NHS
Maidstone and Tunbridge Wells
NHS Trust

Annual Report and Accounts 2019/20

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 2019/20", 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 2019/20; and a review of financial performance for 2019/20
  - A summary of the Trust's Quality Accounts for 2019/20
  - A Sustainability Report. This follows the standard reporting format from the NHS Sustainable Development Unit.
- "Accountability Report for 2019/20", which is divided into the following sections:
  - "Corporate Governance Report for 2019/20", which includes:
    - A Directors' report (providing details about the Trust Board; a Statement regarding Directors' 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"
    - A "Statement of Directors' responsibilities in respect of the accounts"
    - The "Annual Governance Statement for 2019/20"
  - "Remuneration and Staff Report for 2019/20" (including details of 'off-payroll' engagements)
- "Financial Statements for 2019/20", 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 18th June 2020.

[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

Contents

Performance Report for 2019/20: Overview 4
The purpose of the overview section 5
The purpose and activities of Maidstone and Tunbridge Wells NHS Trust 5
A message from the Chair of the Trust Board and Chief Executive 7
Snapshot of 2019/20 9
Key issues and risks affecting delivery of the Trust's key objectives 12
Adoption of the 'going concern' basis 14
Performance summary for 2019/20 15
Performance Report for 2019/20: Performance analysis 16
How the Trust measures performance 17
Development and performance in 2019/20 18
Financial performance in 2019/20 20
Performance Report for 2019/20: Sustainability Report 24
Accountability Report for 2019/20: Corporate Governance report 32
Directors' report 33
Statement of the Chief Executive's responsibilities as the Accountable Officer of the Trust 45
Statement of Directors' responsibilities in respect of the accounts 46
Annual Governance Statement for 2019/20 47
Accountability Report for 2019/20: Remuneration and Staff Report 61
Accountability and audit report for 2019/20: Independent Auditor's report to the Directors of Maidstone and Tunbridge Wells NHS Trust 74
Glossary of NHS terms 80
Financial Statements for 2019/20 83

NHS
Maidstone and Tunbridge Wells
NHS Trust

Performance Report for 2019/20: Overview

taking Pride

MTW
exceptional people, outstanding care

The purpose of the overview section

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 2019/20. 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 over 6,000 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.

Tunbridge Wells Hospital is a Private Finance Initiative (PFI) hospital[3] and the majority of the site provides single bedded en-suite 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 two 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. The Education Centre at Tunbridge Wells Hospital, with its full resuscitation simulation suite, enables the Trust to offer excellent clinical training. The Trust has strong clinical, academic and research links with London hospitals, including joint appointments. Many staff are nationally recognised for excellence in their fields.

[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)

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)
- 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.

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 of the Trust Board and Chief Executive

It was easy to forget during the unprecedented times that started in March 2020 because of the COVID-19 pandemic that many areas of hospital life continued as normal and we are delighted to share that we achieved many of our plans for 2019/20, including the financial plan, which generated a £7m surplus. This fantastic achievement means we'll be able to make further developments and investments in improving our services for patients and staff during 2020/21.

It has been a successful 12 months in other areas too, and we have made some outstanding advances and improvements to the care we give our patients and how we run our services. This has been down to the hard work and commitment of our staff in delivering the promises we set out to do, so huge praise should be given to everyone at the Trust.

Some of the key achievements we particularly want to highlight are:

- Nurse recruitment – we recruited more than 400 additional trained nurses that are now supporting ward teams to deliver patient care.
- Performance – We turned our cancer performance around in just nine months moving from being the worst performing Trust in the country to one of the best for timely access to treatment – and all this has been done sustainably. Despite a tricky winter we remained in the top 10 of all Trusts for Emergency Department waiting times. We also delivered our Referral to Treatment (RTT) plan a month ahead of schedule to ensure 87% of our patients did not wait longer than they needed to.
- Staff engagement – our culture change programme and feedback from the national NHS staff survey is focusing resources on making the improvements you want so that the Trust becomes a great place to work.
- Investment– delivering our plan in 2018/19 meant we invested in a number of projects, from additional car parking spaces for staff and patients to building a new Acute Assessment Unit to benefit patients and funding a comprehensive IT programme to replace legacy equipment and systems.
- Care Quality Commission (CQC) preparations – the quality initiatives we're implementing have been focused on improving the services we give our patients because it's the right thing to do - and not to do with achieving a particular rating. This has resulted in tangible benefits for our patients and their families, from sharing learning when things don't go to plan, to improving our response rate to complaints and boosting compliance with the Mental Capacity Act.
- Integrated Care Partnership (ICP) – we have played a key role in setting up the West Kent ICP, which has helped us forge stronger relationships with our partners and GPs, and enabled us to be at the forefront of delivering local healthcare services for the future.
- Clinically led – changing the organisational structure of the Trust to put clinicians at the forefront of making decisions about our services has enabled us to make positive patient-focused improvements.

Importantly the quality developments that were implemented during 2019/20 put the Trust in a great place to respond so effectively to the COVID-19 pandemic, which had a significant effect on the Trust from March 2020 onwards. Within days of the first few cases hitting the UK, we'd ramped up our critical care capacity; adapted our hospitals to care for more patients requiring specialist treatment; recruited new or trained and redeployed existing staff to work in different areas; got our levels of Personal Protective Equipment (PPE) right; worked innovatively with the independent sector to ensure planned procedures can continue; provided

excellent infection control and prevention advice and support; and implemented additional staff welfare and wellbeing measures.

By working together, staff have also set us up with a really solid foundation to make 2020/21 even more successful and I look forward to seeing what the next 12 months brings us.

We're so proud of everything our staff have achieved – well done everyone and a very big thank you.

Miles Scott, Chief Executive

18th June 2020

David Highton, Chair of the Trust Board

18th June 2020

Snapshot of 2019/20

April 2019

The Trust delivered the 95% national standard of seeing, admitting or discharging those who attend our Emergency Departments within four hours for March 2019. This was the first time the Trust had achieved this target for a whole month in five years.

May 2019

The newly refurbished Crowborough Birth Centre was officially opened this month by "Call the Midwife" actress Melody Grove, who gave birth to her second child at the midwife-led unit. Special thanks go to the Friends of Crowborough Hospital who donated over £120,000 to renovate the centre, and to the team of midwives who planned and oversaw the refurbishment, making it a calm, modern oasis for women and their birthing partners.

June 2019

The Trust rolled out the national NHS Rainbow Badge scheme across the Trust. Pop up sessions were held at both hospital sites for staff to sign the Rainbow Pledge, receive a badge and get further information about supporting LGBT+ patients, families and colleagues.

July 2019

MTW was one of only nine Trusts in England to have been selected to pilot a virtual consultation system. The system allows patients to attend their clinical consultation using a computer or mobile device. Sexual Health services, Specialist Medicine and the Emergency Department trialled the virtual system.

August 2019

The Morrisons Foundation, part of Wm Morrison Supermarkets PLC, donated £12,800 to purchase new tables and chairs for the Café @ Plus One restaurant at Maidstone Hospital. The donation was made to Maidstone and Tunbridge Wells NHS Charitable Fund, the Trust's dedicated charity.

September 2019

The Trust hit the national standard of treating 85% of cancer patients within 62 days in August - a month earlier than anticipated. It's been the Trust's absolute priority to get back on track to delivering the standard and it's thanks to the incredible efforts of our staff that we achieved this turnaround in performance in less than a year.

October 2019

The Trust treated its first patient on our new Linear Accelerator (LinAc) – the fourth TrueBeam machine to be opened at Maidstone Hospital in four years, and the fifth overall, with our site at Kent and Canterbury Hospital home to the other. The TrueBeam LinAc machine treats cancer patients using the latest technology and with even greater accuracy, ensuring our patients receive the very highest standards of care.

November 2019

The Trust honoured colleagues from all areas of our hospitals at the annual Staff Stars and Long Service Awards. Our Staff Stars Awards marked the achievements of over 400 individuals and teams who have really made a difference to patient care, their service and hospital life.

December 2019

Her Royal Highness The Princess Royal visited Maidstone Hospital on 11th December to officially open its new helipad. A commemorative plaque was unveiled by Her Royal Highness, who also spent time meeting with and talking to teams across the Trust who showcased their work.

January 2020

A new Planned Treatment Unit (PTU) opened at Tunbridge Wells Hospital as part of the Trust's ongoing commitment to ensure patients access emergency care services in a prompt and timely way.

February 2020

Work started on the construction of two car park decks to increase the number of car parking spaces at the Trust. The improvements will see 175 additional spaces at Tunbridge Wells Hospital and 200 spaces at Maidstone Hospital.

March 2020

The UK was hit by the global COVID-19 pandemic. The Trust responded at speed by significantly increasing critical care capacity and putting well-tested business continuity preparations in place to ensure patients who needed specialist respiratory support got the care they needed. We worked closely with partners across the region and nationally to ramp up critical care capacity from 15 beds to 92; support staff, and maximise their availability; facilitated ways to use our beds and staff differently so that we could continue to deliver the best care; and temporarily suspended non-urgent processes to focus support into the areas that most need it.

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

The Trust Board agreed the following key objectives for 2019/20:

- Reduce our falls rate while in hospital to 6 per 1'000 bed days
- Reduce E. coli blood stream infections to 21.5 per 100'000 bed days by March 2020
- Improve complaints performance to 75% across all divisions and directorates by March 2020
- Improve our vacancy rate to 9% by March 2020
- Achieve staff engagement score of ≥ 7.2 within 2019/20
- Implement the planned surgical reconfiguration by the end of 2019/20
- Build new Acute Medical Unit (AMU) to enable a new Hyper Acute Stroke Unit (HASU) by winter 2019
- Ensure that 85% or more of cancer patients are treated within 62 days
- Ensure that 86.7% or more of patients wait no longer than 18 weeks from referral to treatment
- Ensure that 91.67% or more of people presenting to our Accident and Emergency Departments wait no longer than 4 hours
- Deliver a surplus of £6.9m in 2019/20 so that we can invest back into patient care
- Ensure that our Hospital Standardised Mortality Ratio (HSMR) is <100

The key issues and risks affecting delivery of these (as described in the Trust's Board Assurance Framework – see the "Annual Governance Statement for 2019/20" (pages 47 to 60) are outlined below. Details of how the Trust actually performed against these objectives are provided in the "Performance analysis" section (pages 16 to 23).

Reduce our falls rate while in hospital to 6 per 1,000 bed days

The key recognised risks to delivery of this objective were increased demand and escalation of beds resulting in patients nursed in inappropriate areas; staffing (vacancies and unfilled shifts); and staff training on falls prevention and associated equipment.

Reduce E. coli blood stream infections to 21.5 per 100,000 bed days by March 2020

The key recognised risks to delivery of this objective were a national heatwave causing an increased risk of dehydration and subsequent increase risk of Urinary Tract Infections (UTIs); non-compliance with antibiotic therapy for UTIs; urinary catheters being inserted inappropriately and managed incorrectly; non-compliance with antibiotic therapy for Endoscopic Retrograde Cholangiopancreatographies (ERCPs); poor compliance with Infection Prevention & control precautions; and an increased number of infections on the Haematology Ward (Lord North) following a change to the use of a particular recommended form of chemotherapy.

Improve complaints performance to 75% across all divisions and directorates by March 2020

The key recognised risks to delivery of this objective were Divisional performance failure to respond to complaints in a timely manner; resources within the complaints team (particularly in relation to unplanned

absences); IT issues - age of computers (slow to respond); the transition to Datix IQ Cloud, potential issues with functionality; and delays in the timely completion of Serious Incident (SI) investigations, which adversely affects complaint responses.

Improve our vacancy rate to 9% by March 2020

The key recognised risks to delivery of this objective were a national shortage of certain staff groups; if there was a lack of clarity/focus on the key actions required; if there was a lack of capacity from professional groups to be able to support interviewing and the professional development of candidates at scale; if there was inefficiency of recruitment processes; if there was insufficient focus placed on retaining existing staff; if there was uncertainty over the status of vacancies; and uncertainty regarding European Union (EU) Exit ('Brexit') i.e. the impact on the availability of European recruits.

Achieve staff engagement score of ≥ 7.2 within 2019/20

The key recognised risks to delivery of this objective were failure to implement local staff engagement plans; insufficient resource to deliver staff amenities programme; lack of visibility of senior leaders on shop floor; insufficient communication of actions and information to staff; insufficient investment in clinical leadership; and staff not being empowered to influence or implement service changes.

Implement the planned surgical reconfiguration by the end of 2019/20

The key recognised risks to delivery of this objective were a failure to recruit staff in time; and a failure to adequately identify and protect bed space.

Build new AMU to enable a new Hyper Acute Stroke Unit (HASU) by winter 2019

The key recognised risk to delivery of this objective was capital funding not being released from NHS Improvement (NHSI).

Ensure that 85% or more of cancer patients are treated within 62 days

The key recognised risks to delivery of this objective were oncology capacity shortfall due to workforce shortages; confirmation of Clinical Commissioning Group (CCG) funding into cancer to ensure we have sustainable plans in place; increased service demand (higher than national average); pathway issues in Upper GI, Lung, Haematology and Head and Neck; sustainable diagnostic capacity; and pension issues impacting additional sessions for clinicians and their flexibility to respond to increased demand.

Ensure that 86.7% or more of patients wait no longer than 18 weeks from referral to treatment

The key recognised risks to delivery of this objective were the RTT data quality programme that could impact the total size of the waiting list; and CCG funding was still relied upon to ensure we could achieve 86.7%.

Ensure that 91.67% or more of people presenting to our Accident and Emergency Departments wait no longer than 4 hours

The key recognised risks to delivery of this objective were increased demand on services; workforce shortages; and Brexit.

Deliver a surplus of £6.9m in 2019/20 so that we can invest back into patient care

The key recognised risks to delivery of this objective were if there was a lack of senior leadership and commitment; if there were poor financial controls (or if good controls were poorly applied); if there was a lack of commitment by managers; if the Cost Improvement Programme (CIP) schemes were not delivered (regardless of their RAG rating or identified value); if the Trust's plans for 2019/20 had been developed without consideration of best practice elsewhere; if there was insufficient engagement with external stakeholders; if there was a change in the financial circumstances of commissioners, requiring them to take further action to manage demand; if the Trust was unable to access the CCG RTT risk reserve; and if Private Patient Income did not meet the level expected in the plan.

Ensure that our Hospital Standardised Mortality Ratio (HSMR) is <100

The key recognised risks to delivery of this objective were a failure to recruit Medical Consultants to support the achievement of 7-day services; failure to learn from mortality reviews; and weekend-related mortality worsening.

Adoption of the 'going concern' basis

The DHSC 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. 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 Executive Team Meeting, Finance and Performance Committee and 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 2019/20 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. There are no plans to dissolve the Trust or to cease services without transfer to any other NHS body
- The Trust submitted its five-year Long Term Plan for operational and financial plans 2019/20 to 2023/24 in October 2019 on a going concern basis. This was agreed as part of the Kent & Medway system-wide Sustainability and Transformation Partnership (STP) Long Term Plan. The Trust element of the first year of

the plan, 2019/20, has been exceeded with the Trust delivering a £7m surplus including Provider Sustainability Fund (PSF) and Marginal Rate Emergency Tariff (MRET).

- The Trust continues to fully participate in the local Integrated Care System (ICS)/STP and Integrated Care Partnerships (ICPs), leading the West Kent ICP and working in partnership in the West Kent Alliance and as a prime provider. The Trust is leading some of the significant STP work-stream areas and is a key player in consideration of the shape of sustainable 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 impact of COVID-19 paused the business planning process nationally. Nationally-mandated interim financial regime and contracting arrangements will be in place between the Trust and Commissioners from April to July 2020 to enable the Trust to deliver financial breakeven during this period. This arrangement consists of a combination of block payments based on 2019/20 clinical income plus top up payments to match expected expenditure and to cover additional costs related to COVID-19, with no required Cost Improvement efficiencies. The Trust received initial revenue and capital payments for COVID-19 costs in 2019/20. A double block payment from CCGs was made in April to ensure all Trusts had sufficient liquidity to meet debts and to make payments to trade creditors on an enhanced 7 day cycle. This double block payment has meant that the Trust has more cash at its disposal than it would have had from traditional contracting and payment approaches. It is currently anticipated that business planning and contracting will resume during 2020/21 but details of the future financial framework are not yet confirmed. There is no expectation that Trust services will not continue to be provided.

- The Trust's cash flow plans for 2020/21 do not include any assumptions of additional required working capital finance. The existing working capital loans will be converted to Public Dividend Capital (PDC) in September 2020, in accordance with the national changes to the debt regime. The Trust is working with the local ICS/STP to agree capital plans for 2020/21, following the change in capital regime announced in April 2020, including a greater role for the management and prioritisation of resource by the ICS/STP areas.
- There are current uncertainties about the future financial framework that the Trust will operate in post COVID-19, but the Trust does not consider there are any material uncertainties in relation to its status as a going concern.

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

Performance summary for 2019/20

Performance against the Trust's agreed objectives, including the delivery of the financial plan, is described in detail in the "Development and performance in 2019/20" section (pages 18 to 19). 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. Further details on the performance standards for quality of care can be found in the Trust's Quality Accounts for 2019/20, which will be made available in full on the Trust website (www.mtw.nhs.uk).

NHS
Maidstone and Tunbridge Wells
NHS Trust

Performance Report for 2019/20: Performance analysis

taking pride

MTW
exceptional people, outstanding care

How the Trust measures performance

The Trust's Performance Management framework 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. 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 and 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.

The monthly Integrated Performance Report 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/).

The content of the Performance Dashboard is discussed at meetings of the Executive Team Meeting and Trust Board. At the latter, the person responsible for each domain is asked to highlight key issues of note, and explain areas of under/failing performance. Performance against the Trust's agreed objectives is measured and monitored via the Board Assurance Framework, which is described in more detail in the "Annual Governance Statement for 2019/20" later in this Annual Report. In addition to this, the Trust continues to use nationally-published information (where available), to compare performance. This includes national staff and patient surveys 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.

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 and 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 2019/20

The 'key issues and risks affecting delivery of the Trust's objectives' were described earlier in the Report (pages 12 to 14). The Trust's actual performance against each of its 2019/20 objectives is described below.

Reduce our falls rate while in hospital to 6 per 1,000 bed days

This objective was not achieved (rated red within the Board Assurance Framework), as the falls rate for the year was 6.09 per 1,000 bed days. However, a range of actions were taken during 2019/20, which included revised pathways of care and improved patient flow, and the appointment of a new member of staff (reporting to the Falls Prevention Practitioner), to support efforts regarding falls and moving & handling. Further actions will also be taken to improve performance during 2020/21.

Reduce E. coli blood stream infections to 21.5 per 100,000 bed days by March 2020

This objective was not achieved (rated red within the Board Assurance Framework), as the full year rate was 30.9 per 100,000 bed days (the actual number of cases was 75, which compared to 69 in 2018/19). However, a range of actions were taken during 2019/20, which included the establishment of a Urinary Tract Infection (UTI) reduction working group, the auditing of Endoscopic Retrograde Cholangiopancreatographies (ERCPs) prophylaxis, to improve the administration of prophylaxis, and the introduction of a Trust-wide hydration project, to ensure that patients drink enough fluid to reduce the number of UTIs. Further actions will also be taken to improve performance during 2020/21, including the continued promotion of the urinary catheter passport (and monitoring of its use).

Improve complaints performance to 75% across all divisions and directorates by March 2020

This objective was fully achieved (rated green within the Board Assurance Framework) as although overall performance across the year was 67.8%, 75% was achieved for March 2020.

Improve our vacancy rate to 9% by March 2020

This objective was fully achieved (rated green within the Board Assurance Framework), as the vacancy rate at the end of March 2020 was 8.11%.

Achieve staff engagement score of ≥ 7.2 within 2019/20

This objective was not achieved (rated red within the Board Assurance Framework), as the staff engagement score in the 2019 national NHS staff survey (which was published in February 2019) was 7.1. This was a statistically significant improvement on the score from the 2018 survey (7.0), but was still below the score in the objective. However, a range of actions were taken during 2019/20, which included the 'Exceptional

People Outstanding Care' programme (which is described in the "Remuneration and Staff Report"), and further actions will be taken to improve performance during 2020/21.

Implement the planned surgical reconfiguration by the end of 2019/20

It was agreed at the Executive Team Meeting on 21/04/20, and then by the Trust Board on 30/04/20, that the objective should not be allocated a year-end rating, as the Trust had made a deliberate decision in March 2020 to stop the reconfiguration because of the COVID-19 period (although progress with the reconfiguration was in accordance with the objective until that point).

Build new AMU to enable a new Hyper Acute Stroke Unit (HASU) by winter 2019

 This objective was fully achieved (rated green within the Board Assurance Framework), as the AMU at Maidstone Hospital relocated to the new Acute Assessment Unit (AAU) (which is located next to the hospital's Emergency Department) on 11/03/20.

Ensure that 85% or more of cancer patients are treated within 62 days

 This objective was fully achieved (rated green within the Board Assurance Framework), as the full year position to the end of February 2020 is 79.9%, but the Trust has achieved the 85% target every month for the past several months, and the Chief Operating Officer confirmed to the Executive Team Meeting on 21/04/20 that he expected the target to be achieved again for March 2020.

Ensure that 86.7% or more of patients wait no longer than 18 weeks from referral to treatment

 This objective was fully achieved (rated green within the Board Assurance Framework), as at the end of February 2020 the Trust's performance was at 87.3%, and the Executive Team Meeting on 21/04/20, and Trust Board on 30/04/20, agreed that it was not appropriate to take account of the performance for March 2020, as that had been significantly affected by the Trust's management of the COVID-19 period.

Ensure that 91.67% or more of people presenting to our Accident and Emergency Departments wait no longer than 4 hours

 This objective was fully achieved (rated green within the Board Assurance Framework), as performance for 2019/20 was 90.64%, but performance for March 2020 was 93.12%.

Deliver a surplus of £6.9m in 2019/20 so that we can invest back into patient care

 This objective was fully achieved (rated green within the Board Assurance Framework), as the surplus at the end of 2019/20 (subject to external audit) was £7.0m.

Ensure that our Hospital Standardised Mortality Ratio (HSMR) is <100

 This objective was fully achieved (rated green within the Board Assurance Framework), as the HSMR for March 2020 was 91.8, and the ratio has been below 100 throughout 2019/20.

Financial performance in 2019/20

For the financial year 2019/20 the Trust exceeded its control total and reported a surplus of £7.0m, post-Provider Sustainability Funding (PSF), which was £0.1m better than plan. The PSF was achieved in full. There were some aspects of the plan which were not met. The key drivers of this variance are:

- There was an under performance in private patient income which had a net impact of £2.4m
- An overspend in medical staffing of £2.8m
- An overspend in non-pay costs of £3.0m related to outsourcing and clinical supplies

The variances to plan were offset by use of contingency of £3.6m, Public Dividend Capital (PDC) was less than planned by £1.0m, and release of prior year accruals gave a benefit of £3.7m.

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	2019/20 (plan) £m	2019/20 (actual) £m	Variance £m
Income	502.6	513.0	10.4
Operating expenses	(479.4)	(491.8)	(12.4)
Operating surplus / (deficit):	**23.2**	**21.2**	**(2.0)**
Finance income	0.1	0.3	0.2
Finance expense	(15.9)	(15.8)	0.1
PDC dividend charge	(1.6)	(0.6)	1.0
Net finance costs	**(17.4)**	**(16.1)**	**1.3**
Other gains / (losses)	0.0	0.1	0.1
Surplus / (deficit) for the year before technical adjustments	5.8	5.2	(0.6)
Technical adjustments	1.1	1.8	0.7
Surplus / (deficit) for the year after technical adjustments	**6.9**	**7.0**	**0.1**

The Trust incurred additional expenditure pressures arising in the year after the plan was set. The Trust also received funding to support these pressures. The two main pressures were the employers' NHS pension contribution increase of £11.3m and COVID-19 revenue costs of £1.9m. These were both funded by NHS England/NHS Improvement.

One of the key priorities for the 2019/20 financial year was the recovery of cancer access performance at the Trust. To that end, the Trust agreed with its commissioners a significant, and fully funded, investment programme to return the Trust to delivery of all cancer access standards, which it achieved. The cost of this recovery programme was £3.76m, which was funded by West Kent Clinical Commissioning Group (£2.4m),

Kent and Medway Cancer Alliance (£0.5m), Sussex Commissioners (£0.36m) and North Kent Commissioners (£0.5m).

Income

The Trust's income was £513.0m which was above plan by £10.4m by the end of the financial year. The main variance was that the Trust received income of £11.4m more than plan to fund an uplift in employers' NHS pension contribution. The Trust also received £2.1m to support additional costs of £1.9m and loss of income of £0.2m related to COVID-19 and income relating to prior year of £0.7m. This was offset by private patient income shortfall of £3.4m and a reduction in income for pass through costs of £0.1m.

The majority (87%) of the Trust's income is from CCGs or NHS England.

Operating expenses

The Trust's expenditure was £491.8m which was £12.4m adverse to plan. The main variance was an increase in expenditure of £11.4m as a result of the 6.3% uplift in employers' NHS pension contribution. The Trust received funding to cover this cost. The Trust incurred an additional £1.9m of costs in its response to COVID-19. There were pay cost overspends of £2.8m, as a result of additional bank and agency spending in medical staffing, and non-pay costs were £3.0m overspent in clinical supplies and £1.0m in outsourcing. This was offset by a £1.0m underspend in private patients unit as a result of lower activity than planned. The Trust used contingency of £3.6m to cover the additional costs and release of prior year accruals of £3.0m.

Finance costs

The PDC charge was lower than planned by £1m. This was principally driven by a lower than planned year end property valuation and higher average daily cash balances during the year.

Cost Improvement Programme (CIP)

The Trust delivered £22.4m of its CIP, against a target of £22.4m. The total savings were met however £6.7m was non recurrent savings which was an increase of £4m when compared to plan. These are shown by Division in the table below:

CIP programme by Division	2019/20 Plan £'000	2019/20 Actual £'000	Variance £'000
Surgery	4,329	5,150	821
Cancer Services	654	550	(104)
Medicine & Emergency Care	3,821	4,131	310
Women's, Children's and Sexual Health	1,470	2,464	994
Diagnostics and Clinical Support	2,129	3,533	1,404
Estates and Facilities	1,542	1,976	434
Corporate	8,414	4,614	(3,800)
Total	**22,359**	**22,418**	**59**

Capital expenditure plan

During the year the Trust made capital investments of £16.9m including £0.9m of assets funded from donated or charitable fund sources. Significant elements of the programme were:

- £2.2m on backlog maintenance and estates renewals at Maidstone Hospital, and £0.4m planned lifecycle at Tunbridge Wells Hospital.
- £2.6m on diagnostic equipment mostly funded by the national diagnostic fund – two CT scanners, one at each site, and a replacement MRI and Mammography unit at Maidstone Hospital. £3.2m was spent on Trust-wide equipment renewals including £0.8m related to surgical reconfiguration and endoscopy.
- £7.5m of investment was made in ICT and Informatics infrastructure and equipment including software and implementation costs for the new Electronic Patient Record (EPR) and drug prescribing system; desktop device replacements; and additional cyber security infrastructure. The Trust received £2.5m of national PDC funding to support various initiatives within these projects.

The Trust also spent £462k in 2019/20 relating to COVID-19 including assessment pods, anaesthetic machines, video laryngoscopes and laptops for working from home. The Trust has been funded £50k in March for the COVID-19 pods and there is an expectation that PDC will be paid in 2020/21 relating to the remaining expenditure in 2019/20.

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 2019/20 the Trust met its target by managing the year-end position to underspend the EFL by £0.4m, with the actual closing cash balance being £3.4m. The Trust agreed with NHSE/I to carry forward £2m additional cash at year end from previous asset sale proceeds and is seeking agreement from the Department of Health and Social Care to utilise this in 2020/21 as capital resource.

Capital Resource Limit (CRL)

The Trust is expected to manage its capital expenditure within its agreed CRL. For 2019/20 the Trust's CRL was £16.2m which was underspent by £0.2m relating in part to less depreciation spend than planned which reduced available capital cash.

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 three-year period or a five-year period if agreed with the Department of Health and Social Care.

The Trust's latest three-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 break-even duty surplus in 2019/20 of £7.6m (including the post-accounts Provider Sustainability Fund (PSF) reallocation from 2018/19 - see note 52 to the accounts) reducing the cumulative deficit. The Trust's Long Term Plan submission in October 2019 is aimed at further reducing the accumulated deficit.

Accounting Issues

The Accounts have been prepared in accordance with guidance issued by the Department of Health and Social Care and in line with International Financial Reporting Standards (IFRS) as applied in the Department of Health and Social Care Group Accounting Manual. The accounts were prepared under the "Going Concern" concept in

line with the Department of Health and Social Care 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 £77,500[4] excluding VAT (in 2018/19 this was £68,500 excluding VAT). There was no audit of the Quality Accounts in 2019/20 under a variation of arrangements made nationally in response to the COVID-19 pandemic. Grant Thornton UK LLP did not undertake any non-audit work for the Trust in 2019/20.

Looking forward to 2020/21

The impact of COVID-19 has paused the business planning process both nationally and internally within the Trust. Nationally mandated interim contracting arrangements are in place between the Trust and Commissioners from April to July 2020 which will enable the Trust to deliver financial break-even during this period. This arrangement consists of a combination of block payments based on 2019/20 clinical income plus top up payments to match expected expenditure and to cover additional costs related to COVID-19.

The financial regime for capital was updated in April 2020 to move to a more STP/ICS-led approach to managing capital allocations and expenditure. The implications and approach to the new regime is currently being developed within the local ICS system.

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 "Freedom to speak up: raising concerns policy and procedure" 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 (LCFS) is a mandated consultee for such Policies. In addition, 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 (page 32 onwards).

Quality Accounts 2019/20

The Trust's Quality Accounts for 2019/20, which are scheduled to be approved by the Trust Board in July 2020, 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).

[4] Pending finalisation with the External Auditors to reflect the removal of Quality Accounts audit for 2019/20

NHS
Maidstone and Tunbridge Wells
NHS Trust

Performance Report for 2019/20: Sustainability Report

taking Pride

MTW
exceptional people, outstanding care

As an NHS organisation, and as a spender of public funds, we have an obligation to work in a way that has a positive effect on the communities we serve. Sustainability means spending public money well, the smart and efficient use of natural resources and building healthy, resilient communities. By making the most of social, environmental and economic assets we can improve health both in the immediate and long term even in the context of the 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 we consider the social, economic and environmental impacts ensures that the legal requirements in the Public Services (Social Value) Act (2012) are met.

In order to fulfil our responsibilities for the role we play, Maidstone and Tunbridge Wells NHS Trust has the following sustainability mission statement located in our Sustainable Development Management Plan (SDMP): "The provision of Sustainable and Resilient Healthcare and Buildings to ensure Healthy People and Places in Maidstone and Tunbridge Wells NHS Trust".

As a part of the NHS, public health and social care system, it is our duty to contribute towards the level of ambition set in 2014 of reducing the carbon footprint of the NHS, public health and social care system by 34% (from a 1990 baseline) equivalent to a 28% reduction from a 2013 baseline by 2020. We are pleased to announce that this year we have exceeded our target and the 2019/20 carbon emissions from energy consumption are 34% below the 2013/14 baseline.

Policies

In order to embed sustainability within our business it is important to explain where in our process and procedures sustainability features. One of the ways which we embed sustainability is through the use of an SDMP within the Trust. Our SDMP has been reviewed in the last 12 months and approved by the board. We also recognise that our procured services have a substantial sustainability impact. Part of the tender process identifies the key elements of every product to ensure that it is suitable for the Trust. The Trust also requires suppliers to confirm the products adhere to the NHS terms and conditions. This ensures compliance with the environmental and sustainability requirements.

We comply with the Public Services (Social Value) Act by including a section within our tenders that relates to social and environmental impact of the services being procured. If they are critical to that service, then they will be included within the KPIs for ongoing monitoring and management.

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

Adaptation

Climate change brings new challenges to our organisation, both in direct effects to the healthcare estates, but also to patient health. Examples of recent years include the effects of heat waves, extreme temperatures and prolonged periods of cold, floods, droughts etc. Our board approved plans address the potential need to adapt the delivery of 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 our services continue to meet the needs of our local population during such events we have developed and implemented a number of policies and protocols in partnership with other local agencies.

Green Space and Biodiversity

The Trust recognises that its grounds and green spaces are an asset, both due to the natural capital that they represent as a habitat and ecosystem but also as a resource for local communities to utilise and enjoy. In the last year the Trust has commenced working with Kent Wildlife Trust to further develop and maintain the site in a manner that is sympathetic to nature and wildlife.

We continue to work with a wide range of volunteers and partners to provide spaces within the hospital grounds where patients and visitors can access non clinical environments to improve mental and physical wellbeing.

Partnerships

The NHS policy framework already sets the scene for commissioners and providers to operate in a sustainable manner. Crucially for us as a provider, evidence of this commitment will need to be provided in part through contracting mechanisms. For commissioned services here is the sustainability comparator for our CCGs:

Organisation Name	SDMP?	SD Reporting Score
NHS West Kent CCG	No	Minimum
NHS High Weald Lewes Havens CCG	No	Minimum
NHS Medway CCG	No	Good
NHS Swale CCG	No	Excellent
NHS Ashford CCG	No	Poor
NHS Canterbury and Coastal CCG	No	Poor

Performance

Organisation

Since the 2007/8 baseline year, the NHS has undergone a significant restructuring process and one which is still on-going. Therefore in order to provide some organisational context, the following table may help explain how both the organisation and its performance on sustainability has changed over time.

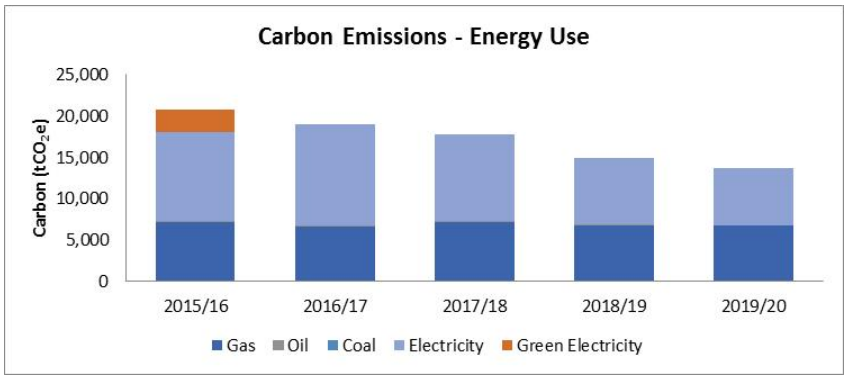
Context info	2007/8	2015/16	2016/17	2017/18	2018/19	2019/20
Floor space (m^2)	109,896	138,533	138,533	138,533	138,533	134,083
Number of staff (WTE)	3,969	4,678	5,130	5,022	5,153	5,313[5]

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.

[5] Readers will note that this figure is different to the WTE figure reported in the "Staff numbers and costs" table within the "Remuneration and Staff Report". This difference arises because there is a difference between "contracted", "worked" and "paid" staff; and the figure in the "Staff numbers and costs" table is an average over the year and is based on when staff are paid (therefore any staff on unpaid leave i.e. maternity leave, long term sickness absence etc. do not feature)

We have exceeded our target and the 2019/20 carbon emissions from energy consumption are 34% below the 2013/14 baseline.

Energy



Managing energy is one aspect of reducing carbon emissions. The Trust has spent £4,762,269 on energy in 2019/20, which is a 3.6% decrease on energy spend from 2018/19. The Trust has continued to maintain the momentum of electrical reduction in both hospitals during the year through a continued focus on efficient use of plant and equipment. There has been a slight increase in gas consumption in the year owing to cooler weather conditions, reducing gas consumption will be a focus for 2020.

Resource		2015/16	2016/17	2017/18	2018/19	2019/20
Gas	Use (kWh)	34,139,781	31,546,328	33,930,120	31,855,591	32,476,847
	tCO_2e	7,145	6,593	7,194	6,766	6,747
Oil	Use (kWh)	635,116	532,926	313,362	280,800	273,640
	tCO_2e	203	169	102	90	87
Coal	Use (kWh)	0	0	0	0	0
	tCO_2e	0	0	0	0	0
Electricity	Use (kWh)	18,564,756	23,801,508	23,652,117	22,899,149	21,576,328
	tCO_2e	10,673	12,301	10,542	8,078	6,818
Green Electricity	Use (kWh)	4,892,105	0	0	0	0
	tCO_2e	2,813	0	0	0	0
Total energy CO_2e		20,833	19,062	17,838	14,934	13,652
Total energy spend		£ 3,919,681	£3,835,790	£4,535,611	£4,912,381	£4,762,269

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.

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 although the level has reduced in the last year. We are committed to increasing focus on this in 2020.

Category	2015/16	2016/17	2017/18	2018/19	2019/20
Internal reuse of durable goods (£)	Not Recorded	Not Recorded	2,000	2,000	2,000
External reuse of durable goods (£)	Not Recorded	Not Recorded	2,500	5,000	2,500

Paper

The movement to a Paperless NHS can be supported by staff reducing the use of paper at all levels, this reduces the environmental impact of paper, reducing cost of paper to the NHS and can help improve data security. The Trust has made huge progress in the last year in drastically reducing the level of paper being procured and is optimistic to continue this pattern into the future.

Paper		2017/18	2018/19	2019/20
Volume used	Tonnes	61	90	62
Carbon emissions	tCO_2e	58	85	58

Travel

We can improve local air quality and carbon emissions through the way we design travel and our services. We have a clear policy on healthy travel for our organisation and we promote healthy and sustainable travel to our stakeholders (staff, patients and the public).

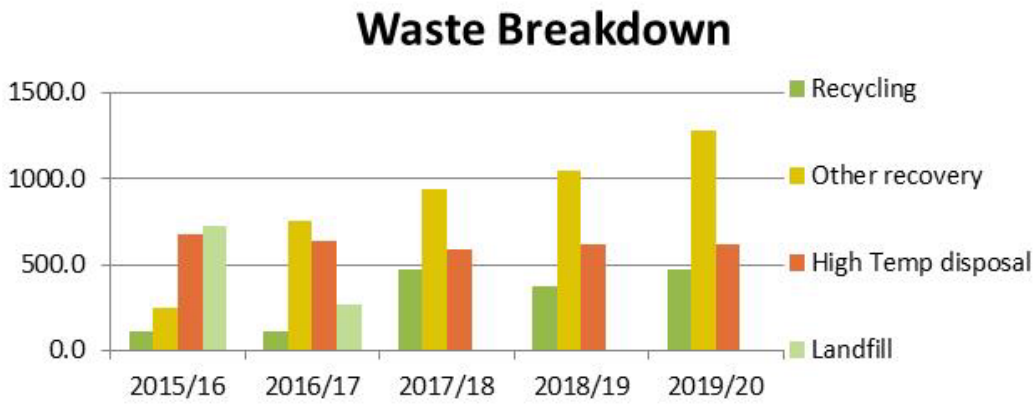
Every action counts and we are a lean organisation trying to realise efficiencies across the board for cost and carbon (CO2e) reductions. We support a culture for active travel to improve staff wellbeing and reduce sickness. Air pollution, accidents and noise all cause health problems for our local population, patients, staff and visitors and are caused by cars, as well as other forms of transport.

Category	Mode	2015/16	2016/17	2017/18	2018/19	2019/20
Patient & visitor travel	Miles ♌	107,404,988	112,158,231	115,563,332	121,747,529	118,743,943
	Miles	38,841.48	40,535.15	41,178.09	44,890	41,040
Business travel & fleet	Miles	1,319,789	1,037,636	1,059,360	0	569,989
	tCO_2e	477	375	377	0	385
Staff commute	Miles	4,493,769	4,927,968	4,824,221	4,824,221	5,105,793
	tCO_2e	1,625	1,781	1,719	1,779	1,765

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 continued to place a 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.



N.B. High temperature ("High Temp") disposal is the incineration of clinical waste. There is no energy recovery from this process at the current time. The Trust sends domestic waste to an 'energy from waste' facility, and this is classed as "Other recovery". Energy from waste cannot be classed as recycling, as that refers to taking a used item, turning it into a

raw material and using that as a basis to manufacture a new product. 'Energy from waste' is about recovering the embedded energy within a product and is lower down the waste hierarchy, this being: reduce (the amount of waste being produced); reuse (items in their existing form); recycle (into new products); recover (the embedded energy); or dispose (through landfill).

Waste		2015/16	2016/17	2017/18	2018/19	2019/20
Recycling	(tonnes)	107	115	468	372	472
	tCO_2e	2	2	7	8	8
Other recovery	(tonnes)	248	756	937	1040	1281
	tCO_2e	16	16	15	15	27
High Temp disposal	(tonnes)	679	639	592	614	621
	tCO_2e	149	141	190	192	137
Landfill	(tonnes)	724	265	0	0	0
	tCO_2e	177	82	0	0	0
Total Waste (tonnes)		1758	1775	1997	2026	2374
Total Waste tCO_2e		333	241	211	215	174

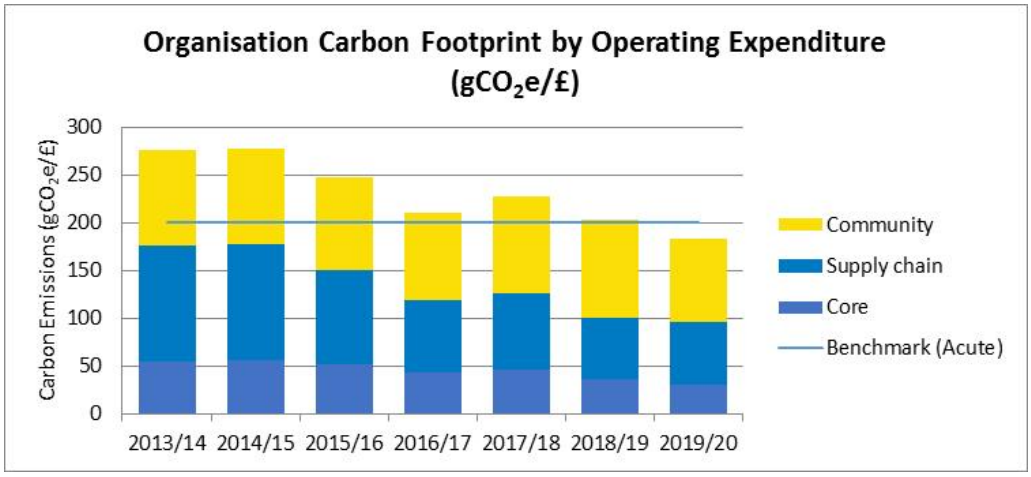
Finite resource use - water

The previous reduction that the Trust had made has been reversed in the last year. This has been partially due to leakage in the system (now fixed) and increased demand across both hospital sites and the Laundry.

Water		2015/16	2016/17	2017/18	2018/19	2019/20
Mains	m^3	205,246	209,205	225,383	211,936	237,616
	tCO_2e	187	190	205	193	216
Water & Sewage Spend		£582,869	£661,990	£761,100	£758,895	£959,889

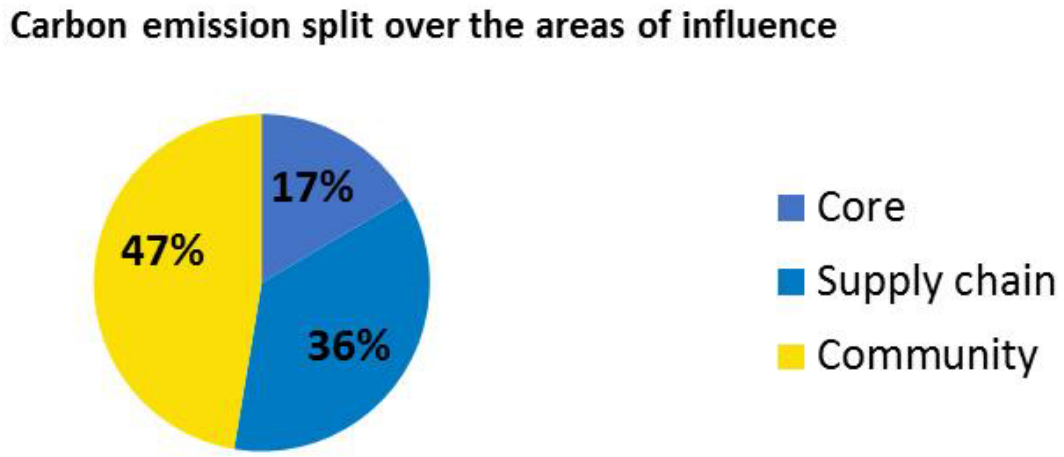
Modelled Carbon Footprint

The information provided in the previous sections of this sustainability report uses the ERIC returns as its data source. However, we are aware that this does not reflect our entire carbon footprint. Therefore, the following information uses a scaled model based on work performed by the Sustainable Development Unit (SDU) in 2009/10. More information available here: 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 90,365 tonnes of carbon dioxide equivalent emissions (tCO_2e). Our carbon intensity per pound is 184 grams of carbon dioxide equivalent emissions per pound of operating expenditure (gCO2e/£). Average emissions for acute services is 200 grams per pound.

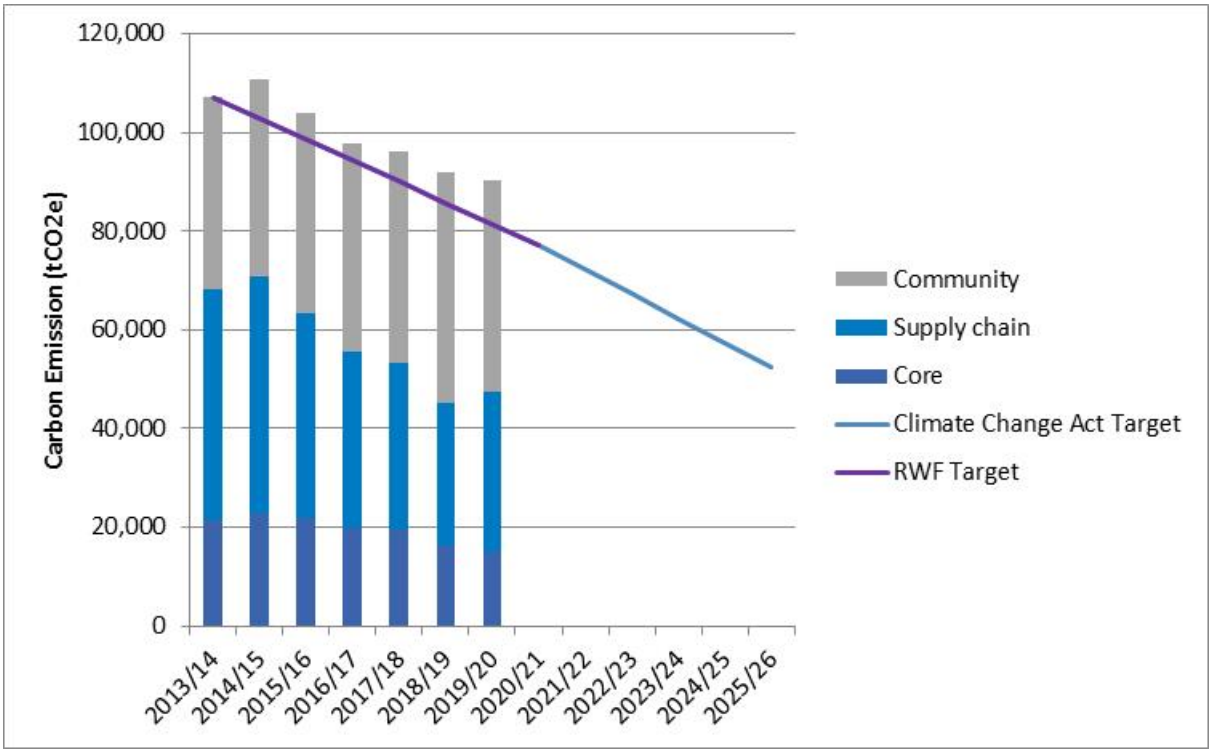


N.B. "Core" emissions are the emissions from the direct activities of the Trust. They include emissions from electricity, gas, fuel from vehicles and generators, biomass, water and sewerage, fugitive emissions from anaesthetic gases, and business travel and mileage. They are calculated by applying intensity metrics to the available data. "Community" emissions are calculated by taking the patient contact caseload figure and applying a similar metric to represent patients' travel to and from the hospitals. "Community" emissions also include a value to cover the commute of Trust staff to and from their workplace.

The distribution of our carbon emissions through our different areas of influence clearly demonstrates that the community element is the largest, of which the carbon footprint of patient travel to and from the hospital sites accounts for 96%.



Modelled trajectory



We are committed to meeting the legal requirements of the climate change act by reducing our emissions in line with the trajectory above. We are currently exceeding the trajectory of these required reductions in respect to our direct emissions (core) but the emissions associated with our supply chain have increased by 8% against last year, this is due to additional spending on construction activities to associated with the development of the Maidstone Hospital site

Declaration

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

Miles Scott, Chief Executive 18th June 2020

NHS
Maidstone and Tunbridge Wells
NHS Trust

Accountability Report for 2019/20: Corporate Governance report

taking pride

MTW
exceptional people, outstanding care

Directors' report

The Trust Board

The Trust Board meets every month (with the exception of August) in public (a 'Part 1' meeting), although the Trust Board meeting in March 2020 was unable to be held in public following HM government's guidance on social distancing. The agenda and reports for the meeting, which took place via a webconference, were however made available via the Trust's website (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), five other Non-Executive Directors (voting members), the Chief Executive, and four other voting member of the Executive Team. Six other non-voting Directors also attend Trust Board meetings, 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 the members of the Executive Team to account.

The Trust Board membership underwent the following changes during the course of the year

- Nazeya Hussain, Non-Executive Director left the Trust Board on 21/06/19
- Emma Pettitt-Mitchell was an Associate Non-Executive Director between 04/06/18 and 26/08/19, but was then appointed as a substantive Non-Executive Director on 27/08/19
- Karen Cox, Associate Non-Executive Director, joined the Trust Board on 27/06/19
- David Morgan, Non-Executive Director, joined the Trust Board on 12/08/19
- Richard Finn, Associate Non-Executive Director, joined the Trust Board on 21/11/19
- Jo Webber, Associate Non-Executive Director, joined the Trust Board on 21/11/19

The Trust Board also held two 'away days' in the year, in June and December 2019 (which focused on future strategy, the development of a more clinically led organisation, the route to "Outstanding" (including the Well-Led domain; and the Exceptional People Outstanding Care programme). The programme of Trust Board Seminars that was established in 2017/18 also continued, and four such Seminars were held (in April, June and October 2019 and February 2020). The issues discussed at the Seminars included the regional NHS structure, the future development of the Kent and Medway Sustainability and Transformation Partnership (STP), and the establishment of the West Kent Integrated Care Partnership (ICP); the content and functioning of the Board Assurance Framework (BAF); the Exceptional People, Outstanding Care programme; the plans to deploy the Electronic Patient Record (EPR); and GCHQ Certified board-level cyber security training).

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 2019/20, 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*∑

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. He lives in south west London with his family.

Maureen Choong

Non-Executive Director*

Maureen joined the Trust 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. In addition to her role on the Trust Board, Maureen chairs the Patient Experience Committee, is Vice-Chair of the Quality Committee and Audit and Governance Committee; and a member of the Remuneration and Appointments 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 Trust Board as Vice Chair, Sarah chairs the Quality Committee, and is the Vice-Chair of the Charitable Funds Committee, Finance and Performance Committee and Remuneration and Appointments Committee and is a member of Audit and Governance Committee. Sarah is also the Senior Independent Director (SID).

* Denotes Trust Board members with voting rights
∑ Denotes member of the Executive Team

Sean Briggs

Chief Operating Officer*∑

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 in 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.

Karen Cox

Associate Non-Executive Director

Professor Karen Cox joined the Trust Board at the end of June 2019. Karen is currently Vice-Chancellor and President of the University of Kent. Karen graduated from King's College London with a BSc (Hons) and her Registered General Nurse (RGN) qualification in 1991. She has held a number of clinical posts in Oxford, Southampton, Gloucestershire and Nottingham, specialising in Oncology and Community Health Care (District Nursing). Karen completed her PhD at University of Nottingham, funded by the Cancer Research Campaign and was appointed a Professor in 2002. She served as Head of the School of Nursing from 2002 until 2007, joined the senior leadership team as a Pro Vice-Chancellor from 2008 until 2013 and became Deputy Vice Chancellor from 2013 to 2017. Karen is also a board member of the Nursing and Midwifery Council (NMC). In addition to her role on the Trust Board, Karen is a member of the Workforce Committee.

Richard Finn

Associate Non-Executive Director

Richard Finn joined the Trust Board in November 2019. He is currently Managing Director of Richard Finn Ltd, an international management consultancy, where he specialises in providing advice on change, organisation development, governance and leadership. Previously he was a Managing Director at Penna PLC, a Director at Crane Davies and Marketing Director at Henley Distance Learning, a division of Henley Management College. Richard has a London BSC(Econ) and Cert Ed (FE), an MA in Management from the University of Kent and C.Dir from the Institute of Directors. He has been a Fellow of the Chartered Institute of Personnel and Development, Institute of Directors and the Chartered Institute of Marketing. He is a member of the Kent Business Advisory Board and the Kent and Medway Economic Partnership Board, the Kent arm of the South East Local Enterprise Partnership (SELEP) Federation. Richard was Chairman of Kent Music from 2007 to 2017, he is a member of the Nominations and Governance & Audit Committees of the Lord's Taverners and as a Liveryman was Chairman of the Pro-Bono Committee of the Livery Company of Management Consultants. Richard has lived all his married life in Kent and currently lives in Detling. In addition to his role on the Trust Board, Richard is the Vice Chair of the Workforce Committee.

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 is also a member of the Audit and Governance and Remuneration and Appointments Committees. Neil has been a local resident for 12 years, is married with two children and lives in Tunbridge Wells.

* Denotes Trust Board members with voting rights
∑ Denotes member of the Executive Team

Simon Hart

Director of Workforce[Σ]

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.

David Morgan

Non-Executive Director[*]

David joined the Trust Board in August 2019. His career has been spent in natural resources, chemicals and technology. He worked for Johnson Matthey plc for twenty years, including ten years as an executive director, and has served on the boards of a number of other companies, both in the UK and internationally. He is currently the Chair of a gold mining company, Nordgold SE, and Deputy Chair of an energy technology company, SFC Energy AG, and has been the Senior Independent Director at the Royal Mint since 2013. David is a chartered accountant, having qualified with KPMG, and chairs the Trust's Audit and Governance and Charitable Funds Committees. David is also a member of the Finance and Performance Committee. Away from work David volunteers as a mentor to staff and students at Imperial College who are looking to start their own businesses; having previously chaired the advisory board of the Department of Chemistry at Imperial. David has lived in Kent for over twenty years and is married with three sons.

Amanjit Jhund

Director of Strategy, Planning and Partnerships[Σ]

Amanjit joined the Board in 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.

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.

* Denotes Trust Board members with voting rights
∑ Denotes member of the Executive Team

Claire O'Brien

Chief Nurse*∑

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

Deputy Chief Executive / Chief Finance Officer*∑

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 Trust Board sub-committees.

Emma Pettitt-Mitchell

Non-Executive Director*

Emma joined the Trust Board in June 2018 as an Associate Non-Executive Director and was appointed as a substantive Non-Executive Director in August 2019. 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 vast 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. Uniquely 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. For the last 2.5 years Emma has also been a Non-Executive Director for a private limited company, 'Commercial Services', one of the largest suppliers and brokers of products and services in the UK.
Emma lives in Kent with her husband Andrew and 3 children. In addition to her role on the Trust Board, Emma chairs the Workforce Committee, is Vice Chair of the Patient Experience Committee and is a member of the Audit and Governance Committee and Remuneration and Appointments Committee.

Jo Webber

Associate Non-Executive Director

Jo Webber joined the Trust Board at the end of November 2019. Jo is currently Chair of In Control, a national charity working for an inclusive society supporting people with disabilities to live independently. Jo graduated from Surrey University with a BSc (Hons) in Human Biology, is a Registered General Nurse (RGN) with a specialist District Nursing qualification and has a Masters degree in Primary Health Care. She has held board level operational and clinical management posts in Community Health and Primary Care Trusts in Nottingham. In 2004 Jo moved to the NHS Confederation, working for eight years analysing the impact of new health policy on health and social care and working nationally to influence its development and delivery. She was a Trustee of the Burdett Trust for Nursing for nine years, giving grants to support nursing research and leadership development. She has a keen interest in improving joint working and integration within and between the NHS and local government, both nationally and on a local level, to deliver better co-ordinated and more responsive services for patients and their carers. In addition to her role on the Trust Board, Jo is a member of the Quality Committee.

* Denotes Trust Board members with voting rights
∑ Denotes member of the Executive Team

Nazeya Hussain, Non-Executive Director (who left the Trust Board on 21st June 2019) also served on the Trust Board during 2019/20.

Statement regarding Directors' disclosure to auditors

Each Director can confirm that they know 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 they ought to have taken" to make themselves 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 2019/20. Attendance at each meeting is shown below:

Trust Board Member	April 2019	May 2019	June 2019	July 2019	September 2019	October 2019	November 2019	December 2019	January 2020	February 2020	March 2020
David Highton, Chair of the Trust Board	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Miles Scott, Chief Executive	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Sean Briggs, Chief Operating Officer	✓	✓	Apologies	✓	✓	✓	✓	✓	✓	Apologies	✓
Maureen Choong, Non-Executive Director	Apologies	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Karen Cox, Associate Non-Executive Director	N/A	N/A	N/A	N/A	✓	✓	✓	Apologies	✓	✓	✓
Sarah Dunnett, Non-Executive Director	Apologies	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Richard Finn, Associate Non-Executive Director	N/A	N/A	N/A	N/A	N/A	N/A	✓	✓	✓	✓	✓
Neil Griffiths, Non-Executive Director	✓	✓	✓	Apologies	✓	✓	✓	✓	✓	✓	✓
Simon Hart, Director of Workforce	✓	✓	✓	Apologies	✓	✓	✓	✓	✓	✓	✓
Nazeya Hussain, Non-Executive Director	Apologies	✓	✓	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Amanjit Jhund, Director of Strategy, Planning and Partnerships	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Peter Maskell, Medical Director	✓	✓	✓	Apologies	✓	✓	✓	✓	✓	✓	✓
David Morgan, Non-Executive Director	N/A	N/A	N/A	✓	✓	✓	✓	✓	✓	✓	✓
Sara Mumford, Director of Infection Prevention & Control	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Claire O'Brien, Chief Nurse	✓	✓	✓	✓	✓	✓	✓	Apologies	✓	✓	✓
Steve Orpin, Deputy Chief Executive / Chief Finance Officer	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Emma Pettitt-Mitchell, Non-Executive Director	✓	✓	Apologies	✓	✓	✓	Apologies	✓	✓	✓	✓
Jo Webber, Associate Non-Executive Director	N/A	N/A	N/A	N/A	N/A	N/A	✓	✓	✓	✓	✓

Appointment and evaluation of Trust Board Members' performance

The Chair of the Trust Board and its Non-Executive Directors are independently appointed by NHS Improvement (NHSI) (operating at the NHS Trust Development Authority legal entity). 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[6]) for Directors. No concerns have been raised in relation to this in 2019/20.

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

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 2019/20 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 (Reg co. no. 10497423) ▪ Chairman, Demelza House Children's Hospice (charity Number: 1039651) ▪ Owner and Director, Hyperium Ltd (Reg co. no.: 04684013) ▪ Director of ACG Lettings Limited (Reg co. no.: 03031999) a property lettings business bequeathed to Demelza by legacy
Miles Scott, Chief Executive	None
Sean Briggs, Chief Operating Officer	None
Maureen Choong, Non-Executive Director	Special Advisory: Care Quality Commission (CQC)
Karen Cox, Associate Non-Executive Director	▪ Vice Chancellor and President, University of Kent ▪ Board Member, Nursing and Midwifery Council ▪ Royal College of Nursing Member ▪ UPP Foundation Advisory Board member ▪ Higher Education Representative/Director, South East Local Partnership (from August 2019) ▪ Member Universities UK membership Committee ▪ Applied Research Collaboration Kent, Surrey, Sussex - Board member - 2019
Sarah Dunnett, Non-Executive Director	▪ Director of CATALYST (london) Ltd (Reg co. no 10121754 ▪ Director of Sevenoaks School (Reg co. no 04908949)
Richard Finn, Associate Non-Executive Director	▪ Director of Richard Finn Ltd ▪ Director of Goring Place ▪ Director of Detling Community Interest Company
Neil Griffiths, Non-Executive Director	▪ Managing Director of TeleTracking Technologies ▪ Board Member, My UCLH ▪ Advisory Council Member, Staff College
Simon Hart, Director of Workforce	None
Amanjit Jhund, Director of Strategy, Planning and Partnerships	▪ Member of UK Labour Party ▪ Member of Socialist Health Association
Peter Maskell, Medical Director	None
David Morgan, Non-Executive Director	▪ Chairman of Nordgold SE ▪ Deputy Chairman of the Supervisory Board of SFC Energy AG ▪ Senior Independent Director, The Royal Mint Limited ▪ Chairman, Piazza Barnaloft Management Limited
Sara Mumford, Director of Infection Prevention & Control	None
Claire O'Brien, Chief Nurse	None
Steve Orpin, Deputy Chief Executive / Chief Finance Officer	Non-Executive Director of NHS Innovations South East
Emma Pettitt-Mitchell, Non-Executive Director	Non-Executive Director of ELM Business Consultancy Ltd (Reg Co. No. 11326434)
Jo Webber, Associate Non-Executive Director	▪ Chair of "In Control Partnerships" Charity ▪ Daughter in Law is Non-Executive Director of East Sussex Hospitals Trust ▪ Daughter In Law is Non-Executive Director of 2-gether Support Solutions

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 2019/20 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 11).

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 2019/20" section later in the Annual Report.

The Trust's Management Structure

The Trust is organised into a number of corporate and clinical Divisions. The latter comprise 18 Clinical Directorates, as follows:

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, Gynaecology 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), or equivalent. 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 strives to deliver the highest standards of care and treatment for all our patients, but despite the best efforts of staff, we do not always get things right. In order to learn and improve our services, we encourage patients and relatives to tell a member of staff as soon as they can, to allow us to put things right as soon as possible. However, for circumstances where concerns cannot be resolved in this way, the Trust has a

formal complaints process. In 2019/20, the Trust received 556 formal complaints (in 2018/19, this was 550), and 64.2% of complaints received were responded to within the agreed timescale (in 2018/19, this was 68.0%).

The Trust's Complaints and Patient Advice and Liaison Service (PALS) – Annual Report (which is due for publication in summer 2020) (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 2019/20, the Trust offered financial remedy in two cases, totalling £50 (one of £40 for travel costs and one of £10 for parking charges). The PHSO also made a recommendation to pay £950 in financial redress in one case (and that payment was duly made). This process excludes any claims for clinical negligence, which are pursued under the Trust's Claims Management Policy.

Disclosure of personal data-related incidents

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

Date (month)	Nature of incident	Nature of data involved	No. of people potentially affected	Notification steps
September 2019	Unauthorised access	Name, address, Date of Birth, contact phone numbers, sex, GP details, appointment type, sensitive healthcare data	Three	All individuals affected were contacted by telephone and/or letter
Further action on information risk	The Trust notified this breach to the ICO who considered the case and concluded that sensitive personal data was involved and that there was potential for the incident to cause distress/detriment and that citizen's rights had been affected and that there had been the unlawful obtaining of personal data. The Trust provided evidence of disciplinary steps taken. The ICO further concluded that the action taken against the employee by the Trust was proportionate to any sanction that may be imposed by a court for an offence of this nature. Consequently, the ICO was satisfied that appropriate measures were taken in this instance.			

The Trust also had the following severity 'Level 1'data-related incidents in the year:

Category	Nature of Incident	Total
A	Corruption or inability to recover electronic data	4
B	Disclosed in error	80
C	Lost in transit	3
D	Lost or stolen hardware	2
E	Lost or stolen paperwork	22
F	Non-secure disposal – hardware	0
G	Non-secure disposal – paperwork	1
H	Unloaded to website in error	0
I	Technical security failing (including hacking)	0
J	Unauthorised access/disclosure	8
K	Other	0

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.

Emergency planning, response and recovery

As a Category One responder under the Civil Contingencies Act 2004, the Trust has specific statutory duties in relation to emergency planning and response. In addition the Trust has other obligations as required by contracts and performance standards set by NHS England.

European Union (EU) Exit

Extensive work was carried out in preparations for the UK's exit from the EU. The Emergency Planning & Response Team worked on planning for both the March 2019 and October 2019 dates. There was a huge additional workload with both internal and external multi agency planning including transport disruption, supplies & procurement, accommodation, staffing and business continuity.

Adverse weather

In July 2019 record breaking heat affected the South East and near continent resulting in heatwave plans being activated. This year the Trust brought in ice cream vans which staff found beneficial. A review of heatwave identified the need to begin a programme of work to install active cooling in some areas at Maidstone Hospital that are prone to high temperatures.

Partnership Working

The Emergency Planning & Response team continued their work to make and enhance effective partnerships with other agencies. Relationships with helicopter providers were enhanced as were relationships with other Category one responders, voluntary providers, armed forces and local businesses. The Trust continued to be represented at the Local Health Resilience Partnership (LHRP) with other parts of the Kent & Medway Health Economy contributing where required. The Trust also continued to support the activities of the Kent Local Resilience Forum through membership of sub groups and working groups to support multi agency planning, training and response.

Helipads & Helicopters

In the summer on 2019, the first flight in to Tunbridge Wells Hospital of the children's air ambulance took place – flying a baby from Hull Royal Infirmary to Tunbridge Wells. This allowed the baby to be flown door to door and prevented a long road journey. The Trust also received funding via the Helicopter Emergency Landing Pads (HELP) appeal in May 2019 to start work on a new helipad at Maidstone Hospital. This was completed in October 2019 and received its first flight in November 2019 allowing Civil Aviation sign off for both day and night use. The Trust now has 24 hour helipads at both main hospital sites.

Exercises and training

In June 2019, "Exercise Boyles" took place at Tunbridge Wells Hospital. This live exercise tested the response to a fire within the theatre complex. The exercise included Kent Fire & Rescue Service, Kent Police, South East Coast Ambulance Service and

Interserve. It tested Communications, Command & control, Joint Emergency Services Interoperability Principles (JESIP) and evacuation procedures.

In October 2019 Exercise Oakwood UXB was a table top exercise in conjunction with Kent & Medway Partnership NHS Trust. It had representation from Explosive ordnance Division from the Ministry of Defence, Police, Fire, Ambulance and Maidstone Borough Council. This exercise examined the issues relating to an unexploded Second World War bomb unearthed on the Maidstone Hospital site.

In October 2019 another table top exercise in conjunction with IT examined the issues relating to a cyber security attack.

Major Incident

On November 6th 2019, a major incident was declared by South East Coast Ambulance Service NHS Foundation Trust, alerting both Maidstone and Tunbridge Wells Hospital. A large number of casualties were reported suffering from the effects of chemical exposure at a farm near Maidstone. The response to the incident by Trust staff was exemplary, but as with any incident response there were learning points which the Trust Resilience Committee will take forward to see if the Trust's plans should be revised.

Assurance

NHS England carry out an annual assurance process and this year the Trust was once again rated fully compliant. A number of areas of good practice were highlighted.

COVID-19

The impact of the COVID-19 pandemic began to be felt materially by the Trust during March 2019/20, but was more significantly felt within 2020/21 (which is outside the scope of this Report). However, the Trust commenced its preparations for the impact in January 2020. A COVID-19 Incident Command Centre was established in March 2020, under the Trust's emergency planning and response framework, and with the Chief Operating Officer as the Strategic Commander. The Command Centre's role was to lead and coordinate the response to the COVID-19 pandemic at the Trust, including acting as the single point of contact for the escalation of issues; acting as the single point of contact for external agencies; being responsible for identifying and mitigating Trust-wide risks; and having decision making over all substantial issues, queries, operational changes and expenditure requests relating to the COVID-19 response..

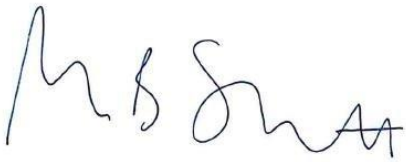
Statement of the Chief Executive's responsibilities as the Accountable Officer of the Trust

The Chief Executive of NHS Improvement, in exercise of powers conferred on the NHS Trust Development Authority, has designated that the Chief Executive should be the Accountable Officer of the Trust. The relevant responsibilities of Accountable Officers are set out in the NHS Trust Accountable Officer Memorandum. 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 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, other items of comprehensive income and cash flows for the year

As far as I am aware, there is no relevant audit information of which the Trust's auditors are unaware, and I have taken all the steps that I ought to have taken to make myself aware of any relevant audit information and to establish that the entity's auditors are aware of that information.

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



Miles Scott,

Chief Executive

18th June 2020

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, other items of comprehensive income and cash flows for the year. In preparing those accounts, the Directors are required to:

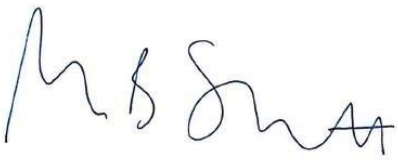
- Apply on a consistent basis accounting policies laid down by the Secretary of State with the approval of the Treasury;
- Make judgements and estimates which are reasonable and prudent;
- State whether applicable accounting standards have been followed, subject to any material departures disclosed and explained in the accounts and;
- Prepare the financial statements on a going concern basis and disclose any material uncertainties over going concern.

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.

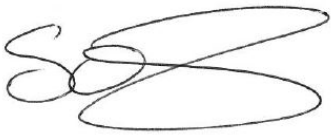
The Directors confirm that the annual report and accounts, taken as a whole, is fair, balanced and understandable and provides the information necessary for patients, regulators and stakeholders to assess the NHS Trust's performance, business model and strategy

By order of the Trust Board



Miles Scott, Chief Executive

18th June 2020



Steve Orpin, Chief Finance Officer

18th June 2020

Annual Governance Statement for 2019/20

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 Maidstone and Tunbridge Wells 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[7].

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 2020 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)[8] and the Security Management Director[9]
- The Chief Operating Officer is the Accountable Emergency Officer for Emergency Preparedness, Resilience & Response (EPRR)[10]

[7] See https://tinyurl.com/NHSAOM
[8] Required by "Firecode – fire safety in the NHS. Health Technical Memorandum 05-01: Managing healthcare fire safety"
[9] Required by the "Secretary of State Directions to NHS Bodies on Security Management Measures 2004 (amended 2006)"

- One of the Non-Executive Directors has been appointed as the Non-Executive Lead for Safeguarding and Resuscitation[11], and they have also been allocated the EPRR portfolio[12]
- The Chair of the Quality Committee is the Non-Executive Director with specific role/responsibilities for leading falls prevention[13], and also the Non-Executive lead on mortality and learning from deaths[14]

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 November 2019, the Trust Board approved a proposal that the 12 objectives within the BAF should be devolved for oversight by one or more Trust Board sub-committees, and that reports on the objectives be submitted to each sub-committee. The proposals noted that after each sub-committee had considered its objectives, the full BAF would then be considered by the Audit and Governance Committee and then be considered by the Trust Board, with the report presented by the Chair of the Audit and Governance Committee (supported by the Trust Secretary and relevant members of the Executive Team). That process was implemented throughout 2019/20, and culminated in the Chair of the Audit and Governance Committee presenting the BAF at the Trust Board meeting on 28/03/20.

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 2019/20, 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 …"; "There is an effective committee structure in place regarding risk management, and the BAF has been regularly presented to the Trust Board following 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 (including the guidance provided to them and the ways in which the Trust seeks to learn from good practice)

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

[10] Required by The Health and Social Care Act 2012
[11] Health Services Circular 2000/028 states that "Chief executives should ensure that"…"a…NED…of the Trust is given designated responsibility on behalf of the Trust Board to ensure that a resuscitation policy is agreed, implemented, and regularly reviewed within the clinical governance framework"
[12] The Core Standards for Emergency Preparedness, Resilience and Response (EPRR) assess whether "The organisation has an identified, active Non-executive Director/Governing Body Representative who formally holds the EPRR portfolio for the organisation"
[13] The Falls and fragility fractures audit programme (FFFAP) pilot national audit of inpatient falls (2015) asks "Does your organisation have a Non-executive Director (or other Board member) who has specific roles/responsibilities for leading falls prevention (can be as part of a wider remit for patient safety)?"
[14] The CQC's "Learning, candour and accountability: A review of the way NHS trusts review and investigate the deaths of patients in England" report states that "We also recommend that provider Boards strongly consider nominating a non-executive director to lead on mortality and learning from deaths"

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); legal services; 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, 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 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 overseen via the Quality Committee, which receives a report from each Divisional clinical governance committee whenever it meets in its 'main' form. The Quality Committee then 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 (as well as oversee quality within the clinical divisions).

Clinical audit is supported by a central team, within the Clinical Governance department, and is primarily overseen by the Clinical Audit Overview Committee. The investigation of, and learning from, incidents are predominantly managed within Directorates and discussed at Divisional, 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, while detailed reports on Complaints and Patient Advice and Liaison Service (PALS) contacts are received by the 'main' Quality Committee.

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 2019/20. 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's preparations and planning for CQC inspections are fully integrated and embedded as part of the Trust's 'business as usual' quality improvement agenda. The Trust 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 NHS Kent and Medway Clinical Commissioning Group, the main commissioner of the Trust's services. The outcomes of the inspections are used to identify areas for improvement, which are then acted upon. The Quality Improvement Committee, which meets monthly and is chaired by the Chief Nurse, provides the governance and oversight of this programme of work.

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 (NHSE) 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 primarily done via the Data Security and Protection Toolkit, and the Trust Board approved the submission against the latest assessment in March 2020, although the submission deadline for the Toolkit was extended to the end of September 2020 because of the COVID-19 period, so the Trust will make its formal submission at some point before the end of September 2020.

An Internal Audit advisory review on "Cyber Security Maturity" was also undertaken as part of the 2019/20 Internal Audit plan, which focused on the maturity in each of the ten data and cyber security standards referred to above. The report was issued in January 2020 and the key findings from the review were as follows:

- Management rated the Trust's dependency on Information technology as high and recognised that Cybercrime was a significant risk. Management considered that untreated cyber risks were at a high level. It was noted that the organisation had invested in improving cyber security measures in the last 12 months.
- The Trust had not experienced any cyber incidents within the last 12 months.
- Out of the ten areas reviewed, one was assessed at the highest level (5) and three at the second-highest level (4)[15]. There were two or more maturity steps between the aspirational level of maturity and the self-assessed level for "User Education and Awareness", "Incident Management" and "Home and Mobile Working", and these areas therefore require improvements to progress the maturity, counter measures and overall Cyber Assurance position.

Furthermore, in July 2019, the Trust achieved 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 achieve Cyber Essentials Plus accreditation by 2021).

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. That approach has continued in subsequent years, and the objectives for 2019/20, which were approved by the Trust Board on 23/05/19, are as follows:

1. Reduce our falls rate while in hospital to 6 per 1'000 bed days
2. Reduce E. coli blood stream infections to 21.5 per 100'000 bed days by March 2020
3. Improve complaints performance to 75% across all divisions and directorates by March 2020
4. Improve our vacancy rate to 9% by March 2020
5. Achieve staff engagement score of ≥ 7.2 within 2019/20
6. Implement the planned surgical reconfiguration by the end of 2019/20
7. Build new AMU to enable a new Hyper Acute Stroke Unit (HASU) by winter 2019
8. Ensure that 85% or more of cancer patients are treated within 62 days
9. Ensure that 86.7% or more of patients wait no longer than 18 weeks from referral to treatment

[15] The levels in Internal Audit's Cyber Maturity model range from 0 ("incomplete - The process is not implemented or fails to achieve its process purpose") to 5 ("Optimizing - The predictable process is continuously improved according to how cyber threats change and how business needs change"). Level 4 is "Predictable – The established process can now be put into action and tested thoroughly for better outcome".

10. Ensure that 91.67% or more of people presenting to our Accident and Emergency Departments wait no longer than 4 hours
11. Deliver a surplus of £6.9m in 2019/20 so that we can invest back into patient care
12. Ensure that our Hospital Standardised Mortality Ratio (HSMR) is <100

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 June 2019, September 2019 and March 2020. A year-end BAF report regarding the achievement of the objectives was received by the Trust Board in April 2020.

In addition, a number of risks were rated as 'red' in 2019/20. Red-rated risks are reviewed and validated at the Executive Team Meeting (see below) each quarter. The underlying risks have been discussed at the Trust Board and its sub-committees throughout 2019/20, and include the cost pressures associated with the use of temporary staff; risk associated with failing to learn from incidents; the inability to fulfil the national standard of 20% of women being cared for by Continuity of Carer teams within the Maternity service; the backlog of typing orthopaedics outpatient clinic letters; and the effect of the COVID-19 (coronavirus) outbreak on the Trust's ability to carry out its functions. 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 (under NHS Improvement's well-led framework)?

The CQC inspection in 2017 that was referred to above rated the Trust as "Good" for the Well-led domain. It is likely that the Trust will be assessed again by the CQC during 2020/21.

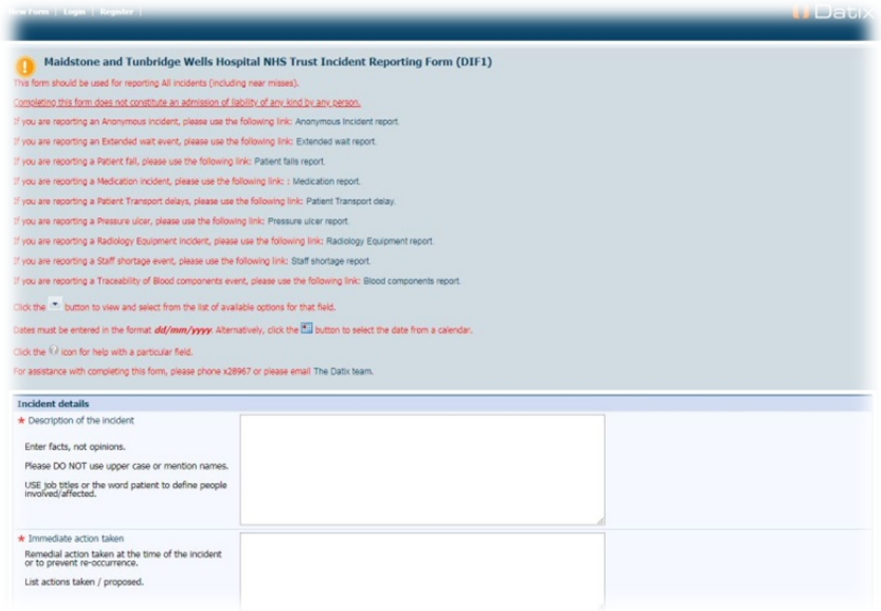
The principal risks to compliance with the NHS provider licence, condition 4 and actions identified to mitigate these risks

In May 2019, the Trust Board completed the required self-certification (for 2018/19) 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 Annual Governance Statement for 2018/19. The Trust Board will be asked to undertake the required self-certification for 2019/20 at its meeting in May 2020, 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, 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 Trust's central communications programme aims to embed risk management via the promotion of a monthly "Safety moment" (which focused 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"[16] 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[17] cover the necessary three components (i.e. evidence-based tools, professional judgement and outcomes).
- The Trust has a workforce plan that is submitted to NHSE/NHSI along with the annual financial and activity plans. The Trust Board discusses all of these plans before submission
- The Executive Team Meeting received monthly updates throughout 2019/20 on progress against the Trust's nursing recruitment plan (which included the recruitment of significant numbers of overseas nursing staff)
- All service changes including those related to skill mix and the introduction of new roles are subject to a QIA process led by the Medical Director and Chief Nurse

[16] "Developing workforce safeguards - Supporting providers to deliver high quality care through safe and effective staffing" (NHS Improvement, October 2018)
[17] "Supporting NHS providers to deliver the right staff, with the right skills, in the right place at the right time" (National Quality Board, July 2016)

- The Trust Board reviews workforce metrics on a monthly basis 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.
- The Trust's Workforce Committee (a sub-committee of the Trust Board, which is chaired by a Non-Executive Director) meets every two months. The Committee's purpose (as stated it its Terms of Reference) is to provide assurance to the Board in the areas of workforce development, planning, performance and employee engagement. The Committee also works to 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.

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 NHSE's "Managing Conflicts of Interest in the NHS" guidance and has not therefore published on its website an up-to-date register of interests, including gifts and hospitality, for decision-making staff within the past twelve months, as required by the "Managing Conflicts of Interest in the NHS" guidance. 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, which the Trust intends to implement in full in 2020/21.

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 primarily overseen by the Trust Board, Finance and Performance Committee and Audit and Governance Committee, although the Workforce Committee, Quality Committee and Remuneration and Appointments Committee have all participated in this oversight during 2019/20. The Trust also undertook detailed preparation for a forthcoming "Use of Resources" assessment during the year, while the Trust's annual Internal Audit plan for 2019/20 included a range of reviews relating to this area, including "Critical Financial Assurance – Financial Accounting and Non Pay" and "Payments for Additional Activity Undertaken by Trust Staff", which achieved overall assessment of "Reasonable Assurance". A further review of "Critical Financial Assurance – Payroll" was commissioned as part of the Internal Audit plan, but this was unable to be completed at the time of this Statement because of the COVID-19 period (during which Internal Audit staff were furloughed).

Information governance incidents

The Trust had one Serious Incident Requiring Investigation involving personal data that met the criteria for reporting to the Information Commissioner's Office (i.e. a 'Level 2' severity incident) during 2019/20. The incident, which related to unauthorised access, was subject to an internal investigation and remedial action was taken. The Information Commissioner's Office was informed of the action taken by the Trust and the Information Commissioner's Office concluded that appropriate measures were taken in this instance.

Data quality and governance

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

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

- The Trust has a "Patient Access to Treatment Policy and Procedure", which encompasses Standard Operational Procedures for waiting list management at all stages of a referral to treatment pathway. The Policy also states the responsibilities of key staff, including those for auditing data quality.
- The Trust also has an "Information Lifecycle Management Policy and Procedure", which describes the Trust's general approach to data quality
- There is a weekly validation process involving operational, management and information leads, to assure the quality of local and national waiting times reporting/data

The quality of performance information is primarily assessed via the Internal Audit programme, and in particular via the review of "Data Quality of Key

Performance Indicators", which forms part of the Internal Audit plan each year. However, although the 2019/20 review started, it was unable to be completed at the time of this report because of the COVID-19 period (during which Internal Audit staff were furloughed). However, the "Data Quality of Key Performance Indicators" that was undertaken as part of the 2018/19 Internal Audit plan (which was issued in May 2019) gave an overall assessment of "Reasonable Assurance" to both of the indicators that were selected (62-day Cancer waiting time target and 18 Weeks Referral to Treatment (RTT) Incomplete Pathway). The review also concluded that "The Trust has an appropriately approved and up to date Information Lifecycle Management Policy and Procedure in place."

In addition, the Trust's contract with the Clinical Commissioning Group (CCG) includes a requirement to have a Data Quality Improvement Plan (DQIP). The governance processes defined in the contract mean that any data quality issues relating to our RTT or cancer waiting times can be raised and resolved via that route. The Trust's commissioners receive copies of the Trust's performance reports, as well as information provided to them via NHSE/I, to support the performance management of the Trust's services (with the aim of ensuring the achievement of key targets such as the RTT and cancer waiting time standards). Any associated data quality issues are raised as part of this dialogue and are managed via the technical groups established under the contract and documented in the DQIP.

Review of effectiveness

As Accountable Officer, I have responsibility for reviewing the effectiveness of the system of internal control. My review of the effectiveness of the system of internal control is informed by the work of the internal auditors, clinical audit and the executive managers and clinical leads within the Trust who have responsibility for the development and maintenance of the internal control framework. I have drawn on the information provided in this Annual Report and other performance information available to me. My review is also informed by comments made by the external auditors in their management letter and other reports. I have been advised on the implications of the result of my review of the effectiveness of the system of internal control by the Trust Board, the Audit and Governance Committee and the 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 2019/20 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 some reviews undertaken by Internal Audit during 2019/20 resulted in a "limited assurance" conclusion. As is the case with all reviews with such a conclusion, the details have been, or will be, 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 Trust Management Executive (TME), Finance and Performance Committee and 'main' Quality Committee during the year. Although a number of the Internal Audit reviews completed in 2019/20 resulted in an overall 'Reasonable assurance' assessment, one led to an assessment of 'Limited assurance'. This related to the implementation of the Trust's Electronic Patient Record (EPR), and actions to address the issues identified in the review will be taken during 2020/21 (which is the year in which the implementation is scheduled to occur).

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

The Trust Board meets every month (with the exception of August) in public (a 'Part 1' meeting), although the Trust Board meeting in March 2020 was unable to be held in public following HM government's guidance on social distancing. The agenda and reports for the meeting, which took place via a webconference, were however made available via the Trust's website.

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

A key tenet of the information the Board receives at each meeting in public is an Integrated Performance Report, which contains up-to-date details of performance across a range of indicators. Some Board meetings also feature "patient experience" and "staff experience" items, which provide invaluable first-hand experience of being a patient of, and working at, the Trust.

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 (although the role and functioning of the Committee is under review, and may change during 2020/21). 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 (although it met several times during 2019/20).

- 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 two months.

Although not a Trust 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, the five Divisional Chiefs of Service and the Director of Estates and Facilities. 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, 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, an Infection Prevention and Control Committee; a Health and Safety Committee; a Drugs, Therapeutics and Medicines Management Committee; an Information Governance Committee; and a Joint Safeguarding Committee.

The impact of the COVID-19 pandemic during 2019/20

The impact of the COVID-19 pandemic began to be felt materially by the Trust during March 2019/20, but was more significantly felt within 2020/21 (which is outside the scope of this Governance Statement). However, despite the unprecedented scale of the impact of COVID-19, the Trust's structure of governance allowed a prompt response to the significant change in circumstances. The Trust commenced its preparations for the impact in January 2020, and regular updates on progress with preparedness started to be considered by the Executive Team Meeting in early February 2020 (with weekly updates being considered from March 2020). A COVID-19 Incident Command Centre was established in March 2020, under the Trust's emergency planning and response framework, and with the Chief Operating Officer as the Strategic Commander. The Command Centre's role was to lead and coordinate the response to the COVID-19 pandemic at the Trust, including acting as the single point of contact for the escalation of issues; acting as the single point of contact for external agencies; being responsible for identifying and mitigating Trust-wide risks; and having decision making over all substantial issues, queries, operational changes and expenditure requests relating to the COVID-19 response.

All of the scheduled meetings of the Trust Board and its sub-committees in March 2020 proceeded, but were held via webconference, to follow HM government's guidance on social distancing.

As could be reasonably expected, the Trust's control environment needed to adapt to the COVID-19 circumstances, and at its meeting on 28/03/20, the Trust Board approved a proposal to temporarily extend the delegated expenditure limits for members of the Executive Team, to add resilience to the system in the event of certain members of the Executive Team being absent because of sickness or self-isolation (in the event of them, or a family member, having COVID-19 symptoms).

The Trust did not experience any notable business continuity issues. However, as part of routine practice, once the COVID-19 period has ended, the Trust will undertake a debrief/'lessons learned' exercise, to identify what worked well, and more importantly, the areas of the Trust's business continuity plan and Major Incident plan that could be improved. It is expected that the outcome of that exercise will, in the first instance, be considered by the Executive Team Meeting in 2020/21.

The Internal Audit plan for 2019/20 was adversely affected by COVID-19, as a number of reviews that were scheduled to be completed in March 2020 were unable to be completed. The Head of Internal Audit's Opinion makes reference to this, but the overall opinion was not significantly affected. The overall review of effectiveness of the control environment as described in this Statement was also not significantly affected.

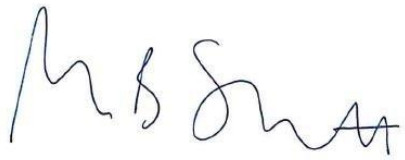
Significant internal control issues

The following significant internal control issue[18] has been identified in 2019/20:

1. Three "Never Events" were declared at the Trust in 2019/20, which related to a lumbar puncture being carried out on the wrong baby; medication being given via the incorrect route; and an injection being administered to a patient's incorrect eye. The incidents were subject to scrutiny through the SI investigation process and the aim is to ensure that lessons are learned to prevent recurrence.

Conclusion

One significant internal control issue was identified in 2019/20, and this is described above, in the body of the Annual Governance Statement.



Miles Scott, Chief Executive

18th June 2020

[18] The Trust considered the following criteria when identifying if any significant internal control issues had occurred during 2019/20: Might the issue prejudice achievement of priorities? Could the issue undermine the integrity or reputation of the NHS? What view does the Audit and Governance Committee take on this point? What advice has internal or external audit given? Could delivery of the standards expected of the Accountable Officer be at risk? Has the issue made it harder to resist fraud or other misuse of resources? Did the issue divert resources from another significant aspect of the business? Could the issue have a material impact on the accounts? Might national or data security or integrity be put at risk? As was noted in the "COVID-19 related considerations for 2019/20 annual reports and accounts disclosures" guidance issued by NHS England/NHS Improvement on 22/04/20, it was not expected that the emergence of COVID-19 in 2019/20 would, in itself, be considered a significant internal control issue.

NHS
Maidstone and Tunbridge Wells
NHS Trust

Accountability Report for 2019/20: Remuneration and Staff Report

taking pride

MTW
exceptional people, outstanding care

Our staff

NHS national staff survey

The Trust recognises that strong staff engagement is key to the success of our organisation. It has been widely proven that high levels of staff engagement lead to better patient outcomes and better use of resources. Staff engagement for us means involving our staff in defining what great experience is, helping to shape the systems and processes that deliver it and "living the values" of our organisation.

The results of the annual NHS National Staff Survey enable us to track our engagement journey and provide a focus on areas that need improvement. In 2019, the survey response rate for the Trust was 51% compared to 33% in the preceding two years. This represents the views of 2978 of our staff which is the highest since 2014 and compares favourably to the average national response rate of 47%. This increase in responses provides us with an improved viewpoint on how our staff are feeling. The results showed statistically significant improvements in immediate managers; morale; quality of appraisals; safety culture; staff engagement; and team working

Just over 66% of staff would recommend the Trust as a place to work, 61% look forward to going to work and 75% are enthusiastic about their jobs. There are, of course, areas that we want to focus on to make the improvements that we need and they are identified as: Safe environment in regards to bullying, harassment and violence; Quality of care; and Equality, Diversity and Inclusion with a focus on career and talent planning, reverse mentoring for our Executive team and piloting a diverse recruitment programme. 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[19] staff numbers	Permanently employed (WTE)[20]	Other (WTE)	Permanently employed (expenditure) (£000s)	Other (expenditure) (£000s)
Medical and dental	706	148	73,110	20,852
Ambulance staff	0	0	0	0
Administration and estates	1,127	77	40,300	3,315
Healthcare assistants and other support staff	1,244	138	34,163	4,305
Nursing, midwifery and health visiting staff	1,450	275	68,500	15,327
Nursing, midwifery and health visiting learners	3	0	72	0
Scientific, therapeutic and technical staff	495	44	24,757	2,918
Social Care Staff	0	0	0	0
Healthcare Science Staff	205	2	11,060	95
Other	0	0	0	0
Apprenticeship levy	0	0	1,157	0
Total	5,230[21]	684	253,119	46,812
Staff engaged on capital projects (excluded from above)	19	5	1,355	721

[19] 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.
[20] This excludes any staff on unpaid leave (and therefore does not equate to the WTE reported within the Sustainability Report)
[21] Readers will note that this figure is different to the WTE figure reported in the "Organisation" table within the "Sustainability Report". This difference arises because there is a difference between "contracted", "worked" and "paid" staff; and the figure in the "Staff numbers and costs" table is an average over the year and is based on when staff are paid (therefore any staff on unpaid leave i.e. maternity leave, long term sickness absence etc. do not feature)

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

Exit packages – disclosures (excluding compulsory redundancies)	Number of exit package agreements 2019/20	Total Value of agreements (£000s)	Number of exit package agreements 2018/19	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	0	0
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	0	0
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 (JCF) and Joint Medical Consultative Committee (JMCC), to discuss key issues and agree relevant employment policies and procedures. Staff are formally consulted when organisational or other work changes are proposed and have the opportunity to comment and input into proposed changes.

Information is cascaded to all staff through a monthly "Team Brief" meeting which is led by the Chief Executive and takes place at both main hospital sites at the same time (Maidstone Hospital is the main site, but there is a video link with Tunbridge Wells Hospital). A weekly Chief Executive's update and "MTW News" newsletter are also issued to all staff via email, enabling messaging on matters of note.

The Trust's Freedom to Speak Up Guardian (FTSUG) submitted reports to the Trust Board each quarter during 2019/20. The FTSUG aims to ensure 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 also have the opportunity to share their experiences with the Trust Board throughout the year, via a "staff experience" item at Trust Board meetings, and in 2019/20 the Board heard from the Chairs of the Staff networks, and received a presentation on Physician Associates and Advanced Clinical Practitioner roles.

Exceptional People, Outstanding Care programme

The Trust recognises the importance of culture and leadership in an organisation's success. In this regard, the Trust embarked on an Exceptional People Outstanding Care cultural and leadership programme during 2029/20. The programme involved three phases: "discovery", "design" (i.e. to develop an Organisational Development strategy), and "delivery" (i.e. implementation of that Strategy). 2019/20 was primarily focused on the discovery phase, which intended to assess the Trust's culture against five elements (vision and values, goals and performance, learning and innovation, support and compassion, and teamwork). Five diagnostics aspects were deployed: Board Interviews; a Behaviour Survey; a Culture and Outcomes Dashboard; Workforce Leadership Analysis; 'Culture Conversations' and 'Patient Experience'. A 'change team' was also established, to lead the work, which involved over 50 staff from all areas of the Trust – clinical and non-clinical.

The findings from the "discovery" phase were presented to the Trust Board at its meeting on 26th March 2020, and although the COVID-19 pandemic meant that the timescales planned to proceed with the second "design" phase had to be adjusted, it is expected that significant progress will be made during 2020/21.

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 apprentices working across its hospitals in a range of roles. 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 medical trainees as well as provides professional development for all doctors in the Trust.

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

We aim to be the best place to be cared for and the best place to work. Our staff will provide the best care when they are confident and able to be their authentic self. And in order to do this we will show fairness, kindness and respect to all – because we are dedicated to diversity.

We know that we are more likely to attract people from a wider pool of talent if we are explicit in our commitment to diversity and inclusion and demonstrate that through the way that we operate. Staff and volunteers are more likely to perform well, feel motivated, committed and therefore be retained if they feel valued and respected in their working environment. Likewise, our patients are more likely to use the services we provide if they believe that they will be treated with dignity and respect. It is about putting diversity and inclusion at the heart of everything we do.

Over the last year, there have been some significant changes within our Black, Asian and Minority Ethnic (BAME) staff network. A new Chair, in the form of Ms Rantimi Ayodele, has seen a re-focus in support to our BAME staff:

- The network has been re-branded and the membership has increased by 100%
- The equality statement that accompanies all job adverts for the Trust has been updated
- The network has collaborated with other staff networks, Human Resources and staff side to review disciplinary and bullying and harassment cases
- A half-day development programme aimed at supporting staff with their career development was delivered
- International Staff drop-in sessions for cohorts of international nurses and other overseas staff have been supported by the network
- A suite of events including meet and greet sessions, steel bands playing for staff and patients and Diwali meet and greet sessions were arranged to celebrate Black History Month in October

The LGBT+ and Allies Networks have had a busy year, starting with Canterbury Pride in June 2019. Staff from the network, our Medical Director (and network Executive Sponsor) joined colleagues from the Rubin Clinic at the Trust, Kent Community Health NHS Foundation Trust and Kent and Medway NHS and Social Care Partnership Trust walking under the banner of "Pride in our NHS".

In June 2019, the Trust also launched the NHS Rainbow Badge – demonstrating that this is an open, non-judgmental and inclusive place for people who identify as LGBT+. With around 25% of our staff wearing the badge, we are committed to ensuring that our LGBT+ colleagues and patients are treated with respect.

Two flagpoles were installed just ahead of Pride season and during August 2019 we were able to fly the Rainbow Flag. August saw us walking once again with colleagues from the Rubin Clinic at Tunbridge Wells Pride.

Our second NHS-led multi organisation LGBT+ Conference in the Kent and Medway area took place in September 2019. Launched by the Trust's Chief Executive, Trust staff were joined by South East Coast Ambulance Service NHS Foundation Trust, Kent Police, Kent Fire and Rescue, HM Prison Maidstone, the Heart of Kent Hospice and other local NHS organisations.

The swansong to 2019 was the installation of our Rainbow Crossing, the first of its kind on an NHS site in Kent.

The gender, age and ethnic group distribution of staff and Trust Board Members (Senior Managers) at the end of 2019/20 is set out below (the 2018/19 equivalent is in brackets).

Gender	Staff [head count]		Trust Board Members	
Male	1463 (1394)	23.6% (24.1%)	10 (8)	58.8% (57.1%)
Female	4735 (4381)	76.4% (75.9%)	7 (6)	41.2% (42.9%)
Grand total	6198 (5775)	-	17 (14)	-

Age	Staff [head count]		Trust Board Members	
Less than or equal to 20 years	46 (42)	0.7% (0.7%)	0 (0)	0% (0%)
21 to 25	419 (374)	6.8% (6.5%)	0 (0)	0% (0%)
26 to 30	791 (698)	12.8% (12.1%)	0 (0)	0% (0%)
31 to 35	781 (649)	12.6% (11.2%)	1 (1)	5.9% (7.1%)
36 to 40	659 (635)	10.6% (11.0%)	1 (1)	5.9% (7.1%)
41 to 45	825 (810)	13.3% (14.0%)	1 (3)	5.9% (21.4%)
46 to 50	840 (805)	13.6% (13.9%)	5 (4)	29.4% (28.6%)
51 to 55	795 (762)	12.8% (13.2%)	1 (2)	5.9% (14.3%)
56 to 50	617 (597)	10.0% (10.3%)	2 (0)	11.8% (0%)
61 to 65	335 (305)	5.4% (5.3%)	4 (3)	23.5% (21.4%)
66 to 70	60 (72)	1.0% (1.2%)	2 (0)	11.8% (0%)
71 years or over	30 (26)	0.5% (0.5%)	0 (0)	0% (0%)

Please note that the data for Trust Board Members is not included within the "Staff [head count]" data, to avoid double counting, even though 8 of the 17 Trust Board members are substantive members of staff.

Ethnic group	Staff [head count]		Trust Board Members	
A White - British	3794 (3739)	61.2% (64.7%)	14 (10)	82.4% (71.4%)
B White - Irish	57 (56)	0.9% (1.0%)	1 (1)	5.9% (7.1%)
C White - Any other White background	442 (440)	7.1% (7.6%)	0 (0)	0% (0%)
C2 White Northern Irish	3 (0)	> 0.1% (0%)	0 (0)	0% (0%)
C3 White Unspecified	1 (1)	> 0.1% (> 0.1%)	0 (0)	0% (0%)
CA White English	1 (1)	> 0.1% (> 0.1%)	0 (0)	0% (0%)
CF White Greek	3 (2)	> 0.1% (> 0.1%)	0 (0)	0% (0%)
CG White Greek Cypriot	1 (0)	> 0.1% (0%)	0 (0)	0% (0%)
CK White Italian	2 (1)	> 0.1% (> 0.1%)	0 (0)	0% (0%)
CP White Polish	8 (9)	0.1% (0.2%)	0 (0)	0% (0%)
CU White Croatian	1 (1)	> 0.1% (> 0.1%)	0 (0)	0% (0%)
CY White Other European	22 (20)	0.4% (0.3%)	0 (0)	0% (0%)
D Mixed - White & Black Caribbean	10 (13)	0.2% (0.2%)	0 (0)	0% (0%)
E Mixed - White & Black African	12 (10)	0.2% (0.2%)	0 (0)	0% (0%)
F Mixed - White & Asian	30 (23)	0.5% (0.4%)	0 (0)	0% (0%)
G Mixed - Any other mixed background	25 (26)	0.4% (0.5%)	0 (0)	0% (0%)
GA Mixed - Black & Asian	1 (1)	> 0.1% (> 0.1%)	0 (0)	0% (0%)
GC Mixed - Black & White	2 (0)	> 0.1% (0%)	0 (0)	0% (0%)
GD Mixed - Chinese & White	1 (0)	> 0.1% (0%)	0 (0)	0% (0%)
GE Mixed - Asian & Chinese	2 (1)	> 0.1% (> 0.1%)	0 (0)	0% (0%)
GF Mixed - Other/Unspecified	3 (1)	> 0.1% (> 0.1%)	0 (0)	0% (0%)
H Asian or Asian British - Indian	566 (372)	9.1% (6.4%)	1 (1)	5.9% (7.1%)
J Asian or Asian British - Pakistani	70 (56)	1.1% (1.0%)	0 (1)	0% (7.1%)
K Asian or Asian British - Bangladeshi	17 (11)	0.3% (0.2%)	0 (0)	0% (0%)
L Asian or Asian British - Any other Asian background	311 (334)	5.0% (5.8%)	0 (0)	0% (0%)
LA Asian Mixed	6 (3)	0.1% (0.1%)	0 (0)	0% (0%)
LB Asian Punjabi	2 (0)	> 0.1% (0%)	0 (0)	0% (0%)
LF Asian Tamil	2 (0)	> 0.1% (0%)	0 (0)	0% (0%)
LH Asian British	3 (1)	> 0.1% (> 0.1%)	0 (0)	0% (0%)
LJ Asian Caribbean	1 (0)	> 0.1% (0%)	0 (0)	0% (0%)
LK Asian Unspecified	3 (0)	> 0.1% (0%)	0 (0)	0% (0%)
M Black or Black British - Caribbean	22 (22)	0.4% (0.4%)	0 (0)	0% (0%)
N Black or Black British - African	182 (139)	2.9% (2.4%)	0 (0)	0% (0%)
P Black or Black British - Any other Black background	13 (14)	0.2% (0.2%)	0 (0)	0% (0%)
PB Black Mixed	1 (0)	> 0.1% (0%)	0 (0)	0% (0%)
PC Black Nigerian	11 (2)	0.2% (> 0.1%)	0 (0)	0% (0%)
PD Black British	4 (2)	0.1% (> 0.1%)	0 (0)	0% (0%)
PE Black Unspecified	1 (0)	> 0.1% (0%)	0 (0)	0% (0%)
R Chinese	35 (34)	0.6% (0.6%)	0 (0)	0% (0%)
S Any Other Ethnic Group	144 (147)	2.3% (2.5%)	0 (0)	0% (0%)
SB Japanese	4 (4)	0.1% (0.1%)	0 (0)	0% (0%)
SC Filipino	19 (7)	0.3% (0.1%)	0 (0)	0% (0%)
SD Malaysian	2 (0)	> 0.1% (0%)	0 (0)	0% (0%)
SE Other Specified	8 (3)	0.1% (0.1%)	0 (0)	0% (0%)
Z Not Stated	350 (279)	5.6% (4.8%)	1 (1)	5.9% (7.1%)
Grand Total	6198 (5932)	-	17 (14)	-

Please note that the data for Trust Board Members is not included within the "Staff [head count]" data, to avoid double counting, even though 8 of the 17 Trust Board members are substantive members of staff.

Staff sickness absence

Sickness absence data can be accessed via the NHS Digital publication series on NHS sickness absence rates (see https://digital.nhs.uk/data-and-information/publications/statistical/nhs-sickness-absence-rates).

Disabled employees

The Trust is committed to taking positive action for disabled people and is recognised as a Disability Confident Committed Employer. We are currently working towards obtaining Level 2 - Disability Confident Employer status which will enable us to play a leading role in changing attitudes for the better.

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 Risk Assessment Policy and Procedure was revised and ratified, this provides greater guidance to risk leads on accurately grading risks.
- The Trust encourages incident reporting and the reporting of non-patient safety incidents increased by over 15%, from 2046 in 2018/19 to 2358 in 2019/20. This was reflected in a 10% increase in the number of staff injuries as a result of accidents in the workplace.
- While it remains the largest health and safety-related incident category, there was a decrease in incidents of violence & harassment against staff. The incidents are largely attributable to patients diagnosed with dementia or those suffering from a mental health crisis. Work is ongoing to mitigate the risk.
- At the end of March 2020, 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 – 25 in 2019/20 compared with 26 in 2018/19.
- Following health and safety inspections of the hospital exterior, extensive works have been carried out to make areas safer, including LED belisha beacons on crossings and the hedge trimming in front of the Priority car park making vehicles exiting significantly safer..

- Smoking signage has been updated on both hospital sites which now carry a more explicit message of prohibition whilst at the same time offering help and advice to those who may wish to quit smoking.
- Regular inspections continued at other off main site locations and significant improvements were made to the Trust's laundry and health records sites.

"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 has established 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 2019/20 for further details of the Remuneration and Appointments Committee).

The Chief Executive and Directors' remuneration is reviewed annually 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 six 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 2020 (subject to audit)

Comparatives for the year ending 31st March 2019 are shown in brackets below the figure for 2019/20.

Name and title (alphabetical by surname) N.B. Dates of service are for the full 2019/20 year unless otherwise disclosed	**(a) Salary** (bands of £5,000)	**(b) Taxable expense payments and other benefits in kind, to the nearest £100**	**(c) Annual performance-related pay and bonuses** (bands of £5,000)	**(d) Long-term performance-related pay and bonuses** (bands of £5,000)	**(f) All pension-related benefits** (bands of £2,500)	**(g) TOTAL (columns a - f)** (bands of £5.000)	**(h) Payments or compensation for loss of office**
	£000	**£00 Λ**	**£000**	**£000**	**£000**	**£000**	£000
Sean Briggs, Chief Operating Officer	125-130 (50-55)	0 (0)	N/A (N/A)	N/A (N/A)	65.0-67.5 (322.5-325)	195-200 (375-380)	N/A (N/A)
Maureen Choong, 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)
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)
Richard Finn, Associate Non-Executive Director (from 21/11/19	0-5 (0)	0 (0)	N/A (N/A)	N/A (N/A)	N/A (N/A)	0-5 (0)	N/A (N/A)
Neil Griffiths, Associate Non-Executive Director	5-10 (0-5)	0 (0)	N/A (N/A)	N/A (N/A)	0 (0)	5-10 (0-5)	N/A (N/A)
Simon Hart, Director of Workforce	130-135 (130-135)	0 (0)	N/A (N/A)	N/A (N/A)	25.0-27.5 (45-47.5)	155-160 (175-180)	N/A (N/A)
David Highton, Chair of the Trust Board	40-45 (35-40)	0 (6)	N/A (N/A)	N/A (N/A)	0 (0)	40-45 (35-40)	N/A (N/A)
Nazeya Hussain, Non-Executive Director (until 21/06/19)	0-5 (0-5)	0 (0)	N/A (N/A)	N/A (N/A)	0 (0)	0-5 (0-5)	N/A (N/A)
Amanjit Jhund, Director of Strategy, Planning & Partnerships	125-130 (60-65)	0 (0)	N/A (N/A)	N/A (N/A)	27.5-30.0 (60-62.5)	155-160 (125-130)	N/A (N/A)
Peter Maskell, Medical Director Ψ	200-205 (200-205)	0 (0)	N/A (N/A)	N/A (N/A)	7.5-10.0 (652.5-655)	205-210 (850-855)	N/A (N/A)
David Morgan, Non-Executive Director (from 12/08/19	0-5 (0)	0 (0)	N/A (N/A)	N/A (N/A)	0 (0)	0-5 (0)	N/A (N/A)
Sara Mumford, Director of Infection Prevention and Control Ψ	175-180 (170-175)	0 (0)	N/A (N/A)	N/A (N/A)	70.0-72.5 (32.5-35)	245-250 (200-205)	N/A (N/A)
Claire O'Brien, Chief Nurse	125-130 (120-125)	0 (0)	N/A (N/A)	N/A (N/A)	7.5-10.0 (110-112.5)	130-135 (230-235)	N/A (N/A)
Steve Orpin, Deputy Chief Executive / Chief Finance Officer	145-150 (145-150)	0 (0)	N/A (N/A)	N/A (N/A)	35-37.5 (107.5-110)	180-185 (250-255)	N/A (N/A)
Emma Pettitt-Mitchell, Non-Executive Director	5-10 (0-5)	0 (0)	N/A (N/A)	N/A (N/A)	0 (0)	5-10 (0-5)	N/A (N/A)
Miles Scott, Chief Executive	225-230 (220-225)	0 (0)	N/A (N/A)	N/A (N/A)	0 (0)	225-230 (220-225)	N/A (N/A)
Jo Webber, Associate Non-Executive Director (from 21/11/19)	0-5 (0)	0 (0)	N/A (N/A)	N/A (N/A)	0 (0)	0-5 (0)	N/A (N/A)

Λ £ hundreds are used for taxable expense payments, and other benefits (column (b)). 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 2020[22] (subject to audit)

Name and title Ψ (alphabetical by surname) N.B. Dates of service are for the full 2019/20 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 2020 (bands of £5,000)	(d) Lump sum at pension age related to accrued pension at 31st March 2020 (bands of £5,000)	(e) Cash Equivalent Transfer Value Λ at 1st April 2019	(f) Real increase in Cash Equivalent Transfer Value Σ	(g) Cash Equivalent Transfer Value Λ at 31st March 2020	(h) Employee's contribution to stakeholder pension
	£000	£000	£000	£000	£000	£000	£000	£000
Sean Briggs, Chief Operating Officer	2.5-5.0	0	20-25	0	147	40	191	19
Simon Hart, Director of Workforce	0-2.5	0	45-50	105-110	755	43	816	21
Amanjit Jhund, Director of Strategy, Planning & Partnerships	0-2.5	0	5-10.0	0	32	23	56	19
Peter Maskell, Medical Director	0-2.5	0	30-35	60-65	513	22	547	13
Sara Mumford, Director of Infection Prevention and Control	2.5-5.0	2.5-5.0	55-60	80-85	889	82	993	22
Claire O'Brien, Chief Nurse	0-2.5	2.5-5.0	50-55	160-165	1202	61	1292	18
Steve Orpin, Deputy Chief Executive / Chief Finance Officer	2.5-5.0	0	55-60	125-130	885	52	958	21
Miles Scott, Chief Executive¥	0	0	0	0	0	0	0	0

Ψ As Non-Executive Directors (and Associate 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. Please however note that the CETV values at 31/03/19 and 31/03/20 may have been calculated using different methodologies, and this may have impacted the "Real increase in Cash Equivalent Transfer Value" figure in the table

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 2019/20

Please also note that the benefits and related CETVs do not allow for a potential adjustment arising from the McCloud judgement (a legal case concerning age discrimination over the manner in which UK public service pension schemes introduced a CARE benefit design in 2015 for all but the oldest members who retained a Final Salary design).

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 2020 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 2019/20 was £227,500 (in 2018/19 this was £222,500). This was 7.5 times (in 2018/19 this was 7.5 times) the median remuneration of the workforce, which was £30,401 (in 2018/19 this was £29,698).

In 2019/20 no employees (in 2018/19, no employees) received remuneration in excess of the highest-paid director. The highest paid Director in the financial year 2019/20 was the Chief Executive (in 2018/19 this was the Chief Executive). Remuneration ranged from £12,477 to £227,500 (in 2018/19 the range was from £12,222 to £222,500).

[22] 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 2020, for more than £245 per day and lasting for longer than six months

	Number
Number of existing engagements as of 31st March 2020 Of which, the number that have existed…	11
for less than one year at the time of reporting =	7
for between one and two years at the time of reporting =	3
for between two and three years at the time of reporting =	1
for between three and four years at the time of reporting =	0
for four 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 2019 and 31st March 2020, for more than £245 per day that last longer than six months

	Number
Number of new engagements, or those that reached six months in duration, between 1st April 2019 and 31st March 2020	6
Of which…	
Number assessed as caught by IR35	0
Number assessed as not caught by IR35	6
Number engaged directly (via PSC contracted to department) and are on the departmental payroll	0
Number of engagements reassessed for consistency/assurance purposes during the year	0
Number of engagements that saw a change to IR35 status following the consistency review	0

Off-payroll Board member / Senior Official engagements

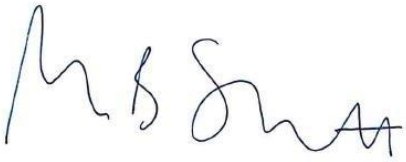
Number of off-payroll engagements of Board members and/or senior officials with significant financial responsibility, during the year	0
Number of individuals that have been deemed "Board members and/or senior officers with significant financial responsibility", during the financial year. This figure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

Expenditure on consultancy staff

The Trust's internal expenditure on consultancy staff for 2019/20 was £571k, a decrease of £376k from previous financial year (£947k in 2018/19). The Trust hosted the Kent and Medway Sustainability and Transformation Partnership (STP) until October 2019 which incurred £57k of consultancy spend compared to £1,336k in 2018/19.

Declaration

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



Miles Scott, Chief Executive

18th June 2020

NHS
Maidstone and Tunbridge Wells
NHS Trust

Accountability and audit report for 2019/20: Independent Auditor's report to the Directors of Maidstone and Tunbridge Wells NHS Trust

taking pride

MTW
exceptional people, outstanding care

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 and Tunbridge Wells NHS Trust (the 'Trust') for the year ended 31 March 2020, which comprise the Statement of Comprehensive Income, the Statement of Financial Position, the Statement of Changes in Equity, the Statement of Cash Flows and notes to the financial statements, including a summary of significant accounting policies. The financial reporting framework that has been applied in their preparation is applicable law and International 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 2019 to 2020.

In our opinion the financial statements:

- give a true and fair view of the financial position of the Trust as at 31 March 2020 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 2019 to 2020; 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.

The impact of macro-economic uncertainties on our audit

Our audit of the financial statements requires us to obtain an understanding of all relevant uncertainties, including those arising as a consequence of the effects of macro-economic uncertainties such as Covid- 19 and Brexit. All audits assess and challenge the reasonableness of estimates made by the Directors and the related disclosures and the appropriateness of the going concern basis of preparation of the financial statements. All of these depend on assessments of the future economic environment and the Trust's future operational arrangements.

Covid-19 and Brexit are amongst the most significant economic events currently faced by the UK, and at the date of this report their effects are subject to unprecedented levels of uncertainty, with the full range of possible outcomes and their impacts unknown. We applied a standardised firm-wide approach in response to these uncertainties when assessing the Trust's

future operational arrangements. However, no audit should be expected to predict the unknowable factors or all possible future implications for an entity associated with these particular events..

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.

In our evaluation of the Directors' conclusions, and in accordance with the expectation set out within the Department of Health and Social Care Group Accounting Manual 2019 to 2020 that the Trust's financial statements shall be prepared on a going concern basis, we considered the risks associated with the Trust's operating activities, including effects arising from macro-economic uncertainties such as Covid- 19 and Brexit. We analysed how those risks might affect the Trust's financial resources or ability to continue operations over the period of at least twelve months from the date when the financial statements are authorised for issue. In accordance with the above, we have nothing to report in these respects.

However, as we cannot predict all future events or conditions and as subsequent events may result in outcomes that are inconsistent with judgements that were reasonable at the time they were made, the absence of reference to a material uncertainty in this auditor's report is not a guarantee that the Trust will continue in operation.

Emphasis of Matter - effects of Covid-19 on the valuation of land and buildings

We draw attention to note 20 of the financial statements, which describes the effects of the Covid-19 pandemic on the valuation of land and buildings as at 31 March 2020. As disclosed in the note, the Trust's external valuer reported a "material valuation uncertainty" in the valuation report due to uncertainties in the markets caused by COVID-19. The valuer has continued to exercise professional judgement in providing the valuation and this remains the best information available to the Trust. Our opinion is not modified in respect of this matter.

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 in April 2015 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 2019 to 2020 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 22 June 2020 we referred a matter to the Secretary of State under section 30(b) of the Local Audit and Accountability Act 2014 in relation to Maidstone and Tunbridge Wells NHS Trust's ongoing breach of its break-even duty for the three year period ending 31 March 2020. In this letter we also reported a planned ongoing breach of the breakeven duty in 2020/21 under section 30(a) of the Local Audit and Accountability Act 2014.

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 2020.

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 April 2020, 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 2020, 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

23 June 2020

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
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 (DTOC)	According to NHS England, a 'delayed transfer of care' occurs when an adult inpatient in hospital is ready to go home or move to a less acute stage of care but is prevented from doing so. Sometimes referred to in the media as 'bed-blocking', delayed transfers of care are a problem as they reduce the number of beds available to other patients who need

Term	Definition/explanation
	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
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
Integrated Care System (ICS)	ICSs brings together local organisations to redesign care and improve population health, creating shared leadership and action to deliver the 'triple integration' of primary and specialist care, physical and mental health services, and health with social care.
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
Marginal Rate Emergency Tariff (MRET)	An adjustment made to the amount a provider of emergency services is reimbursed to encourage health economies to redesign emergency services and manage patient demand for those services. A provider is paid a percentage of the national price for each patient admitted as an emergency over and above a set threshold.
NHS England (NHSE)	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 pathway	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)
Provider Sustainability Fund (PSF)	A fund held by NHS England and NHS Improvement that is available to providers when they that met their control total.
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
Sustainability and Transformation Partnership (STP)	STPs are 44 areas covering all of England, where local NHS organisations and councils have drawn up proposals to improve health and care in the areas they serve.STP can also stand for 'sustainability and transformation plan', plans drawn up in each of these areas setting out practical ways to improve NHS services and population health in every part of England. They aim to help meet a 'triple challenge' set out in the NHS Five Year Forward View – better health, transformed quality of care delivery, and sustainable finances.

NHS
Maidstone and Tunbridge Wells
NHS Trust

Financial Statements for 2019/20

taking pride

MTW
exceptional people, outstanding care

Statement of Comprehensive Income

	Note	2019/20 £000	2018/19 £000
Operating income from patient care activities	3	457,588	403,761
Other operating income	4	55,468	69,408
Operating expenses	9, 10	-491,848	-450,488
Operating surplus/(deficit) from continuing operations		**21,208**	**22,681**
Finance income	13	309	164
Finance expenses	14	-15,729	-15,825
PDC dividends payable		-633	-688
Net finance costs		**-16,053**	**-16,349**
Other gains / (losses)	15	73	13,542
Surplus / (deficit) for the year from continuing operations		**5,228**	**19,874**
Surplus / (deficit) on discontinued operations and the gain / (loss) on disposal of discontinued operations	15	**0**	**0**
Surplus / (deficit) for the year		**5,228**	**19,874**
Other comprehensive income			
Will not be reclassified to income and expenditure:			
Impairments	8	-1,663	2,071
Revaluations	20	76	1,040
Total comprehensive income / (expense) for the period		**3,641**	**22,985**
Adjusted financial performance (control total basis):			
Surplus / (deficit) for the period		5,228	19,874
Remove net impairments not scoring to the Departmental expenditure limit		2,748	780
Remove I&E impact of capital grants and donations		-389	-330
Remove 2018/19 post audit PSF reallocation (2019/20 only)		-583	0
Adjusted financial performance surplus / (deficit)		**7,004**	**20,324**

Statement of Financial Position

	Note	31 March 2020 £000	31 March 2019 £000
Non-current assets			
Intangible assets	17	3,957	3,345
Property, plant and equipment	18	291,187	292,265
Receivables	26	2,925	1,401
Total non-current assets		**298,069**	**297,011**
Current assets			
Inventories	25	8,893	7,820
Receivables	26	35,156	34,429
Cash and cash equivalents	29	3,355	10,406
Total current assets		**47,404**	**52,655**
Current liabilities			
Trade and other payables	30	-38,944	-28,017
Borrowings	32	-33,560	-24,985
Provisions	35	-1,726	-1,467
Other liabilities	31	-3,172	-2,580
Total current liabilities		**-77,402**	**-57,049**
Total assets less current liabilities		**268,071**	**292,617**
Non-current liabilities			
Borrowings	32	-189,879	-223,367
Provisions	35	-1,675	-989
Total non-current liabilities		**-191,554**	**-224,356**
Total assets employed		**76,517**	**68,261**
Financed by			
Public dividend capital		216,405	211,790
Revaluation reserve		30,139	31,782
Income and expenditure reserve		-170,027	-175,311
Total taxpayers' equity		**76,517**	**68,261**

The notes on pages 6 to 47 form

Name

Position Chief Executive Officer

Date 18th June 2020

Statement of Changes in Equity for the year ended 31 March 2020

	Public dividend capital	Revaluation reserve	Income and expenditure reserve	Total
	£000	£000	£000	£000
Taxpayers' and others' equity at 1 April 2019 - brought forward	**211,790**	**31,782**	**-175,311**	**68,261**
Surplus/(deficit) for the year	0	0	5,228	**5,228**
Impairments	0	-1,663	0	**-1,663**
Revaluations	0	76	0	**76**
Transfer to retained earnings on disposal of assets	0	-56	56	**0**
Public dividend capital received	4,615	0	0	**4,615**
Taxpayers' and others' equity at 31 March 2020	**216,405**	**30,139**	**-170,027**	**76,517**

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

	Public dividend capital	Revaluation reserve	Income and expenditure reserve	Total
	£000	£000	£000	£000
Taxpayers' and others' equity at 1 April 2018 - brought forward	**207,329**	**29,852**	**-196,366**	**40,815**
Surplus/(deficit) for the year	0	0	19,874	**19,874**
Impairments	0	2,071	0	**2,071**
Revaluations	0	1,040	0	**1,040**
Transfer to retained earnings on disposal of assets	0	-1,181	1,181	**0**
Public dividend capital received	4,461	0	0	**4,461**
Taxpayers' and others' equity at 31 March 2019	**211,790**	**31,782**	**-175,311**	**68,261**

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.

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	2019/20 £000	2018/19 £000
Cash flows from operating activities			
Operating surplus / (deficit)		21,208	22,681
Non-cash income and expense:			
Depreciation and amortisation	9	13,022	12,987
Net impairments	8	2,748	780
Income recognised in respect of capital donations	4	-890	-740
(Increase) / decrease in receivables and other assets		-1,737	2,970
(Increase) / decrease in inventories		-1,073	-68
Increase / (decrease) in payables and other liabilities		9,218	-14,927
Increase / (decrease) in provisions		944	-393
Net cash flows from / (used in) operating activities		**43,440**	**23,290**
Cash flows from investing activities			
Interest received		309	164
Purchase of intangible assets		-1,536	-1,288
Purchase of PPE and investment property		-13,199	-12,989
Sales of PPE and investment property		73	17,534
Receipt of cash donations to purchase assets		890	740
Net cash flows from / (used in) investing activities		**-13,463**	**4,161**
Cash flows from financing activities			
Public dividend capital received		4,615	4,461
Movement on loans from DHSC		-19,082	-2,174
Movement on other loans		-372	1,376
Capital element of PFI, LIFT and other service concession payments		-5,426	-5,284
Interest on loans		-1,387	-1,588
Other interest		-4	-6
Interest paid on PFI, LIFT and other service concession obligations		-14,370	-14,237
PDC dividend (paid) / refunded		-1,002	-1,066
Net cash flows from / (used in) financing activities		**-37,028**	**-18,518**
Increase / (decrease) in cash and cash equivalents		**-7,051**	**8,933**
Cash and cash equivalents at 1 April - brought forward		**10,406**	**1,473**
Cash and cash equivalents at 31 March	29.1	**3,355**	**10,406**

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 2019/20 issued by the Department of Health and Social Care. The accounting policies contained in the GAM follow International Financial Reporting Standards to the extent that they are meaningful and appropriate to the NHS, as determined by HM Treasury, which is advised by the Financial Reporting Advisory Board. Where the GAM permits a choice of accounting policy, the accounting policy that is judged to be most appropriate to the particular circumstances of the Trust for the purpose of giving a true and fair view has been selected. The particular policies adopted are described below. These have been applied consistently in dealing with items considered material in relation to the accounts.

Accounting convention

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

Note 1.2 Going concern

These accounts have been prepared on a going concern basis.

The DHSC 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 2019/20 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. There are no plans to dissolve the Trust or to cease services without transfer to any other NHS body.

-The Trust submitted its 5 year Long Term Plan for operational and financial plans 2019/20 to 2023/24 in October 2019 on a going concern basis. This was agreed as part of the Kent & Medway system-wide STP Long Term Plan. The MTW element of the first year of the plan, 2019/20, has been exceeded with the Trust delivering a £7m surplus including PSF and MRET.

- The Trust continues to fully participate in the local ICS/STP and ICP partnerships, leading the West Kent ICP and working in partnership in the West Kent Alliance and as a prime provider. The Trust is leading some of the significant STP Work-stream areas and is a key player in consideration of the shape of sustainable 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 impact of COVID-19 has paused the national business planning process. Nationally mandated interim financial regime and contracting arrangements are in place between the Trust and Commissioners from April to July 2020 to enable the Trust to deliver financial breakeven during this period. This arrangement consists of a combination of block payments based on 2019/20 clinical income plus top up payments to match expected expenditure and to cover additional costs related to COVID-19, with no required Cost Improvement efficiencies. The Trust received initial revenue and capital payments for Covid-19 costs in 2019/20. A double block payment from CCGs was made in April to ensure all Trusts had sufficient liquidity to meet debts and to make payments to trade creditors on an enhanced 7 day cycle. This double block payment has meant that the Trust has more cash at its disposal than it would have had from traditional contracting and payment approaches. It is currently anticipated that business planning and contracting will resume during 2020/21 but details of the future financial framework are not yet confirmed. There is no expectation that Trust services will not continue to be provided.

- The Trust's cash-flow plans for 2020/21 do not include any assumptions of additional required working capital finance. The existing working capital loans will be converted to PDC in September 2020 line with the national changes to the debt regime. The Trust is working with the local ICS/STP to agree capital plans for 2020/21 following the change in capital regime announced in April 2020, including a greater role for the management and prioritisation of resource by the ICS/STP patches.

- There are current uncertainties about the future financial framework that the Trust will operate in post Covid 19, but the Trust does not consider there are any material uncertainties in relation to its status as a going concern.

Note 1.3 Interests in other entities

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 1.4 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).

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. This accrual is disclosed as a contract receivable as entitlement to payment for work completed is usually only dependent on the passage of time.

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.

Where the effects of other practical expedients mandated by the GAM are material, these should be disclosed as accounting policies. These include: (1) As per paragraph 121 of the Standard the Trust does not disclose information regarding performance obligations part of a contract that has an original expected duration of one year or less. (2) The GAM does not require the Trust to disclose information where revenue is recognised in line with the practical expedient offered in paragraph B16 of the Standard where the right to consideration corresponds directly with value of the performance completed to date. (3) The GAM has mandated the exercise of the practical expedient offered in C7A of the Standard that requires the Trust to reflect the aggregate effect of all contracts modified before the date of initial application.

Revenue from research contracts

Where research contracts fall under IFRS 15, revenue is recognised as and when performance obligations are satisfied. For some contracts, it is assessed that the revenue project constitutes one performance obligation over the course of the multi-year contract. In these cases it is assessed that the Trust's interim performance does not create an asset with alternative use for the Trust, and the Trust has an enforceable right to payment for the performance completed to date. It is therefore considered that the performance obligation is satisfied over time, and the Trust recognises revenue each year over the course of the contract. Some research income alternatively falls within the provisions of IAS 20 for government grants.

NHS injury cost recovery scheme

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

Provider sustainability fund (PSF) and Marginal rate emergency tariff (MRET)

The PSF and MRET enable providers to earn income linked to the achievement of financial controls and performance targets. Income earned from the funds is accounted for as variable consideration.

Education Income

The Trust receives income from Health Education England for Education (HEE) for the training of medical and non medical trainees as well as other associated training support costs. Revenue is in respect of training provided and is recognised when performance obligations are satisfied when training has been performed. All performance obligation are undertaken within the financial year and is as agree and invoiced to HEE - see note 4.

Note 1.5 Other forms of income

Grants and donations

Government grants are grants from government bodies other than income from commissioners or trusts for the provision of services. Where a grant is used to fund revenue expenditure it is taken to the Statement of Comprehensive Income to match that expenditure. Where the grants is used to fund capital expenditure, it is credited to the consolidated statement of comprehensive income once conditions attached to the grant have been met. Donations are treated in the same way as government grants.

Apprenticeship service income

The value of the benefit received when accessing funds from the Government's apprenticeship service is recognised as income at the point of receipt of the training service. Where these funds are paid directly to an accredited training provider from the Trust's Digital Apprenticeship Service (DAS) account held by the Department for Education, the corresponding notional expense is also recognised at the point of recognition for the benefit.

Note 1.6 Expenditure on employee benefits

Short-term employee benefits

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

Pension costs

NHS Pension Scheme

Past and present employees are covered by the provisions of the two NHS Pension Schemes. Both schemes are unfunded, defined benefit schemes that cover NHS employer, general practices and other bodies, allowed under the direction of Secretary of State for Health and Social Care in England and Wales. The scheme is not designed in a way that would enable employers to identify their share of the underlying scheme assets and liabilities. Therefore, the scheme is accounted for as though it is a defined contribution scheme: the cost to the trust is taken as equal to the employer's pension contributions payable to the scheme for the accounting period. The contributions are charged to operating expenses as 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 3% for 2019/20. The rate remains at 3% from April 2020.

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

Note 1.7 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 1.8 Discontinued operations

Discontinued operations occur where activities either cease without transfer to another entity, or transfer to an entity outside of the boundary of Whole of Government Accounts, such as private or voluntary sectors. Such activities are accounted for in accordance with IFRS 5. Activities that are transferred to other bodies within the boundary of Whole of Government Accounts are ‘machinery of government changes’ and treated as continuing operations.
The Trust does not have any discontinued operations.

Note 1.9 Property, plant and equipment

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, eg, plant and equipment, then these components are treated as separate assets and depreciated over their own useful lives. 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.

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.

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.

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.

For specialised assets, current value in existing use is interpreted as the present value of the asset's remaining service potential, which is assumed to be at least equal to the cost of replacing that service potential. Specialised assets are therefore valued at their depreciated replacement cost (DRC) on a modern equivalent asset (MEA) basis. An MEA basis assumes that the asset will be replaced with a modern asset of equivalent capacity and location requirements of the services being provided. Assets held at depreciated replacement cost have been valued on an alternative site basis where this would meet the location requirements.

Valuation guidance issued by the Royal Institute of Chartered Surveyors states that valuations are performed net of VAT where the VAT is recoverable by the entity. This basis has been applied to the trust's Private Finance Initiative (PFI) scheme where the construction is completed by a special purpose vehicle and the costs have recoverable VAT for the trust.

The financial year 2019/20 is the fifth 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 full on site valuation of the Trust's Land and Building assets at 31st March 2020. The lead relationship partner from Montagu Evans LLP is qualified to BSc MRICS. The results are recorded in the property plant and equipment notes 18 and 20.

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, borrowings 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.

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 has 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.

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 expenditure.

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

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

Impairments

In accordance with the GAM, impairments that arise from a clear consumption of economic benefits or of service potential in the asset are charged to operating expenses. A compensating transfer is made from the revaluation reserve to the income and expenditure reserve of an amount equal to the lower of (i) the impairment charged to operating expenses; and (ii) the balance in the revaluation reserve attributable to that asset before the impairment.

An impairment that arises from a clear consumption of economic benefit or of service potential is reversed when, and to the extent that, the circumstances that gave rise to the loss is reversed. Reversals are recognised in operating expenditure to the extent that the asset is restored to the carrying amount it would have had if the impairment had never been recognised. Any remaining reversal is recognised in the revaluation reserve. Where, at the time of the original impairment, a transfer was made from the revaluation reserve to the income and expenditure reserve, an amount is transferred back to the revaluation reserve when the impairment reversal is recognised.

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

De-recognition

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

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.

Private Finance Initiative (PFI) transactions

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

The annual contract payments are apportioned between the repayment of the liability, a finance cost, the charges for services and lifecycle replacement of components of the asset. The element of the annual unitary payment increase due to cumulative indexation is treated as contingent rent and is expensed as incurred.

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

Services received

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

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.

PFI liability

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

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

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

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

Lifecycle replacement

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.

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

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

Other assets contributed by the NHS Trust to the operator

Assets contributed (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.

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	5	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

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.

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 (set out in IAS 38):

• 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

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.

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 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.

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

Amortisation

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

Useful lives 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
Information technology	2	7
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

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 Energy Efficiency Scheme (formally known as the "Carbon Reduction Commitment") was closed on the 31st March 2019. It has been replaced by the Climate Change Levy (CCL).

Expenditure is recognised in line with the levy charged within the utility billing for energy consumed in accordance with the appropriate chargeable rates.

Note 1.15 Financial assets and financial liabilities

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.

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 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.

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

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.

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.

The Trust as a Lessee

Finance leases

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

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.

Operating leases

Operating lease payments are recognised as an expense on a straight-line basis over the lease term. Lease incentives are recognised initially in other liabilities on the statement of financial position 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.

The Trust as a 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 HM Treasury's discount rates effective for 31 March 2020:

		Nominal rate
Short-term	Up to 5 years	0.51%
Medium-term	After 5 years up to 10 years	0.55%
Long-term	Exceeding 10 years	1.99%

HM Treasury provides discount rates for general provisions on a nominal rate basis. Expected future cash flows are therefore adjusted for the impact of inflation before discounting using nominal rates. The following inflation rates are set by HM Treasury, effective 31 March 2020:

	Inflation rate
Year 1	1.90%
Year 2	2.00%
Into perpetuity	2.00%

Early retirement provisions and injury benefit provisions both use the HM Treasury's pension discount rate of minus 0.5% in real terms.

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; or

• present obligations arising from past events but for which it is not probable that a transfer of economic benefits will arise or for which the amount of the obligation cannot be measured with sufficient reliability.

Note 1.19 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.

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 and grant funded assets,
(ii) average daily cash balances held with the Government Banking Services (GBS) and National Loans Fund (NLF) deposits, excluding cash balances held in GBS accounts that relate to a short-term working capital facility, and
(iii) any PDC dividend balance receivable or payable.

In accordance with the requirements laid down by the Department of Health and Social Care (as the issuer of PDC), the dividend for the year is calculated on the actual average relevant net assets as set out in the "pre-audit" version of the annual accounts. The dividend 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 in which the Trust has no beneficial interest (such as money held on behalf of patients) are not recognised in the accounts. 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.

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.

The Trust has recognised no transfers under this policy in 2019/20.

Note 1.27 Early adoption of standards, amendments and interpretations

No new accounting standards or revisions to existing standards have been early adopted in 2019/20.

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

IFRS 16 Leases

IFRS 16 Leases will replace *IAS 17 Leases, IFRIC 4 Determining whether an arrangement contains a lease* and other interpretations and is applicable in the public sector for periods beginning 1 April 2021. The standard provides a single accounting model for lessees, recognising a right of use asset and obligation in the statement of financial position for most leases: some leases are exempt through application of practical expedients explained below. For those recognised in the statement of financial position the standard also requires the remeasurement of lease liabilities in specific circumstances after the commencement of the lease term. For lessors, the distinction between operating and finance leases will remain and the accounting will be largely unchanged.

IFRS 16 changes the definition of a lease compared to IAS 17 and IFRIC 4. The trust will apply this definition to new leases only and will grandfather its assessments made under the old standards of whether existing contracts contain a lease.

On transition to IFRS 16 on 1 April 2021, the trust will apply the standard retrospectively with the cumulative effect of initially applying the standard recognised in the income and expenditure reserve at that date. For existing operating leases with a remaining lease term of more than 12 months and an underlying asset value of at least £5,000, a lease liability will be recognised equal to the value of remaining lease payments discounted on transition at the trust's incremental borrowing rate (1.27%). The related right of use asset will be measured equal to the lease liability adjusted for any prepaid or accrued lease payments. For existing peppercorn leases not classified as finance leases, a right of use asset will be measured at current value in existing use or fair value. The difference between the asset value and the calculated lease liability will be recognised in the income and expenditure reserve on transition. No adjustments will be made on 1 April 2020 for existing finance leases.

For leases commencing in 2021/22, the trust will not recognise a right of use asset or lease liability for short term leases (less than or equal to 12 months) or for leases of low value assets (less than £5,000). Right of use assets will be subsequently measured on a basis consistent with owned assets and depreciated over the length of the lease term.

The trust has estimated the impact of applying IFRS 16 in 2021/22 on the opening statement of financial position and the in-year impact on the statement of comprehensive income and capital additions as follows:

	£000
Estimated impact on 1 April 2021 statement of financial position	
Additional right of use assets recognised for existing operating leases	53,282
Additional lease obligations recognised for existing operating leases	-52,080
Changes to other statement of financial position line items	0
Net impact on net assets on 1 April 2021	**1,202**
Estimated in-year impact in 2021/22	
Additional depreciation on right of use assets	-4,941
Additional finance costs on lease liabilities	-792
Lease rentals no longer charged to operating expenditure	5,084
Other impact on income / expenditure	60
Estimated impact on surplus / deficit in 2021/22	**-589**
Estimated increase in capital additions for new leases commencing in 2021/22	**0**

The "estimated increase in capital additions for new leases commencing in 2021/22" is zero as currently the Trust has no plans for any new leases that will be entered into within 2021/22.

Note 1.29 Critical judgements in applying accounting policies

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

For 2019/20 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.

The financial statements have been prepared on a going concern basis as set out in note 1.2. In preparing the financial statements the directors have considered the Trust's overall financial position and expectation of future service continuity and financial arrangements.

- 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 DHSC 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 20 for further information.

- 'The Trust has entered into three contracts in 2019/20 for the provision of modular buildings; the Acute Medical Unit (AMU) and two single storey car parks, one on each main site. The contracts have been reviewed and assessed as containing leases under IFRIC 4 and the lease type has been tested in relation to the "tests" set out in IAS 17. All three leases have been assessed as not meeting the criteria for a finance lease and the Trust is therefore accounting for them as operating leases in 2019/20. The AMU reached completion and became available for use on the 20th February 2020. Practical completion on the two car parks was reached at the end of March 2020.

- Charitable Funds remain not material for the Trust and have not been consolidated (see note 45).

Note 1.30 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:
Material areas including estimates within the 2019/20 accounts are as follows:

Property, Plant and Equipment valuation (see accounting policy note 1.9 and also accounts note 20).

- IFRS 15 estimations in determining transaction price or satisfaction of performance obligations where they are satisfied over time. Further detail is given in policy 1.4 Revenue from contracts with customers.
- Pension fund valuation (see note 11).

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 89% 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 1.4

Note 3.1 Income from patient care activities (by nature)	2019/20	2018/19
	£000	£000
Acute services		
Elective income	77,913	61,933
Non elective income	131,006	116,383
First outpatient income	29,892	28,101
Follow up outpatient income	34,543	34,188
A & E income	28,874	24,332
High cost drugs income from commissioners (excluding pass-through costs)	44,432	42,751
Other NHS clinical income	91,582	80,969
All services		
Private patient income	1,322	1,459
Agenda for Change pay award central funding*	0	4,086
Additional pension contribution central funding**	11,381	0
Other clinical income	6,643	9,559
Total income from activities	**457,588**	**403,761**

* Additional costs of the Agenda for Change pay reform in 2018/19 received central funding. From 2019/20 this funding is incorporated into tariff for individual services.

** The employer contribution rate for NHS pensions increased from 14.3% to 20.6% (excluding administration charge) from 1 April 2019. For 2019/20, NHS providers continued to pay over contributions at the former rate with the additional amount being paid over by NHS England on providers' behalf. The full cost and related funding have been recognised in these accounts.

Elective Income – The movement between years represents the introduction of the Prime Provider Model to take responsibility for management of Independent Sector activity in West Kent and has increased Trust revenues by circa £15m. There is corresponding payments within note 7.1

Non Elective Income – The movement between years is largely driven by the increased national investment in tariffs and growth in activity volumes.

Note 3.2 Income from patient care activities (by source)

	2019/20	2018/19
Income from patient care activities received from:	**£000**	**£000**
NHS England	96,528	72,099
Clinical commissioning groups	349,459	316,139
Department of Health and Social Care	0	4,086
Other NHS providers	3,636	3,683
NHS other	0	0
Local authorities	4,563	4,486
Non-NHS: private patients	1,322	1,459
Non-NHS: overseas patients (chargeable to patient)	378	260
Injury cost recovery scheme	930	702
Non NHS: other	772	847
Total income from activities	**457,588**	**403,761**
Of which:		
Related to continuing operations	457,588	403,761
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 20.95% for Maidstone Hospital and 18.32% of Tunbridge Wells Hospital (21.64% Maidstone Hospital and 15.56% Tunbridge Wells in 2018/19). This provision reflect expected rates of collection.

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

	2019/20	2018/19
	£000	£000
Income recognised this year	378	260
Cash payments received in-year	182	293
Amounts added to provision for impairment of receivables	57	49
Amounts written off in-year	0	17

Note 4 Other operating income

	2019/20			2018/19			
	Contract income	Non-contract income	Total	Contract income	Non-contract income	Total	
	£000	£000	£000	£000	£000	£000	
Research and development	1,459	0	**1,459**	1,545	0	**1,545**	
Education and training	10,420	268	**10,688**	10,210	105	**10,315**	
Non-patient care services to other bodies	15,042	0	**15,042**	21,581	0	**21,581**	*
Provider sustainability fund (PSF)	8,234	0	**8,234**	21,037	0	**21,037**	
Marginal rate emergency tariff funding (MRET)	6,199	0	**6,199**	0	0	**0**	
Receipt of capital grants and donations	0	890	**890**	0	740	**740**	
Rental revenue from operating leases	0	187	**187**	0	186	**186**	*
Other income	12,769	0	**12,769**	14,004	0	**14,004**	*
Total other operating income	**54,123**	**1,345**	**55,468**	**68,377**	**1,031**	**69,408**	
Of which:							
Related to continuing operations			**55,468**			**69,408**	
Related to discontinued operations			**0**			**0**	

* Prior year income balances have been restated following a review as it was identified an element of rental revenue was reported under "other income" and "non-patient care services", this has been restated and now appears on the rental revenue line.

Included within other operating income for 2019-20 is £8.2m of Provider Sustainability and Transformation Funding (PSF), of which £7.65m relates to Core PSF and £0.58m of 2018/19 PSF reallocation.

Marginal rate emergency tariff (MRET) - the treatment of MRET has changed in 2019-20 so that it is now paid as a central payment from NHS England. In previous years it was included within non-elective income within note 3.1.

Included within other income is revenue from NHS England for 2019-20 is £8m of Central PFI financial support (2018-19 £8m). The Trust's 2020-21 plan includes £8m recurrent central PFI support.

Further analysis of "other income"	**2019/20**	2018/19
	£000	£000
PFI support income	**8,000**	8,000
Car Parking income	**2,456**	2,373
Catering Income	**952**	1,006
Staff Accommodation	**0**	448
Other	**1,361**	2,227
	12,769	14,054

In 2018/19 the Trust disposed of its staff accommodation at the end of the financial year and entered into two sale and leaseback arrangements. The Trust continues to manage the tenancies and collect the income. For 2018-19 this income was direct other income; for 2019-20 the equivalent income is now netted against the operating lease payments and disclosed in note 11.2 (£626k).

Note 5 Additional information on contract revenue (IFRS 15) recognised in the period

	2019/20	2018/19
	£000	£000
Revenue recognised in the reporting period that was included in within contract liabilities at the previous period end	2,580	2,620
Revenue recognised from performance obligations satisfied (or partially satisfied) in previous periods	0	0

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.

	2019/20	2018/19
Total:	£000	£000
Income	3,325	4,147
Full cost	-2,888	-2,894
Surplus / (deficit)	**437**	**1,253**
Car Parking:		
Income	2,456	2,373
Full cost	-2,191	-1,941
Surplus/(Deficit)	**265**	432
Catering:		
Income	952	1,006
Full cost	-697	-522
Surplus/(Deficit)	**255**	484

Note 7.1 Other auditor remuneration

	2019/20	2018/19
	£000	£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 1.3) the fee for the independent examination of the charitable fund accounts is charged directly to those funds. The total charitable funds income and costs are reported in note 45 as a related party.

Note 7.2 Limitation on auditor's liability

The limitation on auditor's liability for external audit work is £2m (2018/19: £2m).

Note 8 Impairment of assets

	2019/20	2018/19
	£000	£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	2,748	780
Other	0	0
Total net impairments charged to operating surplus / deficit	**2,748**	**780**
Impairments charged to the revaluation reserve	1,663	-2,071
Total net impairments	**4,411**	**-1,291**

The Trust commissioned its independent professional valuers to undertake an full quinquennial valuation as at the 31st March 2020 to support its assessment of year end property valuations. The result of the valuation has been a net decrease in property values leading to a net impairment of £2.2m charged to the Income and Expenditure account together with a net impairment of £1.7m charged to the revaluation reserve. Both the gross impairments and the reversals are disclosed in note 18.1.

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 1.9. For 2019/20 the assessment totalled £0.565m.

Note 9 Operating expenses

	2019/20	2018/19
	£000	£000
Purchase of healthcare from NHS and DHSC bodies*	6,923	12,078
Purchase of healthcare from non-NHS and non-DHSC bodies**	15,798	3,823
Purchase of social care	0	0
Staff and executive directors costs	299,931	270,737
Remuneration of non-executive directors	94	81
Supplies and services - clinical (excluding drugs costs)	37,005	36,349
Supplies and services - general	5,238	5,368
Drug costs (drugs inventory consumed and purchase of non-inventory drugs)	55,034	52,784
Consultancy costs*	625	2,283
Establishment	1,657	2,075
Premises	17,820	17,376
Transport (including patient travel)	2,522	2,061
Depreciation on property, plant and equipment	11,813	12,074
Amortisation on intangible assets	1,209	913
Net impairments	2,748	780
Movement in credit loss allowance: contract receivables / contract assets	471	76
Change in provisions discount rate(s)	35	-9
Audit fees payable to the external auditor		
audit services- statutory audit	84	73
other auditor remuneration (external auditor only)	9	9
Internal audit costs	147	148
Clinical negligence	17,558	18,572
Legal fees	330	258
Insurance	453	362
Education and training	1,884	1,571
Rentals under operating leases	3,372	2,028
Charges to operating expenditure for on-SoFP IFRIC 12 schemes (e.g. PFI / LIFT)	5,199	4,942
Car parking & security	1,075	914
Hospitality	9	21
Losses, ex gratia & special payments	17	18
Other services, eg external payroll	308	289
Other	2,480	2,434
Total	**491,848**	**450,488**
Of which:		
Related to continuing operations	491,848	450,488
Related to discontinued operations	0	0

* reduction in expenditure due to the Trust ceasing to host the STP

** Purchase of healthcare from non-NHS and non DHSC bodies relates to the Trusts role as Prime Provider including related Independent outsourcing costs.

The audit fees included within Note 7.1 above are reported as the gross position, the value excluding VAT for 2019/20 is £70k (2018/19 £61k).

Note 10.1 Employee benefits

	2019/20 Total £000	2018/19 Total £000
Salaries and wages	219,594	202,086
Social security costs	23,565	21,650
Apprenticeship levy	1,157	1,042
Employer's contributions to NHS pensions*	37,561	24,164
Pension cost - other	21	11
Other post employment benefits	0	0
Other employment benefits	0	0
Termination benefits	0	0
Temporary staff (including agency)	20,109	22,874
Total gross staff costs	**302,007**	**271,827**
Recoveries in respect of seconded staff	0	0
Total staff costs	**302,007**	**271,827**
Of which		
Costs capitalised as part of assets	2,076	1,090

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.

* The employer contribution rate for NHS pensions increased from 14.3% to 20.6% totalling £11.4m (excluding administration charge) from 1 April 2019. For 2019/20, NHS providers continued to pay over contributions at the former rate with the additional amount being paid over by NHS England on providers' behalf. The full cost and related funding have been recognised in these accounts.

Note 10.2 Retirements due to ill-health

During 2019/20 there were no early retirements from the trust agreed on the grounds of ill-health (1 in the year ended 31 March 2019). The estimated additional pension liabilities of these ill-health retirements is 0k (£23k in 2018/19).

These estimated costs are calculated on an average basis and will be borne by the NHS Pension Scheme.

Note 11 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 and Social Care in England and Wales. They are not designed to be run in a way that would enable NHS bodies to identify their share of the underlying scheme assets and liabilities. Therefore, each scheme is accounted for as if it were a defined contribution scheme: the cost to the NHS body of participating in each scheme is taken as equal to the contributions payable to that scheme for the accounting period.

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

a) Accounting valuation

A valuation of scheme liability is carried out annually by the scheme actuary (currently the Government Actuary's Department) as at the end of the reporting period. This utilises an actuarial assessment for the previous accounting period in conjunction with updated membership and financial data for the current reporting period, and is accepted as providing suitably robust figures for financial reporting purposes. The valuation of the scheme liability as at 31 March 2020, is based on valuation data as at 31 March 2019, updated to 31 March 2020 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 to 20.6%, and the Scheme Regulations were amended accordingly.

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 3% for 2019/20 (3% for 2020/21). Trust contributions under the NEST scheme for the 2019/20 financial year totalled £21k (£10k 2018/19).

Note 12 Operating leases

Note 12.1 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 and also receives income from various shops in the reception area of Maidstone Hospital.

	2019/20	2018/19	
	£000	£000	
Operating lease revenue			
Minimum lease receipts	187	186	*
Contingent rent	0	0	
Other	0	0	
Total	**187**	**186**	*

	31 March 2020	31 March 2019	
	£000	£000	
Future minimum lease receipts due:			
- not later than one year;	187	187	*
- later than one year and not later than five years;	748	748	*
- later than five years.	1,001	1,188	*
Total	**1,936**	**2,123**	*

* last years values restated to incorporate other rental income previously not disclosed within this note.

Note 12.2 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 Top five material leases are given in detail below:

Apogee - Lease of photocopiers and printers under a managed service arrangement, £707k (£713k 2018-19). The contract is expected to complete in March 2024.

MGIF - lease of Springwood Road staff accommodation. The Trust entered into an operating lease arrangement on the 29th March 2019 with MGIF including 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 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 rent is £537.6k per annum; the rent for the new accommodation will be £960k per annum, subject to RPI uplifts annually, with a cap and collar arrangement. The Trust manages the tenancies with staff and receives the sublease rentals.

WGIF - lease of 32 High Street, Pembury for staff residences, rental of £240k per annum, subject to 5 yearly RPI reviews. The Trust entered into a 25 year operating lease on the 21st February 2019 expiring in February 2044, with a landlord only break clause in February 2033. The Trust manages the tenancies with staff and receives the sublease rentals.

MCH Ltd - operating lease of a modular Acute Medical Unit at Maidstone Hospital for an 8 year term that commenced on the 20th February 2020. The annual rental is a fixed at £993k.

MCH Ltd - two individual operating leases for single storey modular car parks, one at Maidstone Hospital and one at Tunbridge Wells Hospital. The arrangement for each lease is for seven years and commenced on the 31st March 2020. The annual rent for the Maidstone car park is £379k and for Tunbridge Wells is £313k. Both rental levels are fixed for the period.

	2019/20	2018/19
	£000	£000
Operating lease expense		
Minimum lease payments	3,998	2,051
Contingent rents	0	0
Less sublease payments received	-626	-186
Total	**3,372**	**1,865**

	31 March 2020	31 March 2019
	£000	£000
Future minimum lease payments due:		
- not later than one year;	5,013	2,541
- later than one year and not later than five years;	16,945	9,481
- later than five years.	47,234	43,209
Total	**69,192**	**55,231**
Future minimum sublease payments to be received	-44,715	-45,404

Note 13 Finance income

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

	2019/20	2018/19
	£000	£000
Interest on bank accounts	309	164
Interest income on finance leases	0	0
Interest on other investments / financial assets	0	0
Other finance income	0	0
Total finance income	**309**	**164**

Note 14.1 Finance expenditure

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

	2019/20	2018/19
	£000	£000
Interest expense:		
Loans from the Department of Health and Social Care	1,354	1,582
Other loans	0	0
Overdrafts	0	0
Finance leases	0	0
Interest on late payment of commercial debt	4	6
Main finance costs on PFI and LIFT schemes obligations	10,110	10,389
Contingent finance costs on PFI and LIFT scheme obligations	4,260	3,848
Total interest expense	**15,728**	**15,825**
Unwinding of discount on provisions	1	0
Other finance costs	0	0
Total finance costs	**15,729**	**15,825**

Note 14.2 The late payment of commercial debts (interest) Act 1998 / Public Contract Regulations 2015

	2019/20	2018/19
	£000	£000
Total liability accruing in year under this legislation as a result of late payments	0	0
Amounts included within interest payable arising from claims made under this legislation	4	6
Compensation paid to cover debt recovery costs under this legislation	0	0

The Trust made 158 (105 2018/19) late payments incurring interest charges totalling £4k (£6k 2018/19).

Note 15 Other gains / (losses)

	2019/20	2018/19
	£000	£000
Gains on disposal of assets	73	13,542
Losses on disposal of assets	0	0
Total gains / (losses) on disposal of assets	**73**	**13,542**
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
Other gains / (losses)	0	0
Total other gains / (losses)	**73**	**13,542**

All gains on disposals of assets relates to disposals of PPE, primarily on medical equipment and vehicles.

Note 16 Discontinued operations

The Trust has no discontinued operations

Note 17 Intangible assets - 2019/20

	Software licences	Internally generated information technology	Total
	£000	£000	£000
Valuation / gross cost at 1 April 2019 - brought forward	**718**	**9,412**	**10,130**
Additions	1,205	331	**1,536**
Reclassifications	285	0	**285**
Valuation / gross cost at 31 March 2020	**2,208**	**9,743**	**11,951**
Amortisation at 1 April 2019 - brought forward	**527**	**6,258**	**6,785**
Provided during the year	85	1,124	**1,209**
Amortisation at 31 March 2020	**612**	**7,382**	**7,994**
Net book value at 31 March 2020	**1,596**	**2,361**	**3,957**
Net book value at 1 April 2019	**191**	**3,154**	**3,345**

Note 17.1 Intangible assets - 2018/19

	Software licences	Internally generated information technology	Total
	£000	£000	£000
Valuation / gross cost at 1 April 2018 - as previously stated	**616**	**7,868**	**8,484**
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 - as previously stated	**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**

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.

Note 18.1 Property, plant and equipment - 2019/20

	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 2019 - brought forward	**12,114**	**267,652**	**419**	**5,872**	**88,348**	**844**	**20,912**	**2,797**	**398,958**
Additions	0	2,391	0	8,652	3,293	0	1,019	0	**15,355**
Impairments charged to operating expenses	0	-3,808	0	0	0	0	-565	0	**-4,373**
Impairments charged to the revaluation reserve	0	-2,583	0	0	0	0	0	0	**-2,583**
Reversal of impairments credited to operating expenses	0	1,625	0	0	0	0	0	0	**1,625**
Reversal of impairments credited to the revaluation reserve	300	620	0	0	0	0	0	0	**920**
Revaluations	0	-19,940	0	0	0	0	0	0	**-19,940**
Reclassifications	0	0	0	-5,727	4,601	0	841	0	**-285**
Disposals / derecognition	0	0	-419	0	-7,316	-192	-59	0	**-7,986**
Valuation/gross cost at 31 March 2020	**12,414**	**245,957**	**0**	**8,797**	**88,926**	**652**	**22,148**	**2,797**	**381,691**
Accumulated depreciation at 1 April 2019 - brought forward	**0**	**14,052**	**419**	**0**	**70,574**	**840**	**18,690**	**2,118**	**106,693**
Transfers by absorption	0	0	0	0	0	0	0	0	**0**
Provided during the year	0	6,074	0	0	4,384	4	1,095	256	**11,813**
Revaluations	0	-20,016	0	0	0	0	0	0	**-20,016**
Disposals / derecognition	0	0	-419	0	-7,316	-192	-59	0	**-7,986**
Accumulated depreciation at 31 March 2020	**0**	**110**	**0**	**0**	**67,642**	**652**	**19,726**	**2,374**	**90,504**
Net book value at 31 March 2020	**12,414**	**245,847**	**0**	**8,797**	**21,284**	**0**	**2,422**	**423**	**291,187**
Net book value at 1 April 2019	**12,114**	**253,600**	**0**	**5,872**	**17,774**	**4**	**2,222**	**679**	**292,265**

Note - the adjustments within the disposal/derecognmition line relates to housekeeping exercise clearing zero net book value assets for previously disposed PPE

Note 18.2 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 - as previously stated	**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 - as previously stated	**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 18.3 Property, plant and equipment financing - 2019/20

	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 2020									
Owned - purchased	12,414	90,054	0	8,797	19,587	0	2,331	423	**133,606**
Finance leased	0	0	0	0	0	0	0	0	**0**
On-SoFP PFI contracts and other service concession arrangements	0	155,458	0	0	0	0	0	0	**155,458**
Owned - government granted	0	0	0	0	0	0	61	0	**61**
Owned - donated	0	335	0	0	1,697	0	30	0	**2,062**
NBV total at 31 March 2020	**12,414**	**245,847**	**0**	**8,797**	**21,284**	**0**	**2,422**	**423**	**291,187**

Note 18.4 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**
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**

Assets under construction of £8.8m relates to £5m IT projects primarily around Electronic Patient Record System (EPR), £3.6m Plant and Machinery (£1.8m MRI and CT scanners) and £0.2m Building works. These are assets which at 31st March 2020 are classed as "work in progress" and were not available for use at the end of 2019/20.

Note 19 Donations of property, plant and equipment

In the financial year 2019/2020 the Trust purchased medical equipment totalling £890k from Charitable Funds. The main investments were the provision of a helipad at Maidstone Hospital funded by the County Air Ambulance (£300k); the replacement of the florescence imaging equipment for Cancer (£172k) funded by the Peggy Wood Foundation; Urological and surgical cancer equipment funded by the Sutcliffe family donation (£228k); and a variety of medical equipment purchased from donations from the two league of friends organisations £112k).

Note 20 Revaluations of property, plant and equipment

The Trust spent £14.5m on tangible assets and £1.5m on intangible assets from its capital resource in 2019-20. The main items were as follows: one MRI scanner £1m and two CT scanners £0.8m; £3m on Trust-wide medical equipment replacement; £2.2m on backlog maintenance and estates renewals at Maidstone Hospital, with £0.4m of planned lifecycle at the Tunbridge Wells Hospital under the PFI contract; £7.5m on IT and infrastructure projects with £5m on Electronic Patient Record System (EPR) and EPMA projects.

The Trust's depreciation on tangible assets in the year was £11.8m and for intangible assets £1.2m.

Following the 2018-19 audit the Trust had a recommendation to carry out a housekeeping exercise on its zero valued assets held in its asset register. Throughout 2019-20 the Trust reviewed these assets and de-recognised any zero valued assets (excluding Build and Land) that the Trust confirmed as having been disposed. Going forward the Trust will continue to review any zero valued assets held.

The financial year 2019-20 is the fifth year in the current five year cyclical valuation period. A full valuation was previously undertaken in September 2014 with annual 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 full on site valuation of the Trust's Land and Building assets as at 31st March 2020. The lead relationship partner from Montagu Evans LLP is qualified to BSc MRICS.

On formal revaluation (GAM 4.128) cumulative depreciation is "zeroed" as a revaluation in year with a corresponding entry within the cost revaluations row (£20.1m). This is to reset the asset replacement values in line the formal five year valuation.

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 2020 valuation resulted in an overall decrease in the carrying value of the Trust's Land and Property assets as at the 31st March of £3.8m, of which (£3.8m) is an in year charge to I&E impairments and £1.6m reversed previous I&E impairments: both of these are reflected in operating expenses. (£2.6m) relates to an in year impairment charge to the revaluation reserve and £0.9m reversed previous impairments taken to the revaluation reserve. Although there was an increase in some component BCIS indices used to measure valuation changes, there was also a significant reduction in the location factors, adjusting for geographical markets, for both Maidstone and Tunbridge Wells sites.Therefore the overall impact was a downward movement in valuations. The valuer considered the remaining useful economic lives of the assets taking into account backlog and capital work undertaken between valuations, and the age and condition of the properties.

In applying the RICS Valuation Global Standards 2020 the valuer has reported a "material valuation uncertainty" in the valuation report on the basis of uncertainties in markets caused by Covid-19. The values in the report have been used to inform the measurement of the property assets at the valuation date of 31st March 2020 in these financial statements. The valuer has continued to exercise professional judgement in providing the valuation and this remains the best information available to the Trust. Of the £258m net book value of land and buildings subject to valuation, £245.5m relates to specialised assets without any clear market which are valued on a depreciated replacement cost basis. Here the valuer bases their assessment on the cost to the Trust of replacing the service potential of the assets on a modern equivalent asset basis, which is inherently a subjective matter of professional judgement. The uncertainty explained above relates to the estimated cost of replacing the service potential, rather than the extent of the service potential to be replaced. It is possible that the Covid-19 pandemic will affect the Trust's future assessment of what would be required in a modern equivalent asset, but as yet there is insufficient evidence to affect the assumptions used in the valuation. In applying professional judgement the

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 21 Investment Property

The Trust has no investment properties

Note 22 Investments in associates and joint ventures

The Trust has no investments in associates or joint ventures

Note 23 Other investments / financial assets (non-current)

The Trust has no other investments

Note 24 Disclosure of interests in other entities

The Trust have no interests in other entities

Note 25 Inventories

	31 March 2020	31 March 2019
	£000	£000
Drugs	3,332	2,828
Work In progress	0	0
Consumables	975	1,024
Energy	108	151
Other	4,478	3,817
Total inventories	**8,893**	**7,820**
of which:		
Held at fair value less costs to sell	0	0

Inventories recognised in expenses for the year were £57,154k (2018/19: £66,845k). Write-down of inventories recognised as expenses for the year were £0k (2018/19: £0k).

Note 26.1 Receivables

	31 March 2020 £000	31 March 2019 £000
Current		
Contract receivables *	27,526	28,662
Capital receivables	107	107
Allowance for impaired contract receivables / assets	(1,556)	(1,398)
Prepayments (non-PFI)	4,299	3,139
PDC dividend receivable	963	594
VAT receivable	2,424	2,133
Other receivables	1,393	1,192
Total current receivables	**35,156**	**34,429**
Non-current		
PFI prepayments - capital contributions	339	178
PFI lifecycle prepayments	205	221
Other receivables	2,381	1,002
Total non-current receivables	**2,925**	**1,401**
Of which receivable from NHS and DHSC group bodies:		
Current	24,678	25,788
Non-current	910	0

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 26.2 for further information.

Note 26.2 Allowances for credit losses

	2019/20		2018/19	
	Contract receivables and contract assets	All other receivables	Contract receivables and contract assets	All other receivables
	£000	£000	£000	£000
Allowances as at 1 April - brought forward	**1,398**	**0**	**0**	**1,365**
Prior period adjustments			0	0
Allowances as at 1 April - restated	**1,398**	**0**	**0**	**1,365**
Impact of implementing IFRS 9 (and IFRS 15) on 1 April 2019			1,365	(1,365)
New allowances arising	904	0	76	0
Changes in existing allowances	0	0	0	0
Reversals of allowances	-433	0	0	0
Utilisation of allowances (write offs)	-313	0	-43	0
Changes arising following modification of contractual cash flows	0	0	0	0
Foreign exchange and other changes	0	0	0	0
Allowances as at 31 Mar 2020	**1,556**	**0**	**1,398**	**0**

Following the implementation of IFRS 9 in 2018-19 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. For 2019-20 the Trust has reviewed each class and determined that the estimated approach remains valid.

Due to Covid 19 the Trust reviewed further organisations in light of the pandemic and provided additional expected credit loss of c£50k against certain categories of debt in addition to the normal matrix.

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

Note 26.3 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 27 Other assets

The Trust has no other assets

Note 28.1 Non-current assets held for sale and assets in disposal groups

The Trust has no assets held for sale

Note 28.2 Liabilities in disposal groups

The Trust has no liabilites held for sale

Note 29.1 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.

	2019/20	2018/19
	£000	£000
At 1 April	**10,406**	**1,473**
Net change in year	(7,051)	8,933
At 31 March	**3,355**	**10,406**
Broken down into:		
Cash at commercial banks and in hand	24	23
Cash with the Government Banking Service	3,331	10,383
Deposits with the National Loan Fund	0	0
Other current investments	0	0
Total cash and cash equivalents as in SoFP	**3,355**	**10,406**
Bank overdrafts (GBS and commercial banks)	0	0
Drawdown in committed facility	0	0
Total cash and cash equivalents as in SoCF	**3,355**	**10,406**

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. See notes 52 and 53 for further information.

Note 29.2 Third party assets held by the trust

Maidstone And Tunbridge Wells NHS Trust held cash and cash equivalents which relate to monies held by the Trust on behalf of patients or other parties and in which the trust has no beneficial interest. This has been excluded from the cash and cash equivalents figure reported in the accounts.

	31 March 2020	31 March 2019
	£000	£000
Bank balances	0	0
Monies on deposit	0	0
Total third party assets	**0**	**0**

Note 30.1 Trade and other payables

	31 March 2020	31 March 2019
	£000	£000
Current		
Trade payables	12,615	10,267
Capital payables	4,046	1,729
Accruals	15,194	13,166
Social security costs	1,520	80
Other taxes payable	2,919	94
Other payables*	2,650	2,681
Total current trade and other payables	**38,944**	**28,017**
Non-current		
Total non-current trade and other payables	**0**	**0**
Of which payables from NHS and DHSC group bodies:		
Current	7,659	6,433
Non-current	0	0

Note 30.2 Early retirements in NHS payables above

The Trust has not paid any early retirements

Note 31 Other liabilities

	31 March 2020 £000	31 March 2019 £000
Current		
Deferred income: contract liabilities	3,172	2,580
Deferred grants	0	0
Deferred PFI credits / income	0	0
Lease incentives	0	0
Other deferred income	0	0
Total other current liabilities	**3,172**	**2,580**
Non-current		
Deferred income: contract liabilities	0	0
Deferred grants	0	0
Deferred PFI credits / income	0	0
Lease incentives	0	0
Other deferred income	0	0
Net pension scheme liability	0	0
Total other non-current liabilities	**0**	**0**

Note 32.1 Borrowings

	31 March 2020 £000	31 March 2019 £000
Current		
Bank overdrafts	0	0
Drawdown in committed facility	0	0
Loans from DHSC	27,768	19,187
Other loans	443	371
Obligations under finance leases	0	0
Obligations under PFI, LIFT or other service concession contracts	5,349	5,427
Total current borrowings	**33,560**	**24,985**
Non-current		
Loans from DHSC	6,406	34,102
Other loans	1,300	1,744
Obligations under finance leases	0	0
Obligations under PFI, LIFT or other service concession contracts	182,173	187,521
Total non-current borrowings	**189,879**	**223,367**

Department of Health and Social Care (DHSC) normal course of business capital investment 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%

During 2019-20 the Trust repaid £16.9m interim working capital loan. The remaining interim working capital loans of £26.122m have been classified as current liabilities as due within 2020-21.On 2 April 2020, the Department of Health and Social Care (DHSC) and NHS England and NHS Improvement announced reforms to the NHS cash regime for the 2020/21 financial year. During 2020/21 existing DHSC interim revenue and capital loans as at 31 March 2020 will be extinguished and replaced with the issue of Public Dividend Capital (PDC) to allow the repayment. Given this relates to liabilities that existed at 31 March 2020, DHSC has updated its Group Accounting Manual to advise this is considered an adjusting event after the reporting period for providers.

The Trust also has Salix loans total value of £1.7m 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 32.2 Reconciliation of liabilities arising from financing activities - 2019/20

	Loans from DHSC	Other loans	PFI and LIFT schemes	Total
	£000	£000	£000	£000
Carrying value at 1 April 2019	**53,289**	**2,115**	**192,948**	**248,352**
Cash movements:				
Financing cash flows - payments and receipts of principal	-19,082	-372	-5,426	**-24,880**
Financing cash flows - payments of interest	-1,387	0	-10,110	**-11,497**
Non-cash movements:				
Application of effective interest rate	1,354	0	10,110	**11,464**
Carrying value at 31 March 2020	**34,174**	**1,743**	**187,522**	**223,439**

Note 32.3 Reconciliation of liabilities arising from financing activities - 2018/19

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

Note 33 Other financial liabilities

The Trust does not have any other Financial Liabilities

Note 34 Finance leases

The Trust does not have any Finance Leases

Note 35.1 Provisions for liabilities and charges analysis

	Pensions: injury benefits	Legal claims	Other	Total
	£000	£000	£000	£000
At 1 April 2019	436	375	1,645	**2,456**
Transfers by absorption	0	0	0	**0**
Change in the discount rate	35	0	0	**35**
Arising during the year	16	73	934	**1,023**
Utilised during the year	-24	-57	-33	**-114**
Reclassified to liabilities held in disposal groups	0	0	0	**0**
Reversed unused	0	0	0	**0**
Unwinding of discount	1	0	0	**1**
At 31 March 2020	464	391	2,546	**3,401**
Expected timing of cash flows:				
- not later than one year;	24	391	1,311	**1,726**
- later than one year and not later than five years;	97	0	232	**329**
- later than five years.	343	0	1,003	**1,346**
Total	464	391	2,546	**3,401**

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 and equipment totalling £1.6m.

Included within arising in year under "other" is £930k relating to Clinicians' Pension Scheme. Clinicians who are members of the NHS Pension Scheme and who as a result of work undertaken in this tax year (2019-20) face a tax charge in respect of the growth of their NHS pension benefits above their pension savings annual allowance threshold will be able to have this charge paid by the NHS Pension Scheme. The NHSE have used the information provided by Government Actuary's Department (GAD) and Business Services Authority (BSA) and calculated a national 'average discounted value per nomination'. The Trust has followed the guidance and based its provision on this estimated value and applied it to the Trusts data as reported in the NHS Digital's NHS workforce Statistics - November 2019' consultant headcount data which is the same basis that NHSE have used for the National provision within its accounts.

Note 35.2 Clinical negligence liabilities

At 31 March 2020, £230,759k was included in provisions of NHS Resolution in respect of clinical negligence liabilities of Maidstone And Tunbridge Wells NHS Trust (31 March 2019: £228,658k).

The Trust pays an annual premium to the clinical negligence scheme for Trusts (CNST) which is disclosed in operating expenses.

Note 36 Contingent assets and liabilities

	31 March 2020	31 March 2019
	£000	£000
Value of contingent liabilities		
NHS Resolution legal claims	-22	-44
Employment tribunal and other employee related litigation	0	0
Redundancy	0	0
Other	0	0
Gross value of contingent liabilities	**-22**	**-44**
Amounts recoverable against liabilities	0	0
Net value of contingent liabilities	**-22**	**-44**
Net value of contingent assets	**0**	**0**

Contingent Liability for 2019/20 relates to legal claims notified by NHS Resolution of £22k

Note 37 Contractual capital commitments

	31 March 2020	31 March 2019
	£000	£000
Property, plant and equipment	1,994	575
Intangible assets	0	0
Total	**1,994**	**575**

Note 38 Other financial commitments

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

Note 39 Defined benefit pension schemes

The Trust does not have any defined benefit schemes.

Note 40 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 2019/20 year was 2.48%. The RPI uplift for 2020/21 is 2.46%.

Note 40.1 On-SoFP PFI, LIFT or other service concession arrangement 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 2020	31 March 2019
	£000	£000
Gross PFI, LIFT or other service concession liabilities	**321,178**	**336,714**
Of which liabilities are due		
- not later than one year;	15,165	15,536
- later than one year and not later than five years;	59,758	59,985
- later than five years.	246,255	261,193
Finance charges allocated to future periods	-133,656	-143,766
Net PFI, LIFT or other service concession arrangement obligation	**187,522**	**192,948**
- not later than one year;	5,349	5,427
- later than one year and not later than five years;	23,393	22,431
- later than five years.	158,780	165,090

Note 40.2 Total on-SoFP PFI, LIFT and other service concession arrangement commitments

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

	31 March 2020	31 March 2019
	£000	£000
Total future payments committed in respect of the PFI, LIFT or other service concession arrangements	**772,816**	**798,183**
Of which payments are due:		
- not later than one year;	26,000	25,366
- later than one year and not later than five years;	110,665	107,966
- later than five years.	636,151	664,851

Note 40.3 Analysis of amounts payable to service concession operator

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

	2019/20	2018/19
	£000	£000
Unitary payment payable to service concession operator	**25,365**	**24,752**
Consisting of:		
- Interest charge	10,110	10,389
- Repayment of balance sheet obligation	5,426	5,284
- Service element and other charges to operating expenditure	4,975	4,760
- Capital lifecycle maintenance	434	471
- Revenue lifecycle maintenance	0	0
- Contingent rent	4,260	3,848
- Addition to lifecycle prepayment	160	0
	25,365	**24,752**
Other amounts paid to operator due to a commitment under the service concession contract but not part of the unitary payment	224	182
Total amount paid to service concession operator	**25,589**	**24,934**

Note 41 Off-SoFP PFI, LIFT and other service concession arrangements

The Trust has no Off-SoFP schemes

Note 42 Financial instruments

Note 42.1 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 2020 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 capital resourcing limit as approved by DHSC. The Trust is not, therefore, exposed to significant liquidity risks.

Note 42.2 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 2020	Held at amortised cost	Held at fair value through I&E	Held at fair value through OCI	Total book value
	£000	£000	£000	£000
Trade and other receivables excluding non financial assets	29,703	0	0	**29,703**
Other investments / financial assets	0	0	0	**0**
Cash and cash equivalents	3,355	0	0	**3,355**
Total at 31 March 2020	**33,058**	**0**	**0**	**33,058**

Carrying values of financial assets as at 31 March 2019	Held at amortised cost	Held at fair value through I&E	Held at fair value through OCI	Total book value
	£000	£000	£000	£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	10,406	0	0	**10,406**
Total at 31 March 2019	**39,958**	**0**	**0**	**39,958**

Note 42.3 Carrying values 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 2020	Held at amortised cost	Held at fair value through I&E	Total book value
	£000	£000	£000
Loans from the Department of Health and Social Care	34,174	0	**34,174**
Obligations under finance leases	0	0	**0**
Obligations under PFI, LIFT and other service concession contracts	187,522	0	**187,522**
Other borrowings	1,743	0	**1,743**
Trade and other payables excluding non financial liabilities	34,289	0	**34,289**
Other financial liabilities	0	0	**0**
Provisions under contract	0	0	**0**
Total at 31 March 2020	**257,728**	**0**	**257,728**

Carrying values of financial liabilities as at 31 March 2019	Held at amortised cost	Held at fair value through I&E	Total book value
	£000	£000	£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**

Note 42.4 Maturity of financial liabilities

	31 March 2020	31 March 2019
	£000	£000
In one year or less	67,849	52,506
In more than one year but not more than two years	6,819	33,488
In more than two years but not more than five years	21,760	21,232
In more than five years	161,300	168,648
Total	**257,728**	**275,874**

Note 42.5 Fair values of financial assets and liabilities

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

Note 43 Losses and special payments

	2019/20		2018/19	
	Total number of cases	Total value of cases	Total number of cases	Total value of cases
	Number	£000	Number	£000
Losses				
Cash losses	15	22	29	32
Fruitless payments	0	0	0	0
Bad debts and claims abandoned	22	349	20	20
Stores losses and damage to property	0	0	0	0
Total losses	**37**	**371**	**49**	**52**
Special payments				
Compensation under court order or legally binding arbitration award	1	1	0	0
Extra-contractual payments	0	0	0	0
Ex-gratia payments	35	12	40	14
Special severance payments	0	0	0	0
Extra-statutory and extra-regulatory payments	0	0	0	0
Total special payments	**36**	**13**	**40**	**14**
Total losses and special payments	**73**	**384**	**89**	**66**
Compensation payments received		0		0

The Trust has had no cases exceeding £300k

Note 44 Gifts

There were no gifts made by the Trust in 2019/20.

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 2019/20 the Trust has received £4.6m capital funding in the form of Public Dividend Capital. The Trust also has loans with DHSC, interest paid within the year £1.4m, principal repayment of £19m. The balance outstanding for the working capital loans is £26.1m. The Trust has also had a significant number of material transactions with other entities for which the Department is regarded as the parent department eg NHSE/I. Other public sector bodies are recognised as relevant who are not part of the DHSC group eg HMRC. 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
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
NHS Blood and Transplant
NHS Property Services
Kent County Council

From 2020/21 the Kent and Medway CCG's are merging to become Kent and Medway CCG

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 1.3). The transactions between the Trust and the Charity (Maidstone and Tunbridge Wells NHS Charitable Fund - charity registration number 1055215) are however material to the charity and therefore are disclosed below. Please note that this disclosure is based on the draft unaudited position of the charity. The audited accounts of the charity will be available later this year.

	2019-20	2018-19
	£000s	£000s
Total charitable resources expended with the Trust	**1,038**	751
Closing creditor (monies owed to the Trust by the Charity)	**589**	146
Closing debtor (monies owed to the Charity by the Trust)	**0**	0
Total income received by the Charity in the reporting period	**720**	796
Total Charitable Funds at end of the reporting period	**763**	1,170

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

On 2 April 2020, the Department of Health and Social Care (DHSC) and NHS England and NHS Improvement announced reforms to the NHS cash regime for the 2020/21 financial year. During 2020/21 existing DHSC interim revenue and capital loans as at 31 March 2020 will be extinguished and replaced with the issue of Public Dividend Capital (PDC) to allow the repayment (30th September 2020). Given this relates to liabilities that existed at 31 March 2020, DHSC has updated its Group Accounting Manual to advise this is considered an adjusting event after the reporting period for providers. The total for the Trust is £26.1m.

Note 49 Better Payment Practice code

	2019/20	2019/20	2018/19	2018/19
Non-NHS Payables	**Number**	**£000**	**Number**	**£000**
Total non-NHS trade invoices paid in the year	109,425	196,467	118,271	199,748
Total non-NHS trade invoices paid within target	90,990	168,173	102,797	176,625
Percentage of non-NHS trade invoices paid within target	83.2%	85.6%	86.9%	88.4%
NHS Payables				
Total NHS trade invoices paid in the year	2,728	38,336	3,064	39,048
Total NHS trade invoices paid within target	1,825	34,024	1,892	27,230
Percentage of NHS trade invoices paid within target	66.9%	88.8%	61.7%	69.7%

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 limit

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

	2019/20	2018/19
	£000	**£000**
Cash flow financing	-13,214	-10,554
Finance leases taken out in year	0	0
Other capital receipts	0	0
External financing requirement	**-13,214**	**-10,554**
External financing limit (EFL)	-12,858	-1,148
Under / (over) spend against EFL	**356**	**9,406**

The Trust under spent against its External Financing Limit by £0.4m.

Note 51 Capital Resource Limit

	2019/20	2018/19
	£000	**£000**
Gross capital expenditure	16,891	13,639
Less: Disposals	0	-3,999
Less: Donated and granted capital additions	-890	-740
Plus: Loss on disposal from capital grants in kind	0	0
Charge against Capital Resource Limit	**16,001**	**8,900**
Capital Resource Limit	16,218	12,101
Under / (over) spend against CRL	**217**	**3,201**

The Trust underspent its Capital Resource Limit of £16.2m by £0.2m. The Trust underspent its depreciation costs by £0.4m which benefitted the Income and Expenditure position but also reduced the capital it was able to spend - part of this underspend was reflected in a reduction to the CRL in year.

Note 52 Breakeven duty financial performance

	2019/20
	£000
Adjusted financial performance surplus / (deficit) (control total basis)	7,004
Remove impairments scoring to Departmental Expenditure Limit	0
Add back income for impact of 2018/19 post-accounts PSF reallocation	583
Add back non-cash element of On-SoFP pension scheme charges	0
IFRIC 12 breakeven adjustment	0
Breakeven duty financial performance surplus / (deficit)	**7,587**

The breakeven duty performance reports I&E including PSF payments. The Trust met its outturn control total and received core PSF of £7.65m.and £0.58m of 2018/19 PSF reallocation.

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	2019/20
	£000	£000	£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	7,587
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)	(30,359)
Operating income		311,889	322,176	345,101	367,391	375,714	403,310	400,930	430,502	440,269	473,169	513,056
Cumulative breakeven position as a percentage of operating income		(1.0%)	(0.4%)	(0.3%)	(0.3%)	(3.5%)	(3.3%)	(9.1%)	(11.0%)	(13.2%)	(8.0%)	(5.9%)

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 break even duty surplus in 2019/20 of £7.6m (including the post-accounts PSF reallocation from 2018/19 - see note 52) reducing the cumulative deficit. The Trust's Long Term Plan submission in October 2019 is aimed at further reducing the accumulated deficit.

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, and fundraisers. 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

MTW
exceptional people, outstanding care

Maidstone and Tunbridge Wells NHS Trust

Maidstone Hospital, Hermitage Lane, Maidstone, Kent ME16 9QQ

01622 729 000

www.mtw.nhs.uk

@mtwnhs

Maidstone and Tunbridge Wells NHS Trust

mymtwhealthcare

mtw_nhs_trust

mtwnhs

www.linkedin.com/company/2709665

taking pride

Patient First - Respect - Innovation - Delivery - Excellence

MTW exceptional people, outstanding care