MTW
Exceptional people, outstanding care

NHS
Maidstone and Tunbridge Wells
NHS Trust

Annual report and accounts

2020-2021

About this Annual Report

The National Health Service and Community Care Act 1990 requires NHS Trusts to produce an Annual Report. Its content and format must follow the guidance issued by the Department of Health and Social Care (in the form of a 'Group Accounting Manual'). The specific requirements for Annual Reports for 2020/21 are that NHS bodies must publish a single Annual Report and Accounts (ARA) document, comprising the following:

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

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

- "Performance Report for 2020/21", which is split into:
  - An overview. This includes an overview summary; the purpose and activities of the Trust; the Chair and Chief Executive's report; a 'snapshot of the year'; key developments; the key issues and risks affecting delivery of the Trust's objectives; an explanation of the adoption of the going concern basis; and a Performance summary
  - A Performance analysis, which includes details of how the Trust measures performance; the Trust's development and performance in 2020/21; and a review of financial performance for 2020/21
  - A summary of the Trust's Quality Accounts for 2020/21
  - A Sustainability Report. This follows the standard reporting format from the NHS Sustainable Development Unit.
- "Accountability Report for 2020/21", which is divided into the following sections:
  - "Corporate Governance Report for 2020/21", which includes:
    - A Directors' report (providing details about the Trust Board; a Statement regarding Directors' disclosure to auditors; attendance at Trust Board meetings; Directors' interests; the Trust's Management Structure; complaints performance and the Trust's application of the 'Principles for Remedy' guidance; disclosure of "incidents involving data loss or confidentiality breaches"; & details of Emergency Preparedness arrangements)
    - The "Statement of the Chief Executive's responsibilities as the Accountable Officer of the Trust"
    - A "Statement of Directors' responsibilities in respect of the accounts"
    - The "Annual Governance Statement for 2020/21"
  - "Remuneration and Staff Report for 2020/21" (including details of 'off-payroll' engagements)
  - The "Parliamentary Accountability and Audit Report"
- "Financial Statements for 2020/21", including details of Pension Liabilities, exit packages and severance payments; and staff sickness absence data
- Independent Auditor's report to the Directors of Maidstone and Tunbridge Wells NHS Trust.

The Annual Report and Accounts were approved by the Trust Board of Maidstone and Tunbridge Wells NHS Trust on 24th June 2021.

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

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Performance report for 2020-2021:
Overview

The purpose of the overview section

This overview aims to equip the reader with a broad understanding of the Trust, its purpose, the key risks to the achievement of its objectives, and an outline of its performance during 2020/21. For those wishing to read in more detail about the Trust's achievements, the issues it faced and its financial situation, further detail is provided in the rest of the Annual Report and Accounts.

The purpose and activities of Maidstone and Tunbridge Wells NHS Trust

Maidstone and Tunbridge Wells NHS Trust (the Trust) is a large acute hospital Trust in the south east of England. The Trust was legally established on 14th February 2000[2], and provides a full range of general hospital services and some areas of specialist complex care to around 760,000 people living in West Kent and East Sussex. The Trust also provides some aspects of specialist care to a wider population.

The Trust's core catchment areas are Maidstone and Tunbridge Wells and their surrounding boroughs. It employs over 6,500 full and part-time staff, and operates from three main sites (Maidstone Hospital, Tunbridge Wells Hospital and the Crowborough Birth Centre), but also manages services at Kent and Canterbury Hospital and outpatient services at several community locations.

In January 2021 the provision of opthamology services which were previously provided by Moorfields Eye Hospital under Dartford and Gravesham NHS Trust was transferred to the Trust.

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

Maidstone Hospital benefits from its central county location. It hosts the Kent Oncology Centre, providing specialist Cancer services to around two million people across Kent and East Sussex, the fourth largest oncology service in the country. The Trust offers PET/CT (Positron Emission Tomography – Computed Tomography) services in a dedicated building and has a rolling programme to upgrade its Linear Accelerator radiotherapy machines. The Trust also provides sexual health services to the population of Kent and Medway. The Maidstone site also has a state-of-the-art Birth Centre, a dedicated ward for respiratory services and an Academic Centre with a 200 seat auditorium. The Education Centre at Tunbridge Wells

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

Hospital, with its full resuscitation simulation suite, enables the Trust to offer excellent clinical training. The Trust has strong clinical, academic and research links with London hospitals, including joint appointments. Many staff are nationally recognised for excellence in their fields.

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

- Assessment or medical treatment for persons detained under the Mental Health Act 1983 (at Maidstone and Tunbridge Wells Hospitals)
- Diagnostic and screening procedures (at Maidstone and Tunbridge Wells Hospitals)
- Family planning services (at Maidstone and Tunbridge Wells Hospitals)
- Maternity and midwifery services (at Maidstone and Tunbridge Wells Hospitals and Crowborough Birthing Centre)
- Surgical procedures (at Maidstone and Tunbridge Wells Hospitals)
- Termination of pregnancies (at Tunbridge Wells Hospital)
- Treatment of disease, disorder or injury (at Maidstone and Tunbridge Wells Hospitals)

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

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

A message from the Chair of the Trust Board and Chief Executive

When we reflect on 2020/21 it is clear this has been an unprecedented year, dominated by the impact of Covid-19 on both the country and the NHS. The pandemic presented a number of major challenges to the Trust and we are moved and incredibly impressed by the response of all our staff. Across our organisation colleagues demonstrated skill, innovation and dedication – quickly developing new ways of working, adapting patient pathways, and rapidly increasing critical care capacity. Never have the words exceptional people providing outstanding care been so clearly shown each and every day. We are so proud of what staff have achieved, during what was a very stressful time for them and their families, and we want to once again say a heartfelt thank you to each of them.

Despite these challenges, throughout the last year the Trust remained one of the best performing hospital providers in the country. Continuing to provide urgent and emergency care and meeting national performance targets by treating ED and cancer patients quickly and with the highest quality, compassionate care.

Following the first wave of COVID-19, the Trust launched an ambitious, NHS leading, 'reset and recovery' programme. This enabled the Trust to return to pre-COVID-19 levels of activity more quickly than other health organisations both locally and nationally, and focused on restarting routine and non-urgent care in a safe and sustainable way.

In December 2020 the effects of the second wave began to be felt across the Trust and the number of COVID-19 patients far exceeded the first wave. During this time and in response to the immense pressures on staff, the Trust implemented the very successful One Team Runner programme. This provided volunteers to support the wards in non-clinical roles, enabling frontline staff to focus on the delivery of the very best patient care. At the peak of the programme over 250 volunteers were involved across the Trust.

The Trust's vaccination programme started at Maidstone Hospital on 22 December 2020 and within just nine days 6,400 healthcare staff had been vaccinated. In one single day alone 1,284 doses were administered – an average of one person every 30 seconds. Throughout the programme the Trust has continued to work with partners to vaccinate healthcare workers from other organisations as well as making the vaccination available to the Trust's most vulnerable patients. By the end of March 2021, the Trust had successfully vaccinated over 90% of the workforce with their first dose and over 70% with their second dose.

Despite the many impacts of the COVID-19 pandemic we would like to particularly highlight the following key achievements:

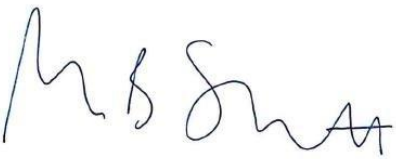
- Finance – achieved the financial plan for 2020/21 and executed one of the largest capital programmes in the history of the Trust
- Performance – continued delivery of the 62-day cancer access standard and consistently featured in the top 10 nationally for Emergency Department performance
- Staff engagement – the overall response rate for the NHS national staff survey saw an increase from 2019/20, despite being undertaken during the second wave of COVID-19. Quarterly 'climate surveys' were also rolled out to enable real time improvements to be delivered

- Service developments – a new purpose built Surgical Assessment Unit (SAU) was constructed at Tunbridge Wells Hospital, the provision of stroke care for Medway and Swale patients was transferred from Medway NHS Foundation Trust, ophthalmology services were transferred from Dartford and Gravesham NHS Trust and the Trust continued the development of the business case for the Kent and Medway Medical School Accommodation, laying the foundations for the future delivery of exceptional patient care

- Shortlisted in the 'Acute or Specialist Trust of the Year' category in this year's prestigious Health Service Journal (HSJ) Awards

Looking forward, we will focus on the lessons learned from COVID-19 which will be built into the Trust's plans for 2021/22, continue to ensure the delivery of the financial plan and restore elective care. During this period strong leadership will be more important than ever which is why 2021/22 will see the delivery of a number of key programmes to support staff and organisational development.

By working together and demonstrating a truly great team spirit, colleagues have built really solid foundations which will ensure even more success in 2021/22. Finally, we would like to thank the public and our local communities for their continued support and the generosity they have shown to the Trust over the last 12 months. From letters of support, appreciation and encouragement to non-financial donations – each have played an important role in helping to maintain staff morale during what has been a truly unique year.



Miles Scott, Chief Executive

24th June 2021

David Highton, Chair of the Trust Board

24th June 2021

Snapshot of 2020/21

April 2020

Following the arrival of COVID-19 in the UK, the Trust began to care for increasing number of COVID-19 patients during the first wave of the pandemic. A Channel 4 film crew led by BAFTA winning and Oscar nominated filmmaker Waad Al-Kateab visited our hospitals and MTW featured in a one hour feature-length special report - 'Are We Winning The Battle Against Coronavirus? This documented emotional first-hand accounts from COVID-19 patients and their families as well our staff working in Intensive Care and on respiratory wards.

May 2020

Our exceptional staff enjoyed a first class service from airline crew when Project Wingman visited our hospitals. Offering teams a luxury space to rest and recharge before, during and after shifts, Project Wingman was organised and delivered by furloughed and grounded cabin crew volunteers. The crews arrived at MTW in May to provide their services in both Maidstone Hospital and Tunbridge Wells Hospitals, so all Trust staff could enjoy refreshments in specially set up break out areas.

June 2020

As the pandemic continued, and the number of Covid patients increased each day, people who had recovered from the virus shared their stories and experiences of the care provided by our clinical teams. This included the story of Peter Ananicz, who spent 17 days on a ventilator at Maidstone Hospital and went on to talk to the Good Morning Britain presenters about his recovery and reunion with wife, Ruth.

July 2020

In support of the MTW Charity's 'Go The Distance' campaign to keep people moving during the pandemic and raise money for NHS colleagues, the Chief Executive, Miles Scott, ran an incredible super-marathon to help hit the £10,000 target. Miles ran from Crowborough Birthing Centre, to Tunbridge Wells Hospital before heading on to the Trust's Healthcare Records base at Paddock Wood and then on to the finish line at Maidstone Hospital, covering a distance of almost 29 miles in under 4 hours.

August 2020

A local coin collector donated special fifty pence pieces to staff in the Trust's Emergency Department who saved his life following a heart attack. Coin collector Warren Light was hospitalised and underwent an operation to have a stent fitted to help open one of the valves of his heart which was partially blocked. He was discharged and returned home just two days before the country went into lockdown.

September 2020

Celebrating outstanding care was a highpoint in September with the Trust providing some of the fastest access to treatment in England. MTW hit the national standard for treating patients within 62 days for twelve months in a row. The accomplishment signified a huge turnaround in performance for MTW, who until August 2019 had not hit the target for five years. The Trust also met the two week wait referral target for eleven consecutive months – meaning even more patients were seen within 14 days of being referred by their GP.

October 2020

For the first time ever, the Trust was rated the best performing trust for emergency care across the country. At MTW staff saw, admitted or discharged over 97% of people attending its emergency departments within the four hour national standard. Since this achievement, the Trust went on to be the top performing departments again at various points throughout the year while also regularly ranking highest in the region.

November 2020

Maidstone Hospital and Maidstone Borough Council (MBC) joined forces to recognise all key workers across the borough who continued to work during Covid-19 by planting over 18,000 bulbs to create a flower garden at the entrance of Maidstone Hospital. The plants would go on to bloom the following spring – almost a year to the day when the Covid-19 pandemic began in the UK

December 2020

A new Surgical Assessment Unit (SAU) opened at Tunbridge Wells Hospital as part of the Trust's ongoing commitment to ensure patients access emergency care services in a prompt and timely way. SAU, which was based inside the hospital, is now located in a new modular building adjacent to the Emergency Department (ED). The move forms part of the Trust's plans to enhance its Same Day Emergency Care (SDEC) pathway so that more patients can benefit.

January 2021

The Trust marked the tenth anniversary of the opening of Tunbridge Wells Hospital in Pembury. Today, the hospital is seen nationally as an example of best practice in design of patient-safe facilities and has attracted widespread international interest. The Trust provides general hospital services and some areas of complex care to around 500,000 people living in the south part of West Kent and the north part of East Sussex.

February 2021

The purchase of a new bladder scanner by former cancer patient, Stephen Stamp benefited patients and staff in the Kent Oncology Centre. Stephen was diagnosed with prostate cancer in early 2020 and credits the treatment he received at the centre with saving his life. He generously donated nearly £7,000 to the Cancer Services Fund, through the Maidstone and Tunbridge Wells NHS Charitable Fund for the new scanner for the Radiotherapy Department.

March 2021

The Covid-19 vaccination programme continued to go from strength to strength as the Trust's vaccination centre at Maidstone Hospital operated to issue thousands of doses. In one single day alone 1,284 doses were administered – equating to one person every 30 seconds for the opening hour. Since the opening in December, the Trust continued to work with partners to vaccinate healthcare workers from other organisations as well as making the vaccination available to the Trust's most vulnerable patients including those within Oncology.

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

The Trust Board agreed the following key objectives for 2020/21:

- To deliver the Trust's financial plan, which is set within the context of its financial strategy, and underpinned by a robust, sustainable recurrent surplus.
- To improve the management of our patient journeys through the utilisation of evidence-based practice to ensure good quality care and achievement of the constitutional access standards within agreed resources.
- To deliver high quality care to our patients and carers and be recognised as an outstanding organisation.
- Delivery of the Allscripts' Electronic Patient Record (EPR) solution "Sunrise"; aligning and supporting the wider strategic objective of digitally transforming the Trust to improve patient outcomes through providing safer and more efficient care.
- To enable fulfilment of the Trust's role in the delivery of an integrated, reputable, high quality, educational programme and student experience for Kent and Medway Medical School (KMMS) students in line with the KMMS curriculum; provision of necessary student accommodation and teaching infrastructure at Maidstone Hospital (MH) and Tunbridge Wells Hospital (TWH) in time for the first intake of KMMS students on 01/09/22.
- To define an estates and facilities strategy and plan for the Trust informed by both the clinical strategy and Reset and recovery workstreams.
- To define the future state (short medium and long term) configuration options for a range of clinical services with timelines and plans for implementation.
- To oversee and enable the Integrated Care Partnership (ICP) Development in West Kent and ensure appropriate stakeholder engagement and participation in the Trust's work (e.g. in clinical strategy development).
- To make the Trust a great place to work - For the Trust to be an excellent organisation that puts staff engagement, well-being and experience at the fore front to nurture a place where people want to come to work, stay, be proud and enable staff to be exceptional by recruiting, retaining and developing exceptional people to deliver outstanding care for our communities.

The key issues and risks affecting delivery of these (as described in the Trust's Board Assurance Framework – see the "Annual Governance Statement for 2020/21" (pages 52 to 64) are outlined below. Details of how the Trust actually performed against these objectives are provided in the "Performance analysis" section (pages 18 to 26).

To deliver the Trust's financial plan, which is set within the context of its financial strategy, and underpinned by a robust, sustainable recurrent surplus

The key recognised risks to delivery of this objective were uncertainty of the change in the finance regime for 2020/21; if there was a lack of senior leadership and commitment; if there was poor financial controls (or if good controls were poorly applied); the additional funding to support COVID-19 could reduce

the focus on meeting the financial plan; if the Trust's plans for 2020/21 had been developed without consideration of best practice elsewhere; if there was insufficient engagement with external stakeholders, particularly given the Clinical Commissioning Group (CCG) restructuring taking place in 2020/21; and if there is a change in the financial circumstances of commissioners, requiring them to take further action to manage demand.

To improve the management of our patient journeys through the utilisation of evidence-based practice to ensure good quality care and achievement of the constitutional access standards within agreed resources

The key recognised risks to delivery of this objective were lack of managerial focus or clinical engagement; COVID-19; additional out of area demand; lack of discharge capacity; and shortage of capacity during winter.

To deliver high quality care to our patients and carers and be recognised as an outstanding organisation

The key recognised risks to delivery of this objective were the potential for teams to lose focus on quality improvement plans due to competing priorities; a further surge of COVID-19 cases resulting in potential redeployment of staff; uncertainty in the future changes in the Care Quality Commission (CQC) inspection methodology; over-reliance on the corporate team leading on the improvement work; and reduced local ownership and engagement with action plans.

Delivery of the Allscripts' Electronic Patient Record (EPR) solution "Sunrise"; aligning and supporting the wider strategic objective of digitally transforming the Trust to improve patient outcomes through providing safer and more efficient care

The key recognised risks to delivery of this objective were the Trust's capacity and capability to manage the volume of change required for EPR & other high-priority initiatives; a second wave of COVID-19 cases resulting in staff not being able to be released for testing or training over the next six months; a lack of operational management engagement resulting in subject matter experts and clinical staff not being made available to the EPR Programme Team; a lack of clinical engagement leading to the Trust's requirements not being properly understood and poor-quality solutions being provided; Windows 10 rollout and its alignment with Sunrise; and the capacity and capability of the IT Team to deliver and support the Sunrise infrastructure .

To enable fulfilment of the Trust's role in the delivery of an integrated, reputable, high quality, educational programme and student experience for Kent and Medway Medical School (KMMS) students in line with the KMMS curriculum; provision of necessary student accommodation and teaching infrastructure at Maidstone Hospital (MH) and Tunbridge Wells Hospital (TWH) in time for the first intake of KMMS students on 01/09/22

The key recognised risks to delivery of this objective were lack of timely information from KMMS regarding student numbers, curriculum and learning objectives, to enable early resource planning and accommodation

scoping; availability of resources required by individual specialities/Departments to provide for student placements; inadequate infrastructure / space (in particular outpatient/ clinic space) to support teaching; the need to co-ordinate where possible to maximise opportunities to develop learning environment with other developments in the Trust; job plan risks regarding the incorporation of additional Programmed Activities (PAs) for medical student Educational/Clinical Supervisor responsibilities; and insufficient accommodation available for students' arrival on placement in September 2022 .

To define an estates and facilities strategy and plan for the Trust informed by both the clinical strategy and Reset and recovery workstreams

The key recognised risks to delivery of this objective were previously failure to perform in the allotted time scale was a risk however the Estates Strategy has now been drafted and is complete, apart from the incorporation of the capital expenditure allocations which are unknown at the time of drafting this document.

To define the future state (short medium and long term) configuration options for a range of clinical services with timelines and plans for implementation

The key recognised risk to delivery of this objective was failure to perform in the allotted time scale..

To oversee and enable the Integrated Care Partnership (ICP) Development in West Kent and ensure appropriate stakeholder engagement and participation in the Trust's work (e.g. in clinical strategy development)

The key recognised risks to delivery of this objective were Lack of Sustainability and Transformation Partnership (STP) /Clinical Commissioning Group (CCG) funding for essential purposes (e.g. clinical backfill); lack of appropriate population health data for decision making and priority setting; lack of Trust between system partners; and lack of delegated authority to support streamlined and quick decision making.

To make the Trust a great place to work - For the Trust to be an excellent organisation that puts staff engagement, well-being and experience at the fore front to nurture a place where people want to come to work, stay, be proud and enable staff to be exceptional by recruiting, retaining and developing exceptional people to deliver outstanding care for our communities

The key recognised risks to delivery of this objective were the impact of the COVID-19 pandemic and 'reset and recovery' needs, especially in light of the second wave and the impact on wellbeing on staff, especially fatigue, psychological wellbeing and the risk of 'burnout'; The ability of staff to be able to create the interventions at the pace required, especially with the engagement, wellbeing & staff experience agenda or broader 'People Strategy'[4]; a national shortage or unavailability of certain staff groups; The need to join up and ensure governance oversight of the transformation agenda for Strategy Deployment[5] ; Organisation

[4] including the Equality, Diversity and Inclusion initiatives required by the NHS People Plan and the Workforce Race Equality Standard (WRES) and Workforce Disability Equality Standard (WDES)

[5] Specifically Strategy Deployment through the Western Sussex Partnership (Patient First Improvement System (PFIS) / PFIP for Leaders) agenda; digitalisation and the implementation of the Elecronic Patient Record (EPR); delivery of the

readiness for and timing of Strategy Deployment initiatives; Lack of support or visibility of senior leaders to ensure alignment of the golden thread of 'Board to Ward' and the 'People Agenda' on Key Themes; Insufficient or non-aligned communications of narrative, actions and information to staff; Insufficient investment to date in senior leadership development, middle management development or Culture and Leadership Programme actions; and Staff not empowered to implement or deliver service changes .

Adoption of the 'going concern' basis

The DHSC Group Accounting Manual (GAM) requires the management of the Trust to consider the following public sector interpretation of IAS 1 in respect of applying the going concern assumption when preparing its accounts. In para 4.13 it states: "For non-trading entities in the public sector, the anticipated continuation of the provision of a service in the future, as evidenced by inclusion of financial provision for that service in published documents, is normally sufficient evidence of going concern. DHSC group bodies must therefore prepare their accounts on a going concern basis unless informed by the relevant body or DHSC sponsor of the intention for dissolution without transfer of services of function to another entity. A trading entity needs to consider whether it is appropriate to continue to prepare its financial statements on a going concern basis where it is being, or is likely to be, wound up".

The Executive Team Meeting and Finance and Performance Committee have assessed the Trust's ability to continue for the foreseeable future in the light of the GAM guidance and have prepared the 2020/21 accounts on a "going concern" basis following consideration of the following:

- There has been no expectation raised in the public arena that healthcare services will not continue to be provided from the two hospital sites. There are no plans to dissolve the Trust or to cease services without transfer to any other NHS body
- The funding regime that has existed for 2020/21 will continue for at least the first half of 2021/22. NHS organisations will submit a formal plan in May.
- The Trust has agreed its 2021/22 capital plans with the Kent & Medway STP which now manages the overall resource level within the patch. The Trust has submitted its five year capital plans to NHS England/Improvement (NHSE/I) in April 2021.
- The Trust continues to fully participate in the STP planning and assurance process. The STP has developed its role as local system lead in ensuring that the patch organisations work collaboratively in delivering income and expenditure and capital control totals. The Trust is a key player in Integrated Care Partnership (ICP) and STP/Integrated Care System (ICS) work on reconfiguring services in the patch for the future e.g. it is one of the selected sites for Hyper Acute Stroke Unit (HASU) as part of the STP-wide Stroke services consultation.

- The Trust will have contracts in place for provision of healthcare services for 2020-21 albeit at this stage they will be at least in part block contract arrangements nationally determined in response to the COVID-

Exceptional People Outstanding Care Programme, including the staff welfare programme and Culture and Leadership Programme (CLP) and associated staff engagement plans; and the Exceptional Leaders programme

19 pandemic. The Trust's main commissioner is NHS Kent & Medway Clinical Commissioning Group (CCG) with other main sources of income from NHSE Specialist Commissioners, NHS East Sussex CCG, NHS West Sussex CCG, NHS Brighton and Hove CCG and NHS Surrey Heartlands CCG. The current financial regime provides certainty for income and cash flows in 2021/22 for at least the first half of the financial year.

- Following the conversion of the working capital loan to Public Dividend Capital (PDC) in 2020/21 the Trust has no working capital loans and has not required any support during 2020/21 and not anticipating requiring support in 2021/22
- The Trust does not consider that there are any material uncertainties to the going concern basis.

For these reasons, the Trust has prepared its 2020/21 annual accounts using the going concern basis in line with the GAM guidance.

Performance summary for 2020/21

Performance against the Trust's agreed objectives, including the delivery of the financial plan, is described in detail in the "Development and performance in 2020/21" section (pages 20 to 22). The Trust's performance activities can be found in full within the monthly Trust Board reports, which are available for review at https://tinyurl.com/MTWTBReports. Further details on the performance standards for quality of care can be found in the Trust's Quality Accounts for 2020/21, which will be made available in full on the Trust website (www.mtw.nhs.uk).

Performance report for 2020-2021:
Performance analysis

How the Trust measures performance

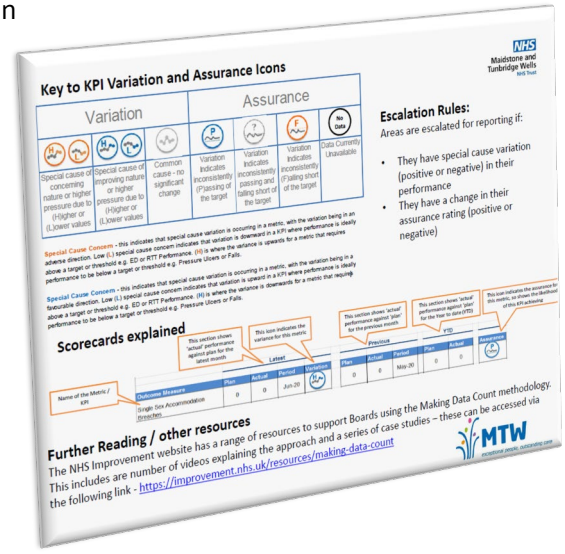
The Trust's Performance Management framework recognises that a high performance culture will only be achieved when performance is managed in a positive and non-punitive way. The Framework aims to ensure that striving for excellence is an integral part of organisational culture. The key focus areas for performance management are:

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

A 'Ward to Board' approach is applied and monitored through a sign-off process at Directorate, then Divisional, level before presentation at monthly Divisional Performance Review meetings and ultimately, the Trust Board.

A whole day each month is devoted to Trust-wide performance management, attended by members of the Executive Team. The Clinical Divisions and Corporate services are accountable for the delivery of their key indicators for Quality, Performance, Finance and Workforce, together with their strategic and Trust-wide programme responsibilities.

The monthly Integrated Performance Report encapsulates the result of these processes and provides the Board with a rich source of information that has been reviewed and substantiated at all levels of the Trust. "The dashboard contains details of all key aspects of performance, under the CQC domains of "Safety", "Effectiveness", "Caring", "Responsiveness" and "Well-Led". In July 2020 the Trust transitioned from a traditional 'Red, Amber, Green' (RAG) rating system which was used to highlight variances against Trust plans for the year and/or the required national target; wherein "Green" indicated "Delivering or exceeding target", "Amber" indicated "Underachieving target"' and "Red" indicated "Failing target"; to a Statistical process control (SPC) process which employs statistical methods to monitor and control a process". Additional performance information is provided on financial matters and clinical quality. These reports are available on the Trust's website, as part of the information provided for Trust Board meetings (see www.mtw.nhs.uk/about-us/trust-board/).



The content of the Performance Dashboard is discussed at meetings of the Executive Team Meeting and Trust Board. At the latter, the person responsible for each domain is asked to highlight key issues of note, and explain areas of under/failing performance. Performance against the Trust's agreed objectives is measured and monitored via the Board Assurance Framework, which is described in more detail in the "Annual Governance Statement for 2020/21" later in this Annual Report. In addition to this, the Trust continues to use nationally-published information (where available), to compare performance. This includes national staff and patient surveys and national clinical audits.

The Trust monitors its progress against the recommendations from its most recent CQC report (March 2018) through an Action Plan "Tracker" which is monitored through the Trust's Quality Improvements Committee.

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

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

Development and performance in 2020/21

The 'key issues and risks affecting delivery of the Trust's objectives' were described earlier in the Report (pages 13 to 16). The Trust's actual performance against each of its 2020/21 objectives is described below.

To deliver the Trust's financial plan, which is set within the context of its financial strategy, and underpinned by a robust, sustainable recurrent surplus

This objective was fully achieved (rated green within the Board Assurance Framework) as The Trust has delivered its financial plan for 2021/22 (subject to audit)

To improve the management of our patient journeys through the utilisation of evidence-based practice to ensure good quality care and achievement of the constitutional access standards within agreed resources

This objective was partially achieved (rated amber within the Board Assurance Framework) as the Trust is in the top five best performing Trusts for the Emergency Department (ED) 4-hour and 62-day cancer waiting time targets; however the adverse impact of the COVID-19 pandemic has meant that the Trust has not achieved the 18-week Referral to Treatment (RTT) waiting time standard, and the number of patients waiting about 52 weeks for treatment has increased.

To deliver high quality care to our patients and carers and be recognised as an outstanding organisation

This objective was partially achieved (rated amber within the Board Assurance Framework) as the Trust has delivered its plans in relation to the project aim, in relation to action plans, Key Lines of Enquiry (KLOE) and the work of the Quality Improvement Committee and is also able to demonstrate that it delivers high quality care to patients and carers, via oversight of quality and safety from the Divisional Directors of Nursing & Quality; the Matrons' quality assurance reviews; monitoring of key quality and safety indicators (which are included in a 'heat map' which we have developed this year); and the development and monitoring of action plans that have been identified through the self-assessments of the Care Quality Commission KLOEs (which are monitored at the Quality Improvement Committee). However the Trust has not yet received an external validation of an "outstanding" rating as the Trust was not inspected by the Care Quality Commission in 2020/21, so is unable to rate the project aim as "Fully achieved".

Delivery of the Allscripts' Electronic Patient Record (EPR) solution "Sunrise"; aligning and supporting the wider strategic objective of digitally transforming the Trust to improve patient outcomes through providing safer and more efficient care

This objective was partially achieved (rated green within the Board Assurance Framework) for the following reasons:

- Stage 3 and 4a of the programme has been completed, which includes the design, build and validation of the Emergency Department (ED), outpatients, order comms, core clinical, therapies and Paediatric workstreams
- The custom code required for the Pathology interface has been delivered by Allscripts
- User Acceptance Testing (UAT) 4 and 5 has been completed, and all 'go live' blockers identified have been addressed
- The Sunrise 18.4 upgrade has been completed.
- All five rounds of Data Priming planned in 20/21 have been concluded
- The Ive programme / Windows 10 rollout, which was scheduled to support the Sunrise 'go live' commenced on time in January 2021. A number of issues during Quarter 4 were identified with the roll out of Windows 10 and plans were put in place. At the end of March 2021 the Ive programme was on track to meet the requirements of the Technical go live in mid-April 2021.
- Due to the second surge of COVID-19, the 'go live' for April 2021 was reviewed and reset to mid-June 2021.
- The design and configuration of the initial Electronic Prescribing and Medicines Administration (EPMA) functionality to 'go live' in December 2021 is currently on track.
- A managed service solution continues to be explored with Allscripts to support IT capacity and capability post go live

To enable fulfilment of the Trust's role in the delivery of an integrated, reputable, high quality, educational programme and student experience for Kent and Medway Medical School (KMMS) students in line with the KMMS curriculum; provision of necessary student accommodation and teaching infrastructure at Maidstone Hospital (MH) and Tunbridge Wells Hospital (TWH) in time for the first intake of KMMS students on 01/09/22

This objective was fully achieved (rated green within the Board Assurance Framework) as the Trust is on track to achieve the final objective by September 2022 when the first KMMS students arrive on placement, and the KMMS have confirmed student placement numbers at the Trust of 40 in Year 3 starting in September 2022. There is also tentative agreement for similar numbers in years 4 and 5, but these have not yet been confirmed. The Programme Specification Curriculum was received 23/11/20 and detailed planning and identification of resource implications is underway through the Specialty Lead Groups starting with Year 3. Clinical teaching facilities have been defined and included in the design of new build facilities at Tunbridge Wells Hospital. The facilities at Maidstone Hospital are being considered as part of the overall post-COVID-19 estate rationalisation work. The medical school accommodation build design and location was agreed with the Non-Executive Director oversight group on 02/02/21 and formal planning approval was submitted on 05/03/21.

To define an estates and facilities strategy and plan for the Trust informed by both the clinical strategy and Reset and recovery workstreams

This objective was fully achieved (rated green within the Board Assurance Framework) as the Trust Estates strategy has been drafted, but it is awaiting the confirmed details of the Trust's capital funding allocation for 2021/22. Once that allocation has been confirmed (via the Kent and Medway Sustainability and Transformation Partnership), a Trust Board Seminar will be scheduled to discuss the draft strategy, prior to it being submitted for approval to a formal Trust Board meeting.

To define the future state (short medium and long term) configuration options for a range of clinical services with timelines and plans for implementation.

 This objective was fully achieved (rated green within the Board Assurance Framework) as although all clinical reconfiguration projects were paused during the COVID-19 second wave, these have now restarted and all are delivering against their agreed timelines. A timeline has been agreed for the cardiology reconfiguration with an 18-month timeline developed and being implemented against for the move of inpatient cardiology services and catheter laboratory to Maidstone Hospital. A timeline has been agreed for gastroenterology reconfiguration with agreement through the Kent County Council Health Overview and Scrutiny Committee (HOSC) by August 2021. Engagement has begun with local members and patients, and an options appraisal has been successfully completed with clinicians. The development of a Tier IV Bariatrics service has been agreed with the Executive Director of Strategy and Population Health at NHS Kent and Medway Clinical Commissioning Group (CCG), and a joint Business Case is being developed for consideration at the Trust Board and CCG Governing Body in May 2021. A Full Business Case (FBC) for a managed MRI service is being developed with approval targeted at the Trust Board in July 2021 and contract award in August 2021.

To oversee and enable the Integrated Care Partnership (ICP) Development in West Kent and ensure appropriate stakeholder engagement and participation in the Trust's work (e.g. in clinical strategy development

 This objective was was fully achieved (rated green within the Board Assurance Framework) for the following reasons:

- The ICP has successfully moved to phase two of its governance structures.
- Transformational priorities have been defined in conjunction with clinical and professional board reviewing population health data.
- The resourcing for ICP development for the year ahead has been agreed with NHS Kent and Medway CCG.
- Cross-organisational discussions on resourcing within the ICP have resulted in a clear implementation and resourcing plan with a trebling of the Joint Project Management Office (JPMO) resource.
- New roles and assigned clinical and professional backfill are allowing integrated models of frailty, health inequalities and Primary Care Network (PCN)-focused workstreams (e.g. primary care demand and capacity) to progress.
- The first new roles have been successfully recruited to and the rest are in the course of being advertised.
- The stakeholder advisory forum and elected members forum are being supported by the NHS Kent and Medway CCG locality team, to ensure appropriate input into ICP work.
- The next stage of development will be to dovetail with the Kent and Medway ICS end state workstream, to ensure that the ICP continues to develop in accordance with the Kent and Medway ICS.

To make the Trust a great place to work - For the Trust to be an excellent organisation that puts staff engagement, well-being and experience at the fore front to nurture a place where people want to come to work, stay, be proud and enable staff to be exceptional by recruiting, retaining and developing exceptional people to deliver outstanding care for our communities

 This objective was partially achieved (rated amber within the Board Assurance Framework) as The Trust has seen improvements in its results from the NHS staff survey in a number of domains, and positive feedback has been provided via the in-year climate surveys; however, several of the Trust's interventions will not start to deliver improvements until 2021/22 (although these have started to be implemented during 2020/21)

Financial performance in 2020/21

For the financial year 2020/21 the Trust reported a surplus of £0.3m, which was £5.3m better than plan. The finance regime for 2020/21 was different to previous years in response to the Covid 19 pandemic. The first half of the year the Trust was retrospectively funded for all costs. The second half of the year the Trust had to work within the Kent and Medway system envelope for funding. The planned £5m deficit related to outstanding annual leave not taken by staff due to the pressures of the pandemic. The final value for this was £4.7m, which was funded in full by NHSE/I.

There were some aspects of the plan which were not met. The key drivers of this variance are:

- There was an underspend in pay due to shortfall in workforce availability
- There was a one-off benefit in non pay of £3.3m for a rate rebate.
- Clinical income was reduced and returned to the system to offset the underspend in pay and non pay.

The variances to plan were offset by Public Dividend Capital (PDC) being less than planned by £1.1m. The Trust didn't hold a contingency in 2020/21, a system contingency was held by Kent and Medway CCG.

Income and Expenditure (financial performance)

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

Statement of Comprehensive Income	2020/21 (plan) £m	2020/21 (actual) £m	Variance £m
Income	540.2	564.2	24.0
Operating expenses	(529.2)	(550.3)	(21.1)
Operating surplus / (deficit):	**11.0**	**13.9**	**2.9**
Finance income	0.0	0.0	0.0
Finance expense	(14.7)	(14.7)	0.0
PDC dividend charge	(2.4)	(1.3)	1.1
Net finance costs	**(17.1)**	**(16.0)**	**1.1**
Other gains / (losses)	0.0	0.0	0.0
Surplus / (deficit) for the year before technical adjustments	(6.1)	(2.1)	4.0
Technical adjustments	1.1	2.4	1.3
Surplus / (deficit) for the year after technical adjustments	**(5.0)**	**0.3**	**5.3**

The Trust incurred additional expenditure pressures arising in the year after the plan was set. The Trust also received funding to support these pressures. The two main pressures were the employers' NHS pension

contribution increase of £12.8m and COVID-19 PPE costs of £7.7m. These were both funded by NHS England/NHS Improvement.

Income

The Trust's income was £564.2m which was above plan by £24.0m by the end of the financial year. The main variances relate to centrally received income of £26.3m. This was £12.8m for the uplift in employers' NHS pension contribution, £4.7m for annual leave accrual, £7.7m PPE push stock received and £1.1m donated assets for COVID 19 equipment. This was offset by a reduction in the CCG income to deliver a breakeven position.

The majority (92%) of the Trust's income is from CCGs or NHS England.

Operating expenses

The Trust's expenditure was £550.3m which was £21.1m adverse to plan. The main variance was an increase in expenditure of £12.8m as a result of the 6.3% uplift in employers' NHS pension contribution. In addition there were non-pay costs of £7.7m for PPE pushstock. The Trust received funding to cover both these costs. The expenditure included an additional £32.8m of costs to respond to COVID-19.

Finance costs

The PDC charge was lower than planned by £1.1m. This was principally driven by a lower than planned year end property valuation and higher average daily cash balances during the year.

Cost Improvement Programme (CIP)

The Trust suspended its Cost Improvement Plan for 2020/21 as part of the changes to the national financial regime.

Capital expenditure plan

During the year the Trust made capital investments of £33.3m including £1.4m of assets funded from donated or charitable fund sources. Significant elements of the programme were:

- £3m for Covid-19 equipment, ICT and estates costs;
- £2.9m for the ongoing EPR programme; £8.9m relating to ICT schemes, mainly the IVE programme on device replacement (£5.5m) and replacement of network infrastructure (£2.9m). In addition, national programme funding enabled spend on the Think 111 project (£0.5m) and Kent and Medway Care Record development (£0.45m).
- Expenditure of £2.8m was invested in the Urgent and Emergency Care projects (including the new SAU at TWH); and £2.9m related to Estates backlog, renewal and PFI Lifecycle.
- Equipment replacement schemes included: £1.7m spent on the endoscopy equipment funded from national PDC; £2.2m replacing a Linear Accelerator at Canterbury; £1.0m replacing major breast screening equipment including the mobile units; £0.9m to update and expand critical care and testing equipment to support Covid-19 treatment; £0.7m to renew the Interventional Radiology room at Maidstone Hospital. This project will be completed in 2021/22; £0.6m for a new CT simulator for Radiotherapy patients and £0.2m on a new Pharmacy robot at Maidstone Hospital; £0.7m for Ophthalmology equipment supporting the service transferred from Moorfields Hospital, and £1.8m of general Trustwide replacement of overage equipment, mostly clinical.

The donated spend of £1.4m includes £1.1m of centrally procured equipment transferred to the Trust during the pandemic. DHSC are proposing to transact these donations during 2021/22 to transfer them formally to Providers as donated assets. For 2020/21 Providers were instructed to recognise the assets in final accounts.

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

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

External Finance Limit (EFL)

The Trust is required to demonstrate that it has managed its cash resources effectively by staying within an agreed limit on the amount of cash it can borrow and spend. In 2020/21 the Trust met its target with a year-end position of an underspend of £4.29m on the EFL.

Capital Resource Limit (CRL)

The Trust is expected to manage its capital expenditure within its agreed CRL. For 2020/21 the Trust's CRL was £32.36m and the Trust spent £31.95m, and underspend of £0.41m. This underspend related to the reimbursement in 2020/21 of Covid-19 capital claims from 2019/20.

Break-even duty

Each NHS Trust has a statutory duty to break-even taking one year with another, measured as the Income and Expenditure position adjusted for specific technical exclusions. This duty is formally measured over a three-year period or a five-year period if agreed with the Department of Health and Social Care.

The Trust's last formal three-year break-even cycle commenced in 2013/14 and was not met by the end of the period in 2015/16. The Trust has achieved break even surpluses and met its NHSEI control totals in each of the last three financial years. The Trust is not in any financial recovery regime relating to its historic accumulated deficit but is required to achieve the in year break even position agreed as part of the Kent and Medway STP system control totals. The Trust has achieved an in-year break-even duty surplus in 2020/21 of £0.33m which was slightly better than plan and its system control total requirement.

Accounting Issues

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

External Auditors

The Trust's External Auditors are Grant Thornton UK LLP. Their charge for the year was £82,100 excluding VAT (in 2019/20 this was £73,000 excluding VAT). There was no audit of the Quality Accounts in 2020/21 under a variation of arrangements made nationally in response to the COVID-19 pandemic. Grant Thornton UK LLP did not undertake any non-audit work for the Trust in 2019/20.

Looking forward to 2021/22

The impact of COVID-19 has delayed the business planning process both nationally and internally within the Trust. Nationally mandated interim contracting arrangements are in place between the Trust and Commissioners from April to September 2021. The financial plan will be Kent and Medway system based and the Trust will work with its partners to deliver a breakeven position for the first half of the year. A further planning round is expected to take place in the first quarter to agree financial plans for the second half of the year.

The financial regime for capital was updated in April 2020 to move to a more STP/ICS-led system approach to managing capital allocations and expenditure. For 2021/22 the Trust's agreed initial resource is £10.2m comprising £8.7m of internally generated and financed resource, £1.2m of PFI lifecycle for the Tunbridge Wells Hospital and £0.3m of system PDC to finance the design fees for the Hyper Acute Stroke Unit.

Countering fraud, bribery and corruption

The Trust has a range of policies and procedures in place to identify and respond to risks of fraud, bribery and corruption, including an "Anti-Fraud, Bribery and Corruption Policy and Procedure"; "Gifts, Hospitality, Sponsorship and Interests Policy and Procedure"; "Standing Financial Instructions", "Risk Management Policy and Procedure", "Serious Incidents (SI) Policy and Procedure", and the "Freedom to speak up: raising concerns policy and procedure" as well as policies relating to, for example, employee verification checks etc. Such Policies are available to all staff via the Trust's Intranet system. The Trust's Local Counter Fraud Specialist (LCFS) is a mandated consultee for such Policies. In addition, the LCFS undertakes a programme of work for the Trust which aims to prevent, deter and detect fraudulent activity. The outcomes of the work are reported to the Audit and Governance Committee, which in turn provides a summary report on its own activity to the Trust Board.

Equality, Diversity and Human Rights

The Trust's activity and policies in this area are explained in the Accountability Report (page 36 onwards).

Quality Accounts 2020/21

The Trust's Quality Accounts for 2020/21, which are scheduled to be approved by the Trust Board in June 2021, can be found on the Trust's website (www.mtw.nhs.uk), or the Trust's page on the NHS England and Improvement website (https://www.england.nhs.uk/publication/maidstone-and-tunbridge-wells-nhs-trust/).

Performance report for 2020-2021:
Sustainability report

As an NHS organisation, and as a spender of public funds, we have an obligation to work in a way that has a positive effect on the communities we serve. Sustainability means spending public money well, the smart and efficient use of natural resources and building healthy, resilient communities. By making the most of by making the most of social, environmental and economic assets we can improve health both in the immediate and long term even in the context of rising cost of natural resources. The commitment to this agenda was reaffirmed in the NHS Long Term Plan with clear targets on carbon and air pollution. Demonstrating that we consider the social, economic and environmental impacts ensures that the legal requirements in the Public Services (Social Value) Act (2012) are met.

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

As the largest public sector emitter of carbon emissions, the health system has a duty to respond to meet the targets which are entrenched in law.

We recognise that the pandemic has led to an increase in some of our emissions, and that our waste, recycling and reuse figures have been negatively affected due to infection prevention protocols. We are committed as a Trust to reversing these trends as soon as possible.

Policies

In order to embed sustainability within our business it is important to explain where in our process and procedures sustainability features.

One of the ways which we embed sustainability is through the use of a Green Plan within the Trust. Our Green Plan has been reviewed in the last 12 months and approved by the Trust board.

We also recognise that our procured services have a substantial sustainability impact. Part of the tender process identifies the key elements of every product to ensure that it is suitable for the Trust. The Trust also requires suppliers to confirm the products adhere to the NHS terms and conditions. This ensures compliance with the environmental and sustainability requirements

Our statement on Modern Slavery is that the Trust uses NHS terms and conditions. The Modern Slavery act is included within these terms and Conditions and suppliers must confirm they comply as part of any contract they sign with us.

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

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

Adaptation

Climate change brings new challenges to our organisation, both in direct effects to the healthcare estates, but also to patient health. Examples of recent years include the effects of heat waves, extreme temperatures and prolonged periods of cold, floods, droughts etc. Our board approved plans address the potential need to adapt the delivery the organisation's activities and infrastructure to climate change and adverse weather events

Events such as heatwaves, cold snaps and flooding are expected to increase as a result of climate change. To ensure that our services continue to meet the needs of our local population during such events we have developed and implemented a number of policies and protocols in partnership with other local agencies.

Green Space and Biodiversity

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

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

Partnerships

The NHS policy framework already sets the scene for commissioners and providers to operate in a sustainable manner. Crucially for us as a provider, evidence of this commitment will need to be provided in part through contracting mechanisms.

For commissioned services our CCG's are NHS Kent and Medway CCG and NHS East Sussex CCG.

Performance

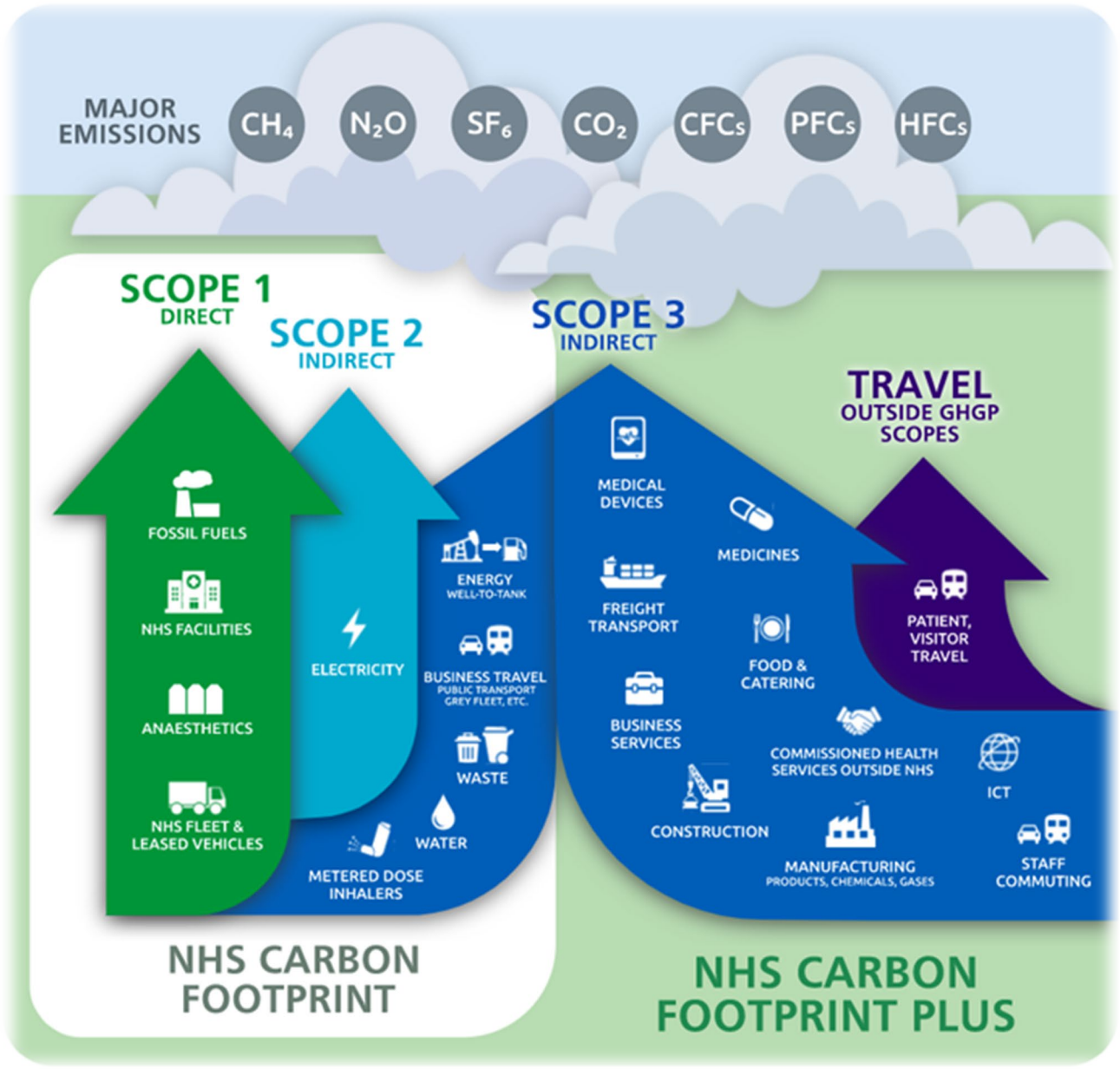
Organisation

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

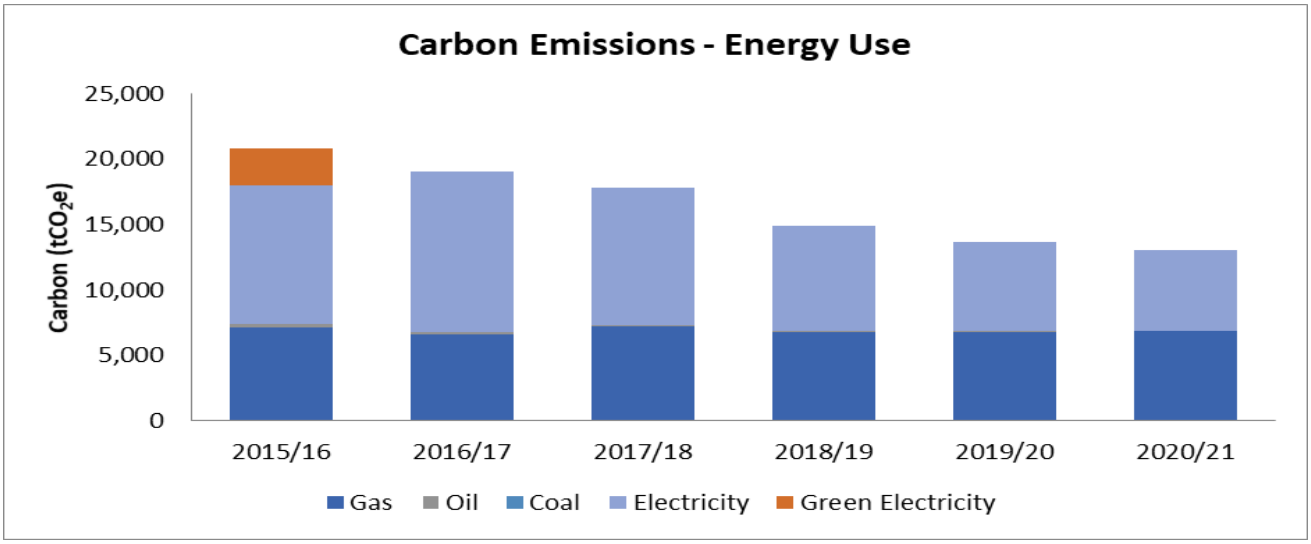
Context info	2007/8	2015/16	2016/17	2017/18	2018/19	2019/20	2020/21
Floor space (m^2)	109,896	138,533	138,533	138,533	138,533	134,083	133,111
Number of staff (WTE)	3,969	4,678	5,130	5,022	5,153	5,313	5,866[6]

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

The NHS has responded to the amended Climate Change Act by committing to be net zero by 2040 for the emissions that are directly controlled, called the NHS carbon footprint, and the net zero by 2045 for the emissions that are influenced, called the NHS carbon footprint plus.



Energy



Managing energy is one aspect of reducing carbon emissions. Maidstone and Tunbridge Wells NHS Trust has spent £4,263,339 on energy in 2020/21, which is a 10.5% decrease on energy spend from last year.

The Trust has gained a marginal reduction in electrical consumption in the last year against 2019/20, this can be partially attributed towards continued good practice and also partially due to the changed dynamic of the hospital during the pandemic.

The gas consumption in the Trust has increased overall, whilst there has been a reduction at Maidstone this has been offset by an increase at Tunbridge Wells. The Trust is committed to reversing this increase where possible in the coming years.

Resource		2015/16	2016/17	2017/18	2018/19	2019/20	2020/21
Gas	Use (kWh)	34,139,781	31,546,328	33,930,120	31,855,591	32,476,847	32,920,550
	tCO_2e	7,145	6,593	7,194	6,766	6,747	6,840
Oil	Use (kWh)	635,116	532,926	313,362	280,800	273,640	224,294
	tCO_2e	203	169	102	90	87	58
Coal	Use (kWh)	0	0	0	0	0	0
	tCO_2e	0	0	0	0	0	0
Electricity	Use (kWh)	18,564,756	23,801,508	23,652,117	22,899,149	21,576,328	21,452,491
	tCO_2e	10,673	12,301	10,542	8,078	6,818	6,181
Green Electricity	Use (kWh)	4,892,105	0	0	0	0	0
	tCO_2e	2,813	0	0	0	0	0
Total energy CO_2e		20,833	19,062	17,838	14,934	13,652	13,079
Total energy spend		£ 3,919,681	£3,835,790	£4,535,611	£4,912,381	£4,762,269	£4,263,339

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

Re-use

Whilst we recognise that the reuse of goods and materials is vitally important for the sustainable future of the NHS, the effects of the pandemic has meant that this project has been suspended because of potential cross contamination issues.

The Trust is committed to restarting this project as soon as conditions allow us to.

Category	2015/16	2016/17	2017/18	2018/19	2019/20	2020/21
Internal reuse of durable goods (£)	Not Recorded	Not Recorded	2,000	2,000	2,000	0
External reuse of durable goods (£)	Not Recorded	Not Recorded	2,500	5,000	2,500	0

Paper

The movement to a Paperless NHS can be supported by staff reducing the use of paper at all levels, this reduces the environmental impact of paper, reducing cost of paper to the NHS and can help improve data security. The progress made by the Trust in the last year has been reversed slightly.

Paper		2017/18	2018/19	2019/20	2020/21
Volume used	Tonnes	61	90	62	68
Carbon emissions	tCO_2e	58	85	58	64

Travel

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

Every action counts and we are a lean organisation trying to realise efficiencies across the board for cost and carbon (CO_2e) reductions. We support a culture for active travel to improve staff wellbeing and reduce sickness. Air pollution, accidents and noise all cause health problems for our local population, patients, staff and visitors and are caused by cars, as well as other forms of transport.

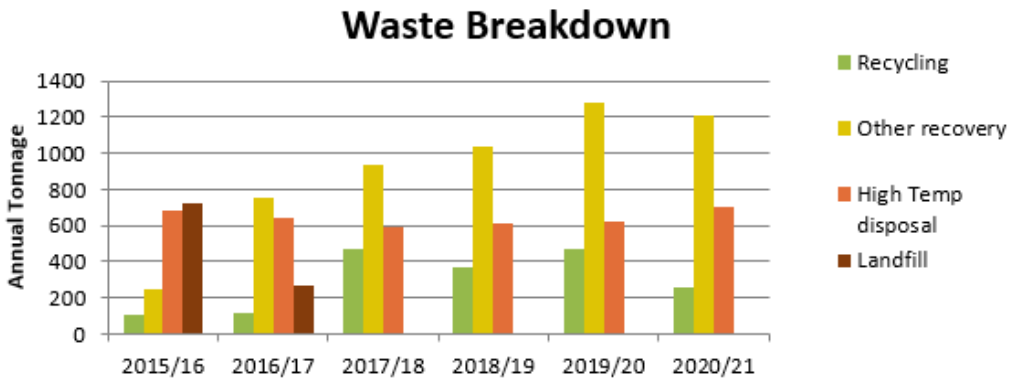
Category	Mode	2015/16	2016/17	2017/18	2018/19	2019/20	2020/21
Patient & visitor travel	Miles ℒ	107,404,988	112,158,231	115,563,332	121,747,529	118,743,943	110,617,477
	Miles	38,841.48	40,535.15	41,178.09	44,890	41,040	38,232
Business travel & fleet	Miles	1,319,789	1,037,636	1,059,360	0	569,989	265,695
	tCO_2e	477	375	377	0	197	92
Staff commute	Miles	4,493,769	4,927,968	4,824,221	4,824,221	5,105,793	5,637,226
	tCO_2e	1,625	1,781	1,719	1,779	1,765	1,948

N.B. tCO_2e = Tonnes of CO_2 equivalent. This is used to measure the equivalent CO_2 concentration which causes the same level of absorption in the atmosphere for other greenhouse gases.

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

Waste

The recycling performance within the Trust has suffered due to the pandemic.



Because of infection concerns, recycling facilities were unable to handle and sort materials which led to a large proportion of waste that would normally be recycled being diverted to energy from waste facilities..

N.B. High temperature ("High Temp") disposal is the incineration of clinical waste. There is no energy recovery from this process at the current time. The Trust sends domestic waste to an 'energy from waste' facility, and this is classed as "Other recovery". Energy from waste cannot be classed as recycling, as that refers to taking a used item, turning it into a raw material and using that as a basis to manufacture a new product. 'Energy from waste' is about recovering the embedded energy within a product and is lower down the waste hierarchy, this being: reduce (the amount of waste being produced); reuse (items in their existing form); recycle (into new products); recover (the embedded energy); or dispose (through landfill).

Waste		2015/16	2016/17	2017/18	2018/19	2019/20	2020/21
Recycling	(tonnes)	107	115	468	372	472	258
	tCO_2e	2	2	7	8	8	5
Other recovery	(tonnes)	248	756	937	1040	1281	1206
	tCO_2e	16	16	15	15	27	25
High Temp disposal	(tonnes)	679	639	592	614	621	704
	tCO_2e	149	141	190	192	137	155
Landfill	(tonnes)	724	265	0	0	0	0
	tCO_2e	177	82	0	0	0	0
Total Waste (tonnes)		1758	1775	1997	2026	2374	2168
Total Waste tCO_2e		333	241	211	215	174	186

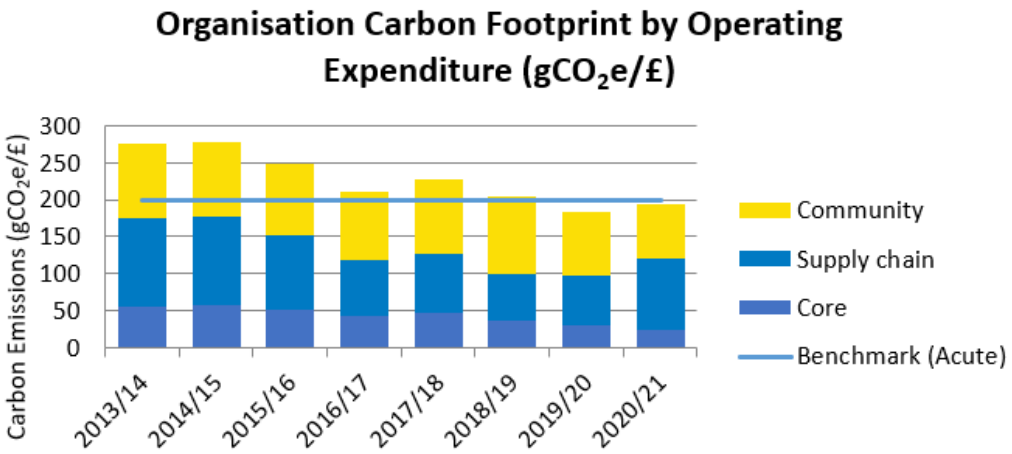
Finite resource use - water

The water consumption has decreased from previous years, partially due to the reduces footfall through the hospitals owing to the pandemic.

Water		2015/16	2016/17	2017/18	2018/19	2019/20	2020/21
Mains	m^3	205,246	209,205	225,383	211,936	237,616	219,389
	tCO_2e	187	190	205	193	216	199
Water & Sewage Spend		£582,869	£661,990	£761,100	£758,895	£959,889	£959,889

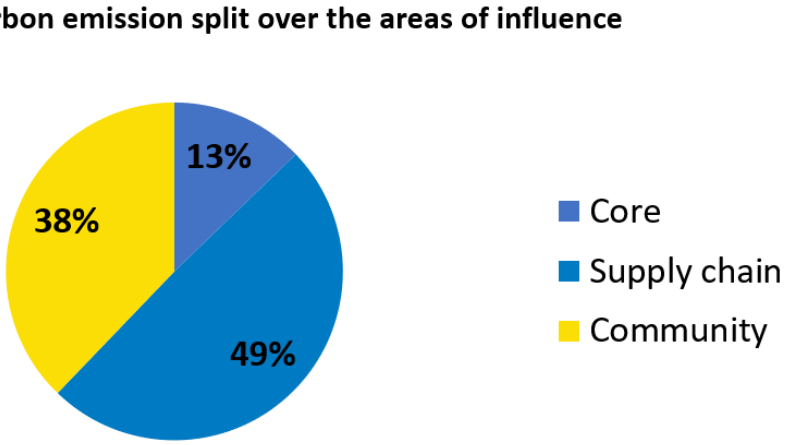
Modelled Carbon Footprint

The information provided in the previous sections of this sustainability report uses the ERIC returns as its data source. However, we are aware that this does not reflect our entire carbon footprint. Therefore, the following information uses a scaled model based on work performed by the Sustainable Development Unit (SDU) in 2009/10. More information available here: http://www.sduhealth.org.uk/policy-strategy/reporting/nhs-carbon-footprint.aspx. The application of this model results in an estimated total carbon footprint of 106,292 tonnes of carbon dioxide equivalent emissions (tCO_2e). Our carbon intensity per pound is 193 grams of carbon dioxide equivalent emissions per pound of operating expenditure (gCO2e/£). Average emissions for acute services is 200 grams per pound.

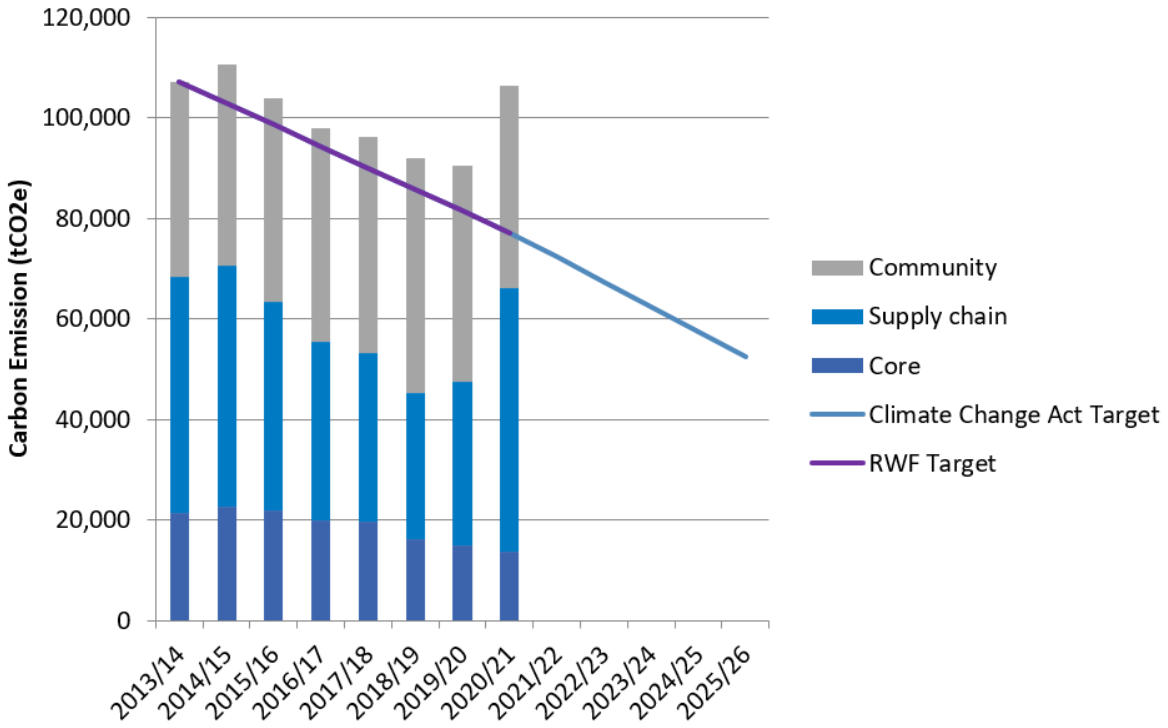


N.B. "Core" emissions are the emissions from the direct activities of the Trust. They include emissions from electricity, gas, fuel from vehicles and generators, biomass, water and sewerage, fugitive emissions from anaesthetic gases, and business travel and mileage. They are calculated by applying intensity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

The distribution of our carbon emissions through our different areas of influence clearly demonstrates that the emissions associated with the supply chain and procurement are the largest component of our carbon footprint. This is reflective of the fact that the goods and services spend profile was 140% higher in 2020/21 than in 2019/20.



Modelled trajectory

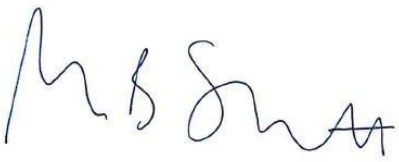


We are committed to meeting the legal requirements of the climate change act by reducing our emissions in line with the trajectory above.

We acknowledge that whilst the core emissions of the Trust have been steadily and consistently falling since 2015/16 the emissions associated with our supply chain have grown significantly. This is attributable to the pandemic and the increased level of procurement and operations.

Declaration

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



Miles Scott, Chief Executive 24th June 2021

Accountability report for 2020-2021:
Corporate governance report

Directors' report

The Trust Board

The Trust Board meets every month (with the exception of August) in public (a 'Part 1' meeting), following HM government's guidance on social distancing the Trust Board meeting has been 'livestreamed' to the Trust's Youtube channel (https://www.youtube.com/channel/UCBV9L-3FLrluzYSc29211EQ) to enable members of the public to observe the proceedings. The agenda and reports for the meetings, which took place via a webconference, were made available via the Trust's website (see www.mtw.nhs.uk/about-us/trust-board/). The Trust Board formally operates in accordance with its Terms of Reference, the Trust's Standing Orders, Scheme of Matters Reserved for the Board and Scheme of Delegation, and Standing Financial Instructions.

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

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

- Simon Hart, Director of Workforce left the Trust Board on 13/08/21
- Cheryl Lee, Interim Director of Workfroce, joined the Trust Board 07/09/20, and subsequently left the Trust Board on 31/03/21

Although outside of the reporting period the following Trust Board membership change should be noted

- Sue Steen, Chief People Officer, Joined the Trust Board on 01/04/21

The Trust Board also held one 'away day' in the year, in December 2020 (which focused on The development of the Kent and Medway Integrated Care System (ICS) and West Kent Integrated Care Partnership (ICP)). The programme of Trust Board Seminars that was established in 2017/18 also continued, and three such Seminars were held (in July and September 2020 and February 2021). The issues discussed at the Seminars included the development of system partnerships; a digital leadership session provided by NHS Providers; and the Strategy Deployment Process and Outcomes.

Trust Board Members

Taking into account the wide experience of all Trust Board Members, the balance and completeness of the Board is considered to be appropriate. At the end of 2020/21, the Trust Board had the following members:

David Highton

Chair of the Trust Board*

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

Miles Scott

Chief Executive*∑

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

Maureen Choong

Non-Executive Director*

Maureen joined the Trust Board in August 2017 as an Associate Non-Executive Director, and was then appointed as a substantive Non-Executive Director in November 2017. She is a Registered Nurse with over 40 years of clinical and leadership experience within the NHS, prior to her retirement in 2016 from her role as Clinical Quality Director with NHSI. Her previous roles included Deputy Chief Nurse with NHS London and both clinical and Director roles in NHS trusts. Since retirement, Maureen has worked with Health Education England as an Improvement Associate. In addition to her role on the Trust Board, Maureen chairs the Patient Experience Committee, is Vice-Chair of the Quality Committee and Audit and Governance Committee; and a member of the Remuneration and Appointments Committee. Maureen is married with two stepchildren and lives in Kent.

Sarah Dunnett OBE

Non-Executive Director*

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

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

Sean Briggs

Chief Operating Officer*Σ

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

Karen Cox

Associate Non-Executive Director

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

Richard Finn

Associate Non-Executive Director

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

Neil Griffiths

Non-Executive Director*

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

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

David Morgan

Non-Executive Director*

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

Amanjit Jhund

Director of Strategy, Planning and Partnerships$^{\Sigma}$

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

Peter Maskell

Medical Director*$^{\Sigma}$

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

Sara Mumford

Director of Infection Prevention and Control

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

Claire O'Brien

Chief Nurse*$^{\Sigma}$

Claire joined the Trust Board in February 2017 as Interim Chief Nurse and was appointed Chief Nurse (substantive) in March 2018. Claire has worked in the NHS for nearly 40 years, qualifying as a Registered General Nurse at King's College London in the early 1980s. She specialised in Cardiothoracic Nursing and has enjoyed a variety of general management and senior nursing roles within South London NHS acute Trusts, more recently as the Deputy Director of Nursing in Lewisham and Greenwich NHS Trust. Claire joined the Trust as Deputy Chief Nurse in April 2016, bringing a wealth of experience in all areas related to Nursing standards, Nurse Education, recruitment and Nursing professional issues. She has considerable experience working with patient representatives, and has a particular interest in engaging with staff and supporting them in their development, recognising the relationship between staff and patient experience, and feels it is vital that staff are valued and supported to provide the best possible care at all times.

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

Steve Orpin

Deputy Chief Executive / Chief Finance Officer*∑

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

Emma Pettitt-Mitchell

Non-Executive Director*

Emma joined the Trust Board in June 2018 as an Associate Non-Executive Director and was appointed as a substantive Non-Executive Director in August 2019. Emma is a highly experienced senior executive with over 21 years' experience with one of the largest retailers (UK and globally) and FTSE 100 companies, Tesco Stores Ltd. Emma's vast experience includes being the customer 'voice', retail, commercial, insight, human resources, buying and marketing, and also includes a highly successful background in the achievement of profitable business growth; through the creation and execution of strategic business plans. Uniquely Emma has worked extensively as a Director in both the private and public sector. Most recently working for Kent County Council, as the Director of Strategic Business Development and Intelligence, leading a large insight team. For the last 2.5 years Emma has also been a Non-Executive Director for a private limited company, 'Commercial Services', one of the largest suppliers and brokers of products and services in the UK.
Emma lives in Kent with her husband Andrew and 3 children. In addition to her role on the Trust Board, Emma chairs the People and Organisational Development Committee., is Vice Chair of the Patient Experience Committee and is a member of the Audit and Governance Committee and Remuneration and Appointments Committee.

Jo Webber

Associate Non-Executive Director

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

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

Simon Hart, Director of Workforce (who left the Trust Board on 13th August 2020) also served on the Trust Board during 2020/21.

Cheryl Lee, Interim Director of Workforce (who joined the Trust Board on 7th September 2020, and left the Trust Board on 1st April 2021) also served on the Trust Board during 2020/21.

Statement regarding Directors' disclosure to auditors

Each Director can confirm that they know of no information which would be relevant to the auditors for the purposes of their audit report, and of which the auditors are not aware, and; has taken "all the steps that they ought to have taken" to make themselves aware of any such information and to establish that the auditors are aware of it.

Attendance at Trust Board meetings

There were 11 formal and 2 extraordinary Trust Board meetings in 2020/21. Attendance at each meeting is shown below:

Trust Board Member	16th April 2020	30th April 2020	May 2020	18th June 2020	25th June 2020	July 2020	September 2020	October 2020	November 2020	December 2020	January 2021	February 2021	March 2021
David Highton, Chair of the Trust Board	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Miles Scott, Chief Executive	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Sean Briggs, Chief Operating Officer	✓	✓	✓	✓	✓	✓	✓	✓	✓	Apologies	✓	✓	✓
Maureen Choong, Non-Executive Director	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Karen Cox, Associate Non-Executive Director	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Sarah Dunnett, Non-Executive Director	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Richard Finn, Associate Non-Executive Director	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Neil Griffiths, Non-Executive Director	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Simon Hart, Director of Workforce	✓	✓	✓	✓	✓	✓	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Amanjit Jhund, Director of Strategy, Planning and Partnerships	✓	✓	✓	Apologies	✓	✓	✓	✓	✓	✓	✓	✓	✓
Cheryl Lee, Interim Director of Workforce	N/A	N/A	N/A	N/A	N/A	N/A	✓	✓	✓	Apologies	✓	✓	✓
Peter Maskell, Medical Director	✓	✓	✓	✓	✓	Apologies	✓	✓	✓	✓	✓	✓	✓
David Morgan, Non-Executive Director	✓	✓	Apologies	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Sara Mumford, Director of Infection Prevention & Control	✓	✓	✓	✓	✓	✓	Apologies	✓	✓	✓	✓	✓	✓
Claire O'Brien, Chief Nurse	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Steve Orpin, Deputy Chief Executive / Chief Finance Officer	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Emma Pettitt-Mitchell, Non-Executive Director	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Jo Webber, Associate Non-Executive Director	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓

Appointment and evaluation of Trust Board Members' performance

The Chair of the Trust Board and its Non-Executive Directors are independently appointed by NHS Improvement (NHSI) (operating at the NHS Trust Development Authority legal entity). The Chief Executive and other Executive posts serving on the Trust Board are appointed by the Trust in liaison with NHSI. All members of the Trust Board are subject to a performance framework through which:

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

- Members of the Executive Team are appraised by the Chief Executive.

Trust Board Members are also subject to an annual self-assessment in accordance with the fit and proper persons requirements (FPPR[7]) for Directors. No concerns have been raised in relation to this in 2020/21.

Directors' interests

The Trust Board and other committees routinely ask that any interests relevant to agenda items be declared at each meeting. In addition, a Register of Directors' interests is maintained. The interests recorded on the Register at the end of 2020/21 for those on the Board at the end of that year were as follows:

Trust Board Member	Details of notifiable interest
David Highton, Chair of the Trust Board	▪ Strategic Health Industry Adviser for Servita Group Ltd (Reg co. no. 10497423) ▪ Chairman, Demelza House Children's Hospice (charity Number: 1039651) ▪ Owner and Director, Hyperium Ltd (Reg co. no.: 04684013) ▪ Director of ACG Lettings Limited (Reg co. no.: 03031999) a property lettings business bequeathed to Demelza by legacy
Miles Scott, Chief Executive	None
Sean Briggs, Chief Operating Officer	None
Maureen Choong, Non-Executive Director	Special Advisor: Care Quality Commission (CQC)
Karen Cox, Associate Non-Executive Director	▪ Vice Chancellor and President, University of Kent ▪ Board Member and Chair, Nursing and Midwifery Council ▪ Royal College of Nursing Member ▪ UPP Foundation Advisory Board member ▪ Member Universities UK membership Committee ▪ Applied Research Collaboration Kent, Surrey, Sussex - Board member - 2019 ▪ Director of South East Local Partnership ▪ Member of University of Kent Academy Trust
Sarah Dunnett, Non-Executive Director	▪ Director of CATALYST (london) Ltd (Reg co. no 10121754 ▪ Interim Non-Executive Director, East Kent Hospitals University Foundation Trust
Richard Finn, Associate Non-Executive Director	▪ Director of Richard Finn Ltd ▪ Director of Goring Place ▪ Director of Detling Community Interest Company
Neil Griffiths, Non-Executive Director	▪ Managing Director of TeleTracking Technologies ▪ Advisory Council Member, Staff College
Amanjit Jhund, Director of Strategy, Planning and Partnerships	▪ Member of UK Labour Party
Cheryl Lee, Interim Director of Workforce	▪ Director of Cheryl Lee Associates Ltd ▪ Director of AZT Developments Ltd
Peter Maskell, Medical Director	None
David Morgan, Non-Executive Director	▪ Deputy Chairman and Non-Executive Director of Nord gold PLC ▪ Chairman and Non-Executive Director of AMTE Power PLC ▪ Chairman, Piazza Barnaloft Management Limited ▪ Son works for Grant Thornton UK LLP
Sara Mumford, Director of Infection Prevention & Control	None
Claire O'Brien, Chief Nurse	None
Steve Orpin, Deputy Chief Executive / Chief Finance Officer	Non-Executive Director of NHS Innovations South East (Reg. Co. No: 05210174)
Emma Pettitt-Mitchell, Non-Executive Director	Non-Executive Director of ELM Business Consultancy Ltd (Reg Co. No. 11326434)
Jo Webber, Associate Non-Executive Director	▪ Chair of "In Control Partnerships" Charity ▪ Daughter in Law is Non-Executive Director of East Sussex Hospitals Trust ▪ Daughter In Law is Non-Executive Director of 2-gether Support Solutions

N.B. Some Directors' notifiable interests changed during the year. Further details can be obtained from the Trust Secretary, who can be contacted via Maidstone Hospital, Hermitage Lane, Maidstone, Kent ME16 9QQ (or see www.mtw.nhs.uk/about-the-trust/trust-board.asp). The interests of Trust Board Members who left the Board during 2020/21 can also be obtained from the Trust Secretary.

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

Pension Liabilities

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

Trust Board sub-committees

The Trust Board has a number of sub-committees, to assist it in meeting its role and duties. Further details are provided in the "Annual Governance Statement for 2020/21" section later in the Annual Report.

The Trust's Management Structure

The Trust is organised into a number of corporate and clinical Divisions. The former includes Corporate Nursing, Emergency Planning, Communications, Estates and Facilities, IT, Finance, Human Resources, and Trust Management. The latter comprise 22 Clinical Directorates, as follows:

Division	Directorate
Medicine and Emergency Care	▶ Emergency Medicine
	▶ Acute Medicine and Geriatrics
	▶ Medical Specialities
Women's, Children's and Sexual Health	▶ Children's Services
	▶ Women's Services
	▶ Sexual Health
Cancer Services	▶ Clinical Haematology
	▶ Oncology
	▶ Cancer and Performance
	▶ Outpatients
Diagnostics and Clinical Support	▶ Pathology
	▶ Pharmacy
	▶ Imaging
	▶ Therapies
	▶ COVID Swabbing and Testing Services
Surgery	▶ General Surgery
	▶ Surgical Specialities
	▶ Theatres and Critical Care
	▶ Orthopaedics
	▶ Head and Neck
	▶ Private Patient Unit
Patient Flow	▶ Flow

Each Division and Directorate is overseen by a clinical management team (triumvirate). The triumvirate is led by a Chief of Service with overall responsibility for the leadership & management of their area. Chiefs of Service are supported by a Divisional Director of Operations (DDO) & Divisional Director of Nursing and

Quality (DDNQ), or equivalent. There is a Clinical Director (CD) for each Directorate and Directorate management teams follow the same triumvirate format as Divisions with Clinical Directors, General Managers, Lead Matrons and Other Professional Leads. All work together to agree annual & strategic plans for their services, are responsible for clinical & operational performance, resource and, communicating and engaging with staff.

Complaints: Ready to listen, ready to learn

The Trust strives to deliver the highest standards of care and treatment for all our patients, but despite the best efforts of staff, we do not always get things right. In order to learn and improve our services, we encourage patients and relatives to tell a member of staff as soon as they can, to allow us to put things right as soon as possible. However, for circumstances where concerns cannot be resolved in this way, the Trust has a formal complaints process. In 2020/21, the Trust received 389 formal complaints (in 2019/20, this was 556), and 71.3% of complaints received were responded to within the agreed timescale (in 2019/20, this was 64.2%).

The Trust's Complaints and Patient Advice and Liaison Service (PALS) – Annual Report (which is due for publication in summer 2021) (www.mtw.nhs.uk/patients-visitors/talk-to-us/making-a-complaint/) provides further detail on: the number of complaints received; the number of complaints which were well founded (upheld); the number of complaints referred to the Parliamentary and Health Service Ombudsman (PHSO); the subject matter of the complaints received; any matters of general importance arising from those complaints or the way in which the complaints were handled; any matters where action has been or is to be taken to improve services as a consequence of those complaints..

'Principles for Remedy'

The Trust applies the 'Principles for Remedy' guidance issued by the PHSO as part of its Policy and Procedure for Management of Concerns and Complaints. Under the Trust's Policy, financial remedy is only considered when a complaint is upheld and the complainant has clearly suffered a financial loss as a result of a service failure or breach of a Trust policy. In such circumstances, the Trust will consider paying a sum that restores the person to the position they would have been in prior to the circumstances which necessitated the complaint. The amount of financial remedy is agreed between the Complaints and PALS Manager and senior Directorate management team, with input from Legal Services as required. During 2020/21, the Trust offered financial remedy in two cases, totalling £162.58 (one of £12.58 for medication costs and one of £150.00 for injustice caused by the loss of the patient's healthcare records, which prevented the Trust from fully investigating the family's complaint). This process excludes any claims for clinical negligence, which are pursued under the Trust's Claims Management Policy.

Disclosure of personal data-related incidents

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

Date of incident (month)	Nature of incident	Number affected	How patients were informed	Lessons learned
July 2020	Unauthorised disclosure	One	The affected individual was contacted by telephone and letter	The Trust notified this breach to the ICO who considered the case and concluded that whilst it is possible a disclosure of personal data occurred, there was no evidence of this. The Trust provided evidence of its internal investigation and of a police investigation. Consequently, the ICO was satisfied that appropriate measures were taken in this instance and that the Trust have suitable processes in place.
November 2020	Unauthorised disclosure	One	The affected individual was contacted by telephone and letter	The Trust notified this breach to the ICO who considered the case and concluded that sensitive personal data was involved and that there was potential for the incident to cause distress/detriment and that citizen's rights had been breached. The Trust provided a package of care, support and mediation in consultation and agreement with the affected data subject. The Trust have taken actions to prevent a recurrence of this incident by provision of addition training to staff members. Consequently, the ICO was satisfied that appropriate measures were taken in this instance.
December 2020	Non-secure disposal - Paperwork	One thousand and twenty-seven	529 of the affected individuals are deceased. A decision was taken not to notify the remining individuals	The Trust notified this breach to the ICO who considered the case and concluded that the incident related to one rogue employee acting without authority. The data in question has been returned to the Trust and made secure. The Trust provided evidence of disciplinary steps taken. The ICO concluded that appropriate measures were taken in this instance and that the incident be considered to be contained.
March 2021	Unauthorised disclosure	One	The affected individual was contacted by telephone and letter	The Trust notified this breach to the ICO who have acknowledged the personal data breach. The Trust are currently awaiting further contact from the ICO. The Trust have instigated its disciplinary procedures in this case and an investigation is ongoing.

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

Category	Nature of Incident	Total
A	Corruption or inability to recover electronic data	0
B	Disclosed in error	93
C	Lost in transit	0
D	Lost or stolen hardware	0
E	Lost or stolen paperwork	20
F	Non-secure disposal – hardware	0
G	Non-secure disposal – paperwork	0
H	Unloaded to website in error	0
I	Technical security failing (including hacking)	0
J	Unauthorised access/disclosure	10
K	Other	0

Policy on setting charges

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

Emergency planning, response and recovery

As a Category One responder under the Civil Contingencies Act 2004, the Trust has specific statutory duties in relation to emergency planning and response. In addition the Trust has other obligations as required by contracts and performance standards set by NHS England. The following section describes the key areas of focus during 2020/21.

European Union (EU) Exit

Extensive work was carried out in preparations for the UK's exit from the EU. There was a huge additional workload with both internal and external multi agency planning including transport disruption, supplies & procurement, accommodation, staffing and business continuity however the Trust remained in a strong position for EU transition due to work undertaken prior to the pandemic.

Incident Co-ordination Centre (ICC)

The Incident Co-ordination Centre (ICC) was developed in response to the command and control requirements of the COVID-19 pandemic to ensure rapid decision making and it is intended that the ICC be continued into "business as usual". The ICC instituted a number of staff welfare initiatives which included breakout spaces in both academic centres with food and drink provided, a daily newsletter called 'the PULSE' to update staff on key actions and a daily Common Operating Picture distributed to managers .

Swabbing Pods and Swabulance

The Emergency Planning & Response team supported the South East Coast Ambulance service to organise a daily "swabulance" for home testing, aided in the establishment of Coronavirus Assessment Pods to isolate, test and assess potentially infected members of the public and were instrumental in setting up the first swabbing site for staff and elective patients at the Hop Farm in Paddock Wood.

Nightingale Hospital

As the operational pressures of the pandemic increased the government requested that Nightingale Hospitals be developed to help care for COVID-19 patients in large, central, locations. The Emergency Planning & Response team were involved in the development of plans to create a Nightingale Hospital at the Kent Country Showground in Detling by utilising inter-agency working. Although the site was not needed it proved the ability of the Trust to quickly response to the situation at hand.

Personal Protective Equipment (PPE)

PPE was a major challenge during the COVID-19 pandemic due to supply chain disruption. The Emergency Planning & Response team worked tirelessly with procurement, corporate nursing and the Trust's five Clinical Divisions every week to ensure there were sufficient supplies and that appropriate fit testing capacity was available to meet demands, thereby ensuring staff safety.

Oxygen Supply to Clinical Areas

The Emergency Planning & Response team worked with the Estates and Facilities Directorate to undertaking testing of the Trust's capacity in relation to the maximum litres per minute of Oxygen that could be delivered to each Clinical area. The testing enabled on-call managers to manage the Trust's Oxygen capacity.

Exercises and training

The training and exercise programme had to either be cancelled or adapted to maintain social distancing rules which presented additional challenges. E-Learning was developed to reduce face to face training, larger venues were booked, with strict infection prevention control measures undertaken to ensure staff safety for the limited practical sessions.

The Chemical Biological Radiation and Nuclear event (CBRNe) training had to be maintained to ensure the trust maintained the capability to respond to such an event.

Loggist training was considered essential to support the Trust's response to COVID-19 and provide a Loggist seven days a week, twelve hours a day in the Incident Co-ordination Centre. The training had to be delivered face to face so more sessions with fewer staff in larger rooms were implemented.

Adverse Weather and Winter Preparedness

The 2020 annual winter exercise was converted into a seminar event, business continuity plans were reviewed and appropriate contingencies such as snow clearing and 4X4 transport to get isolated critical staff into the Trust were reaffirmed.

Assurance

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

Safety Advisory Groups (SAGs)

The Trust continued to offer advice and guidance to any events that came under Sevenoaks District Council, Tonbridge & Malling Borough Council, Maidstone Borough Council and Tunbridge Wells Borough Council. The focus of the guidance was directed at adequate medical cover, provisions for inclement weather, infection prevention and control measures and social distancing.

COVID-19 Vaccination Centre

The Trust's mass vaccination plan, which was developed and exercise tested during the 2012 Olympics was effectively deployed and the Vaccination Centre established at Maidstone Hospital. The mass vaccination plan enabled over 15,000 vaccination doses to be administered in 2020/21 and received commendation from the Secretary of State for Health & Social Care.

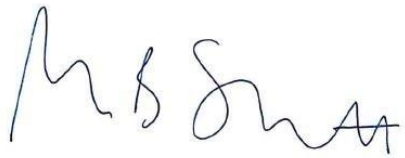
Statement of the Chief Executive's responsibilities as the Accountable Officer of the Trust

The Chief Executive of NHS Improvement, in exercise of powers conferred on the NHS Trust Development Authority, has designated that the Chief Executive should be the Accountable Officer of the Trust. The relevant responsibilities of Accountable Officers are set out in the NHS Trust Accountable Officer Memorandum. These include ensuring that:

- There are effective management systems in place to safeguard public funds and assets and assist in the implementation of corporate governance;
- Value for money is achieved from the resources available to the Trust;
- The expenditure and income of the Trust has been applied to the purposes intended by Parliament and conform to the authorities which govern them;
- Effective and sound financial management systems are in place; and;
- Annual statutory accounts are prepared in a format directed by the Secretary of State to give a true and fair view of the state of affairs as at the end of the financial year and the income and expenditure, other items of comprehensive income and cash flows for the year

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

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



Miles Scott,

Chief Executive

24th June 2021

Statement of Directors' responsibilities in respect of the accounts

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

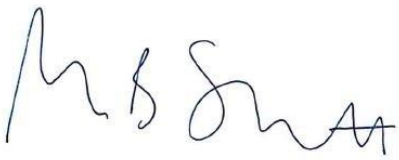
- Apply on a consistent basis accounting policies laid down by the Secretary of State with the approval of the Treasury;
- Make judgements and estimates which are reasonable and prudent;
- State whether applicable accounting standards have been followed, subject to any material departures disclosed and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

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

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

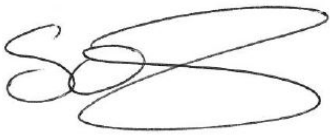
The Directors confirm that the annual report and accounts, taken as a whole, is fair, balanced and understandable and provides the information necessary for patients, regulators and stakeholders to assess the NHS Trust's performance, business model and strategy

By order of the Trust Board



Miles Scott, Chief Executive

24th June 2021



Steve Orpin, Chief Finance Officer

24th June 2021

Annual Governance Statement for 2020/21

Scope of responsibility

As Accountable Officer, I have responsibility for maintaining a sound system of internal control that supports the achievement of the Maidstone and Tunbridge Wells NHS Trust's policies, aims and objectives, whilst safeguarding the public funds and departmental assets for which I am personally responsible, in accordance with the responsibilities assigned to me. I am also responsible for ensuring that Maidstone and Tunbridge Wells NHS Trust is administered prudently and economically and that resources are applied efficiently and effectively. I also acknowledge my responsibilities as set out in the NHS Trust Accountable Officer Memorandum.

The purpose of the system of internal control

The system of internal control is designed to manage risk to a reasonable level rather than to eliminate all risk of failure to achieve policies, aims and objectives; it can therefore only provide reasonable and not absolute assurance of effectiveness. The system of internal control is based on an ongoing process designed to identify and prioritise the risks to the achievement of the policies, aims and objectives of Maidstone and Tunbridge Wells NHS Trust, to evaluate the likelihood of those risks being realised and the impact should they be realised, and to manage them efficiently, effectively and economically. The system of internal control has been in place in Maidstone and Tunbridge Wells NHS Trust for the year ended 31st March 2021 and up to the date of approval of the Annual Report and Accounts.

Capacity to handle risk

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

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

- The Chief Nurse is the Senior Information Risk Owner (SIRO)
- The Medical Director is the Caldicott Guardian and the Responsible Officer (for Medical Revalidation)
- The Chief Executive is the Board Level Director (with fire safety responsibility) and the Security Management Director[8]
- The Chief Operating Officer is the Accountable Emergency Officer for Emergency Preparedness, Resilience & Response (EPRR)[9]

[8] Required by the "Secretary of State Directions to NHS Bodies on Security Management Measures 2004 (amended 2006)"
[9] Required by The Health and Social Care Act 2012

- One of the Non-Executive Directors has been appointed as the Non-Executive Lead for Safeguarding and Resuscitation[10], and they have also been allocated the EPRR portfolio[11]
- The Chair of the Quality Committee is the Non-Executive Director with specific role/responsibilities for leading falls prevention , and also the Non-Executive lead on mortality and learning from deaths[12]

The Trust has a Risk Register and Board Assurance Framework (BAF) and in place, the operation of which are informed by accepted best practice . The BAF is the document through which the Trust Board is apprised of the principal risks to the Trust meeting its key objectives, and to the controls in place to manage those risks. The objectives within the BAF are devolved for oversight by one or more Trust Board sub-committees, and reports on the objectives are submitted to such sub-committees. The full BAF is then considered by the Audit and Governance Committee and then by the Trust Board, with the report presented by the Chair of the Audit and Governance Committee (supported by the Trust Secretary and relevant members of the Executive Team).

As is the case every year, the BAF and Risk Register are subject to review by the Trust's Internal Audit function (which is provided by TIAA Ltd). The review for 2020/21, gave an overall assessment of "Reasonable Assurance".

The ways in which staff are trained or equipped to manage risk in a way appropriate to their authority and duties (including the guidance provided to them and the ways in which the Trust seeks to learn from good practice)

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

Trust staff are involved in risk management processes in a variety of ways, including raising any concerns they may have (anonymously, if they so wish) via a range of methods, including via the Freedom to Speak Up Guardian or their Deputy (who was appointed during 2020/21); being aware of their responsibility to report

[10] Health Services Circular 2000/028 states that "Chief executives should ensure that"…"a…NED…of the Trust is given designated responsibility on behalf of the Trust Board to ensure that a resuscitation policy is agreed, implemented, and regularly reviewed within the clinical governance framework"
[11] The Core Standards for Emergency Preparedness, Resilience and Response (EPRR) assess whether "The organisation has an identified, active Non-executive Director/Governing Body Representative who formally holds the EPRR portfolio for the organisation"
[12] The CQC's "Learning, candour and accountability: A review of the way NHS trusts review and investigate the deaths of patients in England" report states that "We also recommend that provider Boards strongly consider nominating a non-executive director to lead on mortality and learning from deaths"

and act upon any incidents that occur; being involved in risk assessments; and attending regular training updates.

The Trust's mandatory induction and ongoing training programme for all staff reflects the need for staff to have a sound basis in managing risks relating to Information Governance, Infection Prevention and Control, fire safety, Safeguarding, Health and Safety and Moving and Handling. Non-mandatory training is also available to staff on a wide range of issues relating to risk management, both general (e.g. risk assessment) and in response to specific risks (e.g. falls prevention), whilst in-house support and advice on risk management is also available (which includes advice relating to patient safety, health and safety, Emergency Planning & Response and information governance. Certain types of risk are also addressed via the engagement of external expertise. For example, the risk of fraud is managed and deterred via the appointment of a Local Counter Fraud Specialist (LCFS) and the Trust engages a Dangerous Goods Safety Advisor (DGSA) to advise on the safe management of healthcare waste.

The Trust's advisers on risk seek to learn from best practice from a variety of means, including continuing professional development and via networking with counterparts from other organisations.

The risk and control framework

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

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

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

The Trust's Quality Governance arrangements are overseen via the Quality Committee, which receives a report from each Divisional clinical governance committee whenever it meets in its 'main' form[13] . The Quality Committee then aims to seek and obtain assurance on the effectiveness of the Trust's structures, systems and processes to enable delivery of the Trust's objectives relating to quality of care (as well as oversee quality within the clinical divisions)..

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

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

Compliance with CQC registration requirements is ultimately assessed via inspections by the CQC, and the Trust was subject to such inspections in the latter part of 2017 (which resulted in an overall assessment of "Requires Improvement"). However, regular engagement events have taken place with the CQC during 2020/21. Although such engagement events do not affect the Trust's formal assessment rating, the CQC have provided positive feedback on the areas that have been covered by these events.

The Trust's preparations and planning for CQC inspections are fully integrated and embedded as part of the Trust's 'business as usual' quality improvement agenda, and overseen by a Quality Improvement Committee, which is accountable to the Executive Team Meeting (ETM) via the Chief Nurse. The ETM and 'main' Quality Committee receive regular reports on progress with the Trust's ambition to achieve an "Outstanding" rating by the CQC.

How risks to data security are being managed and controlled

Risks to data security are managed and controlled via a range of methods, and the Trust undertakes an assessment against the National Data Guardian's ten data security standards. That assessment is primarily done via the Data Security and Protection Toolkit, and the Trust made a "Standards Met" Toolkit submission for the 2019/20 year on 29th September 2020 (the submission deadline for the Toolkit was extended because of the COVID-19 pandemic). The Trust is required to make its submission for the 2020/21 Toolkit by the end of June 2021 (as the deadline was again extended because of the pandemic).

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

The objectives for 2020/21, which were approved by the Trust Board on 23rd July 2020 , are as follows:

1. Finance and Contracts: To deliver the Trust's financial plan, which is set within the context of its financial strategy, and underpinned by a robust, sustainable recurrent surplus.

[13] The Quality Committee meets monthly, with each alternate month being a 'main' meeting (which involves a broad membership and discussion of a wide range of subjects) or a 'deep dive' (which involves a smaller membership and discussion of a small number of targeted subjects)

2. Operational Performance: To improve the management of our patient journeys through the utilisation of evidence-based practice to ensure good quality care and achievement of the constitutional access standards within agreed resources.
3. Quality and CQC: To deliver high quality care to our patients and carers and be recognised as an outstanding organisation.
4. Electronic Patient Record (EPR): Delivery of Allscripts' EPR solution "Sunrise"; aligning and supporting the wider strategic objective of digitally transforming MTW to improve patient outcomes through providing safer and more efficient care.
5. Education/Kent and Medway Medical School (KMMS): To enable fulfilment of MTW's role in the delivery of an integrated reputable, high quality educational programme and student experience for KMMS students in line with the KMMS curriculum; provision of necessary student accommodation and teaching infrastructure at Maidstone Hospital (MH) and Tunbridge Wells Hospital (TWH) in time for the first intake of KMMS students on 01/09/22.
6. Strategy - Estates: To define an estates and facilities strategy and plan for MTW informed by both the clinical strategy and Reset and recovery workstreams.
7. Strategy – Clinical: To define the future state (short medium and long term) configuration options for a range of clinical services with timelines and plans for implementation.
8. Integrated Care Partnership (ICP)/External: To oversee and enable the ICP Development in West Kent and ensure appropriate stakeholder engagement and participation in MTW's work (e.g. in clinical strategy development).
9. Organisational Development and Workforce: Make MTW a great place to work - For MTW to be an excellent organisation that puts staff engagement, well-being and experience at the fore front to nurture a place where people want to come to work, stay, be proud and enable staff to be exceptional by recruiting, retaining and developing exceptional people to deliver outstanding care for our communities.

The main risks to the achievement of these key objectives (i.e. the issues that could prevent the objectives being achieved) are described within the BAF, and the Trust Board received formal update reports on the performance of each objective, and the management of risks to non-achievement in November 2020 and March 2021. In-year reports BAF reports on specific objectives were also considered by several Trust Board sub-committees. A year-end BAF report regarding the achievement of the objectives was then received by the Trust Board in April 2021.

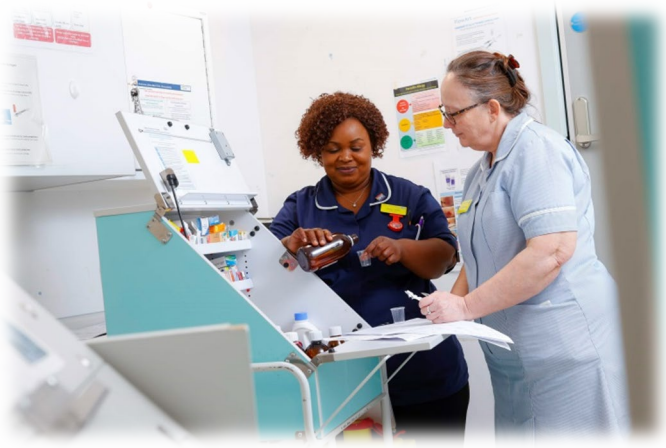
In addition, a number of risks were rated as 'red' in 2020/21. Red-rated risks are reviewed and validated at the ETM (see below) each quarter. The underlying risks have been discussed at the Trust Board and its sub-committees throughout 2020/21, and include the cost pressures associated with the use of temporary staff; risk associated with failing to learn from incidents; the inability to fulfil the national standard of 35% of women being cared for by Continuity of Carer teams within the Maternity service; the risk of harm from delays in psychiatric assessment and implementing the required actions following assessment; the risk of insufficient capacity in certain specialties (glaucoma, ENT, Head and Neck, Critical Care); staffing absences in certain specialties; the ability to undertake timely mortality reviews; statutory legionella management control; the number of policies that had exceeded their review date; and the effect of COVID-19 (coronavirus) outbreak on the Trust's ability to carry out its functions. Each associated risk assessment describes the efforts being made and/or planned to manage and mitigate the risk, and the Trust's Risk and Compliance Manager oversees the regular reviews of the assessments with the relevant risk leads.

Are the Trust's services well-led (under NHS Improvement's well-led framework)?

The CQC inspection in 2017 that was referred to above rated the Trust as "Good" for the Well-led domain. It is likely that the Trust will be assessed again by the CQC during 2021/22.

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

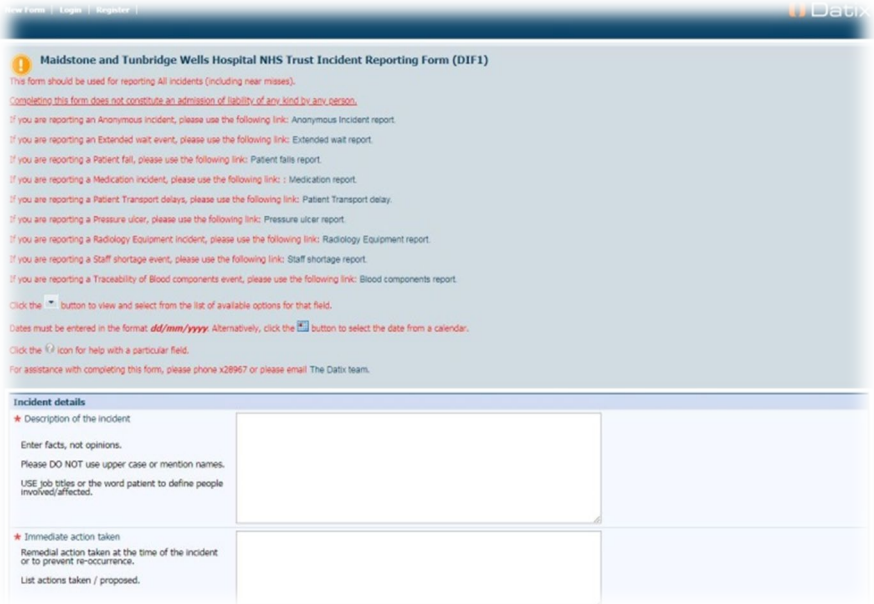
In May 2020, the Trust Board completed the required self-certification (for 2019/20) that the Trust could meet the obligations set out in the NHS Provider Licence (which itself includes requirements to comply with the National Health Service Act 2006, the Health and Social Care Act 2008, the Health Act 2009 and the Health and Social Care Act 2012, and to have regard to the NHS Constitution); and that it complied with governance requirements (condition FT4(8)). The Trust Board confirmed full compliance, on the basis of the content of the Trust's Annual Report, and Annual Governance Statement for 2019/20. The Trust Board will be asked to undertake the required self-certification for 2020/21 at its meeting in May 2021, and it will again be proposed that full compliance be confirmed.



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

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

- The Trust's mandatory induction and ongoing training programme for all staff reflects the need for staff to have a sound basis in managing risks relating to Information Governance, Infection Prevention and Control, fire safety, Safeguarding, Health and Safety and Moving and Handling.
- Incident reporting is openly encouraged across the Trust, and lessons learned from incident investigations are disseminated and promoted (including via the "Governance Gazette" newsletter produced by the Clinical Governance department).
- Risk is regularly discussed at a wide range of forums, including the Trust Board and its sub-committees (which sets the tone for discussions at Divisional-, Directorate- and departmental-levels forums)
- Risk management is incorporated into the Trust's planning and Cost Improvement Programme (CIP) arrangements, via the Quality Impact Assessment (QIA) process.


Maidstone and Tunbridge Wells Hospital NHS Trust Incident Reporting Form (DIF1)

This form should be used for reporting All incidents (including near misses).

Completing this form does not constitute an admission of liability of any kind by any person.

If you are reporting an Anonymous incident, please use the following link: Anonymous Incident report.

If you are reporting an Extended wait event, please use the following link: Extended wait report.

If you are reporting a Patient fall, please use the following link: Patient falls report.

If you are reporting a Medication incident, please use the following link: : Medication report.

If you are reporting a Patient Transport delays, please use the following link: Patient Transport delay.

If you are reporting a Pressure ulcer, please use the following link: Pressure ulcer report.

If you are reporting a Radiology Equipment incident, please use the following link: Radiology Equipment report.

If you are reporting a Staff shortage event, please use the following link: Staff shortage report.

If you are reporting a Traceability of Blood components event, please use the following link: Blood components report.

Click the button to view and select from the list of available options for that field.

Dates must be entered in the format dd/mm/yyyy. Alternatively, click the button to select the date from a calendar.

Click the icon for help with a particular field.

For assistance with completing this form, please phone x28967 or please email The Datix team.

Incident details

★ Description of the incident

Enter facts, not opinions.

Please DO NOT use upper case or mention names.

USE job titles or the word patient to define people involved/affected.

★ Immediate action taken

Remedial action taken at the time of the incident or to prevent re-occurrence.

List actions taken / proposed.

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

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

- A bi-annual review of safe staffing levels is led by the Chief Nurse, using a combination of historical data, professional judgement and reference to quality outcomes. The reviews follow the National Quality Board's 2016 guidance[14] cover the necessary three components (i.e. evidence-based tools, professional judgement and outcomes).
- The Trust has a workforce plan that is submitted to NHS England/Improvement (NHSE/I) along with the annual financial and activity plans. The Trust Board discusses all of these plans before submission
- The ETM received regular updates during 2020/21 on progress against the Trust's recruitment plan
- Service changes including those related to skill mix and the introduction of new roles are subject to a QIA process led by the Medical Director and Chief Nurse
- The Trust Board reviews workforce metrics on a monthly basis as part of its Integrated Performance Report (IPR), to ensure that workforce challenges and risks are understood as part of the wider context of service delivery.
- Where there are critical service risks in relation to staffing and the safe delivery of care these, along with their associated mitigations are escalated to the Trust Board and external regulators as required.

- The Trust's People and Organisational Development Committee (a sub-committee of the Trust Board, which is chaired by a Non-Executive Director) meets every two months. The Committee's purpose (as stated it its Terms of Reference) is to provide assurance to the Board in the areas of people development, planning, performance and employee engagement. The Committee also works to assure the Trust Board that the Trust has the necessary strategies, policies and procedures in place to ensure a high performing and motivated workforce that supports success

Care Quality Commission (CQC) registration

The Trust is fully compliant with the registration requirements of the CQC.

Register of interests

The Trust has an established "Gifts, hospitality, sponsorship and interests policy and procedure". However, it has not yet implemented NHS England "Managing Conflicts of Interest in the NHS" guidance and has not therefore published on its website an up-to-date register of interests, including gifts and hospitality, for decision-making staff within the past twelve months, as required by the "Managing Conflicts of Interest in the NHS" guidance. The Trust's Audit and Governance Committee (which receives reports of declarations made

[14] "Supporting NHS providers to deliver the right staff, with the right skills, in the right place at the right time" (National Quality Board, July 2016)

under the "Gifts, hospitality, sponsorship and interests policy and procedure") has however been kept informed of the Trust's plans regarding the guidance, which the Trust intends to implement in full in 2021/22.

NHS Pension scheme

As an employer with staff entitled to membership of the NHS Pension Scheme, control measures are in place to ensure all employer obligations contained within the Scheme regulations are complied with. This includes ensuring that deductions from salary, employer's contributions and payments into the Scheme are in accordance with the Scheme rules, and that member Pension Scheme records are accurately updated in accordance with the timescales detailed in the Regulations.

Obligations under equality, diversity and human rights legislation

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

Obligations under the Climate Change Act and the Adaptation Reporting requirements

The Trust has undertaken risk assessments and has a sustainable development management plan in place which takes account of UK Climate Projections 2018 (UKCP18). The Trust ensures that its obligations under the Climate Change Act and the Adaptation Reporting requirements are complied with. This is primarily driven by the implementation of the Trust's Sustainable Development Management Plan (SDMP), which is approved by the Trust Board each year (this was approved in May 2020, and is scheduled to be approved next in May 2021).

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

A range of processes are applied to ensure that the Trust's resources are used economically, efficiently and effectively. The monitoring of this is primarily overseen by the Trust Board, Finance and Performance Committee and Audit and Governance Committee, although the People and Organisational Development Committee, Quality Committee and Remuneration and Appointments Committee have all participated in this oversight during 2020/21. The Trust's annual Internal Audit plan for 2020/21 included a range of reviews relating to this area, including "Critical Financial Assurance – Financial Accounting and Non Pay Expenditure", and "Critical Financial Assurance – Payroll", which achieved overall assessment of "Reasonable Assurance".

Information governance incidents

The Trust had four serious incidents involving personal data that met the criteria for reporting to the Information Commissioner's Office (ICO), as described within NHS Digital's Data Security and Protection Toolkit, during 2020/21. Three of the incidents related to unauthorised disclosure, while the other related to the non-secure disposal of paperwork. All four were subject to an internal investigation and remedial action was taken. The ICO confirmed it was satisfied that appropriate measures were taken for three of the incidents, while for the fourth, which was notified to the ICO in March 2021, the Trust is currently awaiting further contact from the ICO..

Data quality and governance

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

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

- The Trust has a "Patient access to elective care policy" (which was revised and ratified in September 2020), which covers the management of waiting lists at all stages of a referral to treatment pathway. The Policy also states the responsibilities of key staff, including those relating to data quality.
- The Trust also has an "Information Lifecycle Management Policy and Procedure", which describes the Trust's general approach to data quality
- There is a validation process involving operational, management and information leads, to assure the quality of local and national waiting times reporting/data.
- The Trust has a Data Quality Steering Group, chaired by the Deputy Chief Executive/Chief Finance Officer, and the Group has, during 2020/21, overseen the creation of a Data Quality Strategy and workplan. This is linked to NHS Digital's Provider Data Quality Assurance Framework, against which a baseline assessment was undertaken, and the workplan has been developed to improving the Trust's position against that assessment. A Task and Finish group, chaired by the Associate Director of Business Intelligence, has been established to deliver the workplan.

The quality of performance information is primarily assessed via the Internal Audit programme, and in particular via the review of "Data Quality of Key Performance Indicators", which forms part of the Internal Audit plan each year. The "Data Quality of Key Performance Indicators" that was undertaken as part of the 2019/20 Internal Audit plan (and which was issued in September 2020 because of the delays arising from the COVID-19 pandemic) covered the Stroke Best Practice Tariff and 18 Weeks Referral to Treatment (RTT) incomplete pathway indicators, and gave an overall assessment of "Reasonable Assurance".

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

Review of effectiveness

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

The Head of Internal Audit Opinion for 2020/21 states that "My overall opinion is that Reasonable assurance can be given that there is a generally sound system of internal control, designed to meet the organisation's objectives, and that controls are generally being applied consistently. However, some weakness in the design and/or inconsistent application of controls, put the achievement of particular objectives at risk.". The last sentence of the Opinion reflects the fact that some reviews undertaken by Internal Audit during 2020/21 resulted in a "limited assurance" conclusion. As is the case with all reviews with such a conclusion, the details have been, or will be, considered at the Audit and Governance Committee and actions to address the weaknesses identified in controls are monitored as part of the routine reports that Internal Audit submit to that Committee.

The Audit and Governance Committee approves the Internal Audit plan for the year and receives details of the findings from each of the Internal Audit reviews that are undertaken. Summary reports of relevant Internal Audit reviews are also submitted to the Trust Management Executive (TME), Finance and Performance Committee, People and Organisational Development Committee, and 'main' Quality Committee during the year. Although a number of the Internal Audit reviews completed in 2020/21 resulted in an overall 'Reasonable assurance' assessment, four led to an assessment of 'Limited assurance'. These related to the processes for the management of post, the effective use of the Electronic Staff Record (ESR), the Oncology ICT Healthcheck, and the Roche Managed Service Contract, and actions to address the issues identified in these reviews will be taken during 2021/22.

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

The Trust Board meets every month (with the exception of August) in public (a 'Part 1' meeting). All Trust Board meetings in 2020/21 were held 'virtually', as a result of the COVID-19 pandemic, and from June 2020, the requirement to meet in public was met via the Trust Board's meetings being broadcast live on the internet, via the Trust's YouTube channel. The agenda and reports for all 'Part 1' Trust Board meetings are available via the Trust's website.

The agenda for Trust Board meetings is mainly focused around the key aspects of operational performance; quality; planning and strategy; assurance and policy; and reports from sub-committees. A separate ('Part 2') meeting is held on the same day as the meeting held in public, to consider confidential matters, in accordance with the Public Bodies (Admission to Meetings)

Act 1960. A 12-month rolling forward programme of agenda items is actively managed to ensure the Board receives the information, and considers the matters it requires to perform its duties efficiently and effectively.

A key part of the information the Board receives at each meeting in public is an IPR, which contains up-to-date details of performance across a range of indicators.

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

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

- The Audit and Governance Committee. This supports the Trust Board by critically reviewing the governance and assurance processes on which the Board places reliance. This therefore incorporates reviewing Governance, Risk Management and Internal Control (including the BAF); oversight of the Internal and External Audit, and Counter Fraud functions. The Committee also undertakes detailed review of the Trust's Annual Report and Accounts, is the Trust's Auditor Panel (in accordance with Schedule 4, Paragraph 1, of the Local Audit and Accountability Act 2014). The Committee is chaired by a Non-Executive Director, and meets five times each year (including a specific meeting to review the Annual Report and Accounts prior to the Trust Board being asked to approve these). All other Non-Executives Directors (apart from the Chair of the Trust Board) are members.
- The Charitable Funds Committee. This aims to ensure that the Maidstone and Tunbridge Wells NHS Trust Charitable Fund is managed efficiently and effectively in accordance with the directions of the Charity Commission, relevant NHS legislation and the wishes of donors, which includes reviewing, and agreeing the Charitable Fund Annual Report and financial accounts, for approval by the Trust Board. The Committee is chaired by a Non-Executive Director, and meets three times per year.
- The Finance and Performance Committee. This aims to provide the Trust Board with: assurance on the effectiveness of financial management, treasury management, investment and capital expenditure and financial governance; an objective assessment of the financial position and standing of the Trust; and advice and recommendations on all key issues of financial management and financial performance. In addition, the Committee receives assurance on informatics (including Information Technology) strategies and plans, and on plans and proposals for major development and investment in Information Technology. The Committee is chaired by a Non-Executive Director, and meets monthly.
- The Patient Experience Committee. This considers the effectiveness of the Trust's progress in utilising the learning from patient and service users experience of Trust services in order to improve, and identify the level of inclusion achieved for patients and service users by Trust operations. The Committee is chaired by a Non-Executive Director, and meets quarterly. In addition to Trust staff, its membership includes representatives from the Trust's catchment area, Healthwatch Kent, and from Leagues of Friends of Maidstone and Tunbridge Wells Hospitals.
- The People and Organisational Development Committee. This provides assurance to the Board in the areas of people development, planning, performance and employee engagement; and works to assure the Trust Board that the Trust has the necessary strategies, policies and procedures in place to ensure a high performing and motivated workforce that supports success. The Committee is chaired by a Non-Executive Director and meets monthly.
- The Quality Committee. This aims to seek and obtain assurance on the effectiveness of the Trust's structures, systems and processes to enable delivery of the Trust's objectives relating to quality of care. The Committee is chaired by a Non-Executive Director and meets monthly. On alternate months, the Committee meets in the form of a 'deep dive', with a reduced membership, to enable a small number of subjects to be scrutinised in greater detail.

- The Remuneration and Appointments Committee. This reviews, on behalf of the Trust Board, the appointment of members of the Executive Team, to ensure such appointments have been undertaken in accordance with Trust Policies. It also reviews the remuneration, allowances and terms of service of such staff; reviews (with the Chief Executive) the performance of members of the Executive Team; oversees appropriate contractual arrangements for such staff (including the proper calculation and scrutiny of termination payments, taking account of such national guidance, as appropriate); and considers and approves, on behalf of the Trust Board, proposals on issues which represent significant change. The Committee is chaired by the Chair of the Trust Board, and meets on an ad-hoc basis (although it met several times during 2020/21).

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

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

In addition to the above committees, there are a range of other forums, structures and processes in place to oversee and manage any issues relevant to particular aspects of risk and governance. In this respect, the Trust has, for example, an Infection Prevention and Control Committee; a Health and Safety Committee; a Drugs, Therapeutics and Medicines Management Committee; an Information Governance Committee; and a Joint Safeguarding Committee.

The impact of the COVID-19 pandemic during 2020/21

The impact of the COVID-19 pandemic began to be felt materially by the Trust during March 2020, but was more significantly felt within 2020/21, particularly during the 'second wave', which was experienced during the winter of 2020/21. However, despite the unprecedented scale of the impact, the Trust's structure of governance allowed a prompt response to the significant change in circumstances. The Incident Command Centre that was established in March 2020, with the Chief Operating Officer as the Strategic Commander, led

and coordinated the Trust's response to the pandemic, including acting as the single point of contact for the escalation of issues; acting as the single point of contact for external agencies; being responsible for identifying and mitigating Trust-wide risks; and having decision-making authority over all substantial issues, queries, operational changes and expenditure requests relating to the COVID-19 response.

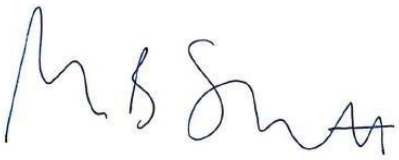
Significant internal control issues

The following significant internal control issue[15] has been identified in 2019/20:

1. Two "Never Events" were declared at the Trust in 2020/21. One related to a misplaced naso-gastric (NG) tube and one involved a retained swab following a delivery. The incidents were subject to scrutiny through the SI investigation process, and the Quality Committee, to aim to ensure that lessons were learnt to prevent recurrence.
2. In November 2020, HM Coroner issued the Trust with a Regulation 28 ("Report to Prevent Future Deaths") report, following the Inquest into the death (in August 2019) of one of the Trust's patients, who sustained a severe head injury following a fall from a trolley in the Clinical Decision Unit. The Trust wrote to HM Coroner in January 2021 to explain the actions that had been taken, and would be taken in the future, to learn from the incident, and prevent it from recurring.

Conclusion

The Trust has maintained a sound system of internal control during 2020/21, and has identified only two significant internal control issues during the year. These are described above, in the body of the Annual Governance Statement.



Miles Scott, Chief Executive

24th June 2021

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

Accountability Report for 2020-2021:
Remuneration and staff report

Our staff

NHS national staff survey

Our aim is to provide high quality compassionate care for our patients that is underpinned by providing high quality compassionate care for our staff. The NHS National Staff Survey, our culture work and our climate surveys are important methods for us to hear the views of our staff. The thoughts, experiences and opinions of everyone across the organisation are vital in gauging how well we are providing the care and support needed to our staff to progress us on our journey to becoming the best place to work.

Our 2020 NHS National Staff Survey response rate saw an increase of 1% compared to 2019 with 3199 staff completing the survey, representing 52% of our workforce. With the national average response rate for acute Trusts being 45% and against the backdrop of a global pandemic, we are delighted to report statistically significant improvements in Health and Wellbeing, Morale, Quality of Care, Safety and Staff Engagement.

Around 92% of respondents felt their role is making a difference to patients/service users, 83% feel satisfied with the quality of care they give to patients/service users and 82% are happy with the standard of care provided by the organisation should a friend or relative need treatment. We have seen a 10% increase in the number of staff feeling that the Trust takes positive action on health and wellbeing since 2019 and 75% of staff would recommend the Trust as a place to work.

We plan to continue the work we started prior to and during the Covid-19 pandemic with a focus on Civility, Dignity and Respect by supporting staff to be confident in speaking up about the issues affecting them; developing a robust and inclusive recruitment practice using Equality, Diversity and Inclusion (EDI) Recruitment Champions; and supporting staff to develop their careers here at the Trust.

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

Employee benefits

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

Staff numbers and costs (subject to audit)

Average[16] staff numbers	Permanently employed (WTE)[17]	Other (WTE)	Permanently employed (expenditure) (£000s)	Other (expenditure) (£000s)
Medical and dental	863	43	95,282	6,972
Ambulance staff	4	0	267	0
Administration and estates	1,178	67	43,733	3,532
Healthcare assistants and other support staff	1,641	1	47,303	53
Nursing, midwifery and health visiting staff	1,753	75	85,571	5,367
Nursing, midwifery and health visiting learners	0	0	10	0
Scientific, therapeutic and technical staff	541	35	27,303	2,552
Social Care Staff	0	0	0	0
Healthcare Science Staff	200	0	10,775	11
Other	0	0	0	0
Apprenticeship levy	0	0	1,277	0
Employers Pension Contribution 6.3%	0	0	12,824	0
Total	6,180[18]	221	324,345	18,487
Staff engaged on capital projects (excluded from above)	16	6	1,308	1,002

[16] The average number of employees is calculated as the whole time equivalent number of employees under contract of service in each week in the financial year, divided by the number of weeks in the financial year.
[17] This excludes any staff on unpaid leave (and therefore does not equate to the WTE reported within the Sustainability Report)
[18] Readers will note that this figure is different to the WTE figure reported in the "Organisation" table within the "Sustainability Report". This difference arises because there is a difference between "contracted", "worked" and "paid" staff; and the figure in the "Staff numbers and costs" table is an average over the year and is based on when staff are paid (therefore any staff on unpaid leave i.e. maternity leave, long term sickness absence etc. do not feature)

The permantantly employed staff costs are further analysed into their component elements in the table below:

The analysis of staff costs by main elements of costs:

Analysis of staff costs	2019/20 Permanently employed (£000s)	2020/21 Permanently employed (£000s)
Salaries and wages	219,594	255,636
Social security costs	23,565	26,419
Apprenticeship levy	1,157	1,277
Pension cost - employer contributions to NHS pension scheme	26,180	29,422
Pension cost - employer contributions paid by NHSE on provider's behalf (6.3%)	11,381	12,824
Pension cost - other*	21	76
Total	281,898	325,654

Exit packages (subject to audit)

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

Exit package cost band (including any special payment element)	*Number of compulsory redundancies	*Cost of compulsory redundancies	Number of other departures agreed	Cost of other departures agreed	Total number of exit packages	Total cost of exit packages	Number of departures where special payments have been made	Cost of special payment element included in exit packages
	Whole numbers only	£s	Whole numbers only	£s	Whole numbers only	£s	Whole numbers only	£s
Less than £10,000	None	N/A	0	0	None	0	None	0
£10,000 - £25,000	None	N/A	0	0	None	0	None	0
£25,001 - £50,000	None	N/A	0	0	None	0	None	0
£50,001 - £100,000	1	67	0	0	1	67	None	0
£100,001 - £150,000	1	123	0	0	1	123	None	0
£150,001 - £200,000	None	N/A	0	0	None	0	None	0
>£200,000	None	N/A	0	0	None	0	None	0
Total	None	N/A	0	0	None	0	None	0

Exit packages – disclosures (excluding compulsory redundancies)	Number of exit package agreements 2020/21	Total Value of agreements (£000s)	Number of exit package agreements 2019/20	Total Value of agreements (£000s)
Voluntary redundancies including early retirement contractual costs	0	0	0	0
Mutually agreed resignations (MARS) contractual costs	0	0	0	0
Early retirements in the efficiency of the service contractual costs	0	0	0	0
Contractual payments in lieu of notice	0	0	0	0
Exit payments following Employment Tribunals or court orders	0	0	0	0
Non contractual payments requiring HMT approval *	0	0	0	0
Total	0	0	0	0
Non-contractual payments made to individuals where the payment value was more than 12 months of their annual salary	0	0	0	0

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

Staff engagement and consultation (understanding and learning from the views of staff)

The Trust meets formally on a regular basis with local Trade Union representatives, via the Joint Consultative Forum (JCF) and Joint Medical Consultative Committee (JMCC), to discuss key issues and agree relevant employment policies and procedures. Staff are formally consulted when organisational or other work changes are proposed and have the opportunity to comment and input into proposed changes.

Information is cascaded to all staff through a monthly "Team Brief" meeting which is led by the Chief Executive and is undertaken virtually. A weekly Chief Executive's update and "MTW News" newsletter are also issued to all staff via email, enabling messaging on matters of note. In addition, key news items are communicated daily via the Pulse – an electronic communication sent to each staff member via email.

The Trust's Freedom to Speak Up Guardian (FTSUG) submitted reports to the Trust Board each quarter during 2020/21. The FTSUG aims to ensure that patients are cared for in a safe way and that staff are able to raise concerns that they feel are not being heard or are unable to raise with management. It is also the Guardian's role to listen in confidence, note concerns and raise issues through the appropriate channels.

A Deputy FTSUG has been recruited on a 0.8 Whole Time Equivalent (WTE) substantive contract who provides a focus on supporting our staff from minority backgrounds.

During 2019/20 as part of the first phase of the culture and leadership programme, Exceptional People Outstanding Care, a culture Change Team was launched. A number of staff around the organisation received training from the NHS Leadership Academy enabling them to undertake surveys, run workshops and carry out interviews and questionnaires with staff to find out about the way things are done at the Trust and what can be done to make positive change in the future.

Towards the end of 2020, the Divisional Voices Leads network was formed. The purpose of the group is to act as a conduit for sharing updates on staff welfare initiatives both from the corporate team and divisions. The Divisional Leads have been able to work with their areas of work to identify trust wide improvement ideas, share engagement and deployment plans and share best practice and good news stories.

Exceptional People, Outstanding Care programme

The Trust recognises the importance of culture and leadership in an organisation's success. In this regard, the Trust embarked on an Exceptional People Outstanding Care cultural and leadership programme during 2019/20. The programme involved three phases: "discovery", "design" (i.e. to develop an Organisational Development strategy), and "delivery" (i.e. implementation of that Strategy).

While the COVID-19 pandemic has clearly had an impact in 2020/21, this has also highlighted the importance of the programme and in addition incorporated an additional emphasis for Staff Welfare, which was successful and well received by our people.

Although the COVID-19 pandemic meant that the timescales planned to proceed with the second "design" phase had to be adjusted, in Autumn 2020 , the programme moved on to the design phase and will complete shortly with a report being taken to Board in Summer 2020. A 'change team' was also maintained and increased, to lead the work, which involved nearly 100 staff from all areas of the Trust – clinical and non-clinical.

This delay has however enabled consideration of the learning from the COVID-19 pandemic, which will be incorporated into the delivery phase. It is expected that significant progress will be made during 2021/22 with the delivery phase. The programme will has also informed and supported the roll out of strategic programmes in 2021/21.

Education and Development

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

Education and training for its next generation of clinical leaders is critical to the Trust's success. The Trust has a vibrant apprenticeship programme, with apprentices working across its hospitals in a range of roles. Having a strong education ethos that supports younger medical students through to high specialty trainees is equally important and the Trust's Medical Education team has worked hard to develop high quality training programmes as well as creating a friendly, supportive environment where trainees can grow and thrive. The team trains and develops medical trainees as well as provides professional development for all doctors in the Trust.

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

Covid-19 has presented an extraordinary challenge in 2020/21 however, the hard work and dedication of the teams involved has allowed for significant changes to be made to continue to support staff education and

development. For example, increased access to, and availability of e-learning programmes and bitesize packages, the launch of the leadership dashboard with a clear aim of supporting staff to learn new skills in response to the changes in the operational context within the Trust and a strong focus on supporting staff health and wellbeing and encouraging meaningful conversations and positive interactions between staff.

Equal opportunities

We are committed to providing services and employment to a community with a diversity of backgrounds. To do this effectively it is essential that we promote equality, embrace diversity and treat all of our patients, relatives, staff and service users with civility, dignity and respect. This is not about treating everyone the same but ensuring that access to opportunities are available to all by taking account of people's differing needs and capabilities. We continue to put diversity and inclusion at the heart of everything we do because we are dedicated to diversity.

Celebrating the diversity of our workforce ensures that we have a representative, supported and well-led organisation where staff perform to their best ability within an environment that promotes civility, dignity and respect.

Black, Asian and Minority Ethnic (BAME) employees

The last year has highlighted the enormity of the impact of Covid-19 and death of George Floyd on our BAME staff. The Cultural and Ethnic Minorities Network were swift to respond to the needs of our BAME community and increased the support they provide by scheduling weekly evening online events. The events were not only supportive to BAME staff but powerful and emotional, enabling white allies to understand more of the lived experiences and fears of their BAME colleagues. Over the year, these meetings have developed into learning events for the whole organisation, bringing in guest speakers from other areas within MTW, the wider NHS and our local MP.

We have embarked upon a Reverse Mentoring programme which includes the Trust Board learning from the lived experiences of staff trained in mentoring skills and plan to roll out a White Ally programme in the coming months. We are also in the early planning stages of a Kent and Medway ICS BAME mentoring programme to support the career development of BAME staff.

In the coming year we plan to support our BAME staff further by:

- Setting KPIs and targets to increase the number of BAME representation at all levels within the Trust
- Organise talent panels to identify staff eligible for promotion and create development opportunities including stretch and acting up assignments
- Introducing values based recruitment practices
- Adapt resources, guides and tools to help leaders have productive conversations about race

LGBT+ employees

As a vibrant network, this group of staff have been disappointed not to have participated in the usual activities that they would normally such as Pride events and our annual LGBT+ conference. They have continued to support each other, continued to recruit allies wishing to display the NHS Rainbow Badge and are excited to launch Pronouns on staff name badges in the coming weeks. There has been a great deal of work taking place with Divisions supporting them to make changes to documents to make the language used gender neutral and, therefore, more inclusive.

With lockdown measures lifting, the group are excited to start planning our third annual LGBT+ conference and other celebration and educational activities during the course of the year.

Disabled employees

This year has seen a re-launch of the Disability Network with more members than before. The group is deciding how it will run and are planning support events for disabled staff and leaders within the organisation to help with productive conversations about disability and support.

The network are keen to drive the implementation of a disability leave policy and health passport to support the needs of disabled people within the workplace.

We have recently submitted our application for Level 3 – Disability Confident Leader status which will demonstrate our commitment and leadership skills in:

- Actively attracting and recruiting disabled people
- Promoting a culture of being disability confident

Fair and inclusive recruitment

We are embarking upon a journey at the Trust that will see changes to way we recruit to roles including Consultant grades by introducing EDI Recruitment Champions. These staff have been provided with the skills to identify bias within shortlisting and interview processes and given the confidence to challenge in a supportive manner to ensure that fairness and equity occurs within our recruitment processes.

Gender	Staff [head count]		Trust Board Members	
Male	1568 (1463)	23.9% (23.6%)	9 (10)	52.9% (58.8%)
Female	4983 (4735)	76.1% (76.4%)	8 (7)	47.1% (41.2%)
Grand total	6551 (6198)	-	17 (17)	-

Age	Staff [head count]		Trust Board Members	
Less than or equal to 20 years	55 (46)	0.8% (0.7%)	0 (0)	0% (0%)
21 to 25	472 (419)	7.2% (6.8%)	0 (0)	0% (0%)
26 to 30	810 (791)	12.4% (12.8%)	0 (0)	0% (0%)
31 to 35	852 (781)	13.0% (12.6%)	1 (1)	5.9% (5.9%)
36 to 40	668 (659)	10.2% (10.6%)	1 (1)	5.9% (5.9%)
41 to 45	851 (825)	13.0% (13.3%)	2 (1)	11.8% (5.9%)
46 to 50	882 (840)	13.5% (13.6%)	2 (5)	11.8% (29.4%)
51 to 55	832 (795)	12.7% (12.8%)	3 (1)	17.6% (5.9%)
56 to 50	672 (617)	10.3% (10.0%)	2 (2)	11.8% (11.8%)
61 to 65	355 (335)	5.4% (5.4%)	3 (4)	17.6% (23.5%)
66 to 70	75 (60)	1.1% (1.0%)	2 (2)	11.8% (11.8%)
71 years or over	27 (30)	0.4% (0.5%)	1 (0)	5.9% (0%)

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

Ethnic group	Staff [head count]		Trust Board Members	
A White - British	3928 (3794)	60.0% (61.2%)	15 (14)	88.2% (82.4%)
B White - Irish	55 (57)	0.8% (0.9%)	1 (1)	5.9% (5.9%)
C White - Any other White background	476 (442)	7.3% (7.1%)	0 (0)	0% (0%)
C2 White Northern Irish	2 (3)	> 0.1% (>0.1%)	0 (0)	0% (0%)
C3 White Unspecified	1 (1)	> 0.1% (> 0.1%)	0 (0)	0% (0%)
CA White English	0 (1)	> 0.1% (> 0.1%)	0 (0)	0% (0%)
CF White Greek	3 (3)	> 0.1% (> 0.1%)	0 (0)	0% (0%)
CG White Greek Cypriot	0 (1)	0% (>0.1%)	0 (0)	0% (0%)
CK White Italian	1 (2)	> 0.1% (> 0.1%)	0 (0)	0% (0%)
CP White Polish	8 (8)	0.1% (0.1%)	0 (0)	0% (0%)
CU White Croatian	1 (1)	> 0.1% (> 0.1%)	0 (0)	0% (0%)
CY White Other European	16 (22)	0.2% (0.4%)	0 (0)	0% (0%)
D Mixed - White & Black Caribbean	15 (10)	0.2% (0.2%)	0 (0)	0% (0%)
E Mixed - White & Black African	15 (12)	0.2% (0.2%)	0 (0)	0% (0%)
F Mixed - White & Asian	32 (30)	0.5% (0.5%)	0 (0)	0% (0%)
G Mixed - Any other mixed background	31 (25)	0.5% (0.4%)	0 (0)	0% (0%)
GA Mixed - Black & Asian	1 (1)	> 0.1% (> 0.1%)	0 (0)	0% (0%)
GC Mixed - Black & White	1 (2)	> 0.1% (>0.1%)	0 (0)	0% (0%)
GD Mixed - Chinese & White	0 (1)	0% (>0.1%)	0 (0)	0% (0%)
GE Mixed - Asian & Chinese	1 (2)	> 0.1% (> 0.1%)	0 (0)	0% (0%)
GF Mixed - Other/Unspecified	1 (3)	> 0.1% (> 0.1%)	0 (0)	0% (0%)
H Asian or Asian British - Indian	594 (566)	9.1% (9.1%)	1 (1)	5.9% (5.9%)
J Asian or Asian British - Pakistani	67 (70)	1.0% (1.1%)	0 (0)	0% (0%)
K Asian or Asian British - Bangladeshi	22 (17)	0.3% (0.3%)	0 (0)	0% (0%)
L Asian or Asian British - Any other Asian background	328 (311)	5.0% (5.0%)	0 (0)	0% (0%)
LA Asian Mixed	5 (6)	0.1% (0.1%)	0 (0)	0% (0%)
LB Asian Punjabi	1 (2)	> 0.1% (>0.1%)	0 (0)	0% (0%)
LF Asian Tamil	2 (2)	> 0.1% (>0.1%)	0 (0)	0% (0%)
LH Asian British	3 (3)	> 0.1% (> 0.1%)	0 (0)	0% (0%)
LJ Asian Caribbean	1 (1)	> 0.1% (>0.1%)	0 (0)	0% (0%)
LK Asian Unspecified	3 (3)	> 0.1% (>0.1%)	0 (0)	0% (0%)
M Black or Black British - Caribbean	25 (22)	0.4% (0.4%)	0 (0)	0% (0%)
N Black or Black British - African	197 (182)	3.0% (2.9%)	0 (0)	0% (0%)
P Black or Black British - Any other Black background	14 (13)	0.2% (0.2%)	0 (0)	0% (0%)
PB Black Mixed	0 (1)	0% (>0.1%)	0 (0)	0% (0%)
PC Black Nigerian	9 (11)	0.1% (0.2%)	0 (0)	0% (0%)
PD Black British	4 (4)	0.1% (>0.1%)	0 (0)	0% (0%)
PE Black Unspecified	1 (1)	> 0.1% (>0.1%)	0 (0)	0% (0%)
R Chinese	31 (35)	0.5% (0.6%)	0 (0)	0% (0%)
S Any Other Ethnic Group	149 (144)	2.3% (2.3%)	0 (0)	0% (0%)
SA Vietnamese	1 (0)	>0.1% (0)	0 (0)	0% (0%)
SB Japanese	4 (4)	0.1% (0.1%)	0 (0)	0% (0%)
SC Filipino	18 (19)	0.3% (0.3%)	0 (0)	0% (0%)
SD Malaysian	2 (2)	> 0.1% (>0.1%)	0 (0)	0% (0%)
SE Other Specified	4 (8)	0.1% (0.1%)	0 (0)	0% (0%)
Z Not Stated / Undeclared	476 (350)	7.3% (5.6%)	0 (1)	0% (5.9%)
Grand Total	6551 (6198)	-	17 (17)	-

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

Staff sickness absence

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

Health and Safety at Work

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

- The Risk Management Policy and Procedure was updated to reflect the current risk grading matrix and committee structure.
- To support the increased number of shielding and non-front line staff working from home the Display Screen Equipment Policy was revised and ratified, with guidance provided to staff.
- The Noise at Work Policy and Procedure was rewritten to incorporate the risks from vibration at work and ratified.
- Risk assessment templates, guidance and support has been provided for managers to support them in assessing the workplace for COVID-19 risks.
- The reduced number of staff and members of public on site during the COVID-19 pandemic did lead to a decrease in the number of non-patient safety incidents. There were 2089 in 2020/21 compared with 2342 in 2019/20, a reduction of around 10%. While it remains the largest health and safety-related incident category, there was a decrease in incidents of violence and harassment against staff. The incidents are largely attributable to patients diagnosed with dementia or those suffering from a mental health crisis. Work is ongoing to mitigate the risk.

- At the end of March 2021, there was a reduction in the number of reports to the Health and Safety Executive under the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations (RIDDOR) 2013 – 22 in 2020/21 compared with 25 in 2019/20. This does not include COVID-19-related occupational disease RIDDOR reports.
- The Trust followed Health and Safety Executive (HSE) guidance in reporting cases under RIDDOR where there was reasonable evidence that staff contracted COVID-19 as a result of workplace exposure. This led to a high number of reports which reflected the extent of the pandemic, requiring vigilence and dedication from those assessing and submitting reports to the HSE.
- A number of temporary structures have been erected on both sites to support social distancing and protect those queueing during the COVID-19 pandemic. These have needed to be assessed to ensure staff and public safety.
- An interim Health and Safety Advisor has been appointed to support the wider health and safety team, bringing a wealth and experience in incident management and investigation.
- The health and safety audit tool has been upgraded and a new electronic inpsection process will be trialled in 2021/22 with the aim of reducing incidents further during the course of the year.

"Senior Managers" remuneration

In accordance with Section 234b and Schedule 7a of the Companies Act, as required by NHS Bodies, this report includes details regarding "senior managers" remuneration. In the context of the NHS, this is defined as: "Those persons in senior positions having authority or responsibility for directing or controlling the major activities of the NHS body. This means those who influence the decisions of the entity as a whole rather than the decisions of individual directorates or departments".

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

The Trust Board has established a Remuneration and Appointments Committee to advise and assist in meeting its responsibilities to ensure appropriate remuneration, allowances and terms of service for the Chief Executive, Directors and other key senior posts (refer to the Annual Governance Statement for 2020/21 for further details of the Remuneration and Appointments Committee).

The Chief Executive and Directors' remuneration is reviewed annually and decisions are based on market rates, national pay awards and performance. Reward is primarily through salary adjustment, although non-recurrent awards can be used to recognise exceptional achievements. Pay rates for Non-Executive Directors of the Trust are determined in accordance with national guidelines, as set by NHSI. Remuneration for the Chair of the Trust Board is also set by NHSI.

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

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

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

Salaries and allowances for the year ending 31st March 2021 (subject to audit)

Comparatives for the year ending 31st March 2020 are shown in brackets below the figure for 2020/21.

Name and title (alphabetical by surname) N.B. Dates of service are for the full 2020/21 year unless otherwise disclosed	**(a) Salary** (bands of £5,000)	**(b) Taxable expense payments and other benefits in kind, to the nearest £100**	**(c) Annual performance-related pay and bonuses** (bands of £5,000)	**(d) Long-term performance-related pay and bonuses** (bands of £5,000)	**(f) All pension-related benefits** (bands of £2,500)	**(g) TOTAL (columns a - f)** (bands of £5.000)	**(h) Payments or compensation for loss of office**
	£000	**£ Λ**	**£000**	**£000**	**£000**	**£000**	£000
Sean Briggs, Chief Operating Officer	135-140 (125-130)	0 (0)	N/A (N/A)	N/A (N/A)	30-32.5 (65.0-67.5)	165-170 (195-200)	N/A (N/A)
Maureen Choong, Non-Executive Director	10-15 (5-10)	0 (0)	N/A (N/A)	N/A (N/A)	0 (0)	10-15 (5-10)	N/A (N/A)
Karen Cox, Associate Non-Executive Director ±	0 (0)	0 (0)	N/A (N/A)	N/A (N/A)	0 (0)	0 (0)	N/A (N/A)
Sarah Dunnett, Non-Executive Director	10-15 (5-10)	0 (0)	N/A (N/A)	N/A (N/A)	0 (0)	10-15 (5-10)	N/A (N/A)
Richard Finn, Associate Non-Executive Director	10-15 (0-5)	0 (0)	N/A (N/A)	N/A (N/A)	0 (0)	10-15 (0-5)	N/A (N/A)
Neil Griffiths, Associate Non-Executive Director	10-15 (5-10)	0 (0)	N/A (N/A)	N/A (N/A)	0 (0)	10-15 (5-10)	N/A (N/A)
Simon Hart, Director of Workforce (until 13/08/20)	85-90 (130-135)	0 (0)	N/A (N/A)	N/A (N/A)	32.5-35.0 (25-27.5)	120-125 (155-160)	N/A (N/A)
David Highton, Chair of the Trust Board	35-40 (40-45)	0 (0)	N/A (N/A)	N/A (N/A)	0 (0)	35-40 (40-45)	N/A (N/A)
Amanjit Jhund, Director of Strategy, Planning & Partnerships	115-120 (125-130)	0 (0)	N/A (N/A)	N/A (N/A)	27.5-30.0 (27.5-30.0)	145-150 (155-160)	N/A (N/A)
Cheryl Lee, Interim Director of Workforce (from 07/09/20)	100-105 (0)	0 (0)	N/A (N/A)	N/A (N/A)	0 (0)	100-105 (0)	N/A (N/A)
Peter Maskell, Medical Director Ψ	205-210 (200-205)	0 (0)	N/A (N/A)	N/A (N/A)	20.0-22.5 (7.5-10)	225-230 (205-210)	N/A (N/A)
David Morgan, Non-Executive Director	10-15 (0-5)[19]	0 (0)	N/A (N/A)	N/A (N/A)	0 (0)	10-15 (0-5)	N/A (N/A)
Sara Mumford, Director of Infection Prevention and Control Ψ	195-200 (175-180)	0 (0)	N/A (N/A)	N/A (N/A)	75.0-77.5 (70-72.5)	270-275 (245-250)	N/A (N/A)
Claire O'Brien, Chief Nurse	130-135 (125-130)	0 (0)	N/A (N/A)	N/A (N/A)	12.5-15.0 (7.5-10)	145-150 (130-135)	N/A (N/A)
Steve Orpin, Deputy Chief Executive / Chief Finance Officer	155-160 (145-150)	0 (0)	N/A (N/A)	N/A (N/A)	32.5-35.0 (35-37.5)	190-195 (180-185)	N/A (N/A)
Emma Pettitt-Mitchell, Non-Executive Director	10-15 (5-10)	0 (0)	N/A (N/A)	N/A (N/A)	0 (0)	10-15 (5-10)	N/A (N/A)
Miles Scott, Chief Executive	225-230 (225-230)	0 (0)	N/A (N/A)	N/A (N/A)	0 (0)	225-230 (225-230)	N/A (N/A)
Jo Webber, Associate Non-Executive Director	10-15 (0-5)[20]	0 (0)	N/A (N/A)	N/A (N/A)	0 (0)	10-15 (0-5)	N/A (N/A)

Λ £ hundreds are used for taxable expense payments, and other benefits (column (b)). All other columns are in £ thousands
Ψ Drs Maskell and Mumford hold clinical roles in the Trust alongside their responsibilities as Senior Managers
± Karen Cox does not receive renumeration from the Trust

[19] David Morgan started in August 2019, therefore the comparator value represents a part year renumeration
[20] Jo Webberjoined the Trust in November 2019, therefore the comparator value represents a part year renumeration

Pension benefits for the year ending 31st March 2021[21] (subject to audit)

Name and title Ψ (alphabetical by surname) N.B. Dates of service are for the full 2020/21 year unless otherwise disclosed	(a) Real increase in pension at pension age (bands of £2,500)	(b) Real increase in pension lump sum at pension age (bands of £2,500)	(c) Total accrued pension at pension age at 31st March 2021 (bands of £5,000)	(d) Lump sum at pension age related to accrued pension at 31st March 2021 (bands of £5,000)	(e) Cash Equivalent Transfer Value Λ at 1st April 2021	(f) Real increase in Cash Equivalent Transfer Value Σ	(g) Cash Equivalent Transfer Value Λ at 31st March 2021	(h) Employee's contribution to stakeholder pension
	£000	£000	£000	£000	£000	£000	£000	£000
Sean Briggs, Chief Operating Officer	0-2.5	0	20-25	0	191	6	219	0
Simon Hart, Director of Workforce (until 13/08/20)	0-2.5	0	50-55	105-110	816	32	876	0
Amanjit Jhund, Director of Strategy, Planning & Partnerships	0-2.5	0	5-10.0	0	56	6	79	0
Cheryl Lee, Interim Director of Workforce¥ (from 07/09/20)	0	0	0	0	0	0	0	0
Peter Maskell, Medical Director	0-2.5	0	30-35	60-65	547	19	589	0
Sara Mumford, Director of Infection Prevention and Control	2.5-5.0	2.5-5.0	65-70	85-90	993	75	1108	0
Claire O'Brien, Chief Nurse	0-2.5	2.5-5.0	55-60	165-170	1292	46	1378	0
Steve Orpin, Deputy Chief Executive / Chief Finance Officer	2.5-5.0	0	60-65	130-135	958	32	1028	0
Miles Scott, Chief Executive¥	0	0	0	0	0	0	0	0

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

Λ A Cash Equivalent Transfer Value (CETV) is the actuarially assessed capital value of the pension scheme benefits accrued by a member at a particular point in time. The benefits valued are the member's accrued benefits and any contingent spouse's (or other allowable beneficiary's) pension payable from the scheme. CETVs are calculated in accordance with the Occupational Pension Schemes (Transfer Values) Regulations 2008. Please however note that the CETV values at 31/03/20 and 31/03/21 may have been calculated using different methodologies, and this may have impacted the "Real increase in Cash Equivalent Transfer Value" figure in the table

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

¥ Miles Scott and Cheryl Lee did not make any contributions into the NHS Pension Scheme in 2020/21

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

Fair pay disclosure (subject to audit)

Reporting bodies are required to disclose the relationship between the remuneration of the highest-paid director in their organisation and the median remuneration of the organisation's workforce. This is calculated at the reporting date i.e. 31st March 2021 by "annualising" the March pay information taking into account temporary staff and adjusting for the full-time effect of part-time staff.

The banded remuneration of the highest paid director in the financial year 2020/21 was £227,500 (2019/20 £227,500). This was 7.4 times (2019/20 7.5) the median remuneration of the workforce, which was £30,615 (2019/20 £30,401). The highest paid Director in the financial year 2020/21 was the Chief Executive (in 2019/20 this was the Chief Executive).

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

In 2020/21 no employees (2019/20 no employees) received remuneration in excess of the highest-paid director. Remuneration ranged from £12,569 to £227,209 (2019/20 £12,477 to £224,963).

Total remuneration includes salary, non-consolidated performance-related pay, benefits-in-kind, but not severance payments. It does not include employer pension contributions and the cash equivalent transfer value of pensions.

Reporting relating to the review of tax arrangements of public sector appointees

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

All off-payroll engagements as of 31st March 2021, for more than £245 per day and lasting for longer than six months

	Number
Number of existing engagements as of 31st March 2021 Of which, the number that have existed…	8
for less than one year at the time of reporting =	4
for between one and two years at the time of reporting =	1
for between two and three years at the time of reporting =	1
for between three and four years at the time of reporting =	2
for four or more years at the time of reporting =	0

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

New off-payroll engagements between 1st April 2020 and 31st March 2021, for more than £245 per day that last longer than six months

	Number
Number of new engagements, or those that reached six months in duration, between 1st April 2020 and 31st March 2021	4
Of which…	
Number assessed as caught by IR35	4
Number assessed as not caught by IR35	0
Number engaged directly (via PSC contracted to department) and are on the departmental payroll	0
Number of engagements reassessed for consistency/assurance purposes during the year	0
Number of engagements that saw a change to IR35 status following the consistency review	0

Off-payroll Board member / Senior Official engagements

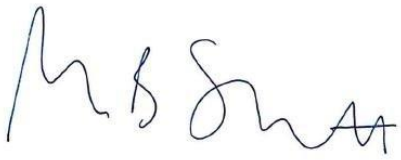
Number of off-payroll engagements of Board members and/or senior officials with significant financial responsibility, during the year	0
Number of individuals that have been deemed "Board members and/or senior officers with significant financial responsibility", during the financial year. This figure includes both off-payroll and on-payroll engagements	18

Expenditure on consultancy staff

The Trust's internal expenditure on consultancy staff for 2020/21 was £3,855k, an increase of £3,284k from previous financial year (£571k in 2019/20). This increase related to IT development projects including Electronic Patient Records implementation.

Declaration

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



Miles Scott, Chief Executive

24th June 2021

Accountability and audit report for 2020-2021:

Independent auditor's report to the directors of Maidstone and Tunbridge Wells NHS Trust

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

Report on the Audit of the Financial Statements

Opinion on financial statements

We have audited the financial statements of Maidstone & Tunbridge Wells NHS Trust (the 'Trust') for the year ended 31 March 2021, which comprise the Statement of Comprehensive Income, the Statement of Financial Position, the Statement of Changes in Equity, the Statement of Cash Flows and notes to the financial statements, including a summary of significant accounting policies. The financial reporting framework that has been applied in their preparation is applicable law and international accounting standards in conformity with the requirements of the Accounts Directions issued under Schedule 15 of the National Health Service Act 2006, as interpreted and adapted by the Department of Health and Social Care Group Accounting Manual 2020 to 2021.

In our opinion, the financial statements:

- give a true and fair view of the financial position of the Trust as at 31 March 2021 and of its expenditure and income for the year then ended;
- have been properly prepared in accordance with international accounting standards as interpreted and adapted by the Department of Health and Social Care Group Accounting Manual 2020 to 2021; and
- have been prepared in accordance with the requirements of the National Health Service Act 2006.

Basis for opinion

We conducted our audit in accordance with International Standards on Auditing (UK) (ISAs (UK)) and applicable law, as required by the Code of Audit Practice (2020) ("the Code of Audit Practice") approved by the Comptroller and Auditor General. Our responsibilities under those standards are further described in the 'Auditor's responsibilities for the audit of the financial statements' section of our report. We are independent of the Trust in accordance with the ethical requirements that are relevant to our audit of the financial statements in the UK, including the FRC's Ethical Standard, and we have fulfilled our other ethical responsibilities in accordance with these requirements. We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our opinion.

Conclusions relating to going concern

We are responsible for concluding on the appropriateness of the Directors' use of the going concern basis of accounting and, based on the audit evidence obtained, whether a material uncertainty exists related to events or conditions that may cast significant doubt on the Trust's ability to continue as a going concern. If we conclude that a material uncertainty exists, we are required to draw attention in our report to the related disclosures in the financial statements or, if such disclosures are inadequate, to modify the auditor's opinion. Our conclusions are based on the audit evidence obtained up to the date of our report. However, future events or conditions may cause the Trust to cease to continue as a going concern.

In our evaluation of the Directors' conclusions, and in accordance with the expectation set out within the Department of Health and Social Care Group Accounting Manual 2020 to 2021 that the Trust's financial statements shall be prepared on a going concern basis, we considered the inherent risks associated with the continuation of services provided by the Trust. In doing so we had regard to the guidance provided in Practice Note 10 Audit of financial statements and regularity of public sector bodies in the United Kingdom (Revised 2020) on the application of ISA (UK) 570 Going Concern to public sector entities. We assessed the

reasonableness of the basis of preparation used by the Trust and the Trust's disclosures over the going concern period.

Based on the work we have performed, we have not identified any material uncertainties relating to events or conditions that, individually or collectively, may cast significant doubt on the Trust's ability to continue as a going concern for a period of at least twelve months from when the financial statements are authorised for issue.

In auditing the financial statements, we have concluded that the Directors' use of the going concern basis of accounting in the preparation of the financial statements is appropriate.

The responsibilities of the Directors with respect to going concern are described in the 'Responsibilities of the Directors and Those Charged with Governance for the financial statements' section of this report.

Other information

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

In connection with our audit of the financial statements, our responsibility is to read the other information and, in doing so, consider whether the other information is materially inconsistent with the financial statements or our knowledge obtained in the audit or otherwise appears to be materially misstated. If we identify such material inconsistencies or apparent material misstatements, we are required to determine whether there is a material misstatement in the financial statements or a material misstatement of the other information. If, based on the work we have performed, we conclude that there is a material misstatement of the other information, we are required to report that fact.

We have nothing to report in this regard.

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

Under the Code of Audit Practice published by the National Audit Office in April 2020 on behalf of the Comptroller and Auditor General (the Code of Audit Practice) we are required to consider whether the Annual Governance Statement does not comply with the guidance issued by NHS Improvement, or is misleading or inconsistent with the information of which we are aware from our audit. We are not required to consider whether the Annual Governance Statement addresses all risks and controls or that risks are satisfactorily addressed by internal controls.

We have nothing to report in this regard.

Opinion on other matters required by the Code of Audit Practice

In our opinion, based on the work undertaken in the course of the audit:

- the parts of the Remuneration and Staff Report to be audited have been properly prepared in accordance with international accounting standards in conformity with the requirements of the Accounts Directions issued under Schedule 15 of the National Health Service Act 2006, as interpreted and adapted by the Department of Health and Social Care Group Accounting Manual 2020 to 2021; and
- based on the work undertaken in the course of the audit of the financial statements and our knowledge of the Trust, the other information published together with the financial statements in the annual report for the financial year for which the financial statements are prepared is consistent with the financial

statements.

Matters on which we are required to report by exception

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

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

We have nothing to report in respect to the above matters except on 22 June 2020 we referred a matter to the Secretary of State under sections 30(b) and 30 (a) of the Local Audit and Accountability Act 2014 in relation to Maidstone and Tunbridge Wells NHS Trust's breach of its three-year break-even duty for the three year period ending 31 March 2020 and its ongoing breach in 2020/21.

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

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

In preparing the financial statements, the Directors are responsible for assessing the Trust's ability to continue as a going concern, disclosing, as applicable, matters related to going concern and using the going concern basis of accounting unless they have been informed by the relevant national body of the intention to dissolve the Trust without the transfer of its services to another public sector entity.

The Audit and Governance Committee is Those Charged with Governance. Those Charged with Governance are responsible for overseeing the Trust's financial reporting process.

Auditor's responsibilities for the audit of the financial statements

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

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

Explanation as to what extent the audit was considered capable of detecting irregularities, including fraud

Irregularities, including fraud, are instances of non-compliance with laws and regulations. We design procedures in line with our responsibilities, outlined above, to detect material misstatements in respect of irregularities, including fraud. Owing to the inherent limitations of an audit, there is an unavoidable risk that material misstatements in the financial statements may not be detected, even though the audit is properly planned and performed in accordance with the ISAs (UK).

The extent to which our procedures are capable of detecting irregularities, including fraud is detailed below:

- We obtained an understanding of the legal and regulatory frameworks that are applicable to the Trust and determined that the most significant which are directly relevant to specific assertions in the financial statements are those related to the reporting frameworks (international accounting standards and the National Health Service Act 2006, as interpreted and adapted by the Department of Health and Social Care Group Accounting Manual 2020 to 2021).
- We enquired of management and the Audit and Governance Committee, concerning the Trust's policies and procedures relating to:
  - the identification, evaluation and compliance with laws and regulations;
  - the detection and response to the risks of fraud; and
  - the establishment of internal controls to mitigate risks related to fraud or non-compliance with laws and regulations.
- We enquired of management, Internal Audit and the Audit and Governance Committee, whether they were aware of any instances of non-compliance with laws and regulations or whether they had any knowledge of actual, suspected or alleged fraud.
- We assessed the susceptibility of the Trust's financial statements to material misstatement, including how fraud might occur, by evaluating management's incentives and opportunities for manipulation of the financial statements. This included the evaluation of the risk of improper revenue or expenditure recognition and management override of controls. We determined that the principal risks were in relation to management override of controls:
  - we considered all journal entries for fraud and set specific criteria to identify entries we considered to be high risk. Such criteria included large manual journals; journals posted by unauthorised users and manual journals entered after the year end date. We also specifically considered all journals posted by senior finance management;
  - management bias in significant accounting estimates such as property, plant and equipment.
- Our audit procedures involved:
  - evaluation of the design effectiveness of controls that management has in place to prevent and detect fraud;
  - journal entry testing, with a focus on entries meeting the criteria determined by the engagement team;
  - challenging assumptions and judgements made by management in its significant accounting estimates in respect of property, plant and equipment valuations;
  - assessing the extent of compliance with the relevant laws and regulations as part of our procedures on the related financial statement item.
- These audit procedures were designed to provide reasonable assurance that the financial statements were

free from fraud or error. However, detecting irregularities that result from fraud is inherently more difficult than detecting those that result from error, as those irregularities that result from fraud may involve collusion, deliberate concealment, forgery or intentional misrepresentations. Also, the further removed non-compliance with laws and regulations is from events and transactions reflected in the financial statements, the less likely we would become aware of it.

- The team communications in respect of potential non-compliance with relevant laws and regulations, including the breach of the Trust's break-even duty for the three-year period ending 31 March 2021, the potential for fraud in revenue and expenditure recognition, and the significant accounting estimates related to property, plant and equipment.
- Assessment of the appropriateness of the collective competence and capabilities of the engagement team included consideration of the engagement team's:
  - understanding of, and practical experience with audit engagements of a similar nature and complexity through appropriate training and participation;
  - knowledge of the health sector and economy in which the Trust operates;
  - understanding of the legal and regulatory requirements specific to the Trust including:
    - the provisions of the applicable legislation;
    - NHS Improvement's rules and related guidance;
    - the applicable statutory provisions.
- In assessing the potential risks of material misstatement, we obtained an understanding of:
  - the Trust's operations, including the nature of its income and expenditure and its services and of its objectives and strategies to understand the classes of transactions, account balances, expected financial statement disclosures and business risks that may result in risks of material misstatement.
  - the Trust's control environment, including the policies and procedures implemented by the Trust to ensure compliance with the requirements of the financial reporting framework.

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

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

Under the Code of Audit Practice, we are required to report to you if, in our opinion, we have not been able to satisfy ourselves that the Trust has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources for the year ended 31 March 2021.

Our work on the Trust's arrangements for securing economy, efficiency and effectiveness in its use of resources is not yet complete. The outcome of our work will be reported in our commentary on the Trust's arrangements in our Auditor's Annual Report. If we identify any significant weaknesses in these arrangements, these will be reported by exception in our Audit Completion Certificate. We are satisfied that this work does not have a material effect on our opinion on the financial statements for the year ended 31 March 2021.

Responsibilities of the Accountable Officer

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

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

We are required under Section 21(3)(c) and Schedule 13 paragraph 10(a) of the Local Audit and Accountability Act 2014 to be satisfied that the Trust has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources. We are not required to consider, nor have we considered, whether all aspects of the Trust's arrangements for securing economy, efficiency and effectiveness in its use of resources are operating effectively.

We undertake our review in accordance with the Code of Audit Practice, having regard to the guidance issued by the Comptroller and Auditor General in April 2021. This guidance sets out the arrangements that fall within the scope of 'proper arrangements'. When reporting on these arrangements, the Code of Audit Practice requires auditors to structure their commentary on arrangements under three specified reporting criteria:

- Financial sustainability: how the Trust plans and manages its resources to ensure it can continue to deliver its services;
- Governance: how the Trust ensures that it makes informed decisions and properly manages its risks; and
- Improving economy, efficiency and effectiveness: how the Trust uses information about its costs and performance to improve the way it manages and delivers its services.

We document our understanding of the arrangements the Trust has in place for each of these three specified reporting criteria, gathering sufficient evidence to support our risk assessment and commentary in our Auditor's Annual Report. In undertaking our work, we consider whether there is evidence to suggest that there are significant weaknesses in arrangements.

Report on other legal and regulatory requirements – Delay in certification of completion of the audit

We cannot formally conclude the audit and issue an audit certificate for Maidstone & Tunbridge Wells NHS Trust for the year ended 31 March 2021 in accordance with the requirements of the Local Audit and Accountability Act 2014 and the Code of Audit Practice until we have completed our work on the Trust's arrangements for securing economy, efficiency and effectiveness in its use of resources. We are satisfied that this work does not have a material effect on the financial statements for the year ended 31 March 2021.

Use of our report

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

Darren Wells

Darren Wells

Key Audit Partner

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

24th June 2021

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

In our auditor's report issued on 28 June 2021, we explained that we could not formally conclude the audit and issue an audit certificate for the Trust for the year ended 31 March 2021, in accordance with the requirements of the Local Audit and Accountability Act 2014 and the Code of Audit Practice, until we had:

- Completed our work on the Trust's arrangements for securing economy, efficiency and effectiveness in its use of resources. We have now completed this work, and the results of our work are set out below.

Opinion on the financial statements

In our auditor's report for the year ended 31 March 2021 issued on 28 June 2021 we reported that, in our opinion the financial statements:

- give a true and fair view of the financial position of the Trust as at 31 March 2021 and of its expenditure and income for the year then ended;
- have been properly prepared in accordance with international accounting standards as interpreted and adapted by the Department of Health and Social Care Group Accounting Manual 2020 to 2021; and
- have been prepared in accordance with the requirements of the National Health Service Act 2006.

No matters have come to our attention since that date that would have a material impact on the financial statements on which we gave this opinion.

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

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

Under the Code of Audit Practice, we are required to report to you if, in our opinion, we have not been able to satisfy ourselves that the Trust has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources for the year ended 31 March 2021.

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

Responsibilities of the Accountable Officer

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

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

We are required under Section 21(3)(c) and Schedule 13 paragraph 10(a) of the Local Audit and Accountability Act 2014 to be satisfied that the Trust has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources. We are not required to consider, nor have we considered, whether all aspects of the Trust's arrangements for securing economy, efficiency and effectiveness in its use of resources are operating effectively.

We have undertaken our review in accordance with the Code of Audit Practice, having regard to the guidance issued by the Comptroller and Auditor General in April 2021. This guidance sets out the arrangements that fall within the scope of 'proper arrangements'. When reporting on these arrangements, the Code of Audit Practice requires auditors to structure their commentary on arrangements under three specified reporting criteria:

- Financial sustainability: how the Trust plans and manages its resources to ensure it can continue to deliver its services;
- Governance: how the Trust ensures that it makes informed decisions and properly manages its risks; and
- Improving economy, efficiency and effectiveness: how the Trust uses information about its costs and performance to improve the way it manages and delivers its services.

We have documented our understanding of the arrangements the Trust has in place for each of these three specified reporting criteria, gathering sufficient evidence to support our risk assessment and commentary in our Auditor's Annual Report. In undertaking our work, we have considered whether there is evidence to suggest that there are significant weaknesses in arrangements.

Report on other legal and regulatory requirements – Audit certificate

We certify that we have completed the audit of Maidstone and Tunbridge Wells NHS Trust for the year ended 31 March 2021 in accordance with the requirements of the Local Audit and Accountability Act 2014 and the Code of Audit Practice.

Use of our report

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

Darren Wells

Darren Wells , Key Audit Partner
for and on behalf of Grant Thornton UK LLP, Local Auditor

London

7th September 2021

Glossary of NHS terms

Term	Definition/explanation
Accident and Emergency (A&E)	Also referred to as Emergency Department (ED)
Ambulatory (Care)	A service where some conditions may be treated without the need for an overnight stay in hospital
Acute Stroke Unit (ASU)	An acute neurological ward providing specialist services for people who have had a new suspected stroke
Care Quality Commission (CQC)	A body that regulates all health & social care services in England. The CQC ensures the quality 7 safety of care in hospitals, dentists, ambulances, & care homes, and the care given in people's own homes. It is an executive non-dep-artmental public body, sponsored by the Department of Health & Social Care
Clinical Commissioning Group (CCG)	CCGs are clinically-led statutory NHS bodies, created following the Health and Social Care Act 2012, responsible for the planning and commissioning of health care services for their local area. CCGs are membership bodies, with local GP practices as the members
Clinical Governance	Clinical Governance is the system through which NHS organisations are accountable for continuously improving the quality of their services and safeguarding high standards of care, by creating an environment in which clinical excellence can flourish
Commissioning	The process of planning, agreeing and monitoring services, ranging from the health-needs assessment for a population, through the clinically based design of patient pathways, to service specification and contract negotiation or procurement, with continuous quality assessment
Control total	A figure calculated by NHSI, on a Trust by Trust basis, which represents the minimum level of financial performance, against which the the Trust's Board/ Governing Body and Chief Executives must deliver in 2018/19, and for which they will be held directly accountable
Cost Improvement Programme (CIP)	Sets out the savings that an NHS organisation plans to make to reduce its expenditure/increase efficiency. It is used to close the gap between the income received by the NHS body and expenditure incurred in any one year
Commissioning for Quality and Innovation (CQUIN)	Introduced in 2009 to make a proportion of healthcare providers' income conditional on demonstrating improvements in quality and innovation in specified areas of patient care. The key aim of the CQUIN framework is to secure improvements in the quality of services and better outcomes for patients
Datix	The Trust's incident reporting and risk management system
Delayed Transfer of Care (DTOC)	According to NHS England, a 'delayed transfer of care' occurs when an adult inpatient in hospital is ready to go home or move to a less acute stage of care but is prevented from doing so. Sometimes referred to in the media as 'bed-blocking', delayed transfers of care are a problem as

Term	Definition/explanation
	they reduce the number of beds available to other patients who need them, as well as causing unnecessarily long stays in hospital for patients
Elective treatment	Treatment that is not urgent and can be planned
Emergency Department (ED)	Also known as Accident and Emergency (A&E)
Escalation	The term used to describe circumstances when clinical areas of the Trust, not ordinarily designated for non-elective inpatient care, are required to be used for that purpose due to non-elective demand
Friends and Family Test (FFT)	A feedback tool, launched in April 2013, that supports the fundamental principle that people who use NHS services should have the opportunity to provide feedback on their experience. It asks people if they would recommend the services they have used and offers a range of responses. When combined with supplementary follow-up questions, the FFT provides a mechanism to highlight both good and poor patient experience
Getting It Right First Time (GIRFT)	A national programme, led by frontline clinicians and designed to improve the quality of care within the NHS by reducing unwarranted variations. GIRFT tackles variations in the way services are delivered across the NHS, and shares best practice between trusts, identifying changes that will help improve care and patient outcomes, as well as delivering efficiencies such as the reduction of unnecessary procedures and cost savings
Hyper Acute Stroke Unit (HASU)	A dedicated Stroke unit bringing experts and equipment under one roof to provide world class treatment 24 hours a day
Integrated Care System (ICS)	ICSs brings together local organisations to redesign care and improve population health, creating shared leadership and action to deliver the 'triple integration' of primary and specialist care, physical and mental health services, and health with social care.
Inpatient	A person who stays in hospital for one or more nights
Length of Stay (LOS)	The period of time a patient remains in hospital or other healthcare facility as an inpatient
Marginal Rate Emergency Tariff (MRET)	An adjustment made to the amount a provider of emergency services is reimbursed to encourage health economies to redesign emergency services and manage patient demand for those services. A provider is paid a percentage of the national price for each patient admitted as an emergency over and above a set threshold.
NHS England (NHSE)	An executive non-departmental public body, sponsored by the Department of Health and Social Care, which leads the NHS in England. It sets the priorities and direction of the NHS and encourages and informs the national debate to improve health and care
NHS Improvement (NHSI)	The body responsible for overseeing NHS Trusts, and independent providers that provide NHS-funded care. It supports providers to give patients consistently safe, high quality, compassionate care within local health systems that are financially sustainable
Non-elective treatment	Treatment that is not planned, but requires admission to hospital

Term	Definition/explanation
Outpatient	A person who goes to a hospital for treatment or assessment, but does not stay overnight
Patient Advice and Liaison Service (PALS)	A service within an NHS Trust offering confidential advice, support and information on health-related matters. It provides a point of contact for patients, their families and their carers
Patient experience	A term used for individual and collective feedback. (1) Individual patient's feedback about their experiences of care or a service e.g. whether they understood the information they were given, their views on the cleanliness of the hospital where they were treated. (2) A combination of all the intelligence held about what patients experience in services, drawing on a range of sources including complaints, compliments, etc.
Patient flow	The course of patients between staff, departments and organisations along a pathway of care
Patient pathway	The route that a patient will take from entry into a hospital or other healthcare seeting until the patient leaves. A template pathway can be created for common services and operations (e.g. emergency care pathway)
Provider Sustainability Fund (PSF)	A fund held by NHS England and NHS Improvement that is available to providers when they that met their control total.
Referral to Treatment (RTT)	The waiting time calculated from the date the Trust receives a referral, to the date the patient either receives treatment or a decision is made that no treatment is required
Ring-fenced beds	Beds allocated for a specific category of patient / treatment (e.g. Stroke or elective orthopaedic beds), not used for general medical patients when the hospital is busy
Serious Incident (SI)	Events in health care where the potential for learning is so great, or the consequences to patients, families and carers, staff or organisations are so significant, that they warrant using additional resources to mount a comprehensive response. SIs can extend beyond incidents which affect patients directly and include incidents which may indirectly impact patient safety or an organisation's ability to deliver ongoing healthcare
Sustainability and Transformation Partnership (STP)	STPs are 44 areas covering all of England, where local NHS organisations and councils have drawn up proposals to improve health and care in the areas they serve.STP can also stand for 'sustainability and transformation plan', plans drawn up in each of these areas setting out practical ways to improve NHS services and population health in every part of England. They aim to help meet a 'triple challenge' set out in the NHS Five Year Forward View – better health, transformed quality of care delivery, and sustainable finances.

Financial statements:
2020-2021

Statement of Comprehensive Income

	Note	2020/21 £000	2019/20 £000
Operating income from patient care activities	3	496,048	457,588
Other operating income	4	68,148	55,468
Operating expenses	6.1	-550,300	-491,848
Operating surplus/(deficit) from continuing operations		**13,896**	**21,208**
Finance income	11	9	309
Finance expenses	12	-14,694	-15,729
PDC dividends payable		-1,285	-633
Net finance costs		**-15,970**	**-16,053**
Other gains / (losses)	13	16	73
Surplus / (deficit) for the year from continuing operations		**-2,058**	**5,228**
Surplus / (deficit) for the year		**-2,058**	**5,228**
Other comprehensive income			
Will not be reclassified to income and expenditure:			
Impairments	7	-2,778	-1,663
Revaluations	17	1,930	76
Total comprehensive income / (expense) for the period		**-2,906**	**3,641**

Note - Adjusted financial performance (control total basis):

The Trust's deficit for 2020/21 was £2.1m. NHS England and Improvement excludes the impact of certain transactions - impairments, revaluations, capital grants and the net impact of "push stock" received from DHSC bodies - for the purposes of measuring NHS Trusts' financial performance. After adjusting for these transactions, the Trust's adjusted financial performance surplus for the year is £0.3m as shown in the table below. The table does not form part of the Statement of Comprehensive Income and represents a note to the accounts.

Adjusted financial performance (control total basis):		
Surplus / (deficit) for the period	-2,058	5,228
Remove net impairments not scoring to the Departmental expenditure limit	4,699	2,748
Remove I&E impact of capital grants and donations	-730	-389
Remove 2018/19 post audit PSF reallocation (2019/20 only)	0	-583
Remove net impact of inventories received from DHSC group bodies for COVID response	-1,581	0
Adjusted financial performance surplus / (deficit)	**330**	**7,004**

Statement of Financial Position

	Note	31 March 2021 £000	31 March 2020 £000
Non-current assets			
Intangible assets	14	10,658	3,957
Property, plant and equipment	15	298,452	291,187
Receivables	19	2,816	2,925
Total non-current assets		**311,926**	**298,069**
Current assets			
Inventories	18	9,988	8,893
Receivables	19	16,812	35,156
Cash and cash equivalents	20	26,221	3,355
Total current assets		**53,021**	**47,404**
Current liabilities			
Trade and other payables	21	-48,934	-38,944
Borrowings	23	-6,830	-33,560
Provisions	24	-3,226	-1,726
Other liabilities	22	-2,454	-3,172
Total current liabilities		**-61,444**	**-77,402**
Total assets less current liabilities		**303,503**	**268,071**
Non-current liabilities			
Borrowings	23	-183,152	-189,879
Provisions	24	-1,800	-1,675
Total non-current liabilities		**-184,952**	**-191,554**
Total assets employed		**118,551**	**76,517**
Financed by			
Public dividend capital		261,345	216,405
Revaluation reserve		29,170	30,139
Income and expenditure reserve		-171,964	-170,027
Total taxpayers' equity		**118,551**	**76,517**

The notes on pages 6 to 48 form part of these accounts.

Name

Position Chief Executive Officer

Date 24th June 2021

Statement of Changes in Equity for the year ended 31 March 2021

	Public dividend capital	Revaluation reserve	Income and expenditure reserve	Total
	£000	£000	£000	£000
Taxpayers' and others' equity at 1 April 2020 - brought forward	**216,405**	**30,139**	**-170,027**	**76,517**
Impairments	0	-2,778	0	**-2,778**
Revaluations	0	1,930	0	**1,930**
Transfer to retained earnings on disposal of assets	0	-121	121	**0**
Public dividend capital received	44,940	0	0	**44,940**
Taxpayers' and others' equity at 31 March 2021	**261,345**	**29,170**	**-171,964**	**118,551**

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

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

Information on reserves

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

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

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

Merger reserve
This reserve reflects balances formed on merger of NHS bodies.

Income and expenditure reserve
The balance of this reserve is the accumulated surpluses and deficits of the trust.

Statement of Cash Flows

	Note	2020/21 £000	2019/20 £000
Cash flows from operating activities			
Operating surplus / (deficit)		13,896	21,208
Non-cash income and expense:			
Depreciation and amortisation	6.1	13,828	13,022
Net impairments	7	4,699	2,748
Income recognised in respect of capital donations	4	-1,392	-890
(Increase) / decrease in receivables and other assets		19,286	-1,737
(Increase) / decrease in inventories		-1,095	-1,073
Increase / (decrease) in payables and other liabilities		7,208	9,218
Increase / (decrease) in provisions		1,624	944
Net cash flows from / (used in) operating activities		**58,054**	**43,440**
Cash flows from investing activities			
Interest received		9	309
Purchase of intangible assets		-3,160	-1,536
Purchase of PPE and investment property		-27,636	-13,199
Sales of PPE and investment property		16	73
Receipt of cash donations to purchase assets		251	890
Net cash flows from / (used in) investing activities		**-30,520**	**-13,463**
Cash flows from financing activities			
Public dividend capital received		44,940	4,615
Movement on loans from DHSC		-27,696	-19,082
Movement on other loans		-351	-372
Capital element of PFI, LIFT and other service concession payments		-5,349	-5,426
Interest on loans		-342	-1,387
Other interest		-5	-4
Interest paid on PFI, LIFT and other service concession obligations		-14,407	-14,370
PDC dividend (paid) / refunded		-1,458	-1,002
Net cash flows from / (used in) financing activities		**-4,668**	**-37,028**
Increase / (decrease) in cash and cash equivalents		**22,866**	**-7,051**
Cash and cash equivalents at 1 April - brought forward		**3,355**	**10,406**
Cash and cash equivalents at 1 April - restated		**3,355**	**10,406**
Cash and cash equivalents at 31 March	20	**26,221**	**3,355**

Notes to the Accounts

Note 1 Accounting policies and other information

Note 1.1 Basis of preparation

The Department of Health and Social Care has directed that the financial statements of the Trust shall meet the accounting requirements of the Department of Health and Social Care Group Accounting Manual (GAM), which shall be agreed with HM Treasury. Consequently, the following financial statements have been prepared in accordance with the GAM 2020/21 issued by the Department of Health and Social Care. The accounting policies contained in the GAM follow International Financial Reporting Standards to the extent that they are meaningful and appropriate to the NHS, as determined by HM Treasury, which is advised by the Financial Reporting Advisory Board. Where the GAM permits a choice of accounting policy, the accounting policy that is judged to be most appropriate to the particular circumstances of the Trust for the purpose of giving a true and fair view has been selected. The particular policies adopted are described below. These have been applied consistently in dealing with items considered material in relation to the accounts.

Accounting convention

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

Note 1.2.1 Going concern

The NHS Trust's annual report and accounts have been prepared on a going concern basis.

The DHSC GAM requires the management of the Trust to consider the following public sector interpretation of IAS 1 in respect of applying the going concern assumption when preparing its accounts stating:

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

The Trust Board have assessed the Trust's ability to continue for the foreseeable future in the light of the GAM guidance and has prepared the 2020/21 accounts on a "going concern" basis following consideration of the following:-

- There has been no expectation raised in the public arena that healthcare services will not continue to be provided from the two hospital sites. There are no plans to dissolve the Trust or to cease services without transfer to any other NHS body.

- The funding regime that has existed for 2020/21 is expected to continue for the first half of 2021/22. NHS organisations will submit a formal plan in May.

- The Trust has agreed its 2021/22 capital plans with the Kent and Medway STP which now manages the overall resource level within the patch. The Trust has submitted its five year capital plans to NHSI/E in April 2021.

- The Trust continues to fully participate in the STP planning and assurance process. The STP has developed its role as local system lead in ensuring that the patch organisations work collaboratively in delivering income and expenditure and capital control totals. The Trust is a key player in ICP and STP/ICS work on reconfiguring services in the patch for the future e.g. it is one of the selected sites for Hyper Acute Stroke Unit as part of the STP-wide Stroke services consultation.

- The Trust will have contracts in place for provision of healthcare services for 2020/21 albeit at this stage they will be at least in part block contract arrangements nationally determined in response to the C-19 pandemic. The Trust's main commissioner is NHS Kent & Medway CCG with other main sources of income from NHSE Specialist Commissioners, NHS East Sussex CCG, NHS West Sussex CCG, NHS Brighton and Hove CCG and NHS Surrey Heartlands CCG. The current financial regime provides certainty for income and cash flows in 2021-22 for at least the first half of the financial year.

- Following the conversion of the working capital loan to PDC in 2020/21 the Trust has no working capital loans and has not required any support during 2020/21 and not anticipating requiring support in 2021/22.

- The Trust does not consider that there are any material uncertainties to the going concern basis.

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

Note 1.2.2 Interests in other entities

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

Note 1.3 Interests in other entities

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

Note 1.4 Revenue from contracts with customers

Where income is derived from contracts with customers, it is accounted for under IFRS 15. The GAM expands the definition of a contract to include legislation and regulations which enables an entity to receive cash or another financial asset that is not classified as a tax by the Office of National Statistics (ONS).

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

Revenue from NHS contracts

The accounting policies for revenue recognition and the application of IFRS 15 are consistently applied. The contracting arrangements in the NHS changed between 2019/20 and 2020/21 affecting the application of the accounting policy under IFRS 15. This difference in application is explained below.

2020/21

The main source of income for the Trust is contracts with commissioners for health care services. In 2020/21, the majority of the trust's income from NHS commissioners was in the form of block contract arrangements. During the first half of the year the trust received block funding from its commissioners. For the second half of the year, block contract arrangements were agreed at a Sustainability and Transformation Partnership level. The related performance obligation is the delivery of healthcare and related services during the period, with the trust's entitlement to consideration not varying based on the levels of activity performed.

The Trust has received additional income outside of the block and system envelopes to reimburse specific costs incurred and other income top-ups to support the delivery of services. Reimbursement and top-up income is accounted for as variable consideration.

Comparative period (2019/20)

In the comparative period (2019/20), the trust's contracts with NHS commissioners included those where the trust's entitlement to income varied according to services delivered. A performance obligation relating to delivery of a spell of health care was generally satisfied over time as healthcare was received and consumed simultaneously by the customer as the Trust performed it. The customer in such a contract was the commissioner, but the customer benefited as services were provided to their patient. Even where a contract could be broken down into separate performance obligations, healthcare generally aligned with paragraph 22(b) of the Standard entailing a delivery of a series of goods or services that were substantially the same and had a similar pattern of transfer. At the year end, the Trust accrued income relating to activity delivered in that year, where a patient care spell was incomplete. This accrual was disclosed as a contract receivable as entitlement to payment for work completed was usually only dependent on the passage of time.

In 2019/20, the Provider Sustainability Fund and Financial Recovery Fund enabled providers to earn income linked to the achievement of financial controls and performance targets. Income earned from the funds is accounted for as variable consideration

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

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

In 2020 to 2021 NHS providers have received reimbursement and top-up income in addition to amounts included in block contracts and system evelopes. This income is earned based on either incurring costs or other aspects of financial performance. In line with IFRS 15, such income should be accounted for as variable consideration.

Revenue from research contracts

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

NHS injury cost recovery scheme

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

Education Income

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

Non-Patient care services to other bodies

The Trust supplies a range of staff and goods to a range of customers, and also rents out facilities. For these services, revenue is recognised as and when performance obligations are satisfied during the period covered by the recharge

Note 1.5 Other forms of income

Grants and donations

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

Apprenticeship service income

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

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

Note 1.6 Expenditure on employee benefits

Short-term employee benefits

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

Pension costs

NHS Pension Scheme

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

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

The Trust participates in the National Employees Savings Trust (NEST) scheme as an alternative to those employees who are not eligible to join the NHS Pension Scheme. This came into effect in July 2013 for this Trust as part of the auto enrolment requirements introduced by the Government. NEST is a defined contribution scheme with a phased employer contribution rate which was 3% for 2020/21. The rate remains at 3% from April 2021.

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

Note 1.7 Expenditure on other goods and services

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

Note 1.8.1 Property, plant and equipment

Recognition

Property, plant and equipment is capitalised where:

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

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

Subsequent expenditure

Subsequent expenditure relating to an item of property, plant and equipment is recognised as an increase in the carrying amount of the asset when it is probable that additional future economic benefits or service potential deriving from the cost incurred to replace a component of such item will flow to the enterprise and the cost of the item can be determined reliably. Where a component of an asset is replaced, the cost of the replacement is capitalised if it meets the criteria for recognition above. The carrying amount of the part replaced is de-recognised. Other expenditure that does not generate additional future economic benefits or service potential, such as repairs and maintenance, is charged to the Statement of Comprehensive Income in the period in which it is incurred.

Measurement

Valuation

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

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

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

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

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

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

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

The financial year 2020/21 is the first year following the five year cyclical valuation period. In keeping with the Trust's policies the Trust commissioned professional valuers, Montagu Evans LLP, to carry out a desk top valuation at 31st March 2021. The lead relationship partner from Montagu Evans LLP is qualified to BSc MRICS. The results are recorded in property plant and equipment notes 15 and 17.

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

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

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

Depreciation

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

Property, plant and equipment which has been reclassified as 'held for sale' cease to be depreciated upon the reclassification. Assets in the course of construction and residual interests in off-Statement of Financial Position PFI contract assets are not depreciated until the asset is brought into use or reverts to the trust, respectively.

Impairments

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

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

De-recognition

Assets intended for disposal are reclassified as 'held for sale' once the criteria in IFRS 5 are met. The sale must be highly probable and the asset available for immediate sale in its present condition subject only to terms which are usual and customary for such sales.

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

Following reclassification, the assets are measured at the lower of their existing carrying amount and their 'fair value less costs to sell'. Depreciation ceases to be charged and the assets are not revalued, except where the 'fair value less costs to sell' falls below the carrying amount. Assets are de-recognised when all material sale contract conditions have been met.

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

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

Donated and grant funded assets

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

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

In 2020/21 this includes assets donated to the trust by the Department of Health and Social Care as part of the response to the coronavirus pandemic. As defined in the GAM, the trust applies the principle of donated asset accounting to assets that the trust controls and is obtaining economic benefits from at the year end.

Note 1.8.2 Private Finance Initative (PFI)

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

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

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

Services received

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

PFI Asset

The PFI assets are recognised as property, plant and equipment, when they come into use. The assets are measured initially at fair value or, if lower, at the present value of the minimum lease payments, in accordance with the principles of IAS 17. Subsequently, the assets are measured at current value in existing use, which is kept up to date in accordance with the Trust's approach for each relevant class of asset in accordance with the principles of IAS 16.

PFI liability

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

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

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

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

Lifecycle replacement

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

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

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

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

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

Other assets contributed by the NHS Trust to the operator

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

Useful lives of property, plant and equipment

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

	Min life Years	Max life Years
Buildings, excluding dwellings	5	60
Plant & machinery	2	15
Transport equipment	5	20
Information technology	3	10
Furniture & fittings	10	20

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

Note 1.9 Intangible assets

Recognition

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

Internally generated intangible assets

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

Expenditure on research is not capitalised. Expenditure on development is capitalised where it meets the requirements set out in IAS 38.

• the project is technically feasible to the point of completion and will result in an intangible asset for sale or use;

• the Trust intends to complete the asset and sell or use it;

• the Trust has the ability to sell or use the asset;

• how the intangible asset will generate probable future economic or service delivery benefits, eg, the presence of a market for it or its output, or where it is to be used for internal use, the usefulness of the asset;

• adequate financial, technical and other resources are available to the trust to complete the development and sell or use the asset and

• the Trust can measure reliably the expenses attributable to the asset during development.

Software

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

Measurement

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

Subsequently intangible assets are measured at current value in existing use. Where no active market exists, intangible assets are valued at the lower of depreciated replacement cost and the value in use where the asset is income generating. Revaluations gains and losses and impairments are treated in the same manner as for property, plant and equipment. An intangible asset which is surplus with no plan to bring it back into use is valued at fair value where there are no restrictions on sale at the reporting date and where they do not meet the definitions of investment properties or assets held for sale.

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

Amortisation

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

Useful lives of intangible assets

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

	Min life Years	Max life Years
Information technology	2	7
Software licences	3	5

Note 1.10 Inventories

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

In 2020/21, the Trust received inventories including personal protective equipment from the Department of Health and Social Care at nil cost. In line with the GAM and applying the principles of the IFRS Conceptual Framework, the Trust has accounted for the receipt of these inventories at a deemed cost, reflecting the best available approximation of an imputed market value for the transaction based on the cost of acquisition by the Department.

Note 1.11 Cash and cash equivalents

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

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

Note 1.12 Financial assets and financial liabilities

Recognition

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

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

Classification and measurement

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

Financial assets and financial liabilities at amortised cost

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

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

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

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

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

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

Impairment of financial assets

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

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

The Trust has used historic data for the last two years to assess the expected credit loss rates that should be applied to trade debtor categories, taking into account the materiality of debtor classes. For 2020/21 the Trust has reassessed the ageing debt classes for the main categories of trade debtor and assessed their expected credit loss characteristics in the light of the current economic situation due to the C-19 pandemic. The Trust has revised its assessment to provide for all main trade classes with debt balances over 60 days (2019-20 over 180 days). The exception to this are Direct Debits where debtors are repaying in accordance to a repayment plan and therefore this is a zero credit loss assessment; overseas visitors and any companies in liquidation are provided in full as soon as the debt is recognised. For 2021/22 the Trust will continue to assess these categories and will amend as necessary.

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

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

Derecognition

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

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

Note 1.13 Leases

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

The Trust as a lessee

Finance leases

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

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

The annual rental charge is split between the repayment of the liability and a finance cost so as to achieve a constant rate of finance over the life of the lease. The annual finance cost is charged to finance costs in the Statement of Comprehensive Income.

Operating leases

Operating lease payments are recognised as an expense on a straight-line basis over the lease term. Lease incentives are recognised initially in other liabilities on the statement of financial position and subsequently as a reduction of rentals on a straight-line basis over the lease term. Contingent rentals are recognised as an expense in the period in which they are incurred.

Leases of land and buildings

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

The Trust as a lessor

Finance leases

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

Operating leases

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

Note 1.14 Provisions

The Trust recognises a provision where it has a present legal or constructive obligation of uncertain timing or amount; for which it is probable that there will be a future outflow of cash or other resources; and a reliable estimate can be made of the amount. The amount recognised in the Statement of Financial Position is the best estimate of the resources required to settle the obligation. Where the effect of the time value of money is significant, the estimated risk-adjusted cash flows are discounted using HM Treasury's discount rates effective for 31 March 2021:

		Nominal rate
Short-term	Up to 5 years	-0.02%
Medium-term	After 5 years up to 10 years	0.18%
Long-term	Exceeding 10 years	1.99%

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

	Inflation rate
Year 1	1.20%
Year 2	1.60%
Into perpetuity	2.00%

Early retirement provisions and injury benefit provisions both use the HM Treasury's pension discount rate of negative 0.95% (2019-20: negative 0.50%) in real terms.

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

Clinical negligence costs

NHS Resolution operates a risk pooling scheme under which the trust pays an annual contribution to NHS Resolution, which, in return, settles all clinical negligence claims. Although NHS Resolution is administratively responsible for all clinical negligence cases, the legal liability remains with the Trust. The total value of clinical negligence provisions carried by NHS Resolution on behalf of the trust is disclosed at note 24.1 but is not recognised in the Trust's accounts.

Non-clinical risk pooling

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

Note 1.15 Contingencies

Contingent assets (that is, assets arising from past events whose existence will only be confirmed by one or more future events not wholly within the entity's control) are not recognised as assets, but are disclosed in note 25 where an inflow of economic benefits is probable.
Contingent liabilities are not recognised, but are disclosed in note 25, unless the probability of a transfer of economic benefits is remote.

Contingent liabilities are defined as:

• possible obligations arising from past events whose existence will be confirmed only by the occurrence of one or more uncertain future events not wholly within the entity's control; or

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

Note 1.16 Public dividend capital

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

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

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

(i) Donated and grant funded assets;
(ii) Average daily cash balances held with the Government Banking Services (GBS) and National Loans Fund (NLF) deposits, excluding cash balances held in GBS accounts that relate to a short-term working capital facility;
(iii) Approved expenditure on COVID-19 capital assets;
(iv) Assets under construction for nationally directed schemes and
(v) Any PDC dividend balance receivable or payable.

This policy is available at https://www.gov.uk/government/publications/guidance-on-financing-available-to-nhs-trusts-and-foundation-trusts.

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

Note 1.17 Value added tax

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

Note 1.18 Climate change levy

Expenditure on the climate change levy is recognised in the Statement of Comprehensive Income as incurred, based on the prevailing chargeable rates for energy consumption.

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

Note 1.19 Losses and special payments

Losses and special payments are items that Parliament would not have contemplated when it agreed funds for the health service or passed legislation. By their nature they are items that ideally should not arise. They are therefore subject to special control procedures compared with the generality of payments. They are divided into different categories, which govern the way that individual cases are handled. Losses and special payments are charged to the relevant functional headings in expenditure on an accruals basis, including losses which would have been made good through insurance cover had the Trust not been bearing their own risks (with insurance premiums then being included as normal revenue expenditure).

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

Note 1.20 Gifts

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

Note 1.21 Early adoption of standards, amendments and interpretations

No new accounting standards or revisions to existing standards have been early adopted in 2020/21.

Note 1.22 Standards, amendments and interpretations in issue but not yet effective or adopted

The DHSC GAM does not require the following IFRS Standards and Interpretations to be applied in 2020-21. These Standards are still subject to HM Treasury FReM adoption.

IFRS 17 Insurance Contracts – Application required for accounting periods beginning on or after 1 January 2023, but not yet adopted by the FReM: early adoption is not therefore permitted.

IFRS 16 Leases - The Standard is effective 1 April 2022 as adapted and interpreted by the FReM.

IFRS 16 Leases

IFRS 16 Leases will replace *IAS 17 Leases, IFRIC 4 Determining whether an arrangement contains a lease* and other interpretations and is applicable in the public sector for periods beginning 1 April 2022. The standard provides a single accounting model for lessees, recognising a right of use asset and obligation in the statement of financial position for most leases: some leases are exempt through application of practical expedients explained below. For those recognised in the statement of financial position the standard also requires the remeasurement of lease liabilities in specific circumstances after the commencement of the lease term. For lessors, the distinction between operating and finance leases will remain and the accounting will be largely unchanged.

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

On transition to IFRS 16 on 1 April 2022, the trust will apply the standard retrospectively with the cumulative effect of initially applying the standard recognised in the income and expenditure reserve at that date. For existing operating leases with a remaining lease term of more than 12 months and an underlying asset value of at least £5,000, a lease liability will be recognised equal to the value of remaining lease payments discounted on transition at the trust's incremental borrowing rate. The trust's incremental borrowing rate will be a rate defined by HM Treasury. Currently this rate is 0.91% but this may change between now and adoption of the standard. The related right of use asset will be measured equal to the lease liability adjusted for any prepaid or accrued lease payments. For existing peppercorn leases not classified as finance leases, a right of use asset will be measured at current value in existing use or fair value. The difference between the asset value and the calculated lease liability will be recognised in the income and expenditure reserve on transition. No adjustments will be made on 1 April 2022 for existing finance leases.

For leases commencing in 2022/23, the trust will not recognise a right of use asset or lease liability for short term leases (less than or equal to 12 months) or for leases of low value assets (less than £5,000). Right of use assets will be subsequently measured on a basis consistent with owned assets and depreciated over the length of the lease term.

The implementation date for IFRS 16 in the NHS was revised to 1 April 2022 in November 2020. Due to the need to reassess lease calculations, together with uncertainty on expected leasing activity is from April 2022 and beyond, a quantification of the expected impact of applying the standard in 2022/23 regarding estimated increases in capital additions commencing in 2022/23. However, the trust does expect this standard to have a material impact on non-current assets, liabilities and depreciation based on existing information.

The Trust has estimated the impact of applying IFRS 16 in 2022/23 on the opening statement of financial position and the in-year impact on the statement of comprehensive income and capital additions as follows:

The Trust has estimated the impact of applying IFRS 16 in 2022/23 on the opening statement of financial position and the in-year impact on the statement of comprehensive income and capital additions as follows:

	£000
Estimated impact on 1 April 2022 statement of financial position	
Additional right of use assets recognised for existing operating leases	49,553
Additional lease obligations recognised for existing operating leases	-48,282
Changes to other statement of financial position line items	0
Net impact on net assets on 1 April 2022	**1,271**
Estimated in-year impact in 2022/23	
Additional depreciation on right of use assets	-4,802
Additional finance costs on lease liabilities	-588
Lease rentals no longer charged to operating expenditure	5,086
Other impact on income / expenditure	31
Estimated impact on surplus / deficit in 2022/23	**-273**
Estimated increase in capital additions for new leases commencing in 2022/23	**0**

Note 1.23 Critical judgements in applying accounting policies

The following are the judgements, apart from those involving estimations (see below) that management has made in the process of applying the trust accounting policies and that have the most significant effect on the amounts recognised in the financial statements, these exclude accounting estimations. For 2020/21 the Trust has identified the following critical judgements that are required to be disclosed under IAS1 paragraph 122. All other material judgements within this financial year relate to estimations and are disclosed in the relevant notes:

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

Assets relating to land and buildings were subject to a desktop valuation as at 31st March 2021, completed on an "modern equivalent asset" basis. An existing use value alternative was used which assumes the assets would be replaced with a modern equivalent, i.e. not a building of identical design - but with the same service provision as the existing asset. The alternative modern equivalent asset may well be smaller (reduced Gross Internal Area than the existing assets which reflects the challenges healthcare providers face when utilising NHS Estate). under the Trust's alternative modern equivalent asset valuation, the modern alternative hospitals are of the same service potential and in the same locations but on a smaller physical footprint to serve the catchment area of population.

The Trust's PFI contract was judged at inception as meeting the IFRIC 12 principles as a service concession arrangement so that the Trust immediately recognised an infrastructure asset and a corresponding finance lease liability, under IAS 17. No change to the underlying contract has subsequently occurred to alter that judgement and the concession continues to be recognised on-SoFP.

Note 1.24 Sources of estimation uncertainty

The following are assumptions about the future and other major sources of estimation uncertainty that have a significant risk of resulting in a material adjustment to the carrying amounts of assets and liabilities within the next financial year:

Material areas including estimates within the 2020/21 accounts are as follows:

Property, Plant and Equipment valuation including PFI infrastructure assets; estimation of the valuation of Property and Land is based upon professional valuer methodologies for applying modern equivalent asset concepts to the estimation of depreciated replacement cost. This methodology assumes a modern asset equivalent (MEA) approach to valuation of Trust’s specialised assets, with replacement buildings being of the same service potential. Inherent within the MEA valuation approach, using the depreciated replacement cost, is the Build Cost Information Service Indices (BCIS) input. The carrying value of assets valued under DRC approach was £240m (part of the £253m land and buildings disclosed in note 15). The valuer uses the latest BCIS information closest to the date of valuation in valuing the Trust’s specialised assets. Significant changes in the BCIS indices used valuations would result in a significantly lower or higher carrying value of building assets held by the Trust. For example a 10% +- percentage change in the building assets would result in a decrease or increase in asset values by £8.5m over the next financial year with an estimated decrease/increase to depreciation of £0.2m.

Note 2 Operating Segments

Maidstone and Tunbridge Wells NHS Trust reports under a single segment of Healthcare. The Board of Directors, led by the Chief Executive, is the chief operating decision maker within the Trust. It is only at this level that the overall financial and operational performance of the Trust is measured.

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

The Trusts income is predominantly from contracts for the provision of healthcare with Clinical Commissioning Groups and NHS England. This accounts for 86% of the Trust total income. Disclosure of all material transactions with related parties is included within note 33 to these financial statements. There are no other parties that account for more than 10% of total income.

Note 3 Operating income from patient care activities

All income from patient care activities relates to contract income recognised in line with accounting policy 1.4

Note 3.1 Income from patient care activities (by nature)	2020/21 £000	Restated 2019/20 £000	
Acute services			
Block contract / system envelope income	465,001	388,543	*
High cost drugs income from commissioners (excluding pass-through costs)	2,575	44,432	
Other NHS clinical income	4,207	5,267	
All services			
Private patient income	677	1,322	
Additional pension contribution central funding	12,824	11,381	
Other clinical income	10,764	6,643	
Total income from activities	**496,048**	**457,588**	

*As part of the coronavirus pandemic response, transaction flows were simplified in the NHS and providers and their commissioners moved onto block contract payments at the start of 2020/21. In the second half of the year, a revised financial framework built on these arrangements but with a greater focus on system partnership and providers derived most of their income from these system envelopes. The £388.5m value has been restated from 2019/20 where this was previously separated by income stream e.g: elective/non-elective income.

In line with NHSE/I reporting guidance, all High Cost Drugs' (HCD's) not subject to pass-through arrangement have been reported within the Block Contract/System Envelope income for 2020/21, the remaining HCD's that are charged on a cost and volume basis during the second half of the year have continued to be reported within the High Cost Drugs income from Commissioners' line, these cover some Specialised Commissioned Drugs, Cancer Drugs Fund and HEp C Drugs. Therefore the majority of the HCD income in 2020/21 is reported within the block contract line whereas it was reported under High Cost Drugs in 2019/20.

The employer pension contribution rate for NHS pensions increased from 14.3% to 20.6% (excluding administration charge) from 1 April 2019. Since 2019/20, NHS providers have continued to pay over contributions at the former rate with the additional amount being paid over by NHS England on providers' behalf. The full cost and related funding of £12.8m have been recognised in these accounts.

The increased movement in 'other clinical income' is in line with national reporting guidance and relates to additional funding to cover the Trusts annual leave accrual £4.7m.

Note 3.2 Income from patient care activities (by source)

Income from patient care activities received from:	2020/21 £000	2019/20 £000
NHS England	104,378	96,528
Clinical commissioning groups	382,002	349,459
Other NHS providers	3,442	3,636
NHS other	1	0
Local authorities	4,177	4,563
Non-NHS: private patients	677	1,322
Non-NHS: overseas patients (chargeable to patient)	189	378
Injury cost recovery scheme	326	930
Non NHS: other	856	772
Total income from activities	**496,048**	**457,588**
Of which:		
Related to continuing operations	496,048	457,588

The income movement in Clinical Commissioning Groups (CCG) income is a result of the increased funding given to the Trust to support the covid-19 pandemic response and is to cover growth, inflationary pressures and additional top-up funds to cover the increased costs during the pandemic.

The reduction in Income from Private Patients between years is a result of Covid-19 and reducing the Trusts ability to treat private patients.

NHS injury cost recovery income is subject to a provision for impairment of receivables, previously the Trust has calculated this estimate using historical information for each main site. For 2020/21 the Trust has re-evaluated this process and for all prior years debt this has been provided for in full and debt relating to 2020/21 the Trust has reverted back to using the DHSC given rate of 22.43%.

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

	2020/21	2019/20
	£000	£000
Income recognised this year	189	378
Cash payments received in-year	138	182
Amounts added to provision for impairment of receivables	217	57
Amounts written off in-year	11	0

Note 4 Other operating income

	2020/21			2019/20		
	Contract income	Non-contract income	Total	Contract income	Non-contract income	Total
	£000	£000	£000	£000	£000	£000
Research and development	1,347	0	**1,347**	1,459	0	**1,459**
Education and training	11,634	513	**12,147**	10,420	268	**10,688**
Non-patient care services to other bodies	14,189	0	**14,189**	15,042	0	**15,042**
Provider sustainability fund (2019/20 only)	0	0	**0**	8,234	0	**8,234**
Marginal rate emergency tariff funding (2019/20 only)	0	0	**0**	6,199	0	**6,199**
Reimbursement and top up funding	29,038	0	**29,038**	0	0	**0**
Receipt of capital grants and donations	0	1,392	**1,392**	0	890	**890**
Charitable and other contributions to expenditure	0	7,743	**7,743**	0	0	**0**
Rental revenue from operating leases	0	107	**107**	0	187	**187**
Other income	2,185	0	**2,185**	12,769	0	**12,769**
Total other operating income	**58,393**	**9,755**	**68,148**	**54,123**	**1,345**	**55,468**
Of which:						
Related to continuing operations			68,148			55,468

Provider Sustainability and Transformation Funding (PSF) and Marginal rate emergency tariff (MRET) ceased at the end of 2019-20.

Included within the receipt of government grants and donations of £1.39m are £1.1m donated equipment from DHSC relating to the covid pandemic. This includes £0.5m on ventilators and monitors, £0.4m on testing equipment and £0.3m on imaging equipment.

Included within charitable and other contributions to expenditure is £7.7m relating to the consumables (inventory) additions from DHSC group bodies donated to the Trust.

Further analysis of "other income"

	2020/21	2019/20
	£000	£000
PFI support income	**0**	8,000
Car Parking income	**350**	2,456
Catering Income	**320**	952
Other	**1,515**	1,361
	2,185	12,769

PFI Support - Due to Covid-19 the financial funding regime in 2020/21 changed, the Trust received funding based on block payments which were calculated based on expenditure. The £8m PFI support income was not received but the shortfall was covered by the block funding which the Trust received, this block payment is reported within patient care income in note 3.2

Car parking - During the pandemic national guidance stated that staff car parking should be free, this reduction and the reduction is the number of patients and visitors attending the hospital resulted in a reduction of c£2.1m in income.

Catering income - the number of patients and visitors who attended the hospital sites in 2020/21 was reduced impacting on the footfall within the restaurants. This reduction and the implementation of various staff wellbeing support packages during the pandemic resulted in a £0.6m reduction in catering income.

Other - the Trust increased the provision held for clinical pensions by £0.2m in 2020/21. This increase was due to a change in discount rate, national guidance confirmed this increase would be offset by additional income

Note 5.1 Additional information on contract revenue (IFRS 15) recognised in the period

	2020/21	2019/20
	£000	£000
Revenue recognised in the reporting period that was included in within contract liabilities at the previous period end	0	2,580

Due to the finance regime for 2020-21 where NHS providers and Commissioners transact via block contract arrangement, the provider's entitlement to income does not vary based on the treatment of individual patients. The prior year value of £2.6m relates to Maternity Pathway, however due to the block arrangements NHSE guidance results in Trusts returning this income back to the Commissioners.

Note 5.2 Fees and charges

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

	2020/21	2019/20
	£000	£000
Income	669	3,325
Full cost	-2,334	-2,888
Surplus / (deficit)	**-1,665**	**437**

Majority of this income is through Car Parking and Catering, however due to the pandemic the Trust did not allow visitors in the hospital therefore the income for both car parking and catering reduced compared to the previous year. The Trust under national guidance gave free car parking to all staff across the hospital sites. The Trust was unable to avoid the majority of the costs as they are fixed in nature.

Note 6.1 Operating expenses

	2020/21	2019/20
	£000	£000
Purchase of healthcare from NHS and DHSC bodies	6,302	6,923
Purchase of healthcare from non-NHS and non-DHSC bodies	6,381	15,798
Staff and executive directors costs	342,645	299,931
Remuneration of non-executive directors	126	94
Supplies and services - clinical (excluding drugs costs)	45,234	37,005
Supplies and services - general	7,206	5,238
Drug costs (drugs inventory consumed and purchase of non-inventory drugs)	52,880	55,034
Inventories written down	673	0
Consultancy costs	3,855	625
Establishment	2,465	1,657
Premises	20,556	17,820
Transport (including patient travel)	1,994	2,522
Depreciation on property, plant and equipment	12,409	11,813
Amortisation on intangible assets	1,419	1,209
Net impairments	4,699	2,748
Movement in credit loss allowance: contract receivables / contract assets	757	471
Change in provisions discount rate(s)	184	35
Audit fees payable to the external auditor		
audit services- statutory audit	99	84
other auditor remuneration (external auditor only)	0	9
Internal audit costs	104	147
Clinical negligence	19,070	17,558
Legal fees	272	330
Insurance	539	453
Education and training	3,466	1,884
Rentals under operating leases	4,804	3,372
Redundancy	189	0
Charges to operating expenditure for on-SoFP IFRIC 12 schemes (e.g. PFI / LIFT)	5,417	5,199
Car parking & security	2,131	1,075
Hospitality	0	9
Losses, ex gratia & special payments	585	17
Other services, eg external payroll	350	308
Other	3,489	2,480
Total	**550,300**	**491,848**
Of which:		
Related to continuing operations	550,300	491,848

Purchase of healthcare from Non-NHS and Non DHSC bodies relates to the Trusts role as Prime Provider including related Independent outsourcing costs. However for 2020/21 this went under the National Contract therefore not paid by the Trust.

Included within supplies and services - clinical are £5.4m (2019-20 £nil) of consumables donated from DHSC group bodies for Covid response

The inventories written down value of £0.7m (2019-20 £nil) relates to consumables donated from DHSC group bodies for Covid response. The £0.7m relates to the difference of the lower of the market values held at the financial year end and the unit prices held for each personal protective equipment item. All the pricing information was provided by the DHSC.

The audit fees included within Note 6.1 above are reported as the gross position, the value excluding VAT for 2020/21 is £82.1k (2019/20 £70k).

Note 6.2 Other auditor remuneration

	2020/21	2019/20
	£000	£000
Other auditor remuneration paid to the external auditor:		
8. Other non-audit services not falling within items 2 to 7 above	0	9
Total	**0**	**9**

The £9k reported in 2019/20 note 6.2 relates to the audit of the Trusts quality accounts. For 2020/21 there is no requirement to audit the quality accounts. As the Trust does not consolidate its charitable funds (see note 1.3) the fee for the independent examination of the charitable fund accounts is charged directly to those funds. The total charitable funds income and costs are reported in note 33 as a related party.

Note 6.3 Limitation on auditor's liability

The limitation on auditor's liability for external audit work is £2 million (2019/20: £2 million).

Note 7 Impairment of assets

	2020/21	2019/20
	£000	£000
Net impairments charged to operating surplus / deficit resulting from:		
Changes in market price	4,699	2,748
Total net impairments charged to operating surplus / deficit	**4,699**	**2,748**
Impairments charged to the revaluation reserve	2,778	1,663
Total net impairments	**7,477**	**4,411**

The Trust commissioned its independent professional valuers to undertake a desktop valuation as at the 31st March 2021 to support its assessment of year end property valuations. The result of the valuation has been a net decrease in property values leading to a net impairment of £3.4m charged to the Income and Expenditure account. In addition an assessment of the current value in exisitng use has been undertaken for IT devices (PCs, Laptops and IPads) has been carried out based on the valuation model used by the Trust, this is in accordance with the Trust's policy 1.9. For 2020/21 the assessment totalled £1.3m (2019-20 £0.565m). These two impairments make up the change in market price figure in note 7.

The net impairments charged to the revaluation reserve is an in-year impairment against the business reserve of £4.3m less reversal of previous balance sheet impairment (£1.6m).

Both the gross impairments and the reversals are disclosed in note 15.3.

Note 8 Employee benefits

	2020/21 Total £000	2019/20 Total £000
Salaries and wages	255,636	219,594
Social security costs	26,419	23,565
Apprenticeship levy	1,277	1,157
Employer's contributions to NHS pensions*	42,246	37,561
Pension cost - other	76	21
Temporary staff (including agency)	19,490	20,109
Total gross staff costs	**345,144**	**302,007**
Recoveries in respect of seconded staff	0	0
Total staff costs	**345,144**	**302,007**
Of which		
Costs capitalised as part of assets	2,310	2,076

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

* The employer contribution rate for NHS pensions increased from 14.3% to 20.6% totalling £12.8m (2019-20 £11.4m excluding administration charge) from 1 April 2020. For 2020/21, NHS providers continued to pay over contributions at the former rate with the additional amount being paid over by NHS England on provider's behalf. The full cost and related funding have been recognised in these accounts.

Note 8.1 Retirements due to ill-health

During 2020/21 there was 1 early retirement from the trust agreed on the grounds of ill-health (none in the year ended 31 March 2020). The estimated additional pension liabilities of these ill-health retirements is £12k (0k in 2019/20).

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

Note 9 Pension costs

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

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

a) Accounting valuation

A valuation of scheme liability is carried out annually by the scheme actuary (currently the Government Actuary's Department) as at the end of the reporting period. This utilises an actuarial assessment for the previous accounting period in conjunction with updated membership and financial data for the current reporting period, and is accepted as providing suitably robust figures for financial reporting purposes. The valuation of the scheme liability as at 31 March 2021, is based on valuation data as at 31 March 2020, updated to 31 March 2021 with summary global member and accounting data. In undertaking this actuarial assessment, the methodology prescribed in IAS 19, relevant FReM interpretations, and the discount rate prescribed by HM Treasury have also been used.

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

b) Full actuarial (funding) valuation

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

The latest actuarial valuation undertaken for the NHS Pension Scheme was completed as at 31 March 2016. The results of this valuation set the employer contribution rate payable from April 2019 at 20.6% of pensionable pay.

The 2016 funding valuation was also expected to test the cost of the Scheme relative to the employer cost cap that was set following the 2012 valuation. In January 2019, the Government announced a pause to the cost control element of the 2016 valuations, due to the uncertainty around member benefits caused by the discrimination ruling relating to the McCloud case.

The Government subsequently announced in July 2020 that the pause had been lifted, and so the cost control element of the 2016 valuations could be completed. The Government has set out that the costs of remedy of the discrimination will be included in this process. HMT valuation directions will set out the technical detail of how the costs of remedy will be included in the valuation process. The Government has also confirmed that the Government Actuary is reviewing the cost control mechanism (as was originally announced in 2018). The review will assess whether the cost control mechanism is working in line with original government objectives and reported to Government in April 2021. The findings of this review will not impact the 2016 valuations, with the aim for any changes to the cost cap mechanism to be made in time for the completion of the 2020 actuarial valuations.

Included within the employee benefits note are employer contributions to NHS Pension scheme £42.2m (£37.6m 2019/20) and other pensions schemes which are NEST and 247 time NEST totalling £76k (£21k 2019/20).

The Trust participates in the National Employees Savings trust (NEST) scheme as an alternative to those employees who are not eligible to join the NHS Pension Scheme. This came into effect in July 2013 for this Trust as part of the auto enrolment requirements introduced by the Government. NEST is a defined contribution scheme with a phased employer contribution rate of 3% for 2020/21 and remains at 3% for 2021/22. Trust contributions under the NEST scheme for the 2020/21 financial year totalled £23k (£21k 2019/20).

Note 10 Operating leases

Note 10.1 Maidstone and Tunbridge Wells NHS Trust as a lessor

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

The Trust leases an element of land on the Maidstone Hospital site to a day nursery contractor and also receives income from various shops in the reception area of Maidstone Hospital.

	2020/21	2019/20
	£000	£000
Operating lease revenue		
Minimum lease receipts	107	187
Total	**107**	**187**

	31 March 2021	31 March 2020
	£000	£000
Future minimum lease receipts due:		
- not later than one year;	188	187
- later than one year and not later than five years;	751	748
- later than five years.	891	1,001
Total	**1,830**	**1,936**

Note 10.2 Maidstone and Tunbridge Wells NHS Trust as a lessee

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

The top five material leases are given in detail below:

Apogee - Lease of photocopiers and printers under a managed service arrangement, £657k (£707k 2019-20). The contract is expected to complete in March 2024.

MGIF - lease of Springwood Road staff accommodation. The Trust entered into an operating lease arrangement on the 29th March 2019 with MGIF including an initial leaseback of the existing staff residences whilst planning permission is sought by the landlord to redevelop the site, including the provision of new staff accommodation. The overarching lease is structured in different tiers, with the initial period phasing into a 40 year primary term lease on the new accommodation, structured into two interlinked lease periods, with an ultimate option for the Trust to acquire the property for fair value at the end of the arrangement. The current rent is £550.8k per annum; the rent for the new accommodation will be £960k per annum, subject to RPI uplifts annually, with a cap and collar arrangement. The Trust manages the tenancies with staff and receives the sublease rentals.

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

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

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

	2020/21	2019/20
	£000	£000
Operating lease expense		
Minimum lease payments	5,325	3,998
Less sublease payments received	-521	-626
Total	**4,804**	**3,372**

	31 March 2021	31 March 2020
	£000	£000
Future minimum lease payments due:		
- not later than one year;	5,630	5,013
- later than one year and not later than five years;	16,082	16,945
- later than five years.	47,577	47,234
Total	**69,289**	**69,192**
Future minimum sublease payments to be received	-44,027	-44,715

Note 11 Finance income

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

	2020/21	2019/20
	£000	£000
Interest on bank accounts	9	309
Total finance income	**9**	**309**

Note 12.1 Finance expenditure

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

	2020/21	2019/20
	£000	£000
Interest expense:		
Loans from the Department of Health and Social Care	281	1,354
Interest on late payment of commercial debt	5	4
Main finance costs on PFI and LIFT schemes obligations	9,816	10,110
Contingent finance costs on PFI and LIFT scheme obligations	4,591	4,260
Total interest expense	**14,693**	**15,728**
Unwinding of discount on provisions	1	1
Other finance costs	0	0
Total finance costs	**14,694**	**15,729**

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

	2020/21	2019/20
	£000	£000
Amounts included within interest payable arising from claims made under this legislation	5	4

Note 13 Other gains / (losses)

	2020/21	2019/20
	£000	£000
Gains on disposal of assets	16	73
Total gains / (losses) on disposal of assets	**16**	**73**
Total other gains / (losses)	**16**	**73**

All gains on disposals of assets relates to disposals of Plant Property and Equipment, primarily on medical equipment and vehicles

Note 14.1 Intangible assets - 2020/21

	Software licences	Internally generated information technology	Intangible assets under construction	Total
	£000	£000	£000	£000
Valuation / gross cost at 1 April 2020 - brought forward	**2,208**	**9,743**	**0**	**11,951**
Additions	0	254	2,906	**3,160**
Reclassifications/ transfers from Assets Under Construction	49	608	4,303	**4,960**
Disposals / derecognition	0	-38	0	**-38**
Valuation / gross cost at 31 March 2021	**2,257**	**10,567**	**7,209**	**20,033**
Amortisation at 1 April 2020 - brought forward	**612**	**7,382**	**0**	**7,994**
Provided during the year	276	1,143	0	**1,419**
Disposals / derecognition	0	-38	0	**-38**
Amortisation at 31 March 2021	**888**	**8,487**	**0**	**9,375**
Net book value at 31 March 2021	**1,369**	**2,080**	**7,209**	**10,658**
Net book value at 1 April 2020	**1,596**	**2,361**	**0**	**3,957**

The debit value of £4.960m on reclassifications/transfers from assets under construction relates to items transferred from Tangible assets, see note 15.1

Note 14.2 Intangible assets - 2019/20

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

Note 15.1 Property, plant and equipment - 2020/21

	Land	Buildings excluding dwellings	Dwellings	Assets under construction	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Valuation/gross cost at 1 April 2020 - brought forward	**12,414**	**245,957**	**0**	**8,797**	**88,926**	**652**	**22,148**	**2,797**	**381,691**
Additions	0	4,721	0	8,260	8,594	236	8,370	0	**30,181**
Impairments charged to operating expenses	0	-4,046	0	0	0	0	-1,262	0	**-5,308**
Impairments charged to the revaluation reserve	0	-4,336	0	0	0	0	0	0	**-4,336**
Reversal of impairments credited to operating expenses	0	609	0	0	0	0	0	0	**609**
Reversal of impairments credited to the revaluation reserve	35	1,523	0	0	0	0	0	0	**1,558**
Revaluations	5	-4,080	0	0	0	0	0	0	**-4,075**
Reclassifications/ transfers from Assets Under Construction	0	461	0	-7,925	2,078	0	426	0	**-4,960**
Disposals / derecognition	0	0	0	0	-8,346	-278	-9,552	0	**-18,176**
Valuation/gross cost at 31 March 2021	**12,454**	**240,809**	**0**	**9,132**	**91,252**	**610**	**20,130**	**2,797**	**377,184**
Accumulated depreciation at 1 April 2020 - brought forward	**0**	**110**	**0**	**0**	**67,642**	**652**	**19,726**	**2,374**	**90,504**
Provided during the year	0	6,060	0	0	4,865	0	1,232	252	**12,409**
Revaluations	0	-6,005	0	0	0	0	0	0	**-6,005**
Disposals / derecognition	0	0	0	0	-8,346	-278	-9,552	0	**-18,176**
Accumulated depreciation at 31 March 2021	**0**	**165**	**0**	**0**	**64,161**	**374**	**11,406**	**2,626**	**78,732**
Net book value at 31 March 2021	**12,454**	**240,644**	**0**	**9,132**	**27,091**	**236**	**8,724**	**171**	**298,452**
Net book value at 1 April 2020	**12,414**	**245,847**	**0**	**8,797**	**21,284**	**0**	**2,422**	**423**	**291,187**

note - the adjustments within the disposal/derecognition line relates to housekeeping exercise clearing zero Net Book Value assets for previously disposed PPE. For further analysis on Assets under Construction can be found in Note 15.3.

The credit value of £4.960m on reclassifications/transfers from assets under construction relates to items on Intangible assets, see note 14

Note 15.2 Property, plant and equipment - 2019/20

	Land	Buildings excluding dwellings	Dwellings	Assets under construction	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Valuation / gross cost at 1 April 2019 - as previously stated	**12,114**	**267,652**	**419**	**5,872**	**88,348**	**844**	**20,912**	**2,797**	**398,958**
Valuation / gross cost at 1 April 2019 - restated	**12,114**	**267,652**	**419**	**5,872**	**88,348**	**844**	**20,912**	**2,797**	**398,958**
Additions	0	2,391	0	8,652	3,293	0	1,019	0	**15,355**
Impairments	0	-6,391	0	0	0	0	-565	0	**-6,956**
Reversals of impairments	300	2,245	0	0	0	0	0	0	**2,545**
Revaluations	0	-19,940	0	0	0	0	0	0	**-19,940**
Reclassifications	0	0	0	-5,727	4,601	0	841	0	**-285**
Disposals / derecognition	0	0	-419	0	-7,316	-192	-59	0	**-7,986**
Valuation/gross cost at 31 March 2020	**12,414**	**245,957**	**0**	**8,797**	**88,926**	**652**	**22,148**	**2,797**	**381,691**
Accumulated depreciation at 1 April 2019 - as previously stated	**0**	**14,052**	**419**	**0**	**70,574**	**840**	**18,690**	**2,118**	**106,693**
Accumulated depreciation at 1 April 2019 - restated	**0**	**14,052**	**419**	**0**	**70,574**	**840**	**18,690**	**2,118**	**106,693**
Provided during the year	0	6,074	0	0	4,384	4	1,095	256	**11,813**
Revaluations	0	-20,016	0	0	0	0	0	0	**-20,016**
Disposals / derecognition	0	0	-419	0	-7,316	-192	-59	0	**-7,986**
Accumulated depreciation at 31 March 2020	**0**	**110**	**0**	**0**	**67,642**	**652**	**19,726**	**2,374**	**90,504**
Net book value at 31 March 2020	**12,414**	**245,847**	**0**	**8,797**	**21,284**	**0**	**2,422**	**423**	**291,187**
Net book value at 1 April 2019	**12,114**	**253,600**	**0**	**5,872**	**17,774**	**4**	**2,222**	**679**	**292,265**

Note 15.3 Property, plant and equipment financing - 2020/21

	Land	Buildings excluding dwellings	Dwellings	Assets under construction	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Net book value at 31 March 2021									
Owned - purchased	12,454	88,379	0	9,132	24,643	236	8,646	171	**143,661**
On-SoFP PFI contracts and other service concession arrangements	0	152,202	0	0	0	0	0	0	**152,202**
Owned - donated/granted	0	63	0	0	2,448	0	78	0	**2,589**
NBV total at 31 March 2021	**12,454**	**240,644**	**0**	**9,132**	**27,091**	**236**	**8,724**	**171**	**298,452**

Note 15.4 Property, plant and equipment financing - 2019/20

	Land	Buildings excluding dwellings	Dwellings	Assets under construction	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Net book value at 31 March 2020									
Owned - purchased	12,414	90,054	0	8,797	19,587	0	2,331	423	**133,606**
On-SoFP PFI contracts and other service concession arrangements	0	155,458	0	0	0	0	0	0	**155,458**
Owned - donated/granted	0	335	0	0	1,697	0	91	0	**2,123**
NBV total at 31 March 2020	**12,414**	**245,847**	**0**	**8,797**	**21,284**	**0**	**2,422**	**423**	**291,187**

Assets under construction (AUC) in year additions of £11.1m relates to Plant & Machinery £6m, IT £2.4m, Intangible of £2.9m and Transport £0.2m. These are assets at 31.3.21 are classed as "work in progress" and were not available for use at the end of 2020-21.

The main AUC projects are: 1) Electronic Patient Records System - £6.9m; 2) Linear Accelerator Machine £2.5m; 3) MRI £1.3m; 4) IT network infrastructure £1.3m; 5) Interventinal radiology £0.7m; 6) Ophthalmology Services £0.7m; 7) Breast Screening Equipment £0.7m and 8) CT Simulator for Radiotherapy £0.6m,

The Trust spent £31.7m on tangible assets and £0.2m on intangible assets from its capital resource in 2020-21. The main items were as follows: Covid-19 IT & equipment (e.g. ventilators), £3m; Electronic Patient Record project £2.9m; ICT Devices replacement project £5.5m plus £0.7m for reset and recovery; Network infrastructure £2.7m; Kent Care record and Think 111 projects £1.1m; expenditure of £2.8m in Urgent & Emergency Care improvements; £2.9m of estates backlog, renewal and PFI Lifecycle. Medical equipment included: £2.3m on a replacement Linear Accelerator machine for radiotherapy at Canterbury; £1.8m on endoscopy equipment; £1.1m replacing major breast screening equipment; £0.9m updating and expanding critical care capacity and testing equipment (supporting C-19 treatment); £0.7m renewing the Interventional Radiology equipment at Maidstone; £0.6m for a new CT simulator for cancer patients; £0.7m for ophthalmology equipment supporting the service transferred from Moorfields Hospital; and £2.0m of general Trust wide equipment replacement. In addition £1.4m of donated capital was recognised in the year which is described in note 16.

Note 16 Donations of property, plant and equipment

In the financial year 2020-21 the Trust recognised donated assets of £1.4m including Trust purchased and centrally procured loan equipment. The Trust acquired three assets from charitable funds and grants totalling £0.3m; of which the most significant was a prone biopsy table for £0.2m. The remaining balance relates to assets loaned to the Trust from DHSC to support clinical teams with Covid-19. These assets will be transferred formally to the Trust in 2021-22 (assuming the Trust wishes to retain them) and all Trusts were instructed to account for these assets within 2020-21 as donated assets.

The most significant of these loan equipment's are 9 ventilators £0.3m, testing equipment £0.4m, mobile x-rays £0.3m.

Note 17 Revaluations of property, plant and equipment

The Trust's depreciation on tangible assets (including donated) in the year was £12.4m and amortisation for intangible assets £1.4m.

The Trust has carried out housekeeping exercise on its zero valued assets held in its asset register. Throughout 2020-21 the Trust reviewed these assets and de-recognised any zero valued assets (excluding Build and Land) that the Trust confirmed as having been disposed. Going forward the Trust will continue to review any zero valued assets held.

The previous financial year a full valuation was undertaken in accordance with the five year cyclical valuation period. in keeping with the Trust previous practice a desktop valuation was commissioned from independent professional valuers, Montagu Evans LLP. This was undertaken on the Trust's Land and Building assets as at 31st March 2021. The lead relationship partner from Montagu Evans LLP is qualified to BSc MRICS.

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

The 31st March 2021 valuation resulted in an overall decrease in the carrying value of the Trust's Land and Property assets as at the 31st March of £4.3m, of which (£4m) is an in year charge to I&E impairments and £0.6m reversed previous I&E impairments: both of these are reflected in operating expenses. (£4.3m) relates to an in year impairment charge to the revaluation reserve and £1.6m reversed previous impairments taken to the revaluation reserve. The downward valuations are driven by an overall reduction in the BCIS indices reflecting the market. However, for some component assets driven by specific BCIS elements there was an increase of £1.9m with no previous reversal to the revaluation reserve. The valuer considered the remaining useful economic lives of the assets taking into account backlog and capital work undertaken between valuations, and the age and condition of the properties.

The valuer has reported that at the valuation date property markets are functioning sufficiently to provide an adequate quantum of market evidence on which to base the opinions of value. Therefore, the valuation is not reported as being subject to a "material valuation uncertainty" as it was in 2019-20.The valuer has continued to exercise professional judgement in providing the valuation; the Trust has reviewed and challenged the valuation in detail and is satisfied that this remains the best information to the Trust.

Fixtures and Fittings are carried at depreciated historic cost as this is not considered to be materially different from fair value. The Trust has reviewed its plant and machinery assets to ensure that both the value and the remaining lives are held at the correct values. An assessment of current value in exisiting use of IT devices (PCs, Laptops and IPads) assets has been carried out based on a valuation model as advised by Trust experts, this is in accordance with the Trust's policy 1.9

Note 18 Inventories

	31 March 2021 £000	31 March 2020 £000
Drugs	3,209	3,332
Consumables	1,089	975
Consumables donated from DHSC group	1,581	0
Energy	108	108
Other	4,001	4,478
Total inventories	**9,988**	**8,893**

Inventories recognised in expenses for the year were £56,932k (2019/20: £57,154k). Write-down of inventories recognised as expenses for the year were £673k (2019/20: £0k).

The inventories written down value of £0.7m (2019-20 £nil) relates to consumables donated from DHSC group bodies for Covid response. The £0.7m relates to the difference of the lower of the market values held at the financial year end and the unit prices held for each personal protective equipment item. All the pricing information was provided by the DHSC.

In response to the COVID 19 pandemic, the Department of Health and Social Care centrally procured personal protective equipment and passed these to NHS providers free of charge. During 2020/21 the Trust received £7,690k of items purchased by DHSC.

These inventories were recognised as additions to inventory at deemed cost with the corresponding benefit recognised in income. The utilisation of these items is included in the expenses disclosed above.

Note 19.1 Receivables

	31 March 2021 £000	31 March 2020 £000
Current		
Contract receivables**	7,239	27,526
Capital receivables	0	107
Allowance for impaired contract receivables / assets*	-1,358	-1,556
Prepayments (non-PFI)	5,206	4,299
PDC dividend receivable	1,136	963
VAT receivable	3,702	2,424
Other receivables	887	1,393
Total current receivables	**16,812**	**35,156**
Non-current		
Contract receivables	1,474	1,471
Allowance for impaired contract receivables / assets*	-924	0
PFI lifecycle prepayments (Revenue variations)	202	205
PFI lifecycle prepayments (Capital)	999	339
Other receivables - Clinician Pension	1,065	910
Total non-current receivables	**2,816**	**2,925**
Of which receivable from NHS and DHSC group bodies:		
Current	5,769	24,678
Non-current	1,065	910

The majority of trade is with Clinical Commissioning Groups (CCGs) as commissioners for NHS patient care services. As CCGs are funded by Government to buy NHS patient care services, no credit scoring of them is considered necessary. The calculation for the allowance of other impaired receivables has been amended to reflect the change in IFRS 9 accounting standards for provision of expected credit losses. Please see note 19.2 for further information.

* For 2020/21 the allowance for impaired contract receivables has been split between non-current and current in respect to RTA CRU receivables. This was not required for 2019/20. For further details on allowance for impaired receivables please see note 19.2.

** The variance between years for contract receivables is due to the new finance regime implemented during Covid 19. To ensure the flow of funds throughout NHS organisations; NHSE Guidelines recommended fixed charges between provider to providers therefore resulting in a reduction of aged debtor balances.

Note 19.2 Allowances for credit losses

	2020/21		2019/20	
	Contract receivables and contract assets	All other receivables	Contract receivables and contract assets	All other receivables
	£000	£000	£000	£000
Allowances as at 1 April - brought forward	**1,556**	**0**	**1,398**	**0**
Allowances as at 1 April - restated	**1,556**	**0**	**1,398**	**0**
New allowances arising	1,403	0	904	0
Reversals of allowances	-646	0	-433	0
Utilisation of allowances (write offs)	-31	0	-313	0
Allowances as at 31 Mar 2021	**2,282**	**0**	**1,556**	**0**

Following the implementation of IFRS 9 in 2018-19 the Trust is required to measure the loss allowance of lifetime expected credit losses at initial recognition of the debt being raised. This is assessed by looking at classes of debtor with common credit characteristics.

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

Under IFRS 9 the Trust attributed the trade debtors into six categories grouped by similar characteristics with assessment based on prior year debt write off levels. Due to Covid 19 and the heightened risk to the economy the Trust has taken a prudent view and for all trade debt categories these are now fully provided for over 60 days

Injury Cost recovery – the Trust decided to adopt its own methodology over 5 years ago and moved away from the DHSC given bad debt provision rate to calculate its own rate. The calculation was based looking at historic data for both the Maidstone and Tunbridge Wells site and comparing the amount of write offs to the initial claim. Given the heightened risk to the economy, for 2021 the Trust has provided in full for all prior year debt, and for 2020/21 the Trust will has reverted back to using the DHSC given rate of 22.43%.

Note 19.3 Exposure to credit risk

The Trust adheres to best practice in credit control activities which includes referral to an external debt collection agency and formal litigation procedures if required to trace debtors and seek to recover overdue debt. In addition the majority of the Trust's revenue comes from contracts with other public sector bodies which in turn are supported by underlying contractual agreements and specific payment terms. As a result, it is deemed that the Trust has a low exposure to credit risk.

Expected credit losses for contract and other receivables are reviewed on a regular basis taking account of historic, current and forecast information to determine a sufficient and appropriate level of allowance for impaired contract and other receivables.

Note 20 Cash and cash equivalents movements

Cash and cash equivalents comprise cash at bank, in hand and cash equivalents. Cash equivalents are readily convertible investments of known value which are subject to an insignificant risk of change in value.

	2020/21	2019/20
	£000	£000
At 1 April	**3,355**	**10,406**
Prior period adjustments		0
At 1 April (restated)	**3,355**	**10,406**
Net change in year	22,866	-7,051
At 31 March	**26,221**	**3,355**
Broken down into:		
Cash at commercial banks and in hand	23	24
Cash with the Government Banking Service	26,198	3,331
Total cash and cash equivalents as in SoFP	**26,221**	**3,355**
Total cash and cash equivalents as in SoCF	**26,221**	**3,355**

The high closing cash balance for 2020/21 relates to £8.6m SLA income adjustment to CCG, £4.8m annual leave funding received to fund the accrual which will be released in 2021/22 and £5.4m to fund capital invoices received in April which relate to 2020/21 capital programme.

Note 21 Trade and other payables

	31 March 2021	31 March 2020
	£000	£000
Current		
Trade payables	13,093	12,615
Capital payables	6,110	4,046
Accruals	26,648	15,194
Social security costs	5	1,520
Other taxes payable	0	2,919
Other payables	3,078	2,650
Total current trade and other payables	**48,934**	**38,944**
Of which payables from NHS and DHSC group bodies:		
Current	11,291	7,659

Included within Accruals value above is an estimate for annual leave untaken of £4.7m.

Note 22 Other liabilities

	31 March 2021	31 March 2020
	£000	£000
Current		
Deferred income: contract liabilities	2,454	3,172
Total other current liabilities	**2,454**	**3,172**

Note 23.1 Borrowings

	31 March 2021	31 March 2020
	£000	£000
Current		
Loans from DHSC	985	27,768
Other loans	443	443
Obligations under PFI, LIFT or other service concession contracts	5,402	5,349
Total current borrowings	**6,830**	**33,560**
Non-current		
Loans from DHSC	5,432	6,406
Other loans	949	1,300
Obligations under PFI, LIFT or other service concession contracts	176,771	182,173
Total non-current borrowings	**183,152**	**189,879**

Within 2020/21 the Trust received £26.1m Public Dividend Capital to repay the working capital loans from DHSC.

The Trust also has Salix loans total value of £1.4m which appears in "other loans" in both current and non current borrowings, this relates to improving the energy efficiency of the Trust. These loans are repayable over 5 years and is interest free. Salix Finance Ltd provides interest-free Government funding to the public sector to improve their energy efficiency, reduce carbon emissions and lower energy bills.

Under IFRS 9 the loan values also include their associated interest charges.

Note 23.2 Reconciliation of liabilities arising from financing activities - 2020/21

	Loans from DHSC	Other loans	Finance leases	PFI and LIFT schemes	Total
	£000	£000	£000	£000	£000
Carrying value at 1 April 2020	**34,174**	**1,743**	**0**	**187,522**	**223,439**
Cash movements:					
Financing cash flows - payments and receipts of principal	-27,696	-351	0	-5,349	**-33,396**
Financing cash flows - payments of interest	-342	0	0	-9,816	**-10,158**
Non-cash movements:					
Application of effective interest rate	281	0	0	9,816	**10,097**
Carrying value at 31 March 2021	**6,417**	**1,392**	**0**	**182,173**	**189,982**

Note 23.3 Reconciliation of liabilities arising from financing activities - 2019/20

	Loans from DHSC	Other loans	Finance leases	PFI and LIFT schemes	Total
	£000	£000	£000	£000	£000
Carrying value at 1 April 2019	**53,289**	**2,115**	**0**	**192,948**	**248,352**
Prior period adjustment	0	0	0	0	**0**
Carrying value at 1 April 2018 - restated	**53,289**	**2,115**	**0**	**192,948**	**248,352**
Cash movements:					
Financing cash flows - payments and receipts of principal	-19,082	-372	0	-5,426	**-24,880**
Financing cash flows - payments of interest	-1,387	0	0	-10,110	**-11,497**
Non-cash movements:					
Application of effective interest rate	1,354	0	0	10,110	**11,464**
Carrying value at 31 March 2020	**34,174**	**1,743**	**0**	**187,522**	**223,439**

Note 24 Provisions for liabilities and charges analysis

	Pensions: injury benefits	Legal claims	2019/20 clinicians' pension reimbursement	Other	Total
	£000	£000	£000	£000	£000
At 1 April 2020	**464**	**391**	**930**	**1,616**	**3,401**
Change in the discount rate	22	0	162	0	**184**
Arising during the year	32	771	0	718	**1,521**
Utilised during the year	-24	-11	0	0	**-35**
Reversed unused	0	-46	0	0	**-46**
Unwinding of discount	1	0	0	0	**1**
At 31 March 2021	**495**	**1,105**	**1,092**	**2,334**	**5,026**
Expected timing of cash flows:					
- not later than one year;	25	1,105	27	2,069	**3,226**
- later than one year and not later than five years;	99	0	59	86	**244**
- later than five years.	371	0	1,006	179	**1,556**
Total	**495**	**1,105**	**1,092**	**2,334**	**5,026**

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

Legal claims are notified at year end to the Trust from NHS Resolution and other solicitors that the Trust engages with.

"Other" includes the provision for dilapidations of leased properties of £0.7m and equipment of £1.5m.

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

Note 24.1 Clinical negligence liabilities

At 31 March 2021, £266,300k was included in provisions of NHS Resolution in respect of clinical negligence liabilities of Maidstone and Tunbridge Wells NHS Trust (31 March 2020: £230,759k).

Note 25 Contingent assets and liabilities

	31 March 2021	31 March 2020
	£000	£000
Value of contingent liabilities		
NHS Resolution legal claims	-43	-22
Net value of contingent liabilities	**-43**	**-22**
Net value of contingent assets	**0**	**0**

Contingent liability for 2020/21 relates to legal claims notified by NHS Resolution of £43k.

Note 26 Contractual capital commitments

	31 March 2021	31 March 2020
	£000	£000
Property, plant and equipment	350	1,994
Intangible assets	326	0
Total	**676**	**1,994**

Note 27 Other financial commitments

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

Note 28 On-SoFP PFI, LIFT or other service concession arrangements

The Trust signed a PFI project agreement on 26th March 2008 for the new Tunbridge Wells Hospital at Pembury. The main building was handed over by the contractor in phases in December 2010 and May 2011 and recognised in the Trust's accounts accordingly. By joint agreement with the Trust's PFI partner the final phase of car parking & landscaping were completed and handed over early in January 2012, although contractual phasing and unitary payments were kept in line with the project agreement completion date of September 2012. The arrangement covers the provision of buildings, hard facilities management services and lifecycle replacement (building & engineering asset renewals). Under the project agreement the Trust has agreed expectations for the provision of these services and has termination options on default. The land remains the Trust's asset throughout the concession. The concession is due to run for 30 years until 2042 when the building will revert to the Trust. The annual unitary payment was contracted at £16.9m at 2005/06 prices, and is subject to an annual uplift by Retail Price Index which for the 2020/21 year was 2.46%. The RPI uplift for 2021/22 is 1.37%.

Note 28.1 On-SoFP PFI, LIFT or other service concession arrangement obligations

The following obligations in respect of the PFI, LIFT or other service concession arrangements are recognised in the statement of financial position:

	31 March 2021	31 March 2020
	£000	£000
Gross PFI, LIFT or other service concession liabilities	**306,014**	**321,178**
Of which liabilities are due		
- not later than one year;	14,942	15,165
- later than one year and not later than five years;	59,344	59,758
- later than five years.	231,728	246,255
Finance charges allocated to future periods	-123,841	-133,656
Net PFI, LIFT or other service concession arrangement obligation	**182,173**	**187,522**
- not later than one year;	5,402	5,349
- later than one year and not later than five years;	24,229	23,393
- later than five years.	152,542	158,780

Note 28.2 Total on-SoFP PFI, LIFT and other service concession arrangement commitments

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

	31 March 2021	31 March 2020
	£000	£000
Total future payments committed in respect of the PFI, LIFT or other service concession arrangements	**744,896**	**772,816**
Of which payments are due:		
- not later than one year;	26,567	26,000
- later than one year and not later than five years;	113,114	110,665
- later than five years.	605,215	636,151

Note 28.3 Analysis of amounts payable to service concession operator

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

	2020/21	2019/20
	£000	£000
Unitary payment payable to service concession operator	**25,989**	**25,365**
Consisting of:		
- Interest charge	9,816	10,110
- Repayment of balance sheet obligation	5,349	5,426
- Service element and other charges to operating expenditure	5,257	4,975
- Capital lifecycle maintenance	315	434
- Contingent rent	4,591	4,260
- Addition to lifecycle prepayment	661	160
Other amounts paid to operator due to a commitment under the service concession contract but not part of the unitary payment	160	224
Total amount paid to service concession operator	**26,149**	**25,589**

Note 29 Off-SoFP PFI, LIFT and other service concession arrangements

The Trust has no Off-SoFP schemes.

Note 30 Financial instruments

Note 30.1 Financial risk management

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

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

Currency risk

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

Interest rate risk

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

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

The Trust therefore has low exposure to interest rate fluctuations.

Credit risk

Because the majority of the Trust's revenue comes from contracts with other public sector bodies, the Trust has low exposure to credit risk. The maximum exposures as at 31 March 2021 are in receivables from customers, as disclosed in the trade and other receivables note.

Liquidity risk

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

Note 30.2 Carrying values of financial assets

Carrying values of financial assets as at 31 March 2021	Held at amortised cost	Held at fair value through I&E	Held at fair value through OCI	Total book value
	£000	£000	£000	£000
Trade and other receivables excluding non financial assets	8,224	0	0	**8,224**
Other investments / financial assets	0	0	0	**0**
Cash and cash equivalents	26,221	0	0	**26,221**
Total at 31 March 2021	**34,445**	**0**	**0**	**34,445**

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

Note 30.3 Carrying values of financial liabilities

Carrying values of financial liabilities as at 31 March 2021	Held at amortised cost	Held at fair value through I&E	Total book value
	£000	£000	£000
Loans from the Department of Health and Social Care	6,417	0	**6,417**
Obligations under finance leases	0	0	**0**
Obligations under PFI, LIFT and other service concession contracts	182,173	0	**182,173**
Other borrowings	1,392	0	**1,392**
Trade and other payables excluding non financial liabilities	44,120	0	**44,120**
Other financial liabilities	0	0	**0**
Provisions under contract	0	0	**0**
Total at 31 March 2021	**234,102**	**0**	**234,102**

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

Note 30.4 Fair Values of Financial Assets and Liabilities

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

Note 31 Losses and special payments

	2020/21		2019/20	
	Total number of cases	Total value of cases	Total number of cases	Total value of cases
	Number	£000	Number	£000
Losses				
Cash losses	15	18	15	22
Bad debts and claims abandoned	18	16	22	349
Total losses	**33**	**34**	**37**	**371**
Special payments				
Compensation under court order or legally binding arbitration award	0	0	1	1
Ex-gratia payments	27	18	35	12
Total special payments	**27**	**18**	**36**	**13**
Total losses and special payments	**60**	**52**	**73**	**384**
Compensation payments received		0		0

The Trust has no cases exceeding £300k.

In keeping with policy 1.24 this note includes losses and compensations paid and accrued but excludes provisions, which are reported under Note 24.

Note 32 Gifts

There were no gifts made by the Trust in 2020/21.

Note 33 Related parties

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

The Department of Health and Social Care (DHSC) is regarded as a related party. During the year 2020/21 the Trust has received £26.1m Revenue Public Dividend Capital (PDC) and £18.8m Capital funding in the form of PDC. The Trust also has loans with DHSC, interest paid within the year £0.3m, principal repayment of £27.7m. The Trust has repaid all the working capital loans within 2020/21. The Trust has also had a significant number of material transactions with other entities for which the Department is regarded as the parent department eg NHSE/I. Other public sector bodies are recognised as relevant who are not part of the DHSC group eg HMRC. The following entities with material transactions of more than £1m are listed below:

East Sussex CCG
Kent and Medway CCG
South East London CCG
West Sussex CCG
NHS England
Health Education England
Kent Community Foundation Trust
East Kent University Hospitals Foundation Trust
Medway NHS Foundation Trust
Dartford and Gravesham NHS Trust
HMRC
NHS Pension Authority
NHS Resolution
NHS Supply Chain
NHS Blood and Transplant
NHS Property Services
Kent County Council

The Trust has also received revenue and capital payments from the Charitable Funds that it controls, the trustees for which are also members of the Trust Board. The Trust has not consolidated the Charitable Funds on the grounds of materiality to the Trust (see policy notes 1.3). The transactions between the Trust and the Charity (Maidstone and Tunbridge Wells NHS Charitable Fund - charity registration number 1055215) are however material to the charity and therefore are disclosed below. Please note that this disclosure is based on the draft unaudited position of the charity. The audited accounts of the charity will be available later this year.

	2020-21	2019-20
	£000s	£000s
Total charitable resources expended with the Trust	**217**	1,038
Closing creditor (monies owed to the Trust by the Charity)	**407**	589
Total income received by the Charity in the reporting period	**540**	720
Total Charitable Funds at end of the reporting period	**1,083**	763

Note 34 Prior period adjustments

The Trust has not made any prior period adjustments.

Note 35 Events after the reporting date

The Trust has no events after the reporting date

Note 36 Better Payment Practice code

	2020/21	2020/21	2019/20	2019/20
Non-NHS Payables	**Number**	**£000**	**Number**	**£000**
Total non-NHS trade invoices paid in the year	92,876	218,998	109,425	196,467
Total non-NHS trade invoices paid within target	89,409	205,094	90,990	168,173
Percentage of non-NHS trade invoices paid within target	96.3%	93.7%	83.2%	85.6%
NHS Payables				
Total NHS trade invoices paid in the year	3,194	39,080	2,728	38,336
Total NHS trade invoices paid within target	2,099	33,006	1,825	34,024
Percentage of NHS trade invoices paid within target	65.7%	84.5%	66.9%	88.8%

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

Note 37 External financing limit

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

	2020/21	2019/20
	£000	**£000**
Cash flow financing	-11,322	-13,214
External financing requirement	**-11,322**	**-13,214**
External financing limit (EFL)	-7,032	-12,858
Under / (over) spend against EFL	**4,290**	**356**

The Trust financed its operating and capital investment activities with £4.3m less cash requirement than expected. This was supported by the national funding regime e.g cash backed annual leave accrual.

Note 38 Capital Resource Limit

	2020/21	2019/20
	£000	**£000**
Gross capital expenditure	33,341	16,891
Less: Donated and granted capital additions	-1,392	-890
Charge against Capital Resource Limit	**31,949**	**16,001**
Capital Resource Limit	32,361	16,218
Under / (over) spend against CRL	**412**	**217**

The £412k underspend against capital resource limit reflects the reimbursement in 2020/21 of Covid-19 capital claims relating to 2019/20 capital expenditure. The Trust was reimbursed by means of additional PDC but this was not available to re-utilise in 2020/21.

Note 39 Breakeven duty financial performance

	2020/21
	£000
Adjusted financial performance surplus / (deficit) (control total basis)	330
Remove impairments scoring to Departmental Expenditure Limit	0
Add back non-cash element of On-SoFP pension scheme charges	0
IFRIC 12 breakeven adjustment	0
Breakeven duty financial performance surplus / (deficit)	**330**

There is no adjustment for the PFI (IFRIC 12) accounting as the on-balance sheet impacts to I&E are currently lower than the equivalent off-balance sheet reporting.

Note 40 Breakeven duty rolling assessment

	2008/09	2009/10	2010/11	2011/12	2012/13	2013/14	2014/15
	£000	£000	£000	£000	£000	£000	£000
Breakeven duty in-year financial performance		189	1,710	300	129	-12,374	157
Breakeven duty cumulative position	-3,260	-3,071	-1,361	-1,061	-932	-13,306	-13,149
Operating income		311,889	322,176	345,101	367,391	375,714	403,310
Cumulative breakeven position as a percentage of operating income		-0.98%	-0.42%	-0.31%	-0.25%	-3.54%	-3.26%

	2015/16	2016/17	2017/18	2018/19	2019/20	2020/21
	£000	£000	£000	£000	£000	£000
Breakeven duty in-year financial performance	-23,413	-10,918	-10,790	20,324	7,587	330
Breakeven duty cumulative position	-36,562	-47,480	-58,270	-37,946	-30,359	-30,029
Operating income	400,930	430,502	440,269	473,169	513,056	564,196
Cumulative breakeven position as a percentage of operating income	-9.12%	-11.03%	-13.24%	-8.02%	-5.92%	-5.32%

The Trust's last formal 3 year break-even cycle commenced in 2013/14 and was not met by the end of the period in 2015/16. The Trust has achieved in year break even duty surpluses and met its NHSEI control totals in each of the last three financial years. The Trust is not in any formal recovery regime relating to recovering its historic accumulated deficit but is required to achieve the in year break even position agreed as part of the overall Kent & Medway STP system control total. The Trust delivered a surplus of £0.3m in 2020/21 which was slightly better than plan and its system control total requirement.

Thank you for your support

Miles Scott, Chief Executive

David Highton, Chair of the Trust Board

The Trust receives support and well wishes from patients, carers, stakeholders, volunteers, and fundraisers. This support is expressed in a varied number of ways, including compliments sent directly to the Trust; letters sent to the local media; comments posted on social media; participation in the Patient Experience Committee; attendance at Trust Board meetings and the Annual General Meeting and fundraising to buy much needed equipment, to name but a few. This support is highly valued by the Trust's staff and the Board - without this, the Trust's task would be far harder. Thank you all.

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NHS
Maidstone and Tunbridge Wells
NHS Trust

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