NHS
Maidstone and Tunbridge Wells
NHS Trust

Annual Report and Accounts 2018/19

taking pride

Patient First – Respect – Innovation – Delivery – Excellence

MTW
exceptional people, outstanding care

About this Annual Report

The National Health Service and Community Care Act 1990 requires NHS Trusts to produce an Annual Report. Its content and format must 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 2018/19 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

Beyond the minimum content required by the Department of Health and Social Care (DHSC), the Trust is expected to include additional information to reflect the position of the Trust within the community and meet the requirements of public accountability. The Report is divided into the following sections:

- "Performance Report for 2018/19", which is split into:
  - An overview. This includes an overview summary; the purpose and activities of the Trust; the Chair and Chief Executive's report; a 'snapshot of the year'; key developments; 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 2018/19; and a review of financial performance for 2018/19
  - A summary of the Trust's Quality Accounts for 2018/19
  - A Sustainability Report. This follows the standard reporting format from the NHS Sustainable Development Unit.
- "Accountability Report for 2018/19", which is divided into the following sections:
  - "Corporate Governance Report for 2018/19", which includes:
    - A Directors' report (providing details about the Trust Board; a Statement as to disclosure to Auditors; attendance at Trust Board meetings; 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 2018/19"
  - "Remuneration and Staff Report for 2018/19" (including details of 'off-payroll' engagements)
- "Financial Statements for 2018/19", including details of 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 23rd May 2019.

[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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Performance Report for 2018/19: Overview

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Summary

This overview aims to equip the reader with a broad understanding of the Trust, its purpose, the key risks to the achievement of its objectives, and an outline of its performance during 2018/19. For those wishing to read in more detail about the Trust's achievements, the issues it faced and its 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 560,000 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 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, 182,000 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 offers 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 (CQC) 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)

[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)

- Surgical procedures (at Maidstone and Tunbridge Wells Hospitals)
- 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.

Partnerships

The Trust's Strategy, updated in October 2017, reflects the NHS Five Year Forward View and is aligned to local plans in the wider health & social care economy and the NHS Long Term Plan published in early 2019. The Trust works closely with the Kent and Medway Sustainability and Transformation Partnership (STP) and currently hosts the majority of STP financial transactions. The continued terms of this hosting were formally approved by the Trust Board in June 2018. The key risks to both parties in the relationship have been assessed and the arrangement is subject to 6-monthly reviews. The Trust's Chief Executive sits on the STP Programme Board & the Trust's Chair is a member of the Non-Executive Director Oversight Group for the STP.

The Trust continued into the second year of the Aligned Incentives Contract with West Kent Clinical Commissioning Group (CCG) for the 2018/19 financial year. The contract 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.

The Trust is part of the West Kent Alliance, a collaborative partnership that commissions or delivers care and support services in West Kent. The Alliance aims to ensure that patients are being seen by the right person, in the right setting, at the right time, thereby reducing unwarranted variation, duplication, gaps and system wide costs and ensuring provision of a safe, clinically and financially sustainable service for patients/users and further strengthening of a high quality workforce.

The West Kent Alliance consists of:

- West Kent CCG
- Maidstone and Tunbridge Wells NHS Trust
- Kent Community Health NHS Foundation Trust
- Kent and Medway NHS and Social Care Partnership Trust
- West Kent Health Ltd
- Sussex and East Surrey CCG.

The launch of the Hospital@Home initiative in 2018, in partnership with Kent Community Health NHS Foundation Trust, and continued roll out of Home First which relies on close working between the Trust, Kent Community Health NHS Foundation Trust and Kent County Council are examples of how the Trust worked together during the year with primary care, community health & mental health partners for the future.

The Trust's objectives and organisational structure are detailed elsewhere within this Annual Report. 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

The twelve month period during which the NHS celebrated its 70th anniversary presented another challenging year for the Trust and the NHS alike. This in itself makes the significant successes delivered by the Trust in 2018/19 all the more meaningful.

The most notable of these successes saw: implementation of a range of quality, patient-centred improvements that resulted in substantial progress in how we care for and treat our patients; meeting of the national standard for Emergency Department performance for March 2019 (the first time we've achieved this for a whole month in five years); and achievement of our financial plan and delivery of our control total for the year, realising a surplus of £20.3m, post Provider Sustainability Funding (PSF), which was £8.6m better than plan.

As a result of patient-focussed improvements delivered during the year:

- Patients are being seen quicker when they attend our Emergency Departments (EDs)
- If a patient needs to be admitted, a bed in the right place is available
- Patients being referred into the Cancer pathway are now better able to access testing and diagnosis as a result of increased capacity.
- More patients waiting for planned care are being seen and treated more quickly
- Patient safety and experience indicators, such as patient falls and complaints, are improving across the Trust.

The role of our staff in delivering these advances cannot be overemphasized. In 2018/19, staff across the Trust consistently demonstrated their willingness to go over and above to ensure that good quality patient care is at the heart of all that we do. The depth and breadth of the quality improvement schemes and financial efficiencies identified by our staff have been pivotal to realisation of our plan - whether it's been a large scale project to improve the care we give our patients, or small tweaks by a department to reduce wastage, everything has added up to put us into financial surplus. This demonstrates that, through our transition to becoming a more clinically-led organisation and our commitment to the principles of "Best Care", staff are being empowered to make the changes they want to see and are in turn, reaping rewards for the Trust. In the year ahead development of our 'Exceptional People, Outstanding Care' programme will help to reinforce and sustain a culture of continuous improvement across the Trust.

The significance to the Trust and our wider community of the announcement by NHS Improvement (NHSI) in October that the Trust was no longer in Financial Special Measures is difficult to overestimate. Achieving this landmark is another essential step in our plans to respond to the findings of the CQC inspection in 2017/18 and become an Outstanding NHS Trust. We continue to work closely with national improvement teams, and some of the most outstanding NHS trusts in the country, to emulate their successes and build on our own achievements to improve our patient experience. Our position going into the year ahead gives us a real opportunity to grow some of our services and build on our good work and continue to identify patient-centred, quality improvements as well as invest in the areas that matter most to patients. Achievement of our financial plan will afford the Trust more flexibility and freedom, and enable investment in frontline care, infrastructure, medical and IT equipment, and upgrades to our estate.

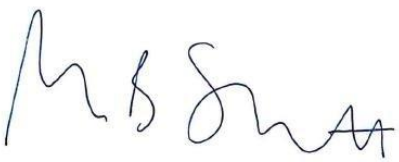
In February, the Trust participated in a Kent-wide event exploring Integrated Care Systems and Integrated Care Partnerships, and the potential benefits this could bring to healthcare in the area. These new systems

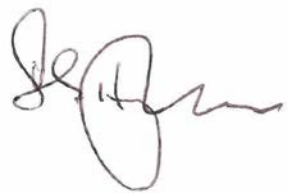
and partnerships aim to join up the services offered by GPs, acute and community care, ensuring the healthcare system can respond rapidly and effectively to patients' needs. As an organisation, we've achieved so much over the past year with significant improvements to our ED performance and better patient flow through our hospitals. We're admitting fewer patients as a result of using our Frailty and Ambulatory units as well as making more use of our partnerships with community teams via Hospital@Home. Plus we've made advances in delivering improved performance in our Cancer and Surgery services, whilst recognising that we have further work to do to ensure delivery of Cancer and Referral to Treatment on a sustainable basis in the year ahead.

However, what the year has demonstrated is that, even for a Trust such as ours that is performing well, the unprecedented - and growing - level of demand for our services is not sustainable. When there is a spike in demand this can undermine all the good work we've put in place. We know we need to tackle this demand better - our healthcare system needs to work differently to deal with it, with a particular focus on health prevention and providing patients with care and treatment in a setting that is appropriate to their needs. We also know that workforce and funding pressures need to be challenged with long-term thinking to ensure that quality of care is not compromised. Trust Board approval during the year of plans involving implementation of an Electronic Patient Record from Autumn 2020 should aid the realisation of efficiency and productivity gains necessary to face the challenges ahead.

Moving into 2019/20, the Trust looks forward to working closely with the STP in Kent and Medway, alongside councils and other partners, to turn the ambitions of the recently published NHS Long Term Plan into local action, through development of a strategy for the area for the next five years.

There have been several changes in Trust Board Members over the past year, most notably the retirement of Chief Operating Officer, Angela Gallagher, who joined the Board in 2011 and placed delivery of quality improvements and high standards of patient care at the heart of her role. The Board also welcomed a number of new Non-Executive Directors, and Associate Non-Executive Directors, as well a new Chief Operating Officer and Director of Strategy, Planning and Partnerships. We would like to thank all staff, volunteers and non-executives for their hard work and ongoing dedication during the year.





Miles Scott, Chief Executive

23rd May 2019

David Highton, Chair of the Trust Board

23rd May 2019

Snapshot of 2018/19

April

The Trust joined the `End PJ Paralysis' campaign which aimed to get patients up, dressed and moving whilst in hospital to avoid problems caused by staying in bed too long. The trial achieved 984 patients Dressed and 1255 Moving during the 70 day challenge period.

May

Crowborough Birth Centre Midwifery volunteer, Kay Sutherland, was nominated for an NHS Lifetime Achievement Award and appeared on BBC's One Show as part of a special programme to celebrate 70 years of the NHS.

June

A new Frailty Unit opened at Tunbridge Wells Hospital, as part of the Trust's commitment to providing high standards of care for older patients. The Unit provides for 10 patients, & brings together experts from a range of clinical teams in a specially designed environment.

October

The Trust welcomed the announcement by NHSI that it was no longer in Financial Special Measures and recognises it as "the result of so much hard work to develop sustainable, high quality services for our patients".

November

The Trust was awarded the Skills for Health Quality Mark in recognition of meeting the nationally recognised bench-mark for its Clinical Support Worker induction programme & delivery of the Care certificate. The programme helps build confidence, self-esteem, aspirations and improved patient care.

December

The Trust's new clinical management structure was launched. As a key step to becoming a Clinically Led Organisation, the new structure comprises 5 Divisions and 18 Directorates, retaining the best features of the organ-isation, whilst enhancing its ability to improve patient & staff experience.

July

Trust staff attended celebratory events to mark the 70th anniversary of the NHS at Westminster Abbey & 10 Downing Street. At home, a personalised birthday card was delivered by Kent Fire and Rescue Service. Guests enjoyed a slice of birthday cake made by students from Mid Kent College.

August

Staff consultation commenced on plans to develop a Clinically Led Organisation as part of the Trust's ambition to become Outstanding. Proposals included development of clinical leadership through an enhanced system of Divisions & Clinical Directorates, adopted by Outstanding trusts

September

Official recommendation was made that one of three new Hyper Acute Stroke Units planned for Kent & Medway was based at Maidstone Hospital. The preferred option was for HASU units, alongside acute stroke units, at Darent Valley Hospital (Dartford), Maidstone Hospital & William Harvey Hospital (Ashford).

January

Colourful blankets were given to elderly patients in a new trial on Edith Cavell Ward at Maidstone Hospital, to see if it helped minimise falls on the ward. The bright blankets help older patients, particularly those with Dementia, find their way back to bed more easily & provide a more homely feel to the ward

February

Kent Oncology Centre at Maidstone Hospital, in partnership with Kent and Medway Cancer Information Project, hosted a Here2Help event in support of World Cancer Day bringing together a number of Cancer charities, to give advice and information about the services available in the local area.

March

The Trust supported National Apprenticeship Week by encouraging jobseekers to look into apprenticeship opportunities and help kick-start their careers. Former Trust apprentice, Hannah Morris, answered questions from the public about her experiences across the Trust's social media channels.

Key developments

Patient Experience

Patient and Carer engagement strategy

Improving quality and experience of care is at the core of the Trust's organisational transformation and improvement journey and is recognised as something that successful organisations do well. In 2018/19 the Trust engaged with patients, carers and a wide range of other stakeholders as equal partners across its geographical scope in helping draft a new strategy to improve the experience of its patients and their carers. Some of the common issues identified by those participating were:

- People felt processed in a system rather than cared for and respected as individuals
- Staff were not always kind and empathetic and did not always look beyond the illness at the whole person
- Hospital routines and habits sometimes frustrated individuals' preferences to maintain independence and control over their lives
- People did not always feel involved in discussions about their care or able to ask important questions
- Individuals felt valued and at ease when staff chatted with them - but not all clinical staff chatted
- Information was not always provided to allow individuals to feel in control and equipped to make plans/good decisions.

These and other findings of engagement events in Maidstone and Tunbridge Wells have been used alongside existing patient experience data & engagement feedback, including complaints, surveys and Healthwatch insight to shape priorities for improvement. The resulting strategy will be launched in 2019. Embedding this strategy will require a major cultural shift over the next 3- 5 years with the goal being to embed patient and carer experience and engagement at the heart of the Trust's planning, decision making and business processes. To enable this, the Trust will support the spread and adoption of existing good practice and seek to learn from the experience of other patient and customer driven organisations.

Details of staff engagement initiatives during the year are provided on page 69.

Accessible Information Standard

The Accessible Information Standard (AIS), set out by NHS England in July 2016, aims to ensure that people who have a disability, impairment or sensory loss get information that they can access and understand. Action taken during the year in support of these aims, includes:

- Establishment of an AIS steering group to support the implementation of the AIS and monitor performance within the Trust
- Appointment of AIS champions to support departments in identifying where improvements can be made, development of better communications tools & awareness of support groups and charities to whom the Trust can signpost service users
- A Baseline Audit of key areas in the Trust completed by AIS steering group members
- A visit by Healthwatch Kent to Maidstone Hospital in partnership with Kent Association for the Blind to review the support available to partially sighted patients.

The Trust has appointed a Learning Disability Liaison Nurse who, as well as supporting the initiatives above, works with adult patients with learning disabilities who have complex needs and a requirement to access emergency, inpatient and outpatient hospital services.

Complaints

Information about complaints is available on pages 50-51

Fundraising and Community engagement

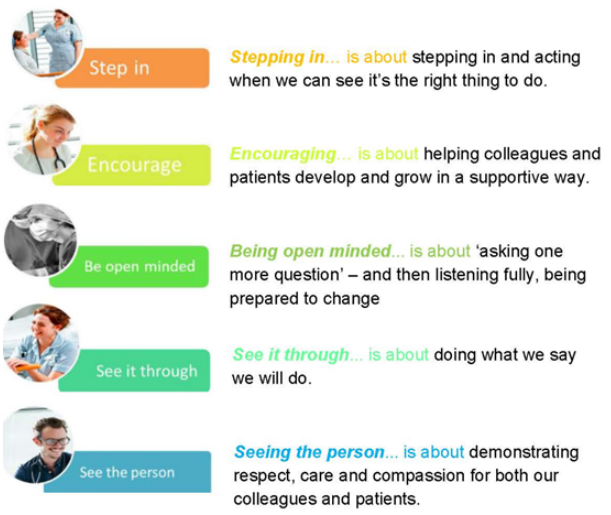
This year, the Trust has continued to welcome generous donors and supporters with their own fundraising ideas. A dedicated Fundraising Manager has been appointed and is actively working with local businesses and partners in the community to encourage corporate donations. In February, the Charity hosted the first regional Association of NHS Charities members meeting attended by NHS Charities including Dartford & Gravesham NHS Trust and East Kent Hospitals.

Becoming a more Clinically led organisation

Equipping employees in every staff group with more autonomy to act, has been proven to enhance the quality and efficiency of health services. In 2018/19, the Trust took a key step in its plans to encourage such empowerment and towards its ambition to establishing itself as an Outstanding provider of NHS care through becoming even more of a clinically-led organisation.

New clinical management arrangements launched during the year, are based on two tiers: Divisions and Directorates. Each Division and Directorate is led by a clinical management team, comprising an overall clinical lead, a senior operational manager and a head of Nursing, Quality and other Clinical professions. The new structure was developed in collaboration and consultation with the Trust's healthcare professionals. More details of the new clinically led structure are provided on page 49. Alongside this new structure, the Trust has also created a vision with its staff to make the Trust a place that they feel part of and, have a genuine stake in. The shared aims to achieve this vision are:

- To create more inclusive clinical leadership and share good leadership behaviours
- To empower and support clinical and healthcare professionals to act
- To champion excellent communication and staff engagement
- To support colleagues to see and lead the whole of their services including Quality, Finance & Workforce
- To make the Trust's clinically-led services even more patient-centred and committed to excellence
- To support clinical teams to take ownership of challenges and solutions
- To secure the time, capability, development and resources to help clinical colleagues get the job done
- To ensure clinical leadership teams take a responsibility for the health of the Trust as well as its patients.



To cultivate the desired leadership behaviours, the Trust invested during the year in leadership development and talent management, and has implemented a Quality, Service Improvement and Redesign (QSIR) faculty to support staff in making the changes they want to see. 5 specific leadership behaviours (see left) have also been identified from

stories that staff have shared about teammates who made a difference to them and to their patients. Leaders have been tasked to agree 'shop floor commitment' with their line manager - an appropriate and realistic commitment to engage with individuals on the frontline – this might be spending time doing a clinical shift, holding regular team meetings or visiting another service area. The five Chiefs of Service have also joined the membership of the Trust's weekly Executive Team Meeting and are therefore now engaged in key decisions about all aspects of the Trust's management.

Improvement - The journey to "Good" and "Outstanding"

Following inspections in 2017, the CQC rated the Trust's overall position unchanged as "Requires Improvement", whilst recognising 'significant and sustained improvement' throughout the Trust since the previous inspection report in 2015.The 17 'should do' actions identified in the CQC's inspection report in 2018 have been incorporated into an Action Plan "Tracker" which is monitored through the Trust's Quality Improvements Committee. In 2018/19, all "should do" recommendations were actioned with management plans in place and alignment to the Trust's Best Care programme (see page 22).

The Quality Improvement Committee leads the development of an improvement plan to support the Trust in moving to "Good" and "Outstanding". Clinical Divisions will take ownership of the key focus areas in the plan and embed quality improvements through the Clinically Led structure launched during the year.

The Trust hosted quarterly engagement visits with the CQC in 2018/19 – which focussed on those services not inspected as part of the last inspection. Staff within the services that supported these days appreciated the opportunity to share their work with the CQC. The CQC also responded positively, describing the process as helping to get a much better understanding of a wider range of services.

Stroke services

In February 2019, following a five-year review of urgent stroke services, led by local stroke specialists, a Hyper Acute Stroke Unit (HASU) at Maidstone Hospital, alongside others at William Harvey Hospital (Ashford) and Darent Valley Hospital (Dartford) were given the go-ahead by a unanimous decision of the Joint Committee of Clinical Commissioning Groups for the Kent and Medway Review of Urgent Stroke Services. Once the new units are up and running, anyone having a stroke in Kent and Medway will be taken to their nearest HASU, which will offer specialist stroke care round the clock every day of the year.

Towards the end of 2018/19, work moved into the implementation phase and it is anticipated that the new Stroke service will begin at Maidstone Hospital and Darent Valley Hospital in Spring 2020, and at William Harvey Hospital in Spring of 2021. Plans for remodelled Stroke services at Maidstone Hospital provide for 38 ring fenced Stroke beds (11 HASU and 27 ASU) and 22 rehabilitation beds, a number identified as the optimum amount of beds to ensure flow for the recognised Stroke activity. Implementation will include transitional ward moves, the development of the new Acute Medical Unit adjacent to the Emergency Department (ED) at Maidstone Hospital during 2019/20. All inpatient Stroke service provision at Tunbridge Wells Hospital will cease, centralising all acute services at Maidstone Hospital.

The Trust will work collaboratively with other providers in Kent and Medway to develop a strategy to recruit the necessary expertise for the facilities. Attracting staff to the local area, especially in lower grade positions, is recognised as a challenge for the year ahead.

Patient flow and Winter planning

In 2018 the Trust made a series of investments to improve patient flow and manage winter pressures:

- A range of innovative measures were introduced in the Trust's EDs, including working with community providers to reduce ED attendances by enhancing services

to treat more patients at home, & increasing the time that assessment units were open to support older frail patients. GP hours within the Trust's EDs were also increased, freeing up time for senior clinicians to see urgent cases more quickly

- Changes were made to better stream patients on arrival at ED to ensure they got the right care, in the right place, at the right time
- Proactive action was taken to address performance against the Referral to Treatment (RTT) standard to shorten planned care waiting times and improve patient experience
- A number of new roles were introduced, including Physician's Associates, Doctor's Assistants and Nurse Endoscopists to ensure patients were seen and treated in a timely manner
- There was a focus on improving theatre and outpatient efficiency as well as adding theatre sessions and outpatient clinics at weekends
- For Cancer services, the number of outpatient clinics was increased, Endoscopy sessions and Radiology, CT and MRI slots and the recruitment process for specialist doctors and clinical staff was improved. As a result, over 100 more patients a week were seen and were able to complete their main diagnostic test
- From December Hospital@Home helped suitable patients return home sooner to recover faster, with the right support. The service offers medical & nursing support at home for a short time and includes senior registered nurses, doctors & healthcare support workers who keep in touch with the patient's GP and hospital staff
- Elderly patients were given frailty scores on admission to enable them to receive the most appropriate care. A new frailty unit was opened at Tunbridge Wells Hospital during the year, in addition to the existing unit at Maidstone Hospital
- Greater focus was applied by external partners on exit routes from hospital. During the year, Pathways 1, 2 & 3 of the Home First initiative were rolled out and the capacity of this service was rolled out for winter.

The Trust and the NHS Long Term Plan

In January 2019, the NHS published its vision for the next 10 years in its Long Term Plan (LTP), setting out a blueprint to tackle major health conditions and investment in the latest technology to provide cutting edge treatment. The LTP focuses on health prevention and early detection of serious health conditions, as well as improved care and integrated support for patients. It sets out guarantees for investment in healthcare, funding a £4.5 billion new service model to provide better, joined up care. The Trust will work closely with the STP in Kent and Medway, alongside councils and other partners, to turn the ambitions of the LTP into local action, and develop a strategy for the area for the next five years.

The Trust's clinically-led restructure in 2018/19 – and plans for the year ahead – is aligned to many of the aims set out in the LTP. Work undertaken with each of the five Divisions to develop clinical service plans for the year will influence what the Trust provides and how it provides it. Backing the workforce and training more professionals to work in the NHS is a key ambition of the LTP and an aim the Trust fully supports. Recruitment is a priority and a strong plan is in place to attract new staff to the Trust. A programme to develop aspiring and existing leaders is being rolled out, with a strong focus on cultivating a culture of quality improvement, communication, engagement and transparency. A particularly exciting development, which will have a hugely positive impact on the Trust's workforce, is the new Kent and Medway Medical School (KMMS), opening in 2020. This will directly increase the doctor population in the county, currently amongst the lowest in the UK. The Trust's Education team is working closely with the KMMS to welcome this expansion, with a potential of up to 120 new medical students expected.

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

The Trust Board agreed the following key objectives for 2018/19:

- To deliver the trajectory agreed with NHS Improvement (NHSI) for the A&E 4 hour waiting time target
- To deliver the trajectory agreed with NHSI for the 62-day Cancer waiting time target
- To deliver the Referral to Treatment (RTT) trajectory agreed with NHSI for patients on an 'incomplete' pathway
- To deliver the financial plan for 2018/19
- To ensure a falls rate of no more than 6.0 per 1000 occupied bed days
- To ensure a pressure ulcer rate of no more than 3.0 per 1000 admissions
- To deliver the agreed 'lessons learned' plan for 2018/19
- To deliver the agreed medical productivity plan for 2018/19
- To deliver a vacancy rate of no more than 9%
- To deliver a staff turnover rate of less than 10%

The key issues and risks affecting delivery of these (as described in the Trust's Board Assurance Framework – see the "Annual Governance Statement for 2018/19" (pages 55-66)) are outlined below. Details of how the Trust actually performed against these objectives are provided in the "Performance analysis" section (pages 21-25).

To deliver the trajectory agreed with NHSI for the A&E 4 hour waiting time target

The key recognised risks to delivery of this objective were: Insufficient capacity to deliver the 'new norm' for non-elective activity; continued higher than planned ED attendances; bed occupancy remaining above 92%; the level of Delayed Transfers of Care (DTOCs) remaining higher than the expected standard; failure to follow best practice in response; and lack of ownership by Clinical Directorates.

To deliver the trajectory agreed with NHSI for the 62-day Cancer waiting time target

The key recognised risks to delivery of this objective were: Insufficient engagement in delivery by clinical staff outside of the Cancer and Haematology Directorate; Pathways not being optimal in relation to achieving the required performance; insufficient capacity to meet the increased demand for 2-week wait clinics and diagnostics (Endoscopy and Radiology); and inability to recruit sufficient staff.

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

The key recognised risks to delivery of this objective were: An insufficient level of elective and outpatient activity being undertaken; non-elective activity increasing beyond current levels (including ED attendances); and additional data quality issues and/or technical 'glitches' following the implementation of the Allscripts Patient Administration System (PAS).

To deliver the financial plan for 2018/19

The key recognised risks to delivery of this objective were: Lack of senior leadership and commitment; poor financial controls (or poor application of good controls); lack of commitment by managers; non-delivery of Cost Improvement Programme (CIP) schemes; lack of consideration of best practice elsewhere in

development of the Trust's plans for the year; insufficient engagement with external stakeholders; and any change in the financial circumstances of commissioners, requiring them to take further action to manage demand.

To ensure a falls rate of no more than 6.0 per 1000 occupied bed days

The key recognised risks to delivery of this objective were: Failure/inability to meet national best practice standards; lack of a full Multi-disciplinary team approach to falls prevention; and lack of flexibility and suitability of clinical support systems.

To ensure a pressure ulcer rate of no more than 3.0 per 1000 admissions

The key recognised risks to delivery of this objective were: Failure to deliver personalised care (i.e. care planning & delivery not being tailored to individual patient need); prolonged 'trolley time' in ED, Radiology, Theatres; unscheduled absence/gaps in the Tissue Viability Nurse service; failure to implement the new NHSI guidance on reporting Deep Tissue Injury (issued in June 2018).

To deliver the agreed 'lessons learned' plan for 2018/19

The key recognised risks to delivery of this objective were: The Trust's incident reporting (Datix) IT system not having the required functionality; availability of IT resource to complete a Datix upgrade(s); Clinical Directorates not being able to release key staff to attend clinical governance meetings; identification of meaningful/measurable metrics to assure that learning is shared and embedded; lack of agreement/support/resource to implement new clinical governance processes proposed (agenda, learning levels, action planning processes); learning input and output from Datix not offering consistency of quality and clarity for lessons to be learned.

To deliver the agreed medical productivity plan for 2018/19

The key recognised risks to delivery of this objective were: Availability of resource at Directorate level to complete all job planning requirements in line with the project timeline; availability of resource to deliver the project in the proposed timescales; lack of enforcement of local standards at Directorate level for job planning; resistance or lack of support from the Joint Medical Consultative Committee (JMCC); the need for significant cultural change to obtain buy-in to undertake and implement Best Value Direct Clinical Care (DCC) and Personalised Metrics; the risk that seasonal Job Plans were not well received by the Consultant body and unenforceable; and Directorate leadership teams' ability to deliver significant cultural change and a challenging work programme.

To deliver a vacancy rate of no more than 9%

The key recognised risks to delivery of this objective were: A national shortage of certain staff groups; any lack of clarity/focus on the key actions required; any lack of clarity over the performance required by each Directorate, and the monitoring of such performance; any inefficiency in recruitment processes; any lack of urgency/commitment by recruiting managers; any uncertainty over the status of vacancies; and uncertainty regarding Brexit i.e. the impact on the availability of European recruits.

To deliver a staff turnover rate of less than 10%

The key recognised risks to delivery of this objective were: A national shortage of certain staff groups creating a more mobile workforce; higher than planned vacancy rates (resulting in more temporary staffing use) typically reducing staff morale; & uncertainty arising from Brexit that might impact on the retention of EU staff.

Adoption of the 'going concern' basis

The DHSC Group Accounting Manual 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. In para 4.12 it states:

"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 Management have assessed the Trust's ability to continue for the foreseeable future in the light of the GAM guidance. The Trust has compiled the 2018/19 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 final business plan to NHSI in April 2019 setting out its operational plans for the following financial year (2019/20) and its capital plans for five years.
- The Trust exited from Financial Special Measures in October 2018, has met its 2018/19 control total, and is planning to fully achieve its 2019/20 control total, including PSF and MRET (Marginal Rate Emergency Tariff) requirements, and therefore to deliver a planned surplus of £6.9m.
- 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 is a key player in consideration of the shape of services in the STP for the future e.g. it is one of the selected sites for a Hyper Acute Stroke Unit as part of the STP-wide Stroke services consultation.
- The Trust will have contracts in place for provision of healthcare services for 2019/20. This includes the "aligned incentives" contract with West Kent CCG (the Trust's main commissioner) and Sussex and East Surrey CCG. The aligned incentives contract represents c.73% of the total clinical income which provides certainty for income and cash flows in 2019/20.
- The Trust has prepared and submitted cash-flow plans for 2019/20 which include the repayment of £16.9m of working capital loans which is planned to be financed from internal resources.
- There are no plans to dissolve the Trust or to cease services without transfer to any other NHS body.
- The Trust does not consider that there are any material uncertainties to the going concern basis. However it has assessed and will disclose within its 2018/19 accounts challenges to its financial plans for 2019/20 around its cost improvement programme and risks to achieving its control total. The main risks are:
  - The Trust has fully identified CIP schemes totalling £16.6m of which £4.9m is currently risk-rated as red. Divisions have been set a target of £19.4m to seek to mitigate any slippage or non-delivery. The Trust has commissioned additional external support to work with Divisions to develop and implement plans with regular monitoring of performance.
  - The Trust's plan assumes that current Stroke services will continue until April 2020 prior to the planned reconfiguration of services. Therefore no additional income assumptions have been made for any additional Stroke activity at Maidstone Hospital. The risk is around one of the current units planned for

closure being subject to operational pressures e.g. loss of staff that causes it to close or reduce activity earlier than planned.

For these reasons, the Trust has prepared its Accounts using the going concern basis in line with the GAM guidance.

Performance summary for 2018/19

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 2018/19" section on the following pages (pages 23-25). 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

The Trust achieved successes in the following areas:

- Prevention of blood clots or venous thromboembolism (VTE) - The Trust ensured that 96.7% of patients were given a VTE Risk Assessment in 2018-19 against a target of 95%%
- Stroke – 91.6% of Stroke patients spent 90% of their time on a dedicated Stroke ward (2017/18, 91.08%) against a target of 80%
- Complaints management – the rate of new complaints at 2.3 per 1000 episodes (2017/18, 1.93), was well within the expected range of between 1.318 and 3.92
- 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.
- 55.9% of patients arriving in ED were treated within 60 minutes of arrival against a target of 50% (58.4% in 2017/18
- Cancer Waiting Time Targets – 31 Day First Definitive Treatment – The Trust achieved this standard ensuring that 96% of patients who needed to start their treatment within 31 days did so
- Cancelled operations – The Trust achieved this standard with 0.69% of operations cancelled at the last minute against the national maximum limit of 0.8%

Elsewhere, the Trust underperformed on several targets, including those relating to Cancer waiting times (62 day first definitive treatment and 2 week wait), Access to treatment, Delayed Transfers of Care and Clostridium Difficile cases. More details are provided in the "Annual Governance Statement for 2018/19" section later (page 54-65).

Further details on the performance standards for quality of care can be found in the Trust's Quality Accounts for 2018/19, which are available in full on the Trust website (www.mtw.nhs.uk).

NHS
Maidstone and Tunbridge Wells
NHS Trust

Performance Report for 2018/19: Performance analysis

taking pride

MTW
exceptional people, outstanding care

How the Trust measures performance

The Trust's Performance Management framework was reviewed and refreshed during 2018/19. The Framework is based upon the national Single Oversight Framework and recognises that a high performance culture will only be achieved when performance is managed in a positive and non-punitive way. The Framework aims to ensure that striving for excellence is an integral part of organisational culture.

Based on the strategic objectives of the Trust, the key focus areas for performance management are:

- Quality – Service safety and quality requirements;
- Performance - National and local standards and performance targets;
- Financial – financial, efficiency and business objectives.

A 'Ward to Board' approach is applied & monitored through a sign-off process at Directorate-, then Divisional-level before presentation at monthly Divisional 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. Each Directorate hosts a twice yearly Strategic Review meeting to provide an update on its Business Plans as part of the Trust's Business Planning and to present any relevant service or business developments. These meetings also provide a forum to discuss any key risks and issues affecting the delivery of key targets, with the Executive Team.

The monthly Trust Board performance dashboard encapsulates the result of these processes and provides the Board with a rich source of information that has been 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 Trust 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/). In 2018/19 a programme of weekly RTT and Cancer performance meetings was established to ensure progress against patient tracking lists.

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 key issues of note, and explain 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, described in more details in the "Annual Governance Statement for 2018/19" (page 54 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 Trust monitors its progress against the recommendations from its most recent CQC report (March 2018) through an Action Plan "Tracker" which is monitored through the Trust's Quality Improvements Committee (see page 14 for more detail).

Best Care

The Best Care programme is the Trust's clinically-led improvement programme that brings together its quality, safety and financial sustainability aims. The programme has five workstreams (outlined below), each with an Executive Sponsor. Monthly workstream programme board meetings receive detailed reports on progress and monitor delivery. A monthly Best Care Programme Board is chaired by the Chief Executive.

- Best Safety (learning lessons and making our services even safer)
- Best Quality (working together to provide great quality care for everyone we see)
- Best Patient Flow (developing the best ways to see our patients)
- Best Workforce (having the best staff available to treat our patients)
- Best Use of Resources (reducing waste and improving value for money)

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

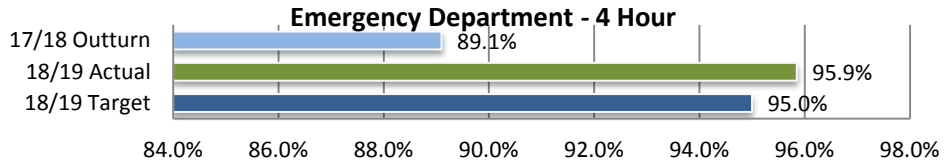
The Trust uses a wide range of KPIs to identify areas of risk and uncertainty. Where these risks and uncertainties can be controlled, these are aimed to be included within the Trust's plans. However, if monitoring of KPIs reveals that performance is at variance from the Trust's plans, mitigating actions may be implemented. The wide range of information collated means that the relationship between different pieces of information is very complex & 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 enacting of mitigations.

Development and performance in 2018/19

The 'key issues and risks affecting delivery of the Trust's objectives' were described earlier in the Report (pages 17-18). The Trust's actual performance against each of its 2018/19 objectives is described below.

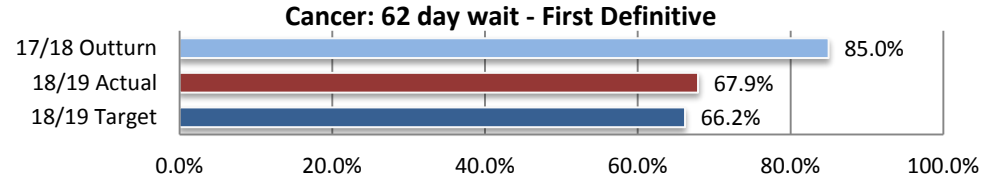
To deliver the trajectory agreed with NHSI for the A&E 4 hour waiting time target

This objective was fully achieved (rated green within the Board Assurance Framework). Although the trajectory for Quarter 3 (90.77%) was not achieved (90.45% performance), the year-end position was 91.86% (which exceeded the trajectory of 90.82%), and the trajectory for March 2019 (95.03%) was achieved.



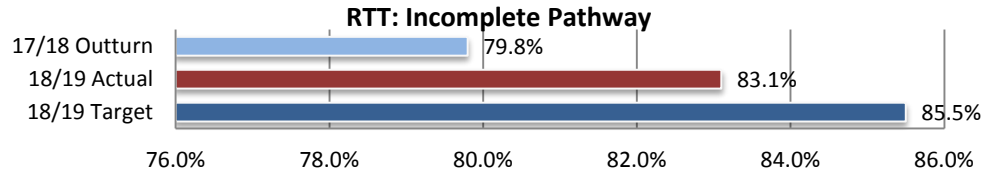
To deliver the trajectory agreed with NHSI for the 62-day Cancer waiting time target

This objective was not achieved (rated red within the Board Assurance Framework) and the Trust has made a commitment to achieve the 85% target by the end of May 2019.



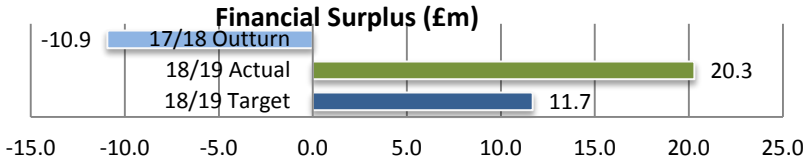
To deliver the Referral to Treatment (RTT) trajectory agreed with NHSI for patients on an 'incomplete' pathway

The trajectory for March 2019 (85.46%) was not achieved (rated red within the Board Assurance Framework) as the performance was 83.1%.



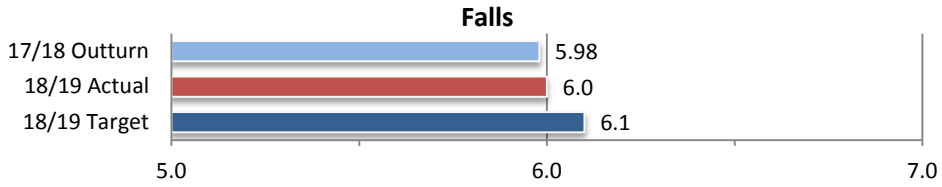
To deliver the financial plan for 2018/19

This objective was fully achieved (rated green within the Board Assurance Framework). The Trust ended 2018/19 with a post-Provider Sustainability Fund (PSF) surplus of £20.324m.



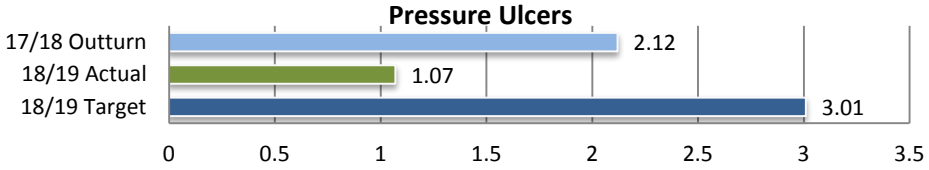
To ensure a falls rate of no more than 6.0 per 1000 occupied bed days

This objective was not achieved (rated red within the Board Assurance Framework). Although the total number of falls was lower in 2018/19 (1500) than in 2017/18 (1581), the Trust ended 2018/19 with a falls rate of 6.1 per 1000 occupied bed days.



To ensure a pressure ulcer rate of no more than 3.0 per 1000 admissions

This objective was fully achieved (rated green within the Board Assurance Framework). The Trust ended 2018/19 with a hospital acquired pressure ulcer rate of 1.07 per 1000 admissions.



To deliver the agreed 'lessons learned' plan for 2018/19

This objective was fully achieved (rated green within the Board Assurance Framework). The Lessons Learned plan spans more than one year and the lessons in respect of 2018/19 were delivered. These include:

- Completed review of Datix system functionality issues & implementation of a new system from April 2019
- Identification of a system and process for cascading learning enabling the Patient Safety Team to cascade relevant learning to each Directorate/Clinical Governance Lead

- A full review of the existing Directorate/Divisional Clinical Governance process (meetings, membership, agenda content, feeder mechanisms, outputs and cascade arrangements) and outputs agreed
- A simple three stage process agreed for Evidencing and Embedding Learning
- A detailed project plan for 2019/20 produced to deliver the remaining work required.

To deliver the agreed medical productivity plan for 2018/19

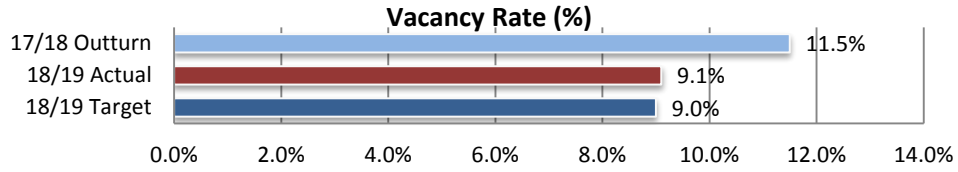
This objective was partially achieved (i.e. rated amber within the Board Assurance Framework). The Medical Productivity plan spans more than one year. The objectives set for the "Job Planning System & Cycle" aspects of the work for 2018/19 have been delivered, but the objectives set for the "Demand & Capacity Planning" and "Best Value" aspects were not delivered as planned.

Details of the aspects delivered are:

- Job Planning System & Cycle:
  - Policy, Standards Document and Professional Activities (PA) Allocation Table (PAAT) negotiated and agreed with the Joint Medical Consultative Committee (JMCC) & subsequently ratified. Bespoke, local PAATs and standards are in place for all Directorates.
  - The Medical Job Planning Consistency Committee (MJPCC) was established & Terms of Reference agreed. Desk top reviews for all Directorates have been completed and a cycle of meetings is in place for 2019/20.
  - Implementation of an E-job planning system. The Trust was noted as an exemplar by the NHSI Wave 2 Workforce Productivity Programme for progress in the first year.
- Demand and Capacity: Ongoing work to review outpatient and theatre demand & capacity with reconciliation back to job plans
- Best Value: Reconciliation of pay against existing job plans. Work has commenced with Directorates to facilitate personalised metrics & Annualised Team job planning in the next round.

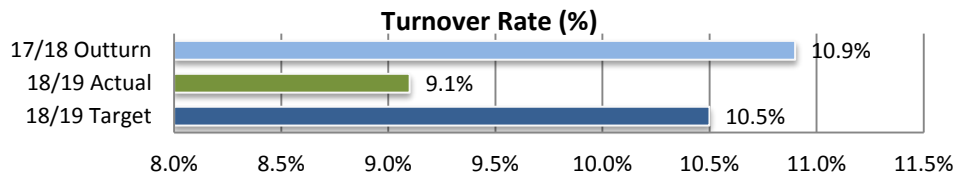
To deliver a vacancy rate of no more than 9%

This objective was not achieved (rated red within the Board Assurance Framework). The Trust ended 2018/19 with a vacancy rate of 9.1%. More information on the Trust's plans for recruitment and engagement initiatives is given on page 69 onwards.



To deliver a staff turnover rate of less than 10%

This objective was fully achieved (rated green within the Board Assurance Framework). The Trust ended 2018/19 with a staff turnover rate of 9.12%.



Financial performance in 2018/19

The Trust started the year in Financial Special Measures (FSM) needing to demonstrate sufficient progress in financial improvement and sustainability. In October 2018 this was achieved when NHSI announced that the Trust was no longer under FSM.

For the financial year 2018/19 the Trust met its control total and reported a surplus of £20.3m, post Provider Sustainability Funding (PSF), which was £8.6m better than plan. The PSF was achieved in full and the Trust received additional PSF of £8.3m. There were some aspects of the plan which were not met. The key drivers of this variance are:

- The Cost Improvement Programme (CIP) delivery was £13.8m compared to a plan of £24.1m, a shortfall of £10.3m
- Additional benefit derived from asset sales of £10.2m.

The Trust incurred additional expenditure of £1.8m to improve RTT and Cancer performance which was funded by West Kent Clinical Commissioning Group (CCG).

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	2018/19 (Plan) £m	2018/19 (Actual) £m	Variance £m
Income	466.4	473.2	6.8
Operating expenses	(442.0)	(450.5)	(8.5)
Operating Surplus / (Deficit):	**24.4**	**22.7**	**(1.7)**
Finance income	0.0	0.2	0.2
Finance expense	(15.8)	(15.8)	(0.0)
PDC dividend charge	(1.3)	(0.7)	0.6
Net finance costs	**(17.1)**	**(16.3)**	**0.7**
Other gains / (losses)	3.3	13.5	10.2
Surplus / (deficit) for the year before technical adjustments	10.7	19.9	9.2
Technical adjustments	1.1	0.5	(0.6)
Surplus / (deficit) for the year after technical adjustments	**11.7**	**20.3**	**8.6**

Income

The Trust's income was £473.2m which was above plan by £6.8m by the end of the financial year. This was mainly due to CIP Slippage of £10.2m in Prime Provider and private patient income and a reduction in income for pass through costs of £1.4m. This was offset by £8.3m additional PSF, £1.8m Cancer and RTT funding, £1.6m benefit from 2017/18 adjustments, £1.7m non Aligned Incentives Contract over-performance and £1.4m additional non-recurrent income support.

The majority (85%) of the Trust's income is from Clinical Commissioning Groups (CCGs) or NHS England.

Operating Expenses

The Trust's expenditure was £450.5m which was £8.5m adverse to plan. There were pay overspends of £4.7m as a result of additional bank and agency spending to cover vacancies and non-pay was £5m overspent in clinical supplies. Both pay and non-pay included additional expenditure for RTT and Cancer performance

improvements. The impact of the 2018/19 pay award was an additional £4m. These were offset by release of reserves of £3.8m and underspends in pass through costs of £1.4m.

Finance Costs

Public Dividend Capital (PDC) charge was lower than expected by £0.5m.

Other Gains

The Trust had planned to have a financial benefit relating to an asset sale. This was higher than expected and in addition a second asset was sold sooner than planned. This resulted in an additional benefit from asset sales of £10.2m.

Cost Improvement Programme (CIP)

The Trust delivered £13.8m of cost improvement plans against a target of £24.1m. The main shortfalls were Prime Provider start delay (£5.5m), Private Patient Income (£1m), STP Medical Rates (£1.7m) and Medicines Management (£1.1m). These are shown by Division below:

CIP programme by Division	2018/19 Plan £'000	2018/19 Actual £'000	Variance £'000
Surgery	11,292	3,224	(8,072)
Cancer Services	1,251	827	(424)
Medical and Emergency Care	3,627	1,223	(2,404)
Women's, Children's and Sexual Health	2,110	1,556	(554)
Diagnostics and Clinical Support	858	767	(91)
Estates and Facilities	2,912	1,780	(1,132)
Corporate	2,007	4,465	2,458
Total	24,061	13,842	-10,219

Capital Expenditure plan

During the year the Trust made capital investments of £13.6m including £0.7m of assets funded from donated or charitable fund sources. Significant elements of the programme were improvements to energy infrastructure/LED lighting (£1.4m) funded from Salix loans, £1.5m on backlog maintenance and estates renewals at Maidstone Hospital, and £0.7m planned lifecycle at the Tunbridge Wells Hospital. In addition there was £0.7m associated with the enabling works for new linear accelerators.

Equipment spend in the year included two replacement linear accelerators funded by national PDC at the Cancer Centre at Maidstone Hospital (£3.4m) and £2.4m for Trust-wide medical equipment replacement. £2.5m of investment was made in ICT infrastructure and equipment including implementation costs for the new electronic patient record system.

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 2018/19 the Trust met its target by managing

the year-end position to underspend the EFL by £9.4m with the actual closing cash balance being £10.4m. The Trust agreed with NHSI to carry forward additional cash at year end (including £8.4m from asset sale proceeds) and is seeking agreement from the Department of Health and Social Care to utilise this in 2019/20 as capital resource.

Capital Resource Limit

The Trust is expected to manage its capital expenditure within its agreed Capital Resource Limit (CRL). For 2018/19 the Trust's CRL was £12.1m which was underspent by £3.2m relating mostly to the disposal of property close to the end of the financial year (net book value £2.4m) and an agreed deferral of £0.3m of central PDC for ICT projects; and partly due to less depreciation spend than planned (£0.5m) which reduced available capital cash. The £2.4m net book value resource and the £0.3m PDC funding is part of the cash balance that the Trust has carried forward into 2019/20.

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 has achieved an in year surplus in 2018/19 of £20.3m, including PSF income, reducing the cumulative deficit accordingly. The Trust' s break-even period has been extended with the plans submitted for 2019/20 aimed at further reducing the accumulated deficit towards the target of formal cumulative break-even by 2023/24.

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. This included for 2018/19 the application of the new accounting standards, IFRS 9 on Financial Instruments, and IFRS 15 on Revenue from Contracts with Customers. The Trust also sold two sets of staff accommodation during the year and entered into leaseback arrangements. Both sets of leases have been assessed as operating leases. 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 2017/18 this was £68,500 excluding VAT) which includes £7,500 relating to the audit of the Quality Accounts. Grant Thornton UK LLP did not undertake any non-audit work for the Trust in 2018/19.

Looking forward to 2019/20

The Trust has set a planned surplus of £6.9m which includes receipt of £7.7m PSF during 2019/20. To deliver this surplus the Trust will need to deliver a £16.6m CIP target. The overall plan shows that 2019/20 will continue to be financially challenging but the underlying position is improving. The table below sets out the Trust's 2019/20 financial plan submitted to NHSI.

Statement of Comprehensive Income	2019/20 (Plan) £m
Income	503.2
Expenditure	(465.4)
EBITDA (surplus):	37.8
EBITDA %	7.5%
Depreciation & other	(29.5)
Net interest	0.1
PDC dividend	(1.6)
Impairments	(1.0)
Total financing and impairments	(32.0)
Surplus/(Deficit) (before technical adjustments)	5.8
Technical adjustments	1.1
Surplus/(Deficit) (after technical adjustments)	6.9

The key movements from 2018/19 outturn to 2019/20 plan are:

The main non recurrent items in the 2018/19 outturn were the benefit on sale of assets £14m, non-recurrent income support £5.2m and PSF funding £12.7m. The non-recurrent items are removed from the plan for 2019/20, which is then increased for activity growth and pay and non-pay inflation. The plan includes an additional £15m of activity as a result of its new Prime Provider status. This means all elective referrals are made directly to the Trust and will outsource patients to the Independent Sector either because of patient choice or where internal capacity is full. There is a cost improvement plan requirement of £16.6m.

The Trust is planning a rolling five year capital programme of total value £56m (excluding donated assets) which includes the following areas of investment:

- Essential improvements in Maidstone Hospital estates (£10.5m) and Tunbridge Wells Hospital lifecycle (£5.4m). £5.6m of this is proposed to be funded from resource that the Trust is requesting to carry forward from the disposal of property assets in 2018/19 into 2019/20 and 2020/21. £2m of the resource is planned to address key property backlog issues. This is subject to approval from DHSC in terms of the allowing the cash carried forward to be spent as capital resource.
- The financial plan does not yet include the Hyper Acute Stroke Unit planned for Maidstone Hospital as part of the recent Kent & Medway STP Business Case, as it has not yet reached final approval through the governance process.
- The Trust's plan has assumed that the NHS England capitally funded national programme of updating linear accelerators will continue and has planned for a replacement linac on an annual basis.
- The Trust's plan includes essential replacement equipment provision of c. £8.4m over the 5 year period from internal resources. This includes the remaining resource being requested to carry forward from the asset sale (£0.8m).).
- The Trust's plans for ICT of £7m include its major Electronic Patient Record (EPR) project and an Electronic Prescribing and Medicines Administration (EPMA) prescribing system for which national PDC funding is being sought (£1.5m).
- In addition the Trust needs to urgently replace some critical Imaging equipment (e.g. CT scanners) and will be looking to apply for an emergency capital loan 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.

Countering fraud, bribery and corruption

The Trust has a range of policies and procedures in place to identify and respond to risks of fraud, bribery and corruption, including an "Anti-Fraud, Bribery and Corruption Policy and Procedure"; "Gifts, Hospitality, Sponsorship and Interests Policy and Procedure"; "Standing Financial Instructions", "Risk Management Policy and Procedure", "Serious Incidents (SI) Policy and Procedure", and the "Speak Out Safely (SOS) Policy and Procedure (formerly Whistle Blowing)" as well as policies relating to, for example, employee verification checks etc. Such Policies are available to all staff via the Trust's Intranet system. The Trust's Local Counter Fraud Specialist is a mandated consultee for such Policies. A specialised training event was held with Trust Staff Side representatives in 2018/19, helping them to better understand the role of the NHS Counter Fraud Service (LCFS) and how they can best assist members under investigation. Training to all Staff Side representatives included raising awareness of Bribery legislation. In addition, as noted above, the LCFS undertakes a programme of work for the Trust which aims to prevent, deter and detect fraudulent activity. The outcomes of the work are reported to the Audit and Governance Committee, which in turn provides a summary report on its own activity to the Trust Board.

Equality, Diversity and Human Rights

The Trust's activity and policies in this area are explained in the Accountability Report.

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Performance Report for 2018/19: Summary of Quality Accounts

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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 to list the improvement priorities for the coming year.

This section contains a summary of the Quality Accounts for 2018/19; 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 2018/19

Performance against selected 2018/19 priorities, as stated in the 2017/18 Quality Accounts, is outlined 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:

- "Embedding an open & transparent culture that embraces 'lessons learned'"- During the year there was some limited success with improving rates of incident reporting, with an initial rise, then subsequent return to static; Improvement was achieved in the investigation and closure of incidents, ensuring that staff received timely feedback when they reported an incident; the agenda for the Trust's Clinical Governance meetings was revised to promote the 'lessons learned' agenda; 5 courses of Root Cause Analysis training was delivered; dates for Duty of Candour training were confirmed; Schwarz rounds are due to commence within the Trust in April 2019
- "Achievement of consistent recognition and rapid treatment of Sepsis in both ED and inpatient departments and ultimate reduction in the number of avoidable deaths" - No Serious Incidents (SI) were declared in Quarters 1, 2 and 3 as a result of a delayed diagnosis of Sepsis; 1 SI was reported in Quarter 4 for delayed diagnosis of Sepsis; full compliance with the standard for screening and treatment was met during Quarters 2, 3 and 4 (and was narrowly missed in Q1); Sepsis was the focus of the Trust's safety moment during the month of September; a Sepsis Study day was held and a Sepsis scenario is now used in Simulation training.
- "Improvement in outcomes for expectant mothers and their babies in line with 'Better Births' and the National Maternity Transformation work" – Significant work was undertaken with the NHSI Maternal & Neonatal Safety Collaborative (MatNeo), which aims to provide "support for front line staff to create the conditions for continuous improvement, a safety culture and a national maternal and neonatal learning system". Through this work a project was identified and is moving forward to: reduce smoking in pregnancy (specifically increasing the number of women who stop smoking between booking and delivery); increase the administration of Magnesium Sulphate to women for whom imminent premature birth is anticipated.

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:

- "Development of a patient engagement strategy to ensure views are sought and triangulated with themes and trends from patient surveys, complaints etc. to inform strategic direction" - Patient Public and Engagement events took place in October 2018, with follow-up workshops in November to group themed feedback from

the first session. A Patient and Carer Engagement Strategy has been drafted and will be finalised for implementation in 2019/20

- "Continued work with external partners such as Healthwatch, NHSI, CQC and West Kent CCG to help inform the Board of areas for concern including the Internal Assurance inspection programme" – The Trust engaged throughout the year with external partners and received feedback to help improve patient pathways. Specific examples include ED site visits by Healthwatch, and Healthwatch representation at the Trust's Patient Public and engagement events. Healthwatch attended the Trust Board meeting in December 2018 following its earlier review against the Accessible Information Standard. Four successful CQC engagement days took place throughout the year with core service presentations given by staff from Maternity, Outpatient Services, End of Life Care, Radiology and Pathology Services; Work with the CCG continued through the Quality Review Group and the Internal Assurance programme; the Quality Lead from NHSI attended a review of the Trust's Never Events Working Group and was instrumental in supporting ongoing work to improve the complaints standard.
- "To recognise and respond to the specific needs of patients with complex needs" – A scoping exercise with carers of people with dementia was undertaken to identify the potential need for a drop in /nurse-led clinic; this is now being explored further under the Aligned Incentive Contract. The Trust's Learning Disability Liaison Nurse provided training sessions to 353 members of Trust staff and to patients with learning disabilities in the community, & supported several patients in attending appointments and surgery.

Clinical Effectiveness: To improve the management of patient flow through the delivery of safe and effective care for patients by whichever pathway of care best meets those needs

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

- "Sustaining previous work undertaken to avoid unnecessary admissions to hospital through the development of alternative care models/pathways" – There was an increase during the year in zero length of stay pathways (no overnight stay); There has been development of direct GP admissions and direct ambulance conveyance to the appropriate unit within the hospital, i.e. Ambulatory Emergence care (AEC) or Frailty Unit, was developed; further ambulatory pathways were created to increase zero length of stay; additional hours for GP's within ED were approved
- "Working with mental health partners to reduce the number of frequent attendances of patients in crisis attending our emergency departments" - Following the previous year's success in reducing the number of attendances for 25 patients by 43%, a further cohort was identified & the plans of care for these patients reviewed by the Multi-disciplinary and professional team that includes SECAmb and KMPT to ensure that a consistent and cohesive approach is applied to support the individuals' ongoing care needs
- "Working in collaboration with community and local authority colleagues to further develop pathways to support the timely discharge of patients" – The Trust continued its work with partners to promote the timely discharge of patients, notably including implementation of the Virtual ward/ Hospital@Home service in Winter 2018/19.

Quality Improvement priorities for 2019/20

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. The Trust's priorities for 2018/19 were developed through engagement of a wide cross-section of its staff.

The Trust's 3 quality priorities for 2019/20 are:

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

The key objectives involve:

- Creating a safety culture that embraces 'lessons learned'. This will include:
  - Increasing the number of incidents that are reported to identify themes to support change
  - Continued focus on reducing mortality figures in line with the national average (HSMR/SHMI) through learning from mortality reviews
  - Supporting staff to share their experiences and to encourage their development
- Reducing healthcare associated infections, in particular:
  - Clostridium Difficile
  - Gram negative bloodstream infections
  - MRSA/MSSA bloodstream infections
- Improvement in outcomes for expectant mothers and their babies in line with 'Better Births' and the National Maternity Transformation work
- Improvement in the care of the deteriorating patient through the promotion of early recognition, response and appropriate escalation

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:

- Embedding and delivery of the Quality Improvement Plan
- Improving recognition and timely decision making for the provision of End of Life Care
- To recognise and respond to the specific needs of patients with complex needs including:
  - Working with partner organisations to deliver all aspects of the Accessible Information Standard
  - Development of training strategies to support staff in delivering care appropriate to their patients' needs

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

The key objectives involve:

- Improving the delivery of access standards and thereby timely treatment for patients accessing care through both Emergency and Planned pathways of care.
  - To ensure that an increasing number of patients are seen and treated within 4hrs through the EDs
  - To reduce the number of patients waiting for procedures on the elective waiting list whilst ensuring that they do not come to harm
  - Improvements in timeliness of diagnosis, decision making and treatment for Cancer patients
- Improving patient flow through the development of alternative care models/pathways.
- Reduction in cancelled operations
- Development of new and enhanced roles to improve pathways of care and raise staff morale.

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.

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Performance Report for 2018/19: Sustainability Report

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As an NHS organisation and 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 rising cost of natural resources. The commitment to this agenda was reaffirmed in the NHS Long Term Plan with clear targets on carbon and air pollution. Demonstrating that it considers the social, economic and environmental impacts, ensures that the legal requirements in the Public Services (Social Value) Act (2012) are met by the Trust.

In order to fulfil its responsibilities for the role it plays, the Trust has the following sustainability mission statement embodied in 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, the Trust has a duty to contribute equally towards the UK government carbon budgets to at least reduce emissions by 34% (from a 2007 baseline) equivalent to a 28% reduction from a 2013 baseline by 2020. The aim is to have a local target by reducing carbon emissions 28% by 2020/21 using 2013/14 as the baseline year. The ambition of the NHS Long Term Plan is to continue to contribute to the next milestone of a 51% reduction by 2025.

Policies

In order to embed sustainability within the Trust's business it is important to explain where sustainability features in its process and procedures. One of the ways in which an organisation can embed sustainability is through the use of an SDMP. The Trust Board approved the Trust's SDMP in the last 12 months and the plans for a sustainable future are clearly laid out and well known within the organisation.

The Trust undertakes a sustainability impact assessment during the development of a business case for products and services. The Trust does not currently use the Sustainable Development Assessment Tool (SDAT). The Trust's suppliers are required to confirm they comply with the Modern Slavery Act as part of their contractual obligations.

Adaptation

Climate change brings new challenges to the Trust's business both in direct effects to its healthcare estates, but also to patient health. Examples of such challenges in recent years include the effects of heat waves, extreme temperatures and prolonged periods of cold, floods, droughts etc. The Trust's Board approved plans address the potential need to adapt the delivery the organisation's activities and infrastructure to climate change and adverse weather events. Events such as heatwaves, cold snaps and flooding are expected to increase as a result of climate change. To ensure that services continue to meet the needs of the local population during such events a number of policies and protocols have been developed and implemented in partnership with other local agencies.

Partnerships

The NHS policy framework already sets the scene for Providers to operate in a sustainable manner. As a provider, the Trust will need to provide evidence of this commitment in part through contracting mechanisms. The Trust has not currently established any strategic partnerships.

Green Space and Biodiversity

The Trust recognises its grounds & green spaces as assets, both through the natural capital they represent as a habitat and ecosystem & as a resource for local communities to utilise and enjoy. It is improving access to its green spaces and natural environments for stakeholders and is committed to maintaining & enhancing the biodiversity capacity of its managed estate. In the last year a complete refurbishment of the Lung garden has been undertaken in association with the Lung Awareness charity, as well as completion of a Stroke garden.

Performance

Organisation

Since the 2007 baseline year, the NHS has undergone a significant restructuring process, which is still ongoing. In order to provide some organisational context, the following table explains how both the organisation and its performance on sustainability has changed over time.

Context info	2007/08	2015/16	2016/17	2017/18	2018/19
Floor space (m^2)	109,896	138,533	138,533	138,533	138,533
Number of staff (WTE)	3,969	4,678	5,130	5,022	5,153

In 2014 the Sustainable Development Strategy outlined an ambition to reduce the carbon footprint of the NHS as a system by 28% (from a 2013 baseline) by 2020. The NHS Long Term Plan reaffirms the commitment for the health and care system to provide at least an equal contribution to the UK government carbon budgets. The Trust has supported this ambition as detailed below:

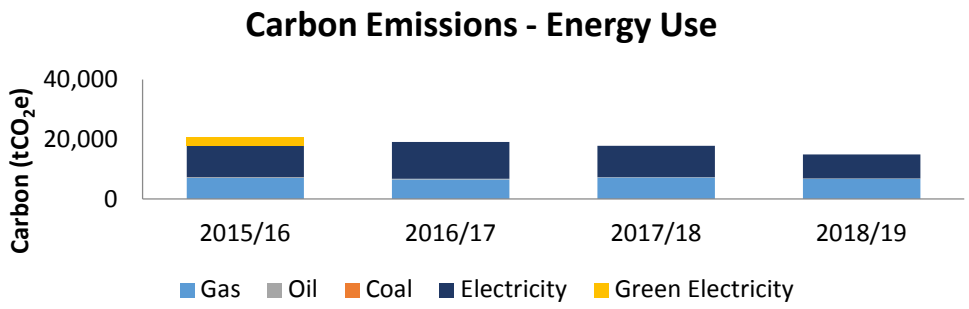
Energy

Managing energy is one aspect of reducing carbon emissions. The Trust spent £4,912,381 on energy in 2018/19, an 8.3% increase on energy spend from the previous year. Significant progress has been made in the reduction of both electrical & gas consumption in the last year through the completion of a Trust-wide LED lighting upgrade & the installation of a flue gas economiser to one of the boilers at Maidstone.

Resource[4]		2013/14	2014/15	2015/16	2016/17	2017/18	2018/19
Gas	Use (kWh)	34,135,656	32,905,482	34,139,781	31,546,328	33,930,120	31,855,591
	tCO_2e	7,242	6,904	7,145	6,593	7,194	6,766
Oil	Use (kWh)	955,973	1,110,958	635,113	532,926	313,362	280,800
	tCO_2e	305	356	203	147	102	90
Coal	Use (kWh)	0	0	0	0	0	0
	tCO_2e	0	0	0	0	0	0
Electricity	Use (kWh)	224,551	1,331,564	18,564,756	23,801,508	23,652,117	22,899,149
	tCO_2e	126	825	10,673	12,301	10,542	8,078
Green Electricity	Use (kWh)	22,477,329	21,816,665	4,892,105	0	0	0
	tCO_2e	12,585	13,512	2,813	0	0	0
Total energy CO_2e		20,258	21,597	20,834	19,041[5]	17,838	14,934
Total energy spend		£4,039,990	£3,814,599	£3,919,681	£3,835,790	£4,535,611	£4,912,381

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.

[4] Data for energy resource usage before 2016/17 was reviewed and revalidated in 2016/17
[5] This figure has been amended to correct an error in the Annual Report 2016/17



Re-use

The re-use of goods and community equipment in the NHS has several key co-benefits, reducing cost to the NHS. It also reduces emissions from procuring and delivery of new goods and can provide social value when items are re-used in the community. The Trust has continued to partner with local reuse organisations to find homes for assets that are still usable. The Trust is committed to mainstreaming this activity in 2019/20.

Category		2015/16	2016/17	2017/18	2018/19
Internal reuse of durable goods	£	Not Recorded	Not Recorded	2,000	2,000
External reuse of durable goods	£	Not Recorded	Not Recorded	2,500	5,000

Paper

The movement to a Paperless NHS can be supported by staff reducing the use of paper at all levels, this lessens the environmental impact of paper, reducing cost of paper to the NHS and can also help improve data security. The Trust is committed to make incremental progress in its reduction of paper and is seeking to implement a paperless system where possible. However the level of paper procured in the last year is counterproductive to this ambition.

Paper		2017/18	2018/19
Volume used	Tonnes	61	90
Carbon emissions	tCO_2e	58	85

Travel

Improvements can be made to local air quality and carbon emissions through the way that the Trust designs its travel arrangements and services. The Trust has a clear policy on healthy travel for the organisation and healthy and sustainable travel is promoted to our stakeholders (staff, patients and the public).

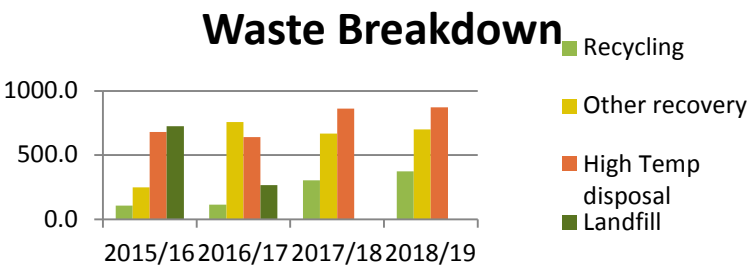
The Trust is a lean organisation and every actions counts in trying to realise efficiencies across the board for cost and carbon (CO_2e) reductions. A culture for active travel is supported to improve staff wellbeing and reduce sickness. Air pollution, accidents and noise all cause health problems for the local population, patients, staff and visitors and are caused by cars, as well as other forms of transport

Category	Mode	2014/15	2015/16	2016/17	2017/18	2018/19
Patient & visitor travel	Miles ♌	104,162,344	107,404,988	112,158,231	115,563,332	121,747,529
	Miles	38,272.30	38,841.48	40,535.15	41,178.09	44,890
Business travel & fleet		1,170,280	1,319,789	1,037,636	1,059,360	0
	tCO_2e	430	477	375	377	0
Staff commute	Miles	4,610,964	4,493,769	4,927,968	4,824,221	4,824,221
	tCO_2e	1,694	1,625	1,781	1,719	1,779

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

Waste

The Trust has placed significant focus on the enhanced segregation of clinical waste in the last year, which has seen an increase in the levels of compliance in clinical areas as well as generating cost savings in disposal of clinical waste. This has been supported by continued solid progress in raising recycling levels and volumes throughout the Trust.



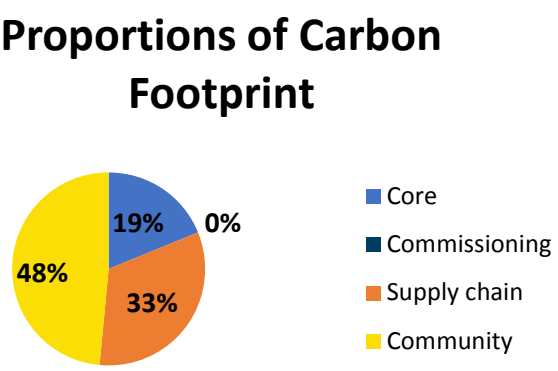
Waste		2013/14	2014/15	2015/16	2016/17	2017/18	2018/19
Recycling	(tonnes)	268.00	214.97	107.00	115.00	304.00	372.00
	tCO_2e	5.63	4.51	2.14	2.42	6.62	7.95
Other recovery	(tonnes)	166.00	211.00	248.00	756.00	668.00	700.00
	tCO_2e	3.49	4.43	4.96	15.88	14.54	14.97
High Temp disposal	(tonnes)	573.00	682.52	679.00	639.00	861.54	872.00
	tCO_2e	126.06	150.15	148.70	140.58	189.54	191.84
Landfill	(tonnes)	723.00	699.42	724.00	265.00	0.0	0.00
	tCO_2e	176.71	170.95	176.96	82.15	0.00	0.00
Total Waste (tonnes)		1730.00	1807.91	1758.00	1775.00	1833.54	1944.00
% Recycled or Re-used		15%	12%	6%	6%	17%	19%
Total Waste tCO_2e		311.89	330.04	332.76	241.03	210.69	214.76

Finite resource use – water

The Trust has made steady progress in the reduction of water consumption in the last year through and has ensured that sub-metering has been installed to ensure the accuracy of billing.

Water		2013/14	2014/15	2015/16	2016/17	2017/18	2018/19
Mains	m^3	186,570	186,441	205,246	209,205	225,383	211,936
	tCO_2e	170	170	187	190	205	193
Water & Sewage Spend		£684,307	£539,538	£582,869	£661,990	£761,100	£758,895

Modelled Carbon Footprint

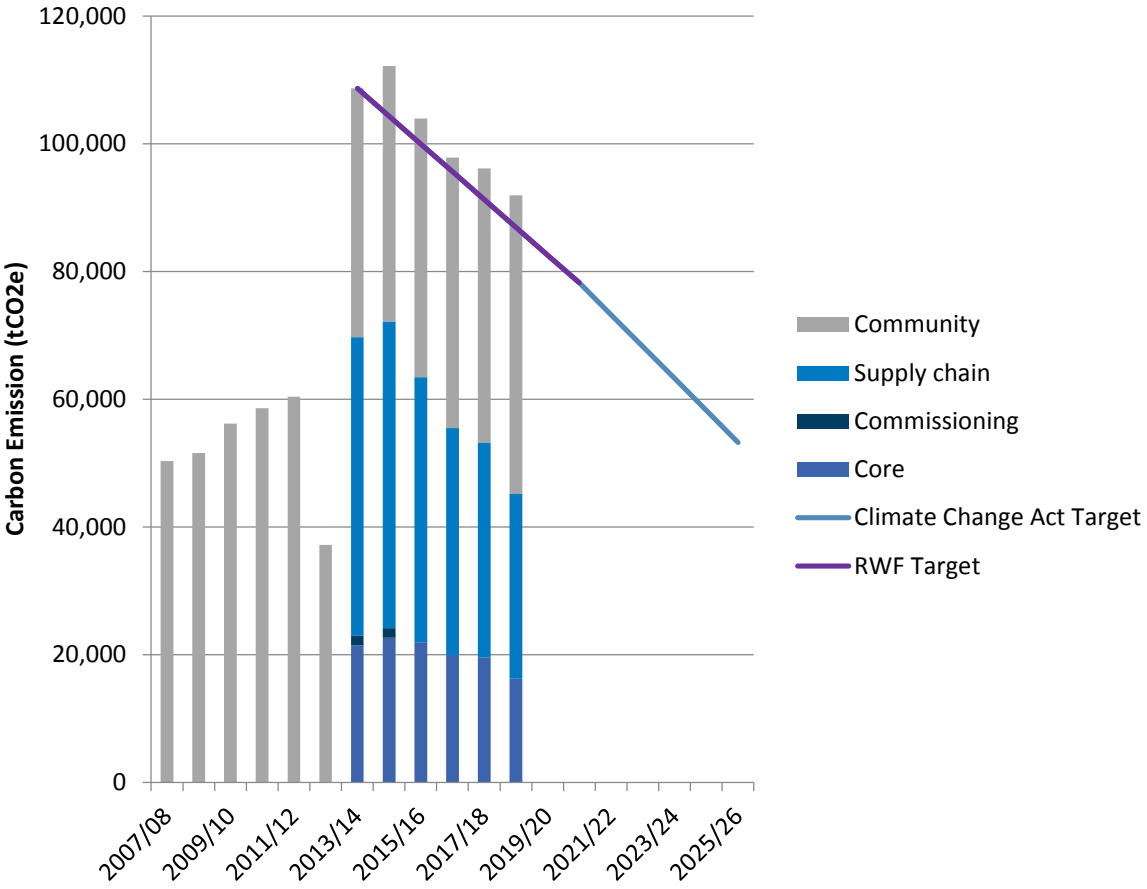


The information provided in the earlier sections of this sustainability report uses Estates Return Information Collection (ERIC) returns as its data source. However, this does not reflect the Trust's entire carbon footprint. The following information uses a scaled model based on work performed by the Sustainable Development Unit (SDU) in 2009/10. More information is available at: http://www.sduhealth.org.uk/policy-strategy/reporting/nhs-carbon-footprint.aspx

The application of this model results in an estimated total carbon footprint of 88,454 tonnes of carbon dioxide equivalent emissions (tCO_2e). The Trust's carbon intensity per pound is 204 grams of carbon dioxide equivalent emissions per pound of operating expenditure (gCO2e/£) against average emissions for NHS acute services of 200 grams per pound.

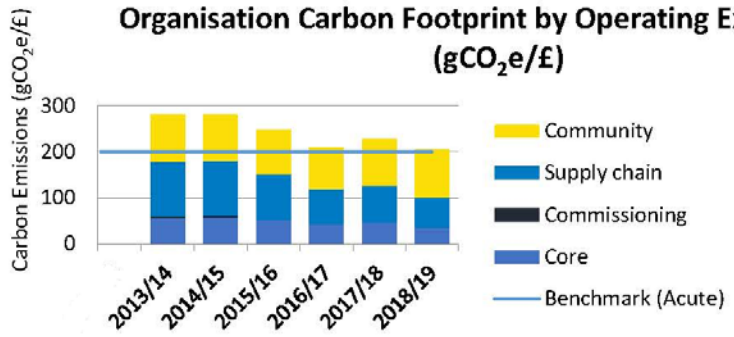
Modelled Trajectory

The Trust is committed to meeting the legal requirements of the Climate Change Act by reducing its emissions in line with the trajectory outlined above. These reductions are currently on track in respect of direct emissions. Progress is however challenged by increasing patient contacts and their associated carbon footprint.



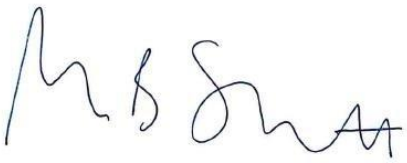
Benchmarking

The Trust has made good progress in 2018/19 in its performance in relation to the benchmark for other acute NHS Trusts.



Declaration

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



Miles Scott, Chief Executive

23rd May 2019

Maidstone and Tunbridge Wells NHS Trust

Accountability Report for 2018/19: Corporate Governance report

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Directors' report

The Trust Board

The Trust Board meets monthly, except in August, in public. The times and venues of these meeting are available in advance 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 membership underwent changes during the course of the year with the retirement of longstanding Chief Operating Officer, Angela Gallagher, in November 2018 and appointment of Sean Briggs to the role. Deputy Chief Executive, Jim Lusby, left the Trust at the end of April 2018 and Amanjit Jhund assumed the new role of Director of Strategy, Planning and Partnerships in October 2018. There were additionally new Non-Executive Director and Associate Non-Executive Director appointments. The Trust uses executive search facilities and advertising to attract the broadest range of appropriately skilled candidates when vacancies arise.

One of the Trust's two 'away days' in 2018/19 gave consideration to evaluating the Board's effectiveness, including reflection of the Board's purpose and accountability; measures of success and the need to adapt and continuously improve. The programme of regular Board Seminars established in 2017/18 continued every other month allowing more focussed consideration of key themes collectively by the Board. In 2018/19, these included a review of private patient services, risks associated with the Trust's planned levels of income in 2018/19, as well as a session attended by 'Getting It Right First Time' (GIRFT) representatives to review the GIRFT programme in more detail.

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 2018/19, the Trust Board had the following members:

David Highton

Chair of the Trust Board*

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. From 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 in Meopham & Sittingbourne, and currently lives in Whitstable.

Miles Scott

Chief Executive*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 NHSI, 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 13 and 14. 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 NHSI. 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 chairs the Patient Experience Committee and is Acting Chair of the Audit and Governance Committee. 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 was 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.

Trust Board Members (continued)

Sean Briggs

Chief Operating Officer*Σ

Sean joined the Trust as Chief Operating Officer designate in October 2018 and became the substantive Chief Operating Officer and member of the Trust Board on 3rd December 2018. Sean has a broad experience working within a variety of healthcare settings, but has spent most of this time in the acute setting in hospitals such as St George's NHS Foundation Trust and Epsom and St Helier Hospital where he held a number of senior managerial roles. Sean is passionate about improving clinical engagement and patient care across the Trust, and has a strong track record in improving hospital operational performance whilst delivering a number of high profile clinical strategic changes, most notably the development of the 24/7 Thrombectomy service at St George's.

Neil Griffiths

Non-Executive Director*♎

Neil joined the Board as an Associate Non-Executive Director in June 2018, and was appointed a substantive Non-Executive Director in February 2019, when he also assumed the chair of the Finance and Performance Committee. Neil is a career healthcare executive and Board leader with over 25 years public and private sector experience. His career has included strategic, operational, change management and commercial roles in and around hospitals in the UK. Neil was previously a Board member and Deputy Chief Executive at University College London Hospitals NHS Foundation Trust, a leading acute academic hospital provider in the UK. Neil's other career experience includes helping lead the team and development of the McKinsey Hospital Institute (MHI) in the UK as part of a global initiative for McKinsey & Company to develop analytical tools and performance improvement support for hospitals. Neil is currently Managing Director of TeleTracking Technologies in the UK, a global leader in the provision of services and technology supporting healthcare organisations to improve productivity and patient flow. Neil has been a local resident for 12 years, is married with 2 children and lives in Tunbridge Wells.

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.

Nazeya Hussain

Non-Executive Director*♎

Nazeya joined the Board in July 2017. Nazeya has 19 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. Nazeya is Chair of the Workforce Committee and Vice Chair of the Audit and Governance Committee. She is married with two children and lives in Sussex.

Amanjit Jhund

Director of Strategy, Planning and PartnershipsΣ

Amanjit joined the Board on 1st October 2018. Prior to joining the Trust, Amanjit was Director of Strategy and Transformation at Croydon Health Services NHS Trust, and previously worked as an Expert on Healthcare Systems and Services for McKinsey and Company in London. Amanjit is a doctor by background and first joined the NHS 12 years ago, working in hospitals in both Scotland and England gaining experience in a wide variety of medical specialties. Amanjit holds a professional registration with the General Medical Council and has degrees in both medicine and physiology.

Trust Board Members (continued)

Peter Maskell

Medical Director*Σ

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 CQC. 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 Trust's Deputy Medical Director. 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.

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 nearly 40 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

Chief Finance Officer*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 and also holds the role of Deputy Chief Executive .

Emma Pettitt-Mitchell

Associate Non-Executive Director

Emma joined the Board as an Associate Non-Executive Director in June 2018 and is Vice Chair of the Patient Experience Committee. Emma is a highly experienced senior executive with over 21 years' experience with one of the largest retailers (UK and globally) and FTSE 100 companies, Tesco Stores Ltd. Emma's extensive experience includes being the customer 'voice', retail, commercial, insight, human resources, buying and marketing, and also includes a highly successful background in the achievement of profitable business growth through the creation and execution of strategic business plans. Emma has worked extensively as a Director in both the private and public sector, most recently working for Kent County Council, as the Director of Strategic Business Development and Intelligence, leading a large insight team. In the last 3 years Emma has also held various Non-Executive Director positions'. Emma lives in Kent with her husband Andrew and 3 children.

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

The following individuals also served on the Trust Board during 2018/19:

- Angela Gallagher, Chief Operating Officer (joined the Board in October 2011 and left on 30th November 2018)
- Tim Livett, Non-Executive Director (joined the Board in June 2017 and left on 28th February 2019)
- Jim Lusby, Deputy Chief Executive (joined the Board in April 2015 and left on 30th April 2018)
- Steve Phoenix, Non-Executive Director (joined the Board in December 2017 and left on 31st December 2018)

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 2018/19. Attendance at each meeting is shown below:

Trust Board Member	April 2018	May 2018	June 2018	July 2018	September 2018	October 2018	November 2018	December 2018	January 2019	February 2019	March 2019
David Highton, Chair of the Trust Board	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Sean Briggs, Chief Operating Officer	N/A[6]						✓	✓	✓	✓	✓
Maureen Choong, Non-Executive Director	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Sarah Dunnett, Non-Executive Director	Apologies	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Angela Gallagher, Chief Operating Officer	✓	✓	✓	✓	✓	✓	✓	N/A[7]			
Neil Griffiths, Non-Executive Director	N/A[8]		✓	✓	Apologies	✓	✓	✓	✓	✓	✓
Simon Hart, Director of Workforce	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Nazeya Hussain, Non-Executive Director	✓	✓	✓	Apologies	✓	✓	✓	Apologies	✓	✓	✓
Amanjit Jhund, Director of Strategy, Planning and Partnerships	N/A[9]					✓	✓	✓	✓	✓	✓
Tim Livett, Non-Executive Director	Apologies	✓	Apologies	✓	✓	✓	✓	✓	✓	Apologies	N/A[10]
Jim Lusby, Deputy Chief Executive	✓	N/A[11]									
Peter Maskell, Medical Director	✓	✓	✓	✓	✓	✓	✓	Apologies	✓	✓	✓
Sara Mumford, Director of Infection Prevention & Control	✓	Apologies	Apologies	✓	✓	✓	✓	Apologies	✓	✓	✓
Claire O'Brien, Chief Nurse	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Steve Orpin, Chief Finance Officer	✓	✓	✓	Apologies[12]	✓	Apologies[12]	✓	Apologies[12]	✓	✓	✓
Emma Pettitt-Mitchell, Associate Non-Executive Director	N/A[13]		✓	✓	Apologies	✓	✓	✓	✓	✓	✓
Steve Phoenix, Non-Executive Director	✓	✓	✓	✓	✓	✓	✓	✓	N/A[14]		
Miles Scott, Chief Executive	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓

[6]Sean Briggs joined the Trust on 29th October 2018 (as Chief Operating Officer designate) and became substantive Chief Operating Officer on 3rd December 2018

[7]Angela Gallagher left the Trust on 30th November 2018

[8]Neil Griffiths joined the Trust Board on 4th June 2018 as an Associate Non-Executive Director (i.e. non-voting), and was appointed as a Non-Executive Director on 15th February 2019

[9]Amanjit Jhund joined the Trust on 1st October 2018

[10] Tim Livett left the Trust on 28th February 2019

[11] Jim Lusby left the Trust on 30th April 2018

[12]Hannah Ferris, Deputy Director of Finance (Financial Performance) attended in Steve Orpin's place on 26th July, 25th October & 20th December 2018

[13]Emma Pettitt-Mitchell joined the Trust Board on 4th June 2018 as an Associate Non-Executive Director (i.e. non-voting)

[14]Steve Phoenix left the Trust on 31st December 2018

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 through which:

- 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[15]) for Directors. No concerns have been raised in relation to this in 2018/19.

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 2018/19 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	▪ Strategic Health Industry Adviser for Servita Group Ltd (company number: 10497423 - a professional services company operating in the UK, Middle & Far East) ▪ Chairman, Demelza House Children's Hospice (charity Number: 1039651) ▪ Owner and Director, Hyperium Ltd (company number: 04684013)
Sean Briggs, Chief Operating Officer	None
Maureen Choong, Non-Executive Director	▪ Specialist Adviser, Care Quality Commission ▪ Governor, Positive Ageing Research Institute, Anglia Ruskin University
Sarah Dunnett, Non-Executive Director	▪ Director of Catalyst (London) Ltd (company number: 10121754) ▪ Director of Sevenoaks School (company number: 04908949)
Neil Griffiths, Non-Executive Director	▪ Managing Director, Tele Tracking Technologies ▪ Advisory Council Member, The Staff College: Leadership in Healthcare (Staff College) (charity number: 1169166; company: 10316815) ▪ Director, MY UCLH Ltd (company number: 09563304)
Simon Hart, Director of Workforce	None
Nazeya Hussain, Non-Executive Director	None
Amanjit Jhund, Director of Strategy, Planning & Partnerships	Member of the UK Labour Party
Peter Maskell, Medical Director	None
Sara Mumford, Director Infection Prevention & Control	None
Claire O'Brien, Chief Nurse	None
Steve Orpin, Chief Finance Officer	Non-Executive Director, NHS Innovations South East Limited (company number: 05210174) – serves as a Director as a result of the Trust acting as Guarantor
Emma Pettitt-Mitchell, Associate Non-Executive Director	Non-Executive Director, Glacies Limited (company number: 08773286) Non-Executive Director, ELM Business Consultancy (company number: 08773286)
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 2018/19 can also be obtained from the Trust Secretary.

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 2018/19' section later in the Annual Report. The scope,

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

effectiveness and membership of Trust Board sub-committees was reviewed during the year as part of one of the Trust Board's 'away days'.

The Trust's Management Structure

The Trust is organised into a number of Corporate and Clinical Directorates. Following a restructure during the year (see pages 13-14 for more detail). Following the Trust's restructure in 2018/19 to become more clinically led, Clinical services are now arranged within 5 Divisions, encompassing 18 Directorates:

Division	Directorate
Medicine and Emergency Care	▶ Emergency Medicine ▶ Acute Medicine and Geriatrics ▶ Medical Specialities
Women's, Children's and Sexual Health	▶ Children's Services ▶ Women's Services ▶ Sexual Health
Cancer Services	▶ Clinical Haematology ▶ Oncology
Diagnostics and Clinical Support	▶ Pathology ▶ Pharmacy ▶ Imaging ▶ Therapies ▶ Outpatients
Surgery	▶ General Surgery ▶ Urology, Gynae Oncology, Breast & Vascular Surgery ▶ Theatres and Critical Care ▶ Orthopaedics ▶ Head and Neck

Each Division and Directorate is overseen by a clinical management team (triumvirate). The triumvirate is led by a Chief of Service with overall responsibility for the leadership & management of their area. Chiefs of Service are supported by a Divisional Director of Operations (DDO) & Divisional Director of Nursing and Quality (DDNQ). There is a Clinical Director (CD) for each Directorate and Directorate management teams follow the same triumvirate format as Divisions with Clinical Directors, General Managers, Lead Matrons and Other Professional Leads. All work together to agree annual & strategic plans for their services, are responsible for clinical & operational performance, resource and, communicating and engaging with staff.

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 2018/19, the Trust received 550 formal complaints (in 2017/18, this was 503), and 68.0% of complaints received were responded to within the agreed timescale (in 2017/18, this was 63.6%).

The Trust's Complaints and Patient Advice and Liaison Service (PALS) – Annual Report (due for publication in June 2019) (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 2018/19, the Trust offered financial remedy in 6 cases, totalling £2534.30[1]. There were no further recommendations by the PHSO for Financial redress in other cases. 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 no Serious Incidents Requiring Investigation involving personal data that met the criteria for reporting to the Information Commissioner's Office (i.e. a 'Level 2' severity incident).

The Trust 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	84
C	Lost in transit	11
D	Lost or stolen hardware	3
E	Lost or stolen paperwork	7
F	Non-secure disposal – hardware	0
G	Non-secure disposal – paperwork	7
H	Unloaded to website in error	0
I	Technical security failing (including hacking)	0
J	Unauthorised access/disclosure	8
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.

[1] This is based on complaints received between 01/4/18 and 31/03/19 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

Emergency preparedness

As a Category One responder under the Civil Contingencies Act 2004, the Trust has specific statutory duties in relation to emergency planning and response. Additionally, NHS England and West Kent CCG impose a number of contractual duties and requirements in relation to resilience. The NHS England Emergency Preparedness, Resilience and Response (EPRR) assurance assessment, undertaken in the summer of 2018, found the Trust to be substantially compliant.

Incidents that took place during the year

The Trust mounted a number of emergency responses during the year, including a major incident standby in May in response to an episode on Detling Hill involving firearms. Unseasonably hot summer weather tested the Trust's heatwave planning and response to high temperatures - Tunbridge Wells Hospital stood up well with its modern design, whilst some areas at Maidstone Hospital required portable air conditioning. A report was compiled to review the management of responses to a heatwave in the future following the report from the Parliamentary Select Committee on heatwave resilience. In August a Coach crash on the M25, resulted in the Ambulance Service declaring major incidents at both Trust main sites, as well other hospitals. This provided a good test of procedures and a focussed debrief was held to consider any necessary amendments to plans. Throughout the year various highways issues affected the Trust, including a major sinkhole opening on the A26, and various long-term roadworks and closures on the motorway network. The team worked with Kent Highways and Highways England to mitigate some of the adverse effects on the organisation.

Multi-agency cooperation & training

NHS confederation's "When tragedy strikes" report, published in 2018, reviewed key learning from incidents around the UK in the previous year & made a number of observations , most fundamentally that planning and rehearsal, multi-agency collaboration, & support for both patients and staff are vital to providing the best possible care when tragedy strikes. The importance of Major Incident exercises was also acknowledged.

Exercise Shakespeare, held in April, in North Kent enabled staff to play the part of casualties and bystanders to test emergency service responses to a firearms incident. Exercise Nightingale, in May, at Tunbridge Wells Hospital tested radiation emergency arrangements with Dungeness Nuclear Power Station, Kent Fire & Rescue Service and SECAmb. It allowed ED and Medical Physics staff and incident commanders to respond to a live simulated nuclear incident and provided a full communications test.

The Trust annual table top exercise was held in June at the Kent Event Centre. Over 60 Trust staff worked with colleagues from SECAmb and the independent sector to respond to a large train crash. Exercise Ragdoll, also in June, enabled staff to work with Kent Police to respond to a simulated missing child, allowing both Police and hospital staff opportunity to consider the key issues in working together. The Trust's annual winter exercise, Exercise Polar saw over 60 staff with partner agencies including West Kent CCG, SECAmb, Kent Community Health and Kent County Council working through winter contingencies.

During the year the team forged new partnerships in the community and reinforced others. Working with Kent Association for the Blind enabled the development of skills to ensure those who are visually impaired can be safely treated in chemical or radiation incidents where decontamination is required. Practical training with guide dogs that would also require decontamination has been beneficial. Helen Grant MP visited Maidstone Hospital to view the training first hand following the Salisbury Nerve Agent attack earlier in 2018.

The Trust is a member of the Kent Resilience Forum which brings together all the emergency services and other responders such as the NHS, utilities and the voluntary sector. More information about their work, including the community risk register is available at www.kentprepared.org.uk .The Trust has worked for some time to develop the next generation of emergency planning professionals and to promote NHS Emergency Planning as a career choice amongst new graduates. The Trust's first such student placement is now working for the Department for International Development and had a key role in the Ebola response.

Brexit

Planning for Brexit was a major part of the year's activity with the Trust working in partnership with the Local Resilience Forum, Multi agency partners, NHS partners, suppliers and staff to ensure it would be able to continue to deliver high quality, safe care to its patients in any outcome. At the end of the year the situation remained fast-moving and fluid, and extensive planning and preparation for an EU Exit was ongoing. This included the establishment of local contingency plans and measures to ensure that suppliers, contracts and supplies of medicines remain robust.

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

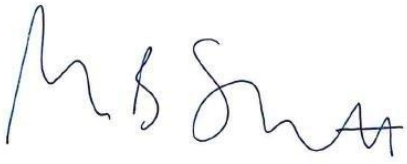
The Chief Executive of the NHS Trust Development Authority has designated that the Chief Executive should be the Accountable Officer to the Trust. The relevant responsibilities of Accountable Officers are set out in the Accountable Officers Memorandum issued by the Chief Executive of the NHS Trust Development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

23rd May 2019

Annual Governance Statement for 2018/19

Scope of responsibility

As Accountable Officer, I have responsibility for maintaining a sound system of internal control that supports the achievement of Maidstone and Tunbridge Wells 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[16].

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 2019 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, including 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 Executive is the Board Level Director (with fire safety responsibility) and the Security Management Director
- The Chief Operating Officer is the Accountable Emergency Officer for Emergency Preparedness, Resilience & Response (EPRR)
- One of the Non-Executive Directors has been appointed as the Non-Executive Lead for Safeguarding and also for Resuscitation
- The Chair of the Quality Committee is the Non-Executive Director with specific role/responsibilities for leading falls prevention , and also the Non-Executive lead on mortality and learning from deaths
- A further Non-Executive Director has been allocated the EPRR portfolio

The Trust has a Risk Register and Board Assurance Framework (BAF) and 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 main content of the Risk Register are reviewed regularly at the Audit

[16] See https://tinyurl.com/NHSAOM

and Governance Committee, Executive Team Meeting and Trust Management Executive (TME), whilst the relevant aspects of both are reviewed regularly at the Finance and Performance Committee (the Trust Board confirmed in July 2018 that it not consider it necessary for the same approach to be applied to the Workforce Committee or Quality Committee, as the key objectives were already covered in the Committees' routine business).

As is the case every year, the BAF and Risk Register are subject to review by the Trust's Internal Audit function (which is provided by TIAA Ltd). The review for 2018/19, 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…"; "It was confirmed that there is an effective committee structure in place and that the BAF has been regularly presented to the Trust Board after review by the Audit and Governance Committee."; and "The Trust has clear risk management processes in place to support the identification and management of risks with red rated risks within the Trust Risk Register being reviewed by the Trust Management Team on a quarterly basis".

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 patient safety/clinical risk management; clinical governance; clinical audit; complaints; the Patient Advice and Liaison Service (PALS); medico-legal service and claims handling; and 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) via a range of methods, including via the freedom to Speak Up Guardian; being aware of their responsibility to report and act upon any incidents that occur; being involved in risk assessments; and attending regular training updates.

The Trust's mandatory induction and ongoing training programme for all staff reflects the need for staff to have a sound basis in managing risks relating to Information Governance, Infection Prevention and Control, fire safety, Safeguarding Children and Vulnerable Adults, Health and Safety and Moving and Handling. Non-mandatory training is also available to staff on a wide range of issues relating to risk management, both general (e.g. risk assessment) and in response to specific risks (e.g. falls prevention), whilst in-house support and advice on risk management is also available (which includes advice relating to patient safety, health and safety, Emergency Planning & Response and information governance. 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 Trust's advisers on risk seek to learn from best practice from a variety of means, including continuing professional development and via networking with counterparts from other organisations.

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. Mitigations are aimed to be identified in advance (where appropriate), so that these can be applied should the identified risk materialise. 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. A report from each Trust Clinical Governance Committee is submitted to each 'main' Quality Committee. The Quality Committee then aims to seek and obtain assurance on the effectiveness of the Trust's structures, systems and processes.

Clinical audit is supported by a central team, within the Clinical Governance department, and is primarily overseen by the Clinical Audit Overview Committee, a sub-committee of 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, and an SI report is submitted to each 'main' Quality Committee.

Complaints are managed by the central complaints team in partnership with the relevant Directorates and Divisions. 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 2018/19, a "Data Quality of Key Performance Indicators" was undertaken and 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 (which resulted in an overall assessment of "Requires Improvement"). However, quarterly engagement events have taken place with the CQC during

2018/19. Although such engagement events do not affect the Trust's formal assessment rating, the CQC have provided positive feedback on the areas that have been visited during these events.

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, and the Trust undertakes an assessment against the ten 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). That assessment is done via the Data Security and Protection Toolkit, and the Trust Board approved the submission against the latest assessment in March 2019.

The Trust is also moving ahead with the work required to achieve the Cyber Essentials Plus Accreditation, which is a government-backed, industry-supported scheme designed to help organisations protect themselves against common on-line threats. It is mandatory that all NHS organisations are Cyber Essentials Plus accredited by 2021 and the Trust intends to complete the accreditation by the summer of 2019.

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. On 24/05/18, the Board then approved the proposal to continue with that approach for 2018/19 (and also that all the objectives for 2018/19 address the underlying risk that the Trust is unable to demonstrate clinical operational or financial sustainability) and duly approved the following key objectives for 2018/19:

1. To deliver the trajectory agreed with NHS Improvement for the A&E 4 hour waiting time target
2. To deliver the trajectory agreed with NHS Improvement for the 62-day Cancer waiting time target
3. To deliver the Referral to Treatment (RTT) trajectory agreed with NHS Improvement for patients on an 'incomplete' pathway
4. To deliver the financial plan for 2018/19
5. To ensure a falls rate of no more than 6.0 per 1000 occupied bed days
6. To ensure a pressure ulcer rate of no more than 3.0 per 1000 admissions
7. To deliver the agreed 'lessons learned' plan for 2018/19
8. To deliver the agreed medical productivity plan for 2018/19
9. To deliver a vacancy rate of no more than 9%
10. To deliver a staff turnover rate of less than 10%

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 2018 and February 2019. A year-end BAF report regarding the achievement of the objectives is scheduled to be received by the Trust Board in April 2019.

In addition, a number of risks were rated as 'red' in 2018/19. Red-rated risks are reviewed and validated at the Executive Team Meeting (which have, since January 2019, included the Chiefs of Service for each clinical Division) each quarter, and the underlying risks have been discussed at the Trust Board, 'main' Quality Committee, Finance and Performance Committee, Workforce Committee and/or TME throughout 2018/19, and include the following:

- Achieving the Cancer waiting time targets
- The cost pressures associated with the use of temporary staff
- Nursing staffing levels in Emergency Medicine (particularly the Acute Medicine and Geriatrics and Medical Specialty Wards at Tunbridge Wells Hospital) and Orthopaedics
- Medical staffing shortage in Surgery impacting on inability to deliver emergency & elective care
- Risk associated with failing to learn from incidents
- Lack of capacity to assess and treat within clinically recommended timeframes in the general Ophthalmic and Medical Retinal Service
- Increased risk of harm to patients and staff as a result of delays to psychiatric assessment in the Emergency Medicine and Acute Medicine and Geriatrics Directorates
- Shortage of paediatric middle grade doctors on day shifts for paediatrics
- Shortage of radiotherapy therapeutic radiographers and consultant grade oncologists
- The effect of failing to maintain a quality management system in Blood Sciences

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 with the relevant risk leads.

Are the Trust's services well-led?

The CQC inspection in 2017 that was referred to above rated the Trust as "Good" for the Well-led domain. However an in-house Well-Led assessment is intended to be taken during 2019/20.

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

In May 2018, the Trust Board completed the required self-certification (for 2017/18) 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 2017/18. The Trust Board will be asked to undertake the required self-certification for 2018/19 at its meeting in May 2019, 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:

- The Trust's mandatory induction and ongoing training programme for all staff reflects the need for staff to have a sound basis in managing risks relating to Information Governance, Infection Prevention and Control, fire safety, Safeguarding Children and Vulnerable Adults, Health and Safety and Moving and Handling.

- 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). The Medical Director also commissioned a Task and Finish Group to consider How do we learn? Do we share learning across and between Directorates? Do we learn from the more generic, cross-cutting themes and issues? What is everyone else doing across the NHS in respect of learning lessons? and How do we benchmark ourselves in relation to our incidence of recurrence of big issues?. The findings of the Task and Finish Group's work are reported via the Best Safety workstream, but were shared more widely at the TME meeting on 17/04/19
- The Trust's central communications programme aims to embed risk management via the promotion of a monthly "Safety Moment" (which focuses on a different theme each month) and "Take Five, Talk Five" programmes (which promotes clinical teams taking five minutes from their days to discuss a pertinent key issue)
- 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 Divisional-, Directorate- and departmental-levels forums)
- Risk management is incorporated into the Trust's planning arrangements and Quality Impact Assessment (QIA) process, which is overseen by the Project Management Office (PMO)

The key ways in which the Trust ensures that short, medium and long-term workforce strategies and staffing systems are in place (which assure the Board that staffing processes are safe, sustainable and effective)

The Trust complies with the "Developing Workforce Safeguards" recommendations via the following methods:

- A bi-annual review of safe staffing levels is led by the Chief Nurse, using a combination of historical data, professional judgement and reference to quality outcomes. The reviews follow the National Quality Board's 2016 guidance cover the necessary three components: evidence-based tools, professional judgement and outcomes
- The Trust has an effective workforce plan that is submitted to NHSI along with the annual financial and activity plans. The Trust Board discusses all of these plans before submission and specifically considered issues arising from the workforce plan at the March 2018 Trust Board meeting
- All service changes including those related to skill mix and the introduction of new roles are subject to a Quality Impact Assessment (QIA) process led by the Medical Director and Chief Nurse
- The Trust Board reviews all workforce metrics on a monthly basis and does so as part of its wider review of quality, safety, performance and finance metrics, to ensure that workforce challenges and risks are understood as part of the wider context of service delivery
- Where there are critical service risks in relation to staffing and the safe delivery of care these, along with their associated mitigations are escalated to the Trust Board and external regulators as required.

Care Quality Commission (CQC) registration

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

Register of interests

The Trust has an established "Gifts, hospitality, sponsorship and interests policy and procedure". However, it has not yet implemented NHS England's "Managing Conflicts of Interest in the NHS" guidance and has not therefore published an up-to-date register of interests for decision-making staff within 2018/19. The Trust's Audit and Governance Committee (which receives reports of declarations made under the "Gifts, hospitality,

sponsorship and interests policy and procedure") has however been kept informed of the Trust's plans regarding the guidance, and the Trust will implement the guidance in full during 2019/20.

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 has a Sustainable Development Management Plan in place which takes account of UK Climate Projections 2018 (UKCP18). The Trust ensures that its 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 2018/19. The Trust's annual Internal Audit programme for 2018/19 included a range of reviews relating to this area, including "Critical Financial Assurance - Payroll" and "Critical Financial Assurance - Financial Accounting and Non Pay Expenditure", which achieved overall assessment of "Reasonable Assurance" (although a "limited assurance" assessment was obtained for the "Critical Financial Assurance - Salary Overpayments" review). In addition, Internal Audit undertook an advisory in relation to the operation of the Aligned Incentives Contract during 2018/19.

Furthermore, in October 2018, NHSI removed the Trust from Financial Special Measures (FSM), as a result of improvements in financial performance and management at the Trust. NHSI had placed the Trust in FSM in July 2016. The Trust then met its financial plan for 2018/19 by achieving a post-Provider Sustainability Fund (PSF) surplus of £20.324m[17].

Information governance incidents

Four information governance incidents triggered the use of the Data Security and Protection Incident Reporting Tool during 2018/19, and two further incidents were reported internally as SIs. Details of these incidents were reported to the Trust Board in March 2019 as part of the annual update from the Senior Information Risk Owner. Each incident was subject to an internal investigation whereby root causes were identified and remedial actions detailed and implemented. However, none of the incidents met the threshold for notification to the Information Commissioner's Office.

[17] It should be noted that the annual accounts will not be approved by the Trust Board until 23/05/19.

Annual Quality Accounts

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 Accounts 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 2017/18 Quality Accounts (which was concluded in 2018/19) resulted in an unqualified limited assurance report. The External Audit of the 2018/19 Quality Accounts will be available in the summer of 2019.

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

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

The following processes are also 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 also 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, as part of a "Data Quality of Key Performance Indicators" review. The latest (2018/19) 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 the Cancer 62 Day wait and 18 weeks Referral to Treatment (RTT) incomplete pathway. The review led to an overall assessment of "Reasonable Assurance" (with the same conclusion being allocated to each indicator), and although some areas for improvement were identified, the overall conclusion included the comments that "The Trust has an appropriately approved and up to date Information Lifecycle Management Policy and Procedure in place", "The figures reported to the Trust Board for Cancer 62 Day Wait, were found to be accurately reported based on the data available from the source data system", and "For the RTT 18 week incomplete pathway, the figures reported could not be verified to the data available from the source data system due to a technical issue with the setup of the report used for reporting aggregate numbers. This resulted in the Trust under reporting performance of an average 0.22% on a monthly basis. However, it should be noted that this did not have a material impact on the total figures and percentages reported".

Review of effectiveness

As Accountable Officer, I have responsibility for reviewing the effectiveness of the system of internal control. My review of the effectiveness of the system of internal control is informed by the work of the Internal Auditors, Clinical Audit and the executive managers and clinical leads within the Trust who have responsibility for the development and maintenance of the internal control framework. I have drawn on the information provided in this Annual Report and other performance information available to me. My review is also informed by comments made by the External Auditors in their management letter and other reports. I have been advised on the implications of the result of my review of the effectiveness of the system of internal control by the Trust Board, Audit and Governance Committee, and Quality Committee, and a plan to address weaknesses and ensure continuous improvement of the system is in place.

The Head of Internal Audit Opinion for 2018/19 states that "My overall opinion is that reasonable assurance can be given that there is a generally sound system of internal control, designed to meet the organisation's objectives, and that controls are generally being applied consistently. However, some weakness in the design and/or inconsistent application of controls, put the achievement of particular objectives at risk". The last sentence of the Opinion reflects the fact that two of the reviews undertaken by Internal Audit during 2018/19 (those relating to "Server Management" and "Salary Overpayments") resulted in a "limited assurance" conclusion. As is the case with all reviews with such a conclusion, the details have been considered at the Audit and Governance Committee and actions to address the weaknesses identified in controls are monitored as part of the routine reports that Internal Audit submit to that Committee.

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 2018/19 resulted in an overall 'Reasonable assurance' assessment, a number also led to an assessment of 'Limited assurance'. These latter reviews have been considered at the Executive Team Meeting (in full) and the Audit and Governance Committee (in summary form), and actions to address the weaknesses identified in controls have been taken (or will be taken during 2019/20).

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 (which during 2018/19 were re-ordered on Board meeting agendas to include such reports as part of the review of the latest monthly performance). 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. Board meetings also have alternative "patient experience" and "staff experience" items, which provide invaluable first-hand experience of being a patient of, and working at, the Trust.

In 2018/19, the following changes in personnel occurred within the Trust Board (in chronological order):

- Nazeya Hussain was appointed as a substantive Non-Executive Director in mid-April 2018 (Ms Hussain had joined the Trust Board in July 2017 as an Associate Non-Executive Director)
- Jim Lusby (Deputy Chief Executive) left the Trust Board at the end of April 2018
- Emma Pettitt-Mitchell (Associate Non-Executive Director) joined the Trust Board in June 2018
- Neil Griffiths joined the Trust Board in June 2018, as an Associate Non-Executive Director and was then appointed as a substantive Non-Executive Director on in February 2019
- Amanjit Jhund (Director of Strategy, Planning and Partnerships) joined the Trust Board in October 2018
- Sean Briggs joined the Trust in late October 2018 (as Chief Operating Officer designate) and became the substantive Chief Operating Officer in December 2018
- Angela Gallagher (Chief Operating Officer) left the Trust Board at the end of November 2018
- Steve Phoenix (Non-Executive Director) left the Trust Board at the end of December 2018
- Tim Livett (Non-Executive Director) left the Trust Board at the end of February 2019

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 Trust 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 BAF); 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, is 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 Non-Executive Director, and meets five 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 Non-Executives Directors (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 Non-Executive Director, 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 informatics (including Information Technology) strategies and plans, and on plans and proposals for major development and investment in Information Technology. The Committee is chaired by a Non-Executive Director, 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 Non-Executive Director, 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 Non-Executive Director 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 Non-Executive Director and meets every 2 months.

Although not a Board sub-committee, the Executive Team Meeting enables key clinical and managerial issues to be discussed, debated, developed, scrutinised, monitored and agreed and/or approved. The Executive Team Meeting meets every week, is chaired by the Chief Executive and its membership comprises all members of the Executive Team and the five Divisional Chiefs of Service. The Executive Team Meeting is authorised to make decisions on any matter that is not reserved for the Trust Board or its sub-committees, and the key issues considered are reported to the Trust Board as part of the monthly report from the Chief Executive.

The TME, which meets quarterly, also supports the delivery of robust risk management policies and processes and the identification and addressing of all key risk issues. The meeting is chaired by the Chief Executive and its membership comprises circa 50 senior clinical and managerial leaders from across the Trust.

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 2018/19:

1. Although the Trust successfully achieved its planned performance on a number of important indicators, it failed to meet its 18-week Referral to Treatment (RTT) waiting time target trajectory. Weaknesses in the Trust's Patient Tracking List (PTL)/patient administration systems led to the Trust varying from its trajectory in the first Quarter of the year. Considerable steps have been taken to review these systems and to undertake additional activity to recover the position, and at the end of March 2019, the Trust had exceeded its plan to reduce the number of patients waiting and had increased compliance with the RTT standard (from 79% to 83%).

2. The Trust failed to meet the waiting target relating to 62-day first definitive treatment for cancer. The principal control issue was that demand and capacity were seriously out of balance, which meant that the Trust's plan for the year was unrealistic. A further increase in referrals in the first six months of 2018 pushed the Trust's performance to historically low levels. The Trust has however worked hard, with support from commissioners and NHS Improvement, to rebalance demand and capacity, to modernise its pathways and to strengthen its patient administration and the Trust is now on track to recover the standard on a sustainable basis during 2019/20
3. The Trust's complaints response performance declined during 2018/19. The Trust's complaints target is currently set at 75% of complaints being responded to within 25 days of receipt. The target was finally achieved in January 2019 (at 82.2%) following monthly monitoring meetings with Directorates who were failing to provide timely responses. However, in recognition of the challenge to achieving sustainable delivery of the target, the Executive Team Meeting approved a Business Case (in April 2019) to provide additional resilience within the Trust's Complaints and PALS service.
4. During June, July and August 2018 a higher than expected number of hospital-attributable Clostridium difficile cases were seen across the Trust. No evidence of cross infection had been found, but an outbreak was declared on 12/09/18 in order to highlight and prioritise the work needed to prevent further infections. An outbreak management plan was developed and approved by the Executives. However, by the end of October 2018 both hospital sites had had a period of over a month without a case of Clostridium difficile and the rate had returned to the baseline, so the outbreak was declared as closed. A closure report was submitted to the Trust Board in November 2018 by the Director of Infection Prevention and Control.
5. The Trust continued to have challenges in complying with the traceability of blood components requirements of the Blood Safety and Quality Regulations 2005 during 2018/19. Under the Regulations, the Trust needs to positively confirm the fate of every unit of blood that is administered, and the Medicines and Healthcare products Regulatory Agency (MHRA) identified the Trust as non-compliant with that requirement in October 2015. A further visit by the MHRA in December 2018 again highlighted poor traceability and required that monthly reports on the issue be submitted to me, as Chief Executive. The Trust plans to address the situation by the full installation of the "Bloodhound" Electronic Blood Tracking System during 2019/20.
6. One "Never Event" was declared at the Trust in 2018/19, which related to the retention of swab string in a woman who had an instrumental delivery in May 2018. The incident was subject to scrutiny to aim to ensure that lessons were learnt to prevent recurrence.
7. HM Coroner issued the Trust with one Regulation 28 ("Report to Prevent Future Deaths") report during 2018/19, following the Inquest into the death (in March 2018) of one of the Trust's patients, Timothy Mason. The Trust responded to HM Coroner as required and Mr Mason's family subsequently attended the Trust Board meeting in February 2019, at which the Chair of the Trust Board offered the Board's condolences and apologies for Mr Mason's death. A Task and Finish Group to address the issues raised by the case was established at the end of 2018/19, and the Group's findings will be overseen by the Quality Committee during 2019/20.

Conclusion

The significant internal control issues identified in 2018/19 are described above, in the body of the Annual Governance Statement.

Miles Scott, Chief Executive 23rd May 2019

NHS
Maidstone and Tunbridge Wells
NHS Trust

Accountability Report for 2018/19: Remuneration and Staff Report

taking pride

MTW
exceptional people, outstanding care

Our staff

Staff Survey

The Trust recognises that maintaining a highly skilled and engaged workforce and fostering a culture where staff feel involved and valued is fundamental to its ability to provide the highest consistent, quality care to its patients and to succeeding in its journey to becoming Outstanding. Staff feedback is critical to shaping how the Trust moves forward and in 2018 the Trust took part in the annual National NHS Staff Survey. The Trust's results have remained static over the past few years, placing MTW very much in the middle of the pack of its peers. Whilst this is encouraging in that, despite unprecedented demand and being in Financial Special Measures for part of the period, there has been no deterioration in how staff feel about working at the Trust, the aim for future year's is to achieve better than average.

In 2018/19, the Trust took the following steps towards ensuring improved engagement:

- Implementation of a Clinically Led Management structure (as detailed elsewhere in this report)
- Senior Management support for a programme of widespread senior staff visits throughout the organisation as part of a 'shop floor commitment' aimed at sharing the issues that staff experience on a daily basis across the Trust
- Managers commitment to holding regular team meetings to embed understanding of what was happening in the Trust
- Introduction of a Team Brief to improve the flow of communication and keep staff up-to-date with key quality, safety and staff matters
- Undertakings by each Division to develop its own local plan of action, in collaboration with its teams.

The Staff Survey findings have been grouped into 5 categories which will provide the focus for further work in 2019/20.

- Leadership & Culture – visibility of senior leaders, leading by example, safety culture, equality, diversity & inclusion, safe environment, quality of appraisals, immediate managers
- Engagement & Responsiveness – increased opportunities for staff to provide feedback, relevant and timely actions from feedback, back to the floor
- Choice & Control – involvement in local change
- Information & Communication – CEO update, team meetings, awareness of key roles and post-holders within the Trust, improvement in IT systems
- Integration – Understanding departmental pressures, rotations & transfers, career pathways & Quality of Care

The full staff survey results are available at: http://www.nhsstaffsurveyresults.com/

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[18] staff numbers	Permanently employed (WTE)[19]	Other (WTE)	Permanently employed (expenditure) (£000s)	Other (expenditure) (£000s)
Medical and dental	666	137	64,276	19,109
Ambulance staff	0	0	0	0
Administration and estates	1106	69	36,642	2,434
Healthcare assistants and other support staff	1210	126	31,132	3,942
Nursing, midwifery and health visiting staff	1343	309	60,661	17,183
Nursing, midwifery and health visiting learners	8	0	171	0
Scientific, therapeutic and technical staff	480	42	22,065	2,238
Social Care Staff	0	0	0	0
Healthcare Science Staff	195	3	9,702	140
Other	0	0	0	0
Apprenticeship levy	0	0	1,042	0
Total	5009	685	225,692	45,046
Staff engaged on capital projects (excluded from above)	11	2	866	225

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	0	0	None	0	None	0
£10,000 - £25,000	None	N/A	0	0	None	0	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	None	N/A	0	0	None	0	None	0

[18] 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.
[19] 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 2018/19	Total Value of agreements (£000s)	Number of exit package agreements 2017/18	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	0	0	15	78
Exit payments following Employment Tribunals or court orders	0	0	0	0
Non contractual payments requiring HMT approval *	0	0	0	0
Total	0	0	15	78
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.

Staff engagement and 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. As evidenced by the Trust-wide consultation during the year around the implementation of the new Clinically Led structure, staff are formally consulted when organisational or other work changes are proposed and have the opportunity to comment and input into proposed changes.

Information is cascaded to all staff through a quarterly Open Staff Meeting system, which involves a face-to-face meeting with two Executive Directors (including the Chief Executive) at both main hospital sites. A weekly Chief Executive's update and "MTW News" newsletter are issued to all staff via email, enabling messaging on matters of note. In 2018/19, the Trust conducted quarterly staff Friends and Family tests to help it gauge the level of satisfaction and engagement amongst staff and offers a range of support mechanisms for staff, beyond that provided by line managers. This includes a comprehensive Employee Assistance Programme providing 24 hour support and a full Occupational Health service.

2018/19 saw the appointment of new joint Staff Side chairs and a new Freedom to Speak Up (FTSU) Guardian, selected following an open recruitment process. The FTSU Guardian role is about ensuring that patients are cared for in a safe way and that staff are able to raise concerns that they feel are not being heard or are unable to raise with management. It is also the Guardian's role to listen in confidence, note concerns and raise issues through the appropriate channels.

Staff have the opportunity to share their experiences with the Trust Board throughout the year. In 2018/19 the Board heard from the Joint Chairs of Staff Side, the Chairs of the Staff networks, junior doctor representatives and staff and managers undertaking and supporting Care Support Worker and Nurse Associate apprenticeships.

Education and Development

The Trust takes the ongoing development of its staff very seriously. Each hospital site has an Education / Academic Centre, giving dedicated staff teaching space, and a library. Staff have an annual appraisal with a plan of personal development and access to education teams to support them with advice and guidance about development needs. In-house learning activities & funding for staff to access external training are available.

Education and training for its next generation of clinical leaders is critical to the Trust's success. The Trust has a vibrant apprenticeship programme, with 83 apprentices working across its hospitals in a range of roles. During the year, the first cohort of 15 Trainee Nursing Associate apprentices was welcomed, helping to ensure a strong sustainable nursing workforce for the future. Once qualified, Nursing Associates will register with the Nursing and Midwifery Council and take on more duties & responsibility than in their previous roles, enabling Registered Nurses to spend more time on the assessment & care associated with complex needs.

Having a strong education ethos that supports younger medical students through to high specialty trainees is equally important and the Trust's Medical Education team has worked hard to develop high quality training programmes as well as creating a friendly, supportive environment where trainees can grow and thrive. The team trains and develops 350 medical trainees as well as providing professional development for all doctors in the Trust.

The Human Factors in Healthcare course rolled out in 2018/19 highlighted that healthcare really is a 'team sport'. 80% of patient safety issues are due to errors associated with human factors, such as communication with colleagues, the working environment and equipment used. The course addresses how staff can adopt positive safety behaviours by acknowledging & understanding these human factors, in a no blame culture. It is intended for at least 70% of the Trust's staff – clinical and non-clinical - to participate in the training.

Fostering strong team working and putting education & development at the core of the organisation is an integral part of the Trust's journey to being more clinically led. Trusts that engage in education & development are safer and have better clinical outcomes. Critically, evidence of a strong learning ethos, in a supportive environment, with good team spirt, will also encourage others to want to work for the Trust.

Equal opportunities

In 2018/19, the Trust continued to support and build upon a culture that enabled people to work in a safe environment, free from discrimination & where all individuals are valued and treated fairly. Led by the Head of Staff Engagement & Equality, the programme ensured that Trust policies and procedures deliver equity from recruitment throughout the career development of its workforce. In essence, the Trust's aim is that all people are treated with kindness and respect and to ensure that they are accepted without exception.

In October 2018, the Cultural Diversity Network proudly hosted Black History Month – an event that heard from four inspirational black female speakers about how they have succeeded in their lives. During the year, the Cultural Diversity Network Chair was involved in a review of disciplinary cases, which demonstrated that ethnic origin had no apparent influence in terms of the investigations and outcomes for each case.

The LGBT+ and Allies Networks hosted the first NHS-led multi organisation LGBT+ Conference in the Kent and Medway area in October 2018 during Hate Crime Awareness Week. Launched by the Trust's Chief Executive, Trust staff were joined by SECAmb, Kent Police, Kent Fire and Rescue, HM Prison Maidstone, the Heart of Kent Hospice and other local NHS organisations. The Medical Director spoke in his role as Executive Sponsor on the importance of his role within the network. The Trust is a Stonewall Diversity Champion Partner and the LGBT+ network has increased the Trust's Workplace Equality Index Score once again this year, demonstrating its commitment to improving the working lives of LGBT+ colleagues.

In 2018/19, leads from each staff network joined the Equality Lead to review bullying and harassment cases from the previous year. The investigations and outcomes were judged to be appropriate in all cases reviewed. Improvements were identified and actions taken forward including promotion of Bullying and Harassment Awareness for staff.

The second Trust Gender Pay Gap was submitted in March 2019 showing a 26% gap between the pay of men and women. With the data reporting cycle a year in retrospect, it is expected that this gap will reduce with effect from 2020 as a result of actions taken in 2018/19.

The gender, age and ethnic group distribution of staff and Trust Board Members (Senior Managers) at the end of 2018/19 is set out below (the 2017/18 equivalent is in brackets):

Gender	Staff [head count]		Trust Board Members	
Male	1434 (1655)	24.2% (24.8%)	8 (8)	57% (57%)
Female	4498 (5031)	75.8% (75.2%)	6 (6)	43% (43%)

Age (age at 31/03/18)	Staff [head count]		Trust Board Members	
16-30	1147 (1484)	19.3% (22.2%)	0 (0)	(0%)
31-40	1332 (1519)	22.5% (22.7%)	2 (1)	14.3% (7.1%)
41-50	1650 (1750)	27.8% (26.2%)	6 (4)	42.9 (28.6%)
51-60	1388 (1451)	23.4% (21.7%)	3 (7)	21.4% (50%)
61 and over	415 (482)	7% (7.2%)	3 (2)	21.4% (14.3%)

Ethnic group [20]	Staff [head count]		Trust Board Members	
Asian/Asian British: Any other Asian background	343 (384)	5.8% (5.7%)	0 (0)	(0%)
Asian/Asian British: Bangladeshi	10 (13)	0.2% (0.2%)	0 (0)	(0%)
Asian/Asian British: Indian	386 (410)	6.5% (6.1%)	1 (0)	7.1% (0%)
Asian/Asian British: Pakistani	61 (68)	1.0% (1.0%)	1 (1)	7.1% (7.1%)
Black/African/Caribbean/Black British: African	151 (173)	2.5% (2.6%)	0 (0)	0 (0%)
Black/African/Caribbean/Black British: Any other Black/African/Caribbean background	16 (15)	0.2% (0.2%)	0 (0)	0 (0%)
Black/African/Caribbean/Black British: Caribbean	23 (27)	0.4% (0.4%)	0 (0)	0 (0%)
Mixed/Multiple ethnic groups: Any other Mixed/Multiple ethnic background	37 (45)	0.6% (0.7%)	0 (0)	0 (0%)
Mixed/Multiple ethnic groups: White & Asian	23 (41)	0.4% (0.6%)	0 (0)	0 (0%)
Mixed/Multiple ethnic groups: White & Black African	11 (14)	0.2% (0.2%)	0 (0)	0 (0%)
Mixed/Multiple ethnic groups: White and Black Caribbean	13 (18)	0.2% (0.3%)	0 (0)	0 (0%)
White: Any other White background	476 (598)	8% (8.9%)	0 (0)	0 (0%)
White: English/Welsh/Scottish/Northern Irish/British	3828 (4322)	64.5% (64.6%)	11 (11)	78.7% (78.6%)
White: Irish	57 (79)	1% (1.2%)	1 (2)	7.1% (14.3%)
Any other ethnic group	202 (241)	3.4% (3.6%)	0 (0)	0 (0%)
Not known / not stated / undefined	295 (238)	5% (3.6%)	0 (0)	0 (0%)

Staff sickness absence

The staff sickness absence for 2018/19 (and 2017/18) is reported below:

	2018/19	2017/18
Total days lost (adjusted to the Cabinet Office measure)	40,312	43,165
Total staff years (WTE)	5,050	5,070
Average working days lost	8	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 2018/19 are actually for the calendar year 2018(i.e. January to December 2018), whilst the figures for 2017/18 are for the calendar year 2017. However, the DHSC considers the figures for the calendar year to be a reasonable proxy for the financial year.

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

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 is a forum for staff to talk about issues that specifically affect them and provides advice and guidance to anyone approaching it for help. It also provides an element of scrutiny when required to consider reports on monitoring data and will lead actions following the submission of the Workforce Disability Equality Standard in 2019.

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."

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:

- The Health and Safety Policy and Procedure was revised and ratified
- There was a small increase in the number of staff injuries as a result of accidents in the workplace
- There was a significant increase of incidents of violence & harassment against staff, largely attributable to patients diagnosed with dementia or those suffering from a mental health crisis. To mitigate this, security arrangements have been put in place for one to one care of violent and aggressive patients and conflict resolution training has been reviewed and updated to respond to changing trends. In addition, staff are encouraged to report assaults by those lacking capacity to ensure the issue is communicated, appropriate resources are in place and any harm sustained is recorded accurately
- At the end of March 2019, there was no significant change in the number of reports to the Health and Safety Executive under the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations (RIDDOR) 2013 – 26 in 2018/19 compared with 24 in 2017/18
- Following health and safety inspections of the hospital exterior, work was carried out to further reduce the risk of trip and other health and safety hazards
- Regular inspections continued at other off main site locations and significant improvements were made to the Trust's laundry site.

"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 2018/19 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 NHSI. 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.

There are no staff sharing arrangements in place for any of the Trust's senior managers.

Salaries and allowances for the year ending 31st March 2019 (subject to audit)

Comparatives for the year ending 31st March 2018 are shown in brackets below the figure for 2018/19.

Name and title (alphabetical by surname) N.B. Dates of service are for the full 2018/19 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
Sean Briggs, Chief Operating Officer (from 29/10/18)	50-55 (0)	0 (0)	N/A (N/A)	N/A (N/A)	322.5-325 (N/A)	375-380 (N/A)	N/A (N/A)
Maureen Choong, Non-Executive Director	5-10 (0-5)	0 (0)	N/A (N/A)	N/A (N/A)	N/A (N/A)	5-10 (0-5)	N/A (N/A)
Sarah Dunnett, Non-Executive Director	5-10 (5-10)	0 (0)	N/A (N/A)	N/A (N/A)	N/A (N/A)	5-10 (5-10)	N/A (N/A)
Angela Gallagher, Chief Operating Officer (until 30/11/18)	80-85 (125-130)	0 (0)	N/A (N/A)	N/A (N/A)	0 (100-102.5)	80-85 (225-230)	N/A (N/A)

Name and title (alphabetical by surname) N.B. Dates of service are for the full 2018/19 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
Neil Griffiths, Associate Non-Executive Director (from 04/06/18), Non-Executive Director (from 15/02/19)	0-5 (N/A)	0 (N/A)	N/A (N/A)	N/A (N/A)	0 (N/A)	0-5 (N/A)	N/A (N/A)
Simon Hart, Director of Workforce	130-135 (40-45)	0 (0)	N/A (N/A)	N/A (N/A)	45-47.5 (147.5-150)	175-180 (190-195)	N/A (N/A)
David Highton, Chair of the Trust Board	35-40 (35-40)	0 (6)	N/A (N/A)	N/A (N/A)	N/A (N/A)	35-40 (35-40)	N/A (N/A)
Nazeya Hussain, Non-Executive Director	0-5 (0-5)	0 (0)	N/A (N/A)	N/A (N/A)	N/A (N/A)	0-5 (0-5)	N/A (N/A)
Amanjit Jhund, Director of Strategy, Planning & Partnerships (from 01/10/18)	60-65 (0)	0 (0)	N/A (N/A)	N/A (N/A)	60-62.5 (0)	125-130 (0)	N/A (N/A)
Tim Livett, Non-Executive Director (until 28/02/19)	5-10 (0-5)	0 (0)	N/A (N/A)	N/A (N/A)	N/A (N/A)	5-10 (0-5)	N/A (N/A)
Jim Lusby, Deputy Chief Executive (until 30/04/18)	10-15 (130-135)	0 (0)	N/A (N/A)	N/A (N/A)	0 (67.5-70)	10-15 (205-210)	N/A (N/A)
Peter Maskell, Medical Director Ψ	200-205 (195-200)	0 (0)	N/A (N/A)	N/A (N/A)	652.5-655 (0)	850-855 (195-200)	N/A (N/A)
Sara Mumford, Director of Infection Prevention and Control Ψ	170-175 (160-165)	0 (0)	N/A (N/A)	N/A (N/A)	32.5-35 (72.5-75)	200-205 (235-240)	N/A (N/A)
Claire O'Brien, Chief Nurse	120-125 (110-115)	0 (0)	N/A (N/A)	N/A (N/A)	110-112.5 (237.5-240)	230-235 (345-350)	N/A (N/A)
Steve Orpin, Chief Finance Officer	145-150 (125-130)	0 (0)	N/A (N/A)	N/A (N/A)	107.5-110 (20-22.5)	250-255 (150-155)	N/A (N/A)
Emma Pettitt-Mitchell, Associate Non-Executive Director (from 04/06/18)	0-5 (N/A)	0 (N/A)	N/A (N/A)	N/A (N/A)	N/A (N/A)	0-5 (N/A)	N/A (N/A)
Steve Phoenix, Non-Executive Director (until 31/12/18)	0-5 (0-5)	0 (0)	N/A (N/A)	N/A (N/A)	0 (N/A)	0-5 (0-5)	N/A (N/A)
Miles Scott, Chief Executive	220-225 (45-50)	0 (0)	N/A (N/A)	N/A (N/A)	0 (382.5-385)	220-225 (430-435)	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

Pension benefits for the year ending 31st March 2019[21] (subject to audit)

Name and title Ψ (alphabetical by surname) N.B. Dates of service are for the full 2018/19 year unless otherwise disclosed	(a) Real increase in pension at pension age (bands of £2,500)	(b) Real increase in pension lump sum at pension age (bands of £2,500)	(c) Total accrued pension at pension age at 31st March 2019 (bands of £5,000)	(d) Lump sum at pension age related to accrued pension at 31st March 2019 (bands of £5,000)	(e) Cash Equivalent Transfer Value Λ at 1st April 2018	(f) Cash Equivalent Transfer Value Λ at 31st March 2019	(g) Real increase in Cash Equivalent Transfer Value Σ	(h) Employer's contribution to stakeholder pension
	£000	£000	£000	£000	£000	£000	£000	£000
Sean Briggs, Chief Operating Officer (from 29/10/18)	5-7.5	0	15-20	0	0	147	62	8
Angela Gallagher, Chief Operating Officer (until 30/11/18)	0	0	0	0	0	0	0	12
Simon Hart, Director of Workforce	0-2.5	0-2.5	44-49	105-110	617	755	119	21
Amanjit Jhund, Director of Strategy, Planning & Partnerships (from 01/10/18)	0-2.5	0	0-5	0	0	32	16	9
Jim Lusby, Deputy Chief Executive (until 30/04/18)	0	0	0	0	0	0	0	0
Peter Maskell, Medical Director	0	62.5-65	30-35	60-65	0	513	513	13
Sara Mumford, Director of Infection Prevention and Control	0-2.5	0	50-55	75-80	756	889	111	21
Claire O'Brien, Chief Nurse	2.5-5	15-17.5	50-55	150-155	969	1202	204	18
Steve Orpin, Chief Finance Officer	5.0-7.5	5-7.5	50-55	125-130	689	885	176	21
Miles Scott, Chief Executive¥	0	0	0	0	0	0	0	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

¥ Miles Scott did not make any contributions into the NHS Pension Scheme in 2018/19

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 2019 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 2018/19 was £220,000 to £225,000 (in 2017/18 this was £215,000 to £220,000). This was 7.5 times (in 2017/18, this was 7.5 times) the median remuneration of the workforce, which was £29,698 (2017/18 £28,746).

In 2018/19 no employees (in 2017/18, this was 2 employees) received remuneration in excess of the highest-paid director. The highest paid Director in the financial year 2018/19 was the Chief Executive (in 2017/18 this was the Chief Executive). Remuneration ranged from £12,222 to £222,500 (2017/18 £12,710 to £234,957)

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

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.

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 2019, for more than £245 per day and lasting for longer than 6 months

	Number
Number of existing engagements as of 31st March 2019	23
Of which, the number that have existed…	
for less than 1 year at the time of reporting =	6
for between 1 and 2 years at the time of reporting =	14
for between 2 and 3 years at the time of reporting =	3
for between 3 and 4 years at the time of reporting =	0
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 2018 and 31st March 2019, 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 2018 and 31st March 2019	25
Of which:	
No. assessed as caught by IR35	1
No. assessed as not caught by IR35	22
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	2
No. of engagements that saw a change to IR35 status following the consistency review	0

Off-payroll Board member / Senior Official engagements

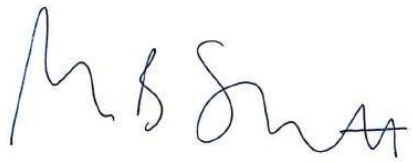
Number of off-payroll engagements of Board members and/or senior officials with significant financial responsibility, during the year	0
Number of individuals that have been deemed "Board members and/or senior officers with significant financial responsibility", during the financial year. This figure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

Expenditure on consultancy staff

The Trust's internal expenditure on consultancy staff for 2018/19 was £947 k, an increase of £541k (£406k in 2017/18). The Trust hosts the Kent and Medway Sustainability and Transformation Partnership (STP) which incurred £1,336 k of consultancy spend compared to £7,190k in 2017/18.

Declaration

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



Miles Scott, Chief Executive

23rd May 2019

Maidstone and Tunbridge Wells NHS Trust

Accountability and audit report for 2018/19: Independent Auditor's report to the Directors of the Trust

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

Report on the Audit of the Financial Statements

Opinion

We have audited the financial statements of Maidstone & Tunbridge Wells NHS Trust (the 'Trust') for the year ended 31 March 2019, which comprise the Statement of Comprehensive Income, the Statement of Financial Position, the Statement of Changes in Taxpayers Equity, the Statement of Cash Flows and notes to the financial statements, including a summary of significant accounting policies. The financial reporting framework that has been applied in their preparation is applicable law and International Financial Reporting Standards (IFRSs) as adopted by the European Union, and as interpreted and adapted by the Department of Health and Social Care Group Accounting Manual 2018- 19.

In our opinion the financial statements:

- give a true and fair view of the financial position of the Trust as at 31 March 2019 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 2018-19; 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.

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 audit or otherwise appears to be materially misstated. If we identify such material inconsistencies or apparent material misstatements, we are required to determine whether there is a material misstatement in the financial statements 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 the 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 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 2018-19 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 issue a report 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 refer a matter to the Secretary of State under Section 30 of the Local Audit and Accountability Act 2014 because we have reason to believe that the Trust, or an officer of the Trust, is about to make, or has made, a decision which involves or would involve the body incurring unlawful expenditure, or is about to take, or has begun to take a course of action

which, if followed to its conclusion, would be unlawful and likely to cause a loss or deficiency; or

- we make 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 15 May 2018 we referred a matter to the Secretary of State under section 30(a) of the Local Audit and Accountability Act 2014 in relation to Maidstone and Tunbridge Wells NHS Trust's planned breach of its break-even duty for the three year period ending 31 March 2019.

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

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 they have been informed by the relevant national body of the intention to dissolve the Trust without the transfer of its services to another public sector entity. The Audit and Governance Committee is Those Charged with Governance. Those charged with governance are responsible for overseeing the Trust's financial reporting process.

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

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

Under the Code of Audit Practice, we are required to report to you if, in our opinion we have not been able to satisfy ourselves that the Trust has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources for the year ended 31 March 2019.

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

Responsibilities of the Accountable Officer

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(1)(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 2019, 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.

Use of our report

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.

Darren Wells

Darren Wells

Key Audit Partner

for and on behalf of Grant Thornton UK LLP, Local Auditor Crawley

24 May 2019

Glossary of NHS terms

Term	Definition/explanation
Accident and Emergency (A&E)	Also referred to as Emergency Department (ED)
Ambulatory (Care)	A service where some conditions may be treated without the need for an overnight stay in hospital
Acute Stroke Unit (ASU)	An acute neurological ward providing specialist services for people who have had a new suspected stroke
Best Care Programme	Launched in 2018, the Trust's chosen platform to deliver continual transformation and service improvements programmes
Care Quality Commission (CQC)	A body that regulates all health & social care services in England. The CQC ensures the quality 7 safety of care in hospitals, dentists, ambulances, & care homes, and the care given in people's own homes. It is an executive non-dep-artmental public body, sponsored by the Department of Health & 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 2018/19, 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
Datix	The Trust's incident reporting and risk management system
Delayed Transfer of Care	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

Term	Definition/explanation
(DTOC)	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
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 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
Getting It Right First Time (GIRFT)	A national programme, led by frontline clinicians and designed to improve the quality of care within the NHS by reducing unwarranted variations. GIRFT tackles variations in the way services are delivered across the NHS, and shares best practice between trusts, identifying changes that will help improve care and patient outcomes, as well as delivering efficiencies such as the reduction of unnecessary procedures and cost savings
Hyper Acute Stroke Unit (HASU)	A dedicated Stroke unit bringing experts and equipment under one roof to provide world class treatment 24 hours a day
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 by 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

Term	Definition/explanation
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
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)
Referral to Treatment (RTT)	The waiting time calculated from the date the Trust receives a referral, to the date the patient either receives treatment or a decision is made that no treatment is required
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

Term	Definition/explanation
	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 2018/19

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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.

The directors confirm that the annual report and accounts, taken as a whole, is fair, balanced and understandable and provides the information necessary for patients, regulators and stakeholders to assess the NHS Trust's performance, business model and strategy

By order of the Board

23rd May 2019 Date _____ Chief Executive

23rd May 2019 Date _____ Chief Finance Officer

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 2018/19 have been completed and this certificate accompanies them.

Finance Director 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 is one agreed validation which is approved by NHS Improvement.
3. I certify that the information in the TAC schedules is consistent with the financial statements of the NHS Trust.

Stephen Orpin, Chief Finance Officer

23rd May 2019

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 Chief Finance Officer above.

Miles Scott, Chief Executive

23rd May 2019

Statement of Comprehensive Income

	Note	2018/19 £000	2017/18 £000
Operating income from patient care activities	3	403,761	382,745
Other operating income	4	69,408	57,524
Operating expenses	7, 9	-450,488	-421,213
Operating surplus/(deficit) from continuing operations		**22,681**	**19,056**
Finance income	12	164	47
Finance expenses	13	-15,825	-15,118
PDC dividends payable		-688	-451
Net finance costs		**-16,349**	**-15,522**
Other gains / (losses)	14	13,542	89
Gains / (losses) arising from transfers by absorption	46	0	0
Corporation tax expense		0	0
Surplus / (deficit) for the year from continuing operations		**19,874**	**3,623**
Surplus / (deficit) on discontinued operations and the gain / (loss) on disposal of discontinued operations	15	**0**	**0**
Surplus / (deficit) for the year		**19,874**	**3,623**
Other comprehensive income			
Will not be reclassified to income and expenditure:			
Impairments	8	2,071	434
Revaluations	19	1,040	328
Total comprehensive income / (expense) for the period		**22,985**	**4,385**
Adjusted financial performance (control total basis):			
Surplus / (deficit) for the period		19,874	3,623
Remove impact of consolidating NHS charitable fund		0	0
Remove net impairments not scoring to the Departmental expenditure limit		780	-14,662
Remove (gains) / losses on transfers by absorption		0	0
Remove I&E impact of capital grants and donations		-330	249
Prior period adjustments		0	0
Remove non-cash element of on-SoFP pension costs		0	0
CQUIN risk reserve adjustment (2017/18 only)		0	-134
Remove 2016/17 post audit STF reallocation (2017/18 only)		0	0
Adjusted financial performance surplus / (deficit)		**20,324**	**-10,924**

Statement of Financial Position

	Note	31 March 2019 £000	31 March 2018 £000
Non-current assets			
Intangible assets	16	3,345	2,612
Property, plant and equipment	17	292,265	294,014
Investment property	20	0	0
Receivables	25	1,401	1,201
Other assets	26	0	0
Total non-current assets		**297,011**	**297,827**
Current assets			
Inventories	24	7,820	7,752
Receivables	25	34,429	37,454
Other assets	26	0	0
Non-current assets held for sale / assets in disposal groups	27	0	0
Cash and cash equivalents	28	10,406	1,473
Total current assets		**52,655**	**46,679**
Current liabilities			
Trade and other payables	29	-28,017	-43,893
Borrowings	32	-24,985	-24,469
Other financial liabilities	30	0	0
Provisions	34	-1,467	-1,743
Other liabilities	31	-2,580	-2,620
Liabilities in disposal groups	27	0	0
Total current liabilities		**-57,049**	**-72,725**
Total assets less current liabilities		**292,617**	**271,781**
Non-current liabilities			
Trade and other payables	29	0	0
Borrowings	32	-223,367	-229,860
Other financial liabilities	30	0	0
Provisions	34	-989	-1,106
Other liabilities	31	0	0
Total non-current liabilities		**-224,356**	**-230,966**
Total assets employed		**68,261**	**40,815**
Financed by			
Public dividend capital		211,790	207,329
Revaluation reserve		31,782	29,852
Financial assets reserve		0	0
Other reserves		0	0
Income and expenditure reserve		-175,311	-196,366
Total taxpayers' equity		**68,261**	**40,815**

The notes on pages 6 to 50 form part of these accounts.

Name 

Position Chief Executive

Date **23 May 2019**

Statement of Changes in Taxpayers Equity for the year ended 31 March 2019

	Public dividend capital	Revaluation reserve	Financial assets reserve*	Other reserves	Income and expenditure reserve	Total
	£000	£000	£000	£000	£000	£000
Taxpayers' equity at 1 April 2018 - brought forward	**207,329**	**29,852**	**0**	**0**	**-196,366**	**40,815**
Impact of implementing IFRS 15 on 1 April 2018	0	0	0	0	0	**0**
Impact of implementing IFRS 9 on 1 April 2018	0	0	0	0	0	**0**
Surplus/(deficit) for the year	0	0	0	0	19,874	**19,874**
Other transfers between reserves	0	0	0	0	0	**0**
Impairments	0	2,071	0	0	0	**2,071**
Revaluations	0	1,040	0	0	0	**1,040**
Transfer to retained earnings on disposal of assets	0	-1,181	0	0	1,181	**0**
Share of comprehensive income from associates and joint ventures	0	0	0	0	0	**0**
Public dividend capital received	4,461	0	0	0	0	**4,461**
Public dividend capital repaid	0	0	0	0	0	**0**
Public dividend capital written off	0	0	0	0	0	**0**
Other movements in public dividend capital in year	0	0	0	0	0	**0**
Other reserve movements	0	0	0	0	0	**0**
Taxpayers' equity at 31 March 2019	**211,790**	**31,782**	**0**	**0**	**-175,311**	**68,261**

* Following the implementation of IFRS 9 from 1 April 2018, the 'Available for sale investment reserve' is now renamed as the 'Financial assets reserve'

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

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

Information on reserves

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

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

Financial assets reserve / Available-for-sale investment reserve
This reserve comprises changes in the fair value of financial assets measured at fair value through other comprehensive income. When these instruments are derecognised, cumulative gains or losses previously recognised as other comprehensive income or expenditure are recycled to income or expenditure, unless the assets are equity instruments measured at fair value through other comprehensive income as a result of irrevivable election at recognition.

Other reserves
The Trust has no other reserves.

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

Statement of Cash Flows

	Note	2018/19 £000	2017/18 £000
Cash flows from operating activities			
Operating surplus / (deficit)		22,681	19,056
Non-cash income and expense:			
Depreciation and amortisation	7.1	12,987	13,710
Net impairments	8	780	-14,662
Income recognised in respect of capital donations	4	-740	-159
Amortisation of PFI deferred credit		0	0
Non-cash movements in on-SoFP pension liability		0	0
(Increase) / decrease in receivables and other assets		2,970	8,959
(Increase) / decrease in inventories		-68	193
Increase / (decrease) in payables and other liabilities		-14,927	-8,813
Increase / (decrease) in provisions		-393	-156
Tax (paid) / received		0	0
Other movements in operating cash flows		0	0
Net cash generated from / (used in) operating activities		**23,290**	**18,128**
Cash flows from investing activities			
Interest received		164	47
Purchase and sale of financial assets / investments		0	0
Purchase of intangible assets		-1,288	-198
Sales of intangible assets		0	0
Purchase of property, plant, equipment and investment property		-12,989	-12,253
Sales of property, plant, equipment and investment property		17,534	1,840
Receipt of cash donations to purchase capital assets		740	159
Prepayment of PFI capital contributions		0	0
Cash movement from acquisitions / disposals of subsidiaries		0	0
Net cash generated from / (used in) investing activities		**4,161**	**-10,405**
Cash flows from financing activities			
Public dividend capital received		4,461	2,363
Public dividend capital repaid		0	0
Movement on loans from the Department of Health and Social Care		-2,174	9,358
Movement on other loans		1,376	739
Other capital receipts		0	0
Capital element of finance lease rental payments		0	0
Capital element of PFI, LIFT and other service concession payments		-5,284	-5,028
Interest on loans		-1,588	-1,263
Other interest		-6	0
Interest paid on finance lease liabilities		0	0
Interest paid on PFI, LIFT and other service concession obligations		-14,237	-13,855
PDC dividend (paid) / refunded		-1,066	16
Financing cash flows of discontinued operations		0	0
Cash flows from (used in) other financing activities		0	0
Net cash generated from / (used in) financing activities		**-18,518**	**-7,670**
Increase / (decrease) in cash and cash equivalents		**8,933**	**53**
Cash and cash equivalents at 1 April - brought forward		**1,473**	**1,420**
Prior period adjustments		0	0
Cash and cash equivalents at 1 April - restated		**1,473**	**1,420**
Cash and cash equivalents transferred under absorption accounting	46	0	0
Unrealised gains / (losses) on foreign exchange		0	0
Cash and cash equivalents at 31 March	28.1	**10,406**	**1,473**

Notes to the Accounts

Note 1 Accounting policies and other information

Note 1.1 Basis of preparation

The Department of Health and Social Care has directed that the financial statements of the Trust shall meet the accounting requirements of the Department of Health and Social Care Group Accounting Manual (GAM), which shall be agreed with HM Treasury. Consequently, the following financial statements have been prepared in accordance with the GAM 2018/19 issued by the Department of Health and Social Care. The accounting policies contained in the GAM follow International Financial Reporting Standards to the extent that they are meaningful and appropriate to the NHS, as determined by HM Treasury, which is advised by the Financial Reporting Advisory Board. Where the GAM permits a choice of accounting policy, the accounting policy that is judged to be most appropriate to the particular circumstances of the Trust for the purpose of giving a true and fair view has been selected. The particular policies adopted are described below. These have been applied consistently in dealing with items considered material in relation to the accounts.

Note 1.1.1 Accounting convention

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

Note 1.1.2 Going concern

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 2018/19 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 final business plan to NHSI in April 2019 setting out its operational plans for the following financial year (2019/20) and its capital plans for five years.

- The Trust exited from financial special measures in October 2018, has met its 2018/19 control total, and is planning to fully achieve its 2019/20 control total, including PSF and MRET requirements, and therefore to deliver a planned surplus of £6.9m.

- 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. it is one of the selected sites for Hyper Acute Stroke Unit as part of the STP-wide Stroke services consultation.

- The Trust will have contracts in place for provision of healthcare services for 2019/20. This includes the "aligned incentives" contract with West Kent (the Trust's main commissioner) and Sussex and East Surrey CCGs. The aligned incentives contract represents c.73% of the total clinical income which provides certainty for income and cash flows in 2019/20.

- The Trust prepared and submitted cash-flow plans for 2019/20 which include the repayment of £16.9m of working capital loans, which is planned to be financed from internal resources.

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

- The Trust does not consider that there are any material uncertainties to the going concern basis. However it has assessed and will disclose within its 2018/19 accounts challenges to its financial plans for 2019/20 around its cost improvement programme and risks to achieving its control total. The main risks are:

a) The Trust has fully identified CIP schemes totalling £16.6m but £4.9m are risks current rated as red. Divisions have been set a target of £19.4m to seek to mitigate any slippage or non-delivery. The Trust has commissioned additional external support to work with Divisions to develop and implement plans with regular monitoring of performance.

b) The Trust's plan assumes that the current stroke services will continue until April 2020 prior to the planned reconfiguration of services. Therefore no additional income assumptions have been made for any additional stroke activity at Maidstone Hospital. The risk is around one of the current units planned for closure being subject to operational pressures e.g. loss of staff that causes it to close or reduce activity earlier than planned.

Note 1.2 Interests in other entities and consolidation

The Trust does not have interests in subsidiaries, associates, joint ventures or joint operations and the Trust does not consolidate its charitable funds on the basis that the value is not material

Note 1.3.1 Revenue from contracts with customers

Where income is derived from contracts with customers, it is accounted for under IFRS 15. The GAM expands the definition of a contract to include legislation and regulations which enables an entity to receive cash or another financial asset that is not classified as a tax by the Office of National Statistics (ONS). As directed by the GAM, the transition to IFRS 15 in 2018/19 has been completed in accordance with paragraph C3 (b) of the Standard: applying the Standard retrospectively but recognising the cumulative effects at the date of initial application (1 April 2018).

Revenue in respect of goods/services provided is recognised when (or as) performance obligations are satisfied by transferring promised goods/services to the customer and is measured at the amount of the transaction price allocated to those performance obligations. At the year end, the Trust accrues income relating to performance obligations satisfied in that year. Where the Trust's entitlement to consideration for those goods or services is unconditional a contract receivable will be recognised. Where entitlement to consideration is conditional on a further factor other than the passage of time, a contract asset will be recognised. Where consideration received or receivable relates to a performance obligation that is to be satisfied in a future period, the income is deferred and recognised as a contract liability.

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

Revenue from NHS contracts

The main source of income for the Trust is contracts with commissioners for health care services. A performance obligation relating to delivery of a spell of health care is generally satisfied over time as healthcare is received and consumed simultaneously by the customer as the Trust performs it. The customer in such a contract is the commissioner, but the customer benefits as services are provided to their patient. Even where a contract could be broken down into separate performance obligations, healthcare generally aligns with paragraph 22(b) of the Standard entailing a delivery of a series of goods or services that are substantially the same and have a similar pattern of transfer. At the year end, the Trust accrues income relating to activity delivered in that year, where a patient care spell is incomplete.

Revenue is recognised to the extent that collection of consideration is probable. Where contract challenges from commissioners are expected to be upheld, the Trust reflects this in the transaction price and derecognises the relevant portion of income.

Where the Trust is aware of a penalty based on contractual performance, the Trust reflects this in the transaction price for its recognition of revenue. Revenue is reduced by the value of the penalty.

The Trust does not receive income where a patient is readmitted within 30 days of discharge from a previous planned stay. This is considered an additional performance obligation to be satisfied under the original transaction price. An estimate of readmissions is made at the year end this portion of revenue is deferred as a contract liability.

The Trust receives income from commissioners under Commissioning for Quality and Innovation (CQUIN) schemes. The Trust agrees schemes with its commissioner but they affect how care is provided to patients. That is, the CQUIN payments are not considered distinct performance obligations in their own right; instead they form part of the transaction price for performance obligations under the contract.

PFI support income will be recognised as revenue when all, or substantially all, of the promised funding has been received by the Trust.

Provider Sustainability Fund (PSF)

The PSF enables NHS providers to earn income linked to the achievement of financial controls and performance targets. Access to both the general and targeted elements of PSF are unlocked as NHS providers meet their financial control totals. At each quarter, a minimum of 70% of allocated funding will be released upon achievement of the financial control total, with up to a further 30% released where a provider also meets its agreed trajectories for delivery of operational standards

In line with IFRS 15, PSF should be accounted for as variable consideration. Paragraph 51 of the Standard identifies that consideration would be variable if a fixed amount is promised as a performance bonus.

Revenue from research contracts

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

NHS injury cost recovery scheme

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

Note 1.3.2 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.

Note 1.3.3 Other income

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.

Note 1.4 Expenditure on employee benefits

Short-term employee benefits

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

Pension costs

NHS Pension Scheme

Past and present employees are covered by the provisions of the 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. Therefore 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 2% for 2018/19. The rate increases to 3% in April 2019.

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

Note 1.5 Expenditure on other goods and services

Expenditure on goods and services is recognised when, and to the extent that they have been received, and is measured at the fair value of those goods and services. Expenditure is recognised in operating expenses except where it results in the creation of a non-current asset such as property, plant and equipment.

Note 1.6 Property, plant and equipment

Note 1.6.1 Recognition

Property, plant and equipment is capitalised where:

• it is held for use in delivering services or for administrative purposes
• it is probable that future economic benefits will flow to, or service potential be provided to, the trust
• it is expected to be used for more than one financial year
• the cost of the item can be measured reliably
• the item has cost of at least £5,000, or
• collectively, a number of items have a cost of at least £5,000 and individually have cost of more than £250, where the assets are functionally interdependent, had broadly simultaneous purchase dates, are anticipated to have similar disposal dates and are under single managerial control.

Where a large asset, for example a building, includes a number of components with significantly different asset lives, 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.

Note 1.6.2 Measurement

Valuation

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

All assets are measured subsequently at valuation. Assets which are held for their service potential and are in use (ie operational assets used to deliver either front line services or back office functions) are measured at their current value in existing use. Assets that were most recently held for their service potential but are surplus with no plan to bring them back into use are measured at fair value where there are no restrictions on sale at the reporting date and where they do not meet the definitions of investment properties or assets held for sale.

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 values are not materially different from those that would be determined at the end of the reporting period. Current values in existing use are determined as follows:

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

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 2018/19 is the fourth year in the current five year cyclical valuation period. A full valuation was undertaken in September 2014 with desktop valuations undertaken in each subsequent financial year. 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 and Building assets at 31st March 2019. 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 17.

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 the assets are brought into use.

IT equipment, transport equipment, furniture and fittings, and plant and machinery that are held for operational use are valued at depreciated historic cost where these assets have short useful lives or low values or both, as this is not considered to be materially different from current value in existing use. 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 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.

6 **Note 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. The carrying amount of the part replaced is de-recognised. Other expenditure that does not generate additional future economic benefits or service potential, such as repairs and maintenance is charged to the Statement of Comprehensive Income in the period in which it is incurred.

7 **Note 1.7 Depreciation**

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

Property, plant and equipment which have been reclassified as ‘held for sale’ cease 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.

7 **Note 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’.

7 **Note 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.

Other impairments are treated as revaluation losses. Reversals of 'other impairments' are treated as revaluation gains.

7 **Note 1.7.3 De-recognition**

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 abandoned or significant changes made to it.

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

Property, plant and equipment which is to be scrapped or demolished does not qualify for recognition as 'held for sale' and instead is retained as an operational asset and the asset's useful 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.

7 **Note 1.7.4 Donated and grant funded assets**

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

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

8 **Note 1.8 Private Finance Initiative (PFI) and Local Improvement Finance Trust (LIFT) 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".

The service charge is recognised in operating expenses and the finance cost is charged to finance costs in the Statement of Comprehensive Income.

Note 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.

Note 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.

Note 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.

Note 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.

Note 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.

Note 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.

Note 1.9 Useful lives of property, plant and equipment

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

	Min life Years	Max life Years
Buildings, excluding dwellings	1	60
Dwellings	1	60
Plant & machinery	5	15
Transport equipment	5	15
Information technology	3	5
Furniture & fittings	10	10
X-ray tubes	2	2

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

Note 1.10 Intangible assets

Note 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.

Note 1.10.2 Internally generated intangible assets

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

Expenditure on research is not capitalised.

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 sale or use
• 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.

Note 1.10.3 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.

Note 1.10.4 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 or IFRS 5.

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

Note 1.10.5 Amortisation

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

Note 1.10.6 Useful economic life of intangible assets

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

	Min life Years	Max life Years
Intangible assets - internally generated		
Information technology	2	7
Intangible assets - purchased		
Software licences	3	5

Note 1.11 Inventories

Inventories are valued at the lower of cost and net realisable value. The cost of inventories is measured using the first in, first out (FIFO) method.

Note 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.

Note 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 Trust's cash management. Cash, bank and overdraft balances are recorded at current values.

Note 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.

Note 1.15 Financial assets and financial liabilities

Note 1.15.1 Recognition

Financial assets and financial liabilities arise where the Trust is party to the contractual provisions of a financial instrument, and as a result has a legal right to receive or a legal obligation to pay cash or another financial instrument. The GAM expands the definition of a contract to include legislation and regulations which give rise to arrangements that in all other respects would be a financial instrument and do not give rise to transactions classified as a tax by ONS.

This includes the purchase or sale of non-financial items (such as goods or services), which are entered into in accordance with the Trust's normal purchase, sale or usage requirements and are recognised when, and to the extent which, performance occurs, ie, when receipt or delivery of the goods or services is made.

Note 1.15.2 Classification and measurement

Financial assets and financial liabilities are initially measured at fair value plus or minus directly attributable transaction costs except where the asset or liability is not measured at fair value through income and expenditure. Fair value is taken as the transaction price, or otherwise determined by reference to quoted market prices or valuation techniques.

Financial assets are classified as subsequently measured at fair value through income and expenditure.

Financial liabilities classified as subsequently measured 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.

Note 1.15.3 Financial assets and financial liabilities at amortised cost

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

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

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

Note 1.15.4 financial assets measured at fair value through other comprehensive income

A financial asset is measured at fair value through other comprehensive income where business model objectives are met by both collecting contractual cash flows and selling financial assets and where the cash flows are solely payments of principal and interest. Movements in the fair value of financial assets in this category are recognised as gains or losses in other comprehensive income except for impairment losses. On de-recognition, cumulative gains and losses previously recognised in other comprehensive income are reclassified from equity to income and expenditure, except where the Trust elected to measure an equity instrument in this category on initial recognition.

Note 1.15.5 Financial assets and financial liabilities at fair value through income and expenditure

Financial assets measured at fair value through profit or loss are those that are not otherwise measured at amortised cost or at fair value through other comprehensive income. This category also includes financial assets and liabilities acquired principally for the purpose of selling in the short term (held for trading) and derivatives. Derivatives which are embedded in other contracts, but which are separable from the host contract are measured within this category. Movements in the fair value of financial assets and liabilities in this category are recognised as gains or losses in the Statement of Comprehensive income.

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.

Note 1.15.6 Impairment of financial assets

For all financial assets measured at amortised cost including lease receivables, contract receivables and contract assets or assets measured at fair value through other comprehensive income, the Trust recognises an allowance for expected credit losses.

The Trust adopts the simplified approach to impairment for contract and other receivables, contract assets and lease receivables, measuring expected losses as at an amount equal to lifetime expected losses. For other financial assets, the loss allowance is initially measured at an amount equal to 12-month expected credit losses (stage 1) and subsequently at an amount equal to lifetime expected credit losses if the credit risk assessed for the financial asset significantly increases (stage 2).

The Trust has used historic data for the last two years to assess the expected credit loss rates that should be applied to trade debtor categories, taking into account the materiality of debtor classes.

For financial assets that have become credit impaired since initial recognition (stage 3), expected credit losses at the reporting date are measured as the difference between the asset's gross carrying amount and the present value of estimated future cash flows discounted at the financial asset's original effective interest rate.

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

Note 1.15.7 Derecognition

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

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

Note 1.16 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.

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

Operating leases

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

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

Leases of land and buildings

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

Note 1.16.2 The Trust as lessor

Finance leases

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

Operating 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 as an expense on a straight-line basis over the lease term.

Note 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 0.29% (2017/18 positive 0.10%) 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:

All 2018/19 percentages are expressed in nominal terms with 2017/18 being the last financial year that HM Treasury provided real general provision discount rates.

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.

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 34.2 but is not recognised in the Trust's accounts.

Non-clinical risk pooling

The Trust participates in the Property Expenses Scheme and the Liabilities to Third Parties Scheme. Both are risk pooling schemes under which the Trust pays an annual contribution to NHS Resolution and in return receives assistance with the costs of claims arising. The annual membership contributions, and any "excesses" payable in respect of particular claims are charged to operating expenses when the liability arises.

Note 1.18 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 35 where an inflow of economic benefits is probable.

Contingent liabilities are not recognised, but are disclosed in note 35, 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; o
- present obligations arising from past events but for which it is not probable that a transfer of economic benefits will arise or for which the amount of the obligation cannot be measured with sufficient reliability.

Note 1.19 Public dividend capital

Public dividend capital (PDC) is a type of public sector equity finance based on the excess of assets over liabilities at the time of establishment of the predecessor NHS organisation. HM Treasury has determined that PDC is not a financial instrument within the meaning of IAS 32.

At any time, the Secretary of State can issue new PDC to, and require repayments of PDC from, the Trust. PDC is recorded at the value received.

A charge, reflecting the cost of capital utilised by the Trust, is payable as public dividend capital dividend. The charge is calculated at the rate set by HM Treasury (currently 3.5%) on the average relevant net assets of the Trust during the financial year. Relevant net assets are calculated as the value of all assets less the value of all liabilities, except for

(i) donated assets (including lottery funded assets),
(ii) average daily cash balances held with the Government Banking Services (GBS) and National Loans Fund (NLF) deposits, excluding cash balances held in GBS accounts that relate to a short-term working capital facility, and
(iii) any PDC dividend balance receivable or payable.
(iv) any PSF bonus is excluded from the PDC calculation

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

Note 1.20 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.

Note 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.

Note 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 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.

Note 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*.

Note 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.

Note 1.25 Gifts

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

Note 1.26 Transfers of functions to / from other NHS bodies / local government bodies

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.

Note 1.27 Critical judgements in applying accounting policies

The following are the critical judgements, apart from those involving estimations (see below 1.27.1) 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 2018/19 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 1.27.1).

Material areas of critical judgements within the 2018/19 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 Provider Sustainability Funding (PSF). The Trust has submitted a financial plan for 2019/20 to NHS Improvement which is planning on delivering the agreed control totals and, including planned PSF and MRET funding, a £6.9m surplus for 2019/20. Note 4 (Other Operating Income) contains a reference in respect of future PSF 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.

- The Trust has disposed of residential properties during the year and entered into lease agreements, a sale and leaseback arrangement. Judgement has been applied to the accounting treatment of these transactions applying IAS 16, IFRS 15 and IAS 17 on various key elements of de-recognition of assets, recognition of the gain on disposal and lease classification. This has included taking advice from professional advisers, including valuations from the Trust's independent valuers. The Trust determined that disposals of property had occurred and that it had entered into operating leases with the successful purchasers. the effect of this judgement is that any gain on disposal has been recognised immediately within the statement of comprehensive income account. If the Trust had determined that the leases were finance leases, any gain on disposal would be deferred and amortised over the period of the lease.

- 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.

27 **Note 1.27.1 Sources of estimation uncertainty**

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, Disclosures will be included 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 2018/19 accounts are as follows:

- Property, Plant and Equipment valuation including PFI infrastructure assets (see accounting policy note 1.6 and also accounts note 19)
- IFRS 15 estimations in determining transaction price or satisfaction of performance obligations where they are satisfied over time. Further detail is given in policy 1.3 Revenue from contracts with customers.
- Pension fund valuation (see note 9).

28 **Note 1.28 Early adoption of standards, amendments and interpretations**

No new accounting standards or revisions to existing standards have been early adopted in 2018/19.

29 **Note 1.29 Standards, amendments and interpretations in issue but not yet effective or adopted**

The DHSC GAM does not require the following IFRS standards and interpretations to be applied in 2018-19. These standards are still subject to HM Treasury FReM adoption, with IFRS 16 being for implementation in 2019-20, and the government implementation date for IFRS 17 still subject to HM Treasury consideration.

- IFRS 16 leases – Application required for accounting periods beginning on or after 1 April 2020, 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.

- IFRIC 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 Trusts income is predominantly from contracts for the provision of healthcare with clinical Commissioning Groups and NHS England. This accounts for 84% of the Trusts total income.

Note 3 Operating income from patient care activities

All income from patient care activities relates to contract income recognised in line with accounting policy 1.3.1

Note 3.1 Income from patient care activities (by nature)	**2018/19 £000**	**2017/18 £000**
Acute services		
Elective income	61,933	69,204
Non elective income	116,383	103,779
First outpatient income	28,101	25,994
Follow up outpatient income	34,188	32,650
A & E income	24,332	21,645
High cost drugs income from commissioners (excluding pass-through costs)	42,751	42,791
Other NHS clinical income	80,969	75,864
All services		
Private patient income	1,459	2,426
Agenda for Change pay award central funding	4,086	0
Other clinical income	9,559	8,392
Total income from activities	**403,761**	382,745

In 2018/19 the Trust received income from Department of Health and Social Care to fund the Agenda for Change pay award of £4.1m. This income was not given via this route in 2017/18 and is included within tariff for 2019/20.

Note 3.2 Income from patient care activities (by source)

Income from patient care activities received from:	**2018/19 £000**	**2017/18 £000**	
NHS England	72,099	71,361	
Clinical commissioning groups	316,139	299,745	*
Department of Health and Social Care	4,086	0	
Other NHS providers	3,683	3,187	
NHS other	0	0	
Local authorities	4,486	4,161	
Non-NHS: private patients	1,459	2,426	
Non-NHS: overseas patients (chargeable to patient)	260	270	
Injury cost recovery scheme	702	840	
Non NHS: other	847	755	*
Total income from activities	**403,761**	382,745	
Of which:			
Related to continuing operations	**403,761**	382,745	
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 21.64% for Maidstone Hospital and 15.56% of Tunbridge Wells Hospital (22.49% Maidstone Hospital and 18.14% Tunbridge Wells in 2017/18). This provision reflect expected rates of collection.

*Prior year comparators moving £0.755m from CCG to non-NHS other income as it relates to MSK services in Sussex to a non-NHS commissioner.

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

	2018/19	2017/18
	£000	£000
Income recognised this year	260	270
Cash payments received in-year	293	152
Amounts added to provision for impairment of receivables	49	54
Amounts written off in-year	17	29

Note 4 Other operating income

	2018/19	2017/18
	£000	£000
Other operating income from contracts with customers:		
Research and development (contract)	1,545	1,696
Education and training (excluding notional apprenticeship levy income)	10,210	10,039
Non-patient care services to other bodies	21,694	25,230
Provider sustainability / sustainability and transformation fund income (PSF / STF)	21,037	6,952
Income in respect of employee benefits accounted on a gross basis	0	0
Other contract income	14,054	13,403
Other non-contract operating income		
Research and development (non-contract)	0	0
Education and training - notional income from apprenticeship fund	105	22
Receipt of capital grants and donations	740	159
Charitable and other contributions to expenditure	0	0
Support from the Department of Health and Social Care for mergers	0	0
Rental revenue from finance leases	0	0
Rental revenue from operating leases	23	23
Amortisation of PFI deferred income / credits	0	0
Other non-contract income	0	0
Total other operating income	**69,408**	57,524
Of which:		
Related to continuing operations	69,408	57,524
Related to discontinued operations	0	0

Included within other operating income for 2018-19 is £21.04m of Provider Sustainability and Transformation Funding (PSF), which includes £0.3m of incentive PSF (Finance), £5.82m of PSF General Distribution (£3.040m 2017/18) and £2.24m PSF (bonus). The Trust's 2019-20 plan includes £7.7m of PSF funding.

Included within other income is revenue from NHS England for 2018-19 is £8m of Central PFI financial support (2017-18 £8m). The Trust's 2019-20 plan includes £8m recurrent central PFI support.

Included within the non-patient care services to other bodies is income of £6.2m (£8m 2017/18) 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 7.1.

Further analysis of "other income"	**2018/19**	2017/18
	£000	£000
PFI support income	**8,000**	8,000
Car Parking income	**2,373**	2,094
Catering Income	**1,006**	1,041
Staff Accommodation	**448**	478
Other	**2,227**	1,790
	14,054	13,403

Note 5.1 Additional information on revenue from contracts with customers recognised in the period

	2018/19
	£000
Revenue recognised in the reporting period that was included in within contract liabilities at the previous period end	2,620
Revenue recognised from performance obligations satisfied (or partially satisfied) in previous periods	0

Note 5.2 Transaction price allocated to remaining performance obligations

Revenue from existing contracts allocated to remaining performance obligations is expected to be recognised:	31 March 2019 £000
within one year	0
after one year, not later than five years	0
after five years	0
Total revenue allocated to remaining performance obligations	**0**

The Trust has exercised the practical expedients permitted by IFRS 15 paragraph 121 in preparing this disclosure. Revenue from (i) contracts with an expected duration of one year or less and (ii) contracts where the trust recognises revenue directly corresponding to work done to date is not disclosed. The Trust has carried forward no income at year end where the performance obligation is not expected to be completed within one year or where the Trust recognises revenue corresponding to work done to date.

Note 6 Fees and charges

HM Treasury requires disclosure of fees and charges income. The following disclosure is of income from charges to service users where income from that service exceeds £1 million and is presented as the aggregate of such income. The cost associated with the service that generated the income is also disclosed.

	2018/19	2017/18
	£000	£000
Income	4,147	4,010
Full cost	-2,894	-2,733
Surplus / (deficit)	**1,253**	1,277
Car Parking		
Income	2,373	2,094
Full cost	-1,941	-1,884
Surplus/(Deficit)	**432**	210
Catering Income		
Income	1,006	1,041
Full cost	-522	-437
Surplus/(Deficit)	**484**	604

Note 7.1 Operating expenses

	2018/19	2017/18
	£000	£000
Purchase of healthcare from NHS and DHSC bodies	12,078	8,561
Purchase of healthcare from non-NHS and non-DHSC bodies	3,823	4,091
Purchase of social care	0	0
Staff and executive directors costs	270,737	255,640
Remuneration of non-executive directors	81	73
Supplies and services - clinical (excluding drugs costs)	36,349	32,514
Supplies and services - general	5,368	5,443
Drug costs (drugs inventory consumed and purchase of non-inventory drugs)	52,784	52,920
Inventories written down	0	0
Consultancy costs	2,283	7,606
Establishment	2,075	1,764
Premises	17,376	19,130
Transport (including patient travel)	2,061	1,946
Depreciation on property, plant and equipment	12,074	12,744
Amortisation on intangible assets	913	966
Net impairments	780	-14,662
Movement in credit loss allowance: contract receivables / contract assets	76	0
Movement in credit loss allowance: all other receivables and investments	0	731
Increase/(decrease) in other provisions	0	25
Change in provisions discount rate(s)	-9	7
Audit fees payable to the external auditor		
audit services- statutory audit	73	73
other auditor remuneration (external auditor only)	9	9
Internal audit costs	148	159
Clinical negligence	18,572	20,911
Legal fees	258	162
Insurance	362	28
Research and development	0	0
Education and training	1,571	1,113
Rentals under operating leases	2,028	2,019
Early retirements	0	0
Redundancy	0	0
Charges to operating expenditure for on-SoFP IFRIC 12 schemes (e.g. PFI / LIFT)	4,942	4,733
Charges to operating expenditure for off-SoFP PFI / LIFT schemes	0	0
Car parking & security	914	834
Hospitality	21	8
Losses, ex gratia & special payments	18	12
Grossing up consortium arrangements	0	0
Other services, eg external payroll	289	282
Other	2,434	1,371
Total	**450,488**	421,213
Of which:		
Related to continuing operations	**450,488**	421,213
Related to discontinued operations	0	0

For further information on impairments please see Note 8.

The corresponding operating expenses relating to the STP as mentioned in income note 4 of £6.2m (£7.2m 2017/18), this is in a combination of areas including purchase of healthcare from NHS and DHSC bodies and consultancy .

The audit fees included within Note 7.1 above are reported as the gross position, the value excluding VAT for 2018/19 is £61k (2017/18 £61k).

Note 7.2 Other auditor remuneration

	2018/19 £000	2017/18 £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	9
Total	**9**	9

The £9k reported in note 7.2 relates to the audit of the Trusts quality accounts. As the Trust does not consolidate its charitable funds (see note 1.2) 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 45 as a related party.

Note 7.3 Limitation on auditor's liability

The limitation on auditor's liability for external audit work is £2m (2017/18: £2m).

Note 8 Impairment of assets

	2018/19 £000	2017/18 £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	780	-14,662
Other	0	0
Total net impairments charged to operating surplus / deficit	**780**	-14,662
Impairments charged to the revaluation reserve	-2,071	-434
Total net impairments	**-1,291**	-15,096

The Trust commissioned its independent professional valuers to undertake an interim desktop valuation as at the 31st March 2019 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.

The property valuation resulted in a net impairment of £0.29m comprising impairments charged to operating expenses of £4.75m offset by the reversal of impairments of £4.46m.

A fair value assessment of IT tangible assets has been carried out based on the valuation model used by the Trust, this is in accordance with the Trust's policy 1.6.2. For 2018/19 the assessment totalled £0.49m.

Note 9 Employee benefits

	2018/19 Total £000	2017/18 Total £000
Salaries and wages	202,086	189,751
Social security costs	21,650	20,549
Apprenticeship levy	1,042	991
Employer's contributions to NHS pensions	24,164	22,979
Pension cost - other	11	5
Other post employment benefits	0	0
Other employment benefits	0	0
Termination benefits	0	0
Temporary staff (including agency)	22,874	22,857
Total gross staff costs	**271,827**	257,132
Recoveries in respect of seconded staff	**0**	0
Total staff costs	**271,827**	257,132
Of which		
Costs capitalised as part of assets	1,090	1,492

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's annual report.

Note 9.1 Retirements due to ill-health

During 2018/19 there was 1 early retirement from the Trust agreed on the grounds of ill-health (4 in the year ended 31 March 2018). The estimated additional pension liabilities of these ill-health retirements is £23k (£209k in 2017/18).

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

Note 10 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 for Health 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 2019, is based on valuation data as 31 March 2018, updated to 31 March 2019 with summary global member and accounting data. In undertaking this actuarial assessment, the methodology prescribed in IAS 19, relevant FReM interpretations, and the discount rate prescribed by HM Treasury have also been used.

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

b) Full actuarial (funding) valuation

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

The latest actuarial valuation undertaken for the NHS Pension Scheme was completed as at 31 March 2016. The results of this valuation set the employer contribution rate payable from April 2019. The Department of Health and Social Care have recently laid Scheme Regulations confirming that the employer contribution rate will increase to 20.6% of pensionable pay from this date.

The 2016 funding valuation was also expected to test the cost of the Scheme relative to the employer cost cap set following the 2012 valuation. Following a judgment from the Court of Appeal in December 2018 Government announced a pause to that part of the valuation process pending conclusion of the continuing legal process.

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 2% for 2018/19 (3% for 2019/20). Trust contributions under the NEST scheme for the 2018/19 financial year totalled £10k (£5k 2017/18).

Note 11 Operating leases

Note 11.1 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

	2018/19 £000	2017/18 £000
Operating lease revenue		
Minimum lease receipts	23	23
Total	**23**	23

	31 March 2019 £000	31 March 2018 £000
Future minimum lease receipts due:		
- not later than one year;	23	23
- later than one year and not later than five years;	94	94
- later than five years.	117	141
Total	**234**	258

Note 11.2 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 main operating leases with values charged to operating expenses in year are disclosed below:

Apogee - Lease of photocopiers and printers under a managed service arrangement, £713k (£805k 2017-18). The contract is expected to complete in March 2024.

Ash Corporate Finance - lease of the laundry land, buildings and equipment, £299k (£263k 2017-18). 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, £253k (£236k 2017-18). This arrangement completes in May 2020 with an option to extend for up to a further 3 years.

MGIF - lease of Springwood Road staff accommodation. The Trust disposed of the Springwood Road site on the 28th March 2019 and entered into an operating lease arrangement with MGIF which includes an initial leaseback of the existing staff residences whilst planning permission is sought by the landlord to redevelop the site, including the provision of new staff accommodation. The overarching lease is therefore structured in different tiers, with the initial period phasing into a 40 year primary term lease on the new accommodation, structured into two interlinked lease periods, with an ultimate option for the Trust to acquire the property for fair value at the end of the arrangement. The initial rent is £537.6k per annum; the rent for the new accommodation will be £960k per annum. The rent will be subject to RPI uplifts annually, with a cap and collar arrangement. The Trust manages the tenancies with staff and receives the sublease rentals. The lease commenced on the 29th March 2019 with an accrual for 3 days costs included within the 2018/19 accounts (£4k).

WGIF - lease of 32 High Street, Pembury for staff residences, rental of £240k per annum, subject to 5 yearly RPI reviews. The Trust disposed of the 32 High St property in February 2019 and entered into a 25 year operating lease expiring in February 2044, with a landlord only break clause in February 2033. The Trust has recognised the part year lease cost in the minimum lease payments (£26k). The Trust manages the tenancies with staff and receives the sublease rentals.

	2018/19 £000	2017/18 £000
Operating lease expense		
Minimum lease payments	2,051	2,019
Contingent rents	0	0
Less sublease payments received	-23	0
Total	**2,028**	2,019

	31 March 2019 £000	31 March 2018 £000
Future minimum lease payments due:		
- not later than one year;	2,541	2,000
- later than one year and not later than five years;	9,481	4,257
- later than five years.	43,209	1,468
Total	**55,231**	7,725
Future minimum sublease payments to be received	**-45,404**	0

Note 12 Finance income

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

	2018/19 £000	2017/18 £000
Interest on bank accounts	164	47
Interest income on finance leases	0	0
Interest on other investments / financial assets	0	0
Other finance income	0	0
Total finance income	**164**	47

Note 13.1 Finance expenditure

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

	2018/19 £000	2017/18 £000
Interest expense:		
Loans from the Department of Health and Social Care	1,582	1,248
Other loans	0	0
Overdrafts	0	0
Finance leases	0	0
Interest on late payment of commercial debt	6	14
Main finance costs on PFI and LIFT schemes obligations	10,389	10,657
Contingent finance costs on PFI and LIFT scheme obligations	3,848	3,198
Total interest expense	**15,825**	15,117
Unwinding of discount on provisions	0	1
Other finance costs	0	0
Total finance costs	**15,825**	15,118

Note 13.2 The late payment of commercial debts (interest) Act 1998 / Public Contract Regulations 2015

	2018/19 £000	2017/18 £000
Total liability accruing in year under this legislation as a result of late payments	0	0
Amounts included within interest payable arising from claims under this legislation	6	14
Compensation paid to cover debt recovery costs under this legislation	0	0

The Trust made 105 late payments incurring interest charges totalling £6k.

Note 14 Other gains / (losses)

	2018/19 £000	2017/18 £000
Gains on disposal of assets	13,542	89
Losses on disposal of assets	0	0
Total gains / (losses) on disposal of assets	**13,542**	89
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 financial assets mandated as fair value through OCI	0	0
Total other gains / (losses)	**13,542**	89

The Trust disposed of the staff residential property at 32 High St in February 2019 for a gross sales price of £5.65m, which after deduction of costs of sale of £0.15m and accounting for the net book value of the asset (£1.63m), generated a net gain of £3.87m.

The Trust disposed of a group of staff residences at Maidstone (Springwood Road) in March 2019 for a gross sales price of £12.5m, which after deduction of costs of sale and accounting for the net book value of the asset, generated a net gain of £9.67m.

Note 15 Discontinued operations

The Trust has no discontinued operations.

Note 16.1 Intangible assets - 2018/19

	Software licences £000	Internally generated information technology £000	Total £000
Valuation / gross cost at 1 April 2018 - brought forward	**616**	**7,868**	**8,484**
Transfers by absorption	0	0	**0**
Additions	102	1,186	**1,288**
Reclassifications	0	358	**358**
Valuation / gross cost at 31 March 2019	**718**	**9,412**	**10,130**
Amortisation at 1 April 2018 - brought forward	**488**	**5,384**	**5,872**
Provided during the year	39	874	**913**
Amortisation at 31 March 2019	**527**	**6,258**	**6,785**
Net book value at 31 March 2019	**191**	**3,154**	**3,345**
Net book value at 1 April 2018	**128**	**2,484**	**2,612**

Note 16.2 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**
Additions	0	198	**198**
Impairments	0	-3,665	**-3,665**
Reclassifications	37	3,789	**3,826**
Valuation / gross cost at 31 March 2018	**616**	**7,868**	**8,484**
Amortisation at 1 April 2017 - brought forward	**431**	**4,475**	**4,906**
Prior period adjustments	0	0	**0**
Amortisation at 1 April 2017 - restated	**431**	**4,475**	**4,906**
Provided during the year	57	909	**966**
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 17.1 Property, plant and equipment - 2018/19

	Land	Buildings excluding dwellings	Dwellings	Assets under construction	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Valuation/gross cost at 1 April 2018 - brought forward	**13,342**	**259,819**	**3,283**	**4,700**	**83,890**	**844**	**20,084**	**2,764**	**388,726**
Additions	0	4,379	0	5,677	1,840	0	455	0	**12,351**
Impairments charged to operating expenses	0	-4,749	0	0	0	0	-489	0	**-5,238**
Impairments charged to the revaluation reserve	0	-1,868	0	0	0	0	0	0	**-1,868**
Reversal of impairments credited to operating expenses	0	4,458	0	0	0	0	0	0	**4,458**
Reversal of impairments credited to the revaluation reserve	0	3,939	0	0	0	0	0	0	**3,939**
Revaluations	0	1,040	0	0	0	0	0	0	**1,040**
Reclassifications	0	634	0	-4,505	2,618	0	862	33	**-358**
Disposals / derecognition	-1,228	0	-2,864	0	0	0	0	0	**-4,092**
Valuation/gross cost at 31 March 2019	**12,114**	**267,652**	**419**	**5,872**	**88,348**	**844**	**20,912**	**2,797**	**398,958**
Accumulated depreciation at 1 April 2018 - brought forward	**0**	**8,142**	**419**	**0**	**65,969**	**835**	**17,484**	**1,863**	**94,712**
Provided during the year	0	5,910	93	0	4,605	5	1,206	255	**12,074**
Disposals / derecognition	0	0	-93	0	0	0	0	0	**-93**
Accumulated depreciation at 31 March 2019	**0**	**14,052**	**419**	**0**	**70,574**	**840**	**18,690**	**2,118**	**106,693**
Net book value at 31 March 2019	**12,114**	**253,600**	**0**	**5,872**	**17,774**	**4**	**2,222**	**679**	**292,265**
Net book value at 1 April 2018	**13,342**	**251,677**	**2,864**	**4,700**	**17,921**	**9**	**2,600**	**901**	**294,014**

Note 17.2 Property, plant and equipment - 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
Valuation / gross cost at 1 April 2017 - as previously stated	**13,496**	**235,321**	**3,480**	**6,184**	**80,952**	**858**	**19,244**	**2,764**	**362,299**
Valuation / gross cost at 1 April 2017 - restated	**13,496**	**235,321**	**3,480**	**6,184**	**80,952**	**858**	**19,244**	**2,764**	**362,299**
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**
expenses	0	19,279	0	0	0	0	0	0	**19,279**
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**
Disposals / derecognition	0	0	0	0	-127	-14	0	0	**-141**
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 - as previously stated	**0**	**2,681**	**295**	**0**	**60,516**	**844**	**16,164**	**1,609**	**82,109**
Accumulated depreciation at 1 April 2017 - restated	**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 17.3 Property, plant and equipment financing - 2018/19

	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 2019									
Owned - purchased	12,114	94,669	0	5,872	16,678	4	2,181	679	**132,197**
Finance leased	0	0	0	0	0	0	0	0	**0**
On-SoFP PFI contracts and other service concession arrangements	0	158,893	0	0	0	0	0	0	**158,893**
Off-SoFP 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	38	0	0	1,096	0	41	0	**1,175**
NBV total at 31 March 2019	**12,114**	**253,600**	**0**	**5,872**	**17,774**	**4**	**2,222**	**679**	**292,265**

Note 17.4 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**
Off-SoFP 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 18 Donations of property, plant and equipment

In the financial year 2018/19 the Trust purchased medical equipment totalling £740k from Charitable Funds. The main investment was the replacement of the Cardiac Catheterisation Laboratory equipment at Tunbridge Wells Hospital for £459k from the Mollie Hayling Cardiology Legacy Fund. Other significant equipment purchased from Charitable Funds was an ultrasound and stepper for brachytherapy prostate cancer treatment at Maidstone Hospital (£89k) funded from the Sutcliffe Fund; and a Cardiac Holter system for £39k from the David Crow Legacy Cardiology Fund.

The Maidstone League of Friends purchased a rapid assessment ultrasound for the emergency department (£42k); an Endobronchial Ultrasound (£53k) for respiratory disease diagnosis, and a flexible nasendoscope integrated into a system with video-stroboscopy and recording equipment for fibreoptic evaluations of swallowing by therapy staff (£57k).

Note 19 Revaluations of property, plant and equipment

The Trust spent £12.4m on tangible assets from its capital resource in 2018/19. The main items were two linear accelerator machines funded from national PDC (£3.4m) plus £0.7m of enabling works from Trust resource; £2.4m on Trust-wide medical equipment replacement; £1.5m on backlog maintenance and estates renewals at Maidstone Hospital, with £0.7m of planned lifecycle at the Tunbridge Wells Hospital under the PFI contract (as notified by the Trust's PFI partner and accounted for under IFRIC 12 - £471k related to the in year unitary payment and £260k related to a release of previous prepayments); £1.4m on LED lighting at Maidstone and TWH funded from Salix loans; £1.2m of investment in ICT infrastructure and equipment including implementation costs for the new Electronic Patient Record system (EPR).

The Trust's depreciation on tangible assets in the year was £12.1m and for intangible assets £0.9m.

The financial year 2018/19 is the fourth year in the current five year cyclical valuation period. A full valuation was undertaken in September 2014 with desktop valuations in each subsequent financial years. 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 and Building assets at 31st March 2019. The lead relationship partner from Montagu Evans LLP is qualified to BSc MRICS.

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

The 31st March 2019 valuation resulted in an overall increase in the carrying value of the Trust's Land and Property assets of £2.8m, of which (£4.7m) is an in year charge to I&E impairments and £4.5m reversed previous I&E impairments both of these are reflected in operating expenses. (£1.9m) relates to an in year increase to the revaluation reserve and £3.9m reversed previous revaluation reserve entries and £1.04m of uplift revaluation. The overall increase was driven by a rise in component BCIS indices.

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 DHSC GAM 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 20 Investment Property

The Trust has no investment properties

Note 21 Investments in associates and joint ventures

The Trust has no investments in associates of joint ventures

Note 22 Other investments / financial assets (non-current)

The Trust has no other investments

Note 23 Disclosure of interests in other entities

The Trust have no interests in other entities

Note 24 Inventories

	31 March 2019 £000	31 March 2018 £000
Drugs	**2,828**	2,952
Work In progress	**0**	0
Consumables	**1,024**	1,053
Energy	**151**	153
Other	**3,817**	3,594
Total inventories	**7,820**	7,752
of which:		
Held at fair value less costs to sell	**0**	0

Inventories recognised in expenses for the year were £66,845k (2017/18: £53,044k). Write-down of inventories recognised as expenses for the year were £0k (2017/18: £0k).

Note 25.1 Trade receivables and other receivables

	31 March 2019 £000	31 March 2018 £000
Current		
Contract receivables*	28,662	0
Contract assets*	0	0
Trade receivables*	0	14,439
Capital receivables	107	107
Accrued income*	0	16,583
Allowance for Expected Credit Loss*	-1,398	0
Allowance for other impaired receivables	0	-1,365
Deposits and advances	0	0
Prepayments (non-PFI)	3,139	3,289
PFI prepayments - capital contributions	0	0
PFI lifecycle prepayments	0	0
Interest receivable	0	0
Finance lease receivables	0	0
PDC dividend receivable	594	216
VAT receivable	2,133	2,543
Corporation and other taxes receivable	0	0
Other receivables	1,192	1,642
Total current trade and other receivables	**34,429**	37,454
Non-current		
Contract receivables*	0	0
Contract assets*	0	0
Trade receivables*	0	0
Capital receivables	0	0
Accrued income*	0	0
Allowance for impaired contract receivables / assets*	0	0
Allowance for other impaired receivables	0	0
Deposits and advances	0	0
Prepayments (non-PFI)	178	439
PFI prepayments - capital contributions	221	193
PFI lifecycle prepayments	0	0
Interest receivable	0	0
Finance lease receivables	0	0
VAT receivable	0	0
Corporation and other taxes receivable	0	0
Other receivables	1,002	569
Total non-current trade and other receivables	**1,401**	1,201
Of which receivables from NHS and DHSC group bodies:		
Current	**25,788**	27,897
Non-current	0	0

*Following the application of IFRS 15 from 1 April 2018, the Trust's entitlements to consideration for work performed under contracts with customers are shown separately as contract receivables and contract assets. This replaces the previous analysis into trade receivables and accrued income. IFRS 15 is applied without restatement therefore the comparative analysis of receivables has not been restated under IFRS 15.

The 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. The calculation for the allowance of other impaired receivables has been amended to reflect the change in IFRS 9 accounting standards for provision of expected credit losses. Please see note 25.2 for further information.

Note 25.2 Allowances for credit losses - 2018/19

	Contract receivables and contract assets	All other receivables
	£000	£000
Allowances as at 1 Apr 2018 - brought forward		**-1,365**
Impact of implementing IFRS 9 (and IFRS 15) on 1 April 2018	1,365	-1,365
Transfers by absorption	0	0
New allowances arising	76	0
Changes in existing allowances	0	0
Reversals of allowances	0	0
Utilisation of allowances (write offs)	-43	0
Changes arising following modification of contractual cash flows	0	0
Foreign exchange and other changes	0	0
Allowances as at 31 Mar 2019	**1,398**	-2,730

Following the implementation of IFRS 9 the previous bad debt provision calculation, which the Trust provided for all trade debtors over 120 days has been superseded under IFRS 9 the Trust is required to measure the loss allowance of lifetime expected credit losses at initial recognition of the debt being raised. This is assessed by looking at classes of debtor with common credit characteristics.

The expected credit loss is only applied to trade debtors. NHS organisation are excluded from the calculation as NHS debt is considered to be part of "intra-company" transactions. It does also apply to Local Authorities

The Trust has used the ageing debt classes to consider the main categories of trade debtor and assessed their expected credit loss characteristics. For all debt categories all trade debt over 180 days is provided for. The Trust used historic data to assess the level of credit notes and write offs raised within the period per category of aged debt. Using the percentages the Trust grouped the categories together with similar credit characteristics to form the calculation matrix.

In addition injury cost recovery debt is provided for in accordance with the approach set out in note 3.2

Note 25.3 Allowances for credit losses - 2017/18

IFRS 9 and IFRS 15 are adopted without restatement therefore this analysis is prepared in line with the requirements of IFRS 7 prior to IFRS 9 adoption. As a result it differs in format to the current period disclosure.

	All receivables
	£000
Allowances as at 1 Apr 2017 - as previously stated	-797
Prior period adjustments	0
Allowances as at 1 Apr 2017 - restated	-797
Transfers by absorption	0
Increase in provision	-1,220
Amounts utilised	163
Unused amounts reversed	489
Allowances as at 31 Mar 2018	-1,365

Note 25.4 Exposure to credit risk

Under IFRS 9 the Trust is required to measure the loss allowance of lifetime expected credit losses at initial recognition of the debt being raised. This is assessed by looking at classes of debtor with common credit characteristics.

Note 26 Other assets

The Trust has no other assets.

Note 27 Non-current assets held for sale and assets in disposal groups

	2018/19 £000	2017/18 £000
NBV of non-current assets for sale and assets in disposal groups at 1 April	**0**	**1,742**
Prior period adjustment		0
NBV of non-current assets for sale and assets in disposal groups at 1 April - restated	**0**	**1,742**
Transfers by absorption	0	0
Assets classified as available for sale in the year	0	0
Assets sold in year	0	-1,742
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 sale	0	0
NBV of non-current assets for sale and assets in disposal groups at 31 March	**0**	0

The Trust has no assets held for sale for 2018/19.

Note 27.1 Liabilities in disposal groups

The Trust has no liabilities in disposal groups

Note 28.1 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.

	2018/19	2017/18
	£000	£000
At 1 April	**1,473**	1,420
Prior period adjustments	0	0
At 1 April (restated)	**1,473**	1,420
Net change in year	8,933	53
At 31 March	**10,406**	1,473
Broken down into:		
Cash at commercial banks and in hand	23	67
Cash with the Government Banking Service	10,383	1,406
Deposits with the National Loan Fund	0	0
Other current investments	0	0
Total cash and cash equivalents as in SoFP	**10,406**	1,473
Bank overdrafts (GBS and commercial banks)	0	0
Drawdown in committed facility	0	0
Total cash and cash equivalents as in SoCF	**10,406**	1,473

The Trust has obtained agreement from NHS Improvement to carry forward additional cash at year end from its asset disposals to support its future capital plans. The capital resourcing is subject to approval from DHSC. See notes 50 and 51 for further information.

Note 28.2 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 2019	31 March 2018
	£000	£000
Bank balances	0	1
Monies on deposit	0	0
Total third party assets	**0**	1

Note 29.1 Trade and other payables

	31 March 2019 £000	31 March 2018 £000
Current		
Trade payables	10,267	21,144
Capital payables	1,729	2,628
Accruals	13,166	12,994
Receipts in advance (including payments on account)	0	0
Social security costs	80	2,801
VAT payables	0	0
Other taxes payable	94	2,429
PDC dividend payable	0	0
Accrued interest on loans*	0	111
Other payables	2,681	1,786
Total current trade and other payables	**28,017**	43,893
Non-current		
Trade payables	0	0
Capital payables	0	0
Accruals	0	0
Receipts in advance (including payments on account)	0	0
VAT payables	0	0
Other taxes payable	0	0
Other payables	0	0
Total non-current trade and other payables	**0**	0
Of which payables from NHS and DHSC group bodies:		
Current	**6,433**	8,767
Non-current	0	0

*Following adoption of IFRS 9 on 1 April 2018, loans are measured at amortised cost. Any accrued interest is now included in the carrying value of the loan within note . IFRS 9 is applied without restatement therefore comparatives have not been restated.

The Trust paid its March 2019 PAYE and National Insurance payments in March, ahead of the due date in April, so reduced its year end payables balance compared with 2017/18.

Note 29.2 Early retirements in NHS payables above

The Trust has not paid any early retirements

Note 30 Other financial liabilities

The Trust does not have any other financial liabilities.

Note 31 Other liabilities

	31 March 2019 £000	31 March 2018 £000
Current		
Deferred income: contract liabilities	2,580	2,620
Deferred grants	0	0
PFI deferred income / credits	0	0
Lease incentives	0	0
Other deferred income	0	0
Total other current liabilities	**2,580**	2,620

The Trust has no non-current other liabilities

Note 32 Borrowings

	31 March 2019 £000	31 March 2018 £000
Current		
Bank overdrafts	0	0
Drawdown in committed facility	0	0
Loans from the Department of Health and Social Care	19,187	19,082
Other loans	371	103
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)	5,427	5,284
Total current borrowings	**24,985**	24,469
Non-current		
Loans from the Department of Health and Social Care	34,102	36,276
Other loans	1,744	636
Obligations under finance leases	0	0
PFI lifecycle replacement received in advance	0	0
Obligations under PFI, LIFT or other service concession contracts	187,521	192,948
Total non-current borrowings	**223,367**	229,860

Department of Health and Social Care (DHSC) loans totalling £29m were taken out in previous years 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 is due to be repaid in February 2020 and has a fixed interest rate of 1.5%.

Within the £34.1m loans from DHSC is an interim revolving working capital loan of £12.132m which is repayable in 2020/21 and has a fixed interest rate of 3.5%. The remaining balance is a combination of 5 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 has Salix loans total value of £2.1m which appears in "other loans" in both current and non current borrowings, this relates to improving the energy efficiency of the Trust. These loans are 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.

Under IFRS 9 the loan values also include their associated interest charges which were previously included under trade payables.

Note 32.1 Reconciliation of liabilities arising from financing activities

	Loans from DHSC	Other loans	Finance leases	PFI and LIFT schemes	Total
	£000	£000	£000	£000	£000
Carrying value at 1 April 2018	**55,358**	**739**	**0**	**198,232**	**254,329**
Cash movements:					
Financing cash flows - payments and receipts of principal	-2,174	1,376	0	-5,284	**-6,082**
Financing cash flows - payments of interest	-1,588	0	0	-10,389	**-11,977**
Non-cash movements:					
Impact of implementing IFRS 9 on 1 April 2018	111	0	0	0	**111**
Transfers by absorption	0	0	0	0	**0**
Additions	0	0	0	0	**0**
Application of effective interest rate	1,582	0	0	10,389	**11,971**
Change in effective interest rate	0	0	0	0	**0**
Changes in fair value	0	0	0	0	**0**
Other changes	0	0	0	0	**0**
Carrying value at 31 March 2019	**53,289**	**2,115**	**0**	**192,948**	**248,352**

Note 33 Finance leases

The Trust does not have any Finance Leases

Note 34.1 Provisions for liabilities and charges analysis

	Pensions: early departure costs	Pensions: injury benefits*	Legal claims	Equal Pay (including Agenda for Change)	Redundancy	Other	Total
	£000	£000	£000	£000	£000	£000	£000
At 1 April 2018	**0**	**454**	**411**	**0**	**0**	**1,984**	**2,849**
Transfers by absorption	0	0	0	0	0	0	**0**
Change in the discount rate	0	-9	0	0	0	0	**-9**
Arising during the year	0	16	101	0	0	40	**157**
Utilised during the year	0	-25	-83	0	0	-236	**-344**
Reclassified to liabilities held in disposal groups	0	0	0	0	0	0	**0**
Reversed unused	0	0	-54	0	0	-143	**-197**
Unwinding of discount	0	0	0	0	0	0	**0**
At 31 March 2019	**0**	**436**	**375**	**0**	**0**	**1,645**	**2,456**
Expected timing of cash flows:							
- not later than one year;	0	24	375	0	0	1,068	**1,467**
- later than one year and not later than five years;	0	94	0	0	0	457	**551**
- later than five years.	0	318	0	0	0	120	**438**
Total	**0**	**436**	**375**	**0**	**0**	**1,645**	**2,456**

* In 2018/19 the analysis of provisions has been revised to separately identify provisions for injury benefit liabilities. In previous periods, these provisions were included within early departure costs.

Pension Injury Benefit 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.

Other includes the provision for dilapidations of leased properties/equipment £1.6m and onerous contract provision £0.1m.

Note 34.2 Clinical negligence liabilities

At 31 March 2019, £228,658k was included in provisions of NHS Resolution in respect of clinical negligence liabilities of Maidstone And Tunbridge Wells NHS Trust (31 March 2018: £209,175k).

Note 35 Contingent assets and liabilities

	31 March 2019 £000	31 March 2018 £000
Value of contingent liabilities		
NHS Resolution legal claims	-44	-47
Employment tribunal and other employee related litigation	0	0
Redundancy	0	0
Other	0	0
Gross value of contingent liabilities	**-44**	-47
Amounts recoverable against liabilities	0	0
Net value of contingent liabilities	**-44**	-47
Net value of contingent assets	**0**	0

Contingent Liability for 2018/19 relates to legal claims notified by NHS Resolution of £44k

Note 36 Contractual capital commitments

	31 March 2019 £000	31 March 2018 £000
Property, plant and equipment	575	428
Intangible assets	0	0
Total	**575**	428

Note 37 Other financial commitments

The Trust has no commitments to making payments under non-cancellable contracts (which are not leases, PFI contracts or other service concession arrangement).

Note 38 Defined benefit pension schemes

The Trust does not have any defined benefit schemes

Note 39 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 2018/19 year was 3.61%. The RPI uplift for 2019/20 is 2.48%.

Note 39.1 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 2019 £000	31 March 2018 £000
Gross PFI, LIFT or other service concession liabilities	**336,714**	352,387
Of which liabilities are due		
- not later than one year;	15,536	15,673
- later than one year and not later than five years;	59,985	60,582
- later than five years.	261,193	276,132
Finance charges allocated to future periods	-143,766	-154,155
Net PFI, LIFT or other service concession arrangement obligation	**192,948**	198,232
- not later than one year;	5,427	5,284
- later than one year and not later than five years;	22,431	21,865
- later than five years.	165,090	171,083

Note 39.2 Total on-SoFP PFI, LIFT and other service concession arrangement commitments

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

	31 March 2019 £000	31 March 2018 £000
Total future payments committed in respect of the PFI, LIFT or other service concession arrangements	**798,183**	823,081
Of which liabilities are due:		
- not later than one year;	25,366	24,752
- later than one year and not later than five years;	107,966	105,352
- later than five years.	664,851	692,977

Note 39.3 Analysis of amounts payable to service concession operator

This note provides an analysis of the unitary payments made to the service concession operator:

	2018/19 £000	2017/18 £000
Unitary payment payable to service concession operator	**24,752**	23,888
Consisting of:		
- Interest charge	10,389	10,657
- Repayment of finance lease liability	5,284	5,028
- Service element and other charges to operating expenditure	4,760	4,503
- Capital lifecycle maintenance	471	371
- Revenue lifecycle maintenance	0	0
- Contingent rent	3,848	3,198
- Addition to lifecycle prepayment	0	131
Other amounts paid to operator due to a commitment under the service concession contract but not part of the unitary payment	182	230
Total amount paid to service concession operator	**24,934**	24,118

Note 40 Off-SoFP PFI, LIFT and other service concession arrangements

The Trust has no Off-SoFP schemes

Note 41 Financial instruments

Note 41.1 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 2019 are in receivables from customers, as disclosed in the trade and other receivables note.

Liquidity risk

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

Note 41.2 Carrying values of financial assets

IFRS 9 Financial Instruments is applied retrospectively from 1 April 2018 without restatement of comparatives. As such, comparative disclosures have been prepared under IAS 39 and the measurement categories differ to those in the current year analyses.

Carrying values of financial assets as at 31 March 2019 under IFRS 9	Held at amortised cost £000	Held at fair value through I&E £000	Held at fair value through OCI £000	Total book value £000
Trade and other receivables excluding non financial assets	29,552	0	0	**29,552**
Other investments / financial assets	0	0	0	**0**
Cash and cash equivalents at bank and in hand	10,406	0	0	**10,406**
Total at 31 March 2019	**39,958**	**0**	**0**	**39,958**

Carrying values of financial assets as at 31 March 2018 under IAS 39	Loans and receivables £000	Assets at fair value through the I&E £000	Held to maturity £000	Available-for-sale £000	Total book value £000
Trade and other receivables excluding non financial assets	32,195	0	0	0	**32,195**
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**

Note 41.3 Carrying value of financial liabilities

IFRS 9 Financial Instruments is applied retrospectively from 1 April 2018 without restatement of comparatives. As such, comparative disclosures have been prepared under IAS 39 and the measurement categories differ to those in the current year analyses.

Carrying values of financial liabilities as at 31 March 2019 under IFRS 9	Held at amortised cost £000	Held at fair value through the I&E £000	Total book value £000
Loans from the Department of Health and Social Care	53,289	0	**53,289**
Obligations under finance leases	0	0	**0**
Obligations under PFI, LIFT and other service concession contracts	192,948	0	**192,948**
Other borrowings	2,115	0	**2,115**
Trade and other payables excluding non financial liabilities	27,522	0	**27,522**
Other financial liabilities	0	0	**0**
Provisions under contract	0	0	**0**
Total at 31 March 2019	**275,874**	**0**	**275,874**

Carrying values of financial liabilities as at 31 March 2018 under IAS 39	Other financial liabilities £000	Held at fair value through the I&E £000	Total book value £000
Loans from the Department of Health and Social Care	55,358	0	**55,358**
Obligations under finance leases	0	0	**0**
Obligations under PFI, LIFT and other service concession contracts	198,232	0	**198,232**
Other borrowings	739	0	**739**
Trade and other payables excluding non financial liabilities	30,780	0	**30,780**
Other financial liabilities	0	0	**0**
Provisions under contract	0	0	**0**
Total at 31 March 2018	**285,109**	**0**	**285,109**

Note 41.4 Fair values of financial assets and liabilities

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

Note 41.5 Maturity of financial liabilities

	31 March 2019 £000	31 March 2018 £000
In one year or less	52,506	55,249
In more than one year but not more than two years	33,488	19,880
In more than two years but not more than five years	21,232	34,394
In more than five years	168,648	175,586
Total	**275,874**	285,109

Note 42 Losses and special payments

	2018/19		2017/18	
	Total number of cases Number	Total value of cases £000	Total number of cases Number	Total value of cases £000
Losses				
Cash losses	29	32	35	35
Fruitless payments	0	0	0	0
Bad debts and claims abandoned	20	20	11	32
Stores losses and damage to property	0	0	17	2
Total losses	**49**	**52**	63	69
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	40	14	32	11
Special severance payments	0	0	0	0
Extra-statutory and extra-regulatory payments	0	0	0	0
Total special payments	**40**	**14**	32	11
Total losses and special payments	**89**	**66**	95	80
Compensation payments received		0		0

The Trust has had no cases exceeding £300k.

Note 43 Gifts

There were no gifts made by the Trust in 2018/19 or in 2017/18

Note 44.1 Initial application of IFRS 9

IFRS 9 Financial Instruments as interpreted and adapted by the GAM has been applied by the Trust from 1 April 2018. The standard is applied retrospectively with the cumulative effect of initial application recognised as an adjustment to reserves on 1 April 2018.

IFRS 9 replaces IAS 39 and introduces a revised approach to classification and measurement of financial assets and financial liabilities, a new forward-looking 'expected loss' impairment model and a revised approach to hedge accounting.

Under IFRS 9, borrowings from the Department of Health and Social Care, which were previously held at historic cost, are measured on an amortised cost basis. Consequently, on 1 April 2018 borrowings increased by £111k, and trade payables correspondingly reduced.

Reassessment of allowances for credit losses under the expected loss model resulted in a £0k decrease in the carrying value of receivables.

The GAM expands the definition of a contract in the context of financial instruments to include legislation and regulations, except where this gives rise to a tax. Implementation of this adaptation on 1 April 2018 has led to the classification of receivables relating to Injury Cost Recovery as a financial asset measured at amortised cost. The carrying value of these receivables at 1 April 2018 was £0k.

The injury cost recovery opening receivables balance at 1st April 2018 was £2.139m and the closing balance at the end of March 2019 is £2.137m.

Note 44.2 Initial application of IFRS 15

IFRS 15 Revenue from Contracts with Customers as interpreted and adapted by the GAM has been applied by the Trust from 1 April 2018. The standard is applied retrospectively with the cumulative effect of initial application recognised as an adjustment to the income and expenditure reserve on 1 April 2018.

IFRS 15 introduces a new model for the recognition of revenue from contracts with customers replacing the previous standards IAS 11, IAS 18 and related Interpretations. The core principle of IFRS 15 is that an entity recognises revenue when it satisfies performance obligations through the transfer of promised goods or services to customers at an amount that reflects the consideration to which the entity expects to be entitled to in exchange for those goods or services.

As directed by the GAM, the Trust has applied the practical expedient offered in C7A of the standard removing the need to retrospectively restate any contract modifications that occurred before the date of implementation (1 April 2018).

Note 45 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 (DHSC) is regarded as a related party. During the year 2018/19 the Trust has received £4.5m capital funding in the form of Public Dividend Capital. The Trust also has loans with DHSC, interest paid within the year £1.6m, principal repayment of £4.7m 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
Thanet CCG
Horsham and Mid Sussex CCG
Wessex Specialised Commissioning Hub
South East Specialised Commissioning Hub
Kent Community Foundation Trust
East Kent University Hospitals Foundation Trust
Medway NHS Foundation Trust
NHS England
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 1.2). 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.

	2018-19	2017-18
	£000s	£000s
Total charitable resources expended with the Trust	**751**	267
Closing creditor (monies owed to the Trust by the Charity)	**146**	0
Closing debtor (monies owed to the Charity by the Trust)	**0**	43
Total income received by the Charity in the reporting period	**796**	208
Total Charitable Funds at end of the reporting period	**1,170**	1,129

Note 46 Transfers by absorption
The Trust has no transfers by absorption

Note 47 Prior period adjustments
The Trust has no prior period adjustments

Note 48 Events after the reporting date
The Trust has no events after the reporting date.

Note 49 Better Payment Practice code

	2018/19 Number	2018/19 £000	2017/18 Number	2017/18 £000
Non-NHS Payables				
Total non-NHS trade invoices paid in the year	118,271	199,748	124,829	199,536
Total non-NHS trade invoices paid within target	102,797	176,625	37,856	88,464
Percentage of non-NHS trade invoices paid within target	**86.9%**	**88.4%**	30.3%	44.3%
NHS Payables				
Total NHS trade invoices paid in the year	3,064	39,048	3,077	31,872
Total NHS trade invoices paid within target	1,892	27,230	446	22,661
Percentage of NHS trade invoices paid within target	**61.7%**	**69.7%**	14.5%	71.1%

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 50 External financing

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

	2018/19 £000	2017/18 £000
Cash flow financing	-10,554	7,379
Finance leases taken out in year	**0**	0
Other capital receipts	**0**	0
External financing requirement	**-10,554**	7,379
External financing limit (EFL)	-1,148	7,852
Under / (over) spend against EFL	**9,406**	473

The Trust under spent against its External Financing Limit by £9.4m. This relates to £8.4m from the Maidstone asset sale agreed with NHSI to carry forward into 2019/20, £0.3m HSLI National PDC for ICT developments into 2019/20 to support the national position, £0.7m cash to support revenue commitments carried forward into 2019/20.

Note 51 Capital Resource Limit

	2018/19 £000	2017/18 £000
Gross capital expenditure	13,639	11,503
Less: Disposals	-3,999	-1,742
Less: Donated and granted capital additions	-740	-159
Plus: Loss on disposal from capital grants in kind	**0**	0
Charge against Capital Resource Limit	**8,900**	9,602
Capital Resource Limit	12,101	10,580
Under / (over) spend against CRL	**3,201**	978

The Trust underspent its Capital Resource Limit of £12.1m by £3.2m. The main reason for this was the disposal of its Maidstone residences at the end of the financial year which released £2.4m net book value resource. This has been carried forward in cash terms into 2019/20. The Trust also agreed to defer £0.3m of central PDC related to ICT developments into 2019/20 to support the national position. The Trust also underspent its depreciation costs by £0.5m which benefitted the Income and Expenditure position but reduced the capital it was able to spend.

Note 52 Breakeven duty financial performance

	2018/19 £000
Adjusted financial performance surplus / (deficit) (control total basis)	20,324
Remove impairments scoring to Departmental Expenditure Limit	0
Add back non-cash element of On-SoFP pension scheme charges	0
IFRIC 12 breakeven adjustment	0
Breakeven duty financial performance surplus / (deficit)	**20,324**

The breakeven duty performance reports I&E including PSF payments. The Trust met its outturn control total and received core PSF of £12.7m plus further incentive PSF of £8.3m.

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

Note 53 Breakeven duty rolling assessment

	1997/98 to 2008/09	2009/10	2010/11	2011/12	2012/13	2013/14	2014/15	2015/16	2016/17	2017/18	2018/19
		£000	£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	20,324
Breakeven duty cumulative position	-3,260	-3,071	-1,361	-1,061	-932	-13,306	-13,149	-36,562	-47,480	-58,270	-37,946
Operating income		311,889	322,176	345,101	367,391	375,714	403,310	400,930	430,502	440,269	473,169
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%	-8.02%

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 has achieved an in year surplus in 2018/19 of £20.3m reducing the cumulative deficit. The Trust's breakeven period has been extended with the plans submitted for 2019/20 aimed at further reducing the accumulated deficit towards the target of formal cumulative break-even by 2023/24. The Trust will be preparing a formal five year plan during the course of 2019/20 to support its goals of underlying recurrent balance and cumulative break even.

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 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 exited Financial Special Measures in October 2018.

The Trust prepared and submitted cash-flow plans for 2019/20 which include the repayment of £29m of working capital loans, the majority of which is planned to be financed from internal resources plus an additional £11m cash support. Subsequently NHSI have clarified that one of the loans, for £12.132m, does not fall due until 2020/21. Therefore the Trust will not require the additional cash support if it does not need to repay the loan in 2019/20.

NHS
Maidstone and Tunbridge Wells
NHS Trust

Thank you for your support

Miles Scott, Chief Executive

David Highton, Chair of the Trust Board

The Trust receives support and well wishes from patients, carers, stakeholders, volunteers, fundraisers and Members (of which we have over 10,000). This support is expressed in a varied number of ways, including compliments sent directly to the Trust; letters sent to the local media; comments posted on social media; participation in the Patient Experience Committee; attendance at Trust Board meetings and the Annual General Meeting and fundraising to buy much needed equipment, to name but a few.

This support is highly valued by the Trust's staff and the Board - without this, the Trust's task would be far harder. Thank you all.

taking pride

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Maidstone and Tunbridge Wells NHS Trust

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