Maidstone and Tunbridge Wells NHS Trust

Annual Report and Accounts 2017/18

taking pride

Patient First – Respect – Innovation – Delivery - Excellence

About this Annual Report

The National Health Service and Community Care Act 1990 requires NHS Trusts to produce an Annual Report. The content and format is required to follow the guidance issued by the Department of Health and Social Care (in the form of a 'Group Accounting Manual'). The specific requirements for Annual Reports for 2017/18 are that NHS bodies must publish a single Annual Report and Accounts (ARA) document, comprising the following:

- A Performance Report (which must include an overview, and a performance analysis)
- An Accountability Report (which must include: a Corporate Governance Report and a Remuneration and Staff Report[1])
- The Financial Statements

The Department of Health and Social Care's guidance sets out the minimum content of the Annual Report. Beyond this however, the Trust is expected to take ownership of the Report and ensure that additional information is included where necessary to reflect the position of the Trust within the community and give sufficient information to meet the requirements of public accountability. The Report is divided into several sections:

- "Performance Report for 2017/18", which is split into the following sections:
  - An overview. This includes an overview summary; the purpose and activities of the Trust; the Chair and Chief Executive's report; the 'story of the year' (month by month); the key issues and risks affecting delivery of the Trust's objectives; an explanation of the adoption of the going concern basis; and a Performance summary
  - A Performance analysis, which includes details of how the Trust measures performance; the Trust's development and performance in 2017/18; and a review of financial performance for 2017/18
  - A summary of the Trust's Quality Accounts for 2017/18
  - A Sustainability Report. This follows the standard reporting format from the NHS Sustainable Development Unit
- "Accountability Report for 2017/18", which is divided into the following sections:
  - "Corporate Governance Report for 2017/18", which in turn is divided into:
    - A Directors' report (which provides details of the Trust Board; a Statement as to disclosure to Auditors; attendance at Trust Board meetings; details of Directors' interests; the Trust's Management Structure; complaints performance and the Trust's application of the 'Principles for Remedy' guidance; disclosure of "incidents involving data loss or confidentiality breaches"; & details of Emergency Preparedness arrangements)
    - The "Statement of the Chief Executive's responsibilities as the Accountable Officer of the Trust"
    - The "Annual Governance Statement for 2017/18"
  - "Remuneration and Staff Report for 2017/18" (including details of 'off-payroll' engagements)
- "Financial Statements for 2017/18", which includes Pension Liabilities, exit packages and severance payments; and staff sickness absence data
- Independent Auditor's report to the Directors of Maidstone and Tunbridge Wells NHS Trust

The Annual Report and Accounts were approved by the Trust Board of Maidstone and Tunbridge Wells NHS Trust on 24th May 2018.

[1] The Trust is not required to produce a Parliamentary Accountability and Audit Report, and therefore the required disclosures on remote contingent liabilities, losses and special payments, gifts, and fees and charges are included within the Financial Statements and Notes to the Accounts

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Maidstone and Tunbridge Wells NHS Trust

Performance Report for 2017/18: Overview

taking Pride

Summary

The purpose of this overview is to give the reader sufficient, summarised information to understand the Trust, its purpose, the key risks to the achievement of its objectives, and an outline of its performance during the year 2017/18. For those wishing to read more about the Trust's achievements, the issues it faced and its detailed financial situation, further detail is provided in the rest of the Annual Report and Accounts.

The purpose and activities of Maidstone and Tunbridge Wells NHS Trust

Maidstone and Tunbridge Wells NHS Trust (the Trust) is a large acute hospital Trust in the south east of England. The Trust was legally established on 14th February 2000[2], and provides a full range of general hospital services and some areas of specialist complex care to around 590,000 people living in West Kent and East Sussex. The Trust also provides some aspects of specialist care to a wider population.

The Trust's core catchment areas are Maidstone and Tunbridge Wells and their surrounding boroughs. It employs a team of approximately 5000 full and part-time staff, and operates from three main sites (Maidstone Hospital, Tunbridge Wells Hospital and the Crowborough Birth Centre), but also manages services at Kent and Canterbury Hospital and outpatient services at several community locations. The Trust has over 800,000 patient visits a year, 172,000 of these through its Emergency Departments (EDs) which are accessible at both main hospital sites.

Tunbridge Wells Hospital is a Private Finance Initiative (PFI) hospital[3] and the majority of the site provides single bedded ensuite accommodation for inpatients in a modern, state of the art environment. It is a designated Trauma Unit, undertakes the Trust's emergency surgery and is the main site for Women's and Children's, and Orthopaedic services.

Maidstone Hospital benefits from its central county location. It hosts the Kent Oncology Centre, providing specialist cancer services to around 2 million people across Kent and East Sussex, the fourth largest oncology service in the country. The Trust offers PET/CT (Positron Emission Tomography – Computed Tomography) services in a dedicated building and has a rolling programme to upgrade its Linear Accelerator radiotherapy machines. The Maidstone site also has a state of the art Birth Centre, a dedicated ward for respiratory services and an Academic Centre with a 200 seat auditorium. With the Education Centre at Tunbridge Wells Hospital, and its full resuscitation simulation suite, the Trust is able to offer excellent clinical training. The Trust has strong clinical, academic and research links with London hospitals, including joint appointments. Many staff are also nationally recognised for excellence in their fields.

The Trust is registered with the Care Quality Commission to provide the following Regulated Activities:

- Assessment or medical treatment for persons detained under the Mental Health Act 1983 (at Maidstone and Tunbridge Wells Hospitals)
- Diagnostic and screening procedures (at Maidstone and Tunbridge Wells Hospitals)
- Family planning services (at Maidstone and Tunbridge Wells Hospitals)
- Maternity and midwifery services (at Maidstone and Tunbridge Wells Hospitals and Crowborough Birthing Centre)
- Surgical procedures (at Maidstone and Tunbridge Wells Hospitals)

[2] See The Maidstone and Tunbridge Wells National Health Service Trust (Establishment) Order 2000
[3] The PFI Project Company is "Kent and East Sussex Weald Hospital Ltd" (KESWHL)

- Termination of pregnancies (at Tunbridge Wells Hospital)
- Treatment of disease, disorder or injury (at Maidstone and Tunbridge Wells Hospitals)

For further details of the Trust's CQC Registration, see www.cqc.org.uk/provider/RWF/registration-info.

The Trust approved an updated Trust Strategy in October 2017 following engagement with staff, patients and partner organisations (see page 16). The Strategy reflects the NHS Five Year Forward View and is aligned to local plans in the wider health and social care economy. There is a strong focus on the Kent and Medway Sustainability and Transformation Partnership (STP) and working in partnership as a key driver for sustainability. The Trust's objectives and organisational structure are detailed elsewhere within this Annual Report.

The Trust entered into an Aligned Incentives Contract with West Kent Clinical Commissioning Group (CCG) for the 2017/18 financial year. The contract is for a 2 year period and marks a departure from the traditional 'Payment by Results' contract approach, instead seeking to incentivise both contracted parties to work together to deliver common aims, in particular, the removal of costs from the system.

Details of the Trust's business model and environment, organisational structure, objectives and strategies can be found within the Performance Report Overview and Performance Analysis.

A message from the Chair and Chief Executive

We would like to jointly welcome you to our Annual Report and Accounts for Maidstone and Tunbridge Wells NHS Trust.

The Trust implemented a series of carefully planned and closely monitored clinically-led service changes during 2017/18 to improve its patient and staff experience. The developments continue into 2018/19 as part of our new Best Care Strategy. Best Care has been developed for the Trust to meet the changing health needs of its population, to improve the quality of its services, address national staffing challenges and continue to carefully reduce its recurrent deficit.

The Trust was independently assessed by the Care Quality Commission (CQC) in 2017/18 and takes confidence from the regulator's feedback, which supports its direction of travel to make our Trust a sustainable, caring and improvement driven organisation. The CQC found `significant and sustained improvement' through its inspections, and is sufficiently assured that, while the Trust remains in Financial Special Measures, it continues to carefully improve quality whilst reducing cost.

The CQC has also found strong leadership and an open and honest culture throughout the Trust. The Trust has taken on board the CQC's improvement ideas and is going many steps further with the development of its own Quality Strategy, which is being delivered through Best Care.

The Trust has sought to improve its staff engagement during 2017/18 with the implementation of Listening into Action (LiA). A number of clinically-led improvements have occurred throughout the year as a consequence of LiA, which seeks to empower our staff to make the changes they want to see that improve our patient and staff experience.

Parts of our Best Care Strategy are going to further improve our patient, staff and stakeholder engagement this year, supporting one of our key quality aims of becoming a truly patient-centred provider of personalised care.

Similar to many NHS Trusts nationally, we have continued to see year on year increases in the number of patients requiring emergency care and hospital admission. The Trust deployed a range of measures during 2017/18 as part of a robust clinically-led Winter Plan to maintain high quality, safe standards of care for its patients. The measures, which steadily improved the Trust's Emergency Department performance at a time of unprecedented demand for patient care, included changes to our patient pathways and development of new clinical roles.

Despite the best efforts of both Maidstone and Tunbridge Wells hospitals to work in unison, the use of more of our finite resources to treat emergency patients safely, national suspension of elective surgery, and prolonged periods of snow, collectively impacted on our ability to maintain the Referral to Treatment (RTT) waiting time standard. The Trust has also struggled to consistently meet the Cancer 62-day standard. Both of these areas are the subject of ongoing programmes of intensive improvement work from the outset of 2018/19.

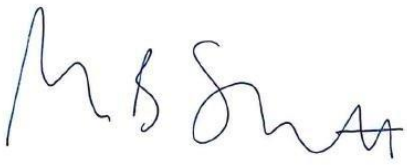
Looking forward to the year ahead, our annual plan for 2018/19 puts us within touching distance of becoming a strong independent Trust that can make more of its long-held aspirations for its services, patient care and everyday working lives a reality. The plan moves us to within 12 months of securing long-term financial sustainability and has the potential to create enormous investment opportunity along the way.

Over the last two years, we have managed to reduce our underlying deficit from £37 million to £18 million, and it is planned to eradicate that over the next 2 years. Consequently, in 2018/19, we will be delivering a savings programme of £24 million – an amount similar to the savings delivered by the Trust in 2017/18.

By achieving this year's plan, the Trust will:

- move out of Financial Special Measures and be considerably closer to achieving long-term underlying financial sustainability
- be able to earn £12 million in additional funding from the NHS Provider Sustainability Fund to spend in 2019/20. This will provide more cash for us to invest in capital improvements in future years
- have its lowest ever underlying deficit to tackle in 2019/20, so we can regain our autonomy and authority to make significant changes for the better.

The Trust Board has undergone significant changes in its membership during the course of the year and, as well as the appointment of a new Chair and a new Chief Executive, has welcomed several new Non-Executive Directors, and Associate Non-Executive Directors, as well a new Director of Workforce. We would like to thank all staff, volunteers and non-executives for their hard work and ongoing dedication during the year and to particularly recognise Glenn Douglas, who left the Trust in 2017 after 10 years as Chief Executive, for his commitment and service in that time. With our combined commitment, energy and expertise, we look forward to working together to achieve these aspirations and to creating a better Trust for all of us.



Miles Scott, Chief Executive

24th May 2018

David Highton, Chair of the Trust Board

24th May 2018

The story of the year

April 2017

Looking back a year, emergency admissions were 18% higher for April 2017 than in April 2016 and attendances were up 10% for the same period. This continued to impact on the Trust's ability to see all of its planned patients as quickly as both it, and they, would want, and remains the reason why the Trust continued to devote its time and focus throughout the year ahead on enhancing patient flow through its hospitals.

The Trust agreed its new set of key objectives for 2017/18 in April, focussed on providing safe, high quality services for patients over the coming year. The objectives, approved by the Trust Board, consolidated some of the Trust's most important challenges into a single, 6-point list that all staff could support and apply their collective efforts to achieving for the Trust's patients. Details of these objectives are given on pages 17 and 18.

May 2017

The Trust welcomed David Highton as the new Chair of the Trust Board in May. David commenced his appointment with an extensive programme of induction visits, site tours and meetings to familiarise himself with the workings and facilities of the Trust. There is more information on David's professional background in the Directors' Report.

The Trust's second 'Rapid Improvement Week' was held during May and included the opening of the Tunbridge Wells Orthopaedic Unit, which enabled the provision of 23 ring-fenced beds for Orthopaedics, thereby increasing the capability to treat more patients & reduce the number of cancellations. The week also saw improved patient flow which enabled the Trust to achieve the highest number of patients ever discharged via the Discharge Lounge in a single day.

June 2017

June saw confirmation that the Trust's £645,000 bid for national funding had been agreed to help improve patient flow through its Emergency Departments (EDs). This allowed the Trust to move forward at pace to transform its EDs on both sites to provide dedicated co-located areas for GP-led care, thereby allowing up to 20% of ED patients to be seen more appropriately by GPs working in the ED. These changes would require building works at Tunbridge Wells Hospital (including an extension at the front of the ED) and creation of a dedicated area at Maidstone ED to provide a better GP-led service there.

Opening of the Frailty Unit in June 2017

Early June also saw the opening of the Chaucer Acute Frailty Unit (CAFU) at Maidstone Hospital. The Unit offered 11 assessment spaces and 14 short-stay inpatient beds, for those patients needing to stay for up to 48 hours. A multi-disciplinary team worked together to set up innovative new pathways, whereby patients are assessed for suitability in ED and then referred to the CAFU according to agreed criteria. The system promotes national best practice, and supports rapid turnover and admission avoidance where it is safe and appropriate to do so.

The results for the 2016 National Inpatient Survey were published in June and provided a platform for further improvements during the year. Looking at two key indicators, 97.4% of patients felt they were treated with respect and dignity, and 97.6% of patients felt well looked after by the Trust's staff. The full survey report is available at: http://www.cqc.org.uk/provider/RWF/survey/3

July 2017

From the beginning of July, the Trust began a 20-week period focused on making 10 clinically-driven changes that had been identified by its staff to improve patient care under the newly launched Listening into Action (LiA) initiative (page 16). The programme places more of the ideas that staff have at the centre of improvements within their organisations and has been adopted by other Trusts in recent years with noteworthy positive results.

Also in July, the Trust received official notification from the Care Quality Commission (CQC) asking it to prepare for unannounced visits as part of its routine inspection process. More information on the outcome of this process is given later in this section (pages 13 to 14).

August 2017

The Trust was one of the first in the south east of England to introduce Emergency Department Practitioners (EDPs) to work alongside doctors to treat and care for patients with more serious conditions in the ED. The new team was created in August 2017 as part of the Trust's proactive approach to maintaining high quality safe services and its continued commitment to raising standards in patient care. EDPs are Nurses and Paramedics who have been highly trained to perform advanced clinical roles, treating and caring for patients independently, with supervision from consultant doctors. Nine EDPs currently make up the team at the Trust, who work across both hospital sites. The project was so successful and patient satisfaction levels sufficiently improved that, by the end of 2017/18, there were plans to recruit and train additional staff.

A new scanning service based at Maidstone Hospital saw its first patients at the end of August. The brand new PET/CT scanning unit, located next to Kent Oncology Centre, is run by Alliance Medical and replaced the mobile scanner that has been coming to Maidstone for over 10 years. The new unit provides easier and better access for patients in the local area, and means more patients can be seen and scanned than previously with the mobile scanner.

The end of August also saw the launch of the Trust's International Nursing Recruitment Campaign. Skype interviews were carried out for 9 candidates from Nigeria, India and the Philippines, and 9 conditional offers were made on the day.

September 2017

The first LiA Crowd Fixing events were held in September at both of the Trust's main hospital sites. Attendance at both events was good and staff from across the Trust worked together in groups to identify and discuss their biggest frustrations with a view to collectively defining the problem and finding solutions. Many diverse issues were raised along with some great suggestions to tackle them. The feedback from the sessions was very positive with people saying they felt enlightened, encouraged and enthused again after the events. The month also saw the departure, after 10 years service, of Glenn Douglas as the Trust's Chief Executive (see page 15 for more details).

October 2017

October saw the launch of a new "Allscripts" Patient Administration System (PAS) within the Trust. The new system went live, in phases, across ED, the Intensive Care Unit (ICU) and all inpatient and then outpatient areas across the Trust. The Trust introduced "floorwalkers" and "superusers" at both hospitals to act as the first point of call for help and advice on using the new system. Despite these measures, following the go live, some significant problems were encountered which resulted in patients attending for clinics that had been cancelled and rescheduled, clinics being double booked and patients not turning up for appointments. The project team worked hard to successfully resolve these issues.

Work commenced in October in the ED at Tunbridge Wells Hospital on improvements to the department and creation of a space for GPs to see patients. This project was part of the Developing Primary Care initiative (GP streaming) and marked realisation of the plans outlined in 'June 2017' (see earlier).

The first of a series of unannounced CQC inspections was held at both main Trust hospital sites during the month.

November 2017

Late in November 2017, Kent Oncology Centre at Maidstone Hospital officially opened its new radiotherapy machine, which had the very latest state-of-the-art "Truebeam" treatment technology installed. The £2million technology will help to more quickly and accurately treat certain types of cancers which can be relatively mobile within a patient's body. The completion of this project was part of the ongoing 10 year major capital programme being undertaken by the Trust to replace several major pieces of radiotherapy treatment equipment across Kent.

December 2017

December 2017 saw over 800 more ED attendances and 650 more emergency admissions than in December 2016. This was a challenging backdrop for the roll out of the 'Best Care, Best Patient Flow' project at Tunbridge Wells Hospital in the month. The Trust worked with an external consultancy, 2020 Delivery Ltd, on 4 weeks of improvement to ensure the Trust's emergency flows were as efficient as possible. The work combined interviews, analysis, observations, engagement events and improvement experiments. The latter were conducted in a "sprint" fortnight and focused on three areas: reducing ED pressure; establishing the Ambulatory Emergency Care (AEC) Unit and reducing length of stay in the Acute Medical Unit (AMU); and increasing early in the day discharging. Overall, performance was sustained and the Trust remained 44th nationally, against the backdrop of a very challenging period (the Trust experienced its busiest Christmas Day on record in December with more than 360 people attending its two EDs).

Also in December, the CQC conducted the 'Well-Led' aspect of its inspection, carrying out interviews with key members of the Executive Team and senior staff across the Trust.

January 2018

Miles Scott took up post as the Trust's new Chief Executive early in January and stated that "I am delighted to have been appointed Chief Executive at Maidstone and Tunbridge Wells NHS Trust. I have been very impressed by the staff I have met and look forward to working together to deliver outstanding patient and staff experience." Later in January, Clinical leads for the national Emergency Care Improvement Programme (ECIP) highlighted good practice in the Trust following a review of quality, safety and patient flow in its EDs. ECIP leads identified the Trust's Quality Rounds as one of the best initiatives they had witnessed.

February 2018

Although the site pressures during February were challenging, the Trust performed exceptionally well against its regional and national peers against the ED 4-hour waiting time standard (that at least 95% of patients attending ED should be admitted to hospital, transferred to another provider or discharged within 4 hours). The Trust was successful in over 90% of all ED attendances being seen within 4 hours and ranked 1st in the NHS Improvement Group Benchmarking (out of 49 Trusts being supervised), 3rd in the NHS England South Region (out of 11 Trusts locally) and 22nd out of 137 Trusts nationally.

Also in February, a large group of staff spent over an hour with the Secretary of State for Health and Social Care, the Rt Hon Jeremy Hunt MP, in an informal question and answer session at Tunbridge Wells Hospital. During his presentation, Mr Hunt told staff that he was impressed with the Trust's infection control journey and that the Trust had set an example for the whole of the NHS.

The NHS e-Referral Service (e-RS) went live within the Trust in late February when the first outpatient Consultant-led appointment slots were made available for GPs and patients to book hospital appointments online. e-RS is intended to improve the referral experience for patients and better support current and future business processes for clinicians and administrative staff. In so doing, it will create a more patient-centred service and support the drive towards paperless referrals and a paperless NHS by 2020.

March 2018

March 2018 opened with heavy snow and staff went to extraordinary lengths to get to work. Some individuals walked for miles in the snow; others used their vehicles to collect colleagues and then drop them home again after their shifts. Numerous staff also stayed overnight to care for patients and to ensure they could carry out their shift the following day.

The Acute Frailty Unit opened as planned on 21st March on Ward 2 at Tunbridge Wells Hospital, in two rooms. Two patients were seen on the first day, one of whom was discharged the same day. This initiative will be developed in order to improve patient flow and quality of care for this group of patients.

The first cohort of student nurses from Greenwich University started their placements with the Trust in March. The group of 5 pre-registration nurses came into the Trust to undertake their inductions before starting work in acute wards and Outpatients. This was the first time the Trust had taken Greenwich University students on the pre-registration Nursing programme.

The story of the year: Care Quality Commission (CQC) inspection

The Trust received official notification from the CQC in July 2017, asking it to prepare for unannounced visits to the Trust's facilities as part of its routine inspection process. The Trust was one of the first in the country to undergo the CQC's new-look system of assessment, launched in June 2017, which decreed that every Trust in the country would be reviewed at least once a year by the CQC, using its revised system of review.

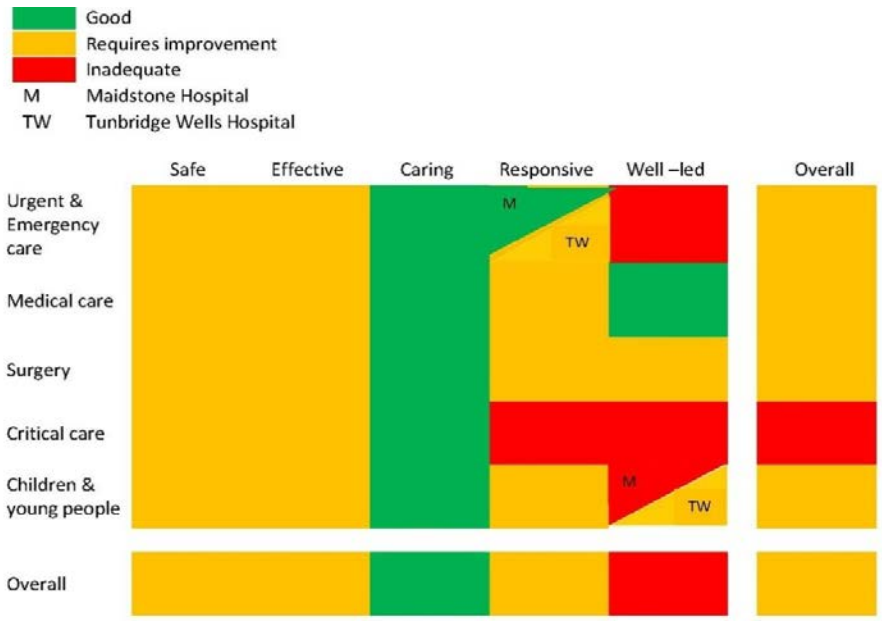
The CQC asks the following 5 questions of all healthcare providers that it inspects:

- Is the practice safe?
- Is the practice effective?
- Is the practice caring?
- Is the practice responsive?
- Is the practice well-led?

The Trust's preparations for the process included the formation of a central project team to manage the inspections and the Trust's planning for the visits. Informal CQC drop-in sessions were held at alternate hospital sites on a weekly basis throughout autumn 2017, which were open to all staff to discuss any concerns and to share experiences.

The CQC's inspections consisted of 12 separate unannounced and announced visits, carried out between October and December 2017. Five core services at the Trust were inspected.

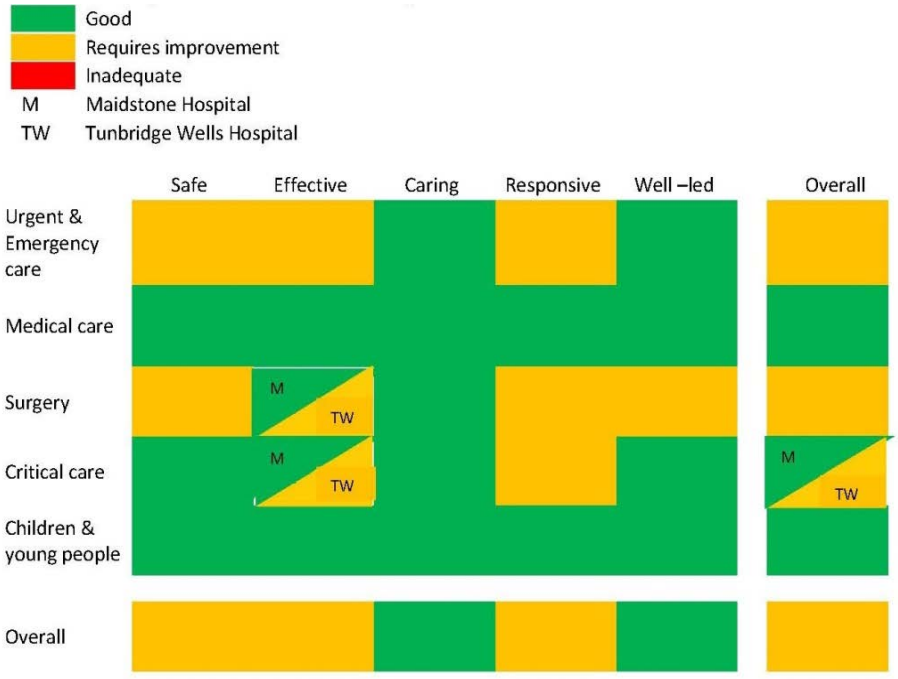
Following these visits, the CQC's inspection report was received on 9th March 2018 and awarded the Trust a 'Requires Improvement' rating (the same rating the Trust received at its previous CQC inspection in 2015). However, the report reflects significant improvements since that last inspection, and a 'good' rating was received in over two-thirds of the CQC standards across the 5 core services that were inspected – a significant increase from less than a third in 2015. In addition, no individual standards were rated as "Inadequate", compared to 6 in the 2015 inspection.



'Before' - Overview of the ratings for the 2015 inspection

The report emphasises "significant and sustained improvement throughout the Trust", with noted improvements in the well-led domain, resulting in a 'good' rating overall for the Trust (compared to a rating of 'inadequate' for this domain at the 2015 inspection). The Trust Board and senior leadership team were recognised as having 'a clear vision and values that were at the heart of all the work within the organisation'.

Each one of the Trust's inspected services was rated 'Good' in the Caring domain. The report also highlights the improvements made in several service areas since the last inspection, and examples of outstanding practice in urgent and emergency care, surgery, critical care services and services for children and young people were noted by the CQC's inspectors during their visits.



'After' - Overview of the ratings for the 2018 inspection

Overall, the Trust received 17 specific recommendations from the CQC which were incorporated into the Trust's Quality Improvement Plan.

The key findings from the Inspection Report and links to the full report were also shared with all staff and open sessions to discuss and reflect on the report with Trust Executives and the CQC Project Team Leads were held in March 2018. The full report can be accessed via the CQC website - www.cqc.org.uk/provider/RWF

The story of the year: The Kent and Medway Sustainability & Transformation Partnership

One of the ways that the Trust is helping to collectively address the challenges faced in health and social care is through its involvement with the Kent and Medway Sustainability and Transformation Partnership (STP). The STP brings together Clinical Commissioning Groups (CCGs), NHS service providers and Local Authorities to transform services in accordance with the published NHS five year plans and STP Case for Change. The STP serves a population of circa 1.8 million with combined Health and Social Care annual budgets of £3.6 billion.

The Trust is a full partner in the Kent and Medway STP and has been involved in all areas of its programme. Glenn Douglas, the Trust's long-standing Chief Executive until September 2017, was Senior Responsible Officer of the STP until his appointment as its Chief Executive in September 2017. In November 2017, the Maidstone and Tunbridge Wells NHS Trust Board formally approved arrangements for the Trust's hosting of the STP's financial and procurement transactions and services, to clarify governance and reporting arrangements and promote a more active engagement from a wider range of staff in STP programmes.

In late March 2018, 6 CCGs across Kent and Medway announced the appointment of Mr Douglas as their single Accountable Officer (a position which he will hold alongside his duties as Chief Executive of the STP). The appointment covers the CCGs of: Ashford; Canterbury and Coastal; Dartford, Gravesham and Swanley; Swale; Medway; and West Kent. Alongside this appointment, the CCGs are establishing a shared management team and a strategic commissioning function. This new shared leadership approach will strengthen how CCGs work together - driving service improvements and channelling resources to where they are most needed - front line services.

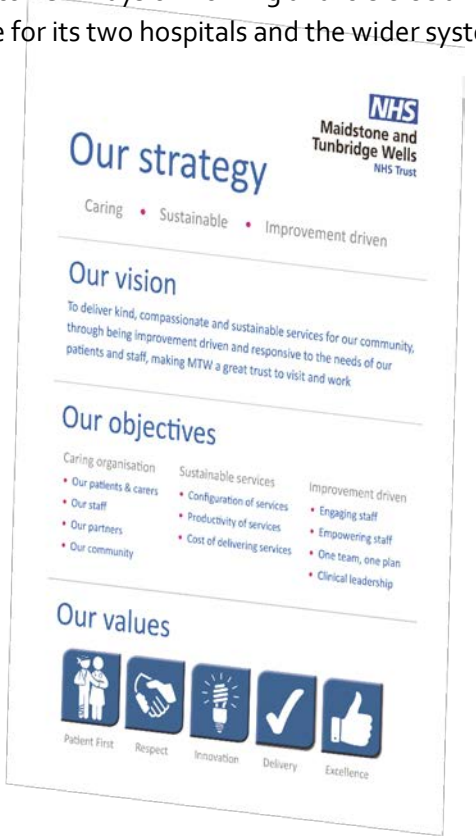
The story of the year: Shaping the future of Stroke services

As the culmination of its Stroke care review which started in 2014, in early 2018 the Kent and Medway STP launched a 10-week public consultation on the future of urgent Stroke services in Kent and Medway. The STP's proposal, in response to national evidence, was to establish 3 Hyper Acute Stroke Units (HASUs) operating 24 hours a day, 7 days a week, to care for all Stroke patients across Kent and Medway. The Trust Board formally approved the Trust's response to the consultation in March 2018 and the Trust looks forward to hearing the outcome in the autumn of 2018.

More information about the Stroke care review and other workstreams of the STP is available at: https://kentandmedway.nhs.uk/

The story of the year: A new Strategy

The Trust recognises that the next few years will be vitally important to its future and to the NHS in West Kent and the High Weald. STPs across the country are pointing to new ways of working and it is crucial for the Trust to be able to clearly describe what the future looks like for its two hospitals and the wider system within which it provides care.



To ensure clarity in this, the Trust launched its new 5 year Strategy in late 2017, having developed its feedback from staff, patients and partner organisations.

The Strategy establishes the vision to "deliver kind, compassionate and sustainable services for our community, through being improvement driven and responsive to the needs of our patients and staff, making MTW a great Trust to visit and work in".

Its 3 key strategic objectives in order to achieve its vision

and become a high performing organisation are:

1. To be recognised as a caring organisation
2. To provide sustainable services
3. To be improvement driven across all areas

The story of the year: Listening into Action

The Chief Executive announced the Trust's adoption of 'Listening into Action' (LiA) in June 2017. LiA is a process used successfully by now high performing Trusts that supports and empowers staff to make changes for the better. It does this through providing staff with a voice, across all levels of the organisation, and engaging them to make the changes they feel are important to patients and to the work of the Trust.

Listening into Action

Work on LiA was kick-started with a 'Pulse Check' staff survey in June/July 2017, which aimed to determine current levels of staff engagement and help identify the frustrations that staff faced in undertaking their roles. The 'Pulse Check' generated around 1600 completed questionnaires and 2600 comments/ideas for improvement. Staff engagement was revealed as low and frustrations with resolving issues high. The Trust's results were average compared to others at the same stage of the LiA journey. Each Division developed an action plan to address the key concerns raised and these are monitored to track progress.

In July 2017, the Trust launched 10 clinical pioneer teams to bring about change on key identified issues within 20 weeks. To demonstrate a commitment to listening to staff, the Trust asked Consultant and Nursing leads for their top improvement ideas and ran an open evaluation process to select the 10 taken forward, which were:

1. Reducing time to theatre for Fractured Neck of Femur patients

2. Improving care for patients with Inflammatory Bowel Disease (IBD)
3. Improving access to Diabetes care for young adults
4. Shortening wait times in Ophthalmology through virtual clinics in Medical Retina
5. Shortening time to treatment for Oncology Prostate patients
6. Improving the use of GPs in the Emergency Department (ED)
7. Shortening wait times for Breast Clinic patients
8. Improving antenatal services at Maidstone Hospital
9. Streamlining the Pre Assessment process for the young, fit and well
10. Improving inefficient and frustrating IT systems for our junior doctors

By the end of 2017/18, all the pioneer teams had made a significant change within their areas with beneficial impact. Success was notably achieved through the teams engaging with colleagues and sharing their concerns before jointing identifying and then implementing a solution together. Taking just one of the schemes above - Shortening time to treatment for Oncology Prostate patients – the following differences were made against the original mission to integrate pre-biopsy prostate MRI findings into decision making within the prostate pathway and reduce MRI waiting times for patients:

- The median time to MRI based decision reduced from 35 days to 4 days
- The median time to biopsy discussion clinic, 34 days (range 13 to 38 days)
- No unnecessary post-MRI discussion clinics were held
- There was a 30% reduction in the number of Transrectal ultrasound guided (TRUS) biopsies

In September 2017, the Trust ran a series of 'crowdfixing' events, open to up to 80 staff at a time, to further explore the changes that staff wished to see. Feedback from those attending was very positive and identified 5 key areas of significant concern for staff. Then, at the beginning of 2018, 'Pass It On' events showcased what had been achieved through LiA to date, particularly celebrating the success of the Clinical Pioneer Teams. Towards the end of 2017/18, the Trust also looked to identify the next clinical teams by providing each Directorate with the opportunity to run an LiA improvement process, as well as supporting the first 10 with the next step on their improvement journey.

Key issues and risks affecting delivery of the Trust's key objectives

The Trust Board agreed the following key objectives for 2017/18:

- To reduce mortality (Hospital Standardised Mortality Ratio (HSMR)) in line with the national average
- To deliver the agreed 2017/18 trajectory for the A&E 4 hour waiting time target
- To maintain a vacancy rate of no more than 8.5%
- To deliver the control total for 2017/18 (of a pre-Sustainability and Transformation Fund (STF) deficit of no more £4.5m, or otherwise agreed by NHS Improvement)
- To deliver the agreed 2017/18 trajectory for the 62-day Cancer waiting time target
- To deliver the agreed Referral to Treatment (RTT) trajectory for patients on an 'incomplete' pathway

The key issues and risks affecting delivery of these (as described in the Trust's Board Assurance Framework – see the "Annual Governance Statement for 2017/18") are outlined on page 18. Details of how the Trust actually performed in response to these can be found in the "Performance analysis" section (pages 23 to 24).

To reduce mortality (Hospital Standardised Mortality Ratio (HSMR)) in line with the national average

In order to achieve this, it was known that the following potential risks needed to be managed effectively: the issue being afforded inappropriate/insufficient priority; insufficient analytical support to understand the data; failure to follow best practice in response; and lack of ownership by Clinical Directorates.

To deliver the agreed 2017/18 trajectory for the A&E 4 hour waiting time target

In order to achieve this, it was known that the following potential risks needed to be managed effectively: the capacity required to deliver the 'new norm' for non-elective activity being insufficient; A&E attendances continuing to remain higher than plan; bed occupancy remaining above 92%; the level of Delayed Transfers of Care (DTOCs) remaining higher than the expected standard; failure of the Trust to adopt and/or implement the latest best practice in relation to patient streaming and other aspects; and the identified Social Care changes that create capacity failing to materialise

To maintain a vacancy rate of no more than 8.5%

In order to achieve this, it was known that the following potential risks needed to be managed effectively: a national shortage of certain staff groups; lack of clarity/focus on the key actions required and the performance required by each Directorate, and the monitoring of such performance; inefficiency of recruitment processes; lack of urgency/commitment by recruiting managers; uncertainty over the status of vacancies; and absence of Director-level ownership of the objective.

To deliver the control total for 2017/18 (of a pre-Sustainability and Transformation Fund (STF) deficit of no more £4.5m, or otherwise agreed by NHS Improvement)

In order to achieve this, it was known that the following potential risks needed to be managed effectively: lack of senior leadership and commitment; poor financial controls (or poor application of good controls); lack of commitment by managers; if the level of the Cost Improvement Programme (CIP) has not been fully identified and CIP schemes were not rated 'green'; development of the Trust's plans for 2017/18 without consideration of best practice elsewhere; non-acceptance of the Trust's plans by NHS Improvement (NHSI); and insufficient engagement with external stakeholders

To deliver the agreed 2017/18 trajectory for the 62-day Cancer waiting time target

In order to achieve this, it was known that the following potential risks needed to be managed effectively: insufficient engagement by clinical staff outside of the Cancer and Haematology Directorate; pathways not being optimal in relation to achieving the required performance; insufficient communication of the performance needed beyond the Cancer and Haematology Directorate (as only 1/3 of delivery was within that Directorate's control – the remainder was within Diagnostics, Surgery & Medicine).

To deliver the agreed Referral to Treatment (RTT) trajectory for patients on an 'incomplete' pathway

In order to achieve this, it was known that the following potential risks needed to be managed effectively: an insufficient level of elective and Outpatient activity being undertaken; and continuation of non-elective activity at existing levels (including ED attendances).

The controls in place to manage the identified risks described above were monitored by the Trust Board and other forums throughout the year.

Adoption of the 'going concern' basis

The Department of Health and Social Care (DHSC) Group Accounting Manual (GAM) requires the management of the Trust to consider the following public sector interpretation of International Accounting Standards (IAS) 1 in respect of applying the going concern assumption when preparing its accounts, stating:

"For non-trading entities in the public sector, the anticipated continuation of the provision 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. DHSC group bodies must therefore prepare their accounts on a going concern basis unless informed by the relevant body or DHSC sponsor of the intention for dissolution without transfer of services of function to another entity. A trading entity needs to consider whether it is appropriate to continue to prepare its financial statements on a going concern basis where it is being, or is likely to be, wound up"

The Trust Board has assessed the Trust's ability to continue for the foreseeable future in the light of the GAM guidance, and has prepared the 2017/18 accounts on a "going concern" basis following consideration of the following:-

- There has been no expectation raised in the public arena that healthcare services will not continue to be provided from the two hospital sites
- The Trust submitted its initial business plan to NHS Improvement (NHSI) in March 2018 setting out its operational plans for the following financial year (2018/19) and its capital plans for five years. The final plan submission was made on 30th April 2018
- The Trust continues to fully participate in the Sustainability and Transformation Partnership (STP) planning process including the submission of the forward 5 year financial and operating plans on a going concern basis. The Trust is leading some of the significant workstream areas and is a key partner in consideration of the shape of services in the STP for the future
- The Trust has existing contracts in place for provision of healthcare services for 2018/19 being the second year of contracts signed in 2017/18. This includes the Aligned Incentives Contract (AIC) with two of its Clinical Commissioning Groups (CCGs): West Kent (the Trust's main commissioner) and High Weald Lewes Havens. The exact value of the year two contracts will be concluded using the agreed contract approach as part of the current business planning round. The current level of difference under discussion is immaterial in value
- The Trust has prepared and will be submitting cash-flow forecasts for 2018/19 as part of its planning returns which do not include any assumptions of additional required working capital finance
- There are no plans to dissolve the Trust or to cease services without transfer to any other NHS body.

However, the Trust has assessed and disclosed the following challenges to its financial plans for 2018/19 in its Annual Accounts:

- To achieve its 2018/19 control total the Trust will need to deliver a challenging cost improvement programme plus a significant level of other non-recurrent measures. At this stage there is risk around the ability of the Trust to deliver this level of savings within 2018/19
- Failure to achieve the Trust's control total could necessitate additional in year working capital finance to support the Trust's liquidity position and its ability to repay the first of its working capital loans that falls due for repayment in February 2019 (£16.9m).

Performance summary for 2017/18

The Trust's performance activities can be found in full within the monthly Trust Board reports, which are available for review at https://tinyurl.com/MTWTBReports

Performance for the year was varied. Performance against the Trust's agreed objectives, including the delivery of the financial plan, is described in detail in the "Development and performance in 2017/18" section on the following pages (page 23 onwards).

The Trust achieved successes in the following areas:

- Infection prevention and control - the Trust's strong performance in the field of infection prevention and control continued: the Clostridium difficile standard was achieved, with 25 cases against a maximum of 27 cases for the year, equating to a rate of 9.5 cases per 1000 occupied bed days (2016/17, 10.5). There were no cases of post 48 hour MRSA bacteraemia in the year
- Reduction of patient falls - The rate of falls per 1,000 occupied bed days was below the Trust maximum limit of 6.0 at 5.98 for the year (2016/17, 6.07)
- Stroke – 90.9% of Stroke patients spent 90% of their time on a dedicated Stroke ward, attaining a rate of 90.9% (2016/17, 88.5%) against a target of 80%
- Complaints management – the rate of new complaints fell to 1.93 per 1000 episodes (2016/17, 2.47), which was well within the expected range of between 1.318 and 3.92
- Accident and Emergency – Less than 5% of patients left the Trust's Emergency departments before being seen and the standard of 95% of patients arriving in the ED being assessed within 15 minutes of arrival was achieved. 58.4% of patients arriving in ED were treated within 60 minutes of arrival against a target of 50% (an increase of 7% on 2016/17
- Cancelled operations – The Trust achieved the national maximum limit of 0.8% of operations cancelled at the last minute.

Elsewhere, the Trust underperformed on several targets, including those relating to Cancer waiting times, Access to treatment and Delayed Transfers of Care. More details are provided in the "Annual Governance Statement for 2017/18" section later (page 51 onwards).

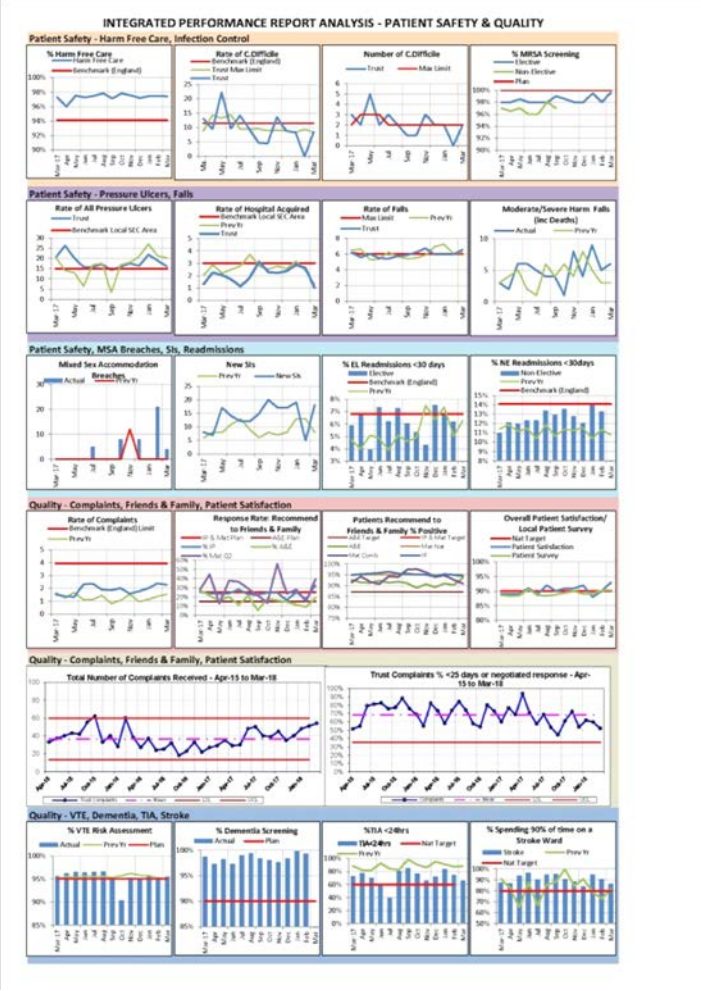
Further details on the performance standards for quality of care can be found in the Trust's Quality Accounts for 2017/18, which are available in full on the Trust website (www.mtw.nhs.uk).

Maidstone and Tunbridge Wells NHS Trust

Performance Report for 2017/18: Performance analysis

taking pride

How the Trust measures performance



The Trust's Performance Management framework is based upon the national Single Oversight Framework and reinforces accountability for delivery at Divisional level. A 'Ward to Board' approach is applied and is monitored through a sign-off process at Directorate-, then Divisional-level before presentation at monthly Executive Performance Review meetings and ultimately, the Trust Board.

A whole day each month is devoted to Trust-wide performance management, attended by members of the Executive Team. The Clinical Divisions and Corporate services are accountable for the delivery of their key indicators for quality, performance, finance and workforce, together with their strategic and Trust-wide programme responsibilities. Every 6 months, a 'deep dive' review is held with the Divisions to promote further understanding of data trends and links and to provide focussed challenge and support.

The monthly Trust Board performance dashboard, which encapsulates the result of these processes, provides the Board with a rich source of information which has been fully reviewed and substantiated at all levels of the Trust. The dashboard contains details of all key aspects of performance, under the CQC domains of "Safety", "Effectiveness", "Caring", "Responsiveness" and "Well-Led". A traditional 'Red, Amber, Green' (RAG) rating system is used to highlight variances against the Trust's plans for the year and/or the required national target. "Green" means "Delivering or exceeding target", "Amber" means "Underachieving target"' and "Red" means "Failing target". Additional performance information is provided on financial matters and clinical quality. These reports are available on the Trust's website, as part of the information provided for Trust Board meetings (see www.mtw.nhs.uk/about-us/trust-board/).

The content of the Performance Dashboard is discussed at meetings of the Trust Management Executive (TME) and Trust Board. The Director responsible for each domain is asked to highlight any key issues of note, and provide an explanation for any areas of under / failing performance. At each Trust Board meeting, the previous month's performance is summarised within a "story of the month".

Performance against the Trust's agreed objectives is measured and monitored via the Board Assurance Framework, which is described in more details in the "Annual Governance Statement for 2017/18" (page 51 onwards).

In addition to this, the Trust continues to use nationally-published information (where available), to compare performance. This includes national staff and patient surveys (which are described elsewhere in this Annual Report); and national clinical audits.

The link between Key Performance Indicators (KPIs), risk and uncertainty

The Trust uses a wide range of KPIs to identify areas of risk and uncertainty. Where these risks and uncertainties can be controlled, these are aimed to be included within the Trust's plans. However, if monitoring of KPIs reveals that performance is at variance from the Trust's plans, mitigating actions may be implemented. The very wide range of information the Trust collates means that the relationship between different pieces of information is very complex. In this regard, the Trust engages the specialist analytical skills of staff within the Finance, Human Resources and Business Intelligence departments to identify themes, variance from plans etc., and to advise on potential actions to address variances, or recommend the enacting of mitigations.

Development and performance in 2017/18

The 'key issues and risks affecting delivery of the Trust's objectives' were described earlier in the Report. The Trust's actual performance against each of its 2017/18 objectives is described below.

To reduce mortality (Hospital Standardised Mortality Ratio (HSMR) in line with the national average

This objective was fully achieved (i.e. rated green within the Board Assurance Framework). The standard HSMR calculation uses a 12 month rolling view of performance. The data for the 12 months from January to December 2017 showed the Trust's HSMR to be 103.1 (and the lower confidence interval crosses the national average relative risk of 100, which therefore equates to the Trust's rate being within the expected range).

To deliver the agreed 2017/18 trajectory for the A&E 4 hour waiting time target

This objective was partially achieved (i.e. rated amber within the Board Assurance Framework). The Trust's performance for 2017/18 was 89.08%. However, this compared to 87.12% in 2016/17, and the Trust continues to perform significantly better than the national average. In both February and March 2018, the Trust's performance was more than 10 percentage points higher than the national average, which placed the Trust in the top performing 20% of Trusts.

To maintain a vacancy rate of no more than 8.5%

This objective was not achieved (i.e. rated red within the Board Assurance Framework). The vacancy rate at the end of 2017/18 was 10.5% (which compared to 8.3% in 2016/17).

To deliver the control total for 2017/18 (of a pre-STF deficit of no more £4.5m, or otherwise agreed by NHS Improvement)

This objective was not achieved (i.e. rated red within the Board Assurance Framework). The Trust's year-end deficit for 2017/18 was £10.9m (including Sustainability and Transformation Fund (STF)) which was £17.6m adverse to the original plan. The Trust achieved the revised forecast that was set in January 2018 of a pre-STF deficit of £17.9m.

To deliver the agreed 2017/18 trajectory for the 62-day Cancer waiting time target

This objective was not achieved (i.e. rated red within the Board Assurance Framework). As the data for Cancer waiting times runs one month behind other performance measures, the final year-end position for 2017/18 was not available at the date of publication. However, 62-day waiting time performance remained static in February 2018 at 67.6%, whilst the forecast 62-day position for March (which was undergoing validation at the time of publication) was 67.7%.

To deliver the agreed Referral to Treatment (RTT) trajectory for patients on an 'incomplete' pathway

This objective was not achieved (i.e. rated red within the Board Assurance Framework). Performance at the end of March 2018 was 81.0% which represented a decrease from that in February 2018. The (revised) trajectory required the Trust to achieve 82.9% by the end of March 2018.

Financial performance in 2017/18

The Trust has had another challenging year financially and continued to be in Financial Special Measures (FSM) as it has been unable to meet its control total. The Trust has been working with NHS Improvement (NHSI) on FSM and has met some of the requirements to come out of Special Measures; the remaining requirement is to demonstrate delivery of financial plans in 2018/19.

The Trust reported a deficit of £10.9m, post Sustainability and Transformation Funding (STF), which was £17.6m adverse to plan. The key drivers of this variance were as follows:

- There was a shortfall on STF income of £4.3m
- The plan included £19m of unidentified cost improvement programme (CIP) schemes which were identified throughout the year; the Trust finished the year £9.2m under delivery on its CIP
- Income shortfalls on private patient income (£3.5m) and Oncology clinical income (£3.1m)
- The Trust received additional income for winter pressures (£1.2m) and the Aligned Incentives Contract (AIC) risk reserve (£1.5m)

Income and Expenditure (Financial Performance)

The table below compares the Trust's income and expenditure plan to the year-end financial position.

Statement of Comprehensive Income	2017/18 (Plan) £m	2017/18 (Actual) £m	Variance £m
Income	436.62	440.27	3.65
Operating expenses	(414.40)	(421.21)	(6.81)
Operating Surplus / (Deficit):	**22.22**	**19.06**	**(3.17)**
Finance income	0.04	0.05	0.01
Finance expense	(15.15)	(15.12)	0.03
PDC dividend charge	(1.47)	(0.45)	1.02
Net finance costs	**(16.57)**	**(15.52)**	**1.05**
Other gains / (losses)	0.00	0.09	0.09
Surplus / (deficit) for the year before technical adjustments	5.65	3.62	(2.03)
Technical adjustments	1.02	(14.55)	(15.57)
Surplus / (deficit) for the year after technical adjustments	**6.67**	**(10.92)**	**(17.60)**

Income

The Trust's income was £440.27m, which was above plan by £3.65m by the end of the financial year. This was mainly due to STF income being below plan by £4.3m and private patient income underperforming by £3.5m. This was offset by favourable variances in clinical income (£1.2m), Education, Training and Research (£0.6m) and on pass through costs for the Sustainability and Transformation Partnership (STP) and Patient Administration System (PAS) implementation of £7.9m and £2.9m respectively.

The Trust had a challenging winter period, when it faced an increasing demand of non-elective activity during quarter 4 of 2017/18. The Trust had planned for this with reduced elective activity planned to manage the increases in non-elective activity. However, the period of escalation lasted longer than expected which led to reductions in elective (£11.2m) and outpatient (£5.4m) activity. This was offset by increases in non-elective activity (£11.2m) and Emergency Department (£2.6m). This was the first year of the Aligned Incentive Contract, which meant that the income from WKCCG) was protected from these variances in activity by £4.0m. The majority (80%) of the Trust's income was from CCGs or NHS England.

Expenditure

The Trust's expenditure was £421.21m which was £6.81m adverse to plan. Pay expenditure was £7.56m adverse to plan, mainly due to slippage on CIP schemes of £6.3m, plus Bank and Agency expenditure to cover vacancies, and additional cover for winter escalation, of £1.4m. Non-pay expenditure was £0.75m favourable to plan, £15.7m favourable relating to reversals of impairments (offset as a technical adjustment) and £10.5m of which related to pass through costs for the STP and Patient Administration System (PAS). The remainder was £2.3m of unachieved CIP, £0.7m for High Cost Drugs and £2.2m for other items.

Cost Improvement Programme (CIP)

The Trust delivered £22.5m of its CIP, against a target of £31.7m.

CIP programme by work stream	2017/18 Plan £'000	2017/18 Actual £'000	Variance £'000
Cancer & Haematology (Planned Care)	2,398	1,821	(577)
Critical Care (Planned Care)	2,170	1,519	(651)
Diagnostics (Planned Care)	1,843	1,154	(689)
Head and Neck (Planned Care)	982	865	(117)
Surgery (Planned Care)	1,796	1,042	(754)
Trauma & Orthopaedics (Planned Care)	5,090	5,156	66
Patient Admin (Planned Care)	110	116	6
Private Patients Unit (Planned Care)	163	128	(35)
Total for Planned Care	**14,552**	**11,801**	**(2,751)**
Urgent Care	**8,884**	**4,796**	**(4,088)**
Women's, Children's & Sexual Health	**3,651**	**1,884**	**(1,767)**
Estates & Facilities	**2,758**	**1,555**	**(1,203)**
Corporate	**1,877**	**2,451**	**574**
Total across all work streams	**31,722**	**22,487**	**(9,236)**

Capital Expenditure plan

During the year the Trust made capital investments of £11.5m including £0.2m of assets funded from donated or charitable fund sources. Significant elements of the programme were £2m of improvements to energy infrastructure (including £0.7m funded from Salix loans[4]), £1.8m on backlog maintenance and estates renewals, £0.6m on GP Emergency Department streaming accommodation, funded by central Public Dividend Capital (PDC), and £0.5m was associated with the enabling works for a Linear Accelerator (LinAc) bought in 2016/17.

[4] Salix Finance Ltd. provides interest-free Government funding to the public sector to improve their energy efficiency, and is funded by the Department for Business, Energy and Industrial Strategy, the Department for Education, the Welsh Government and the Scottish Government.

Equipment spend in the year included £1.7m funded by national PDC for another replacement LinAc at the Cancer Centre at Maidstone Hospital, £0.5m on Tunbridge Wells Hospital theatre equipment, and £1.4m for medical equipment replacement.

£2.3m of investment was made in Information and Communications Technology (ICT) infrastructure and equipment including implementation costs for the new PAS.

The Trust's statutory (i.e. legal) duties

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

External Finance Limit (EFL)

The Trust is required to demonstrate that it has managed its cash resources effectively by staying within an agreed limit on the amount of cash it can borrow and spend. In 2017/18 the Trust met its target by managing the year-end position to underspend the EFL by £0.5m with the actual closing cash balance being £1.5m. In order to support the Trust's financial position an additional £13.99m of working capital financing was agreed with the Department of Health and Social Care (DHSC) and issued as interest bearing loans at an interest rate of 3.5%, repayable in 2020/21.

Capital Resource Limit

The Trust is expected to manage its capital expenditure within its agreed Capital Resource Limit (CRL). For 2017/18 the Trust's CRL was £10.59m which was underspent by £0.98m. This underspend managed the Trust's capital spend within its available cash resource which was lower than its CRL and helped support the Trust's Financial Recovery Plan.

Break-even duty

Each NHS Trust has a statutory duty to break-even taking one year with another, measured as the Income and Expenditure position adjusted for specific technical exclusions. This duty is formally measured over a 3 year period or a 5 year period if agreed with the DHSC.

The Trust's latest 3 year break-even cycle commenced in 2013/14 and was not met by the end of the period in 2015/16. The Trust's break-even period has therefore been extended with the plans submitted for 2018/19 aimed at reducing the accumulated deficit towards the target of formal cumulative break-even by 2021/22.

Accounting Issues

The Accounts have been prepared in accordance with guidance issued by the DHSC and in line with International Financial Reporting Standards (IFRS) as applied in the DHSC Group Accounting Manual. The accounts were prepared under the "Going Concern" concept in line with the DHSC Group Accounting Manual requirements for management consideration. This has been set out in the "Overview" section above.

External Auditors

The Trust's External Auditors are Grant Thornton UK LLP. Their charge for the year was £68,500 excluding VAT (in 2016/17 this was £85,069 excluding VAT) which includes the audit of the Quality Accounts. Grant Thornton UK LLP did not undertake any non-audit work for the Trust in 2017/18.

Looking forward to 2018/19

The Trust has set a planned surplus of £11.7m which includes receipt of £12.7m Provider Sustainability Fund (PSF) during 2018/19. To deliver this surplus the Trust will need to deliver a £24.1m CIP. The overall plan shows that 2018/19 will continue to be financially challenging but the underlying position is improving. The table below sets out the Trust's 2018/19 financial plan submitted to NHS Improvement.

Statement of Comprehensive Income	2018/19 (Plan) £m
Income	466.2
Expenditure	(427.3)
EBITDA (deficit):	38.9
EBITDA %	8%
Depreciation & other	(10.1)
Net interest	(15.8)
PDC dividend	(1.3)
Impairments	(1.0)
Total financing and impairments	(28.2)
Deficit (before technical adjustments)	10.7
Technical adjustments	1.1
Deficit (after technical adjustments)	11.7

The key movements from the 2017/18 out-turn to the 2018/19 plan are inflationary factors such as pay awards; incremental drift; apprentice levy and non-pay (£7.9m); full year impact of investments and non-recurrent CIP schemes (£10m) and a contingency plan of £3.8m. This is offset by the planned £24.1m CIP, non-recurrent savings of £7.3m and NHS tariff inflation and demographic growth of £6.9m. The plan includes Provider Sustainability Funding (PSF) of £12.7m replacing the STF of £11.2m.

The Trust is planning a rolling five year capital programme of total value £61m (excluding donated assets). This includes the following areas of investment:

- Essential improvements in Maidstone backlog estates (£6.3m) and Tunbridge Wells Hospital lifecycle (£4.6m)
- Energy infrastructure improvements that the Trust plans to seek through Salix funding (£1.2m)
- The Trust is planning to apply for loan funding to renew its theatre block at Maidstone Hospital which is nearly 35 years old (£20m over 2 years: 2019/20 and 2020/21) though this may form part of a future STP bid
- The plan includes the Trust's bid for NHS England capital funding under the national programme of updating LinAcs (£1.8m) with the associated Trust resourced enabling works and other equipment (£1.2m). Looking forward the Trust will be seeking loan funding to maintain its programme of LinAc replacement (£7.5m over 3 years)
- The Trust's plan includes essential replacement equipment provision of circa £8m over the 5 year period and ICT projects of £4m. In addition the Trust needs to urgently replace some critical Imaging equipment (CT scanners) and will be looking to apply for capital loans to enable this to take place (£3.2m).

The primary source of capital funding is internally generated cash through deprecation and capital receipts received on the planned sale of assets, net of repayments of principal on the existing capital loans, PFI lease repayments and PFI lifecycle repayments. In addition the Trust plans to seek loan and PDC financing for specific investments as set out above.

Maidstone and Tunbridge Wells NHS Trust

Performance Report for 2017/18: Summary of Quality Accounts

taking pride

Quality Accounts are intended to aid the public's understanding of what the Trust does well; identify where improvements in service quality are required; and list the improvement priorities for the coming year.

This section contains a summary of the Quality Accounts for 2017/18; the full Quality Accounts can be found on the Trust's website (www.mtw.nhs.uk), or the Trust's pages on the NHS Choices website (www.nhs.uk/Services/Trusts/Overview/DefaultView.aspx?id=1178).

Performance against selected key priorities for 2017/18

Performance against some of the 2017/18 priorities, as stated in the 2016/17 Quality Accounts, is detailed below.

Patient Safety: To create reliable processes that will build a supportive environment to reduce avoidable harm

Examples of the goals set, and the action taken in response is described below:

- "Demonstrate an embedded safety culture within all departments undertaking invasive procedures, which complies with the World Health Organisation (WHO) surgical safety methodology": The WHO safety checklist has been further revised for use in Theatres to include anaesthetic nerve blocks and to refine the process for the identification and management of specimens. An assurance auditing process has been introduced to monitor the standard of WHO checklists. A review of the National and Local Standards for invasive procedures continues, working with all Directorates and Specialities to ensure these standards are met.
- "Reduce mortality figures in line with the national average (HSMR/SHMI) through the work of our Mortality Steering group": The observed Mortality rates have been reduced in keeping with expected rates and the Trust is no longer an outlier amongst its peers. A revised mortality review process was introduced in October 2017 as per National Quality Board Guidance (2017) and the Trust's Mortality review compliance is now demonstrating an improvement.
- "Improve outcomes for expectant mothers and their babies in line with the Maternal and Neonatal Health Safety Collaborative": The Trust's Maternity service has been selected by NHS England to be a Maternity Choice and Personalisation Pioneer and many of the Trust's patients have joined the pilot. In addition, work is ongoing to reduce: perineal trauma through the introduction of slow birthing techniques, warm perineal compresses and good birth positioning; reduce unanticipated admission to the Neonatal Unit - introduction of the bobble hat initiative is currently being trialled following positive results in another organisation; and to reduce stillbirths.

Patient Experience: To improve the use of current feedback mechanisms and provide more innovative ways to receive and act upon feedback

Examples of the goals set, and the action taken in response is described below:

- "Achieve consistent monthly response rates to the Friends and Family Test": The Trust's Representative group continues to meet regularly to review the project pathways, data analysis and to maintain a raised awareness of the Friends and Family question. The group continues to explore the feasibility of establishing e-mail alerts to enable earlier response to feedback. Work is progressing between IT and the Paediatric lead for 'iWantGreatCare' (IWGC) to review the IWGC app within Children's services which will seek to promote an increase in feedback
- "Continued work with external partners such as Healthwatch, NHSI, CQC and West Kent CCG to help inform the Trust Board of areas for concern": Regular contact meetings with Healthwatch, the CQC,

NHSI and West Kent CCG are in place to seek and provide assurance in respect of standards of care provided to the Trust's patients

- "Development of a framework to report and monitor the incidence of harm affecting those with cognitive impairment (dementia)": A framework for reporting has been devised via the Dementia Strategy Group. A total of 129 incidents were reported for dementia patients, of these 13 were due to pressure damage; 82 due to falls; 15 due to aggression and 19 had other causes.

Clinical Effectiveness: To improve the management of patient flow

Examples of the goals set, and the action taken in response is described below:

- "Avoidance of unnecessary admissions to hospital through the increased use of ambulatory pathways of care for patients who attend the Trust's Emergency Departments": An Ambulatory Emergency Care bay opened in the Acute Medical Unit in December 2017, accepting all non-elective ambulatory patients and providing 4 spaces which have been configured as 3 trolleys and 3 chairs. Acute Frailty Units have been opened during the year at Maidstone and Tunbridge Wells Hospitals
- "Work with mental health partners to reduce the number of frequent attendances of patients in crisis attending the Trust's Emergency Departments": A Multi-Agency Project Group has been established and, at the end of 2017/18 the Trust reported a 43% reduction in attendances of the 25 patients who had been identified as most benefitting from a targeted multi-professional approach of their health needs
- "Development of pathways that will support the timely discharge of patients": In collaboration with its community colleagues at Kent Community Health Foundation Trust, the Trust has implemented the 'Home First model' which supports three discharge pathways: home with support; transfer to a community hospital for further rehabilitation and an interim placement in a Nursing home. The re-admission rate for patients discharged home is now reducing (from 25.23% baseline period 2016/17 to 23.33% in 2017/18.

Quality improvement priorities for 2018/19

The Trust's quality improvement priorities are a small sample of the range of quality improvement work undertaken within the Trust in any 12 month period. The initiatives selected in previous years invariably continue into subsequent years, although the focus may change according to need. Selecting new initiatives each year ensures that a wide breadth of areas are covered and prioritised. The Trust's priorities for 2018/19 were developed through the engagement of a wide cross-section of its staff, and this process has culminated in the ongoing development of both the Best Care Programme and the Trust's new Quality Strategy 2018-2021, which will unify the achievement of these key deliverables.

The Trust's 3 quality priorities for 2018/9 are:

1. Patient Safety: To create reliable processes that will build a supportive environment to reduce avoidable harm

The key objectives involve:

- Embedding an open and transparent culture that embraces 'lessons learned'
- Achievement of consistent recognition and rapid treatment of sepsis in both emergency and inpatient departments and reduction in the number of avoidable deaths
- Improvement in outcomes for expectant mothers and their babies in line with 'Better Births (A Five Year Forward View for maternity care)' and the National Maternity Transformation Programme.

2. Patient Experience: To improve the use of current feedback mechanisms and provide more innovative ways to receive and act upon feedback

The key objectives involve:

- The development of a patient engagement strategy to ensure views are gained and triangulated with themes and trends from patient surveys and complaints, etc. to improve pathways of care and inform strategic direction
- Continued work with external partners including Healthwatch, NHS Improvement, CQC and CCGs to help inform the Trust of areas for concern, and for inclusion in the Trust's Internal Assurance inspection programme
- To recognise and respond to the specific needs of patients with complex needs.

3. Clinical Effectiveness: To improve the management of patient flow

The key objectives involve:

- Avoiding unnecessary admissions to hospital through the development of alternative care models/pathways
- Working with the Trust's mental health partners to reduce the number of frequent attendances of patients in crisis attending the Trust's EDs
- Work with the Trust's community and local authority colleagues to further develop pathways that will support the timely discharge of patients.

Progress against these objectives will be monitored as part of the Directorate and Trust-level governance structures. Assurance of progress against the above objectives will be presented at monthly Trust Management Executive meetings; Quality Committee and Patient Experience Committee meetings.

Maidstone and Tunbridge Wells NHS Trust

Performance Report for 2017/18: Sustainability Report

taking pride

As an NHS organisation, and as a spender of public funds, the Trust has an obligation to work in a way that has a positive effect on the communities it serves. 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 the Trust can improve health both in the immediate and long term, even in the context of the rising cost of natural resources. Demonstrating that the Trust considers its social and environmental impacts ensures that the legal requirements in the Public Services (Social Value) Act (2012) are met. In order to fulfil its responsibilities for the role it plays, the Trust has the following sustainability mission statement/vision within its Sustainable Development Management Plan (SDMP): "The provision of Sustainable and Resilient Healthcare and Buildings to ensure Healthy People and Places in Maidstone and Tunbridge Wells NHS Trust".

As a part of the NHS, public health and social care system, it is the Trust's duty to contribute towards the level of ambition set in 2014 of reducing the carbon footprint of the NHS, public health and social care system by 34% (from a 1990 baseline) equivalent to a 28% reduction from a 2013 baseline by 2020. It is the Trust's aim to supersede this target by reducing its carbon emissions 28% by 2020/2021 using 2013/14 as the baseline year.

Policies

In order to embed sustainability within the Trust's business it is important to explain where sustainability features in its processes and procedures. Sustainability is considered in relation to Travel, Procurement (environmental and social impact) and Suppliers' impact, but not in relation to Business Cases. One of the ways in which an organisation can embed sustainability is through the use of a Sustainable Development Management Plan (SDMP). The Trust Board approved its SDMP during the year and the Trust's plans for a sustainable future are well known within the organisation and clearly laid out.

As an organisation that acknowledges its responsibility towards creating a sustainable future, the Trust helps to achieve that goal by running awareness campaigns that promote the benefits of sustainability to its staff.

Partnerships

The NHS policy framework already sets the scene for commissioners and providers to operate in a sustainable manner. Crucially for us as a provider, evidence of this commitment will need to be provided in part through contracting mechanisms. However, the Trust has not yet established any strategic partnerships regarding this.

Performance

Trust size

Since the 2007 baseline year, the NHS has undergone a significant restructuring process and this is still on-going. The Table below reflects how the Trust's size has changed over time.

Context info	2007/08	2014/15	2015/16	2016/17	2017/18
Floor space (m^2)	109,896	138,533	138,533	138,533	138,533
Number of staff (WTE)	3,969	4,800	4,678	5,130	5,022

The Trust has supported the ambition outlined by the national Sustainable Development Strategy in 2014 to reduce the carbon footprint of the NHS by 28% (from a 2013 baseline) by 2020 as detailed below:

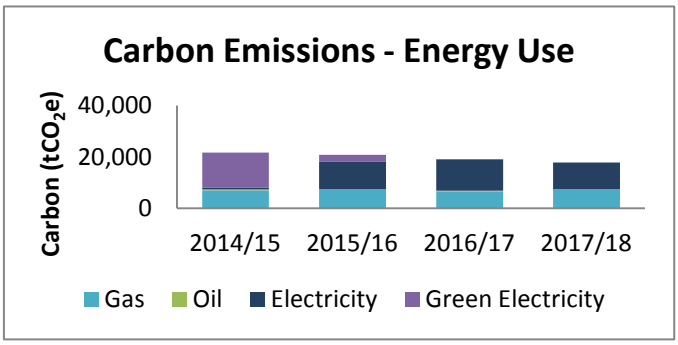
Energy

In 2017/18 the Trust saw a reduction of 7.6% in scope 1 and 2 carbon emissions compared with 2016/17 and emissions are now tracking at 12.8% below the baseline year. This is good progress and indicates that the 28% reduction target is achievable by 2020/21, provided the Trust maintains investment and momentum into energy saving and carbon reduction initiatives.

Resource[5]		2013/14	2014/15	2015/16	2016/17	2017/18
Gas	Use (kWh)	34,135,656	32,905,482	34,139,781	31,546,328	33,930,120
	tCO_2e	7,242	6,904	7,145	6,593	7,194
Oil	Use (kWh)	955,973	1,110,958	635,113	532,926	313,362
	tCO_2e	305	356	203	147	102
Coal	Use (kWh)	0	0	0	0	0
	tCO_2e	0	0	0	0	0
Electricity	Use (kWh)	224,551	1,331,564	18,564,756	23,801,508	23,652,117
	tCO_2e	126	825	10,673	12,301	10,542
Green Electricity	Use (kWh)	22,477,329	21,816,665	4,892,105	0	0
	tCO_2e	12,585	13,512	2,813	0	0
Total energy CO_2e		20,258	21,597	20,834	19,041[6]	17,838
Total energy spend		£4,039,990	£3,814,599	£3,919,681	£3,835,790	£4,535,611

N.B. tCO2e = Tonnes of CO_2 equivalent. This is used to measure the equivalent CO_2 concentration which causes the same level of absorption in the atmosphere for other greenhouse gases.

2017/18 has seen the replacement of over 6000 lamps with low energy LED alternatives, all funded through Salix interest free loans. The year has also seen the installation of new energy efficient chillers, the upgrade of Burner Management System (BMS) controls for the theatre blocks and the addition of a heat recovery module to the main flue of one of the boilers.



The main focus for the next year at Maidstone Hospital is to complete the LED upgrade and continue the process of upgrading and optimising Heating, Ventilation and Air Conditioning (HVAC) plant & controls across the site. At Tunbridge Wells Hospital, Interserve FM has developed a similar list of initiatives and these will be progressed in partnership with KESWHL.

Travel

The Trust is committed to reducing the emissions associated with transport and providing efficient low carbon transport services across its operational environment and we have documented this through the publication of a green travel plan.

Category	Mode	2014/15	2015/16	2016/17	2017/18
Patient & visitor travel	Miles ♌	104,162,344	107,404,988	112,158,231	115,563,332
	Miles	38,272.30	38,841.48	40,535.15	41,178.09
Business travel & fleet	tCO_2e	1,170,280	1,319,789	1,037,636	1,059,360
		430	477	375	377
Staff commute	Miles	4,610,964	4,493,769	4,927,968	4,824,221
	tCO_2e	1,694	1,625	1,781	1,719

N.B. tCO2e = Tonnes of CO_2 equivalent. This is used to measure the equivalent CO_2 concentration which causes the same level of absorption in the atmosphere for other greenhouse gases.

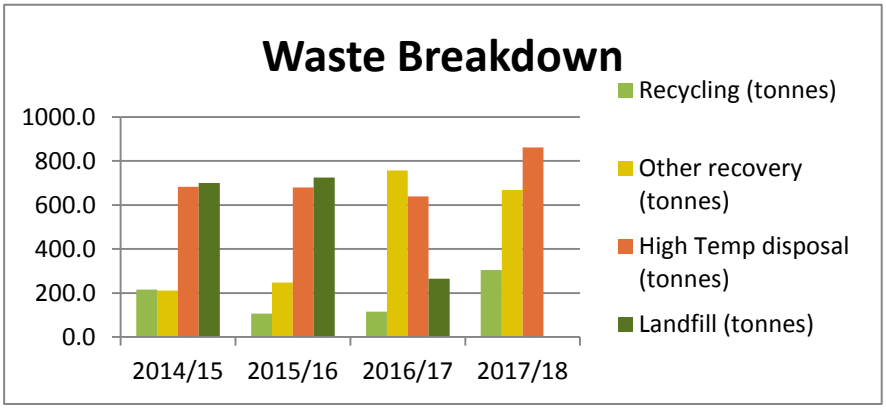
♌ Totals for previous years have been re-stated due to patient & visitor travelled mileages and associated carbon footprint being automatically calculated using externally provided intensity figures

[5] Data for energy resource usage before 2016/17 was reviewed and revalidated in 2016/17

[6] This figure has been amended to correct an error in the Annual Report 2016/17

Waste

The Trust is similarly committed to reducing its environmental impacts and is proud that it has sent no waste to landfill in the reporting period. A formal 3 phase waste strategy has been published that will coordinate and support the Trust's efforts to maintain compliance and to fully integrate the waste hierarchy into all aspects of its operations and to actively demonstrate best practice.



In 2018/19 the Trust has engaged upon several initiatives to reduce the production of waste and to dispose of waste in a more efficient and environmentally friendly manner. It has pioneered the use of the Pacto Safe system for the safe and secure bagging of soft cytotoxic waste, reducing the need for use of single use sharps containers. There has also been a successful trial of reusable sharps containers in several key clinical environments across both main hospital sites and there are aims to roll out this initiative Trust-wide in 2018/19.

Waste		2013/14	2014/15	2015/16	2016/17	2017/18
Recycling	(tonnes)	268.00	214.97	107.00	115.00	304.00
	tCO_2e	5.63	4.51	2.14	2.42	6.62
Other recovery	(tonnes)	166.00	211.00	248.00	756.00	668.00
	tCO_2e	3.49	4.43	4.96	15.88	14.54
High Temp disposal	(tonnes)	573.00	682.52	679.00	639.00	861.54
	tCO_2e	126.06	150.15	148.70	140.58	189.54
Landfill	(tonnes)	723.00	699.42	724.00	265.00	0.0
	tCO_2e	176.71	170.95	176.96	82.15	0.00
Total Waste (tonnes)		1730.00	1807.91	1758.00	1775.00	1833.54
% Recycled or Re-used		15%	12%	6%	6%	17%
Total Waste tCO_2e		311.89	330.04	332.76	241.03	210.69

Water

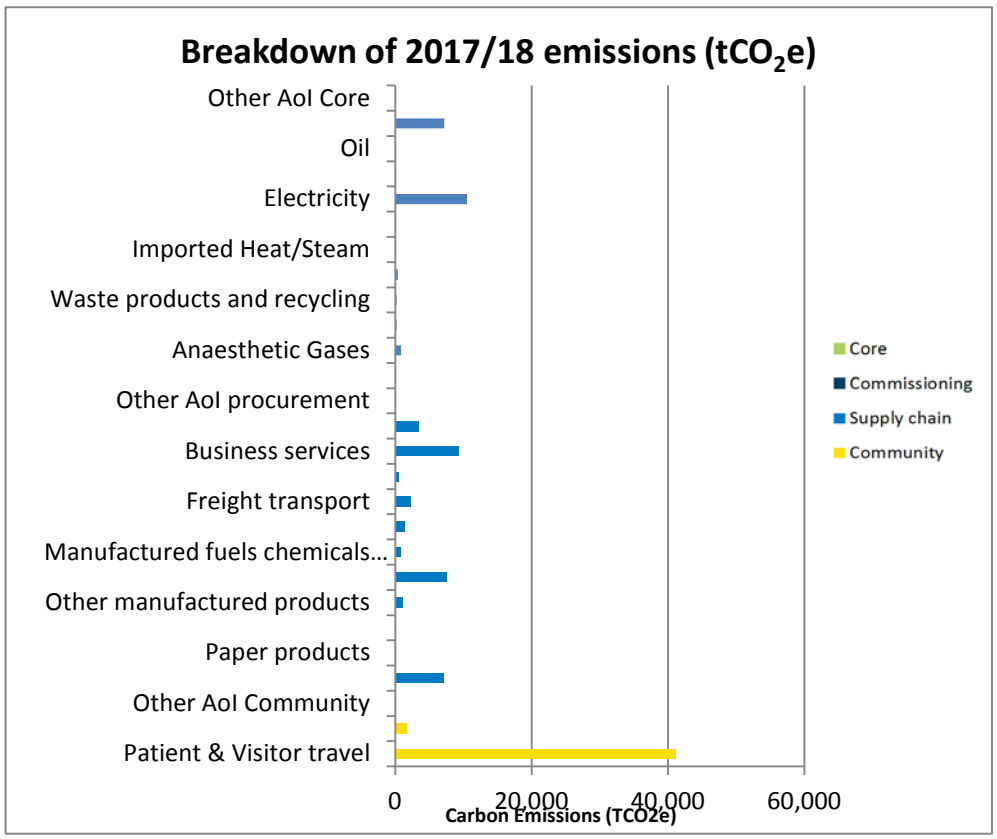
The Trust recognises that its water consumption is increasing on an annual basis within its hospitals and laundry operations. The acute sites are completely linked to patient attendances and the laundry is due to the increased throughput at the sites and the extension of laundry services to other NHS Trusts. The Trust continues to install water saving equipment where possible in association with Aquafund to ensure that its facilities and equipment operate in the most efficient manner possible.

Water		2013/14	2014/15	2015/16	2016/17	2017/18
Mains	m^3	186,570	186,441	205,246	209,205	225,383
	tCO_2e	170	170	187	190	205
Water & Sewage Spend		£684,307	£539,538	£582,869	£661,990	£761,100

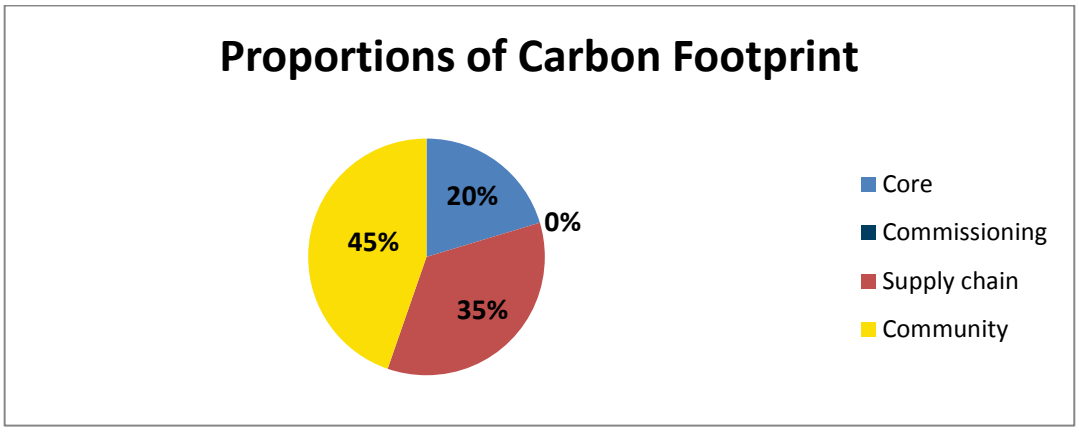
Modelled Carbon Footprint

The information provided in the previous sections of this sustainability report uses the Estates Return Information Collection (ERIC) returns as its data source. However, the Trust is aware that this does not reflect

our entire carbon footprint. Therefore, the following information uses a scaled model based on work performed by the Sustainable Development Unit (SDU) in 2009/10. More information is available at: https://tinyurl.com/NHScarbonfootprint

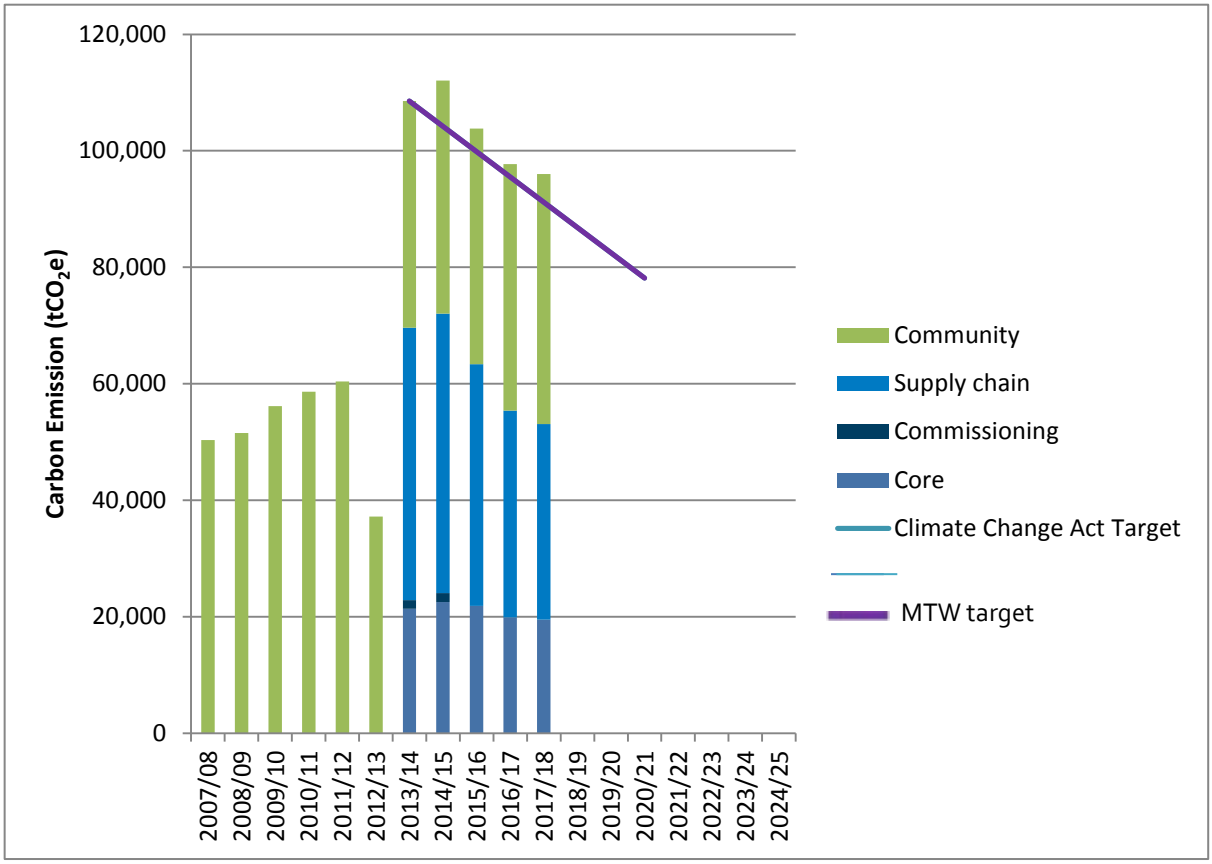


The application of this model results in an estimated total carbon footprint of 54,638 tonnes of carbon dioxide equivalent emissions (tCO_2e). The Trust's carbon intensity per pound is 132 grams of carbon dioxide equivalent emissions per pound of operating expenditure (gCO2e/£). Average emissions for acute services is 200 grams per pound.



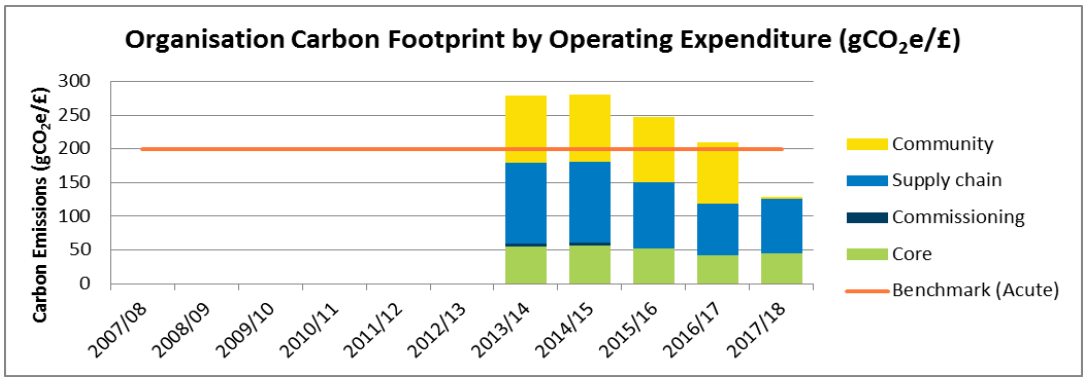
Modelled trajectory

The Trust is committed to meeting the legal requirements of the Climate Change Act 2008 by reducing its emissions in line with the trajectory above. It is currently on track with reductions in respect to its direct emissions but progress is challenged by increasing patient attendances & their associated carbon footprint.



Benchmarking

The table below shows the benchmark for acute trusts in carbon intensity against expenditure. The Trust is making good progress in meeting and exceeding this benchmark. [7]



Adaptation

The Trust recognises that its buildings and facilities have a significant impact on the environment, both due to the embedded carbon and resource depletion involved in their construction and in the energy consumed and carbon produced in their operation. The Trust is ensuring that any refurbishment, redevelopment or new development seeks to minimise the environmental impact and associated carbon footprint of the construction process, the materials used and the subsequent operation of the facility through the use of

[7] Data is not available for the period prior to the 2013/14 financial year.

appropriate technologies and strategies.

The Trust aims to ensure that any redevelopment or new development of its facilities appraises the potential changes to the climate, the potential effects of those changes on the facility and is seeking to mitigate them at the design stage.

The effects of climate change to the Trust have the potential to be severe, and the organisational risk register has been updated to include the appraisal of the legal, financial, infrastructure and service related risks and action plans have been developed to manage the risks that have been identified. The Trust has used standard risk assessment tools and externally available guidance and support to assist with the risk assessment process.

It is recognised that the process of climate change is leading to the normal patterns of weather changing and severe weather events becoming more frequent and prolonged. These include heatwaves, drought and water shortage, extreme cold events and associated snowfall, extreme rainfall and associated fluvial (surface water) flooding, changes to groundwater levels and associated groundwater flooding, severe storms and high winds. The Trust has prepared plans for the risks identified and has integrated the process of planning with the existing processes for Emergency Planning and Business Continuity

Green space & biodiversity

The Trust recognises that its grounds and green spaces are an asset, both due to the natural capital that they represent as a habitat and ecosystem but also as a resource for local communities to utilise and enjoy. The Trust is increasing access to its green spaces and natural environments for stakeholders and will maintain and enhance the biodiversity capacity of its managed estate. A Biodiversity Management Strategy for the entire estate is under development and the Trust will engage with local ecological partners and volunteers in its preparation. The Trust is committed to improving the health and welfare of its staff, both in and outside of the workplace, through the promotion of healthy living options, support services and partnership with organisations that provide specialist services.

Declaration

I confirm adherence to the reporting framework in respect of the Performance Report.

Miles Scott, Chief Executive

24th May 2018

NHS
Maidstone and Tunbridge Wells
NHS Trust

Accountability Report for 2017/18: Corporate Governance report

taking pride

Directors' report

The Trust Board

The Trust Board meets monthly, except in August, in public. The times and venues of these meeting are available on the Trust's website, which also contains the agendas, minutes & reports (see www.mtw.nhs.uk/about-us/trust-board/). The Trust Board formally operates in accordance with its Terms of Reference, the Trust's Standing Orders, Scheme of Matters Reserved for the Board and Scheme of Delegation, and Standing Financial Instructions.

The role of the Trust Board is to determine strategy and policy for the Trust, to monitor in-year performance against plans, to ensure accountability by holding the organisation to account for the delivery of strategy, and to ensure the Trust is well managed and governed. The Trust Board comprises the roles of Chair (Non-Executive), 5 other Non-Executive Directors (voting members), the Chief Executive, and 4 Executive Directors (voting members). Other Directors (non-voting) also attend the Board, and contribute to its deliberations and decision-making. The Non-Executive Directors (NEDs) bring a range of skills and expertise from outside the NHS; their role is to hold Executive Directors to account.

The Trust Board underwent significant changes during the course of the year with the arrival of a new Chair in May 2017; several new Non-Executive Directors, and Associate Non-Executive Directors; the appointment of the Deputy Chief Executive as Acting Chief Executive in September 2017; and the appointment of a new Director of Workforce and a new Chief Executive in December 2017 and January 2018 respectively. The Trust uses executive search facilities and advertising to attract the broadest range of appropriately skilled candidates when vacancies arise.

A Board Development Framework, informed by the practice of other NHS Trusts, and key external guidance from NHS Improvement and the NHS Leadership Academy, was drawn up in November 2017, to reinforce the range of Board development activities already in place to support both new and established Board members. Part of the Board's winter away day in 2017 was then devoted to consideration of Board development needs and, starting in 2018, a programme of regular Board Seminars has been established to allow more focussed consideration of key themes collectively by the Board.

Trust Board Members

Taking into account the wide experience of all Trust Board Members, the balance and completeness of the Board is considered to be appropriate. At the end of 2017/18, the Trust Board had the following members:

David Highton

Chair of the Trust Board (from 8th May 2017)*

David joined the Trust Board on 8th May 2017. Prior to this he was Ministerial Advisor on Private Sector Involvement and Public Private Partnership to the Minister of Public Health in Qatar. Since 2011, he was Executive Director of Corporate Development at Hamad Medical Corporation, the main public hospital provider in Qatar. Prior to moving to Qatar, David worked in the independent health sector, and was an NHS Chief Executive from 1991 to 2003, including at the Chelsea and Westminster Hospital NHS Trust and the Oxford Radcliffe Hospitals NHS Trust. Originally a Chartered Accountant, David worked in publishing, property services, the brewing industry, an industrial starches business, and in the City before joining the NHS as a Finance Director in 1990. David, who is married and has a grown up family, has strong links with Kent, having spent his childhood himself in Meopham & Sittingbourne, and currently lives in Whitstable.

Trust Board Members (continued)

Miles Scott

Chief Executive (from 8th January 2018)*Σ

As the Trust's "Accountable Officer", Miles is responsible for the overall development and performance of the Trust. In addition to being a Board member, he attends several Board sub-committees. Miles joined the Trust on 8th January 2018. Miles has over 30 years' experience in the NHS encompassing acute, community and mental health services, the Department of Health and the King's Fund. Most recently, he worked at a national level with NHS Improvement, focusing on its establishment as a new national organisation and leading the national Ambulance Improvement Programme with NHS England. He was previously Chief Executive of St George's University Hospitals Foundation Trust (2011 to 2016) and prior to that Chief Executive at Bradford Teaching Hospitals NHS Foundation Trust (2005 to 2011) and Harrogate and District NHS Foundation Trust (2001 to 2005). Miles is married to Abbie and has two children aged 12 and 13. He lives in south west London with his family.

Maureen Choong

Non-Executive Director*♎

Maureen joined the Board in August 2017 as an Associate Non-Executive Director, and was then appointed as a substantive Non-Executive Director in November 2017. She is a Registered Nurse with over 40 years of clinical and leadership experience within the NHS, prior to her retirement in 2016 from her role as Clinical Quality Director with NHS Improvement. Her previous roles included Deputy Chief Nurse with NHS London and both clinical and Director roles in NHS Trusts. Since retirement, Maureen has worked with Health Education England as an Improvement Associate. Maureen is married with two stepchildren and lives in Kent.

Sarah Dunnett OBE

Non-Executive Director*♎

Sarah joined the Board in January 2014. Sarah arrived from Dartford and Gravesham NHS Trust, where she had been Chair for the previous 12 years. Sarah's previous experience is in the oil industry, where she held a variety of senior management roles. Her contribution to the NHS was recognised in the 2013 Queen's birthday honours list, when she was awarded an OBE. Sarah is married with three sons. In addition to her role on the Board as Vice Chair, Sarah attends several other Trust Board sub-committees, chairs the Quality Committee, and is the Vice-Chair of the Finance and Performance Committee and Charitable Funds Committee.

Angela Gallagher

Chief Operating Officer*Σ

Angela is the lead for the delivery of patient services through the Trust's Clinical Directorates. Angela joined the Trust in 2004 from North Middlesex University Hospital, and has worked in a variety of senior Nursing and management roles, most recently as Deputy Chief Operating Officer and previously as the 18-week programme director for the Trust. She joined the Trust Board in October 2011, and in addition to her role on the Board, attends several Board sub-committees.

Simon Hart

Director of WorkforceΣ

Simon joined the Trust in December 2017. Prior to this Simon was the Director of Human Resources (HR) & Organisational Development at Oxleas NHS Foundation Trust for 11 years. Before becoming a Director Simon worked in a number of HR positions at Guy's & St. Thomas' NHS Foundation Trust and other NHS organisations in London. Simon has been in the NHS for over 20 years, his first job being to support the introduction of clinical audit to Maidstone GPs in 1993. Simon holds a professional registration with the Chartered Institute of Personnel and Development (CIPD) and completed his MSc in HR leadership in 2006.

Trust Board Members (continued)

Nazeya Hussain

Non-Executive Director[8]

Nazeya joined the Board in July 2017. Nazeya has 18 years' experience in the public sector and is currently Executive Director for Growth at London Borough of Kingston. Her expertise includes public/private sector ventures, asset and estate management, performance management, and organisational transformation. She is married with two children and lives in Sussex.

Tim Livett

Non-Executive Director*♎

Tim joined the Board in June 2017. Tim is Chief Financial Officer of the Wellcome Trust, a global foundation which invests around £1bn pa into bio medical research and associated activities. At Wellcome he is responsible for Finance, Risk Management, IT and Grant Management activities. Prior to joining Wellcome in 2014, Tim has spent the majority of his career in commercial aviation, working for British Airways and, after a short break, at Virgin Atlantic, most recently in the role of Chief Financial Officer. He is married with three sons and lives in Surrey.

Jim Lusby

Deputy Chief Executive$^{\Sigma}$

Jim joined the Trust Board in April 2015 and leads on the development of strategy. Before joining the Trust Jim was a Portfolio Director at the NHS Trust Development Authority (TDA), with responsibility for oversight of NHS Trusts in the South East. During his final five months with the TDA he acted into the position of Director of Delivery & Development for the South of England. Jim joined the TDA from King's Health Partners where he was Director of Integrated Care. He previously held senior positions in South East London Strategic Health Authority, the Department of Health and the Prime Minister's Delivery Unit. Jim will be leaving the Trust Board at the end of April 2018 to undertake a secondment to join the Kent and Medway Sustainability and Transformation Partnership (STP) as Director of System Resilience and Improvement.

Peter Maskell

Medical Director*$^{\Sigma}$

Peter joined the Trust Board in February 2017. Peter qualified from The Royal Free Hospital School of Medicine in 1995. He trained in general and elderly medicine at St Thomas' Hospital/Brighton and Sussex University Hospital, where he also studied for an MSc in gerontology and cognitive decline. Peter became a Consultant in General and Geriatric Medicine with an interest in Stroke medicine at the Trust in 2005, and became clinical lead in 2007. Peter was then appointed as Medical Director of Kent Community Health NHS Foundation Trust in 2012 and during his time there, the Trust attained Foundation Trust status and a 'good' rating from the Care Quality Commission. Clinically, Peter continues to have interests in stroke, frailty and liaison geriatrics.

Sara Mumford

Director of Infection Prevention and Control

Sara joined the Trust Board in November 2007. She leads the Trust's infection prevention strategy. Sara is also a Consultant Microbiologist, and is the Clinical Director for Diagnostics, Pharmacy and Therapies. Sara joined the Trust in 2007, and has previously worked as Consultant Microbiologist at East Kent Hospitals University NHS Foundation Trust, and as a Consultant in Communicable Disease Control (CCDC) at Kent Health Protection Unit.

[8] Nazeya Hussain served as Associate Non-Executive Director from 19th July 2017 until 11th April 2018, when she was appointed Non-Executive Director

Trust Board Members (continued)

Claire O'Brien

Chief Nurse*Σ

Claire joined the Trust Board in February 2017 as Interim Chief Nurse and was appointed Chief Nurse (substantive) in March 2018. Claire has worked in the NHS for over 38 years, qualifying as a Registered General Nurse at King's College London in the early 1980s. She specialised in Cardiothoracic Nursing and has enjoyed a variety of general management and senior nursing roles within South London NHS acute Trusts, more recently as the Deputy Director of Nursing in Lewisham and Greenwich NHS Trust. Claire joined the Trust as Deputy Chief Nurse in April 2016, bringing a wealth of experience in all areas related to Nursing standards, Nurse Education, recruitment and Nursing professional issues. She has considerable experience working with patient representatives, and has a particular interest in engaging with staff and supporting them in their development, recognising the relationship between staff and patient experience, and feels it is vital that staff are valued and supported to provide the best possible care at all times.

Steve Orpin

Director of Finance*Σ

Steve is responsible for providing information and advice to the Trust relating to all financial management issues. Steve joined the Trust Board in April 2014 from Medway NHS Foundation Trust, where he had been Deputy Director of Finance; including a 12-month spell as Director of Finance. Steve has held various positions within the Finance function in a number of NHS organisations across London and the South East in a NHS career spanning over 20 years. Steve is a Fellow of Chartered Association of Certified Accountants and holds an MBA. In addition to his role on the Board, Steve attends several Board sub-committees.

Steve Phoenix

Non-Executive Director* ≙

Steve joined the Trust Board on 1st December 2017 after a 37-year management career in healthcare, predominantly in the NHS. Between 2006 and 2011 he was Chief Executive of NHS West Kent, which included Maidstone and Tunbridge Wells NHS Trust as a major hospital provider. Steve has spent 30 years at Board level in a number of healthcare organisations, including 16 years as Chief Executive. From 2011 he was appointed Group Chief Executive for General Hospitals for Hamad Medical Corporation in Qatar and in 2017 was appointed as Special Adviser to the Minister. Steve has particular interests in strategic leadership, people management and organisation development in health care. He is married and lives in East Sussex.

* Denotes Board members with voting rights
∑ Denotes member of the Executive Team
≙ Denotes member of the Audit and Governance Committee

The following persons also served on the Trust Board during 2017/18:

- Glenn Douglas, Chief Executive (joined the Board in December 2007, and left on 19th September 2017)
- Richard Hayden, Director of Workforce (joined the Board in March 2016, and left at the end of June 2017)
- Alex King, Non-Executive Director (joined the Board in September 2014, and left on 21st March 2018)
- Kevin Tallett, Non-Executive Director (joined the Board in August 2008, and left on 27th July 2017)

Statement as to disclosure to auditors

Each Director can confirm that he or she knows of no information which would be relevant to the auditors for the purposes of their audit report, and of which the auditors are not aware, and; has taken "all the steps that he or she ought to have taken" to make himself/herself aware of any such information and to establish that the auditors are aware of it.

Attendance at Trust Board meetings

There were 11 formal Trust Board meetings in 2017/18. Attendance at each meeting is shown below:

Trust Board Member	April 2017	May 2017	June 2017	July 2017	September 2017	October 2017	November 2017	December 2017	January 2018	February 2018	March 2018
David Highton, Chair of the Trust Board	N/A[9]	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Maureen Choong, Non-Executive Director	N/A[10]				Apologies	✓	✓	✓	✓	✓	✓
Glenn Douglas, Chief Executive	✓	✓	✓	✓	✓	N/A[11]					
Sarah Dunnett, Non-Executive Director	✓	✓	✓	✓	Apologies	✓	✓	✓	Apologies	✓	Apologies
Angela Gallagher, Chief Operating Officer	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Simon Hart, Director of Workforce	N/A[12]							✓	✓	✓	✓
Richard Hayden, Director of Workforce	✓	✓	✓	N/A[13]							
Nazeya Hussain[14], Associate Non-Executive Director	N/A[15]				✓	✓	✓	✓	✓	Apologies	✓
Alex King, Non-Executive Director	✓	✓	✓	✓	Apologies	Apologies	✓	Apologies	Apologies	Apologies	N/A[16]
Tim Livett, Non-Executive Director	N/A[17]		Apologies	✓	✓[18]	Apologies	✓	✓	✓	✓	✓
Jim Lusby, Deputy Chief Executive [19]	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Peter Maskell, Medical Director	✓	✓	Apologies[20]	✓	✓	✓	✓	Apologies	✓	✓	✓
Sara Mumford, Director of Infection Prevention & Control	✓	✓	✓	Apologies	✓	✓	✓	✓	✓	✓	✓
Claire O'Brien, Chief Nurse	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Steve Orpin, Director of Finance	✓	✓	✓	Apologies[21]	✓	✓	✓	✓	✓	✓	✓
Steve Phoenix, Non-Executive Director	N/A[22]							✓	✓	✓	✓
Miles Scott, Chief Executive	N/A[23]								✓	✓	✓
Kevin Tallett, Non-Executive Director	✓	✓	Apologies	✓	N/A[24]						

[9]David Highton joined the Board on 8th May 2017
[10]Maureen Choong joined the Trust Board on 29th August 2017, as an Associate Non-Executive Director (i.e. non-voting), and was then appointed as a Non-Executive Director on 16th November 2017
[11]Glenn Douglas left the Board on 19th September 2017
[12]Simon Hart joined the Trust Board on 1st December 2017, but attended the Trust Board meetings on 29th November 2017
[13]Richard Hayden left the Board at the end of June 2017
[14]Nazeya Hussain served as Associate Non-Executive Director from 19th July until 11th April, when she was appointed Non-Executive Director
[15]Nazeya Hussain joined the Board on 19th July 2017
[16]Alex King retired from the Board on 21st March 2018
[17]Tim Livett joined the Board on 26th June 2017
[18]Tim Livett was not present at the Part 2 meeting on 27th September 2017
[19]Jim Lusby was Acting Chief Executive between 19th September 2017 and 7th January 2018
[20]Paul Sigston, Deputy Medical Director, attended in Peter Maskell's place on 28th June 2017
[21]Sheila Stenson, Deputy Director of Finance (Financial Performance) attended in Steve Orpin's place on 19th July 2017
[22]Steve Phoenix joined the Board on 1st December 2017
[23]Miles Scott joined the Board on 8th January 2018
[24]Kevin Tallett left the Trust Board on 27th July 2017

Appointment and evaluation of Trust Board Members' performance

The Chair of the Trust Board and its Non-Executive Directors are independently appointed by NHSI. The Chief Executive and other Executive posts serving on the Trust Board are appointed by the Trust in liaison with NHSI. All members of the Trust Board are subject to a performance framework which stipulates that:

- The Chair of the Trust Board is appraised via a national framework operated by NHSI;
- Non-Executive Directors and the Chief Executive are appraised by the Chair of the Trust Board; and
- Members of the Executive Team are appraised by the Chief Executive.

Trust Board Members are also subject to an annual self-assessment in accordance with the fit and proper persons requirements (FPPR[25]) for Directors. No concerns have been raised in relation to this in 2017/18.

Directors' interests

The Trust Board and other committees routinely ask that any interests relevant to agenda items be declared at each meeting. In addition, a Register of Directors' interests is maintained. The interests recorded on the Register at the end of 2017/18 for those on the Board at the end of that year were as follows:

Trust Board Member	Details of notifiable interest
David Highton, Chair of the Trust Board	▪ Non-Executive Chairman, Sussex Healthcare Audiology Ltd (company number: 07512308) ▪ Chairman Designate, Demelza House Children's Hospice (charity Number: 1039651) – due to take up post in June 2018 ▪ Owner and Director, Hyperium Ltd (company number: 04684013)
Maureen Choong, Non-Executive Director	▪ Specialist Adviser, Care Quality Commission ▪ Improvement Associate, Health Education England
Sarah Dunnett, Non-Executive Director	Governor of Sevenoaks School (www.sevenoaksschool.org / charity number: 1101358; company number: 04908949)
Angela Gallagher, Chief Operating Officer	None
Simon Hart, Director of Workforce	None
Nazeya Hussain, Associate Non-Executive Director	None
Tim Livett, Non-Executive Director	▪ Director, Diamond Light Source Ltd (Co. no. 04375679) ▪ Director, North London Ventures Ltd (Co. no. 08226374) ▪ Director, Wellcome Trust Nominees Ltd (Co. no. 00594081) ▪ Director, Henry Wellcome Ltd (Company number: 02636171) ▪ Director, Premier Marinas Holdings Ltd (Company number: 05524490) ▪ Director, Genome Research Ltd (Company number: 02742969) ▪ Director, Wellcome Trust Trading Ltd (Company number: 03227027) ▪ Director, Dell Quay Sailing Club Ltd (Company number: 08956103) ▪ Director, Oakdale Residents Ltd (Company number: 01385943) ▪ Director, Gower Place Investments Ltd (Company number: 08594660) ▪ Director, Wellcome Trust GP Ltd (Company number: 05867101) ▪ Director, Wellcome Trust Investments 1 Unltd (Company number: 06483238) ▪ Director, Wellcome Trust Investments 2 Unltd (Company number: 06576220) ▪ Director, Wellcome Trust Investments 3 Ultd (Company number:05391431) ▪ Director, Wellcome Trust Residential 1 Ltd (Company number: 06262798) ▪ Director, Wellcome Trust Residential 1 Ltd (Company number: 06262846) ▪ Director, WT Construction Ltd (Company number: 04122656)
Jim Lusby, Deputy Chief Executive	None
Peter Maskell, Medical Director	None
Sara Mumford, Director Infection Prevention & Control	None
Claire O'Brien, Interim Chief Nurse	None
Steve Orpin, Director of Finance	Director NHS Innovations South East Limited (company number: 05210174) – serves as a Director as a result of the Trust acting as Guarantor
Steve Phoenix, Non-Executive Director	None
Miles Scott, Chief Executive	None

N.B. Some Directors' notifiable interests changed during the year. Further details can be obtained from the Trust Secretary, who can be contacted via Maidstone Hospital, Hermitage Lane, Maidstone, Kent ME16 9QQ (or see www.mtw.nhs.uk/about-the-trust/trust-board.asp). The interests of Trust Board Members who left the Board during 2017/18 can also be obtained from the Trust Secretary.

[25] As introduced by The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

Pension Liabilities

Details of how the Trust treats Pension Liabilities are outlined in the Principal Financial Statements (within Note 9).

Trust Board sub-committees

The Trust Board has a number of sub-committees, to assist it in meeting its role and duties. Further details are provided in the 'Annual Governance Statement for 2017/18' section later in the Annual Report.

The Trust's Management Structure

The Trust is organised into a number of Corporate and Clinical Directorates. Clinical services are arranged within 3 Divisions, encompassing 10 Directorates:

Division	Directorate
Urgent Care	▶ Acute and Emergency ▶ Specialist Medicine and Therapies
Planned Care (Surgery and Critical Care sub-division)	▶ Surgery, Urology and Gynae Oncology ▶ Head and Neck ▶ Trauma and Orthopaedics ▶ Critical Care
Planned Care (Cancer and Clinical Support sub-division)	▶ Cancer, Haematology and Radiology ▶ Pathology and Pharmacy
Women's, Children's and Sexual Health	▶ Women's and Sexual Health ▶ Children's Services

Each Division is overseen by a Director of Operations or equivalent, while each Clinical Directorate has a Clinical Director, General Manager and Lead Matron. Corporate departments (Human Resources, Finance, Estates & Facilities, Clinical Governance and Trust Management) are all responsible to a Member of the Executive Team.

Complaints: Ready to listen, ready to learn

The Trust aims to provide the best possible care and treatment but sometimes, despite the best efforts of staff, things can go wrong. In such circumstances, patients and relatives are encouraged to tell a member of staff on the Ward or in the clinic as soon as they can, to enable their concerns to be responded to as soon as possible. However, for circumstances where concerns cannot be resolved in this way, the Trust has a formal complaints process. In 2017/18, the Trust received 503 formal complaints (in 2016/17, this was 326), and 60.2% of complaints received were responded to within the agreed timescale (in 2016/17, this was 69%).

The Trust's Complaints and Patient Advice and Liaison Service (PALS) – Annual Report (due for publication in June 2018) (www.mtw.nhs.uk/patients-visitors/talk-to-us/making-a-complaint/) provides further detail on: the number of complaints received; the number of complaints which were well founded (upheld); the number of complaints referred to the Parliamentary and Health Service Ombudsman (PHSO); the subject matter of the complaints received; any matters of general importance arising from those complaints or the way in which the complaints were handled; any matters where action has been or is to be taken to improve services as a consequence of those complaints.

'Principles for Remedy'

The Trust applies the 'Principles for Remedy' guidance issued by the PHSO as part of its Policy and Procedure for Management of Concerns and Complaints. Under the Trust's Policy, financial remedy is only considered when a complaint is upheld and the complainant has clearly suffered a financial loss as a result of a service failure or breach of a Trust policy. In such circumstances, the Trust will consider paying a sum that restores the person to the position they would have been in prior to the circumstances which necessitated the complaint. The amount of financial remedy is agreed between the Complaints and PALS Manager and senior Directorate management team, with input from Legal Services as required. During 2017/18, the Trust offered financial remedy in 2 cases, totalling £47.27[26]. Financial redress was also recommended by the PHSO in a further 2 cases, at a total of £500.00[27]. This process excludes any claims for clinical negligence, which are pursued under the Trust's Claims Management Policy.

Disclosure of personal data-related incidents

The Trust had one Serious Incident Requiring Investigation involving personal data that met the criteria for reporting to the Information Commissioner's Office (i.e. a 'Level 2' severity incident) as follows:

Date (month)	Nature of incident	Nature of data involved	No. of people potentially affected	Notification steps
October 2017	Disclosure in error	Name, Address, Date of Birth, Contact Phone Numbers, Sex, GP Details, Appointment Type	67	All individuals affected contacted by telephone and/or letter
Further action on information risk	The Trust notified this breach to the Information Commissioner who considered the case and concluded that sensitive personal data was involved so there was potential for the incident to cause distress/detriment but that significant detriment seemed unlikely. The Trust provided evidence of steps being taken to test the system being used and help prevent such incidents recurring. The Information Commissioner's Office further concluded that it is possible an error occurred with a process that could not have reasonably been foreseen.			

More details of the incident are given in the 'Governance Report'. The Trust also had the following severity 'Level 1' data-related incidents in the year:

Category	Nature of Incident	Total
A	Corruption or inability to recover electronic data	1
B	Disclosed in error	45
C	Lost in transit	2
D	Lost or stolen hardware	1
E	Lost or stolen paperwork	18
F	Non-secure disposal – hardware	0
G	Non-secure disposal – paperwork	3
H	Unloaded to website in error	0
I	Technical security failing (including hacking)	0
J	Unauthorised access/disclosure	5
K	Other	1

Policy on setting charges

The Trust has complied with HM Treasury's guidance on setting charges for information, as set out in Chapter 6 of HM Treasury's "Managing Public Money" guidance.

[26] This is based on complaints received between 01/4/17 and 31/03/18 inclusive, though some complaints received towards the end of that period are still open at the time of this report, so further financial redress may be offered

[27] This is based on recommendations made by the Parliamentary and Health Service Ombudsman between 01/04/17 and 31/03/18, but not all of the relevant complaints were received within that time span

Emergency preparedness

During the year the Emergency Preparedness team continued to increase the resilience of the Trust, foster and enhance partnerships across the county and develop innovative training for those involved in emergency response. As a Category One responder under the Civil Contingencies Act 2004, the Trust has specific statutory duties in relation to emergency planning and response. In addition, the Trust has other obligations as required by contracts and performance standards set by NHS England and Clinical Commissioning Groups (CCGs), and throughout the year a continuous process of exercising, testing, training and assurance took place. As part of this, West Kent CCG endorsed the Trust Board's submission to NHS England of full compliance following a round of emergency preparedness, resilience and response (EPRR) assurance visits.

Incidents that took place during the year

During the year a number of responses were mounted, including the 'WannaCry' cyber-attack which affected the NHS in May 2017. Although the Trust was not directly affected, there were extensive actions and communications taken by the IT directorate to ensure services were able to continue.

2017 was marked by the shocking terrorist attacks in the UK starting with Westminster in March, Manchester in May, London Bridge in June and Parsons Green in September. The national threat level went to Critical on two occasions in both May and September requiring the Trust to implement additional measures and review security. The lessons identified in national debriefs were quickly shared and the Trust considered all of the advice in changing emergency plans. The team, through its extensive networks, has had the opportunity to talk directly to some of those involved and understand the issues they faced.

Roadworks caused business continuity issues for the Trust in 2017/18. The team worked hard with multi agency partners to ensure the needs of the NHS were understood by those undertaking the works.

In early 2018, sudden snow caused business continuity challenges overnight and the Trust activated its agreement with South East 4x4 Response Volunteers to assist in transporting staff to the hospitals.

Multi-agency cooperation & training

- Throughout the year, the Trust continued to play a full part in local authority Safety Advisory Groups across its catchment area, thereby playing an important role in protecting public safety at large events. The team undertook multiagency site visits at the War & Peace Event at the Hop Farm, the Kent County Show and various music festivals and concerts, all with the aim of reducing Emergency Department (ED) attendances
- The Trust presented two partnership awards, firstly to the Kent Event Centre & County Show for work in successfully reducing hospital attendances from large events, and then to the crew of the HM Coastguard Rescue Helicopter Team for their support in live training and exercising
- The Trust is part of the Kent Resilience Forum made up of all multi agency partners, military and voluntary sector organisations
- The excellent relationship with all helicopter providers was maintained at both of the Trust's key sites. This allowed for live helicopters during exercises, valuable training provided to both ground staff who make landings safe and the critical care teams who might receive or transfer by air. Partnership options are being explored to make the landing site at Maidstone Hospital more permanent.

Training exercises during the year included:

- A trauma network exercise in March which looked at casualty distribution from a mass casualty incident in conjunction with other trusts in the South East London Kent & Medway Trauma Network
- During May, unannounced exercises were started in both EDs. These allowed staff to familiarise themselves with lockdown, triage, access to equipment and procedures for clearing the ED, both in and out of hours
- On July 27th Exercise Lockgate was carried out at Tunbridge Wells Hospital in conjunction with Kent Police, South East Coast Ambulance Service NHS Foundation Trust (SECAmb) and HM Coastguard. The exercise consisted of a full activation of the Major Incident Plan. The hospital was expecting one Priority One patient by helicopter, but when it was landing a minibus arrived with a further 12 casualties, unannounced and un-triaged. This aimed to bring in some of the issues identified in recent terrorist incidents where patients arrived without notice in buses, taxis and private transport. The exercise took place on a very busy day in the ED and staff managed well in dealing with normal activity alongside a major incident response as well
- Exercise Neptune was a live Business Continuity Exercise at Maidstone Hospital which tested a complete failure of water supply in conjunction with South East Water. The exercise tested command & control, live connections to tankers to fill holding tanks, delivery & distribution of thousands of bottles of water and communications both internally and with partner agencies along with media handling
- The Command Accreditation Courses and Continuing Professional Development for on call teams went from strength to strength and awareness training for non-specialist staff is now provided by a DVD which is available on both the Trust intranet and YouTube channel.

Despite adverse weather, HM Coastguard flew into Maidstone Hospital on 18/10/17 to receive an emergency planning partnership award from the Trust for their contribution to resilience and training, presented by Chair of the Trust Board, David Highton.

Statement of the Chief Executive's responsibilities as the Accountable Officer of the Trust

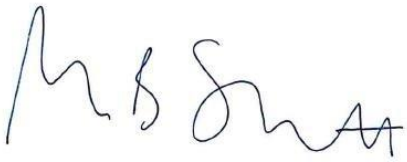
The Chief Executive of the NHS Trust Development Authority has designated that the Chief Executive should be the Accountable Officer to the Trust. The relevant responsibilities of Accountable Officers are set out in the Accountable Officers Memorandum issued by the Chief Executive of the NHS Trust Development Authority (legal entity). 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.



Miles Scott, Chief Executive

24th May 2018

Annual Governance Statement for 2017/18

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[28].

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 Maidstone and Tunbridge Wells 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 Maidstone and Tunbridge Wells NHS Trust for the year ended 31st March 2018 and up to the date of approval of the Annual Report and Accounts.

Capacity to handle risk

The ways in which leadership is given to the risk management process

Risks are identified, analysed and controlled in accordance with the Trust's Risk Management Policy and Procedure. The overall Executive Lead for risk management is the Chief Nurse, who is supported in this role by a range of staff, in particular the Trust Secretary and Risk and Compliance Manager. A number of specific risk-related roles are also held by Trust Board Members, as follows:

- The Chief Nurse is the Senior Information Risk Owner (SIRO)
- The Medical Director is the Caldicott Guardian and the Responsible Officer (for Medical Revalidation)
- The Chief Operating Officer is the Board Level Director (with fire safety responsibility), the Accountable Emergency Officer for Emergency Preparedness, Resilience & Response (EPRR), and the Security Management Director
- One of the Non-Executive Directors (NEDs) has been appointed as the Non-Executive Lead for Safeguarding and also for Resus[29]
- The Chair of the Quality Committee is the NED with specific role/responsibilities for leading falls prevention[30], and is also the Non-Executive lead on mortality and learning from deaths[31]
- A further NED has been allocated the Emergency Preparedness, Resilience and Response (EPRR) portfolio[32]

The Trust has a Board Assurance Framework (BAF) and a Risk Register in place, the operation of which are informed by accepted best practice. The BAF is the document through which the Trust Board is apprised of the principal risks to the Trust meeting its key objectives, and to the controls in place to manage those risks. In addition to the Trust Board, the BAF and Risk Register are reviewed regularly at the Audit and Governance Committee and Trust Management Executive (TME), whilst the relevant aspects of both are reviewed regularly at the Finance and Performance Committee.

[28] See https://tinyurl.com/NHSAOM
[29] Health Services Circular 2000/028 states that "Chief executives should ensure that"…"a…NED…of the Trust is given designated responsibility on behalf of the Trust Board to ensure that a resuscitation policy is agreed, implemented, and regularly reviewed within the clinical governance framework"
[30] The Falls and fragility fractures audit programme (FFFAP) pilot national audit of inpatient falls (2015) asks "Does your organisation have a Non-executive Director (or other Board member) who has specific roles/responsibilities for leading falls prevention (can be as part of a wider remit for patient safety)?"
[31] The CQC's "Learning, candour and accountability: A review of the way NHS trusts review and investigate the deaths of patients in England" report states that "We also recommend that provider Boards strongly consider nominating a non-executive director to lead on mortality and learning from deaths"
[32] The Core Standards for Emergency Preparedness, Resilience and Response (EPRR) assess whether "The organisation has an identified, active Non-executive Director/Governing Body Representative who formally holds the EPRR portfolio for the organisation"

As is the case every year, the BAF and Risk Register are subject to an Internal Audit review. The review for 2017/18, gave an overall assessment of "Reasonable Assurance", and the report's "overall conclusion" included the statements that "The Trust has an appropriately approved and up to date Risk Management Policy and Procedure in place…"; and "It was confirmed that there is an effective committee structure in place and that the BAF and Risk Management processes had been subject to regular review by the Trust Board and Audit and Governance Committee".

The ways in which staff are trained or equipped to manage risk in a way appropriate to their authority and duties

The Trust has in place a range of systems to prevent, deter, manage and mitigate risks and measure the associated outcomes. In addition to the Trust's Risk Management Policy and Procedure, a comprehensive range of risk management policies and guidance is made available to staff. This includes the policies and procedures for risk assessment, incident reporting, managing complaints, investigation of incidents, health and safety, and 'being open' to staff and patients (to support the statutory Duty of Candour). Additional advice on good practice can be obtained from a range of professional and specialist staff. The remit of the Trust's Clinical Governance department includes clinical risk management; clinical governance; clinical audit; complaints; the Patient Advice and Liaison Service (PALS); medico-legal service and claims handling; research and development. The systems to oversee staff health and safety are managed via the Estates and Facilities department, but there is close liaison between the relevant staff. In addition, Directorates and sub-specialities have clinical governance and risk leads. There is a forum for clinical governance and risk management within each Directorate and within the majority of clinical sub-specialties.

Trust staff are involved in risk management processes in a variety of ways, including raising any concerns they may have (anonymously, if they so wish); being aware of their responsibility to report and act upon any incidents that occur; being involved in risk assessments; and attending regular training updates.

In-house support and advice on risk management is available, which includes advice relating to patient safety, health and safety, information governance etc. Certain types of risk are also addressed via the engagement of external expertise. For example, the risk of fraud is managed and deterred via the appointment of a Local Counter Fraud Specialist (LCFS) and the Trust engages a Dangerous Goods Safety Advisor (DGSA) to advise on the safe management of healthcare waste.

The risk and control framework

The key elements of the Risk Management Policy (including the way in which risk (or change in risk) is identified, evaluated, and controlled; and how risk appetites are determined)

Risks are identified, analysed and controlled in accordance with the Trust's Risk Management Policy and Procedure. Most risks are identified at local level and initially managed by department managers. Identified risks are added to the Risk Register and are then either managed locally or escalated through the Trust's management and/or committee structure. The Trust's competent persons (individuals with specialist skills, knowledge and qualifications that are assessed by external bodies who are able to advise managers and employees on all aspects of health, safety and risk) identify hazards within their area of expertise, and undertake Trust-wide risk assessments for hazards that affect multiple areas. Risks are identified, analysed and controlled in accordance with the Trust's Risk Assessment Policy and Procedure and guidance documents, which includes grading risks for their potential impact and likelihood of harm using a standard Risk Categorisation Matrix. The risk score determines the priority, response and level of management required to manage the risk. Risk appetite is the level of risk the Trust will accept for a particular type of risk. When a risk is assessed the uncontrolled risk score is determined, along with a target risk score, which indicates the risk rating that would be considered as satisfactory. This target risk score should be set as high as can be tolerated, and constitutes the risk appetite for that risk.

The key elements of the quality governance arrangements (including how the quality of performance information is assessed and how assurance is obtained routinely on compliance with Care Quality Commission (CQC) registration requirements)

The Trust's Quality Governance arrangements are managed via the Trust Clinical Governance Committee (and its sub-committees); and via a number of associated systems and processes. The Quality Committee then aims to seek and obtain assurance on the effectiveness of these structures, systems and processes.

Clinical audit is supported by a central team, within the Clinical Governance department, and is primarily overseen by the Trust Clinical Governance Committee. The investigation of, and learning from, incidents are predominantly managed within Directorates and discussed at Directorate and specialist clinical governance meetings. Serious Incidents (SIs) are discussed and monitored at a corporate level via the Learning and Improvement (SI) Panel. SIs are reported routinely to the 'main' Quality Committee.

Complaints are managed by the central complaints team in partnership with the Directorates concerned. The rate of new complaints and percentage of complaints responded to within target are monitored monthly at the Trust Board, whilst detailed reports on Complaints and Patient Advice and Liaison Service (PALS) contacts are received twice per year by the Patient Experience Committee and 'main' Quality Committee.

The quality of performance information is primarily assessed via the Internal Audit programme. In 2017/18, a "Review of A&E Data Capture and Recording" was undertaken, which aimed to provide assurance on the accuracy of data capture by the A&E department for activity undertaken and the effectiveness of the processes in place for the capturing and recording of this activity. The review gave an overall assessment of "Reasonable Assurance".

Compliance with CQC registration requirements is ultimately assessed via inspections by the CQC, and the Trust was subject to such inspections in the latter part of 2017. The Trust's overall assessment from the inspections remained as "Requires Improvement", but significant improvement had been made since the previous inspection in 2015, particularly in relation to the "Well-Led" domain, which had been previously rated as "Inadequate", but which was rated as "Good" in 2017/18. This improvement was recognised by the CQC in the "What we found" section of its inspection report with the statement that "We found there had been significant and sustained improvement throughout the trust".

The Trust also however monitors compliance with CQC registration requirements itself, primarily through a programme of in-house assurance visits/inspections. Such inspections, which are managed by the Clinical Governance and Corporate Nursing teams, include patient representatives and representatives from West Kent Clinical Commissioning Group, the main commissioner of the Trust's services. The outcome of the inspections are reported to the Trust Clinical Governance Committee, and areas for improvement are identified and acted upon.

How risks to data security are being managed and controlled

Risks to data security are managed and controlled via a range of methods. The Trust has reviewed the 10 data and cyber security standards that were published jointly by the Department of Health and Social Care, NHS England and NHS Improvement (NHSI) in January 2018 (which were based on the standards recommended by the National Data Guardian, and confirmed by HM Government in July 2017), and a report on compliance with the standard was scheduled to be submitted to the Trust Board on 26th April 2018. The Trust has fully implemented the following standards:

1. A named senior executive is responsible for data and cyber security
2. Achievement of at least level 2 on the current Information Governance Toolkit
4. All staff must complete appropriate annual data security and protection training
5. Organisations must act on CareCERT advisories where relevant; confirm within 48 hours that plans are in place to act on High Severity CareCERT advisories, and evidence this through CareCERT Collect; and identify a primary point of contact to receive and co-ordinate the organisation's response to CareCERT advisories, and provide this information through CareCERT Collect.
7. Staff across the organisation report data security incidents and near misses, and incidents are reported to CareCERT in line with reporting guidelines

8. Organisations must identify unsupported systems (including software, hardware and applications) and have a plan in place by April 2018 to remove, replace or actively mitigate or manage the risks associated with unsupported systems

The Trust has partially implemented the following standards:

3. Preparation for the introduction of the General Data Protection Regulation (GDPR) in May 2018
6. A comprehensive business continuity plan must be in place to respond to data and cyber security incidents
10 Organisations should ensure that any supplier of IT systems (including other heath and care organisations) and the system(s) provided have the appropriate certification

The Trust has not implemented the following standards:

9. Organisations must undertake an on-site cyber and data security assessment if invited to do so by NHS Digital; and act on the outcome of that assessment, including any recommendations, and share the outcome of the assessment with your commissioner. The Trust has not been invited by NHS Digital to undertake an on-site cyber and data security assessment, but has used an external vendor to audit the organisation's data and cyber security risks

Brief description of the organisation's major risks (including how they are/will be managed and mitigated and how outcomes are/will be assessed)

In July 2016, the Trust Board approved the proposal to focus the BAF on a deliberately small number of higher-level objectives to act as proxy indicators (a 'litmus test') for broader performance. The Trust Board then confirmed it wished to adopt this principle in 2017/18, and duly approved the following broad risk and associated key objectives for 2017/18:

Broad risk to be managed	Associated key objective
The Trust fails to improve key aspects of clinical care and safety	1. To reduce mortality (HSMR) in line with the national average
The Trust is unable to manage (either clinically or financially) during the winter period	2. To deliver the agreed 2017/18 trajectory for the A&E 4 hour waiting time target
The Trust does not have the correct level of substantive workforce for effective delivery	3. To maintain a vacancy rate of no more than 8.5%
The Trust fails to demonstrate an ability to achieve future financial viability	4. To deliver the control total for 2017/18 (of a pre-Sustainability and Transformation Fund (STF) deficit of no more £4.5m, or otherwise agreed by NHS Improvement)
The Trust fails to maintain and improve its reputation as a Cancer provider	5. To deliver the agreed 2017/18 trajectory for the 62-day Cancer waiting time target
The Trust is unable to manage (either clinically or financially) during the winter period	6. To deliver the agreed Referral to Treatment (RTT) trajectory for patients on an 'incomplete' pathway

The main risks to the achievement of these key objectives (i.e. the issues that could prevent the objectives being achieved) are described within the BAF, and the Trust Board received formal update reports on the performance of each objective, and the management of risks to non-achievement at its meetings in July, September and November 2017 and February 2018. A year-end BAF report regarding the achievement of the objectives is scheduled to be received by the Trust Board in April 2018.

In addition, a number of risks were rated as 'red' in 2017/18. These risks have been discussed at the Trust Board, 'main' Quality Committee, Finance and Performance Committee, Workforce Committee and/or TME throughout 2017/18, and include the following:

- High staffing, vacancies and turnover, particularly for Nursing staff (in the Acute and Emergency and Specialist Medicine Directorates)
- Ability to manage patient flow due to capacity and demand issues
- Achieving the Cancer waiting time targets

- The gaps in relation to Medical devices training and a trainer/coordinator
- The delivery of the annual financial plan
- The cost pressures associated with the use of temporary staff
- The lack of appropriate Medical cover on night shifts for the Paediatric unit
- The shortage of Paediatric Specialty and Associate Specialist (SAS) ('middle grade') doctors on day shifts for paediatrics
- The delivery of the Cost Improvement Programme (CIP) for the Urgent Care Division
- Nursing staffing levels in Orthopaedics
- The governance arrangements for Point of Care testing
- Risk to Trust Oncologists who are treating Cancer patients from East Kent, due to East Kent radiology reporting delays
- Inability to manage the Haematology workload effectively and in a timely manner due to Consultant vacancies
- Staffing levels in the Occupational Therapy and Physiotherapy teams affecting service delivery
- Procurement of medical devices using Integra without following due process
- Effect of failing to maintain a quality management system in Blood Sciences and Microbiology
- The Health & Safety Executive (HSE) Improvement Notice for the Containment Level (CL) 3 laboratory (which was issued on 15/12/17, and for which the compliance date is 28/02/18) – see the "Significant internal control issues" section for more information on this
- Unreliable data collection tool increasing number of missed referrals from A&E to Virtual Fracture Clinic
- Risk associated with failing to learn from incidents
- Specialist Medicine mortality review compliance

Each associated risk assessment describes the efforts being made and/or planned to manage and mitigate the risk, and the Trust's Risk and Compliance Manager oversees the regular reviews of the assessments.

Are the Trust's services well-led?

As noted above, the CQC inspection in 2017 rated the Trust as "Good" for the Well-led domain. The Trust also undertook a self-assessment against NHSI's Well Led Framework, which was considered by the Trust Board in October 2017. A significant amount of positive assurance / evidence was provided as part of the review (which is publicly available within the Board meeting reports on the Trust's website), but some areas for improvement were also identified. Many of these areas had been addressed by the end of 2017/18, but work to improve further will continue into 2018/19.

The principal risks to compliance with the NHS provider licence, condition 4 and actions identified to mitigate these risks

In May 2017, the Trust Board completed the required self-certification (for 2016/17) that the Trust could meet the obligations set out in the NHS Provider Licence (which itself includes requirements to comply with the National Health Service Act 2006, the Health and Social Care Act 2008, the Health Act 2009 and the Health and Social Care Act 2012, and to have regard to the NHS Constitution); and that it complied with governance requirements (condition FT4(8)). The Trust Board confirmed full compliance, on the basis of the content of the Trust's Annual Report, and Governance Statement for 2016/17. The Trust Board will be asked to undertake the required self-certification for 2017/18 at its meeting in May 2018, and it will again be proposed that full compliance be confirmed.

The key ways in which risk management is embedded in the activity of the organisation

As noted earlier in this Statement, risks are identified, analysed and controlled in accordance with the Trust's Risk Management Policy and Procedure, and a range of supporting systems and processes are in place to embed risk management activity. For example:

- Incident reporting is openly encouraged across the Trust, and lessons learned from incident investigations are disseminated and promoted (including via the "Governance Gazette" newsletter produced by the Clinical Governance department)
- Risk is regularly discussed at a wide range of forums, including the Trust Board and its sub-committees (which sets the tone for discussions at Directorate- and departmental-levels forums)
- Risk management is incorporated into the Trust's planning arrangements, and in 2017/18, the Trust's Quality Impact Assessment (QIA) process was strengthened, following oversight by the Quality Committee

Care Quality Commission (CQC) registration

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

NHS Pension scheme

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.

Obligations under equality, diversity and human rights legislation

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

Obligations under the Climate Change Act and the Adaptation Reporting requirements

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.

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

A range of processes are applied to ensure that the Trust's resources are used economically, efficiently and effectively. The monitoring of this is overseen by the Trust Board, Finance and Performance Committee and Audit and Governance Committee, although the Workforce Committee, Quality Committee and Patient Experience Committee have all participated in this oversight during 2017/18. The Trust's annual Internal Audit programme for 2017/18 included a range of reviews relating to this area, including "Follow Up Review of Audiology Stock Management", "Payroll", "Financial Accounting and Non Pay Expenditure", and "Cost Improvement Plans", which all achieved overall assessment of "Reasonable Assurance" (although a "limited assurance" assessment was obtained for the reviews of "Non Patient Related Income" and "Activity and Income Recording including Implementation of SLAM Costing Model").

Information governance

The Trust was required to report one information governance data protection breach incident to the Information Commissioner's Office (ICO) and the Department of Health and Social Care in the year. This related to batch printing from the new Patient Administration System (PAS) ("Allscripts"). The ICO decided that, after careful consideration, formal enforcement action was not appropriate in respect of this incident.

Annual Quality Account

The Trust's 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 steps which have been put in place to assure the Trust Board that the Quality Account presents a balanced view

The Trust's annual Quality Accounts are reviewed by the Quality Committee, approved by the Trust Board, and published as a separate document. The Trust's Quality Accounts are also independently assessed by External Audit, with regards to whether the performance information reported therein is reliable and accurate. The audit of the 2016/17 Quality Accounts (which was concluded in 2017/18) resulted in an unqualified limited assurance report. The External Audit of the 2017/18 Quality Accounts will be available in the summer of 2018.

The controls in place to ensure the accuracy of data (including the quality and accuracy of elective waiting time data)

The external audit referred to above includes reviewing particular indicators, to help provide assurance that the Quality Account presents a balanced view and that there are appropriate controls in place to ensure the accuracy of data.

The following processes are in place to assure the quality and accuracy of elective waiting time data (and to manage the risks to such quality and accuracy):

- The Trust has a "Patient Access to Treatment Policy and Procedure", which encompasses Standard Operational Procedures for waiting list management at all stages of a referral to treatment pathway. The Policy also states the responsibilities of key staff, including those for auditing data quality. The Policy is currently being reviewed to ensure it is aligned with the Trust's new Patient Administration System (PAS) (see the "Significant issues" section below)
- The Trust also has an "Information Lifecycle Management Policy and Procedure", which describes the Trust's general approach to data quality, including the role of the Data Quality Steering Group
- There is a weekly validation process involving operational, management and information leads, to assure the quality of local and national waiting times reporting/data

Compliance with the above Policies and processes is audited annually by Internal Audit (TIAA Ltd), as part of a "Data Quality of Key Performance Indicators" review. The latest (2017/18) review aimed to provide assurance that, for a sample of Key Performance Indicators (KPIs) reported to the Trust Board, the systems and data relied on to produce the figures were robust, and as a result Trust performance against the criteria is declared accurately, completely and in a timely manner.
The KPIs reviewed were falls, pressure ulcers and the 18 Weeks Referral to Treatment (RTT) incomplete pathway. The review led to an overall assessment of "Reasonable Assurance", and although some areas for improvement were identified, the key findings included the following points:

- "The Trust has an appropriately approved and up to date Information Lifecycle Management Policy and Procedure in place"
- "The figures reported to the Board and on the national submission via the Unify return, for the RTT incomplete pathway, were found to be accurately reported based on the data available from the source data system".

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 NHS 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 and Audit and Governance Committee, and a plan to address weaknesses and ensure continuous improvement of the system is in place.

The Head of Internal Audit Opinion for 2017/18 states that "I am satisfied that sufficient internal audit work has been undertaken to allow me to draw a reasonable conclusion as to the adequacy and effectiveness of Maidstone and Tunbridge Wells NHS Trust's risk management, control and governance processes. In my opinion, except for the Trust's ability to deliver their planned financial control total, Maidstone and Tunbridge Wells NHS Trust has adequate and effective management, control and governance processes to manage the achievement of its objectives".

The Audit and Governance Committee approves the Internal Audit plan for the year and receives details of the findings from each of the Internal Audit reviews that are undertaken. Summary reports of relevant Internal Audit reviews are also submitted to the TME, Finance and Performance Committee and 'main' Quality Committee during the year. Although a number of the Internal Audit reviews completed in 2017/18 resulted in an overall 'Reasonable assurance' assessment, a number also led to an assessment of 'Limited assurance'. These latter reviews have, or will be, considered at the Audit and Governance Committee, and actions to address the weaknesses identified in controls have been taken (or will be taken during 2018/19).

The role of the Trust Board in maintaining and reviewing the effectiveness of the system of internal control

The Trust Board meets in public every month (with the exception of August). The agenda for Board meetings is mainly focused around the key aspects of operational performance; quality; planning and strategy; assurance and policy; and reports from its sub-committees. A separate ('Part 2') meeting is held on the same day as the meeting held in public, to consider confidential matters, in accordance with the Public Bodies (Admission to Meetings) Act 1960. A 12-month rolling forward programme of agenda items is actively managed to ensure the Board receives the information, and considers the matters it requires to perform its duties efficiently and effectively.

A key tenet of the information the Board receives at each meeting in public is an Integrated Performance Report, which contains up-to-date details of performance across a range of indicators, including those within NHSI's Single Oversight Framework for NHS providers. The Board also hears 'patient stories', which provide invaluable first-hand experience of being a patient of the Trust; as well as presentations from its Clinical Directors, General Managers and Matrons. Information reviewed at the Trust Board and its sub-committees are supplemented by Trust Board Members' visits of Wards and Departments (which are reported to the Board 4 times a year).

In 2017/18, the following changes in personnel occurred within the Trust Board (in chronological order):

- Kevin Tallett (NED & Vice Chair of the Trust Board) acted as Chair of the Trust Board from 01/03/17 to 07/05/17
- David Highton (Chair of the Trust Board) started his term of office on 08/05/17
- Richard Hayden (Director of Workforce) left the Trust at the end of June 2017
- Tim Livett (NED) joined the Trust Board on 26/06/17
- Nazeya Hussain (Associate NED) joined the Trust Board on 19/07/17
- Kevin Tallett (NED, Vice and Acting Chair of the Trust Board) left the Trust Board on 27/07/17
- Maureen Choong joined the Trust Board on 29/08/17 as an Associate NED, and was then appointed as a NED on 16/11/17
- Glenn Douglas (Chief Executive) left the Trust Board on 19/09/17
- Jim Lusby (Deputy Chief Executive) was Acting Chief Executive from 19/09/17 to 07/01/18
- Simon Hart (Director of Workforce) joined the Trust on 01/12/17
- Steve Phoenix (NED) joined the Trust Board on 01/12/17
- Miles Scott (Chief Executive) joined the Trust on 08/01/18
- Alex King (NED) left the Trust Board on 21/03/18
- Claire O'Brien was appointed as substantive Chief Nurse on 19/03/18 (Ms O'Brien had been interim Chief Nurse from 27/02/17)

The role of the Trust Board sub-committees and other key forums in maintaining and reviewing the effectiveness of the system of internal control

The Board operates with the following sub-committees (which are listed alphabetically):

- The Audit and Governance Committee. This supports the Trust Board by critically reviewing the governance and assurance processes on which the Board places reliance. This therefore incorporates reviewing Governance, Risk Management and Internal Control (including the Board Assurance Framework); oversight of the Internal and External Audit, and Counter Fraud functions. The Committee also undertakes detailed review of the Trust's Annual Report and Accounts, and has been appointed (by the Trust Board) as the Trust's Auditor Panel, in accordance with Schedule 4, Paragraph 1 of the Local Audit and Accountability Act 2014. The Committee is chaired by a NED, and meets 5 times each year (including a specific meeting to review the Annual Report and Accounts prior to the Trust Board being asked to approve these). All other NEDs (apart from the Chair of the Trust Board) are members.
- The Charitable Funds Committee. This aims to ensure that the Maidstone and Tunbridge Wells NHS Trust Charitable Fund is managed efficiently and effectively in accordance with the directions of the Charity Commission, relevant NHS legislation and the wishes of donors, which includes reviewing, and agreeing the Charitable Fund Annual Report and financial accounts, for approval by the Trust Board. The Committee is chaired by a NED, and meets three times per year.
- The Finance and Performance Committee. This aims to provide the Trust Board with: assurance on the effectiveness of financial management, treasury management, investment and capital expenditure and financial governance; an objective assessment of the financial position and standing of the Trust; and advice and recommendations on all key issues of financial management and financial performance. In addition, the Committee receives assurance on Information Technology performance and business continuity; and advice and recommendations on all aspects of informatics, including Information Technology and telecommunications. The Committee is chaired by a NED, and meets monthly.
- The Patient Experience Committee. This aims to capture the patient and public perception of the services delivered by the Trust, and monitor any aspect of patient experience, on behalf of the Trust Board (or at the request of any Board sub-committee or other relevant Trust committee), as required. The Committee is chaired by a NED, and meets quarterly, and in addition to Trust staff, its membership includes representatives from the Trust's catchment area, Healthwatch Kent, and from Leagues of Friends of Maidstone and Tunbridge Wells Hospitals
- The Quality Committee. This aims to seek and obtain assurance on the effectiveness of the Trust's structures, systems and processes to enable delivery of the Trust's objectives relating to quality of care. The Committee is chaired by a NED and meets monthly. On alternate months, the Committee meets in the form of a 'deep dive', with a reduced membership, to enable a small number of subjects to be scrutinised in greater detail.
- The Remuneration and Appointments Committee. This reviews, on behalf of the Trust Board, the appointment of Executive Directors and other staff appointed on Very Senior Manager (VSM) contracts, to ensure such appointments have been undertaken in accordance with Trust Policies. It also: reviews the remuneration, allowances and terms of service of such staff; reviews (with the Chief Executive), the performance of Executive Directors and other staff appointed on VSM contracts; oversees appropriate contractual arrangements for such staff (including the proper calculation and scrutiny of termination payments, taking account of such national guidance, as appropriate); and considers and approves, on behalf of the Trust Board, proposals on issues which represent significant change. The Committee is chaired by the Chair of the Trust Board, and meets on an ad-hoc basis.
- The Workforce Committee. This aims to provide assurance to the Board in the areas of workforce development, planning, performance and employee engagement; and assure the Board that the Trust has the necessary strategies, policies and procedures in place to ensure a high performing and motivated workforce that is supporting business success. The Committee is chaired by a NED and meets every 2 months.

Attendance records are maintained for the Trust Board and its main sub-committees. The attendance record for Trust Board meetings is reported within the body of the Trust's Annual Report.

Although not a Board sub-committee, the Trust Management Executive (TME) is the senior management committee within the Trust. Its purpose is to oversee and direct: the effective operational management of the Trust, including achievement of standards, targets and other obligations; the delivery of safe, high quality, patient-centred care; the development of Trust strategy, culture and policy; and the identification, mitigation and escalation of assurance and risk issues. The TME meets monthly, and is chaired by the Chief Executive.

In addition to the above committees, there are a range of other forums, 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, a Trust Clinical Governance Committee, an Infection Prevention and Control Committee; a Health and Safety Committee; a Medicines Management Committee; an Information Governance Committee; and Safeguarding Adults and Children Committees.

Significant internal control issues

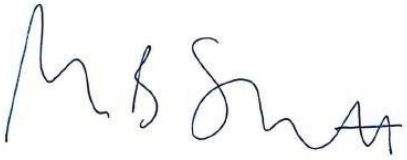
The following significant internal control issues have been identified in 2017/18:

1. On 15th December 2017, the Trust's Microbiology Department was served with an Improvement Notice following a scheduled visit by the Health & Safety Executive (HSE). Action was however taken to address the issues (which related to inadequate arrangements for monitoring and review of the preventative and protective measures necessary to minimise the risk of exposure of employees to hazard group 3 biological agents), and at the follow-up inspection on 27th February 2018, the HSE inspector was satisfied that the Notice could be lifted
2. The Trust was placed into Financial Special Measures (FSM) in July 2016. The Trust has been involved in a number of formal FSM review meetings with NHSI since that time, and although significant progress has been made, the Trust remained in FSM at the end of 2017/18
3. The Trust's year-end deficit for 2017/18 was £17.9m (excluding Sustainability and Transformation Fund (STF)) which was £13.4m adverse to the Trust's original plan (and control total), but achieved the revised year-end forecast that was set in January 2018
4. Although the Trust successfully achieved its planned performance on a number of important indicators, it failed to meet a number of key patient access targets for the year, including that relating to A&E 4-hour waits, 18-week Referral to Treatment (RTT) waiting times, and 62-day first definitive treatment for Cancer
5. Four 'Never Events' were declared at the Trust in 2017/18, which were subject to scrutiny to aim to ensure that lessons were learnt

All of the above issues have been subject to detailed scrutiny at a senior-level in the Trust during 2017/18, and action plans are in place to address any issues that had not been resolved by the end of 2017/18.

Conclusion

The significant internal control issues identified in 2017/18 are described above, in the body of the Annual Governance Statement.



Miles Scott, Chief Executive

24th May 2018

Maidstone and Tunbridge Wells NHS Trust

Accountability Report for 2017/18: Remuneration and Staff Report

taking pride

Our staff

Maintaining a highly skilled and engaged workforce is fundamental to the Trust's ability to provide the highest, consistent, quality care to its patients. This is particularly critical during times of financial constraint and increasingly high demand for the Trust's services. In 2017, the Trust took part in the 15th annual National NHS Staff Survey. The results remained broadly in line with 2016 scores and the Trust remains above the national average as a place to work or receive treatment.

Significantly, as many of its staff thought patient care was the Trust's top priority in 2017, as they did in 2016; the Trust continued with its strong performance for the percentage of staff who felt they had been appraised (91%) and scored within the top 20% of acute trusts for this finding; the Trust's score of 3.80 (out of a maximum score of 5) for staff engagement was in line with Trusts of a similar type. Other notable results included:

- Percentage of staff believing that the organisation provides equal opportunities for career progression or promotion: 90% (national average 85%)
- Percentage of staff agreeing that their roles make a difference to patients/service users: 92% (national average 90%)
- Percentage of staff witnessing potentially harmful errors, near misses or incidents in the last month: 28% (national average 31%)
- Percentage of staff satisfied with the opportunities for flexible working patterns 55% (national average 51%)

Whilst the overall results were good, there are some areas on which the Trust needs to focus:

- Communication between senior management and staff
- Medical engagement
- Job satisfaction, primarily around resourcing and support
- Reporting of discrimination, bullying, harassment and violence

An action plan has been developed to address each of these issues. The full survey results are available at: https://tinyurl.com/MTWstaffsurvey17

Employee benefits

The details within this section relating to staff benefits, analysed by staff grouping, are included in accordance with section 411 of the Companies Act 2006.

Staff numbers and costs (subject to audit)

Average[33] staff numbers	Permanently employed (WTE)[34]	Other (WTE)	Permanently employed (expenditure) (£000s)	Other (expenditure) (£000s)
Medical and dental	650	115	61,902	16,201
Ambulance staff	0	0	0	0
Administration and estates	1054	78	32,575	2,900
Healthcare assistants and other support staff	1216	128	30,135	3,664
Nursing, midwifery and health visiting staff	1351	262	59,091	14,884
Nursing, midwifery and health visiting learners	9	0	257	0
Scientific, therapeutic and technical staff	491	35	21,632	2,577
Social Care Staff	0	0	0	0
Healthcare Science Staff	177	2	8,748	83
Other	0	0	0	0
Apprenticeship levy	0	0	946	45
Total	4948	620	215,286	40,354
Staff engaged on capital projects (excluded from above)	13	5	669	823

Exit packages (subject to audit)

The figures disclosed below relate to exit packages agreed in the year. The actual date of departure might be in a subsequent period, and the expense in relation to the departure costs may have been accrued in a previous period. The data here is therefore presented on a different basis to other staff cost and expenditure notes in the accounts.

Exit package cost band (including any special payment element)	*Number of compulsory redundancies	*Cost of compulsory redundancies	Number of other departures agreed	Cost of other departures agreed	Total number of exit packages	Total cost of exit packages	Number of departures where special payments have been made	Cost of special payment element included in exit packages
	Whole numbers only	£s	Whole numbers only	£s	Whole numbers only	£s	Whole numbers only	£s
Less than £10,000	None	N/A	13	37,000	13	37,000	None	0
£10,000 - £25,000	None	N/A	2	41,000	2	41,000	None	0
£25,001 - £50,000	None	N/A	0	0	None	0	None	0
£50,001 - £100,000	None	N/A	0	0	None	0	None	0
£100,001 - £150,000	None	N/A	0	0	None	0	None	0
£150,001 - £200,000	None	N/A	0	0	None	0	None	0
>£200,000	None	N/A	0	0	None	0	None	0
Total	N/A	N/A	15	78,000	15	78,000	N/A	N/A

[33] The average number of employees is calculated as the whole time equivalent number of employees under contract of service in each week in the financial year, divided by the number of weeks in the financial year.
[34] This excludes any staff on unpaid leave (and therefore does not equate to the WTE reported within the Sustainability Report)

Exit packages – disclosures (excluding compulsory redundancies)	Number of exit package agreements	Total Value of agreements (£000s)	Number of exit package agreements	Total Value of agreements (£000s)
Voluntary redundancies including early retirement contractual costs	0	0	0	0
Mutually agreed resignations (MARS) contractual costs	0	0	0	0
Early retirements in the efficiency of the service contractual costs	0	0	0	0
Contractual payments in lieu of notice	15	78	27	108
Exit payments following Employment Tribunals or court orders	0	0	0	0
Non contractual payments requiring HMT approval *	0	0	0	0
Total	15	78	27	108
Non-contractual payments made to individuals where the payment value was more than 12 months of their annual salary	0	0	0	0

Note * this includes any non-contractual severance payment following judicial mediation and amounts relating to non-contractual payments in lieu of notice.

Health and Safety at Work

The Trust is committed to ensuring the health and safety of its employees, patients, visitors, volunteers, contractors and others affected by its activities. It aims to provide safe and healthy working conditions and seeks the support of staff in achieving this. The use of risk assessment to identify, assess and manage risk is key to health and safety management within the Trust.

During the year:

- A new quality and safety initiative, 'Take 5ive Talk Five!', was launched sharing five key quality and safety messages with staff on a weekly basis
- The Risk Management Policy and Procedure was revised and ratified
- There was a significant reduction of close to 40% in the number of staff injuries as a result of accidents in the workplace
- At the end of March 2018, the number of reports to the Health and Safety Executive under the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations (RIDDOR) 2013 had decreased by more than 35%
- Work was undertaken to reduce the risk of slips, trips and falls on Trust premises and this was reflected in the large reduction in fractures following falls on site to members of the public and visitors.

Employee consultation (understanding and learning from the views of staff)

The Trust meets formally on a regular basis with local Trade Union representatives, via the Joint Consultative Forum and the Joint Medical Consultative Committee, to discuss key issues and agree relevant employment policies and procedures. Staff are formally consulted when organisational or other work changes are proposed and have the opportunity to comment and input into proposed changes. A quarterly Open Staff Meeting system also operates, to cascade information to all staff, which involves a face-to-face meeting with two Executive Directors (including the Chief Executive) at both hospital sites. A weekly Chief Executive's update and "MTW News" newsletter are issued to all staff via email, enabling key messages to be given on matters of note. The Trust also conducts quarterly staff Friends and Family tests to help it gauge the level of satisfaction and engagement amongst staff. The Trust has a range of support mechanisms for staff, beyond that provided by their line manager. This includes a comprehensive Employee Assistance Programme providing 24 hour support and a full Occupational Health service.

The launch of Listening into Action (see the Performance Report Overview) during the year saw every member of staff given a voice and being asked to complete the LiA Pulse Check census. LiA will be fundamental to ensuring that ideas and innovations from staff are heard and implemented on an ongoing basis.

Education and Development

The Trust takes the ongoing development of its staff very seriously. Each hospital site has an Education / Academic Centre, giving dedicated teaching space to staff, and a library. Staff can expect to have an annual appraisal with a plan of personal development and access to education teams to support them with advice and guidance about their development needs. Staff are able to take part in in-house learning activities and funding is also available for staff to access external training. In 2017/18 the Trust provided access to local schools for work experience opportunities, and ran training exercises for staff with HM Coastguard Rescue. The Trust held its annual Learning and Development Achievement Ceremony in September 2017, which all members of staff who receive funding each year were invited to attend and reflect on their achievements, made through undertaking various programmes of study.

Equal opportunities

As demonstrated by the encouraging results in the year's staff survey for this area, which revealed that 90% of staff believed that the Trust provided equal opportunities for career progression or promotion, the Trust is committed to the equality agenda. The strategy demonstrates a commitment to creating a culture that promotes equality & embraces diversity in all its functions as both an employer and a service provider. The Trust's aim is to provide a safe environment, free from discrimination, and a place where all individuals are valued, treated fairly and accepted for who they are without exception. The Trust's drive to embed and mainstream equality into everything it does, is spearheaded by a dedicated Staff Engagement and Equality lead.

A range of activities marked the launch of the Trust's Cultural Diversity Network in June 2017. The Trust hosted talks from NHS Employers (which aims to be the authoritative voice of workforce leaders and experts in HR in the sector), which prompted discussion about what diversity means to individuals, a powerful & poignant talk from a senior member of staff about resilience, and a panel consisting of staff, the NHS Leadership Academy & NHS Digital (the national information and technology partner to the health and social care system) which profiled cultural differences and inclusion within the NHS. The network leads on the Workforce Race Equality Standard (WRES) action plan. This includes the implementation of unconscious bias awareness into recruitment training and the review of selected recruitment and disciplinary outcomes to ensure fair process.

The Trust launched its LGBT (lesbian, gay, bisexual, and transgender) staff network in May 2017 to provide a forum for staff to raise issues and concerns around sexual orientation and gender identity at work, as well as to provide advice and guidance to the Trust as to how it can best support its staff from the LGBT community. The network is open to all staff irrespective of sexual orientation or gender identity. The group has taken part in a number of promotional and awareness raising activities including participation in the first Tunbridge Wells Pride march.

LGBT history month was celebrated with a collaborative event to demonstrate acceptance – entitled "Standing Together, Caring Together". Members of the LGBT+ network and LGBT Ally network joined with staff from Kent Police and Kent Fire and Rescue Service to mark this.

2018 saw the first release of the Trust's Gender Pay Gap – showing a 26% gap between the pay of men and women, an action plan has been created. The plan includes understanding more about the data and running a series of articles about inspirational women in the Trust. International Women's Day was celebrated with a timeline showing the job roles of the female relatives of our staff reaching back into the early 1900's. Stories of their experiences were also published. International Men's Day will be celebrated in November 2018.

The Trust operates a translation service, providing a one stop shop for all translation requirements and providing written translation, face to face language translation, British Sign Language (BSL), Deaf/Blind services and telephone interpreting. Telephone interpreting is available 24 hours a day, 7 days a week, 365 days a year. Requests for face to face and BSL interpreting may be made both in-an-out-of-hours through an online portal. The Trust published its new Interpreting and Translation Policy in August 2017 which ensures that patients have equal access to high quality and safe patient care, and enables compliance with equality legislation, Care Quality Commission outcomes and other relevant standards.

The gender, age and ethnic group distribution of staff and Trust Board Members (Senior Managers) at the end of 2017/18 is set out below (the 2016/17 equivalent is in brackets):

Gender	Staff [head count]		Trust Board Members	
Male	1655 (1548)	24.8% (24.3%)	8 (7)	57% (63.6%)
Female	5031 (4819)	75.2% (75.7%)	6 (4)	43 % (36.4%)

Age (age at 31/03/18)	Staff [head count]		Trust Board Members	
16-30	1484 (1329)	22.2% (20.9%)	0 (0)	0% (0%)
31-40	1519 (1363)	22.7% (21.4%)	1 (1)	7.1% (9.1%)
41-50	1750 (1670)	26.2% (26.2%)	4 (3)	28.6% (27.3%)
51-60	1451 (1394)	21.7% (21.9%)	7 (6)	50% (54.5%)
61 and over	482 (611)	7.2% (9.6%)	2 (1)	14.3% (9.1%)

Ethnic group [35]	Staff [head count]		Trust Board Members	
Asian/Asian British: Any other Asian background	384 (360)	5.7% (5.7%)	0 (0)	0% (0%)
Asian/Asian British: Bangladeshi	13 (7)	0.2% (0.1%)	0 (0)	0% (0%)
Asian/Asian British: Indian	410 (342)	6.1% (5.4%)	0 (0)	0% (0%)
Asian/Asian British: Pakistani	68 (52)	1.0% (0.8%)	1 (0)	7.1% (0%)
Black/African/Caribbean/Black British: African	173 (148)	2.6% (2.3%)	0 (0)	0% (0%)
Black/African/Caribbean/Black British: Any other Black/African/Caribbean background	15 (14)	0.2% (0.2%)	0 (0)	0% (0%)
Black/African/Caribbean/Black British: Caribbean	27 (18)	0.4% (0.3%)	0 (0)	0% (0%)
Mioed/Multiple ethnic groups: Any other Mioed/Multiple ethnic background	45 (36)	0.7% (0.6%)	0 (0)	0% (0%)
Mioed/Multiple ethnic groups: White & Asian	41 (39)	0.6% (0.6%)	0 (0)	0% (0%)
Mioed/Multiple ethnic groups: White & Black African	14 (9)	0.2% (0.1%)	0 (0)	0% (0%)
Mioed/Multiple ethnic groups: White and Black Caribbean	18 (19)	0.3% (0.3%)	0 (0)	0% (0%)
White: Any other White background	598 (578)	8.9% (9.1%)	0 (0)	0% (0%)
White: English/Welsh/Scottish/Northern Irish/British	4322 (4213)	64.6% (66.2%)	11 (10)	78.6% (91%)
White: Irish	79 (73)	1.2% (1.1%)	2 (1)	14.3 % (9%)
Any other ethnic group	241 (199)	3.6% (3.1%)	0 (0)	0% (0%)
Not known / not stated / undefined	238 (260)	3.6% (4.1%)	0 (0)	0% (0%)

[35] Recommended Office of National Statistics (ONS) Ethnicity Classifications, 2012

Staff sickness absence

The staff sickness absence for 2017/18 (and 2016/17) is reported below:

	2017/18	2016/17
Total days lost (adjusted to the Cabinet Office measure)	43,165	47,119
Total staff years (WTE)	5,070	5,197
Average working days lost	9	9

N.B. This data is provided via the Department of Health and Social Care (DHSC) (as it is necessary to reconcile NHS Electronic Staff Record data with the 'Cabinet Office' data reported by central Government, to permit aggregation across the NHS). The sickness absence figures reported for 2017/18 are actually for the calendar year 2017 (i.e. January to December 2017), whilst the figures for 2016/17 are for the calendar year 2016. However, the DHSC considers the figures for the calendar year to be a reasonable proxy for the financial year.

Disabled employees

The Trust is committed to taking positive action for disabled people and is recognised as a Disability Confident Committed Employer. The Disability Network, launched in September 2017, aims to bring together staff with physical and non-visible disabilities and will help the Trust move from being a Disability Confident Committed Employer to Disability Confident Employer by 2019. The group is also working on raising awareness of disabilities and will be instrumental in creating an action plan following the Workforce Disability Equality Standard (WDES) which will be published later in 2018.

During the year, the Trust has continued to apply its "Recruitment, Selection & Employment Checks Policy and Procedure" which ensures that any disabled applicant who meets the minimum criteria for a role must be offered an interview. The Trust's "Equality and diversity policy and procedure (incorporating Single Equality Scheme (SES))" requires the Trust to make reasonable adjustments for any member of staff with a disability or developing a disability during their time working with the Trust, to prevent them from being placed at a substantial disadvantage in all aspects of employment, and ensures that selection for employment, training and promotion are based solely on objective and job related criteria."

"Senior Managers" remuneration

In accordance with Section 234b and Schedule 7a of the Companies Act, as required by NHS Bodies, this report includes details regarding "senior managers" remuneration. In the context of the NHS, this is 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".

It is usually considered that the regular attendees of the entity's Board meetings are its "Senior Managers", and the Chief Executive has confirmed that the definition of "Senior Managers" only applies to Trust Board Members (refer to the 'Directors' Report' for further details). With the exception of the Non-Executive Directors (whose remuneration is set by NHSI) all "Senior Managers" are on "Very Senior Manager" (VSM) contracts and salaries are agreed with each individual.

The Trust Board maintains a Remuneration and Appointments Committee to advise and assist in meeting its responsibilities to ensure appropriate remuneration, allowances and terms of service for the Chief Executive, Directors and other key senior posts (refer to the Annual Governance Statement for 2017/18 for further details of the Remuneration and Appointments Committee).

The Chief Executive and Directors' remuneration is reviewed annually by the Committee and decisions are based on market rates, national pay awards and performance. Reward is primarily through salary adjustment, although non-recurrent awards can be used to recognise exceptional achievements.

Pay rates for Non-Executive Directors of the Trust are determined in accordance with national guidelines, as set by NHS Improvement. Remuneration for the Chair of the Trust Board is also set by NHSI.

The Directors are normally on permanent contracts and subject to a minimum of 6 months' notice period; the Chief Executive's notice period is 6 months. Contract, interim and seconded staff will all have termination clauses built into their letters of engagement, which will be broadly in line with the above. All Director contracts contain a 'Fit and Proper Person' clause stating that the post holder will be unable to continue as a Trust Board Member should they meet any of the criteria for being "unfit" within The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Termination arrangements are applied in accordance with statutory regulations as modified by Trust or National NHS conditions of service agreements, and the NHS pension scheme. The Remuneration and Appointments Committee will agree any severance arrangements following appropriate approval from NHSI and HM Treasury as appropriate. The figures included in the tables below show details of salaries, allowances, pension entitlements and any other remuneration of the Trust's 'Senior Managers' i.e. non-recurrent awards etc.

Salaries and allowances for the year ending 31st March 2018 (subject to audit)

Comparatives for the year ending 31st March 2017 are shown in brackets below the figure for 2017/18.

Name and title (alphabetical by surname) N.B. Dates of service are for the full 2017/18 year unless otherwise disclosed	**(a) Salary** (bands of £5,000) **£000**	**(b) Taxable expense payments and other benefits in kind, to the nearest £100** **£00 Λ**	**(c) Annual performance -related pay and bonuses** (bands of £5,000) **£000**	**(d) Long-term performance-related pay and bonuses** (bands of £5,000) **£000**	**(f) All pension-related benefits** (bands of £2,500) **£000**	**(g) TOTAL (columns a - f)** (bands of £5.000) **£000**	**(h) Payments or compensation for loss of office** £000
Maureen Choong, Non-Executive Director (from 29/08/17)	0-5 (0)	0 (0)	0 (0)	N/A (N/A)	N/A (N/A)	0-5 (0)	N/A (N/A)
Glenn Douglas, Chief Executive (until 19/09/17)	95-100 (200-205)	30 (70)	0 (0)	0 (0)	N/A (0)	95-100 (205-210)	N/A (N/A)
Sarah Dunnett, Non-Executive Director	5-10 (5-10)	0 (0)	0 (0)	N/A (N/A)	N/A (N/A)	5-10 (5-10)	N/A (N/A)
Angela Gallagher, Chief Operating Officer	125-130 (120-125)	0 (0)	0 (0)	0 (0)	100-102.5 (2.5-5.0)	225-230 (125-130)	N/A (N/A)
Simon Hart, Director of Workforce	40-45 (0)	0 (0)	0 (0)	N/A (N/A)	147.5-150 (N/A)	190-195 (0)	N/A (N/A)
Richard Hayden, Director of Workforce (until end June 2017)	30-35 (110-115)	0 (0)	0 (0)	N/A (0)	15-17.5 (85-87.5)	45-50 (195-200)	N/A (N/A)
David Highton, Chair of the Trust Board (from 08/05/17)	35-40 (0)	6 (0)	0 (0)	N/A (N/A)	N/A (N/A)	35-40 (0)	N/A (N/A)
Nazeya Hussain, Associate Non-Executive Director (from 19/07/17)	0-5 (0)	0 (0)	0 (0)	N/A (N/A)	N/A (N/A)	0-5 (0)	N/A (N/A)
Alex King, Non-Executive Director (until 21/03/18)	5-10 (5-10)	0 (0)	0 (0)	N/A (N/A)	N/A (N/A)	5-10 (5-10)	N/A (N/A)
Tim Livett, Non-Executive Director (from 26/06/17)	0-5 (0)	0 (0)	0 (0)	N/A (N/A)	N/A (N/A)	0-5 (0)	N/A (N/A)
Jim Lusby, Deputy Chief Executive Σ	135-140 (130-135)	0 (0)	0 (0)	0 (0)	67.5-70 (87.5 -90)	205-210 (215-220)	N/A (N/A)
Peter Maskell, Medical Director Ψ	195-200[36] (35-40)	0 (0)	0 (0)	0 (0)	0 (0)	195-200 (35-40)	N/A (N/A)

[36] 155-160 of this relates to Dr Maskell's role as Medical Director; the remainder relates to his clinical duties

Name and title (alphabetical by surname) N.B. Dates of service are for the full 2017/18 year unless otherwise disclosed	(a) Salary (bands of £5,000) £000	(b) Taxable expense payments and other benefits in kind, to the nearest £100 £00 Λ	(c) Annual performance -related pay and bonuses (bands of £5,000) £000	(d) Long-term performance-related pay and bonuses (bands of £5,000) £000	(f) All pension-related benefits (bands of £2,500) £000	(g) TOTAL (columns a - f) (bands of £5.000) £000	(h) Payments or compensation for loss of office £000
Sara Mumford, Director of Infection Prevention and Control Ψ	160-165[37] (155-160)	0 (0)	0 (0)	0 (0)	72.5-75 (57.5-60)	235-240 (210-215)	N/A (N/A)
Claire O'Brien, Interim Chief Nurse	110-115 (5-10)	0 (N/A)	0 (N/A)	0 (N/A)	237.5-240 (0)	345-350 (5-10)	N/A (N/A)
Steve Orpin, Director of Finance	125-130 (125-130)	0 (0)	0 (0)	0 (0)	20-22.5. (27.5-30)	150-155 (155-160)	N/A (N/A)
Steve Phoenix, Non-Executive Director (from 01/12/17)	0-5 (0)	0 (0)	0 (0)	N/A (N/A)	N/A (N/A)	0-5 (0)	N/A (N/A)
Miles Scott, Chief Executive (from 08/01/18)	45-50 (0)	0 (0)	0 (N/A)	N/A (N/A)	382.5-385 (N/A)	430-435 (0)	
Kevin Tallett, Non-Executive Director Σ (until 27/07/17)	5-10 (5-10)	0 (0)	0 (0)	N/A (N/A)	N/A (N/A)	5-10 (5-10)	N/A (N/A)

Λ £ hundreds are used for taxable expense payments, and other benefits (column (b)). For this Trust, they relate to the non-cash benefit of a lease car. All other columns are in £ thousands

Ψ Drs Maskell and Mumford hold clinical roles in the Trust alongside their responsibilities as Senior Managers

Σ Kevin Tallett served as Acting Chair of the Trust Board from 01/03/17 to 07/05/17

Σ Jim Lusby served as Acting Chief Executive from 19/09/17 and 07/01/18

Pension benefits for the year ending 31st March 2018[38] (subject to audit)

Name and title Ψ (alphabetical by surname) N.B. Dates of service are for the full 2017/18 year unless otherwise disclosed	(a) Real increase in pension at pension age (bands of £2,500) £000	(b) Real increase in pension lump sum at pension age (bands of £2,500) £000	(c) Total accrued pension at pension age at 31st March 2018 (bands of £5,000) £000	(d) Lump sum at pension age related to accrued pension at 31st March 2018 (bands of £5,000) £000	(e) Cash Equivalent Transfer Value Λ at 1st April 2017 £000	(f) Cash Equivalent Transfer Value Λ at 31st March 2018 £000	(g) Real increase in Cash Equivalent Transfer Value Σ £000	(h) Employer's contribution to stakeholder pension £000
Glenn Douglas, Chief Executive (until 19/09/17)Ω	0	0	0	0	0	0	0	0
Angela Gallagher, Chief Operating Officer	5.00-7.5	15-17.5	50-55	155-160	936	1105	160	0
Simon Hart, Director of Workforce (from 01/12/17)	2.5-5	0-2.5	40-45	100-105	561	617	17	0
Richard Hayden, Director of Workforce (until end June 2017)	0-2.5	0	20-25	50-55	244	272	6	0
Jim Lusby, Deputy Chief Executive	2.5-5	2.5-5	35-40	90-95	514	606	88	0
Peter Maskell, Medical Director Ж	0	0	0	0	0	0	0	0
Sara Mumford, Director of Infection Prevention and Control Ψ	2.5-5	2.5-5	50-55	75-80	649	753	97	0
Claire O'Brien, Chief Nurse	10-12.5	32.5-35	45-50	135-140	704	969	257	0

[37] Only 15-20 of this relates to Dr Mumford's role as Director of Infection Prevention and Control; the remainder relates to her clinical duties

[38] The Trust only makes contributions into the NHS pension scheme and the National Employment Savings Trust (NEST) scheme

Name and title Ψ (alphabetical by surname) N.B. Dates of service are for the full 2017/18 year unless otherwise disclosed	(a) Real increase in pension at pension age (bands of £2,500) £000	(b) Real increase in pension lump sum at pension age (bands of £2,500) £000	(c) Total accrued pension at pension age at 31st March 2018 (bands of £5,000) £000	(d) Lump sum at pension age related to accrued pension at 31st March 2018 (bands of £5,000) £000	(e) Cash Equivalent Transfer Value Λ at 1st April 2017 £000	(f) Cash Equivalent Transfer Value Λ at 31st March 2018 £000	(g) Real increase in Cash Equivalent Transfer Value Σ £000	(h) Employer's contribution to stakeholder pension £000
Steve Orpin, Director of Finance	0-2.5	0	45-50	115-120	617	685	62	0
Miles Scott, Chief Executive (from 08/01/18)	15-17.5	47.5-50	70-75	210-215	0	1356	313	0

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

Λ 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 (or other allowable beneficiary's) pension payable from the scheme. CETVs are calculated in accordance with the Occupational Pension Schemes (Transfer Values) Regulations 2008

Σ Real Increase in CETV 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 scheme or arrangement) and uses common market valuation factors for the start and end of the period

Ω Mr Douglas did not make any contributions into the NHS Pensions scheme in 2017/18

Ж Dr Maskell did not make any contributions into the NHS Pensions scheme in 2017/18

Fair pay disclosure (subject to audit)

Reporting bodies are required to disclose the relationship between the remuneration of the highest-paid director in their organisation and the median remuneration of the organisation's workforce. This is calculated at the reporting date i.e. 31st March 2018 by "annualising" the March pay information taking into account temporary staff and adjusting for the full-time effect of part-time staff.

The banded remuneration of the highest paid director in the financial year 2017/18 was £215,000 to £220,000 (in 2016/17 this was £200,000 to £205,000). This was 7.5 times (in 2016/17, this was 7.1 times) the median remuneration of the workforce, which was £28,746 (2016/17 £28,462). The difference is due to a change in post holder.

In 2017/18, 2 employees (in 2016/17, this was 11 employees) received remuneration in excess of the highest-paid Director. These were all Medical staff. Remuneration ranged from £12,710 to £234,957 (in 2016/17 the range was from £6,042 to £279,930). The highest paid Director in the financial year 2017/18 was the Chief Executive (in 2016/17 this was the Chief Executive). This is based on annualising the pay of Directors in post as at 31st March 2018 and so does not reflect actual remuneration in the year (as reported in the "Salaries and Allowances" table above) where individuals have taken up post during the 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. The calculations of the median pay included in this analysis is based on the month 12

Reporting relating to the review of tax arrangements of public sector appointees (not subject to audit)

As part of the Review of Tax arrangements of Public Sector Appointees published by the Chief Secretary to the Treasury on 23rd May 2012, the Trust in common with all public bodies, is required to publish information in relation to the number of 'off-payroll' arrangements meeting the specific criteria set by the Treasury. Individuals that are 'on-payroll' are subject to Pay As You Earn (PAYE), with income tax and employee National Insurance Contributions (NICs) deducted by the Trust at source. Individuals engaged to provide services to the Trust but who do not have PAYE and NICs deducted at source are 'off-payroll'.

All off-payroll engagements as of 31st March 2018, for more than £245 per day and lasting for longer than 6 months

	Number
Number of existing engagements as of 31st March 2018 Of which, the number that have existed…	7
for less than 1 year at the time of reporting =	5
for between 1 and 2 years at the time of reporting =	1
for between 2 and 3 years at the time of reporting =	0
for between 3 and 4 years at the time of reporting =	1
for 4 or more years at the time of reporting =	0

All existing off-payroll engagements have at some point been subject to a risk based assessment, as to whether assurance was required that the individual is paying the right amount of tax. Where necessary, that assurance has been sought.

New off-payroll engagements between 1st April 2017 and 31st March 2018, for more than £245 per day that last longer than 6 months

	Number
Number of new engagements, or those that reached 6 months in duration, between 1st April 2017 and 31st March 2018	11
Of which:	
No. assessed as caught by IR35	1
No. assessed as not caught by IR35	9
No. engaged directly (via PSC contracted to department) and are on the departmental payroll	0
No. of engagements reassessed for consistency / assurance purposes during the year	1
No. of engagements that saw a change to IR35 status following the consistency review	0

Off-payroll Board member / Senior Official engagements

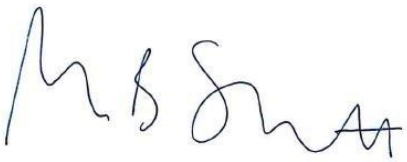
Number of off-payroll engagements of Board members and/or senior officials with significant financial responsibility, during the year	0
Number of individuals that have been deemed "Board members and/or senior officers with significant financial responsibility", during the financial year. This figure includes both off-payroll and on-payroll engagements	0

Expenditure on consultancy staff

The Trust's internal expenditure on consultancy staff for 2017/18 was £406,000, a reduction of £62,000 (£468,000 in 2016/17). The Trust hosts the Kent and Medway Sustainability and Transformation Partnership (STP) which incurred £7.2m of consultancy spend compared to £3.4m in 2016/17.

Declaration

I confirm adherence to the reporting framework in respect of the Accountability Report.



Miles Scott, Chief Executive

24th May 2018

Maidstone and Tunbridge Wells NHS Trust

Accountability and audit report for 2017/18: Independent Auditor's report to the Directors of the Trust

taking pride

Independent Auditor's report to the Directors of Maidstone and Tunbridge Wells NHS Trust

Opinion

We have audited the financial statements of Maidstone and Tunbridge Wells NHS Trust (the 'Trust') for the year ended 31 March 2018 which comprise the Statement of Comprehensive Income, the Statement of Financial Position, the Statement of Changes in Equity, the Statement of Cash Flows and Notes to the Accounts, including Accounting policies and other information. The financial reporting framework that has been applied in their preparation is applicable law and the Department of Health and Social Care Group Accounting Manual 2017-18 and the requirements of the National Health Service Act 2006.

In our opinion the financial statements:

- give a true and fair view of the financial position of the Trust as at 31 March 2018 and of its expenditure and income for the year then ended; and
- have been properly prepared in accordance with International Financial Reporting Standards (IFRSs) as adopted by the European Union, as interpreted and adapted by the Department of Health and Social Care Group Accounting Manual 2017-18; and
- have been prepared in accordance with the requirements of the National Health Service Act 2006.

Basis for opinion

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

Who we are reporting to

This report is made solely to the Directors of the 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 Trust's Directors those matters we are required to state to them in an auditor's report and for no other purpose. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the Trust and the Trust's Directors, as a body, for our audit work, for this report, or for the opinions we have formed.

Conclusions relating to going concern

We have nothing to report in respect of the following matters in relation to which the ISAs (UK) require us to report to you where:

- the Directors' use of the going concern basis of accounting in the preparation of the financial statements is not appropriate; or
- the Directors have not disclosed in the financial statements any identified material uncertainties that may cast significant doubt about the Trust's ability to continue to adopt the going concern basis of accounting for a period of at least twelve months from the date when the financial statements are authorised for issue.

Other information

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

In connection with our audit of the financial statements, our responsibility is to read the other information and, in doing so, consider whether the other information is materially inconsistent with the financial

statements or our knowledge obtained in the course of our work including that gained through work in relation to the Trust's arrangements for securing value for money through economy, efficiency and effectiveness in the use of its resource or otherwise appears to be materially misstated. If we identify such material inconsistencies or apparent material misstatements, we are required to determine whether there is a material misstatement in the financial statements or a material misstatement of the other information. If, based on the work we have performed, we conclude that there is a material misstatement of this other information, we are required to report that fact.

We have nothing to report in this regard.

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

Under the Code of Audit Practice published by the National Audit Office on behalf of the Comptroller and Auditor General (the Code of Audit Practice) we are required to consider whether the Annual Governance Statement does not comply with the guidance issued by NHS Improvement or is misleading or inconsistent with the information of which we are aware from our audit. We are not required to consider whether the Annual Governance Statement addresses all risks and controls or that risks are satisfactorily addressed by internal controls.

We have nothing to report in this regard.

Opinion on other matters required by the Code of Audit Practice

In our opinion:

- the parts of the Remuneration Report and Staff Report to be audited have been properly prepared in accordance with IFRSs as adopted by the European Union, as interpreted and adapted by the Department of Health and Social Care Group Accounting Manual 2017-18 and the requirements of the National Health Service Act 2006; and
- based on the work undertaken in the course of the audit of the financial statements and our knowledge of the Trust gained through our work in relation to the Trust's arrangements for securing economy, efficiency and effectiveness in its use of resources, the other information published together with the financial statements in the annual report for the financial year for which the financial statements are prepared is consistent with the financial statements.

Matters on which we are required to report by exception

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

- we have reported a matter in the public interest under Section 24 of the Local Audit and Accountability Act 2014 in the course of, or at the conclusion of the audit; or
- we have referred a matter to the Secretary of State under Section 30 of the Local Audit and Accountability Act 2014 because we had reason to believe that the Trust, or an officer of the Trust, was about to make, or had made, a decision which involved or would involve the body incurring unlawful expenditure, or was about to take, or had 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 have made a written recommendation to the Trust under Section 24 of the Local Audit and Accountability Act 2014 in the course of, or at the conclusion of the audit.

We have nothing to report in respect of the above matters except on 25 May 2018 we referred a matter to the Secretary of State under section 30(b) of the Local Audit and Accountability Act 2014 in relation to the Trust's breach of its breakeven duty for the three year period 31 March 2018.

Responsibilities of the Directors and Those Charged with Governance for the financial statements

As explained more fully in the Statement of Director's Responsibilities, the Directors are responsible for the preparation of the financial statements in the form and on the basis set out in the Accounts Directions, for being satisfied that they give a true and fair view, and for such internal control as the Directors determine is necessary to enable the preparation of financial statements that are free from material misstatement, whether due to fraud or error.

In preparing the financial statements, the Directors are responsible for assessing the Trust's ability to continue as a going concern, disclosing, as applicable, matters related to going concern and using the going concern basis of accounting unless the Trust lacks funding for its continued existence or when policy decisions have been made that affect the services provided by the Trust.

The Audit and Governance Committee is Those Charged with Governance.

Auditor's responsibilities for the audit of the financial statements

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

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

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

Qualified conclusion

On the basis of our work, having regard to the guidance issued by the Comptroller & Auditor General in November 2017, except for the effects of the matter described in the basis for qualified conclusion section of our report we are satisfied that, in all significant respects Maidstone and Tunbridge Wells NHS Trust put in place proper arrangements for securing economy, efficiency and effectiveness in its use of resources for the year ended 31 March 2018.

Basis for qualified conclusion

Our review of the Trust's arrangements for securing economy, efficiency and effectiveness in its use of resources identified the following matter:

The Trust's outturn position for 2017/18 was a £10.9 million deficit, a £17.6 million deterioration against the £6.7 million surplus target agreed with NHS Improvement. This brings the Trust's cumulative deficit to £58.3 million as at 31 March 2018. The Trust delivered £22.9 million of CIPs against its planned position of £31.7 million. The Trust remains in NHS Improvement's financial special measures regime.

This matter identifies weaknesses in the Trust's arrangements for setting a sustainable budget and delivering against its savings plans. This matter is evidence of weaknesses in proper arrangements for sustainable resource deployment in planning finances effectively to support the sustainable delivery of strategic priorities and maintain statutory functions.

Responsibilities of the Accountable Officer

As explained in the Statement of the Chief Executive's Responsibilities, as the Accountable Officer of the Trust, the Accountable Officer is responsible for putting in place proper arrangements for securing economy, efficiency and effectiveness in the use of the Trust's resources.

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

We are required under Section 21(3)(c) and 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 and to report where we have not been able to satisfy ourselves that it has done so. We are not required to consider, nor have we considered, whether all aspects of

the Trust's arrangements for securing economy, efficiency and effectiveness in its use of resources are operating effectively.

We have undertaken our review in accordance with the Code of Audit Practice, having regard to the guidance on the specified criterion issued by the Comptroller and Auditor General in November 2017, as to whether in all significant respects, 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. The Comptroller and Auditor General determined this criterion as that necessary for us to consider under the Code of Audit Practice in satisfying ourselves whether the Trust put in place proper arrangements for securing economy, efficiency and effectiveness in its use of resources for the year ended 31 March 2018, and to report by exception where we are not satisfied.

We planned our work in accordance with the Code of Audit Practice. Based on our risk assessment, we undertook such work as we considered necessary to be satisfied that the Trust has put in place proper arrangements for securing economy, efficiency and effectiveness in its use of resources.

Report on other legal and regulatory requirements – Certificate

We certify that we have completed the audit of the financial statements of Maidstone and Tunbridge Wells NHS Trust in accordance with the requirements of the Local Audit and Accountability Act 2014 and the Code of Audit Practice.

Darren Wells

Darren Wells
Engagement Lead
for and on behalf of Grant Thornton UK LLP

2nd Floor
St John's House
Haslett Avenue West
Crawley
RH10 1HS

25 May 2018

Glossary of NHS terms

Term	Definition/explanation
Ambulatory (Care)	A service where some conditions may be treated without the need for an overnight stay in hospital
Care Quality Commission (CQC)	The body that regulates all health and social care services in England. The CQC ensures the quality and safety of care in hospitals, dentists, ambulances, and care homes, and the care given in people's own homes. CQC is an executive non-departmental public body, sponsored by the Department of Health and Social Care.
Clinical Commissioning Group (CCG)	CCGs are clinically-led statutory NHS bodies, created following the Health and Social Care Act 2012, responsible for the planning and commissioning of health care services for their local area. CCGs are membership bodies, with local GP practices as the members
Clinical Governance	Clinical Governance is the system through which NHS organisations are accountable for continuously improving the quality of their services and safeguarding high standards of care, by creating an environment in which clinical excellence can flourish.
Commissioning	The process of planning, agreeing and monitoring services, ranging from the health-needs assessment for a population, through the clinically based design of patient pathways, to service specification and contract negotiation or procurement, with continuous quality assessment
Control total	A figure calculated by NHSI, on a Trust by Trust basis, which represents the minimum level of financial performance, against which the the Trust's Board/ Governing Body and Chief Executives must deliver in 2017/18, and for which they will be held directly accountable
Cost Improvement Programme (CIP)	Sets out the savings that an NHS organisation plans to make to reduce its expenditure/increase efficiency. It is used to close the gap between the income received by the NHS body and expenditure incurred in any one year
Commissioning for Quality and Innovation (CQUIN)	Introduced in 2009 to make a proportion of healthcare providers' income conditional on demonstrating improvements in quality and innovation in specified areas of patient care. The key aim of the CQUIN framework is to secure improvements in the quality of services and better outcomes for patients
Delayed Transfer of Care (DTOC)	According to NHS England, a 'delayed transfer of care' occurs when an adult inpatient in hospital is ready to go home or move to a less acute stage of care but is prevented from doing so. Sometimes referred to in the media as 'bed-blocking', delayed transfers of care are a problem as they reduce the number of beds available to other patients who need them, as well as causing unnecessarily long stays in hospital for patients
Elective treatment	Treatment that is not urgent and can be planned

Term	Definition/explanation
Emergency Department (ED)	Also known as Accident and Emergency (A&E)
Escalation	The term used to describe circumstances when clinical areas of the Trust, not ordinarily designated for non-elective inpatient care, are required to be used for that purpose due to non-elective demand
Financial Special Measures (FSM)	The Financial Special Measures programme, was launched by NHSI in July 2016 to provide a rapid turnaround package for Trusts which had either not agreed savings targets, or planned to make savings but deviated significantly from this plan
Friends and Family Test (FFT)	A feedback tool, launched in April 2013, that supports the fundamental principle that people who use NHS services should have the opportunity to provide feedback on their experience. It asks people if they would recommend the services they have used and offers a range of responses. When combined with supplementary follow-up questions, the FFT provides a mechanism to highlight both good and poor patient experience
Inpatient	A person who stays in hospital for one or more nights
Length of Stay (LOS)	The period of time a patient remains in hospital or other healthcare facility as an inpatient
NHS England	An executive non-departmental public body, sponsored the Department of Health and Social Care, which leads the NHS in England. It sets the priorities and direction of the NHS and encourages and informs the national debate to improve health and care
NHS Improvement (NHSI)	The body responsible for overseeing NHS Trusts, and independent providers that provide NHS-funded care. It supports providers to give patients consistently safe, high quality, compassionate care within local health systems that are financially sustainable
Non-elective treatment	Treatment that is not planned, but requires admission to hospital
Outpatient	A person who goes to a hospital for treatment or assessment, but does not stay overnight
Patient Advice and Liaison Service (PALS)	A service within an NHS Trust offering confidential advice, support and information on health-related matters. It provides a point of contact for patients, their families and their carers
Patient Experience	A term used for individual and collective feedback. (1) Individual patient's feedback about their experiences of care or a service e.g. whether they understood the information they were given, their views on the cleanliness of the hospital where they were treated. (2) A combination of all the intelligence held about what patients experience in services, drawing on a range of sources including complaints, compliments, etc.
Patient flow	The course of patients between staff, departments and organisations along a pathway of care

Term	Definition/explanation
Patient Pathhway	The route that a patient will take from entry into a hospital or other healthcare seeting until the patient leaves. A template pathway can be created for common services and operations (e.g. emergency care pathway)
Ring-fenced beds	Beds allocated for a specific category of patient / treatment (e.g. Stroke or elective orthopaedic beds), not used for general medical patients when the hospital is busy
Serious Incident (SI)	Events in health care where the potential for learning is so great, or the consequences to patients, families and carers, staff or organisations are so significant, that they warrant using additional resources to mount a comprehensive response. SIs can extend beyond incidents which affect patients directly and include incidents which may indirectly impact patient safety or an organisation's ability to deliver ongoing healthcare
Single Oversight Framework (SOF)	A framework which applies to all NHS Trusts and is designed to help providers attain, and maintain, CQC ratings of 'Good' or 'Outstanding'. The framework replaced the Monitor 'Risk Assessment Framework' and the NHS Trust Development Authority 'Accountability Framework' in October 2016
Sustainability and Transformation Fund (STF)	Money allocated by the NHS to support the transformation of services and systems, which is paid subject to the achievement of stipulated targets. The general element of the STF is allocated primarily to Trusts providing acute emergency care, as they remain under the greatest financial and operational pressure
Sustainability and Transformation Partnership (STP)	STPs are 44 areas covering all of England, where local NHS organisations and councils have drawn up proposals to improve health and care in the areas they serve.STP can also stand for 'sustainability and transformation plan', plans drawn up in each of these areas setting out practical ways to improve NHS services and population health in every part of England. They aim to help meet a 'triple challenge' set out in the NHS Five Year Forward View – better health, transformed quality of care delivery, and sustainable finances.

NHS
Maidstone and Tunbridge Wells
NHS Trust

Financial Statements for 2017/18

taking Pride

Statement of directors' responsibilities in respect of the accounts

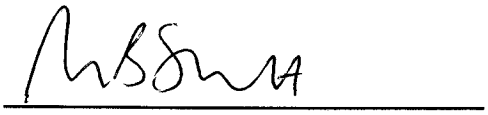
The directors are required under the National Health Service Act 2006 to prepare accounts for each financial year. The Secretary of State, with the approval of HM Treasury, directs that these accounts give a true and fair view of the state of affairs of the trust and of the income and expenditure, recognised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

24th May 2018 Date  Chief Executive

24th May 2018 Date  Director of Finance

2017-18 Annual Accounts of Maidstone and Tunbridge Wells Trust

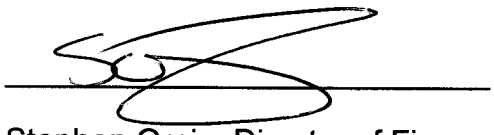
Certificate on summarisation schedules

Trust Accounts Consolidation (TAC) Summarisation Schedules for Maidstone and Tunbridge Wells NHS Trust

Summarisation schedules numbers TAC01 to TAC34 and accompanying WGA sheets for 2017/18 have been completed and this certificate accompanies them.

Director of Finance Certificate

1. I certify that the attached TAC schedules have been compiled and are in accordance with:
   - the financial records maintained by the NHS trust
   - accounting standards and policies which comply with the Department of Health and Social Care's Group Accounting Manual and
   - the template accounting policies for NHS trusts issued by NHS Improvement, or any deviation from these policies has been fully explained in the Confirmation questions in the TAC schedules.
2. I certify that the TAC schedules are internally consistent and that there are no validation errors.
3. I certify that the information in the TAC schedules is consistent with the financial statements of the NHS Trust.

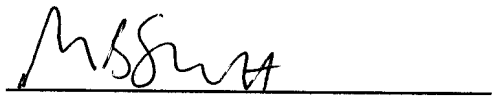


Stephen Orpin, Director of Finance

24th May 2018

Chief Executive Certificate

1. I acknowledge the attached TAC schedules, which have been prepared and certified by the Finance Director, as the TAC schedules which the Trust is required to submit to NHS Improvement.
2. I have reviewed the schedules and agree the statements made by the Director of Finance above.



Miles Scott, Chief Executive

24th May 2018

Statement of Comprehensive Income

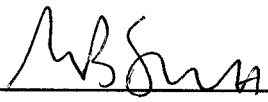
	Note	2017/18 £000	2016/17 £000
Operating income from patient care activities	3	**382,745**	376,413
Other operating income	4	**57,524**	54,089
Operating expenses	6, 8	**-421,213**	-466,121
Operating surplus/(deficit) from continuing operations		**19,056**	-35,619
Finance income	11	**47**	34
Finance expenses	12	**-15,118**	-14,647
PDC dividends payable		**-451**	-1,851
Net finance costs		**-15,522**	-16,464
Other gains / (losses)	13	**89**	17
Surplus / (deficit) for the year from continuing operations		**3,623**	-52,066
Surplus / (deficit) on discontinued operations and the gain / (loss) on disposal of discontinued operations	14	**0**	0
Surplus / (deficit) for the year		**3,623**	-52,066
Other comprehensive income			
Will not be reclassified to income and expenditure:			
Impairments	7	**434**	-24,643
Revaluations	18	**328**	1,161
Total comprehensive income / (expense) for the period		**4,385**	-75,548
Adjusted financial performance			
Surplus / (deficit) for the period (before consolidation of charity)		**3,623**	-52,066
Add back all I&E impairments / (reversals)		**-14,662**	41,293
Surplus / (deficit) before impairments and transfers		**-11,039**	-10,773
Remove capital donations / grants I&E impact		**249**	-145
CQUIN Risk Reserve - 1617 CT non achievement adjustment	50	**-134**	0
Adjusted financial performance surplus / (deficit)	50	**-10,924**	-10,918
Adjusted financial performance excluding STF		**-17,876**	-16,595

Statement of Financial Position

	Note	31 March 2018 £000	31 March 2017 £000
Non-current assets			
Intangible assets	15	**2,612**	3,219
Property, plant and equipment	16	**294,014**	280,190
Trade and other receivables	24	**1,201**	1,496
Total non-current assets		**297,827**	284,905
Current assets			
Inventories	23	**7,752**	7,945
Trade and other receivables	24	**37,454**	46,419
Non-current assets held for sale / assets in disposal groups	26	**0**	1,742
Cash and cash equivalents	27	**1,473**	1,420
Total current assets		**46,679**	57,526
Current liabilities			
Trade and other payables	28	**-43,893**	-50,354
Borrowings	31	**-24,469**	-9,660
Provisions	33	**-1,743**	-1,744
Other liabilities	30	**-2,620**	-5,745
Liabilities in disposal groups	26	**0**	0
Total current liabilities		**-72,725**	-67,503
Total assets less current liabilities		**271,781**	274,928
Non-current liabilities			
Trade and other payables	28	**0**	0
Borrowings	31	**-229,860**	-239,601
Provisions	33	**-1,106**	-1,260
Other liabilities	30	**0**	0
Total non-current liabilities		**-230,966**	-240,861
Total assets employed		**40,815**	34,067
Financed by			
Public dividend capital		**207,329**	204,966
Revaluation reserve		**29,852**	30,304
Other reserves		**0**	0
Income and expenditure reserve		**-196,366**	-201,203
Total taxpayers' equity		**40,815**	34,067

The notes on pages 7 to 46 form part of these accounts.

The financial statements on pages 2 to 6 were approved by the Board on 24th May 2017 and signed on its behalf by:

Chief Executive Officer:  **Date:** 24th May 2018

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

	Public dividend capital	Revaluation reserve	Other reserves	Income and expenditure reserve	Total
	£000	£000	£000	£000	£000
Taxpayers' equity at 1 April 2017 - brought forward	**204,966**	**30,304**	**0**	**-201,203**	**34,067**
Surplus/(deficit) for the year	0	0	0	3,623	**3,623**
Impairments	0	434	0	0	**434**
Revaluations	0	328	0	0	**328**
Transfer to retained earnings on disposal of assets	0	-1,214	0	1,214	**0**
Public dividend capital received	2,363	0	0	0	**2,363**
Taxpayers' equity at 31 March 2018	**207,329**	**29,852**	**0**	**-196,366**	**40,815**

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

	Public dividend capital	Revaluation reserve	Other reserves	Income and expenditure reserve	Total
	£000	£000	£000	£000	£000
Taxpayers' equity at 1 April 2016 - brought forward	**203,264**	**53,800**	**0**	**-149,151**	**107,913**
Prior period adjustment	0	0	0	0	**0**
Taxpayers' equity at 1 April 2016 - restated	**203,264**	**53,800**	**0**	**-149,151**	**107,913**
Surplus/(deficit) for the year	0	0	0	-52,066	**-52,066**
Impairments	0	-24,643	0	0	**-24,643**
Revaluations	0	1,161	0	0	**1,161**
Transfer to retained earnings on disposal of assets	0	-14	0	14	**0**
Public dividend capital received	1,702	0	0	0	**1,702**
Taxpayers' equity at 31 March 2017	**204,966**	**30,304**	**0**	**-201,203**	**34,067**

Information on reserves

1 Public dividend capital

Public dividend capital (PDC) is a type of public sector equity finance based on the excess of assets over liabilities at the time of establishment of the predecessor NHS organisation. Additional PDC may also be issued to trusts by the Department of Health and Social Care. A charge, reflecting the cost of capital utilised by the trust, is payable to the Department of Health as the public dividend capital dividend.

2 Income and expenditure reserve

The balance of this reserve is the accumulated surpluses and deficits of the Trust. These are not adjusted for techncial items as allowed in the break even duty performance, such as impairments or the impact of the on Statement of Financial Position accounting for the Private Finance Initiative.

3 Revaluation reserve

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

4 Available-for-sale investment reserve

This reserve comprises changes in the fair value of available-for-sale financial instruments. When these instruments are derecognised, cumulative gains or losses previously recognised as other comprehensive income or expenditure are recycled to income or expenditure. The Trust has no available-for-sale investments.

5 Other reserves

The Trust has no other reserves.

Statement of Cash Flows

	Note	2017/18 £000	2016/17 £000
Cash flows from operating activities			
Operating surplus / (deficit)		**19,056**	-35,619
Non-cash income and expense:			
Depreciation and amortisation	6.1	**13,710**	13,255
Net impairments	7	**-14,662**	41,293
Income recognised in respect of capital donations	4	**-159**	-361
(Increase) / decrease in receivables and other assets		**8,959**	-14,436
(Increase) / decrease in inventories		**193**	341
Increase / (decrease) in payables and other liabilities		**-8,813**	11,216
Increase / (decrease) in provisions		**-156**	-774
Net cash generated from / (used in) operating activities		**18,128**	14,915
Cash flows from investing activities			
Interest received		**47**	34
Purchase of intangible assets		**-198**	-902
Purchase of property, plant, equipment and investment property		**-12,253**	-6,834
Sales of property, plant, equipment and investment property		**1,840**	0
Receipt of cash donations to purchase capital assets		**159**	361
Net cash generated from / (used in) investing activities		**-10,405**	-7,341
Cash flows from financing activities			
Public dividend capital received		**2,363**	1,702
Public dividend capital repaid		**0**	0
Movement on loans from the Department of Health and Social Care		**9,358**	12,416
Movement on other loans		**739**	0
Capital element of PFI, LIFT and other service concession payments		**-5,028**	-4,774
Interest paid on PFI, LIFT and other service concession obligations		**-13,855**	-13,546
Other interest paid		**-1,263**	-1,095
PDC dividend (paid) / refunded		**16**	-2,054
Net cash generated from / (used in) financing activities		**-7,670**	-7,351
Increase / (decrease) in cash and cash equivalents		**53**	223
Cash and cash equivalents at 1 April - brought forward		**1,420**	1,197
Prior period adjustments		**0**	0
Cash and cash equivalents at 1 April - restated		**1,420**	1,197
Cash and cash equivalents transferred under absorption accounting	44	**0**	0
Cash and cash equivalents at 31 March	27.1	**1,473**	1,420

Notes to the Accounts

1 Note 1 Accounting policies and other information

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. 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.

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.

1.1.2 Going Concern

These accounts have been prepared on a going concern basis.

The DH Group Accounting Manual (GAM) requires the management of the Trust to consider the following public sector interpretation of IAS 1 in respect of applying the going concern assumption when preparing its accounts, stating:

''For non-trading entities in the public sector, the anticipated continuation of the provision 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. DHSC group bodies must therefore prepare their accounts on a going concern basis unless informed by the relevant body or DHSC sponsor of the intention for dissolution without transfer of services of function to another entity. A trading entity needs to consider whether it is appropriate to continue to prepare its financial statements on a going concern basis where it is being, or is likely to be, wound up"

The Trust Board have assessed the Trust's ability to continue for the foreseeable future in the light of the GAM guidance and has prepared the 2017/18 accounts on a "going concern" basis following consideration of the following:-

● There has been no expectation raised in the public arena that healthcare services will not continue to be provided from the two hospital sites.

● The Trust has submitted its initial business plan to NHSI in March 2018 setting out its operational plans for the following financial year (2018/19) and its capital plans for five years. The final plan submission will be made on the 30th April.

●The Trust continues to fully participate in the STP planning process including the submission of the forward 5 year financial and operating plans on a going concern basis. The Trust is leading some of the significant Work-stream areas and a key player in consideration of the shape of services in the STP for the future (e.g. the Stroke services consultation).

● The Trust has existing contracts in place for provision of healthcare services for 2018/19 being the second year of contracts signed last year. This includes the "aligned incentives" contract with two of its CCGs, West Kent (the Trust's main commissioner) and High Weald and Lewes Haven. The exact value of the year two contracts will be concluded using the agreed contract approach as part of the current business planning round. The current level of difference under discussion is immaterial in value.

● The Trust has prepared and will be submitting cash-flow forecasts for 2018/19 as part of its planning returns which do not include any assumptions of additional required working capital finance.

● There are no plans to dissolve the Trust or to cease services without transfer to any other NHS body.

However the Trust has assessed the following challenges to its Financial Plans for 2018/19:

● To achieve its 2018/19 control total the Trust will need to deliver a challenging cost improvement programme plus a significant level of other non-recurrent measures. At this stage there is risk around the ability of the Trust to deliver this level of savings within 2018/19.

● Failure to achieve the Trust's control total could necessitate additional in year working capital finance to support the Trust's liquidity position and its ability to repay the first of its working capital loans that falls due for repayment in February 2019 (£16.9m).

1.1.3 Critical judgements in applying accounting policies

The following are the critical judgements, apart from those involving estimations (see below 1.1.4) that management has made in the process of applying the NHS Trust's accounting policies and that have the most significant effect on the amounts recognised in the financial statements.
For 2017/18 the Trust has identified the following critical judgements that are required to be disclosed under IAS1 paragraph 122. All other material judgements within this financial year relate to estimations and are disclosed in the relevant notes (see 1.1.4)

Material areas of critical judgements within the 2017/18 accounts are as follows:

The financial statements have been prepared on a going concern basis as set out in note 1.1.2. In preparing the financial statements the directors have considered the Trust's overall financial position and expectation of future contractual income, cost improvements and Sustainability and Transformation Funding (STF). The Trust will be submitting a financial plan for 2018/19 to NHS Improvement which delivers agreed control totals and, including planned STF funding, £17.7m surplus for 2018/19. Note 4 (Other Operating Income) contains a reference in respect of future STF Funding.

- The Trust has applied the concept of Modern Equivalent Asset (MEA) to estimate the valuation of its property assets, as applicable, under the guidance of the DH GAM and its independent professional valuers. This may result in impairment costs or reversals falling to be recognised in reserves or the income and expenditure statement as appropriate. Please see note 18 for further information.

- Charitable Funds are not material for the Trust and have not been consolidated.

- The Trust's PFI contract continues to be judged as falling under IFRIC 12 principles as a service concession arrangement with the trust recognising an infrastructure asset and a corresponding finance lease liability, under IAS 17.

1.1.4 Key sources of estimation uncertainty

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 where arising, will be disclosed within the relevant note. The disclosure will include the nature of the assumption and the carrying amount of the asset/liability at the Statement of Financial Position date, sensitivity of the carrying amount to the assumptions, expected resolution of uncertainty and range of possible outcomes within the next financial year. The disclosure will also include an expectation of changes to past assumptions if the uncertainty remains unresolved. The following are assumptions about the future and other major sources of estimation uncertainty that have a significant risk of resulting in a material adjustment to the carrying amounts of assets and liabilities within the next financial year:

Material areas including estimations within the 2017/18 accounts are as follows:

- Property, Plant and Equipment valuation including PFI infrastructure assets (see accounting policy note 1.6 below and also accounts note 18)

- Pension fund valuation (see note 9).

1.2 Interests in other entities

The Trust does not have any interests in other entities.

1.3 Income

Income in respect of services provided is recognised when, and to the extent that, performance occurs and is measured at the fair value of the consideration receivable. The main source of income for the trust is contracts with commissioners in respect of health care services. At the year end, the trust accrues income relating to activity delivered in that year, where a patient care spell is incomplete.

Interest revenue is accrued on a time basis, by reference to the principal outstanding and interest rate applicable.

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

Income from the sale of non-current assets is recognised only when all material conditions of sale have been met, and is measured as the sums due under the sale contract.

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.

1.3.1 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 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.

1.4 Expenditure on employee benefits

Short-term employee benefits

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

Pension Costs
NHS Pension Scheme

Past and present employees are covered by the provisions of the 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.

The Trust participates in the National Employees Savings Trust (NEST) scheme as an alternative to those employees who are not eligible to join the NHS Pension Scheme. This came into effect in July 2013 for this Trust as part of the auto enrolment requirements introduced by the Government. NEST is a defined contribution scheme with a phased employer contribution rate which was 1% for 2017/18.

The schemes are subject to a full actuarial valuation every four years and an accounting valuation every year.

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.

1.6 Property, plant and equipment
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 will be supplied to the NHS Trust;
- it is expected to be used for more than one financial year;
- the cost of the item can be measured reliably;
- the item cost at least £5,000; or
- Collectively, a number of items have a total cost of at least £5,000 and individually have a cost of more than £250, where the assets are functionally interdependent, they had broadly simultaneous purchase dates, are anticipated to have simultaneous disposal dates and are under single managerial control; or
- Items form part of the initial equipping and setting-up cost of a new building, ward or unit, irrespective of their individual or collective cost.

Where a large asset, for example a building, includes a number of components with significantly different asset lives, the components are treated as separate assets and depreciated over their own useful economic lives, where this would lead to a different depreciation profile. In respect of building and dwelling assets, the Trust has determined that it is appropriate to depreciate the component blocks of the two hospital sites and individual dwellings separately, as this takes into consideration the age and condition of the asset components and their differing depreciation profile and follows the external valuation schedules. The individual elements (e.g. walls, floors, lifts, heating etc.) within these blocks are not deemed to be significant in relation to the block assets.

1.6.2 Measurement

Valuation

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

Land and buildings used for the Trust's services or for administrative purposes are stated in the statement of financial position at their revalued amounts, being the fair value at the date of revaluation less any impairment.

Revaluations of property, plant and equipment are performed with sufficient regularity to ensure that carrying amounts are not materially different from those that would be determined at the end of the reporting period. Current values in existing use are determined as follows:

- Land and non-specialised buildings – market value for existing use.
- Specialised buildings – depreciated replacement cost, 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 financial year 2017/18 is the third year in the current five year cyclical valuation period. A full valuation was undertaken in September 2014 with desktop valuations at 31st March 2015, 31st March 2016 and 30th September 2016. In keeping with the Trust's policies the Trust commissioned professional valuers, Montagu Evans LLP, to carry out a desktop valuation of the Trust's Land, Building and Dwelling assets at 31st January 2018 with an assessment of materiality conducted for 31st March 2018. The lead relationship partner from Montagu Evans LLP is qualified to BSc MRICS. The results are recorded in the property plant and equipment notes 16 and 18.

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.

IT equipment, transport equipment, furniture and fittings, and plant and machinery that are held for operational use are valued at depreciated historic cost where these assets have short useful economic lives or low values or both, as this is not considered to be materially different from current value in existing use. The Trust periodically reviews annually high value plant and machinery assets (net book value over £100k) to ensure these are held at the correct values and remaining useful lives. IT assets are also subject to annual review.

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. Any residual balance in the revaluation reserve in respect to an individual asset is transferred to the retained earnings reserve on disposal of the asset.

1.6.3 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. 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.

1.7 Depreciation, amortisation and impairments

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.

Otherwise, depreciation or amortisation is charged to write off the costs or valuation of property, plant and equipment and intangible non-current assets, less any residual value, on a straight line basis over their estimated useful lives. The estimated useful life of an asset is the period over which the NHS Trust expects to obtain economic benefits or service potential from the asset. This is specific to the NHS Trust and may be shorter than the physical life of the asset itself. Estimated useful lives and residual values are reviewed each year end, with the effect of any changes recognised on a prospective basis. Assets held under finance leases are depreciated over the shorter of the lease term and the estimated useful lives.

At each financial year-end, the NHS Trust checks whether there is any indication that its property, plant and equipment or intangible non-current assets have suffered an impairment loss. If there is indication of such an impairment, the recoverable amount of the asset is estimated to determine whether there has been a loss and, if so, its amount. Intangible assets are tested for impairment at the point that they are brought into use.

1.7.1 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'.

1.7.2 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.

1.7.3 De-recognition (held for sale)

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 ie:

- management are committed to a plan to sell the asset
- an active programme has begun to find a buyer and complete the sale
- the asset is being actively marketed at a reasonable price
- the sale is expected to be completed within 12 months of the date of classification as 'held for sale' and
- the actions needed to complete the plan indicate it is unlikely that the plan will be dropped or significant changes made to it.

Following reclassification, the assets are measured at the lower of their existing carrying amount and their 'fair value less costs to sell'.

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.

The profit or loss arising on disposal of an asset is the difference between the sale proceeds and the carrying amount and is recognised in the Statement of Comprehensive Income. On disposal, the balance for the asset on the revaluation reserve is transferred to retained earnings.

1.7.4 Donated, government grant and other grant funded assets

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

The donated and grant funded assets are subsequently accounted for in the same manner as other items of property, plant and equipment.

1.8 Private Finance Initiative (PFI) transactions

PFI transactions which meet the IFRIC 12 definition of a service concession, as interpreted in HM Treasury's FReM, are accounted for as 'on-Statement of Financial Position' by the Trust. In accordance with IAS 17, the underlying assets are recognised as property, plant and equipment, together with an equivalent finance lease liability. Subsequently, the assets are accounted for as property, plant and equipment and/or intangible assets as appropriate.

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
c) Payment for the replacement of components of the asset during the contract 'lifecycle replacement'.

1.8.1 Services received

The fair value of services received in the year is recorded under the relevant expenditure headings within 'operating expenses' in the Statement of Comprehensive Income.

1.8.2 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 at current value in existing use, which is kept up to date in accordance with the Trust's approach for each relevant class of asset in accordance with the principles of IAS 16.

1.8.3 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.

1.8.4 Lifecycle replacement

Components of the asset replaced by the operator during the contract ('lifecycle replacement') are capitalised where they meet the NHS Trust's criteria for capital expenditure. They are capitalised at the time they are provided by the operator and are measured initially at their fair value.

The element of the annual unitary payment allocated to lifecycle replacement is pre-determined for each year of the contract from the operator's planned programme of lifecycle replacement. Where the lifecycle component is provided earlier or later than expected, a short-term accrual or prepayment is recognised respectively.

Where the fair value of the lifecycle component is less than the amount determined in the contract, the difference is recognised as an expense when the replacement is provided. If the fair value is greater than the amount determined in the contract, the difference is treated as a 'free' asset and a deferred income balance is recognised. The deferred income is released to operating income over the shorter of the remaining contract period or the useful economic life of the replacement component.

1.8.5 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.

1.8.6 Other assets contributed by the NHS Trust to the operator

Assets contributed (e.g. cash payments, 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.

1.9 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:

	Min life Years	Max life Years
Buildings, excluding dwellings	1	60
Dwellings	1	60
Plant & machinery	5	15
Transport equipment (including vehicles)	5	15
Information technology	3	5
Furniture & fittings	10	10
X ray Tubes	2	2
Software Licences (intangibles)	3	5
IT - In House and Third Party Software (intangibles)	2	7

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.

1.10 Intangible assets

1.10.1 Recognition

Intangible assets are non-monetary assets without physical substance which are capable of being sold separately from the rest of the trust's business or which arise from contractual or other legal rights. They are recognised only where it is probable that future economic benefits will flow to, or service potential be provided to, the trust and where the cost of the asset can be measured reliably.

Intangible assets acquired separately are initially recognised at cost. Software that is integral to the operation of hardware, for example an operating system, is capitalised as part of the relevant item of property, plant and equipment. Software that is not integral to the operation of hardware, for example application software, is capitalised as an intangible asset. Expenditure on research is not capitalised: it is recognised as an operating expense in the period in which it is incurred. Intangible assets are assessed for impairment when they are first brought into use. Expenditure on development is capitalised only where all of the following can be demonstrated:

- the project is technically feasible to the point of completion and will result in an intangible asset for
- the Trust intends to complete the asset and sell or use it
- the Trust has the ability to sell or use the asset
- how the intangible asset will generate probable future economic or service delivery benefits, eg, the presence of a market for it or its output, or where it is to be used for internal use, the usefulness of the asset;
- adequate financial, technical and other resources are available to the trust to complete the development and sell or use the asset and
- the Trust can measure reliably the expenses attributable to the asset during development.

Internally generated goodwill, brands, mastheads, publishing titles, customer lists and similar items are not capitalised as intangible assets.

1.10.2 Software

Software which is integral to the operation of hardware, eg an operating system, is capitalised as part of the relevant item of property, plant and equipment. Software which is not integral to the operation of hardware, eg application software, is capitalised as an intangible asset.

1.10.3 Measurement

Intangible assets are recognised initially at cost, comprising all directly attributable costs needed to create, produce and prepare the asset to the point that it is capable of operating in the manner intended by management.

Subsequently intangible assets are measured at current value in existing use. Where no active market exists, intangible assets are valued at the lower of depreciated replacement cost and the value in use where the asset is income generating. Revaluations gains and losses and impairments are treated in the same manner as for property, plant and equipment. An intangible asset 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.

Intangible assets held for sale are measured at the lower of their carrying amount or "fair value less costs to sell".

1.10.4 Amortisation

Intangible assets are amortised over their expected useful economic lives in a manner consistent with the consumption of economic or service delivery benefits.

1.11 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. The cost of inventories is measured using the first in, first out (FIFO) method.

1.12 Investment properties

Investment properties are measured at fair value. Changes in fair value are recognised as gains or losses in income/expenditure.

The Trust has no investment properties.

1.13 Cash and cash equivalents

Cash is cash in hand and deposits with any financial institution repayable without penalty on notice of not more than 24 hours. Cash equivalents are investments that mature in 3 months or less from the date of acquisition and that are readily convertible to known amounts of cash with insignificant risk of change in value.

In the Statement of Cash Flows, cash and cash equivalents are shown net of bank overdrafts that are repayable on demand and that form an integral part of the NHS Trust's cash management. Cash, bank and overdraft balances are recorded at current values.

1.14 Carbon Reduction Commitment Scheme (CRC)

The CRC scheme is a mandatory cap and trade scheme for non-transport CO2 emissions. The trust is registered with the CRC scheme, and is therefore required to surrender to the Government an allowance for every tonne of CO2 it emits during the financial year. A liability and related expense is recognised in respect of this obligation as CO2 emissions are made.

The carrying amount of the liability at the financial year end will therefore reflect the CO2 emissions that have been made during that financial year, less the allowances (if any) surrendered voluntarily during the financial year in respect of that financial year.

The liability will be measured at the amount expected to be incurred in settling the obligation. This will be the cost of the number of allowances required to settle the obligation.

Allowances acquired under the scheme are recognised as intangible assets if they are not expected to be realised within twelve months, and otherwise as other current assets.

1.15 Financial instruments and financial liabilities

Recognition

Financial assets and financial liabilities which arise from contracts for the purchase or sale of non-financial items (such as goods or services), which are entered into in accordance with the trust's normal purchase, sale or usage requirements, are recognised when, and to the extent which, performance occurs, ie, when receipt or delivery of the goods or services is made. These are derecognised when the contractual rights have expired or the asset has been transferred or when the liability has been paid or has expired.

De-recognition (held for sale)

All financial assets are de-recognised when the rights to receive cash flows from the assets have expired or the trust has transferred substantially all of the risks and rewards of ownership.

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

Classification and measurement

Financial assets are categorised as financial assets at fair value through income and expenditure, held to maturity investments, or 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

Financial liabilities are initially recognised at fair value through income and expenditure. The Trust's liabilities are held at cost as this is not believed to be materially different to fair value in respect of current liabilities.

Financial assets and financial liabilities at "fair value through income and expenditure"

Financial assets and financial liabilities at "fair value through income and expenditure" are financial assets or financial liabilities held for trading. A financial asset or financial liability is classified in this category if acquired principally for the purpose of selling in the short-term. Derivatives are also categorised as held for trading unless they are designated as hedges. Embedded derivatives that have different risks and characteristics to their host contracts, and contracts with embedded derivatives whose separate value cannot be ascertained, are treated as financial assets/financial liabilities at fair value through profit and loss. They are held at fair value, with any resultant gain or loss recognised in calculating the NHS Trust's surplus or deficit for the year. The net gain or loss incorporates any interest earned on the financial asset/liability

The Trust does not have any embedded derivatives that have different risks and characteristics to the host contracts, therefore the Trust does not have any financial assets/liabilities at fair value through profit and loss.

Loans and receivables

Loans and receivables are non-derivative financial assets with fixed or determinable payments which are not quoted in an active market.

The Trust's loans and receivables comprise: cash and cash equivalents, NHS receivables, accrued income and other receivables.

Loans and receivables are recognised initially at fair value, net of transactions costs, and are measured subsequently at amortised cost, using the effective interest method. The effective interest rate is the rate that discounts exactly estimated future cash receipts through the expected life of the financial asset or, when appropriate, a shorter period, to the net carrying amount of the financial asset.

Interest on loans and receivables is calculated using the effective interest method and credited to the Statement of Comprehensive Income.

Available for sale financial assets

Available-for-sale financial assets are non-derivative financial assets which are either designated in this category or not classified in any of the other categories. They are included in long-term assets unless the trust intends to dispose of them within 12 months of the Statement of Financial Position date.

Available-for-sale financial assets are recognised initially at fair value, including transaction costs, and measured subsequently at fair value, with gains or losses recognised in reserves and reported in the Statement of Comprehensive Income as an item of "other comprehensive income". When items classified as "available-for-sale" are sold or impaired, the accumulated fair value adjustments recognised are transferred from reserves and recognised in "finance costs" in the Statement of Comprehensive Income.

Other financial liabilities

All other financial liabilities are recognised initially at fair value, net of transaction costs incurred, and measured subsequently at amortised cost using the effective interest method. The effective interest rate is the rate that discounts exactly estimated future cash payments through the expected life of the financial liability or, when appropriate, a shorter period, to the net carrying amount of the financial liability.

They are included in current liabilities except for amounts payable more than 12 months after the 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.

Impairment of financial assets

At the Statement of Financial Position date, the trust assesses whether any financial assets, other than those held at "fair value through income and expenditure" are impaired. Financial assets are impaired and impairment losses are recognised if, and only if, there is objective evidence of impairment as a result of one or more events which occurred after the initial recognition of the asset and which has an impact on the estimated future cash flows of the asset.

1.16 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.

1.16.1 The Trust as 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.

1.16.2 The NHS Trust as lessor

Amounts due from lessees under finance leases are recorded as receivables at the amount of the NHS Trust's net investment in the leases. Finance lease income is allocated to accounting periods so as to reflect a constant periodic rate of return on the Trust's net investment outstanding in respect of the leases.

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

The balance is subsequently released to operating income over the life of the concession on a straight-line basis

1.17 Provisions

The Trust recognises a provision where it has a present legal or constructive obligation of uncertain timing or amount; for which it is probable that there will be a future outflow of cash or other resources; and a reliable estimate can be made of the amount. The amount recognised in the Statement of Financial Position is the best estimate of the resources required to settle the obligation. Where the effect of the time value of money is significant, the estimated risk-adjusted cash flows are discounted using the discount rates published and mandated by HM Treasury.

Early retirement provisions are discounted using HM Treasury's pension discount rate of positive 0.1% (2016/17 positive 0.24%) in real terms. All other provisions are subject to three separate discount rates according to the expected timing of cash flows from the Statement of Financial Position date:

• A short term rate of negative 2.42% (2016/17: negative 2.70%) for expected cash flows up to and including 5 years

• A medium term rate of negative 1.85% (2016/17: negative 1.95%) for expected cash flows over 5 years up to and including 10 years

• A long term rate of negative 1.56% (2016/17: negative 0.80%) for expected cash flows over 10 years.

All percentages are in real terms.

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.

Present obligations arising under onerous contracts are recognised and measured as a provision. An onerous contract is considered to exist where the Trust has a contract under which the unavoidable costs of meeting the obligations under the contract exceed the economic benefits expected to be received under it.

1.17.1 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 33 but is not recognised in the Trust's accounts.

1.17.2 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.

1.18 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 33 where an inflow of economic benefits is probable.

Contingent liabilities are not recognised, but are disclosed in note 33, 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.

1.19 Public Dividend Capital (PDC) and PDC dividend

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.

1.20 Value Added Tax

Most of the activities of the trust are outside the scope of VAT and, in general, output tax does not apply and input tax on purchases is not recoverable. Irrecoverable VAT is charged to the relevant expenditure category or included in the capitalised purchase cost of fixed assets. Where output tax is charged or input VAT is recoverable, the amounts are stated net of VAT.

1.21 Corporation tax

The Trust is not liable directly for Corporation tax and has no subsidiary companies or other associated interests that would attract Corporation tax.

1.22 Foreign exchange

The functional and presentational currency of the trust is sterling.

A transaction which is denominated in a foreign currency is translated into the functional currency at the spot exchange rate on the date of the transaction.

Where the trust has assets or liabilities denominated in a foreign currency at the Statement of Financial Position date:

• monetary items (other than financial instruments measured at "fair value through income and expenditure") are translated at the spot exchange rate on 31 March;

• non-monetary assets and liabilities measured at historical cost are translated using the spot exchange rate at the date of the transaction and;

• non-monetary assets and liabilities measured at fair value are translated using the spot exchange rate at the date the fair value was determined.

Exchange gains or losses on monetary items (arising on settlement of the transaction or on re-translation at the Statement of Financial Position date) are recognised in income or expense in the period in which they arise.

Exchange gains or losses on non-monetary assets and liabilities are recognised in the same manner as other gains and losses on these items.

1.23 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* .

1.24 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.

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

For functions that have been transferred to the Trust from another NHS / local government body, the assets and liabilities transferred are recognised in the accounts as at the date of transfer. The assets and liabilities are not adjusted to fair value prior to recognition. The net gain / loss corresponding to the net assets/ liabilities transferred is recognised within income / expenses, but not within operating activities.

For property plant and equipment assets and intangible assets, the cost and accumulated depreciation / amortisation balances from the transferring entity's accounts are preserved on recognition in the trust's accounts. Where the transferring body recognised revaluation reserve balances attributable to the assets, the trust makes a transfer from its income and expenditure reserve to its revaluation reserve to maintain transparency within public sector accounts.

For functions that the trust has transferred to another NHS / local government body, the assets and liabilities transferred are de-recognised from the accounts as at the date of transfer. The net loss / gain corresponding to the net assets/ liabilities transferred is recognised within expenses / income, but not within operating activities. Any revaluation reserve balances attributable to assets de-recognised are transferred to the income and expenditure reserve. Adjustments to align the acquired function to the trust's accounting policies are applied after initial recognition and are adjusted directly in taxpayers' equity.

1.26 Research and Development

Research and development expenditure is charged against income in the year in which it is incurred, except insofar as development expenditure relates to a clearly defined project and the benefits of it can reasonably be regarded as assured. Expenditure so deferred is limited to the value of future benefits expected and is amortised through the SOCI on a systematic basis over the period expected to benefit from the project. It should be revalued on the basis of current cost. The amortisation is calculated on the same basis as depreciation, on a quarterly basis.

1.27 Early adoption of standards, amendments and interpretations

No new accounting standards or revisions to existing standards have been early adopted in 2017/18.

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

The HM Treasury FReM does not require the following Standards and Interpretations to be applied in 2017-18. New accounting standards to be applied in 2018-19 are IFRS 9 and IFRS 15. IFRS 16 will be implemented in 2019/20.

● 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. The Trust does not consider that application of this standard is likely to have a material impact on its accounts.

● 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. This standard may affect recognition of some elements of current contractual payments, this is not considered by the Trust to be likely have a material impact. The Trust will continue to assess the impact with its CCG partners in the light of further guidance.

● IFRS 16 Leases – Application required for accounting periods beginning on or after 1 January 2019, but not yet adopted by the FReM: early adoption is not therefore permitted. The impact of applying this standard cannot yet be quantified as guidance on how it will be adopted into NHS accounting is awaited.

● IFRS 17 Insurance Contracts - Application required for accounting periods beginning on or after 1 January 2021, but not yet adopted by the FReM: early adoption is not therefore permitted.

● IFRS 22 Foreign Currency Transactions and Advance Consideration - Application required for accounting periods beginning on or after 1 January 2018.

● IFRS 23 Uncertainty over Income Tax Treatments - Application required for accounting periods beginning on or after 1 January 2019.

Note 2 Operating Segments

Maidstone and Tunbridge Wells NHS Trust reports under a single segment of Healthcare. The Trust has considered the possibility of reporting two segments, relating to Healthcare and Non Healthcare Income, but this does not reflect current Trust Board reporting practice which reports on both the aggregate Trust position and by Directorate. Each of the significant directorates are deemed to have similar economic characteristics under the Healthcare banner and can therefore be aggregated in accordance with the requirements of IFRS 8.

The Trust's income is predominantly from contracts for the provision of healthcare with clinical Commissioning Groups and NHS England. This accounts for 87% of the Trusts total income.

Note 3 Operating income from patient care activities

Note 3.1 Income from patient care activities (by nature)	2017/18 £000	2016/17 £000
Acute services		
Elective income	**69,204**	69,577
Non elective income	**103,779**	99,730
First outpatient income	**25,994**	27,080
Follow up outpatient income	**32,650**	37,335
A & E income	**21,645**	18,681
High cost drugs income from commissioners (excluding pass-through costs)	**42,791**	35,015
Other NHS clinical income	**75,864**	74,686
All services		
Private patient income	**2,426**	4,799
Other clinical income	**8,392**	9,510
Total income from activities	**382,745**	376,413

Note 3.2 Income from patient care activities (by source)

Income from patient care activities received from:	2017/18 £000	2016/17 £000
NHS England	**71,361**	71,154 *
Clinical Commissioning Groups	**300,500**	290,681
Department of Health and Social Care	**0**	8
Other NHS providers	**3,187**	3,451
NHS other	**0**	505
Local authorities	**4,161**	4,602
Non-NHS: private patients	**2,426**	4,799
Non-NHS: overseas patients (chargeable to patient)	**270**	321
NHS injury scheme	**840**	762
Non NHS: other	**0**	130
Total income from activities	**382,745**	376,413
Of which:		
Related to continuing operations	**382,745**	376,413
Related to discontinued operations	**0**	0

NHS injury cost recovery income is subject to a provision for impairment of receivables which the Trust has estimated using historical information for each main site. The provision rates are 22.49% for Maidstone Hospital and 18.14% of Tunbridge Wells Hospital (21.93% Maidstone Hospital and 16.25% Tunbridge Wells in 2016/17). This provision reflect expected rates of collection.

* Previously included within Note 3.2 was revenue from NHS England in respect of £8m Central PFI financial support, this has been re-categorised as "other income" in Note 4 following 2017/18 guidance in the accompanying summarisation schedules (TACs).

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

	2017/18	2016/17
	£000	£000
Income recognised this year	**270**	321
Cash payments received in-year	**152**	120
Amounts added to provision for impairment of receivables	**54**	165
Amounts written off in-year	**29**	0

Note 4 Other operating income

	2017/18	2016/17
	£000	£000
Research and development	**1,696**	2,573
Education and training	**10,061**	10,507
Receipt of capital grants and donations	**159**	361
Charitable and other contributions to expenditure	**0**	0
Non-patient care services to other bodies	**25,230**	20,159
Sustainability and transformation fund income	**6,952**	5,677
Rental revenue from operating leases	**23**	23
Other income	**13,403**	14,789
Total other operating income	**57,524**	54,089
Of which:		
Related to continuing operations	**57,524**	54,089
Related to discontinued operations	**0**	0

Included within other operating income for 2017-18 is £6.952m of Sustainability and Transformation Funding (STF), which includes £3.040m of STF General Distribution. The Trust's 2018-19 plan includes £15.72m of STF funding.

Included within other income is revenue from NHS England for 2017-18 is £8m of Central PFI financial support (2016-17 £8m). The Trust's 2018-19 plan includes £8m recurrent central PFI support. This was previously treated as income from patient care activities in note 3.2.

Included within the non-patient care services to other bodies is income of £8m (£3.3m 2016/17) relating to the Kent and Medway Sustainability and Transformation Partnership (STP). The Trust agreed during 2017/18 to become the financial host of the STP budget. This funding is provided in accordance with agreements made by each STP body with STP management to cover the costs of the planned annual programme. The costs are reported within the Trusts operating costs in note 6.1.

Further analysis of "other income"	2017/18	2016/17
	£000	£000
PFI support income	**8,000**	8,000
Car Parking income	**2,094**	2,346
Catering Income	**1,041**	1,114
Staff Accommodation	**478**	523
Other	**1,790**	2,806
	13,403	14,789

Note 5 Fees and charges relating to "other Income"

(aggregate of all schemes which individually have a cost exceeding £1m)	2017/18	2016/17
	£000	£000
Income	**4,010**	4,247
Full cost	**-2,733**	-2,913
Surplus / (deficit)	**1,277**	1,334
Car Parking		
Income	**2,094**	2,346
Full cost	**-1,884**	-1,795
Surplus/(Deficit)	**210**	551
Catering Income		
Income	**1,041**	1,114
Full cost	**-437**	-648
Surplus/(Deficit)	**604**	466

Note 6.1 Operating expenses

	2017/18	2016/17	
	£000	£000	
Purchase of healthcare from NHS and DHSC bodies	**8,561**	7,673	
Purchase of healthcare from non-NHS and non-DHSC bodies	**4,091**	8,643	
Staff and executive directors costs	**255,640**	252,156	**
Remuneration of non-executive directors	**73**	75	
Supplies and services - clinical (excluding drugs costs)	**32,514**	34,623	*
Supplies and services - general	**5,443**	5,356	
Drug costs (drugs inventory consumed and purchase of non-inventory drugs)	**52,920**	51,700	*
Consultancy costs	**7,606**	3,839	
Establishment	**1,764**	1,976	
Premises	**19,130**	14,546	
Transport (including patient travel)	**1,946**	2,078	*
Depreciation on property, plant and equipment	**12,744**	12,303	
Amortisation on intangible assets	**966**	952	
Net impairments	**-14,662**	41,293	
Increase/(decrease) in provision for impairment of receivables	**731**	-421	
Increase/(decrease) in other provisions	**25**	0	
Change in provisions discount rate(s)	**7**	40	
Audit fees payable to the external auditor			
audit services- statutory audit	**73**	89	
other auditor remuneration (external auditor only)	**9**	13	
Internal audit costs	**159**	151	
Clinical negligence	**20,911**	18,231	
Legal fees	**162**	249	
Insurance	**28**	373	*
Research and development	**0**	0	
Education and training	**1,113**	937	
Rentals under operating leases	**2,019**	2,104	*
Charges to operating expenditure for on-SoFP IFRIC 12 schemes (e.g. PFI / LIFT) on IFRS basis	**4,733**	4,437	*
Charges to operating expenditure for off-SoFP IFRIC 12 schemes	**0**	0	
Car parking & security	**834**	816	*
Hospitality	**8**	0	
Losses, ex gratia & special payments	**12**	29	*
Other services, eg external payroll	**282**	262	
Other	**1,371**	1,598	*
Total	**421,213**	**466,121**	
Of which:			
Related to continuing operations	**421,213**	466,121	
Related to discontinued operations	**0**	0	

For further information on impairments please see Note 7.

* prior year figures have been amended in line with the revised disclosures within this note

** Staff and executive directors costs were previously shown separately under Employee Benefits.

The corresponding operating expenses relating to the STP as mentioned in income note 4, primarily relate to consultancy of £7.2m (£3.4m 2016/17) and purchase of healthcare from NHS and DHSC bodies £0.8m (£0.2m 2016/17).

The audit fees included within Note 6.1 above are reported as the gross position, the value excluding VAT for 2017/18 is £61k (2016/17 £75k).

Note 6.2 Other auditor remuneration

	2017/18 £000	2016/17 £000
Other auditor remuneration paid to the external auditor:		
1. Audit of accounts of any associate of the trust	**0**	0
2. Audit-related assurance services	**0**	0
3. Taxation compliance services	**0**	0
4. All taxation advisory services not falling within item 3 above	**0**	0
5. Internal audit services	**0**	0
6. All assurance services not falling within items 1 to 5	**0**	0
7. Corporate finance transaction services not falling within items 1 to 6 above	**0**	0
8. Other non-audit services not falling within items 2 to 7 above	**9**	13
Total	**9**	13

The £9k reported in note 6.2 relates to the audit of the Trust's quality accounts. As the Trust does not consolidate its charitable funds (see note 1.1.3) the fee for the independent examination of the charitable fund accounts is charged directly to those funds. The total charitable funds income and costs are reported in note 43 as a related party.

Note 6.3 Limitation on auditor's liability	2017/18 £000	2016/17 £000
Limitation on auditor's liability	**2,000**	0

Note 7 Impairment of assets

	2017/18 £000	2016/17 £000
Net impairments charged to operating surplus / deficit resulting from:		
Loss or damage from normal operations	**0**	0
Over specification of assets	**0**	0
Abandonment of assets in course of construction	**0**	0
Unforeseen obsolescence	**0**	0
Loss as a result of catastrophe	**0**	0
Changes in market price	**-14,662**	41,293
Other	**0**	0
Total net impairments charged to operating surplus / deficit	**-14,662**	41,293
Impairments charged to the revaluation reserve	**-434**	24,643
Total net impairments	**-15,096**	65,936

The Trust commissioned its independent professional valuers to undertake an interim desktop valuation as at the 31st January 2018 to support its assessment of year end property valuations. The result of the valuation has been a net increase in property valuations leading to the reversal of previous impairments charged to the Income and Expenditure account. This is reflected in the movement on impairments reported above.

Note 8 Employee benefits

	2017/18 Total £000	2016/17 Total £000
Salaries and wages	**189,751**	189,250
Social security costs	**20,549**	18,526
Apprenticeship levy	**991**	0
Employer's contributions to NHS pensions	**22,979**	22,850
Pension cost - other	**5**	6
Temporary staff (including agency)	**22,857**	23,747
Total gross staff costs	**257,132**	**254,379**
Recoveries in respect of seconded staff	**0**	0
Total staff costs	**257,132**	**254,379**
Of which		
Costs capitalised as part of assets	**1,492**	2,223

Further information on staff benefits by category of staff, exit packages and staff sickness absence is reported in the remuneration and staff section of the Trust annual report.

Note 8.1 Retirements due to ill-health

During 2017/18 there were 4 early retirements from the trust agreed on the grounds of ill-health (7 in the year ended 31 March 2017). The estimated additional pension liabilities of these ill-health retirements is £209k (£413k in 2016/17).

The cost of these ill-health retirements will be borne by the NHS Business Services Authority - Pensions Division.

Note 9 Pension costs

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

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

a) Accounting valuation

A valuation of scheme liability is carried out annually by the scheme actuary (currently the Government Actuary's Department) as at the end of the reporting period. This utilises an actuarial assessment for the previous accounting period in conjunction with updated membership and financial data for the current reporting period, and is accepted as providing suitably robust figures for financial reporting purposes. The valuation of the scheme liability as at 31 March 2018, is based on valuation data as 31 March 2017, updated to 31 March 2018 with summary global member and accounting data. In undertaking this actuarial assessment, the methodology prescribed in IAS 19, relevant FReM interpretations, and the discount rate prescribed by HM Treasury have also been used.

The latest assessment of the liabilities of the scheme is contained in the report of the scheme actuary, which forms part of the annual NHS Pension Scheme Accounts. These accounts can be viewed on the NHS Pensions website and are published annually. Copies can also be obtained from The Stationery Office.

b) Full actuarial (funding) valuation

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

The 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 next actuarial valuation is to be carried out as at 31 March 2016 and is currently being prepared. The direction assumptions are published by HM Treasury which are used to complete the valuation calculations, from which the final valuation report can be signed off by the scheme actuary. This will set the employer contribution rate payable from April 2019 and will consider the cost of the scheme relative to the employer cost cap. There are provisions in the Public Service Pension Act 2013 to adjust member benefits or contribution rates if the cost of the scheme changes by more than 2% of pay. Subject to this 'employer cost cap' assessment, any required revisions to member benefits or contribution rates will be determined by the Secretary of State for Health after consultation with the relevant stakeholders.

The Trust participates in the National Employees Savings Trust (NEST) scheme as an alternative to those employees who are not eligible to join the NHS Pension Scheme. This came into effect in July 2013 for this Trust as part of the auto enrolment requirements introduced by the Government. NEST is a defined contribution scheme with a phased employer contribution rate, set at 1% for 2017/18. Trust contributions under the NEST scheme for the 2017/18 financial year totalled £5k (£6k 2016/17).

Note 10 Operating leases

Note 10.1 Maidstone And Tunbridge Wells NHS Trust as a lessor

This note discloses income generated in operating lease agreements where Maidstone And Tunbridge Wells NHS Trust is the lessor.

The Trust leases an element of land on the Maidstone Hospital site to a day nursery contractor

	2017/18	2016/17
	£000	£000
Operating lease revenue		
Minimum lease receipts	**23**	23
Contingent rent	**0**	0
Other	**0**	0
Total	**23**	**23**

	31 March 2018	31 March 2017
	£000	£000
Future minimum lease receipts due:		
- not later than one year;	**23**	29
- later than one year and not later than five years;	**94**	147
- later than five years.	**141**	206
Total	**258**	**382**

Note 10.2 Maidstone And Tunbridge Wells NHS Trust as a lessee

This note discloses costs and commitments incurred in operating lease arrangements where Maidstone And Tunbridge Wells NHS Trust is the lessee.

The three main operating leases with values charged to operating expenses in year are disclosed below:

Danwood - Lease of photocopiers and printers under a managed service arrangement, £805k (£875k 2016-17). The contract is expected to complete in June 2021.

Ash Corporate Finance - lease of the laundry land, buildings and equipment, £263k (£323k 2016-17). The lease is for a 25 year term and contains a break clause in December 2020.

Roche Diagnostic Limited - lease of equipment to support the pathology and clinical chemistry managed service, £236k (£253k 2016-17). This arrangement completes in May 2020 with an option to extend for up to a further 3 years.

	2017/18	2016/17
	£000	£000
Operating lease expense		
Minimum lease payments	**2,019**	2,104
Contingent rents	**0**	0
Less sublease payments received	**0**	0
Total	**2,019**	**2,104**

	31 March 2018	31 March 2017
	£000	£000
Future minimum lease payments due:		
- not later than one year;	**2,000**	2,112
- later than one year and not later than five years;	**4,257**	8,015
- later than five years.	**1,468**	1,300
Total	**7,725**	**11,427**
Future minimum sublease payments to be received	0	0

Note 11 Finance income

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

	2017/18	2016/17
	£000	£000
Interest on bank accounts	**47**	34
Total	**47**	**34**

Note 12.1 Finance expenditure

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

	2017/18	2016/17
	£000	£000
Interest expense:		
Loans from the Department of Health and Social Care	**1,248**	1,086
Interest on late payment of commercial debt	**14**	8
Main finance costs on PFI and LIFT schemes obligations	**10,657**	10,912
Contingent finance costs on PFI and LIFT scheme obligations	**3,198**	2,635
Total interest expense	**15,117**	**14,641**
Unwinding of discount on provisions	**1**	6
Other finance costs	**0**	0
Total finance costs	**15,118**	**14,647**

Note 12.2 The late payment of commercial debts (interest) Act 1998 / Public Contract Regulations 2015

	2017/18	2016/17
	£000	£000
Total liability accruing in year under this legislation as a result of late payments	**0**	0
Amounts included within interest payable arising from claims made under this legislation	**14**	8
Compensation paid to cover debt recovery costs under this legislation	**0**	0

The Trust made 15 late payment and interest charges totalling £14k .

Note 13 Other gains / (losses)

	2017/18	2016/17
	£000	£000
Gains on disposal of assets	**89**	17
Losses on disposal of assets	**0**	0
Total gains / (losses) on disposal of assets	**89**	17
Gains / (losses) on foreign exchange	**0**	0
Fair value gains / (losses) on investment properties	**0**	0
Fair value gains / (losses) on financial assets / investments	**0**	0
Fair value gains / (losses) on financial liabilities	**0**	0
Recycling gains / (losses) on disposal of available-for-sale financial investments	**0**	0
Total other gains / (losses)	**89**	**17**

Note 14 Discontinued operations

The Trust has no discontinued operations

Note 15.1 Intangible assets - 2017/18

	Software licences £000	Internally generated information technology £000	Total £000
Valuation / gross cost at 1 April 2017 - brought forward	**579**	**7,546**	**8,125**
Transfers by absorption	0	0	**0**
Additions	0	198	**198**
Impairments	0	-3,665	**-3,665**
Reversals of impairments	0	0	**0**
Revaluations	0	0	**0**
Reclassifications	37	3,789	**3,826**
Disposals / derecognition	0	0	**0**
Gross cost at 31 March 2018	**616**	**7,868**	**8,484**
Amortisation at 1 April 2017 - brought forward	**431**	**4,475**	**4,906**
Transfers by absorption	**0**	**0**	**0**
Provided during the year	57	909	**966**
Impairments	**0**	**0**	**0**
Reversals of impairments	**0**	**0**	**0**
Revaluations	**0**	**0**	**0**
Reclassifications	**0**	**0**	**0**
Disposals / derecognition	**0**	**0**	**0**
Amortisation at 31 March 2018	**488**	**5,384**	**5,872**
Net book value at 31 March 2018	**128**	**2,484**	**2,612**
Net book value at 1 April 2017	**148**	**3,071**	**3,219**

Note 15.2 Intangible assets - 2016/17

	Software licences £000	Internally generated information technology £000	Total £000
Valuation / gross cost at 1 April 2016 - as previously stated	**458**	**6,749**	**7,207**
Prior period adjustments	**0**	**0**	**0**
Valuation / gross cost at 1 April 2016 - restated	**458**	**6,749**	**7,207**
Transfers by absorption	0	0	**0**
Additions	121	781	**902**
Reclassifications	0	16	**16**
Valuation / gross cost at 31 March 2017	**579**	**7,546**	**8,125**
Amortisation at 1 April 2016 - as previously stated	**366**	**3,588**	**3,954**
Prior period adjustments	**0**	**0**	**0**
Amortisation at 1 April 2016 - restated	**366**	**3,588**	**3,954**
Transfers by absorption	**0**	**0**	**0**
Provided during the year	**65**	**887**	**952**
Amortisation at 31 March 2017	**431**	**4,475**	**4,906**
Net book value at 31 March 2017	**148**	**3,071**	**3,219**
Net book value at 1 April 2016	**92**	**3,161**	**3,253**

Note 16.1 Property, plant and equipment - 2017/18

	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 2017 - brought forward	**13,496**	**235,321**	**3,480**	**6,184**	**80,952**	**858**	**19,244**	**2,764**	**362,299**
Valuation/gross cost at start of period as FT	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
Transfers by absorption	0	0	0	0	0	0	0	0	**0**
Additions	0	4,612	20	4,630	1,147	0	896	0	**11,305**
Impairments charged to operating expenses	-38	-466	-37	0	0	0	-411	0	**-952**
Impairments charged to the revaluation reserve	-116	-2,362	-187	0	0	0	0	0	**-2,665**
Reversals of impairments credited to operating expenses	0	19,279	0	0	0	0	0	0	**19,279**
Reversals of impairments credited to the revaluation reserve	0	3,092	7	0	0	0	0	0	**3,099**
Revaluations	0	328	0	0	0	0	0	0	**328**
Reclassifications	0	15	0	-6,114	1,918	0	355	0	**-3,826**
Transfers to/ from assets held for sale	0	0	0	0	0	0	0	0	**0**
Disposals / derecognition	0	0	0	0	-127	-14	0	0	**-141**
Transfer to FT upon authorisation	0	0	0	0	0	0	0	0	**0**
Valuation/gross cost at 31 March 2018	**13,342**	**259,819**	**3,283**	**4,700**	**83,890**	**844**	**20,084**	**2,764**	**388,726**
Accumulated depreciation at 1 April 2017 - brought forward	**0**	**2,681**	**295**	**0**	**60,516**	**844**	**16,164**	**1,609**	**82,109**
Provided during the year	**0**	**5,461**	**124**	**0**	**5,580**	**5**	**1,320**	**254**	**12,744**
Disposals / derecognition	0	0	0	0	-127	-14	0	0	**-141**
Accumulated depreciation at 31 March 2018	**0**	**8,142**	**419**	**0**	**65,969**	**835**	**17,484**	**1,863**	**94,712**
Net book value at 31 March 2018	**13,342**	**251,677**	**2,864**	**4,700**	**17,921**	**9**	**2,600**	**901**	**294,014**
Net book value at 1 April 2017	**13,496**	**232,640**	**3,185**	**6,184**	**20,436**	**14**	**3,080**	**1,155**	**280,190**

Note 16.2 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 - as previously stated	**18,275**	**297,231**	**4,085**	**3,016**	**79,024**	**960**	**19,009**	**2,755**	**424,355**
Valuation / gross cost at 1 April 2016 - restated	**18,275**	**297,231**	**4,085**	**3,016**	**79,024**	**960**	**19,009**	**2,755**	**424,355**
Additions	0	2,400	22	3,830	2,066	0	310	9	**8,637**
Impairments charged to operating expenses	0	-41,188	0	0	0	0	-118	0	**-41,306**
Impairments charged to the revaluation reserve	-4,863	-23,329	37	0	0	0	0	0	**-28,155**
Reversals of impairments credited to operating expenses	0	13	0	0	0	0	0	0	**13**
Reversals of impairments credited to the revaluation reserve	0	203	0	0	0	0	0	0	**203**
Revaluations	609	516	36	0	0	0	0	0	**1,161**
Reclassifications	0	0	0	-662	603	0	43	0	**-16**
Transfers to / from assets held for sale	-525	-525	-700	0	0	0	0	0	**-1,750**
Disposals / derecognition	0	0	0	0	-741	-102	0	0	**-843**
Valuation/gross cost at 31 March 2017	**13,496**	**235,321**	**3,480**	**6,184**	**80,952**	**858**	**19,244**	**2,764**	**362,299**
Accumulated depreciation at 1 April 2016 - as previously stated	**0**	**0**	**161**	**0**	**56,941**	**924**	**14,524**	**1,408**	**73,958**
Accumulated depreciation at 1 April 2016 - restated	**0**	**0**	**161**	**0**	**56,941**	**924**	**14,524**	**1,408**	**73,958**
Provided during the year	**0**	**5,993**	**139**	**0**	**4,308**	**22**	**1,640**	**201**	**12,303**
Impairments	0	-3,309	0	0	0	0	0	0	**-3,309**
Transfers to/ from assets held for sale	0	-3	-5	0	0	0	0	0	**-8**
Disposals/ derecognition	0	0	0	0	-733	-102	0	0	**-835**
Accumulated depreciation at 31 March 2017	**0**	**2,681**	**295**	**0**	**60,516**	**844**	**16,164**	**1,609**	**82,109**
Net book value at 31 March 2017	**13,496**	**232,640**	**3,185**	**6,184**	**20,436**	**14**	**3,080**	**1,155**	**280,190**
Net book value at 1 April 2016	**18,275**	**297,231**	**3,924**	**3,016**	**22,083**	**36**	**4,485**	**1,347**	**350,397**

Note 16.3 Property, plant and equipment financing - 2017/18

	Land	Buildings excluding dwellings	Dwellings	Assets under construction	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Net book value at 31 March 2018									
Owned - purchased	13,342	94,280	2,864	4,700	16,558	9	2,590	901	**135,244**
Finance leased	0	0	0	0	0	0	0	0	**0**
On-SoFP PFI contracts and other service concession arrangements	0	157,365	0	0	0	0	0	0	**157,365**
PFI residual interests	0	0	0	0	0	0	0	0	**0**
Owned - government granted	0	0	0	0	0	0	0	0	**0**
Owned - donated	0	32	0	0	1,363	0	10	0	**1,405**
NBV total at 31 March 2018	**13,342**	**251,677**	**2,864**	**4,700**	**17,921**	**9**	**2,600**	**901**	**294,014**

Note 16.4 Property, plant and equipment financing - 2016/17

	Land	Buildings excluding dwellings	Dwellings	Assets under construction	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Net book value at 31 March 2017									
Owned - purchased	13,496	90,619	3,185	6,184	18,830	14	3,065	1,155	**136,548**
Finance leased	0	0	0	0	0	0	0	0	**0**
On-SoFP PFI contracts and other service concession arrangements	0	141,992	0	0	0	0	0	0	**141,992**
PFI residual interests	0	0	0	0	0	0	0	0	**0**
Owned - government granted	0	0	0	0	0	0	0	0	**0**
Owned - donated	0	29	0	0	1,606	0	15	0	**1,650**
NBV total at 31 March 2017	**13,496**	**232,640**	**3,185**	**6,184**	**20,436**	**14**	**3,080**	**1,155**	**280,190**

Note 17 Donations of property, plant and equipment

Within the financial year 2017/18 the Trust purchased medical equipment totalling £159k from Charitable Funds. The three main items purchased were a vascular ultrasound for cardiology at Tunbridge Wells Hospital from the Mollie Hayling Cardiology Legacy for £16k and a portable Echo Machine for Maidstone Cardiology from the David Crow legacy for £67k. The Trust also brought a Ultrasound for Oncology for £49k.

The Tunbridge Wells League of Friends have purchased a Fetal Monitor and Resuscitaire for the Maternity department and they have also bought a bladder scanner for ward 10 in total was £20k. The Maidstone League of Friends at Maidstone have purchased a bladder scanner for MSSU for £7k.

Note 18 Revaluations of property, plant and equipment

The Trust spent £11.5m on tangible assets from its capital resource in 2017/18. The main items were a £2.3m linear accelerator machine, with £1.7m being funded from central PDC, £4.7m of backlog estates and renewal schemes, £2.3m on information Technology projects, and £1.8m on medical and other equipment. In addition £371k of lifecycle capital was recognised as undertaken by the Trust's PFI partner in the year and accounted for under IFRIC 12.

The Trust's depreciation on tangible assets in the year was £12.7m and for intangible assets it was £1m.

The financial year 2017/18 is the third year in the current five year cyclical valuation period. A full valuation was undertaken in September 2014 with desktop valuations at 31st March 2015, 31st March 2016 and 30th September 2016. In keeping with the Trust's policies the Trust commissioned professional valuers, Montagu Evans LLP, to carry out a desktop valuation of the Trust's Land, Building and Dwelling assets at 31st January 2018 with an assessment of materiality conducted for 31st March 2018. Following the assessment the BCIS movement is immaterial therefore the values at year end are based on the valuation of 31st January 2018.

Specialist properties (main hospitals) have been valued on Depreciation Replacement Cost (DRC) using the modern Equivalent Assets (MEA) valuation concept. Non specialised buildings and land have been valued on an Existing Use Value (EUV) basis and key worker accommodation has been valued on an EUV - Social Housing basis in line with RICS guidelines, and taking account the Trust's previous approach to the application of MEA e.g. the PFI property valued excluding recoverable VAT.

The 31st January 2018 valuation resulted in an overall increase in the carrying value of the Trust's Land and Property assets of £19.5m, of which £18.7m reversed previous I&E impairments reflected in operating expenses and £0.4m reversed previous revaluation reserve entries. The increase was driven by a rise in component BCIS indices with specific areas such as wards increasing significantly.

The Valuers considered the remaining useful economic lives of the Property assets taking into account work undertaken between valuations, and the age and condition of the properties.

For intangible asset classes there is no active market for specialised software / licences. The DH Manual prescribes that in such cases where there is no active market and the asset is not income generating, the asset should be carried at depreciated replacement cost. For the purposes of arriving at fair value, this asset class is held at depreciated historic cost as a reasonable proxy to fair value. The Trust recognises intangible assets initially at cost and then reviews subsequently their measurements at current value in existing use to identify if any impairments arisen.

Fixtures and equipment are carried at depreciated historic cost as this is not considered to be materially different from fair value. The Trust has reviewed its plant and machinery assets to ensure that both the value and the remaining lives are held at the correct values. A fair value assessment of IT tangible assets has been carried out based on a valuation model as advised by Trust experts, this is in accordance with the Trust's policy 1.6.2.

Note 19.1 Investment Property

The Trust has no investment properties

Note 20 Investments in associates and joint ventures

The Trust has no investments in associates or joint ventures

Note 21 Other investments / financial assets (non-current)

The Trust have no other investments

Note 22 Disclosure of interests in other entities

The Trust have no interests in other entities

Note 23 Inventories

	31 March 2018 £000	31 March 2017 £000
Drugs	**2,952**	3,336
Work In progress	**0**	0
Consumables	**1,053**	888
Energy	**153**	114
Other	**3,594**	3,607
Total inventories	**7,752**	**7,945**
of which:		
Held at fair value less costs to sell	**0**	0

Additions of inventories recognised in expenses for the year were £53,044k (2016/17 £53,864k). Write-down of inventories recognised as expenses for the year were £0k (2016/17 £0k).

Note 24.1 Trade receivables and other receivables

	31 March 2018 £000	31 March 2017 £000
Current		
Trade receivables	**14,439**	38,147 *
Capital receivables (including accrued capital related income)	**107**	107
Accrued income	**16,583**	1,045 *
Provision for impaired receivables	**-1,365**	-797
Deposits and advances	**0**	0
Prepayments (non-PFI)	**3,289**	3,685 *
PDC dividend receivable	**216**	683
VAT receivable	**2,543**	2,068
Other receivables	**1,642**	1,481
Total current trade and other receivables	**37,454**	**46,419**
Non-current		
Prepayments (non-PFI)	**439**	308
PFI prepayments - capital contributions	**193**	158
Other receivables	**569**	1,030
Total non-current trade and other receivables	**1,201**	**1,496**
Of which receivables from NHS and DHSC group bodies:		
Current	**27,897**	35,961
Non-current	**0**	0

The great majority of trade is with Clinical Commissioning Groups (CCGs) as commissioners for NHS patient care services. As CCGs are funded by Government to buy NHS patient care services, no credit scoring of them is considered necessary. A provision for the impairment of trade receivables is made for debts over 120 days.

* prior year comparators have been reclassified in line with the 2017/18 disclosures

Note 24.2 Provision for impairment of receivables

	2017/18	2016/17
	£000	£000
At 1 April as previously stated	**-797**	**-1,273**
Prior period adjustments	**0**	0
At 1 April - restated	**-797**	**-1,273**
Transfers by absorption	**0**	0
Increase in provision	**-1,220**	421
Amounts utilised	**163**	55
Unused amounts reversed	**489**	0
At 31 March	**-1,365**	**-797**

The provision of receivables includes provision for all non-NHS invoices over 120 days overdue plus any other invoices that are deemed to be a specific risk. In addition injury cost recovery debt is provided for in accordance with the approach set out in note 3.2

Note 24.3 Credit quality of financial assets

	31 March 2018	31 March 2017
	Trade and other receivables	Trade and other receivables
Ageing of impaired financial assets	£000	£000
0 - 30 days	**13**	31
30-60 Days	**23**	29
60-90 days	**92**	60
90- 180 days	**362**	122
Over 180 days	**875**	555
Total	**1,365**	**797**
Ageing of non-impaired financial assets past their due date		
0 - 30 days	**0**	0
30-60 Days	**1,888**	2,552
60-90 days	**1,295**	2,650
90- 180 days	**1,078**	1,855
Over 180 days	**2,311**	926
Total	**6,572**	**7,983**

The provision of impaired receivables includes provisions for all non-NHS invoices over 120 days overdue plus any other invoices that are deemed to be a specific risk. This includes provisions for impaired injury cost recovery debt.

Non-impaired financial assets over 120 days relates to debt to other NHS bodies, the Trust does not provide for this debt category.

Note 25 Other assets
The Trust has no other assets

Note 26 Non-current assets held for sale and assets in disposal groups

	2017/18 £000	2016/17 £000
NBV of non-current assets for sale and assets in disposal groups at 1 April	**1,742**	0
Prior period adjustment		0
NBV of non-current assets for sale and assets in disposal groups at 1 April - restated	**1,742**	0
Transfers by absorption	**0**	0
Assets classified as available for sale in the year	**0**	1,742
Assets sold in year	**-1,742**	0
Impairment of assets held for sale	**0**	0
Reversal of impairment of assets held for sale	**0**	0
Assets no longer classified as held for sale, for reasons other than disposal by sale	**0**	0
NBV of non-current assets for sale and assets in disposal groups at 31 March	**0**	**1,742**

The Trust Board approved the disposal of two residential properties at Pembury in December 2016; the Spring and Hillcroft. These were previously held at fair value as assets surplus to use with no plan to bring back into use. The assets were immediately available for sale, there was a clear plan for disposal (the assets were duly registered on the public sector notification site) and expectation of sale within a year. Therefore the assets were reclassified from non current assets to assets held for sale.

The Hillcroft property was sold and proceeds were received in September 2017. The Spring property was sold and proceeds received in January.

Note 26.1 Liabilities in disposal groups

The Trust has no liabilities in disposal groups

Note 27.1 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	2016/17
	£000	£000
At 1 April	**1,420**	**1,197**
Prior period adjustments	**0**	0
At 1 April (restated)	**1,420**	**1,197**
Transfers by absorption	**0**	0
Net change in year	**53**	223
At 31 March	**1,473**	**1,420**
Broken down into:		
Cash at commercial banks and in hand	**67**	54
Cash with the Government Banking Service	**1,406**	1,366
Deposits with the National Loan Fund	**0**	0
Other current investments	**0**	0
Total cash and cash equivalents as in SoFP	**1,473**	**1,420**
Bank overdrafts (GBS and commercial banks)	**0**	0
Drawdown in committed facility	**0**	0
Total cash and cash equivalents as in SoCF	**1,473**	**1,420**

Note 27.2 Third party assets held by the trust

The Trust held cash and cash equivalents which relate to monies held by the Trust on behalf of patients or other parties. This has been excluded from the cash and cash equivalents figure reported in the accounts.

	31 March 2018	31 March 2017
	£000	£000
Bank balances	**1**	1
Monies on deposit	**0**	0
Total third party assets	**1**	**1**

Note 28.1 Trade and other payables

	31 March 2018 £000	31 March 2017 £000
Current		
Trade payables	**21,144**	28,027
Capital payables	**2,628**	3,410
Accruals	**12,994**	12,247
Receipts in advance (including payments on account)	**0**	0
Social security costs	**2,801**	2,751
VAT payables	**0**	0
Other taxes payable	**2,429**	2,409
PDC dividend payable	**0**	0
Accrued interest on loans	**111**	105
Other payables	**1,786**	1,405
Total current trade and other payables	**43,893**	**50,354**

* Deferred income is now in Note 30, was previously in Trade and other payables note

Non-current

The Trust does not have any non-current liabilities

Of which payables from NHS and DHSC group bodies:		
Current	**8,767**	4,455
Non-current	**0**	0

Note 28.2 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 2018 Number	31 March 2017 £000	31 March 2017 Number
- to buy out the liability for early retirements over 5 years	**0**		0	
- number of cases involved		**0**		0
- outstanding pension contributions	**3,191**		3,159	

Note 29 Other financial liabilities

The Trust has no other financial liabilities

Note 30 Other liabilities

	31 March 2018 £000	31 March 2017 £000
Current		
Deferred income	**2,620**	5,745
Deferred grants	**0**	0
PFI deferred income / credits	**0**	0
Lease incentives	**0**	0
Total other current liabilities	**2,620**	**5,745**

Non-current

The Trust does not have any non-current liabilities

Note 31 Borrowings

	31 March 2018 £000	31 March 2017 £000
Current		
Bank overdrafts	**0**	0
Drawdown in committed facility	**0**	0
Loans from the Department of Health and Social Care	**19,082**	4,632
Other loans	**103**	0
Obligations under finance leases	**0**	0
PFI lifecycle replacement received in advance	**0**	0
Obligations under PFI, LIFT or other service concession contracts (excl. lifecycle)	**5,284**	5,028
Total current borrowings	**24,469**	**9,660**
Non-current		
Loans from the Department of Health and Social Care	**36,276**	41,368
Other loans	**636**	0
Obligations under finance leases	**0**	0
PFI lifecycle replacement received in advance	**0**	0
Obligations under PFI, LIFT or other service concession contracts	**192,948**	198,233
Total non-current borrowings	**229,860**	**239,601**

Department of Health (DoH) loans totalling £29m have been taken out to finance the Trust capital programme. The £11m loan received on the 15th March 2010 has a final repayment date of 15th March 2025, with a fixed interest rate of 3.91%. The loan of £12m taken out on the 15th September 2010 has a final repayment date of 15th September 2020 with a fixed interest rate of 2.02%. The loan of £6m taken out on the 15th December 2010 has a final repayment date of 15th September 2035 at a fixed rate of 4.73%

Included within the £19.1m Loans from the Department of Health and Social Care is £16.9m single currency loan which was previously classed as non current. This loan is to be repaid in February 2019 and has a fixed interest rate of 1.5%.

Within the £36.3m loans from DoH is an interim revolving capital loan of £12.132m which is repayable in 2019/20 and has a fixed interest rate of 3.5%. The remaining balance within the DoH loans is a combination of 3 working capital loans totalling £13.99m which were taken out in 2017/18. These loans are repayable in 2020/21 and have a fixed interest rate of 3.5%

The Trust also took out a Salix loan of £739k which appears in "other loans" in both current and non current borrowings, this relates to improving the energy efficiency of the Trust. This loan is repayable over 5 years and is interest free. Salix Finance Ltd provides interest-free Government funding to the public sector to improve their energy efficiency, reduce carbon emissions and lower energy bills. Salix is funded by the Department for Business, Energy and Industrial Strategy, the Department for Education, the Welsh Government and the Scottish Government and was established in 2004 as an independent, publicly funded company, dedicated to providing the public sector with loans for energy efficiency projects.

Note 32 Finance leases

The Trust does not have any finance leases

Note 33.1 Provisions for liabilities and charges analysis

	Pensions - early departure costs	Legal claims	Re-structuring	Continuing care	Equal Pay (including Agenda for Change)	Redundancy	Other	Total
	£000	£000	£000	£000	£000	£000	£000	£000
At 1 April 2017	**443**	**413**	**0**	**0**	**0**	**0**	**2,148**	**3,004 ***
Transfers by absorption	0	0	0	0	0	0	0	**0**
Change in the discount rate	7	0	0	0	0	0	0	**7**
Arising during the year	26	261	0	0	0	0	0	**287**
Utilised during the year	-23	-57	0	0	0	0	-164	**-244**
Reclassified to liabilities held in disposal groups	0	0	0	0	0	0	0	**0**
Reversed unused	0	-206	0	0	0	0	0	**-206**
Unwinding of discount	1	0	0	0	0	0	0	**1**
At 31 March 2018	**454**	**411**	**0**	**0**	**0**	**0**	**1,984**	**2,849**
Expected timing of cash flows:								
- not later than one year;	23	411	0	0	0	0	1,309	**1,743**
- later than one year and not later than five years;	92	0	0	0	0	0	675	**767**
- later than five years.	339	0	0	0	0	0	0	**339**
Total	**454**	**411**	**0**	**0**	**0**	**0**	**1,984**	**2,849**

Pension early departure costs relate to two ill health injury benefits calculated by current payment made by NHS Pensions Agency adjusted for average life expectancy using tables published by the National Statistics Office. Legal claims include estimates notified by NHS Resolution.

*Prior year amendment between "Pensions early departure" category and "other" of £17k, no change to the overall balance

Other includes the provision for dilapidations of leased properties/equipment £1.8m and onerous contract provision £0.2k

Note 33.2 Clinical negligence liabilities

At 31 March 2018, £209,175k was included in provisions of NHS Resolution in respect of clinical negligence liabilities of Maidstone And Tunbridge Wells NHS Trust (31 March 2017: £164,886k).

Note 34 Contingent assets and liabilities

	31 March 2018 £000	31 March 2017 £000
Value of contingent liabilities		
NHS Resolution legal claims	**-47**	-57
Employment tribunal and other employee related litigation	**0**	0
Redundancy	**0**	0
Other	**0**	0
Gross value of contingent liabilities	**-47**	**-57**
Amounts recoverable against liabilities	**0**	0
Net value of contingent liabilities	**-47**	**-57**
Net value of contingent assets	**0**	0

Contingent liability relates to legal claims notified by NHS Resolution of £47k

Note 35 Contractual capital commitments

	31 March 2018 £000	31 March 2017 £000
Property, plant and equipment	**428**	710
Intangible assets	**0**	0
Total	**428**	**710**

Note 36 Other financial commitments

The Trust is committed to making payments under non-cancellable contracts (which are not leases, PFI contracts or other service concession arrangement), analysed by the period during which the payment is made:

	31 March 2018 £000	31 March 2017 £000
not later than 1 year	**0**	0
after 1 year and not later than 5 years	**0**	0
paid thereafter	**0**	0
Total	**0**	**0**

Note 37 Defined benefit pension schemes

The Trust does not have any defined benefit schemes

Note 38 On-SoFP PFI, LIFT or other service concession arrangements

The Trust signed a PFI project agreement on 26th March 2008 for the new Tunbridge Wells Hospital at Pembury. The main building was handed over by the contractor in phases in December 2010 and May 2011 and recognised in the Trust's accounts accordingly. By joint agreement with the Trust's PFI partner the final phase of car parking & landscaping were completed and handed over early in January 2012, although contractual phasing and unitary payments were kept in line with the project agreement completion date of September 2012. The arrangement covers the provision of buildings, hard facilities management services and lifecycle replacement (building & engineering asset renewals). Under the project agreement the Trust has agreed expectations for the provision of these services and has termination options on default. The land remains the Trust's asset throughout the concession. The concession is due to run for 30 years until 2042 when the building will revert to the Trust. The annual unitary payment was contracted at £16.9m at 2005/06 prices, and is subject to an annual uplift by Retail Price Index which for the 2017/18 year was 3.23%. The RPI uplift for 2018/19 is 3.61%.

Note 38.1 Imputed finance lease obligations

Maidstone And Tunbridge Wells NHS Trust has the following obligations in respect of the finance lease element of on-Statement of Financial Position PFI and LIFT schemes:

	31 March 2018 £000	31 March 2017 £000
Gross PFI, LIFT or other service concession liabilities	**352,387**	**368,073**
Of which liabilities are due		
- not later than one year;	**15,673**	15,686
- later than one year and not later than five years;	**60,582**	61,316
- later than five years.	**276,132**	291,071
Finance charges allocated to future periods	**-154,155**	-164,812
Net PFI, LIFT or other service concession arrangement obligation	**198,232**	**203,261**
- not later than one year;	**5,284**	5,028
- later than one year and not later than five years;	**21,865**	21,462
- later than five years.	**171,083**	176,771

Note 38.2 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	**823,081**	846,969
Of which liabilities are due:		
- not later than one year;	**24,752**	23,888
- later than one year and not later than five years;	**105,352**	102,782
- later than five years.	**692,977**	720,299

Note 38.3 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	**23,888**	23,142
Consisting of:		
- Interest charge	**10,657**	10,912
- Repayment of finance lease liability	**5,028**	4,774
- Service element and other charges to operating expenditure	**4,503**	4,268
- Capital lifecycle maintenance	**371**	247
- Revenue lifecycle maintenance	**0**	0
- Contingent rent	**3,198**	2,635
- Addition to lifecycle prepayment	**131**	306
Other amounts paid to operator due to a commitment under the service concession contract but not part of the unitary payment	**230**	169
Total amount paid to service concession operator	**24,118**	**23,311**

Note 39 Off-SoFP PFI, LIFT and other service concession arrangements

Maidstone And Tunbridge Wells NHS Trust incurred the following charges in respect of off-Statement of Financial Position PFI and LIFT obligations:

	31 March 2018 £000	31 March 2017 £000
Charge in respect of the off SoFP PFI, LIFT or other service concession arrangement for the period	**0**	0
Commitments in respect of off-SoFP PFI, LIFT or other service concession arrangements:		
- not later than one year;	**0**	0
- later than one year and not later than five years;	**0**	0
- later than five years.	**0**	0
Total	**0**	**0**

Note 40 Financial instruments

Note 40.1 Financial risk management

Financial reporting standard IFRS 7 requires disclosure of the role that financial instruments have had during the period in creating or changing the risks a body faces in undertaking its activities. Because of the continuing service provider relationship that the NHS Trust has with commissioners and the way those commissioners are financed, the NHS Trust is not exposed to the degree of financial risk faced by business entities. Also financial instruments play a much more limited role in creating or changing risk than would be typical of listed companies, to which the financial reporting standards mainly apply. The NHS Trust has limited powers to borrow or invest surplus funds and financial assets and liabilities are generated by day-to-day operational activities rather than being held to change the risks facing the NHS Trust in undertaking its activities.

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 NHS Improvement. 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.

The Trust may also borrow from government for revenue financing subject to approval by NHS Improvement. Interest rates are confirmed by the Department of Health (the lender) at the point borrowing is undertaken.

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 primary care Trusts, 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.

Note 40.2 Carrying values of financial assets

	Loans and receivables	Assets at fair value through the I&E	Held to maturity at	Available-for-sale	Total book value
	£000	£000	£000	£000	£000
Assets as per SoFP as at 31 March 2018					
Embedded derivatives	0	0	0	0	**0**
Trade and other receivables excluding non financial assets - with NHS and DH bodies	27,363	0	0	0	**27,363**
Trade and other receivables excluding non financial assets - with other bodies	4,832	0	0	0	**4,832**
Other investments / financial assets	0	0	0	0	**0**
Cash and cash equivalents at bank and in hand	1,473	0	0	0	**1,473**
Total at 31 March 2018	**33,668**	**0**	**0**	**0**	**33,668**

	Loans and receivables	Assets at fair value through the I&E	Held to maturity	Available-for-sale	Total book value
	£000	£000	£000	£000	£000
Assets as per SoFP as at 31 March 2017					
Embedded derivatives	0	0	0	0	**0**
Trade and other receivables excluding non financial assets - with NHS and DH bodies	35,278	0	0	0	**35,278**
Trade and other receivables excluding non financial assets - with other bodies	6,400	0	0	0	**6,400**
Other investments / financial assets	0	0	0	0	**0**
Cash and cash equivalents at bank and in hand	1,420	0	0	0	**1,420**
Total at 31 March 2017	**43,098**	**0**	**0**	**0**	**43,098**

Note 40.3 Carrying value of financial liabilities

	Other financial liabilities	Liabilities at fair value through the I&E	Total book value
	£000	£000	£000
Liabilities as per SoFP as at 31 March 2018			
Embedded derivatives	0	0	**0**
Borrowings excluding finance lease and PFI liabilities	56,097	0	**56,097**
Obligations under finance leases	0	0	**0**
Obligations under PFI, LIFT and other service concession contracts	198,232	0	**198,232**
Trade and other payables excluding non financial liabilities - with NHS and DH bodies	2,383	0	**2,383**
Trade and other payables excluding non financial liabilities - with other bodies	28,397	0	**28,397**
Other financial liabilities	0	0	**0**
Provisions under contract	0	0	**0**
Total at 31 March 2018	**285,109**	**0**	**285,109**

	Other financial liabilities	Liabilities at fair value through the I&E	Total book value
	£000	£000	£000
Liabilities as per SoFP as at 31 March 2017			
Embedded derivatives	0	0	**0**
Borrowings excluding finance lease and PFI liabilities	46,000	0	**46,000**
Obligations under finance leases	0	0	**0**
Obligations under PFI, LIFT and other service concession contracts	203,261	0	**203,261**
Trade and other payables excluding non financial liabilities - with NHS and DH bodies	4,455	0	**4,455**
Trade and other payables excluding non financial liabilities - with other bodies	40,334	0	**40,334**
Other financial liabilities	0	0	**0**
Provisions under contract	0	0	**0**
Total at 31 March 2017	**294,050**	**0**	**294,050**

Note 40.4 Fair values of financial assets and liabilities

The Trust uses the book value (carrying value) as a reasonable approximation of fair value

Note 40.5 Maturity of financial liabilities

	31 March 2018	31 March 2017
	£000	£000
In one year or less	55,249	51,991
In more than one year but not more than two years	19,880	9,916
In more than two years but not more than five years	34,394	50,914
In more than five years	175,586	181,229
Total	**285,109**	**294,050**

Note 41 Losses and special payments

	2017/18		2016/17	
	Total number of cases	**Total value of cases**	**Total number of cases**	**Total value of cases**
	Number	**£000**	**Number**	**£000**
Losses				
Cash losses	**35**	**35**	40	45
Fruitless payments	**0**	**0**	0	0
Bad debts and claims abandoned	**11**	**32**	5	2
Stores losses and damage to property	**17**	**2**	9	0
Total losses	**63**	**69**	**54**	**47**
Special payments				
Compensation under court order or legally binding arbitration award	**0**	**0**	0	0
Extra-contractual payments	**0**	**0**	0	0
Ex-gratia payments	**32**	**11**	40	27
Special severance payments	**0**	**0**	0	0
Extra-statutory and extra-regulatory payments	**0**	**0**	0	0
Total special payments	**32**	**11**	**40**	**27**
Total losses and special payments	**95**	**80**	**94**	**74**
Compensation payments received		**0**		0

The Trust has had no cases exceeding £300k

Note 42 Gifts

	2017/18		2016/17	
	Total number of cases	**Total value of cases**	**Total number of cases**	**Total value of cases**
	Number	**£000**	**Number**	**£000**
Total gifts	**0**	**0**	0	0

Note 43 Related parties

During the year none of the Department of Health and Social Care Ministers, Trust Board members or members of the key management staff, or parties related to any of them, have undertaken and material transactions with Maidstone and Tunbridge Wells NHS Trust.

The Department of Health and Social Care is regarded as a related party. During the year 2017/18 the Trust has received £13.99m working capital financing and £2.36m capital funding in the form of Public Dividend Capital. The Trust also has loans with DH, interest paid within the year £1.2m, principal repayment of £2.4m and the balance outstanding for the working capital loans is £43m. The Trust has also had a significant number of material transactions with the Department, and with other entities for which the Department is regarded as the parent department. The following entities with material transactions of more than £1m are listed below:

Ashford CCG
Medway CCG
West Kent CCG
High Weald Lewes Havens CCG
Dartford, Gravesham and Swanley CCG
Swale CCG
Hastings and Rother CCG
South Kent Coast CCG
Canterbury and Coastal CCG
Wessex Specialised Commissioning Hub
South East Specialised Commissioning Hub
Kent Community Foundation Trust
East Kent University Hospitals Foundation Trust
Medway NHS Foundation Trust
King's College Hospital NHS Foundation Trust
NHS England - South East Specialised Commissioning Hub
NHS England - South East Local Office
NHS England - Core
Dartford and Gravesham NHS Trust
Health Education England
HMRC
NHS Pension Authority
NHS Resolution
NHS Supply Chain
Kent County Council
NHS Blood and Transplant
Maidstone Borough Council
Tunbridge Wells Borough Council

The Trust has also received revenue and capital payments from the Charitable Funds that it controls, the trustees for which are also members of the Trust Board. The Trust has not consolidated the Charitable Funds on the grounds of materiality to the Trust (see policy notes 1.1.3). The transactions between the Trust and the Charity (Maidstone and Tunbridge Wells NHS Charitable Fund - charity registration number 1055215) are however material to the charity and therefore are disclosed below. Please note that this disclosure is based on the draft unaudited position of the charity. The audited accounts of the charity will be available later this year.

	2017-18	**2016-17**
	£000s	**£000s**
Total charitable resources expended with the Trust	**267**	866
Closing creditor (monies owed to the Trust by the Charity)	**0**	477
Closing debtor (monies owed to the Charity by the Trust)	**43**	0
Total income received by the Charity in the reporting period	**208**	291
Total Charitable Funds at end of the reporting period	**1,129**	**1,151**

Note 44 Transfers by absorption
The Trust has no transfers by absorption

Note 45 Prior period adjustments
The Trust has no prior period adjustments

Note 46 Events after the reporting date
The Trust has no events after the reporting period to report

Note 47 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	**124,829**	**199,536**	103,549	175,490
Total non-NHS trade invoices paid within target	**37,856**	**88,464**	59,344	105,628
Percentage of non-NHS trade invoices paid within target	**30.33%**	**44.33%**	57.31%	60.19%
NHS Payables				
Total NHS trade invoices paid in the year	**3,077**	**31,872**	2,775	32,678
Total NHS trade invoices paid within target	**446**	**22,661**	990	21,653
Percentage of NHS trade invoices paid within target	**14.49%**	**71.10%**	35.68%	66.26%

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.

Note 48 External financing

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

	2017/18 £000	2016/17 £000
Cash flow financing	**7,379**	9,121
Finance leases taken out in year	**0**	0
Other capital receipts	**0**	0
External financing requirement	**7,379**	9,121
External financing limit (EFL)	**7,852**	9,541
Under / (over) spend against EFL	**473**	420

Note 49 Capital Resource Limit

	2017/18 £000	2016/17 £000
Gross capital expenditure	**11,503**	9,539
Less: Disposals	**-1,742**	-8
Less: Donated and granted capital additions	**-159**	-362
Plus: Loss on disposal of donated/granted assets	**0**	0
Charge against Capital Resource Limit	**9,602**	9,169
Capital Resource Limit	**10,580**	12,529
Under / (over) spend against CRL	**978**	3,360

The Trust underspent its capital resource as part of its financial recovery plan

Note 50 Breakeven duty financial performance

	2017/18 £000
Adjusted financial performance surplus / (deficit) (control total basis)	**-10,924**
Remove impairments scoring to Departmental Expenditure Limit	**0**
Add back income for impact of 2016/17 post-accounts STF reallocation	**0**
Add back non-cash element of On-SoFP pension scheme charges	**0**
Remove CQUIN risk reserve adjustment	**134**
IFRIC 12 breakeven adjustment	**0**
Breakeven duty financial performance surplus / (deficit)	**-10,790**

The breakeven duty performance reports I&E including STF payments

There is no adjustment for the PFI (IFRIC12) accounting as the On-balance sheet impacts to I&E are currently lower than the equivalent Off-Balance sheet reporting

The in year deficit was driven by slippage on the cost improvement programme (£9.2m) and reduction in Private Patient Income (£3.5m)

Note 51 Breakeven duty rolling assessment

	2008/09	2009/10	2010/11	2011/12	2012/13	2013/14	2014/15	2015/16	2016/17	2017/18
		£000	£000	£000	£000	£000	£000	£000	£000	£000
Breakeven duty in-year financial performance		189	1,710	300	129	-12,374	157	-23,413	-10,918	-10,790
Breakeven duty cumulative position	-3,260	-3,071	-1,361	-1,061	-932	-13,306	-13,149	-36,562	-47,480	-58,270
Operating income		311,889	322,176	345,101	367,391	375,714	403,310	400,930	430,502	440,269
Cumulative breakeven position as a percentage of operating income		-0.98%	-0.42%	-0.31%	-0.25%	-3.54%	-3.26%	-9.12%	-11.03%	-13.24%

The Trusts latest 3 year break-even cycle commenced in 2013/14 and was not met by the end of the period in 2015/16. The Trust's breakeven period has therefore been extended with the plans submitted for 2018/19 aimed at returning the Trust to in year breakeven and reducing the accumulated deficit towards the target of formal cumulative break-even by 2021/22.

The Trust's cumulative deficit position has arisen from a number of factors including high levels of non elective admissions and delayed discharges requiring escalation of emergency capacity, and a consequent reduction the Trust's capacity to manage its elective demand within its capacity, reducing elective income and necessitating private sector usage; reliance on temporary staffing and high levels of agency increasing the cost base; significant cost pressures from clinical negligence premia.

The Trust entered into Financial Special Measures in July 2016 and has worked with a Finance Improvement Director and NHSI to agree a financial recovery plan that is reducing the Trust's underlying deficit position. The Trust continues to be supported by NHSI with regular monitoring meetings.

The Trust has managed its capital and cash positions to ensure it requires the minimum level of working capital finance to sustain operational liquidity. Its plans for 2018/19 aim to manage within its own resources and to repay the first of its existing working capital loans to fall due in February 2019.