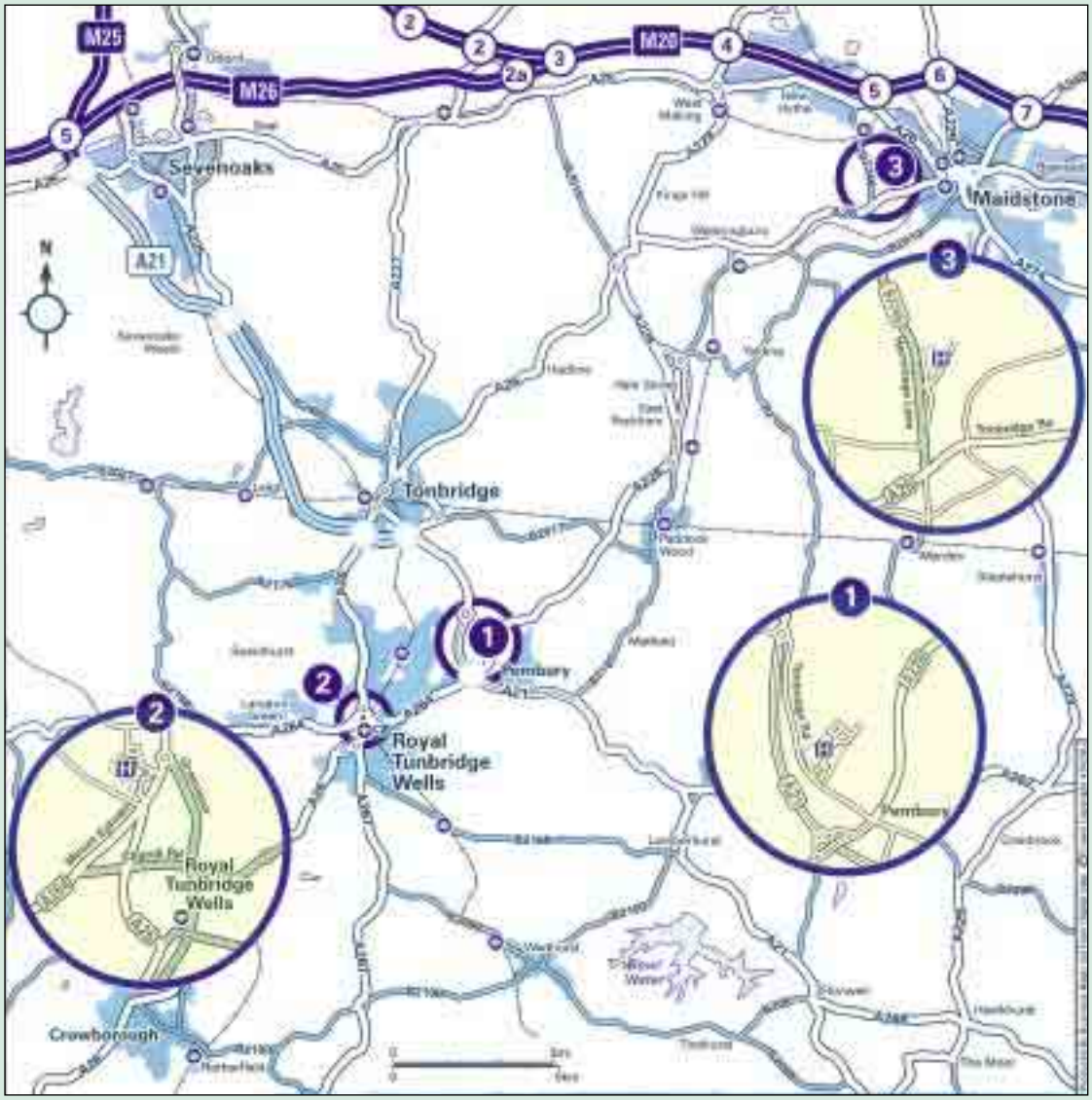
Maidstone and Tunbridge Wells NHS

NHS Trust



1. Pembury Hospital 2. Kent and Sussex Hospital 3. Maidstone Hospital

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Maidstone and Tunbridge Wells NHS
NHS Trust

Annual Report 2002-2003

Patients are the central focus of all we do

Picture courtesy of the Kent and Sussex Courier

Chairman's Report

Our annual report for 2002/03 will describe many fine achievements, which are a tribute to our team of more than 4,000 staff. They have worked incredibly hard this year to provide an excellent quality of care to twenty percent more patients that were referred to us by local GPs.

We have many accomplishments to celebrate, including the opening of our new Eye, Ear and Mouth Unit and a new Orthopaedic Centre. We have also begun work on a new Breast Centre. However, despite these very positive developments, the Trust has some significant issues to resolve.

I took the chair in July 2003 to learn that we had received a "zero star rating". I believe it is important for our patients to understand that being awarded no stars does not mean that we deliver a poor quality of care. On the contrary, our patients can be confident that, based on most measures of clinical performance, we rank above average and in some cases well above average. Where we fall down is in the time we take to begin treatment of some of those patients.

I am determined that we must do everything we can to meet our "access" targets as a matter of priority. In 2003/04 the key targets are no more than 4 hours waiting in A&E, 21 weeks for an outpatient appointment, or 9 months to be admitted to a hospital bed. The Trust believes that these are minimum acceptable standards of care, which we must all strive to exceed, eventually by a very significant margin.

Last year we admitted more than 34,000 day care and inpatients. Of these, 70% were admitted within six months. By the year end, just 3 patients had been waiting more than twelve months. The story with outpatients was very similar. There were more than 300,000 attendances at our out-patient clinics. We performed 59,000 first time appointments, 20% more than the year before. Yet at the end of the year, just 20 patients were waiting more than 21 weeks for their first out-patient appointment. It is the very smallness of these numbers that gives me confidence that, with application, we can learn to do much better and quickly.

The Trust also faces a challenging financial problem. Our report shows that the Trust had accumulated a financial deficit of more than £8 million by the end of 2002/03. The potential deficit in the current year could be greater, if substantial savings are not achieved. The principal reason for this underlying deficit is simple. Our costs are still rising faster than our income, which increased last year by a healthy £14 million. However, in order to treat more patients, our staff numbers had to be increased by 450 including as many as 50 more doctors. As a result, our employee costs alone grew by £11 million which is an increase of 10%.

We have already agreed a financial recovery plan. This shows that, in order to break even and repay our debt by the end of the current financial year, the whole of South West Kent must address a potential deficit of nearly £12 million. This will be very challenging. If we are to succeed we need more creative thinking by everyone involved, including those working for the Primary Care Trusts. I intend to make it one of my top priorities to encourage a collaborative approach to addressing this fundamental problem.

Our staff have a vital part to play both in providing our patients with good quality care and in bringing about essential changes in our methods of care. Many of our doctors have already become intimately involved in the change process. But everyone will need to play a part. Our cleaners and caterers are as important to us as our doctors and nurses. On behalf of the Board I would like to thank all of our people for their efforts over the past year and for their commitment to the future.

I would also like to thank Anne Chapman, who left at the end of June after eight years as a non-executive director with the former Mid Kent Healthcare Trust and more than three years in the Chair of the Maidstone and Tunbridge Wells NHS Trust. She will be a hard act to follow.

James Lee, Chairman

Chief Executive's Report

This report covers the year April 2002 to March 2003 and also takes the opportunity to look ahead to the current year.

It is clear to all involved with the Trust either as an employee, patient, relative or member of the public, that the Trust has been going through some difficult times and continues to do so in the year 2003/04.

It is important, however, in times like these, to recognise the areas of excellence which exist within the Trust and to celebrate the fact that on examination of many indicators of clinical care the Trust scores highly.

This report gives examples of the good work carried out by the Trust. Staff should continue to take pride in these achievements and patients and their relatives find these improvements reassuring.

Some notable achievements of 2002/03 are:

- The opening of an £11.3 million Eye, Ear and Mouth Unit at Maidstone Hospital.
- Refurbishment of Wards at Kent & Sussex Hospital at a cost of almost £400,000.
- The opening of a Home from Home unit in the Labour Suite at Pembury Hospital
- Opening of a £2 million Orthopaedic Unit at Maidstone Hospital.
- Pembury Hospital gaining top marks for cleanliness and tidiness following a PEAT (Patient Environment Action Team) inspection.

However, it is also a fact that during the year in question the Trust struggled to meet the ever more exacting key patient standards set by the Government in the areas of access, i.e. speed at which patients receive treatment and financial management.

This culminated in the Trust receiving a zero star rating in July 2003 for its performance in the year 2002/03. These problems persist into this year and are being addressed in the following ways:-

- Building a new top management team. A new chairman commenced in July 2003, an interim CEO from a three star trust started in January 2003 and a substantive CEO will start in November 2003.
- Reviewing the internal systems, processes, policies and procedures and embarking on a major training programme for staff to ensure that they are aware of the standards expected and their role in achieving them.
- Developing the cadre of clinical leaders within the Trust.
- Securing excellent working relationships with the Trust's external partners particularly the Strategic Health Authority and commissioning Primary Care Trusts.
- Commencing a major piece of work with the PCTs to review the Trust's service strategy which includes developing a comprehensive financial recovery plan.

There is clearly a long way to go and there will be difficult times ahead, but a good start has been made.

Finally, to end on a positive note, as the interim CEO brought into the Trust to help it through these difficult times, from January to October 2003, I have found the staff a delight to work with.

I would like to take this opportunity in public to thank them for all their hard work and enthusiasm. I am convinced that their spirit and the actions outlined above will help carry the Trust through to better times ahead.

Mark Davies
Chief Executive

Introduction

Maidstone and Tunbridge Wells NHS Trust is a large acute hospital Trust. We provide a full range of general hospital services to around half a million people living in the south of west Kent and parts of north east Sussex.

Many of the people we serve live in Maidstone and Tunbridge Wells and surrounding rural areas.

In addition, the Trust provides cancer services, through its cancer centre at Maidstone and Kent & Canterbury Hospitals, for the whole of Kent and Hastings and Rother, about 1.8 million people. We also provide ophthalmology services to the people of Medway.

The Trust was formed in 2000 following the merger of Mid-Kent Healthcare NHS Trust and the Kent and Sussex Weald NHS Hospitals Trust.

Our Staff

We employ a team of more than 4,000 whole time equivalent staff including agency staff, which includes approximately

- 411 Medical and dental
- 2 Ambulance staff
- 1,029 Administration and estates
- 466 Healthcare assistants and other support staff
- 1,645 Nursing, midwifery and health visiting staff
- 492 Scientific, Therapeutic and technical staff

Our Budget

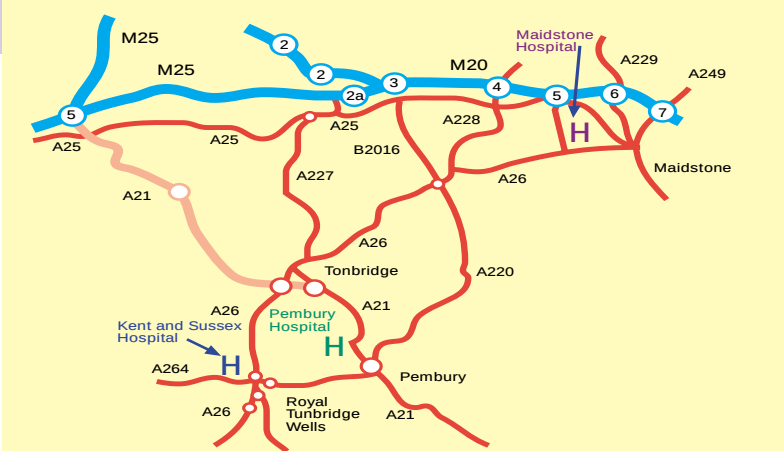
Our annual budget last year was £169.9 million. This year's budget for 2003/04 is £176.4 million.

Our staff treated more patients than ever before last year. By the end of March 2003 the Trust had carried out 34,364 day case and inpatient elective admissions, which was almost 2,000 more than the year before.

The Trust's 157 consultants and their teams carried out many more first outpatient appointments. We held 11,000 more first time appointments in 2002/03 compared to the year before.

The Government Office for the South East (GOSE) approved our plans to build a new £257 million hospital at Pembury in April after Tunbridge Wells Borough Council gave the scheme planning permission.

A Planning Inquiry was held in July into plans by



Kilmartin Property Group to build the new hospital at an alternative site at Knights Park, after that scheme was refused planning consent.

The outcome of the inquiry is likely to be known at the end of 2003. If Kilmarting Property Group gain planning consent, the Trust will have two sites to choose from.

Work is currently underway to develop both options, so that a comparison can be made should there be a choice of sites to build the high quality hospital on.

We also saw our staff from the Kent County Ophthalmic and Aural Hospital in Church Street, Maidstone, move to a new £11.3 million Eye, Ear and Mouth Unit at Maidstone Hospital in April, 2003.

Our Board

The Trust is led by a board of directors:

Chairman	James Lee (from 1/7/02)
Chairman	Anne Chapman (from 1/4/02 - 30/6/03)
Non-executive Director	Peter Cox
Non-executive Director	Ian Nash
Non-executive Director	John Cartwright
Non-executive Director	Dr Gillian Bullock
Non-executive Director	Winston Tayler
Chief Executive	Mark Davies (from 20/1/03)
Chief Executive	Steven Collinson (from 1/4/02 - 14/1/03)
Assistant Chief Executive	Noelle Bowden (from 17/3/03)
Director of Finance and IM & T	Paul Darling
Director of Strategic Development	Brigid Musselwhite (from 3/3/03)
Director of Strategic Development	Lynne Clemence (from 1/4/02 - 7/11/02)
Medical Director	Dr Charles Unter
Director of Nursing	Bernard Place
Director of Human Resources and Organisational Development	Ruth McAll (from 7/4/03)

Director of Human Resources	Chris Wilson (1/4/02 - 30/9/02)
Director of Estates and Facilities	Bob Pepper
Director of Operations	Val Thompson (1/4/02 - 31/10/02)

James Lee took over as Trust Chairman on 1 July 2003, after Anne Chapman left the Trust on 30 June 2003.

Mark Davies joined the Trust as interim Chief Executive on January 20, 2003, after Chief Executive Stephen Collinson left the Trust on 14 January, 2003. Rose Gibb was appointed as the Trust's new Chief Executive in July 2003 and is due to join the Trust in November.

The Chairman and five Non-executive Directors have been appointed by the Secretary of State for Health, through national advertisement. Non-executive Directors are appointed for a maximum term of four years which is renewable after that time.

They are members of the public who live in the area that the Trust serves. Their role is to provide independent judgement on strategic issues facing the Trust as well as to bring their individual and community experience to help the Board make decisions over the running of the Trust's hospitals.

The Chief Executive is appointed to the Trust following an open advertisement with an interview and external assessment. Chief Executives may be removed from post by the Chairman.

The eight Executive Directors who are all Board members, led by the Chief Executive, are full-time salaried members of staff and are responsible for the day-to-day running of the Trust. They are selected in line with the Department of Health guidance on recruitment of executive directors and have endorsed the codes of conduct for managers working in the NHS.

Details of the Directors remuneration can be found on page 39. The salaries of the Directors are determined by the Remuneration Committee.

The Trust Board meets in public each month. Dates of the meetings are available by telephoning Darren Yates on 01892 673700. You can also call this number for a copy of the agenda for the next meeting or for minutes of previous meetings.

A Register of Board Members interests is kept by the Head of Corporate Services and can be inspected on request.

The Trust Board has established a number of Board sub-committees to ensure that its stewardship of public funds is properly regulated and staff appropriately paid.

Our Committees:

In 2002/03:
Anne Chapman was Chairman of the Governance & Risk Committee, PFI Project Board, Modernisation Steering Group, Consent Working Group, Remuneration Committee, Charitable Funds Committee and Advisory Appointments Committees (consultants).

Peter Cox was Chairman of the Human Resources Sub-Committee and was Vice Chairman of the Audit Committee.

Winston Tayler was Chairman of the Patient & Public Involvement Sub-Committee and a member of the Performance Committee, PFI Clinical Reference Group and undertook Resource Prioritisation Group duties. He also acted as a convenor of Trust Complaints Panels.

Ian Nash was Chairman of the Audit Committee and member of Charitable Funds and Remuneration Committees

Gillian Bullock was a member of the Clinical Governance Committee, Research & Development Committee, Modernisation Steering Group, Remuneration Committee and Charitable Funds Committee.

John Cartwright was Chairman of the Performance Committee, Emergency Capacity Group, and KCOAH Project Board. He was also a member of the Audit Committee and Remuneration Committee and convenor of Trust Complaints Panels.

Dr Bullock also attended the Board meetings of the South West Kent and the Sussex Downs & Weald Primary Care Trusts and Mr Cartwright attended Board meetings of the Maidstone Weald Primary Care Trust.

The Trust's Chairman and Chief Executive are reviewing the committee structures and membership for 2003/04.

Our Statement of Values

We established a statement of Values in October. They are:

1. Patients are the central focus of all we do. We will strive to provide them with the very best healthcare we can achieve with our resources,

seeking their involvement in the management of their own care and in delivery of our services generally.
2. We will involve patients and the local community in planning our services, seeking their views on the services we provide, and acting on these views to secure continuous improvement.
3. Our staff are our main asset; we will value them, give them clear direction, listen to them, involve them in the planning and delivery of services, provide the right training and development and support them as they seek to deliver high quality healthcare.
4. We will strive to provide high quality, safe and purpose-designed healthcare facilities, which we believe are essential for the effective delivery of healthcare.
5. Our services are only a part of the whole healthcare system. We will work with local partner agencies to ensure integrated, seamless care for all patients and their carers, and we will ensure that effective partnerships, or service net works are supported and managed.
6. We will continuously challenge and question the way in which we work, seeking always to improve service quality through service redesign and modernisation.
7. We will work flexibly with a willingness to change in response to new challenges or changing expectations.

Our Hospitals

The Trust primarily works from four clinical sites. Maidstone Hospital, Kent and Sussex Hospital (Tunbridge Wells), Pembury Hospital (Trust headquarters) and Preston Hall (Aylesford, near Maidstone). We also provide cancer services at Kent Oncology Centre at Kent & Canterbury Hospital in Canterbury and homeopathy services at the Homeopathic Hospital in Tunbridge Wells.

The Trust is also the host body for the Health Informatics Service (HIS) and Local Implementation Strategy (LIS), IM&T projects for NHS bodies in Kent.

During 2002/3, the Kent County Ophthalmic and Aural Hospital in Church Street, Maidstone, closed its doors for the last time after serving the local population for 160 years. Ophthalmic, ear, nose and throat (ENT), oral surgery and orthodontic services transferred to the new Eye, Ear and Mouth Unit at Maidstone Hospital.

Maidstone Hospital is just a few miles outside the town centre. The district general hospital opened in 1983. Since then, additional wings have been added and the specialist Kent Oncology Centre opened in 1993.

Kent and Sussex Hospital is in the centre of Tunbridge Wells and opened in 1935 at a cost of £180,000. Pembury Hospital is on the outskirts of the town centre. It was previously a Victorian workhouse and some of its buildings date from the mid 19th Century.

Accident and Emergency services, paediatrics, women's services and surgical care are provided at both Maidstone and Kent and Sussex/Pembury Hospitals. Both Maidstone and Kent and Sussex have adult Intensive Care facilities. The Trust links with Guy's Hospital in South East London for the provision of children's intensive care.

Pembury Hospital complements Kent and Sussex, providing ward space for paediatrics, obstetrics and gynaecology, elderly care and some day case surgery. Significant diagnostic activity takes place on this site. It also provides dermatology, ophthalmology and rheumatology services.

Preston Hall is situated two miles from Maidstone Hospital and provides some outpatient accommodation for breast screening and direct access X-ray. Diagnostic services are also located on this site.

On Friday, April 11, 2003, the Kent County Ophthalmic and Aural Hospital in Church Street, Maidstone, closed its doors for the last time after serving the local population for 160 years. Ophthalmic, ear, nose and throat (ENT), oral surgery and orthodontic services are now provided at the new Eye, Ear and Mouth Unit at Maidstone Hospital.

You can contact us at:

Kent and Sussex Hospital
Mount Ephraim, Tunbridge Wells,
Kent TN4 8AT
Telephone: 01892 526111

Pembury Hospital
Tonbridge Road, Pembury,
Tunbridge Wells, Kent TN2 4QJ
Telephone: 01892 823535

Maidstone Hospital
Hermitage Lane, Maidstone,
Kent ME16 9QQ
Telephone: 01622 729000
Our website address is:
www.kentandmedway.nhs.uk

OUR SERVICES ARE PROVIDED BY SEVEN CLINICAL CARE GROUPS.

- surgical services
- critical care
- women's and children's services
- emergency services

- diagnostic and clinical services
- cancer services
- clinical governance

Non clinical services are provided by the Finance and IM&T, Human Resources, Estates and Facilities and Corporate Services Departments.

SURGICAL SERVICES CARE GROUP

This care group is responsible for the management of in-patient, out-patient and day case services in the specialties of general surgery, vascular, urology, ear, nose and throat (ENT), ophthalmology and trauma and orthopaedics.

Contacts:

Associate Medical Director
Mr Kenneth Tuson

General Manager
Mavis Williams

To contact the Surgical Services Care Group call 01622 224226 (Maidstone Hospital).

CRITICAL CARE CARE GROUP

This care group is responsible for the Trust's operating theatres, day surgery (including endoscopy), intensive therapy units (ITU), high dependency units (HDU), anaesthesia, pain and outreach services.

The Trust has 20 operating theatres: 6 at Kent and Sussex Hospital, 3 at Pembury Hospital, 7 at Maidstone Hospital.

There are also 2 day theatres at Maidstone Hospital and labour ward theatres at Pembury and Maidstone Hospitals. ITU and HDU are run at Kent and Sussex and Maidstone hospitals providing a total of 13 beds.

Contacts:

Associate Medical Director
Dr Andy Pyne

General Manager
Amy Page

To contact the Critical Care Group call 01892 526111 (Kent & Sussex Hospital)

WOMEN'S AND CHILDREN'S CARE GROUP

This care group provides an integrated maternity service, with a fully developed community element, to ensure as much patient choice as possible regarding location and type of ante-natal care and birth. The gynaecology services include in-patient and day case surgery, outpatient care, colposcopy and laser treatment. It also includes paediatrics and the special care baby unit (SCBU).

Services are based at Pembury Hospital and Maidstone Hospital and provide high quality obstetric, midwifery and gynaecology services.

The Care Group also provides Gynae-Oncology services for West Kent at Maidstone Hospital. It also has a POSCU (Paediatric Oncology Shared Care Unit), a Diana community nursing team and generic Paediatric community nursing team.

Contacts:

Associate Medical Director
Dr Tony Hulse

General Manager
Pat Graves

To contact the Women's and Children's Care Group call 01622 224246 (Maidstone Hospital)

EMERGENCY SERVICES CARE GROUP

This care group provides 24 hour, 7-days-a-week accident and emergency services at the Kent and Sussex and Maidstone Hospitals. Immediate assessment and care is provided for patients suffering from recent injuries and sudden illness.

The care group also provides care of elderly and rehabilitation services, rheumatology, dermatology, GUM, diabetes, cardiology, general medicine and is also responsible for emergency planning and homeopathy.

The accident and emergency departments at Kent & Sussex and Maidstone Hospitals are designated major injury centres prepared to cope with major incidents. There is a helipad at Maidstone Hospital next to the accident and emergency department, which is often used by the Kent Air Ambulance.

Contacts:

Associate Medical Director
Dr Paul Reynolds

General Manager
Teo Vogiatzis (Acting)

Head of Nursing
Linda Summerfield

To contact the Emergency Services Care Group call 01892 526111 (Kent & Sussex Hospital)

DIAGNOSTIC AND CLINICAL SERVICES CARE GROUP

This care group provides radiology, pathology and pharmaceutical services for the Trust.

A comprehensive diagnostic radiology service for the Trust's hospital-based services as well as local GPs is provided. This includes:

- CT (Computerised Tomography) scanning
- Ultrasound
- MRI (Magnetic Resonance Imaging)
- Digital subtraction angiography
- Mammography
- Interventional techniques

There are X-ray departments at the Kent & Sussex, Maidstone and Pembury Hospitals.

The pathology service provides a high quality, comprehensive analytical and advice service within the Trust, to our local GPs and local independent hospitals.

Contacts:

Associate Medical Directors
Dr Carol Brunell
Dr John Schofield

General Manager
Graham West

To contact the Diagnostic and Clinical Services Care Group call 01622 224074 (Maidstone Hospital).

CANCER CARE GROUP (Oncology)

This care group provides highly specialised cancer services for the residents of Kent and parts of east Sussex. These services are based at two dedicated cancer centres - Maidstone Hospital in the west and the Kent & Canterbury Hospital in the east of the county.

Five other hospitals in Kent - Darent Valley, Medway, Kent & Sussex, Ashford and Margate - offer initial assessment and early treatment. Only the cancer centres provide specialised treatment such as radiotherapy and complex chemotherapy.

Considerable investment work is underway in Kent to meet new national standards for cancer patients and to improve the quality of their care.

Contacts:

Associate Medical Director
Prof Roger James

General Manager
Jo Yardley

To contact the Cancer Care Group call 01622 225011/225049/225018/225135 (Maidstone Hospital).

CLINICAL GOVERNANCE CARE GROUP

Clinical Governance is the term adopted by the NHS to cover systems and processes for monitoring and improving clinical services. The purpose of clinical governance is to ensure that patients safely receive the highest quality of NHS care possible. It makes clear that the Trust and its entire staff are accountable for the quality of care.

The Clinical Governance Care Group provides leadership, direction and facilitation for the clinical governance agenda of the Trust. It guides and supports the other Care Groups in the development of their programmes and oversees our achievement of the Clinical Governance Development Plan and the action identified through our recent review by the Commission for Health Improvement (CHI). Clinical Audit, Complaints and Claims Management, the Patient Advice and Liaison Service (PALS) and the Library and Information Services are all managed within the Care Group, which also provides the focus for research and development, clinical risk management and the production of patient information.

For clinical governance to be effective it needs to be a continuous process of improvement, as we listen to our patients and learn from our mistakes. We strive to provide a patient-centred approach that means treating patients courteously, involving them in decisions about their care and keeping them informed and seeking their views on the services and responding positively when patientsí expectations are not satisfied.

Contacts:

Associate Medical Director
Dr Wilson Bolsover

General Manager
Judith Clabby (Acting)

To contact the Clinical Governance Care Group call 01892 673725 (Pembury Hospital)

CHANGING THE WAY WE WORK

In order to improve patient access to our services and to ensure that the patient becomes the focus of all that we do we are continually looking at how we can change the ways in which we have traditionally worked. In addition to the medical and technological advances being made, this involves new ways of working in terms of different roles for staff, new systems of working, as well as ensuring that the views of patient and public are taken into account.

It is a tribute to our staff, who, in addition to their normal duties, make the time and find the energy and enthusiasm to deliver the changes needed to modernise the local NHS.

During the year the Trust has played its part in delivering a range of national and local initiatives and progress has been made in the following areas:

- The introduction of booking systems whereby patients can telephone the Trust to make appointments convenient to them rather than just one date being offered by the Trust, as was previously the case.
  We will be extending this system across more departments and clinics during 2003/4;

- In the latter part of the year the Trust joined the national Emergency Services Collaborative in order to learn from other hospitals and national experts, how to consistently ensure that patient stays in the A&E Department are kept below 4 hours. More benefits from this initiative will be seen in 2003/4 as a result;

- Much progress has been achieved in improving Cancer services for patients. Endoscopy services, which can provide early diagnosis of cancer, were reviewed and improvements are now being made in respect of better use of facilities and a reduction in cancelled appointments. In Urology, Prostate Assessment Nurses have been introduced to ensure that Consultants can spend more time on more complex investigations and Nurse led assessments have been introduced for patients with suspected Colo-Rectal cancer;

- In Coronary Heart Disease a number of improvements have been made. The national target for ensuring that patients who have suffered heart attacks are given 'clot busting' drugs within 20 minutes is being surpassed. The Trust has introduced Rapid Access Pain clinics and the maximum waiting time is under 2 weeks. Progress has also been made in the treatment of patients with Angina, Heart Failure and also rehabilitation services for people who have suffered heart attacks or undergone heart surgery.

- We have set up a Theatre and Pre-Operative Assessment Project in the year with the objectives of making best use of operating theatre time through better scheduling and of reducing cancelled operations still further by ensuring that patients are fit for surgery before they come into hospital;

- The Trust has worked with South West Kent Primary Care Trust in developing a scheme whereby General Practitioners can take on some work that previously has been carried out only in hospitals. Such a scheme has been introduced at Sevenoaks Hospital in respect of routine Ear, Nose and Throat conditions, thus enabling the Hospital Consultant to spend more time on more complex cases;

- The Trust has started the early planning with local PCTs, the Department of Health and independent health organisations, for a new, purpose built Day Surgery and Diagnostic Centre at Maidstone Hospital. This facility will enable much faster access to day surgery for patients and will be operational in April 2005;

- The Trust is also the host body for the Health Information Service (HIS) and Local Implementation Strategy (LIS), whose function is to co-ordinate and rationalise IM&T strategy and health systems implementation for the NHS bodies in Kent.

The Trust has made good progress to improve services in the year but we recognise that we have much more to do to ensure that service changes are made and spread throughout the organisation. All staff have a role to play in service improvement, in delivering better services to patients, maintaining good links with General Practitioners and ensuring that we can benefit from ongoing education, training and development of our staff, which underpin successful change.

Healthcare Providers Working in Partnership

Maidstone and Tunbridge Wells NHS Trust continues to forge excellent working relationships with its external partners, particularly the Kent and Medway Strategic Health Authority and commissioning Primary Care Trusts.

The Trust is working closely with Maidstone Weald and South West Kent PCTs on a review of its service strategy, which includes developing a comprehensive financial recovery plan.

Local GPs and clinicians working in the NHS across the South of West Kent, linking closely with NHS managers, have been encouraged to take the lead to step up improvements to deliver better health services for local patients.
New relationships are being forged between hospital clinicians and local GPs who will be looking at new ways of working to enable patients to be seen and treated more quickly.

There is already a lot of good work being done within the NHS locally. The partners intend to build on this work and seize new opportunities to deliver a greater range of services for our patients nearer to their own homes.

Clinicians and GPs will be looking at how services within the hospitals and GP surgeries can become more efficient to improve patient care and will be consulting with both patients and the public on any changes.

One of the key priorities will be to make sure that our Trust meets the accident and emergency target, which is that 90% of patients should be admitted, transferred or discharged within four hours of arrival by September, 2003.

Already the Modernisation Agency is providing support to the Trust and this is leading to improvements being made.

Developing new specialist roles for GPs, nurses and therapists is also on the agenda, so that procedures normally done in hospital can be carried out in doctors' surgeries, which will reduce the number of patients needing to be referred to hospital. They will also be working with social services and those health professionals who provide services out in the community to find new solutions to reducing the length of time patients need to be in hospital.

LEARNING FROM PATIENTS' FEEDBACK

Occasionally, patients tell us that they are dissatisfied with the service they have received from us or the facilities provided in our hospitals. We strive to respond to all such expressions of dissatisfaction as quickly as possible and resolve the issues raised with us. Last year we received a total of 812 formal letters of complaint and responded to 69% of these within the 20 working day target of the NHS Complaints Procedure.

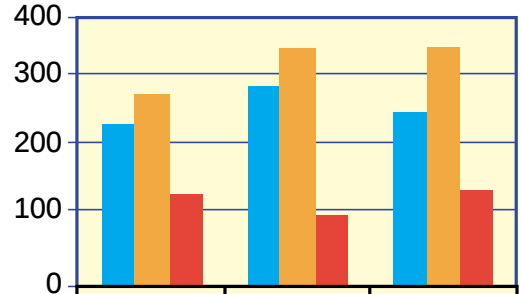
Of these complaints about 32% related to inpatient experiences, 43% to outpatient experiences and 18% related to care, waiting times and the environment in our two Accident and Emergency Departments.

We try to meet with complainants wherever possible as this, we have found, is a very good way of resolving their concerns and providing additional information. We also try to make changes for the better from the patient feedback we receive.

We have been concerned with waiting times for our patients in A&Es awaiting treatment and/or admission to a ward and for some treatments and diagnostic tests, so have taken action to streamline care in A&Es. This has included employing emergency nurse practitioners who are able to treat and discharge some categories of patients without the need to see a doctor, opening an acute assessment unit and working with the emergency services collaborative on a range of other improvements.

We have undertaken recruitment drives in some areas to increase staffing and have obtained additional funding for radiotherapy equipment to keep waiting times for this important treatment as low as possible.

Comparison of complaints between Inpatients, Outpatients and A&E.



	2000/01	2001/02	2002/03
Inpatient	242	298	257
Outpatient	287	352	352
A&E	137	105	143

Extra clinics have been run at weekends in some areas to speed up diagnosis, for example colonoscopies.

We have invested in new telephonic equipment to improve the access for patients wishing to confirm or change their appointments at Maidstone Hospital.

The audiology service, which provides such an important function for patients with hearing impairment is under review so that we can identify ways of improving it.

Very often patients' complaints and those from their relatives include an element of communication and information giving. Patient care is complex and very often involves many different members of staff with different jobs to do and in different departments. This remains a challenge for us to ensure that these separations do not adversely interrupt smooth patient care.
During the year, there were two independent reviews of complaints where we were unable to resolve these locally and the Convenor, a Non Executive Director of the Trust, considered there were still questions to be answered. We have also received one report from the Health Service Commissioner (Ombudsman). The reports from these reviews and the recommendations from them are being taken forward through the Trust's clinical governance framework.

Getting it right

But, many more of our patients are very satisfied with the care they receive from us and regularly tell us this. On average we receive notification from a small sample of our wards that in excess of 100 letters and cards of appreciation are received by the staff caring directly for our patients every month.

Continuing our theme of putting patients first, our Patient Advice and Liaison Service (PALS) enjoyed its first full year of service in 2002/03.

PALS has proved to be very popular with patients, relatives, carers and staff with a total of 2,411 people having used the service in the last year. Providing information on health related topics has accounted for 1,018 of the enquiries and a further 1,393 have resulted in the provision of help, advice and support to people using the NHS.

PALS was launched at Maidstone Hospital in January 2002 and at Kent and Sussex Hospital in April 2002. Access to a ready source of advice and information is key to the success of PALS. Two HealthShops have been set up in the main entrances at Maidstone and Kent & Sussex Hospitals. Both offices have wheelchair access, telephones, faxes, text telephones, loops and email to ensure that people can access the service in the way that is most suitable for them.

There are two PALS Officers and a team of valued volunteers who help to provide the service for our patients.

The PALS Officers work with staff at all levels within the organisation and liaise with their colleagues from other organisations to ensure that patients' views and concerns are fed back appropriately to continuously monitor and improve our services.

The PALS Officers are actively involved in a variety of projects and working groups set up to improve the patient experience. It has also been a busy year for PALS promoting the service and working with local support groups and organisations to ensure that people know about the service.

Reports are produced monthly by PALS for a variety of committees including the Management and Trust Boards to ensure that patients' views and concerns are raised at the highest level within the organisation. A joint action plan is also produced monthly with the Customer Services and the Claims Departments to ensure that we learn lessons from patients' feedback. In this first full year of service, PALS has been working on a variety of subjects with members of staff at all levels throughout the organisation, including managers, directors, specialist nurses and primary care teams. Listed below are some of these areas of work:

- Main Outpatients - with patient involvement, working with staff to improve displays and notice boards
- Intensive Care - working to improve information to patients
- Wheelchairs - ensuring space is allocated for wheelchair users to avoid exclusion from waiting areas
- Relatives room A&E Maidstone - working towards improving facilities
- Organ donation - policy being written for Trust following concerns raised by relative
- Flower policy - being written for Trust after receiving several complaints after wards had banned cut flowers
- Appointments line - new system installed at Maidstone following complaints from the public
- Bereavement booklet - working with chaplaincy team to develop a trust wide booklet
- Supporting several deaf patients when interpreters have not been available
- Basic Sign Language Course was set up for staff wanting to learn basic sign language
- Deaf Awareness - circulation of information leaflets to all areas
- Making information available on audiotape for people with impaired vision

In the year ahead the PALS Officers aim to continue

working on specific projects and with support groups to ensure that hard to reach groups are included.

For more information on the service please contact Karen Beesley, PALS Officer, Tunbridge Wells on 01892 526111 or Annie Oakley, PALS Officer, Maidstone on 01622 224960.

Research and Development

The Trust's Research and Development team supports existing and encourages new research ensuring that all projects and clinical trials, whether NHS driven or externally sponsored are conducted to the highest standards. Findings from research are shared within the Trust and we participate in many multi-site research projects conducted nationally, chiefly in the field of cancer treatments.

In Critical Care, the intensive care team of outreach nurses tested national research findings that key indicators of critical illness are missed on general wards.

In Cancer Services the clinical staff regularly undertake research both locally and as part of national projects on new combinations of radiotherapy and chemotherapy treatments to continuously improve their efficacy.

The Kent and Medway Cancer Research Network was established early in 2003 as part of the National Cancer Research Network. This aims to double the number of trials running in this important area of research by April 2004, and Kent Oncology Centre at Maidstone and Canterbury continues to be at the centre of this research work.

The Haematology Research Unit tested drug resistance in fresh tumour samples in the laboratory to assist clinicians in the best choices of medication for individual patients. The Unit, which was based at Pembury Hospital and relied on grants and charitable donations to run, closed in 2003. However, its reseach and good work is being continued by other units in the country.

Detailed information on the Trust's R&D activities is published annually in the Research & Development Annual Report, available from the R&D Department at Preston Hall.

There have been a number of changes in the Research and Development Committee this year. John Schofield, Consultant Pathologist now chairs the Committee and Heather Gillham was appointed as Research and Development Manager in May. The new committee is looking forward to the challenges of maintaining an efficient and effective system of Research Governance for the Trust within the evolving legislative framework.

Examples of Local Research

Rheumatology Department

Rheumatoid arthritis (RA) is a common inflammatory disease, which causes the joints to become inflamed and affects other parts of the body. It can cause long-term disability due to progressive, widespread joint damage.

Current treatment uses slow-acting anti-rheumatic drugs. This treatment does not always prevent joint damage progressing or stop long-term disability.

A team from Kings College Hospital considered the need for early stronger therapy, which combines two slow acting anti-rheumatic drugs with steroids.

This new treatment is being tested in centres throughout the country in a clinical trial called the CARDERA trial. Recruitment to the trial was over a two-year period, which ended in September 2002.

Patients were recruited to the CARDERA trial from the Rheumatology Departments at Maidstone and Tunbridge Wells.

Oncology

The established reputation of the Kent Oncology Centre has enabled patients to have access to new and innovative treatments in the form of a clinical trial.

Trials are underway looking at different site specific cancers (eg breast, colorectal, lung etc) as well as more widespread disease. The results of completed trials are published regularly in renowned medical journals and presented at both national and international conferences.

There is a team of specially trained research nurses based in the Cancer Centre at Maidstone Hospital. These nurses are the first point of contact for patients who are taking part in a clinical trial.

Some useful websites to find out more about health service research include:
www.controlled-trials.com
www.cancerbacup.org.uk
www.ctu.mrc.ac.uk/ukcccr
www.cancerhelp.org.uk
www.doh.gov.uk
www.nelh.nhs.uk

For further information contact the Trust's Research and Development manager Heather Gillham on 01622 225627.

PUTTING THE PATIENT FIRST

Reducing Waiting Times

Our Trust had difficulties meeting some of the Government's patient waiting time targets by the end of March 2003.

By the end of the March no one should have been waiting longer than 12 months for **elective admission**.

We carried out 34,364 day cases and inpatient elective admissions last year, which was almost 2,000 more than the year before.

At the end of March, three patients had been waiting over 12 months for elective admission, breaching the target, although 70 percent of patients were actually admitted within six months.
We should have also ensured that no patients were waiting longer than 21 weeks to see a consultant for a **first** (GP referred) **outpatient appointment** by the end of March.

Despite seeing an increase in GP referrals (we saw 11,000 more first time appointments this year than last, 58,758 compared to 48,765), we had 20 patients waiting over 21 weeks at the end of March, breaching the waiting time target.

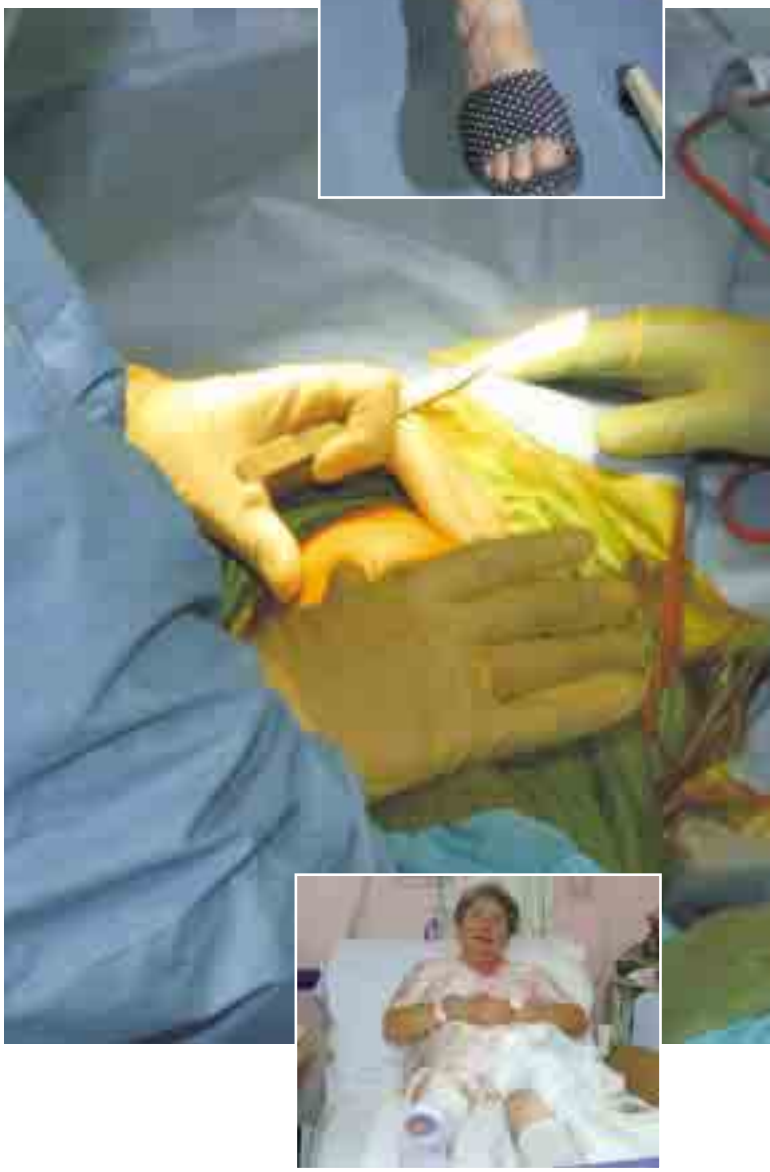
Although 70 percent of first outpatient appointments were carried out within 13 weeks, we had a number of patients who waited over 26 weeks. The 26 week breaches were not reported to the Kent and Medway Strategic Health Authority and an investigation was launched into the waiting list irregularities.

The Trust's 157 consultants and their teams carried out more than 124,000 first GP referred outpatient and follow up appointments in 2002/03.

Total new and follow up attendances in 2002/03 at outpatient clinics, for all sources of referral (GP referral, consultant to consultant, self-referral, social security, family planning, health visitors, Social Services, dentists, from our casualty departments, private practice, optometrists and orthoptists) was just over 300,000.

In addition, close to 26,000 appointments were made where, unfortunately, patients did not attend.

The Trust is also working hard to see outpatients as quickly as possible and reduce any waiting time. A recent Patient Survey in outpatients showed that 74 percent of patients were seen within 30 minutes of their appointment time. A further 15 percent were seen between 31 and 60 minutes, 7 percent waited more than an hour and four percent more than two hours.
We also had to ensure that patients who had their



operations cancelled were readmitted within 28 days. We carried out 34,364 operations during 2002/03, but regrettably 58 people who had cancelled operations waited longer than four weeks to be re-admitted.

Our **Accident and Emergency Departments** at Maidstone and Kent & Sussex Hospitals saw 86,015 patients between them in 2002/03.

The Trust had to ensure that by the end of March, 90 percent of all A&E patients were being seen, treated, transferred or discharged within four hours.
Seven out of every 10 patients (71%) who came into A&E were seen on time, but this was short of the target. Also no patients should have waited longer than 12 hours to be admitted on to a ward from A&E after a decision to admit them. A total of 16,654 patients were admitted via A&E during 2002/03. Of that total less than one percent (161 patients) waited longer than 12 hours.

We are working hard to ensure all of our patients can access our services promptly and are making sure our systems are robust enough to cut waiting times even further.

By the end of March 2004 all patients should receive their inpatient or day case care within **nine months** of being placed on a waiting list.

At the same time, we will also have to ensure that no patients are waiting longer than **17 weeks** for a first outpatient appointment by the end of March.

We must also ensure that all our A&E patients are seen, admitted, transferred or discharged within **four hours** by April, 2004.
Our other goals include continuing to make sure all patients with suspected cancer are seen by one of our consultants within **two weeks** of being referred to us by their GP.

We are also working hard to ensure that all patients who have breast cancer start their treatment within **one month** of being diagnosed. All patients who are urgently referred to us with suspected breast cancer should be diagnosed and start their treatment in **two months**.

Another important goal for our Trust is to have as many single sex wards as possible.

Maidstone Hospital was designed with six-bed bay wards and dedicated toilet facilities. This means it allows for single sex accommodation.

However, at Kent and Sussex and Pembury Hospitals where the wards are mainly Nightingale style it is not always possible, when under extreme pressure, to provide single sex wards.

PUTTING THE PATIENT FIRST

Meet the Team

In our introduction we mentioned that we have more than 4,000 members of staff.

While they have a variety of different jobs to do and roles to play, they all have one thing in common. Every member of our staff has a vital role to play in providing patients with good quality care.

From painters and decorators to paediatricians and porters, we believe all of our staff are equally important.

The people who appear on the front cover of our Annual Report are all members of our own staff. They come from a variety of departments and have different jobs to do.

They are just a fraction, however, of the huge number of staff who are involved somewhere along the line in making sure our patients are well looked after.

One of our young inpatients drew up a list of the staff who in some way helped with his care during his time with us.

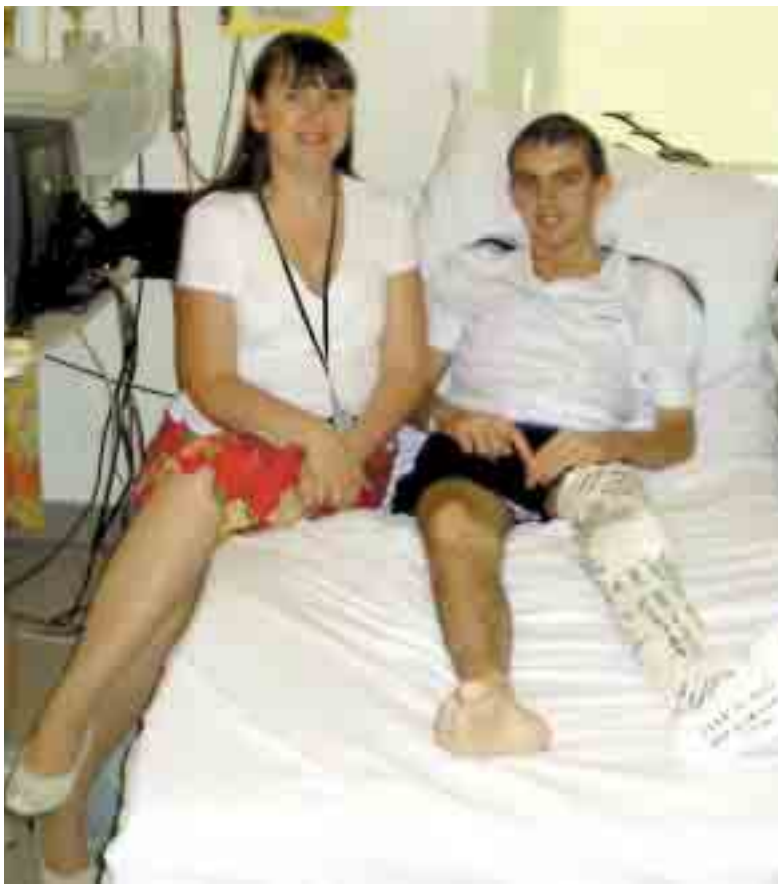
Sixteen-year-old Rob Brivio was brought into hospital suffering from double pneumonia on March 16 this year. He was in hospital for four months and had many more months of physio ahead of him when he left us.

The avid Queens Park Rangers fan doesn't remember much about being brought into hospital. He does remember, however, waking up on April 12, his 16th birthday, not at home but on a life support machine in intensive care at Guy's Hospital.

Rob was so poorly when he reached us he had to be transferred to Great Ormond Street Hospital and then Guy's Hospital in London for specialist care. He suffered three cardiac arrests and nerve damage to his left leg, but fought back to make a recovery and spent the best part of three months with us.

Before he left, Rob made a list of all the different staff who had helped him during his stay with us. There were over 40 of them.

The staff he listed included: ambulance driver, A&E triage nurse, resuscitation doctors and nurses, paediatric registrars and senior house officers, ITU nurses and doctors, staff nurses, student nurses, consultants, play specialist, medical students, sonographers, porters, domestics, ward clerk, pain control team, orthopaedic team, physio, occupational therapist, dietician, chaplain, security guard, café staff, PALS, League of Friends, flower shop staff, administration, tissue viability nurse, growth



nurse, echocardiogram technician, lung specialist, nurse manager, theatre porters, anaesthetist, EMG technician, speech therapist, psychologist, neurologist, surgical appliances technician, pharmacy staff, plaster room technician, Transport staff, hospital radio, works department... and the newspaper salesman!

Patients might not actually come face to face with all the staff involved in their treatment but they are there, nevertheless, working tirelessly behind the scenes.

A large number of patients, for instance, need blood tests when they come into hospital.

What they won't see are the teams of bio-medical scientists who carry out those tests in our blood transfusion departments. They carried out **eight** million blood tests last year.

It doesn't stop there either. We created new posts last year to help meet the needs of our patients.

Brenda Bignall, for instance, joined gynaecology as an Advanced Nurse Practitioner in Colposcopy and Hysteroscopy. We also appointed a Nurse Consultant in Gynaecological Oncology, Pam Pickering. We believe both these posts were the first of their kind in the country.

Other new roles included the appointment of Sally Smith as Nurse Consultant for Outreach for the Trust.

The main priorities for this role are to ensure that all patients who are at risk of becoming critically ill are identified in an early and timely manner, so that Sally and her team can ensure that they assess these individual patients and then work with the ward staff to ensure that they receive the most appropriate and best nursing and medical care that is available to them.

We also rely on an army of volunteer workers who help provide services to patients and staff in all our hospitals.

The work they do ranges from providing a library service to the wards to helping with administration tasks. They run the hospital shops, tea bars and hospital radio and provide transport to and from hospital.

Our volunteers range in age from 16 to 90 and together work hundreds of hours per week. To them all, we would like to say a very big thank you.

The contribution all our Hospital League of Friends and WRVS make is truly immeasurable. They not only give up many hundreds of hours of their own time, they also help raise many hundreds of thousands of pounds for our wards and departments to buy new equipment.

We don't just care for our patients, we also care for our staff. We have a team of people who help look after our staff when they need it most and also provide them with training opportunities.

Occupational health advisors, health and safety officers, payroll clerks, training administrators, recruitment officers, human resources advisors, chaplains, manual handling officers, and a childcare co-ordinator are just a few of the team who are on hand to help our staff.

The Trust's Resuscitation Training Team, under the expert leadership of Victor Nebbolio, trained over 7000 staff in Basic Life Support across the whole of the local health community in the last year.

Victor's team have also made a significant contribution to the resuscitation training for Kent Ambulance Service Staff. This has been so successful that the model of training that has been devised is about to be extended to include staff from other Ambulance Trusts across the country and also to police officers from the Kent Police Force, including the immigration officers.

Occupational Health

During the year there has been changes in the way Occupational Health has been delivered within the Trust.

The consultant support to the service was provided by a private organisation and this has now ceased and we are currently appointing a consultant who will be employed by the Trust on a part time basis.
A review of the occupational health service provided by the Trust was undertaken earlier in the year and this highlighted a need to employ more qualified occupational health nurses. It also stated that there was a need to review processes and systems within the department.

An occupational health nurse was appointed on a contract basis to implement this review and we are in the middle of recruiting to vacant nursing posts.

The review has enabled the department to refocus and develop a better access for staff who need to use these services.

The services being developed will help reduce work related illness and accidents in the workplace through education and promotion in line with the Government's Health Promoting Hospital and Health at work in the NHS initiatives.

Health and Safety

The Trust seeks to provide a safe working environment, safe equipment and safe working practices to ensure the safety and health of its staff, patients and visitors. This is achieved through a programme of continuous risk assessment, staff consultation and adverse incident investigations.

The Trust has health and safety policies and procedures to advise and assist all staff in managing health and safety in their areas of work. This is supported by a comprehensive training programme, providing staff with the necessary skills and knowledge to manage risk effectively.

In the year 2002/03, the Trust has been the focus of both internal and external inspection and audit to assess its health and safety management systems. The Trust acknowledges that whilst many areas of good practice have been identified, there is still room for improvement. To this end, The Trust has developed a health and safety plan for progressive improvement over the coming 12 months.

Right People, Right Job

Our Staff

We think our staff are pretty fantastic and we're not alone.

Over the course of the year many of our staff were presented with awards and accolades for their achievements.

Many of them also put themselves out, above and beyond the call of duty, to help others simply because they care.

The Trust's Senior Chief Hearing Therapist **Mary Thomas** was invited to meet Prime Minister Tony Blair in February in recognition of her contribution to the Allied Health Professionals.

Mary has worked in hearing therapy for 17 years. Her work in recent years has included using her expertise to good effect on national committees.

She sat on a pioneering committee that looked at state registration of clinical physiologists and was also on the Greenaway Committee that looked at audiology education.

Mary also helped put together a £2.8 million business plan for the Department of Health for a stop gap training course for 80 trainee hearing therapists with the University of Bristol.

She is also a former chairman of the Academic Board of the British Society of Hearing Therapists.

Coroner's Officer **Frank Tulley** who has an office at Maidstone Hospital was made an MBE in 2002 for his services to the Coroner in Maidstone.

Friends in the hospital's administration department described Frank as a wonderful person to work with.

Junior Doctor at Maidstone Hospital Mr **Indie Singh** FRCS, Registrar to Mr Geoff Trotter, won a prize for his research at the Worldwide health conference in Mexico.

Maidstone Hospital's **Catering Department** had a busy year last year but all the hard work paid off when they won an award for their healthy food and high standards of hygiene.
The department won a Kent Heartbeat Award for promoting healthier choices of food, provision of a non-smoking dining area and high standards of hygiene.

The department keeps the award for 18 months. The Kent-wide multi-agency health scheme was set up to help in the fight against coronary heart disease.

Radiation therapy and radiotherapy services at both **Kent Oncology Centre** sites at Maidstone and Kent and Canterbury Hospitals were given the seal of approval for quality. KOC met standards and guidelines for establishing and implementing a quality management system in both areas thanks to the hard work and commitment of all oncology staff.

The Trust also presented a host of staff and departments with Employee and Team of the Month awards during 2002/03 for going that extra mile.

Our staff are also willing to go that extra mile when it comes to helping others. Always keen to do something for a good cause, our staff ran marathons, held sponsored events and even donned their Red Noses for Red Nose day during 2002/03.

Improving Working Lives

We passed another major milestone in 2002/03 in our ongoing efforts to improve the working lives of all our staff.

The Trust heard at the end of the financial year that it had successfully achieved part two of the NHS Plan's Improving Working Lives Standard.

The Standard consists of three parts and we are now just one step away from achieving full accreditation.

The Improving Working Lives Standard states that all staff working for the NHS are entitled to work in an organisation that can prove it is investing in more flexible, supportive and family friendly working arrangements to improve diversity, tackle discrimination and harassment and develop staff skills to improve patient services.

We believe IWL is equally important for our patients as it also helps us deliver better patient care through improved staff recruitment and retention. Patients also want to be treated by well-motivated fairly rewarded staff.

We achieved the first part of the Standard after pledging to improve the working lives of our staff and setting up an IWL working group to make improvements.

The second part required the Trust to provide a portfolio of evidence covering a wide range of our policies and procedures that help improve the working lives of all our staff.

The paper evidence provided around 25 percent of the evidence required to pass the second part of the Standard. An IWL Assessment Team also visited the Trust's hospitals in December and carried out one to one interviews with staff, interviews with staff groups, staff side representatives and focus groups.

It was through these that the assessors were able to determine whether the organisation has a culture of improving working lives, and whether or not we are actively striving to deliver the Standard.

The feedback was generally good but the report also made recommendations as to what the Trust's priorities should be for action to improve working lives still further.

The Trust is now working on an Action Plan to improve any weak areas picked up in the assessment. Any gaps have to be remedied for the Trust to achieve full accreditation.

The Trust had to demonstrate that it is making real progress in areas such as:

- Supporting and promoting a range of flexible working practices
- Improving childcare provision
- Investing more in the training and development of staff

- Making the working lives of staff safer by protecting them from violence, harassment and bullying.

Many of the Trust's new initiatives to improve working lives were brought in on the back of what its employees asked for in a Staff Opinion Survey.

The Trust is pushing ahead with plans for créche facilities at Maidstone and Pembury hospitals, has introduced a range of flexible working policies, and produced a zero-tolerance policy to protect staff against violent or abusive patients.

Staff Opinion Survey

We surveyed our staff in the autumn to gather their opinions on how we work as a Trust and where we could make improvements.

A total of 1,164 staff returned their forms in the 2002 Staff Opinion Survey, which was slightly down on the year before.

Our staff said their top priorities centred round perceptions of pay, conditions of service, opportunities for promotion and job security.

Their number one priority was for the Trust to have an Equitable Reward Structure.

Overall, our staff said they found their work very rewarding and personally fulfilling. However, there was general dissatisfaction about pay and conditions. Of particular concern was that pay and promotion are not linked to good performance.

After listening to what our staff had to say, we used the results of the survey (which were analysed by an independent organisation) to consider the priorities for action for the Trust.

These have been linked with the feedback following the Commission for Health Improvement review and common themes have been identified.

An example of this would be the need to ensure that staff have appraisals and personal development plans.

In addition each care group has received feedback from the survey via their Lead HR Adviser in order that they can formulate local action plans for change.

The top 10 areas of priority, as highlighted by our staff, were:

1. Equitable Reward Structure
2. Staff Involvement
3. Work Arrangements
4. Recognition and Independence
5. Relationship with Manager

6. Open Communication
7. Health and Safety
8. Work Objectives and Role Clarity
9. Equality of Opportunity
10. Freedom from Harassment and Bullying.

Equal Opportunities

The Trust is committed to equal opportunities and welcomes diversity.

Our Policy for Managing Diversity sets out the Trust's commitment to valuing people as individuals and aims to ensure that no patient, employee or prospective employee is discriminated against.

To support this, the Trust has put in place a policy for employing people with a disability and is working towards full implementation of the 2 ticks symbol.

We are committed to effective implementation of both Policies across the Trust and to raising awareness of individual responsibility to ensure no person is disadvantaged.

The Trust has been successful in achieving the Improving Working Lives Practice standard and has put in place action plans to develop key areas, which include Equality and Diversity, Staff Involvement, flexible working and Childcare.

The Trust has appointed a Childcare Coordinator who works closely with Staff to support them to meet their childcare needs and improve access for Trust employees to affordable childcare services.

The Trust is keen to work closely with staff and their

recognised representatives. A Joint Consultative Forum meets regularly and is a productive group tackling issues such as policy reviews, Improving Working Lives and pay and terms and conditions.

Staff involvement is recognised as critical to our success as an organisation and is encouraged through many forums and our communication routes.

The Trust is committed to developing our HR Strategy and investing in all staff related issues including training and development opportunities, reducing turnover, developing Recruitment and Retention issues, successfully managing sickness absence levels, and risk management with an aim of becoming a Model employer.

FOOD FOR THOUGHT

Our hard working catering staff served around three quarters of a million patient meals in 2002/03.

The total number of patient meals served last year on all of our sites was 710,532.

Our patients also got through 317,164 pints of milk and 41,485 loaves of bread.

At Maidstone Hospital, for instance, patients ate their way through 118,200 tubs of ice cream, 3,142 fresh cauliflowers, 2,171 salmon steaks, 5,599 punnets of cress, 49,740 jacket potatoes, 14,355 chicken portions, and 1,705 litres of fresh whipping cream. They also managed to drink 118,600 cartons of orange juice!

Clinical Governance

Clinical Governance is the name given to the framework by which we ensure that our Trust and individual members of staff deliver high-quality healthcare for our patients.

It involves setting standards and ensuring that

national and local standards are maintained, listening to feedback from patients and their relatives and carers, reviewing the quality of our services, helping staff to evaluate their practice and the outcomes of treatment, identifying and managing clinical risks and improving quality.

There were many examples in 2002/03 of the ways in which we have improved our processes and practices and thereby, improving matters for our patients.

Some of those improvements resulted directly from the experiences of individual patients, some from the desire of our staff to do the best they can for those patients and some are in response to influences such as the National Institute for Clinical Excellence (NICE) or the Commission for Health Improvement (CHI).

CHI

The year was dominated by the CHI clinical governance review last autumn. The visiting team set out to discover what it is like to be a patient in this Trust, how good our systems for safeguarding and improving the quality of care are and to assess the organisation's capacity to improve the patient's experience.

To do this they focussed on the care processes for patients with a fractured hip, requiring vascular surgery and those using the urology service, using those as models for structures and processes within our Trust.

The Commission identified the areas of notable practice in the Trust as the handbook for junior doctors working in the pre-assessment unit, the comprehensive process for patients' consent for vascular surgery, good examples of staff training partnerships with external agencies, including the police and voluntary organisations and the support given to doctors and nurses caring for critically ill patients on wards.

The Commission considered that the work undertaken by the urology team to involve patients and the local prostate support association in developing an enhanced patient pathway for prostate cancer treatment and to raise awareness in the community, was worthy of sharing with the rest of the NHS.

However, the Commission also recognised that there were issues of clinical governance on which the Trust, and its partners, should focus attention, such as eradicating mixed sex wards, reducing waiting times in A&Es, reducing infection rates, reviewing vascular surgical cover out of hours, ensuring the appropriate skill mix and numbers of nursing staff on its wards, strengthening its risk management processes and ensuring that staff are provided with information from the incident reporting system.

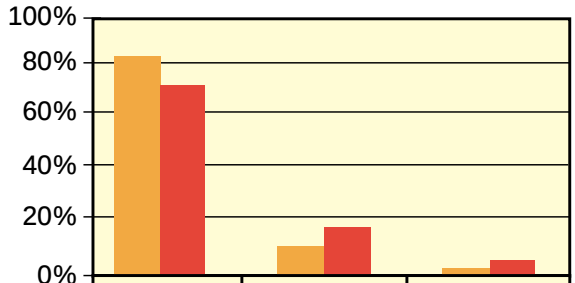
The Trust welcomed the report which underpinned a number of initiatives already underway to improve services and which helped to focus attention on some of the infrastructure issues, such as information systems. During 2003-2004 the Trust will be taking forward the action necessary to address all of these issues with its partners in health and social services.

Patient Survey

One of the best ways of monitoring how our services are received by those who use them is through patient feedback. During 2002-2003 we participated in the national inpatient survey, asking 850 people who had been patients in one of our hospitals what they thought of the service provided. This covered environmental issues, such as the cleanliness of our wards, the skills and attitude of our staff and the timeliness of treatment. Our patients told us that our

Overall, where you treated with dignity and respect

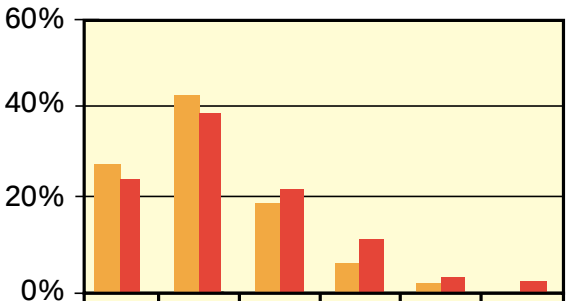
Number of patients who answered this question: 514 outpatients 385 A&E



	All of the time	Some of the time	No
Outpatients	88%	11%	1%
A&E	78%	19%	3%

How would you rate the care you received?

Number of patients who answered this question: 516 outpatients 388 A&E



	Excellent	Very good	Good	Fair	Poor	Very poor
Outpatients	29%	43%	19%	7%	1%	0%
A&E	26%	39%	21%	10%	3%	2%

staff were courteous, information was provided by clinical staff in a sympathetic way, the wards were not unduly noisy and discharge arrangements worked well. Help was frequently given with meals when needed and patients were not upset by the presence of medical students or by being asked for their details too frequently. Some patients, however, reported that their level of pain was sometimes too high, even though medication was given promptly and indicated that they had had to wait for admission to a bed longer than they would have liked. Many patients were unhappy being nursed in a mixed sex ward and would have liked more information about the ward routine and about how they would feel after operation.

In January 2003 we repeated the survey, this time for patients using our outpatient and A&E departments. While the Trust performed significantly better than the national average in some areas, patients also felt there was room for improvement in others.

Generally, however, the majority of patients felt they were treated with respect and dignity and that the care they received was either excellent, very good or good.

The Trust performed significantly better than average in the Outpatient Survey in areas such as:

- Convenience of car parking
- Staff not contradicting themselves when providing information
- Patients feeling they could discuss issues in privacy
- Patients knowing how to complain if necessary

Areas where the Trust performed less well than average in the Outpatient Survey centred round patients not being as fully informed as they would like to have been about what would happen in relation to their treatment (including how to find out their test results) and to the organisation of the department.

The Trust's A&E Departments performed significantly better than average in:

- Convenience of car parking
- Lower proportion of patients waiting more than two hours to be examined
- Patients having enough time to fully discuss health/medical problems
- Doctors and nurses not talking over the patient
- Patients not asked name and address too often
- Patient's family/home situation taken into account fully

The Trust's A&E Departments performed less well than average in giving patients information on their individual priority level and waiting times, higher proportion of patients staying in A&E in excess of eight hours, waiting more than eight hours to be admitted and patients not given a choice of follow-up appointment times.
86 percent of patients who took part in the A&E Survey said the care they received was either excellent, very good or good, compared to a national average of 85 percent. 78 percent of A&E patients said they were treated with respect and dignity all the time, compared to 77 percent nationally.

91 percent of patients who took part in the Outpatients Survey said the care they received was either excellent, very good or good, compared to a national average of 94 percent. 88 percent of Outpatients said they were treated with respect and dignity all the time, compared to 87 percent nationally.

IMPROVEMENTS FROM PATIENT FEEDBACK

Examples of ways in which we have improved our services as a direct result of patient feedback from the inpatient survey include

- reorganising pain clinic arrangements to minimise waits and avoid cancellations
- extra colonoscopy sessions to shorten waiting times
- accepting telephone referrals from GPs to the ECG department
- major changes in services in A&Es, including additional medical staff, reduced reliance on agency nurses, Emergency Nurse Practitioners seeing and treating patients without the need to wait for a doctor and, during 2003-4, trialling a GP referral unit in one of the A&E departments
- additional car parking provided
- process for the issue of medical certifications amended

The appointment of a Clinical Risk Manager has also enabled the Trust to develop its processes to improve patient safety.

The focus has been on raising staff awareness, introducing care group risk co-ordinator roles, improving the reporting of clinical incidents and giving feedback to staff, care groups and committees. Action cards have been introduced to assist staff when investigating reported incidents. There is also a monthly Clinical Risk Monitoring Group, which reviews these and other clinical risks.

STAFF FOCUS

Staff are encouraged to put forward ideas for change through a variety of routes. We have staff forums and a staff involvement policy. Monthly communication briefings from out Trust Board also provide an opportunity for feedback from staff.

EMERGENCY PLANNING

The year ended April 2003 has been a very busy one for emergency planning.

During the year there were a number of emergency planning issues to deal with including the fire service industrial action, Gulf War, development of our Chemical, Biological, Radiological and Nuclear incident capabilities, development of our own internal resilience planning and several incidents.

The National Audit Office Report 'Facing the challenge' along with the changes in the NHS including development of Lead PCTs assuming the old Health Authority functions have all led to an interesting year.

Incidents:

During the past twelve months the Trust has responded to several real incidents - the most serious being the fire that broke out on May 12th 2002 at the Kent and Sussex Hospital resulting in evacuation

Fire at Kent & Sussex Hospital

of several areas and some 9 fire appliances attending the hospital. The incident was dealt with effectively and the emergency services were quick to praise the Trust for its response. As a result of the debrief and investigations a new internal emergency plan has been developed and implemented.

Also during October and November 2002 the Trust responded to an outbreak of the Winter Vomiting Virus which affected all of our hospitals. This was controlled by the Infection Control Team who worked tirelessly during the outbreak. The outbreak tested various aspects of emergency planning such as the use of control rooms, use of the voluntary aid societies and media management. Throughout the year there has been closer co-operation between emergency planning and infection control including the publication of the major outbreak plan as part of the Major Incident Plan.

Over December 2002 into January 2003, severe weather caused some major flooding within the Trust catchment area and staff within the Trust were warned and accommodation was provided for stranded staff along with a great deal of co-operation with our primary care trusts and Kent Ambulance Service. As a result some work is on going looking at the safety of Midwives and District Nurses and how we alert them in Severe Weather and also identifying vulnerable patients in the community. Similar plans were put into effect for the snowfall in January/February.

Exercises:

Over the last twelve months the trust has undertaken several exercises which are listed below, all hot on the heals of Exercise Freya the multi national nuclear exercise held in March 2002. The Trust also sent a mobile medical team to the annual Channel Tunnel Exercise in April 2002. The Trust accepts that exercise testing of its plans is important and a mandatory requirement highlighted in the Controls Assurance standards. The Trust has already started to plan its full scale 'live' exercise planned for the Summer of 2003.

Exercise Spa 6 - October 2002. This was part of the Trust's communications exercise programme designed to test the cascades and systems around the Trust for alerting and informing.

Exercise Spa 7 - March 2003. This communications exercise was postponed due to the Gulf War and was rescheduled for June 2003.

Exercise IT Crash - September 2002. This was a tabletop exercise involving all departments and care groups within the hospital and centred around a fire at Pembury Hospital which knocked out the IT control/comms Room leading to a loss of IT systems around the Trust.
The exercise featured the response to the fire and then the follow on aspects of disaster recovery and business continuity. Lessons were learnt from this and are being implemented around the Trust.

Chemical, Biological, Radiation and Nuclear Incident Response:

Throughout the last twelve months the Trust has developed its capacity to respond to CBRN incident. In **August 2002** the Trust hosted a trainers event at Pembury Hospital attended by representatives from hospitals and ambulance trusts from across the South East to introduce the new chemical protection suits and decontamination units.

Decontamination Unit and Chemical Protection Suit in use for training.

In **October 2002** the Emergency Planning Officer attended the trainers course at Plysu in Milton Keynes and in **December 2002** at ALSG in Manchester becoming one of the regional key trainers. The Trust then hosted a regional training event at Pembury Hospital to train other trusts in the decontamination techniques in **January 2003** and supported a similar event held at St Richards Hospital in Chichester in **February 2003**.

The Trust's estates department has installed the necessary facilities such as power and lighting to enable training to commence on the use of this new decontamination equipment. Training has already started and the appeal for volunteers from around the Trust to support A&E and be trained was successful with over 40 volunteers coming forward.

These resources are more likely to be utilised for a chemical accident such as a tanker crash or industrial plant accident.

The Trust is now working to develop its self referrers plan and is actively working with the fire brigade to manage large scale self referring patients to A&E in the event of a CBRN incident. In addition the Trust's Major Incident Plan has been updated to reflect this type of incident.

Response to the National Audit Office Report

In January 2003 the National Audit Office produced their report **Facing the Challenge: NHS Emergency Planning**. This report highlighted deficiencies in the NHS Emergency Planning Response and as a result the Trust was asked by the Department of Health to self assess its plans and submit a report to the Strategic Health Authority for examination by the Health Emergency Planning Advisor and the Chief Executive of the Health Authority.

It was reported that the HEPA was satisfied that our arrangements were satisfactory and this has been reported up to the DoH. At the same time the Board received a report on Emergency Planning from the Emergency Planning Officer highlighting areas of good practice and areas which were in need of further development.

The Board endorsed the views of the Emergency Planning Officer and additional funding and resources were identified. In addition the Emergency Planning Committee is now chaired by the Director of Nursing as an executive director indicating the importance the Trust place on its emergency preparedness arrangements.

Whole Health Economy Work:

During the year the post of Emergency Planning Officer was shared between the two adjoining Primary Care Trusts and this arrangement has been very successful. This is a full time post divided between the

three organisations. This will mean that next year's report will be a joint report between all three organisations highlighting further the joint working between the organisations. A 'whole system' approach to emergency planning has benefits especially in integrating PCT and acute trust responses to an emergency. This arrangement has already reaped rewards especially during flooding at New Year but also in joint training and sharing good practice, resources and costs.

Training:

Emergency Planning training has been held across the Trust during the year and recently a study day has been developed featuring both conventional and CBRN incidents. This study day has been well attended with over 300 staff who have attended or are booked onto training. Further department specific training has also been carried out. In addition to this all Level 1 and Executive On Call Staff have been given on call emergency guides with various phone numbers, action cards and resources to make life easier whilst on call.

Fire Service Strike:

Collaboration between Emergency Planning and Fire Safety led to detailed plans being laid down to manage fire incidents in the periods of fire brigade industrial action. During the strike there were several fire alarms that were confirmed as false alarms. Only one incident involved a green goddess and army crews responding to the Kent & Sussex Hospital for an incident that was reported as smoke but was dust. All plans worked very well. Internal Emergency Plans for managing such incidents were formally adopted by the Emergency Planning Committee.

Developments during the year:

During the year Emergency Planning and IT systems have been working jointly and we now have our plan electronically available on the intranet and a new emergency planning intranet site live from May. This will enable us to post messages about incidents, highlight training and post documents such as new guidance.

Throughout the year IT have worked hard to help emergency planning and have been successful in helping especially in getting e mail/NHS net access for staff in emergencies and developing the intranet site.

During the year the Emergency Planning Officer has forged close working relationships with other full time EPOs in neighbouring trusts allowing exchange of good practice and ideas and help with training.

Building On Sure Foundations

What a difference a day makes - or 365 and a quarter to be exact.

In little over a year the Trust has seen a huge amount of development take place with new buildings opening, projects coming on line and wards being revamped.
One of the single biggest achievements in the Trust's relatively short history may have finally been achieved in 10 days, but it was years in the making.

After 160 years Maidstone's much loved **Kent County Ophthalmic and Aural Hospital** closed its doors for the last time at six o'clock on Friday, April 11 this year.

Over the course of 10 days staff helped transfer tons of equipment over from KCOAH into a new £11.3 million Eye, Ear and Mouth Unit at Maidstone Hospital.

At 7am on Tuesday, April 22, the new Unit opened. The first patient arrived for a cataract operation 15 minutes later.

Former Health Secretary Alan Milburn performed the topping-out ceremony for the new building in June 2002. He told Trust staff then: 'It is pleasing to see the building work here and it is the first down payment to giving this area the modern facilities that it deserves.'

The Trust saw a flurry of activity in 2002/03 with a new £2 million Orthopaedic Unit opening at **Maidstone Hospital** in January.

The state-of-the-art facility has a Laminar Flow Theatre that should help reduce infection rates in joint replacement surgery at the hospital.

In July 2002 the Trust officially opened a £40,000 'Home from Home' unit in the Labour suite at **Pembury Hospital**. The unit is designed for women who want to give birth in a homelike environment but with the added security of medical staff and facilities close at hand.

Patients were evacuated from **Kent and Sussex Hospital** in May of last year when a fire broke out in a disused ward.

Ward 14 has now been completely refurbished and reopened as a new elective medical unit.

The Trust also upgraded Hargraves, and Wards 7, 11 at Kent and Sussex Hospital. The total cost of revamping all three wards was £398,000.
The Trust also unveiled multi-million pound plans in August for a £7.4 million expansion to the oncology

centre at Maidstone. By 2006 a major extension will have been built behind the centre to house an extra linear accelerator, which is going to cost £1 million. There will also be an extra treatment chamber built so that the existing linear accelerators can be replaced. A second treatment simulator will also be installed.

The Trust also received hundreds of thousands of pounds from the New Opportunities Fund in 2002/03 to buy a new MRI machine at Pembury Hospital.

Plans are also progressing to build a multi-million pound Diagnostic and Treatment Centre at Maidstone Hospital. The centre will help reduce waiting times for day case surgery and help us to see and treat more patients.

New Hospital for Tunbridge Wells

The Trust is continuing to work towards the procurement of a new hospital for Tunbridge Wells using the Private Finance Initiative. During the past year some key milestones have been met.

The scheme is to provide a new 595-bed acute general hospital, a 56-bed Mental Health Unit, keyworker accommodation and associated car parking.

The remainder of the PFI Project at Tunbridge Wells was considered for a Government initiative to 'batch' Hospital schemes together, in order to attract major consortiums to fund and build the Hospital developments. However, as no suitable 'batch' partners were available, the scheme is now likely to run independently.

Work continued through the year to seek Outline Planning Approval for the Tunbridge Wells development and the scheme had to go through a number of local committees before being sent to the Government Offices of the South East for their approval of the scheme. An announcement by the Secretary of State to endorse the approval of the application was received in April 2003.

During the year the Trust has established a number of clinical and non-clinical working groups, which were responsible for the production of clinical models of care, specifications of what each department requires and how they will function.

In line with the National guidance of Health & Social Care, the Trust moved forward its plans to involve patients and the general public more fully in its proposals and development plans, by establishing a Patient & Public Involvement Strategy for the Project.

The next steps for the project include the collation of information from the clinical and non-clinical working groups, patients and the general public, to form the baseline data on which the Trust and the selected PFI Private Partner will design the hospital and develop the methods of service delivery.

Discussions around the siting of the new Hospital continue but are expected to be resolved by the end of 2003.

The Trust is planning to complete the development of the contract documentation during the coming year with a view to going to the market during 2004 to select a PFI partner.

Keeping Our Hospitals Clean

Pembury Hospital scored top marks for cleanliness and tidiness in 2003.

The hospital's high standards are a marked improvement on previous years.

Two years ago the hospital was ranked among the worst in the country. Today it is among the best, with standards of cleanliness and tidiness generally exceeding patients' expectations.

Maidstone Hospital also scored top marks for cleanliness in 2003. The hospital has now scored top marks for cleanliness in four successive inspections.

Kent and Sussex Hospital is maintaining acceptable standards of cleanliness, which generally meet patient needs, but with room for improvement in some areas.

All three hospitals are providing food that generally meet patient needs, but with room for improvement in some areas.

Our hospitals are annually inspected by Patient Environment Action Teams (PEAT) who look at cleanliness and food standards as part of the Government's Clean Hospital and Bettter Hospital Food programme.

PEAT teams assess cleanliness across 18 criteria. The criteria include the cleanliness of wards, reception and waiting areas, corridors and other common areas, toilets, furniture, linen and the grounds and gardens/fabric of the hospital.

Food is marked on presentation, quality, choice/menu, portion size, temperature, meal timings, delivery/ service and beverages.

The marks are turned into a traffic light rating system. Green hospitals provide high standards, which almost always meet patient needs and generally exceed

expectations. Amber hospitals provide standards that generally meet patient needs, but where there is room for improvement in some areas. Red hospitals provide poor standards, which do not meet patient needs and where urgent improvement is needed as a matter of urgency.
Maidstone and Pembury hospitals got green lights for cleanliness in 2003 and Kent and Sussex got an amber rating. All three hospitals got amber ratings for food.

In 2002 Kent and Sussex and Pembury hospitals got amber ratings for cleanliness and food, while Maidstone Hospital got a green for cleanliness and food.

Upgrading Our Buildings And Equipment

Our Capital Programme gets bigger every year, and 2002/03 was no exception. The programme for the year exceeded £17million compared to £10.5 million the year before.

The capital investment in Maidstone and Tunbridge Wells has grown dramatically over the years.

Prior to Trust merger, neither Kent & Sussex Weald or Mid Kent Healthcare NHS Trustsí capital programmes exceeded £2-£3 million.

In 2002/03 we spent:

- £7 million on the new Eye, Ear and Mouth Unit at Maidstone.
- £398,000 to upgrade Hargraves, and Wards 7, 11 and 14 at Kent and Sussex
- £50,000 to expand the car parking at Pembury
- £1.75 million on a new Orthopaedic Unit at Maidstone
- £380,000 to expand the Oncology Pharmacy at Maidstone
- £500,000 on backlog maintenance
- £265,000 to upgrade the Treatment Planning system in Oncology
- £250,000 to upgrade Burslem House, Tunbridge Wells
- Upgrade to Pharmacy IT systems (£18,000)

In 2002/03 we bought:

Medical equipment replacement - including

- Anaesthetic machines (£700,000)
- Treadmills (£33,000)
- Urology Equipment (£63,000)
- Gastroscopes (£50,000)
- Two lasers for Ophthalmology (£55,000)
- Cystoscopes (£60,000)
- Ventilators for SCBU (£40,000)
- Ventilators for ICU (£41,000)
- Replacement breast screening trailer (£65,000)
- Replacement diagnostic equipment (£630,000)
- Replacement oncology equipment (£250,000)
- Purchase and installation of a replacement simulator in Oncology (£450,000)
- Chemical decontamination Equipment (£20,000)
- Teleradiology link to Kings (£50,000)

FINANCIAL OVERVIEW

The 2002/03 financial year proved to be very challenging as expected. The Trust treated approximately 20% more patients than the previous year resulting in substantial increases in drug and other non-pay expenditure. In addition the Trust continues to experience staff shortages with ongoing reliance on agency staff continuing to place pressure on pay expenditure. Although the Trust reported a deficit mainly due to the above issues, this masked significant achievement against the Performance Improvement Plan.

The Trust has three key statutory financial duties and two key financial performance targets set by the NHS Executive. Performance in each of these areas is described below.

1) BREAK-EVEN DUTY

The Trust is required to break-even on Income and Expenditure taking one year with another. This duty is usually measured by assessing performance over a three-year period. The Trust had an operating deficit of £4,040,000 for the year ended 31 March 2003, representing 2.28% of turnover. The operating deficit for the year ended 31 March 2002 was £4,153,000 (2.59% of turnover) and the operating surplus for the year ended 31 March 2001 was £104,000. The Trust therefore has a cumulative deficit since merger on 1 April 2000 of £8,089,000.

2) CAPITAL COST ABSORPTION DUTY

The Trust is required to absorb the cost of capital at a rate of 6% of average relevant net assets. The rate is calculated as the percentage that dividends paid on public dividend capital, totalling £6,907,000, bears to the average relevant net assets of £92,508.000, that is 7.5%. The Trust therefore exceeded the 6% target. The 7.5% achieved is marginally above the normal range of 5.5% - 6.5% expected and arises from lower than expected depreciation charges resulting from capital programme slippage and major capital projects accounted for in capital charges estimates but not subsequently funded.

3) EXTERNAL FINANCING LIMIT DUTY

This duty is a measure of the Trust's ability to manage its cash. The External Financing Limit set by the NHS Executive for the year was £9,674,000. The Trust marginally overshot the target by £3,000 or 0.03%, which was considered immaterial.

The Trust also had a Capital Resource Limit target of £16,764,000, which it met exactly.

4) MANAGEMENT COST TARGET

The Trust's Management Costs for the year were £6,282,000 compared to £6,076,000 in 2001/02. The Trust has marginally reduced its management costs as a percentage of related income from 4.0% in 2001/02 to 3.9% in 2002/03.

The Trust complied with the requirements of the letter from the Permanent Secretary/Chief Executive at the Department of Health of 11 April 2002 on senior managers pay by restricting pay awards to this group to 3.6% for the year ended 31 March 2003.

5) BETTER PAYMENT PRACTICE CODE TARGET

The Confederation of British Industry (CBI) sets a target to pay all trade creditors within 30 days of receipt of goods or a valid invoice (whichever is later) unless other payment terms have been agreed. The Trustís compliance with this is as follows:

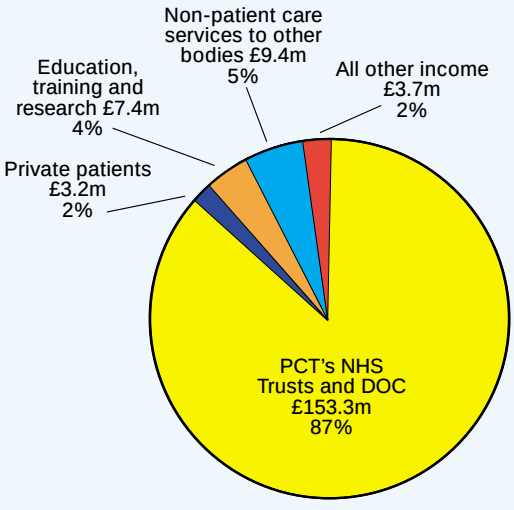
	2002/03 Number	2002/03 £000	2001/02 Number	2001/02 £000
Total bills paid in the year	88,104	85,121	92,245	84,419
Total bills paid within target	59,053	64,217	50,456	55,276
Percentage of bills paid Within target	**67%**	**75%**	**55%**	**65%**

The Trust has therefore paid 12% more invoices by number within 30 days in 2002/03 compared to the previous year and continually strives to improve this performance.

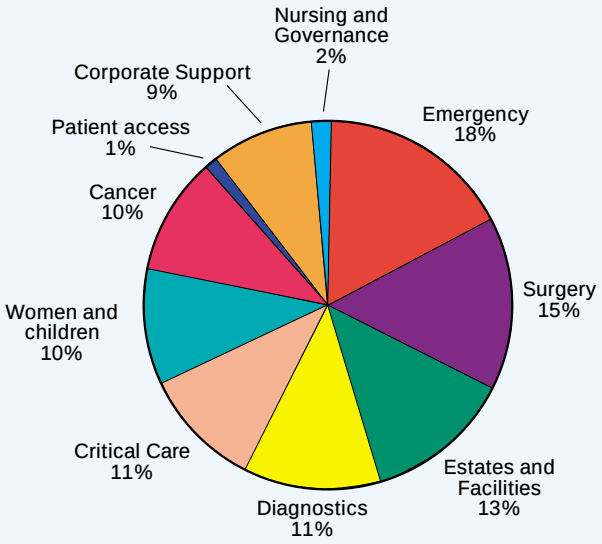
The Trust did not make any payments to Trade Creditors under the Late Payment of Commercial Debts (Interest) Act 1998.

ANALYSIS OF TRUST INCOME FOR 2002/03

The majority of the Trustís income, almost 90%, comes from the provision of direct patient care. However the Trust also receives income for staff education and for the provision of services to other NHS organisations in the locality.

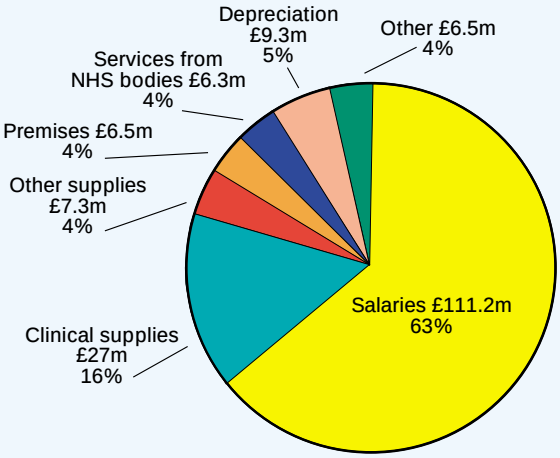


EXPENDITURE ANALYSIS BY CARE GROUP (PATIENT SERVICE) 2002/03



Clinical care groups manage almost 80% of the Trust's resources. This ensures that decisions are made by the Clinicians, Managers and other frontline staff who are responsible for delivering care to patients on a day-to-day basis.

ANALYSIS OF OPERATING EXPENDITURE BY EXPENSE TYPE FOR 2002/03



Staff are the key to delivering high quality healthcare to patients. The Trust employs over 4,000 whole time equivalent staff including 411 doctors, 1,645 nurses and midwives and 492 therapeutic, scientific and technical staff.

FINANCIAL OUTLOOK FOR 2003/04

The Trust is required to prepare a Financial Recovery Plan (FRP) to identify how a balanced position will be achieved by March 2004, given the 3 year break-even duty and therefore, the requirement for the previous years' Trust debt to be fully repaid. An initial draft has been prepared and submitted to the Strategic Health Authority, which identified a remaining savings target of £3.9m after taking account of the schemes and initiatives identified to date. It is recognised by the Local Health Community that this remaining savings gap cannot be tackled by the Trust alone. Therefore, the Trust is working with its PCT partners to identify a range of further measures and initiatives to produce the required balanced year-end position.

The host PCT has accepted that cash brokerage will be required in 2003/04 to enable the Trust to meet its liabilities as they fall due and has undertaken to make it available as required. The 2002/03 cash brokerage of £17 million will be repaid in 2003/04. The host PCT has agreed initial cash brokerage of £23 million for 2003/04, which the Trust considers would be the maximum requirement if the financial recovery plan was not effective. The Trust recognises the potential risk to its cash flow presented through hosting the Health Informatics Service and as cluster lead for NHS Professionals. The Trust will be taking all appropriate steps to mitigate against this risk such as formal agreement of payment terms.

SUMMARY FINANCIAL STATEMENTS

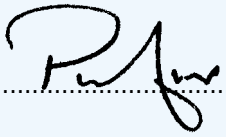
The following Summary Financial Statements are extracted from the audited Annual Accounts of the Trust. Copies of the full Annual Accounts are available from the Director of Finance, Trust Headquarters, Pembury Hospital, Tonbridge Road, Pembury, Tunbridge Wells, Kent, TN2 4QJ Telephone 01892 823535 ext 3800.

STATEMENT OF THE CHIEF EXECUTIVE'S RESPONSIBILITIES AS THE ACCOUNTABLE OFFICER OF THE TRUST

The Secretary of State has directed that the Chief Executive should be the Accountable Officer to the Trust. The relevant responsibilities of Accountable Officers, including their responsibility for the propriety and regularity of the public finances for which they are answerable, and for the keeping of proper records, are set out in the Accountable Officers' Memorandum issued by the Department of Health.

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.

Date: 29/07/03



.....Chief Executive

STATEMENT OF DIRECTORS' RESPONSIBILITIES IN RESPECT OF THE ACCOUNTS

The directors are required under the National Health Services Act 1977 to prepare accounts for each financial year. The Secretary of State, with the approval of the Treasury, directs that these accounts give a true and fair view of the state of affairs of the Trust and of the income and expenditure of the Trust for that period. 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; and

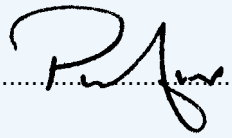
- State whether applicable accounting standards have been followed, subject to any material departures disclosed and explained in the accounts.

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

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

By order of the Board

Date: 29/07/03



.....Chief Executive

Date: 29/07/03

.....Finance Director

STATEMENT OF DIRECTORS' RESPONSIBILITY IN RESPECT OF INTERNAL CONTROL

The Board is accountable for internal control. As Accountable Officer, and Chief Executive Officer of this Board, I have responsibility for maintaining a sound system of internal control that supports the achievement of the organisation's objectives, and for reviewing its effectiveness. The system of internal control is designed to manage rather than eliminate the risk of failure to achieve these objectives; it can therefore only provide reasonable and not absolute assurance of effectiveness.

The system of internal control is based on an ongoing risk management process designed to identify the principal risks to the achievement of the organisation's objectives; to evaluate the nature and extent of those risks; and to manage them efficiently, effectively and economically. The system of internal control is underpinned by compliance with the requirements of the core Controls Assurance standards:

- Governance
- Financial Management
- Risk Management

As Accountable Officer, I also have responsibility for reviewing the effectiveness of the system of internal control. My review of the effectiveness of the system of internal control has taken account of the work of the executive management team within the organisation who have responsibility for the development and maintenance of the internal control framework, and of the internal auditors. I have also taken account of comments made by external auditors and other review bodies in their reports.

The assurance framework is still being finalised and will be fully embedded during 2003/04 to provide the necessary evidence of an effective system of internal control.

The actions taken so far include:

- a self assessment exercise against the core controls assurance standards (Governance, Risk Management and Financial Management), and the development of action plans towards substantial compliance
- the development of an action plan to enhance clinical governance arrangements, in accordance with CHI recommendations

The following work is still outstanding and will be progressed in line with the following timetable:-

- to complete the development of a comprehensive assurance framework - Quarter 4 2003/04
- the development of risk assessments throughout the organisation - Quarter 4 2003/04
- to implement the significant action plans arising from the CHI review - Quarter 4 2003/04
- to implement action plans for the core controls assurance standards - Quarter 4 2003/04.

Signed.....Chief Executive Officer

Date: 29/07/03 (on behalf of the board)

INDEPENDENT AUDITORS' REPORT TO THE DIRECTORS OF MAIDSTONE AND TUNBRIDGE WELLS NHS TRUST ON THE SUMMARY FINANCIAL STATEMENTS

We have examined the summary financial statements set out on pages 31 to 34 and 39 and 40.

This report is made solely to the Board of Maidstone and Tunbridge Wells NHS Trust in accordance with Part II of the Audit Commission Act 1998 and for no other purpose, as set out in paragraph 54 of the Statement of Responsibilities of Auditors and of Audited Bodies, prepared by the Audit Commission.

Respective responsibilities of directors and auditors
The directors are responsible for preparing the Annual Report. Our responsibility is to report to you our opinion on the consistency of the summary financial statements with the statutory financial statements. We also read the other information contained in the Annual Report and consider the implications for our report if we become aware of any misstatements or material inconsistencies with the summary financial statements.

Basis of opinion
We conducted our work in accordance with Bulletin 1999/6 'The auditor's statement on the summary financial statements' issued by the Auditing Practices Board for use in the United Kingdom.

Opinion
In our opinion the summary financial statements are consistent with the statutory financial statements of the Trust for the year ended 31 March 2003 on which we have issued an unqualified opinion.

Signature PricewaterhouseCoopers

Date:1st September 2003

PRICEWATERHOUSECOOPERS

Southwark Towers, 32 London Bridge Street, London, SE1 9SY

INCOME AND EXPENDITURE ACCOUNT FOR THE YEAR ENDED 31 March 2003

	NOTE	2002/03 £000	Restated* 2001/02 £000
Income from activities:			
Continuing operations	3	**157,679**	143,448
Other operating income			
Continuing operations	4	**19,327**	16,661
Operating expenses:			
Continuing operations	5-7	**(174,245)**	(158,637)
OPERATING SURPLUS			
Continuing operations		2,761	1,472
Exceptional gain: on write-out of clinical negligence provisions	1.9	**0**	7,662
Exceptional loss: on write-out of clinical negligence debtors	1.9	**0**	(7,662)
Profit (loss) on disposal of fixed assets	8	**(7)**	18
SURPLUS BEFORE INTEREST		**2,754**	1,490
Interest receivable		246	283
Interest payable	9	(31)	0
Other finance costs - unwinding of discount		**(102)**	(160)
SURPLUS FOR THE FINANCIAL YEAR		**2,867**	1,613
Public Dividend Capital dividends payable		**(6,907)**	(5,751)
RETAINED DEFICIT FOR THE YEAR	23.5	**(4,040)**	(4,138)

*For explanation of restatement see note 1.11.

BALANCE SHEET AS AT 31 March 2003

	NOTE	£000	31 March 2003 £000	Restated* 31 March 2002 £000
FIXED ASSETS				
Intangible assets	10	**258**		261
Tangible assets	11	**127,655**		105,082
			127,913	105,343
CURRENT ASSETS				
Stocks and work in progress	12	**2,602**		2,478
Debtors	13	**14,761**		14,019
Investments	14	**0**		0
Cash at bank and in hand	18	**581**		470
			17,944	16,967
CREDITORS : Amounts falling due within one year	15		**(29,900)**	(26,722)
NET CURRENT ASSETS (LIABILITIES)			**(11,956)**	(9,755)
TOTAL ASSETS LESS CURRENT LIABILITIES			**115,957**	95,588
CREDITORS: Amounts falling due after more than one year	15		**(247)**	0
PROVISIONS FOR LIABILITIES AND CHARGES	16		**(2,264)**	(2,371)
TOTAL ASSETS EMPLOYED			**113,446**	93,217
FINANCED BY:				
TAXPAYERS' EQUITY				
Public dividend capital			**100,567**	90,855
Revaluation reserve	17		**17,666**	3,720
Donated Asset reserve	17		**3,100**	3,125
Income and expenditure reserve	17		**(7,887)**	(4,483)
TOTAL TAXPAYERS' EQUITY			**113,446**	93,217

*For explanation of restatement see note 1.11.

Signed:.....(Chairman)

Date: 29/07/03

Signed:.....(Chief Executive)

Date: 24/07/03

STATEMENT OF TOTAL RECOGNISED GAINS AND LOSSES FOR THE YEAR ENDED 31 March 2003

	2002/03 £000	Restated* 2001/02 £000
Surplus for the financial year before dividend payments	**2,867**	1,613
Unrealised surplus on fixed asset indexation	**14,785**	2,811
Increases in the donated asset and government grant reserve due to receipt of donated and government grant financed assets	**368**	1,158
Reductions in the donated asset and government grant reserve due to the depreciation, impairment and disposal of donated and government grant financed assets	**(596)**	(455)
Total recognised gains and losses for the financial year	**17,424**	5,127
Prior period adjustment - Pre-95 early retirement	**(609)**	
Total gains and losses recognised in the financial year	**16,815**	

*For explanation of restatement see note 1.11.

CASH FLOW STATEMENT FOR THE YEAR ENDED 31 March 2003

OPERATING ACTIVITIES	NOTE	£000	2002/03 £000	2001/02 £000
Net cash inflow from operating activities	18.1		**14,342**	15,301
RETURNS ON INVESTMENTS AND SERVICING OF FINANCE:				
Interest received		**262**		306
Interest paid		**(31)**		0
Interest element of finance leases		**0**		0
Net cash inflow (outflow) from returns on investments and servicing of finance			**231**	306
CAPITAL EXPENDITURE				
Payments to acquire tangible fixed assets		**(17,619)**		(8,658)
Receipts from sale of tangible fixed assets		**378**		121
Payments to acquire intangible assets		**(102)**		(27)
Net cash inflow (outflow) from capital expenditure			**(17,343)**	(8,564)
DIVIDENDS PAID			**(6,907)**	(5,751)
Net cash inflow (outflow) before management of liquid resources and financing			**(9,677)**	1,292
MANAGEMENT OF LIQUID RESOURCES				
Purchase of investments		**(124,500)**		(40,500)
Sale of investments		**124,500**		40,500
Net cash inflow (outflow) from management of liquid resources			**0**	0
Net cash inflow (outflow) before financing			**(9,677)**	1,292
FINANCING				
Public dividend capital received		**14,012**		10,145
Public dividend capital repaid (not previously accrued)		**(4,300)**		(9,462)
Public dividend capital repaid (accrued in prior period)		**0**		(1,958)
Net cash inflow (outflow) from financing			**9,712**	(1,275)
Increase (decrease) in cash			**35**	17

NOTES TO THE ACCOUNTS

1. ACCOUNTING POLICIES

The Secretary of State for Health has directed that the financial statements of NHS trusts shall meet the accounting requirements of the NHS trusts Manual for Accounts which shall be agreed with HM Treasury. Consequently, the following financial statements have been prepared in accordance with the 2002/03 NHS Trusts Manual for Accounts issued by the Department of Health. The accounting policies contained in that manual follow UK generally accepted accounting practice for companies (UK GAAP) and HM Treasury's Resource Accounting Manual to the extent that they are meaningful and appropriate to the NHS. The accounting policies have been applied consistently in dealing with items considered material in relation to the accounts.

1.1 Accounting convention

These accounts have been prepared under the historical cost convention modified to account for the revaluation of fixed assets at their value to the business by reference to their current costs. NHS Trusts are not required to provide a reconciliation between current cost and historical cost surpluses and deficits.

Acquisitions and discontinued operations

Activities are considered to be 'acquired' only if they are acquired from outside the public sector. Activities are considered to be 'discontinued' only if they cease entirely. They are not considered to be 'discontinued' if they transfer from one NHS body to another.

Income Recognition

Income is accounted for applying the accruals convention. The main source of income for the Trust is from commissioners in respect of health care services provided under Services and Financial Framework agreements. These are agreements under which income is received from commissioners (Primary Care Trusts and Strategic Health Authorities) for the provision of Healthcare Services.

Deferred income

Income is recognised in the period in which services are provided. Where income is received for a specific activity which is to be delivered in the following financial year, that income is deferred.

1.2 Tangible fixed assets

Capitalisation

Tangible assets are capitalised if they are capable of being used for a period which exceeds one year and

- individually have a cost of at least £5,000; or
- collectively have a cost of at least £5,000, where the assets are functionally interdependent, they had broadly simultaneous purchase dates, are anticipated to have simultaneous disposal dates and are under single managerial control; or
- form part of the initial setting-up cost of a new building, irrespective of their individual or collective cost.

Valuation

Tangible fixed assets are stated at the lower of replacement cost and recoverable amount. On initial recognition they are measured at cost (for leased assets, fair value) including any costs such as installation directly attributable to bringing them into working condition. They are restated to current value each year. The carrying values of tangible fixed assets are reviewed for impairment in periods if events or changes in circumstances indicate the carrying value may not be recoverable.

All land and buildings are restated to current value using professional valuations in accordance with FRS 15 every five years and in the intervening years by the use of indices. The buildings index is based on the All in Tender Price Index published by the Building Cost Information Service (BCIS). The land index is based on the residential building land values reported in the Property Market Report published by the Valuation Office.

Professional valuations are carried out by the District Valuers of the Inland Revenue Government Department. The valuations are carried out in accordance with the Royal Institute of Chartered Surveyors (RICS) Appraisal and Valuation Manual insofar as these terms are consistent with the agreed requirements of the Department of Health and HM Treasury. In accordance with the requirements of the Department of Health, the last asset valuations were undertaken in 1999 as at the prospective valuation date of 1 April 2000.

The valuations are carried out primarily on the basis of Depreciated Replacement Cost for specialised operational property and Existing Use Value for non-specialised operational property. The value of land for existing use purposes is assessed at Existing Use Value. For non-operational properties including surplus land, the valuations are carried Out at Open Market Value.

Additional alternative Open Market Value figures have only been supplied for operational assets scheduled for imminent closure and subsequent disposal.

All adjustments arising from indexation and five-yearly revaluations are taken to the Revaluation Reserve. All impairments resulting from price changes are charged to the Statement of Total Recognised Gains and Losses. Falls in value when newly constructed assets are brought into use are also charged there. These falls in value result from the adoption of ideal conditions as the basis for depreciated replacement cost valuations.

Assets in the course of construction are valued at current cost using the indexes as for land and buildings, as above. These assets include any existing land or buildings under the control of a contractor.

Residual interests in off-balance sheet Private Finance Initiative properties are included in tangible fixed assets

at the amount of unitary charge allocated for the acquisition of the residual with an adjustment. The adjustment is the net present value of the change in fair value of the residual as estimated at the start of the contract and at the balance sheet date.

Operational equipment is valued at net current replacement cost through annual uplift by the change in the value of the GDP deflator. Equipment surplus to requirements is valued at net recoverable amount.

Depreciation, amortisation and impairments

Tangible fixed assets are depreciated at rates calculated to write them down to estimated residual value on a straight-line basis over their estimated useful lives. No depreciation is provided on freehold land, assets in the course of construction and assets surplus to requirements.

Assets in the course of construction and residual interests in off-balance sheet PFI contract assets are not depreciated until the asset is brought into use or reverts to the Trust, respectively.

Buildings and dwellings are depreciated on their current value over the estimated remaining life of the asset as advised by the District Valuer. Leaseholds are depreciated over the primary lease term.

Equipment is depreciated on current cost evenly over the estimated life of the asset using the following lives:

	Years
Medical equipment and engineering plant and equipment	5 to 15
Fumiture	10
Mainframe information technology installations	8
Soft furnishings	7
Office and information technology equipment	5
Set-up costs in new buildings	10

Vehicles are depreciated over 7 years.

Where, under Financial Reporting Standard 11, a fixed asset impairment is charged to the Income and Expenditure Account, offsetting income is paid by the Department of Health via the Trust's main commissioner, to offset the charge. The income is used to repay Public Dividend Capital.

1.3 Intangible fixed assets

Intangible assets are capitalised when they are capable of being used in a trust's activities for more then one year; they can be valued; and they have a cost of at least £5,000.

Intangible fixed assets held for operational use are valued at historical cost and are depreciated over the estimated life of the asset on a straight line basis, except capitalised Research and Development which is revalued using an appropriate index figure. The carrying value of intangible assets is reviewed for impairment at the end of the first full year following acquisition and in other periods if events or changes in circumstances indicate the carrying value may not be recoverable.

Purchased computer software licences are capitalised as intangible fixed assets where expenditure of at least £5,000 is incurred. They are amortised over the shorter of the term of the licence and their useful economic lives.

1.4 Donated fixed assets

Donated fixed assets are capitalised at their current value on receipt and this value, is credited to the Donated Asset Reserve. Donated fixed assets are valued and depreciated as described above for purchased assets. Gains and losses on revaluations are also taken to the Donated Asset Reserve and, each year, an amount equal to the depreciation charge on the asset is released from the Donated Asset Reserve to the Income and Expenditure Account. Similarly, any impairment on donated assets charged to the Income and Expenditure Account is matched by a transfer from the Donated Asset Reserve. On sale of donated assets, the value of the sale proceeds is transferred from the Donated Asset Reserve to the Income and Expenditure Reserve.

1.5 Leases

Where substantially all risks and rewards of ownership of a leased asset are borne by the department, the asset is recorded as a tangible fixed asset and a debt is recorded to the lessor of the minimum lease payments discounted by the interest rate implicit in the lease, or at a rate of 6% plus the current inflation rate where this is not known. The interest element of the finance lease payment is charged to the Income and Expenditure Account over the period of the lease at a consistent rate in relation to the balance outstanding. Other leases are regarded as operating leases and the rentals are charged to the Income and Expenditure Account on a straight-line basis over the term of the lease.

1.6 Government Grants

Government grants are grants from government bodies other than funds from NHS bodies or funds awarded by Parliamentary Vote. The government grants reserve is maintained at a level equal to the net book value of the assets which it has financed.

1.7 Private Finance Initiative (PFI) transactions

The NHS follows HM Treasury's Technical Note I (Revised) "How to Account for PFI transactions" which provides definitive guidance for the application of the FRS 5 Amendment.

Where the balance of the risks and rewards of ownership of the PFI property are borne by the PFI operator, the PFI payments are recorded as an operating expense. Where the Trust has contributed assets, a prepayment for their fair value is recognised and amortised over the life of the PFI contract by charge to the Income and Expenditure Account. Where, at the end of the PFI contract, a property reverts to the Trust, the difference between the expected fair value of the residual on reversion and any agreed payment on reversion is built up over the life of the contract by capitalising part of the Unitary charge each year as a tangible fixed asset.

Where the balance of risks and rewards of ownership of the PFI property are borne by the Trust, it is recognised as a fixed asset along with the liability to pay for it which is accounted for as a finance lease. Contract payments are apportioned between an imputed finance lease charge and a service charge.

1.8 Stocks and work-in-progress

Stocks and work-in-progress are valued at the lower of cost and net realisable value. This is considered to be a reasonable approximation to current cost due to the high tumover of stocks. Work-in-progress comprises goods in intermediate stages of production. Partially completed contracts for patient services are not accounted for as work-in-progress.

1.9 Research and development

Research and development expenditure is charged against income in the year in which it is incurred, except insofar as development expenditure relates to a clearly defined project and the benefits of it can reasonably be regarded as assured. Expenditure so deferred is limited to the value of future benefits expected and is amortised through the income and expenditure account on a systematic basis over the period expected to benefit from the project. It is revalued on the basis of current cost through the use of an appropriate index figure. The amortisation charge is based on opening balance sheet values and this basis is consistently applied. NHS Trusts are unable to disclose the amount of research and development expenditure charged in the income and expenditure account (a requirement of SSAP 13) because some research and development activity cannot be separated from patient care activity.

1.10 Provisions

The Trust provides for legal or Constructive obligations that are of uncertain timing or amount at the balance sheet date on the basis of the best estimate of the expenditure required to settle the obligation. Where the effect of the time value of money is significant, the estimated risk-adjusted cash flows are discounted using the Treasury's discount rate of 6% in real terms. Expected reimbursements from Health Authorities relating to 'back to back' arrangements established under HSC 1999/146 are included in debtors.

Clinical negligence costs

From 1 April 2002 the NHS Litigation Authority (NHSLA) took over full financial responsibility for all Trust clinical negligence claims not settled at that date and is responsible for any new cases. Provisions for these are included in the accounts of the NHSLA and not the Trust. As the NHSLA had a Constructive obligation for these liabilities in 2001/02, the transfer was recognised by the Trust as an exceptional gain in the Income and Expenditure at 31 March 2002. The write back of related reimbursements was shown as an exceptional loss. Although the NHSLA is administratively responsible for all clinical negligence cases the legal liability remains with the Trust. The total value ofclinical negligence provisions carried by the NI-ISLA on behalfof the Trust is disclosed at note 16.

Non-clinical risk pooling

The Trust participates in the Property Expenses Scheme and the Liabilities to Third Parties Scheme. The schemes commenced on 1 April 1999. Both are risk pooling schemes under which the trust pays an annual contribution to the NHS Litigation Authority 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 as and when they become due.

1.11 Pension costs

Past and present employees are covered by the provisions of the NHS Pension Scheme. The Scheme is an unfunded, defined benefit scheme that covers NHS employers, General Practices and other bodies. allowed under the direction of Secretary of State, in England and Wales. As a consequence it is not possible for the Trust to identify its share of the underlying scheme liabilities.

The Trust therefore falls within the multi-employer exemption provided by FRSI7, Retirement Benefits, and accounts for its contributions to the NHS Pension Scheme as though this was a defined contribution scheme.

The Scheme is subject to a full valuation every four years (previously every five years). The last valuation took place as at 31 March 1999. Between valuations, the Government Actuary provides an update of the scheme liabilities on an annual basis. The latest assessment of the liabilities of the Scheme is contained in the Scheme Actuary report, which forms part of the annual NHS Pension Scheme (England and Wales) Resource Account, published every October. These accounts can be viewed on the NHS Pensions Agency website at www.nhspa.gov.uk. Copies can also be obtained from The Stationery Office.
NHS bodies are directed by the Secretary of State to charge employers pension costs contributions to operating expenses as and when they become due. Employer contribution rates are reviewed every four years following a scheme valuation carried out by the Government Actuary. On advice from the actuary the contribution may be varied from time to time to reflect changes in the scheme's liabilites.
At the last valuation (31 March 1994) on which contribution rates were based employer contribution rates for 2002/03 were set at 7% of pensionable pay. The total employer contribution payable in 2002/03 was £5,095,602 (£4,695,466 for 2001/02). Employees pay contributions of 6% (manual staff 5%) of their pensionable pay.

The Scheme is a "final salary" scheme. Annual pensions are normally based on 1/80th of the best of the last three years pensionable pay for each year of service. A lump sum normally equivalent to 3 years pension is payable on retirement. Annual increases are applied to pension payments at rates defined by the Pensions (Increase) Act 1971, and are based on changes in retail prices in the twelve months ending 30 September in the previous calendar year. On death, a pension of 50% of the members pension is normally payable to the surviving spouse.

Early payments of a pension, with enhancement, is available to members of the Scheme who are permanently incapable of fulfilling their duties effectively through illness or infirmity. A death gratuity of twice final year's pensionable pay for death in service, and up to five times their annual pension for death after retirement, is payable.

The Scheme provides the opportunity to members to increase their benefits through money purchase Additional Voluntary Contributions (AVCs) provided by an approved panel of life companies. Under the arrangement the employee can make contributions to enhance their pension benefits. The benefits payable relate directly to the value of the investments made.

Additional pension liabilities arising from early retirements are not funded by the scheme except where the retirement is due to ill-health. For post 7 March 1995 early retirements not funded by the scheme, the full amount of the liability for the additional costs is charged to the income and expenditure account at the time the Trust commits itself to the retirement, regardless of the method of payment.

For pre-6 March 1995 early retirements not funded by the scheme, the additional liabilities are recharged to the Trust and were previously included within operating expenses as they arose. In 2002/03 the accounting for pre-6 March 1995 early retirements has been brought into line with that for post-7 March 1995 early retirements. The forecast remaining liability (or remaining prepayment, where the liability has been bought out) has been recognised as a prior period adjustment.

The change in the accounting treatment of pre 6-March 1995 early retirements has effected the prior year comparatives in the following notes:

- Income and Expenditure Account: this statement has been restated to reflect that expenditure is no longer charged to operating expenses on a quarterly basis as disclosed in note 5 and to reflect the unwinding discount for the year in respect of the pre 6-March 1995 retirements.
- Balance Sheet: this statement has been restated to reflect the increase in provisions as disclosed in note 16 and the corresponding decrease in the Income and Expenditure Reserve as disclosed in note 17.
- Statement of Total Recognised Gains and Losses: this statement shows that a prior period adjustment has been made which will reduce the NHS Trust reserves.
- Note 5: expenditure is no longer charged to operating expenses on a quarterly basis;
- Note 16: a provision has been made for the full amount of the liability for pre 6-March 1995 early retirements;
- Note 17: the Income and Expenditure Reserve has been reduced by the amount of the provision.
- Note 22: opening government funds for 2001/02 have been adjusted to reflect the provision.

  The total charge to the Income and Expenditure Reserve at 31 March 2002 was £609,018.

1.12 Liquid resources

Deposits and other investments that are readily convertible into known amounts of cash at or close to their carrying amounts are treated as liquid resources in the cashflow statement. The Trust does not hold any investments with maturity dates exceeding one year from the date of purchase.

1.13 Value Added Tax

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

1.14 Foreign Exchange

Transactions that are denominated in a foreign currency are translated into sterling at the exchange rate ruling on the dates of the transactions. Resulting exchange gains and losses are taken to the Income and Expenditure account.

1.15 Third Party Assets

Assets belonging to third parties (such as money held on behalf of Patients) are not recognised in the accounts since the Trust has no beneficial interest in them.

SALARY AND PENSION ENTITLEMENTS OF SENIOR MANAGERS

Name and Title	Age	Salary (bands of £5000) £000	Other Remunerations (bands of £5000) £000	Golden hello/compensation for loss of office £000	Benefits in kind £000	Real increase in pension at age 60 (bands of £2500) £000	Total accrue pension at age 60 at 31 2003 (bands of £5000) £000
Non Executive Directors							
Miss A.L. Chapman, Chairman	43	20-25	0	0	2	0	0
Mr I.E.Nash	50	5-10	0	0	0	0	0
Mr J.C. Cartwrite	69	5-10	0	0	0	0	0
Dr G. Bullock	67	5-10	0	0	0	0	0
Mr P.C.Cox	57	5-10	0	0	0	0	0
Mr W.J. Tayler	53	5-10	0	0	1	0	0
Senior Managers							
Mr S. Collinson, Chief Executive	44	85-90	0	0	7	0-2.5	30-35
Mr P.M.R. Davies, Chief Executive	44	20-25	0	0	2	2.5-5	25-30
Ms N. Bowden, Assistant Chief Executive	47	0-5	0	0	0	0	0
Dr C.E.M. Unter, Medical Director	52	130-135	0	0	4	2.5-5	20-25
Mr P.G. Darling, Director of Finance and IM&T	43	80-85	0	0	4	0-2.5	25-30
Mr M.R. Bull, Acting Director of Finance	42	45-50	0	0	2	0-2.5	15-20
Mr B. Place, Director of Nursing and Quality	46	70-75	0	0	3	0-2.5	15-20
Mrs M.L. Clemence, Director of Strategic Development	46	40-45	0	0	2	0	0
Mrs B. Musselwhite, Director of Strategic Development	39	5-10	0	0	0	0	0
Mr C.M. Wilson, Director of Human Resources	53	30-35	0	0	2	0	20-25
Mrs V.A. Thompson, Director of Operations	43	45-50	0	0	0	0-2.5	0-5
Mr T. Vogiatzis, Acting Director of Operations	45	15-20	0	0	0	0-2.5	5-10
Mr R.J.T. Pepper, Director of Estates and Facilities	54	55-60	0	0	2	0-2.5	5-10

Posts occupied by more than one senior manager over the year are as follows.

a) Mr Collinson, the Chief Executive, left the Trust on 14 January 2003. Mr Davies Joins as interim Chief Executive until a substantive appointment is made in the Autumn.
b) Mrs Clemence, the Director of Strategic Development, left the Trust on 7 November 2002. Mrs Musselwhite was appointed to this post on 3 March 2003.
c) Mrs Thompson, the Director of Operations, was seconded to the Hampshire and Isle of Wight Strategic Health Authority on 31 October 2002. Mr Vogiatzis acted as caretaker Director of Operations during her secondment.
d) Mr Wilson, The Director of Human Resources left the Trust on 30 September 2002. This vacancy was recruited to in the 2003/04 financial year.

Benefits in kind consist of travel and taxation thereon for non-executive directors, lease cars for executive directors and senior managers and accommodation for the Acting Chief Executive.

EMPLOYEE COSTS AND NUMBERS

Employee costs

	2002/03 £000	2001/02 £000
Salaries and wages	**90,022**	81,021
Social Security Costs	**6,205**	5,845
Employer contributions to NHSPA	**5,096**	4,696
Other pension costs	**0**	47
Agency and seconded Staff	**9,840**	9,283
	111,163	100,892

Average number of employees

	2002/03 Number		2001/02* Number
Medical and dental	**411**	a	361
Ambulance staff	**2**		2
Administration and estates	**1,029**	b	879
Healthcare assistants & other support staff	**466**	c	406
Nursing, midwifery & health visiting staff	**1,645**	d	1,366
Nursing, midwifery & health visiting learners	**0**		0
Scientific, therapeutic and technical staff	**492**	e	580
Other	**I**		2
Total	**4,046**		3,596

* 2001/02 comparatives exclude agency staff

Management costs

	2002/03 £000	2001/02 £000
Management costs	**6,282**	6,076
Income	**161,421**	152,144

Constitution of the Audit Committee

The Trust's Audit Committee members during the year were Mr John Cartwright (Non-Executive Director), Mr Ian Nash (Non- Executive Director Committee Chairman) and Mr Peter Cox (Non-Executive Director).

Summary Business Plan - 2003/04 - Improving Effectiveness, Improving Efficiency.

Message from the Chief Executive

I am very pleased to present the Summary Business Plan for Maidstone and Tunbridge Wells NHS Trust (MTW) for 2003/04.

The last year has been a difficult one for the Trust and we have many challenges ahead of us. It is important for us to keep a sense of balance and I want to stress that the primary concern of this Trust remains the safe and effective care of all our patients. I appreciate the work of staff in ensuring that the patient experience of care is a positive one - thank you.

Having said that, we do have a lot to do in terms of improving the systems and processes of the Trust to ensure that we are in a position to deliver the minimum care standards as set out within the National Plan. We also need to gain control of our expenditure. Unfortunately we finished the 2002/03 year in deficit for the second year running and our challenge to pay such debts off has therefore become even greater.

The Trust's performance position means that there will be even greater control and regulation both within the Trust and from our Commissioners and the Strategic Health Authority. This is going to be difficult but it is our responsibility to improve our performance so that we can be recognised as a high performing, high quality care organisation by all our partners and patients.

We now have a new Chairman - James Lee and a new Chief Executive - Rose Gibb - will start at the beginning of November. At that point the senior management team of the Trust will begin to have some real stability and this will help in moving the Trust forward.

So, in summary, I would say it is going to be a hard year but we need to face the challenges and rise to them. I know that I can count on the commitment and support of staff to ensure our performance improvement.

Mark Davies

Chief Executive

2003/04 Key Objectives

The Trust has identified six strands of objectives for 2003/04 as follows:

Patient Safety

The Trust will take as its primary responsibility the safety and well-being of all using its services.

Patient Access

The Trust will deliver on key National Access Targets as these relate to waiting times for care.

Financial Stability

The Trust will ensure that it meets its financial commitment to break-even in the 2003/04 operating year.

Optimising Resources

The Trust will improve significantly its utilisation of existing resources through a combination of new ways of working and through more efficient planning / scheduling processes.

Partnership Working

The Trust will seek to deliver its objectives through effective partnerships with those involved locally in the delivery of care.

Trust Development

The Trust will ensure that it is in a strong position to manage the challenges and opportunities within the NHS over the medium to long term by building its internal capabilities.

The Key Performance Standards for 2003/04

Emergency Care

1. No patient waiting in A&E 12 hours from decision to admit

2. 90% of patients attending A&E to be seen, admitted, transferred or discharged within 4 hours of attendance throughout the year, working to 100% of patients by April 2004.

Planned Care

3. No patient to wait more than 12 months for admission to hospital at any point throughout the year.

   100% of patients to receive planned inpatient or day case care within nine months of being placed on a waiting list by March 2004 (local target for achievement is January 2004)

4. All patients who have their treatment cancelled on or after the day of admission for non-clinical reasons to be offered alternative dates for admission within 28 days

5. No patient to wait more than 21 weeks for a first appointment following receipt of referral from GP at any point throughout the year

   100% of patients to receive a first outpatient appointment within 17 weeks following receipt of referral from GP by the end of March 2004 (local target for achievement is January 2004)

Finance

6. Deliver on Statutory responsibility to break even.

Cancer Care

7. All patients with a suspected cancer diagnosis to see a hospital consultant within 2 weeks of urgent referral from a GP.

Staffing

8. Maintain Improving Working Lives practice accreditation status

Hospital Cleanliness

9. Whole hospital to be assessed as 'green' within PEAT process

The Trust's full Business Plan outlines how these key standards and objectives will be met and how their achievement will be monitored.