDC dividend payable	578	744
Total IFRS expenditure (IFRIC12)	31,349	31,661
Revenue costs of the same schemes if they had been accounted for under UK GAAP / ESA10 (net of any sublease income)	28,601	27,751
Net IFRS change (IFRIC12)	2,748	3,910
Capital consequences of IFRS: PFI and other items under IFRIC12		
Capital expenditure on a UK GAAP basis	636	615

Note 26 Financial Instruments

Financial risk management

The Trust's treasury management operations are carried out by the finance department, within parameters defined formally within the Trust's standing financial instructions and policies agreed by the board of directors. The Trust's treasury activity is subject to review by the Trust's internal auditors.

Currency risk

The Trust is principally a domestic organisation with the great majority of transactions, assets and liabilities being in the UK and sterling based. The Trust has no overseas operations. The Trust therefore has low exposure to currency rate fluctuations.

Interest rate risk

The Trust borrows from government for capital expenditure, subject to affordability as confirmed by the NHSI. The borrowings are for 1- 25 years, in line with the life of the associated assets, and interest is charged at the National Loans Fund rate, fixed for the life of the loan. The Trust therefore has low exposure to interest rate fluctuations.

Credit risk

Because the majority of the Trust's revenue comes from contracts with other public sector bodies, the Trust has low exposure to credit risk. The maximum exposures as at 31 March 2018 are in receivables from customers, as disclosed in the trade and other receivables note.

Liquidity risk

The Trust's operating costs are incurred under contracts with Clinical Commisiioning Groups, which are financed from resources voted annually by Parliament. The Trust funds its capital expenditure from funds obtained within its prudential borrowing limit. The Trust is not, therefore, exposed to significant liquidity risks.

27 Carrying values of financial assets

	Loans and receivables £000	Total book value £000
Assets as per SoFP as at 31 March 2018		
Trade and other receivables excluding non financial assets	18,224	18,224
Cash and cash equivalents at bank and in hand	4,827	4,827
Total at 31 March 2018	23,051	23,051

	Loans and receivables £000	Total book value £000
Assets as per SoFP as at 31 March 2017		
Trade and other receivables excluding non financial assets	9,971	9,971
Cash and cash equivalents at bank and in hand	7,780	7,780
Total at 31 March 2017	17,751	17,751

Note 28 Carrying value of financial liabilities

	Other financial liabilities £000	Total book value £000
Liabilities as per SoFP as at 31 March 2018		
Borrowings excluding finance lease and PFI liabilities	24,335	24,335
Obligations under PFI, LIFT and other service concession contracts	65,904	65,904
Trade and other payables excluding non financial liabilities	31,468	31,468
Total at 31 March 2018	121,707	121,707

	Other financial liabilities £000	Total book value £000
Liabilities as per SoFP as at 31 March 2017		
Borrowings excluding finance lease and PFI liabilities	10,090	10,090
Obligations under PFI, LIFT and other service concession contracts	67,711	67,711
Trade and other payables excluding non financial liabilities	26,343	26,343
Total at 31 March 2017	104,144	104,144

Note Fair values of financial assets and liabilities

Note Maturity of financial liabilities

	31 March 2018 £000	31 March 2017 £000
In one year or less	36,792	28,359
In more than one year but not more than two years	2,555	5,225
In more than two years but not more than five years	28,042	13,437
In more than five years	54,318	57,123
Total	121,707	104,144

Note 29 Losses and special payments

	2017/18		2016/17	
	Total number of cases Number	Total value of cases £000	Total number of cases Number	Total value of cases £000
Cash losses	7	1	15	3
Bad debts and claims abandoned	21	54	46	65
Total losses	28	55	61	68
Total losses and special payments	28	55	61	68

Note 30 Related party transactions

Dartford & Gravesham NHS Trust is a corporate body established by order of the Secretary of State for Health.
During the year none of the Department of Health Ministers, Trust board members or members of the key management staff, or parties related to any of them, has undertaken any material transactions with Dartford & Gravesham NHS Trust.
of material transactions with the Department and with other entities for which the Department is regarded as the parent Department.

	Income 2017/18 £'000	Income 2016/17 £'000	Receivables 2017/18 £'000	Receivables 2016/17 £'000
Bexley CCG	37,437	32,383	1,945	274
Bromley CCG	1,854	1,709	163	25
Dartford Gravesham & Swanley CCG	143,474	137,541	-	490
Greenwich CCG	4,213	5,036	160	-
Guys & St Thomas NHS Foundation Trust	-	2,140	129	702
Health Education England	5,487	5.483	382	-
Kent Community Health NHS Foundation Trust	430	631	-	226
Kings College NHS Foundation Trust	2,634	3,501	776	2,460
Lewisham & Greenwich NHS Trust	590	2,427	214	1,567
Medway CCG	4,053	3,933	85	105
Medway NHS Foundation Trust	3,534	2,667	1,440	1,371
NHS England	31,759	32,874	5,627	997
Oxleas NHS Foundation Trust	490	530	210	250
Public Health England	2,443	2,516	-	1
Queen Victoria Hospitals NHS Foundation Trust	746	750	364	97
Royal Surrey Hospital NHS Foundation Trust	372	424	-	-
Thurrock CCG	2396	2,218	-	-
West Kent CCG	1,404	1,346	-	189
Dartford & Gravesham NHS Charity	338	322	542	560

	Expenditure 2017/18 £'000	Expenditure 2016/17 £'000	Payables 2017/18 £'000	Payables 2016/17 £'000
Dartford Gravesham & Swanley CCG	60	-	232	-
Guys & St Thomas NHS Foundation Trust	2,347	2,267	1,809	1,421
HMRC	12,773	11,084	3,344	3,091
Kent Community NHS Foundation Trust	1,350	-	263	-
Maidstone & Tunbridge Wells NHS Trust	4,608	3,959	1,408	1,417
Medway NHS Foundation Trust	994	657	1,046	278
NHS Blood and Transplant Authority	1,006	1,081	-	-
NHS Litigation Authority	10,966	7,894	-	-
NHS Pension Scheme (own staff employers and employees)	13,352	12,535	1,915	1,795
Oxleas NHS Foundation Trust	4,878	4,346	1,409	1,065
West Kent CCG	-	-	106	-
Dartford & Gravesham NHS Charity	328	116	-	-

Note 31 Better Payment Practice code

	2017/18 Number	2017/18 £000	2016/17 Number	2016/17 £000
Non-NHS Payables				
Total non-NHS trade invoices paid in the year	38,165	137,328	41,473	110,845
Total non-NHS trade invoices paid within target	20,288	111,321	25,494	91,400
Percentage of non-NHS trade invoices paid within target	53.16%	81.06%	61.47%	82.46%
NHS Payables				
Total NHS trade invoices paid in the year	2,160	35,710	1,901	30,242
Total NHS trade invoices paid within target	424	14,986	637	15,069
Percentage of NHS trade invoices paid within target	19.63%	41.97%	33.51%	49.83%

The Better Payment Practice code requires the NHS body to aim to pay all valid invoices by the due date or within 30 days of receipt of valid invoice, whichever is later.

No liability to pay interest which accrued by failing to pay invoices within the 30 day where obligated to do so.
Total amount of interest paid in the discharge of such liability was £0

Note 32 External finance limit (EFL)

The Trust is given an external financing limit against which it is permitted to underspend:

	2017/18 £000	2016/17 £000
External finance limit (EFL)	16,466	5,459
Cash flow financing (from SoCF)	(129)	(1,908)
External financing requirement	8,004	(1,908)
Under spend against EFL		7,367

Note 33 Capital Resource Limit

The Trust is given a capital resource limit which it is not permitted to exceed.

	2017/18 £000	2016/17 £000
Gross capital expenditure	8,197	5,977
Less: Disposals	(64)	(122)
Less: Donated and granted capital additions	(129)	(116)
Charge against Capital Resource Limit	(8,004)	(5,739)
Capital Resource Limit	8,354	5,975
Under spend against CRL	350	236

The Trust is expected to manage its capital expenditure within its agreed Capital Resource Limit (CRL). In 2017/18, the CRL was set at £8.4m (based on initial depreciation funding which was subsequently reduced by £150k NHSI did not adjust for this); the Trust has underspend against its target by £350k once adjustments are made for offset by disposals and donations totalling £200k.

Note 34 Breakeven duty rolling assessment

	2008/09 £000	2009/10 £000	2010/11 £000	2011/12 £000	2012/13 £000	2013/14 £000	2014/15 £000	2015/16 £000	2016/17 £000	2017/18 £000
Breakeven duty in-year financial performance		115	206	393	361	1,834	235	(7,649)	(382)	(12,129)
Breakeven duty cumulative position	2,745	2,860	3,066	3,459	3,820	5,654	5,889	(1,760)	(2,142)	(14,271)
Operating income		141,935	157,195	169,244	177,204	209,942	226,116	224,593	248,546	253,068
Cumulative breakeven position as a percentage of operating income		2.02%	1.95%	2.04%	2.16%	2.69%	2.60%	-0.78%	-0.86%	-5.64%

In 2015-16 the key drivers of the deficit were reduced income from CCG's due to higher penalties and both pay and non pay expenditure overspends; although the Trust did deliver the £10m CIP's. The Trust and TOA (now NHSI) entered into phase 1 of GRIP and Control framework for the improvement process.

In 2016-17 the key drivers of the defict were reduced income from CCG's due to higher fines and penalties and subsequent impact on the S & T funding as the Trust achieve its control total. The Trust continued the GRIP and Control process to improve the outturn. The Trust planned to achieve its control total in 2017-18.

In 2017-18 the Trust deficit was driven by significant reduction in clinical income and cost pressures around capacity and safety generated overspends against the plan; because of the adverse variance the Trust was unable to secure all of the £7.3m S & T funding (only £1.1m was secured); during the financial year the Trust strengthened its Programme Management Office to manage the savings programme; the Trust also introduced an internal financial recovery plan.

	2017/18 £000
Breakeven duty financial performance 2017/18	
Adjusted financial performance surplus/(deficit) (control total basis)	(15,757)
Remove CQUIN risk reserve adjustment	960
IFRIC 12 breakeven adjustment	2,668
Breakeven duty financial performance surplus/(deficit)	(12,129)

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Dartford and Gravesham
NHS Trust

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Dartford and Gravesham
NHS Trust

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Queen Mary's Hospital
Frognal Avenue Sidcup Kent DA14 6LT Tel: 020 8302 2678

Erith & District Hospital
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