TRUST BOARD MEETING

Formal meeting, which is open to members of the public (to observe). Please note that questions from members of the public should be asked at the end of the meeting, and relate to one of the agenda items

NHS Maidstone and Tunbridge Wells NHS Trust

10.30am – c.1pm WEDNESDAY 24TH MAY 2017
PENTECOST/SOUTH ROOMS, THE ACADEMIC CENTRE, MAIDSTONE HOSPITAL

A G E N D A – PART 1

Ref.	Item	Lead presenter/s	Attachment
5-1	To receive apologies for absence	Chair	Verbal
5-2	To declare interests relevant to agenda items	Chair	Verbal
5-3	Minutes of the Part 1 meeting of 26th April 2017	Chair	1
5-4	To note progress with previous actions	Chair	2
5-5	Safety moment	Chief Nurse	Verbal
5-6	Chair's report	Chair	Verbal
5-7	Chief Executive's report	Chief Executive	3
5-8	Integrated Performance Report for April 2017 ▪ Effectiveness / Responsiveness ▪ Safe / Effectiveness / Caring ▪ Safe (infection control) ▪ Well-Led (finance) ▪ Well-Led (workforce) ▪ Safe / Effectiveness (incl. mortality)	Chief Executive Chief Operating Officer Chief Nurse Dir. of Infect. Prev. & Control Director of Finance Director of Workforce Medical Director	4
	Quality items		
5-9	Planned and actual ward staffing for April 2017	Chief Nurse	5
	Assurance and policy		
5-10	Update on the implementation of the PAS+ (incl. the outcome of the 3 assurance programmes)	Chief Operating Officer	6
5-11	NHS Provider licence: Self-certification for 2016/17	Trust Secretary	7
	Reports from Board sub-committees (and the Trust Management Executive)		
5-12	Audit and Governance Committee, 04/05/17 & 24/05/17 (incl. Audit and Governance Cttee Annual Report for 2016/17)	Committee Chair	8
5-13	Quality Committee, 03/05/17	Committee Chair	9
5-14	Trust Management Executive, 17/05/17	Committee Chair	10
5-15	Finance Cttee, 22/05/17 (incl. approval of the Business Case to replace 2 Linear Accelerators; and quarterly progress update on Procurement Transformation Plan)	Committee Chair / Director of Finance	11 (to follow), 12 & 13
	Annual Report and Accounts		
5-16	Approval of the Annual Report, 2016/17 (incl. Governance Statement)	Chair of the Audit and Governance Committee	14
5-17	Approval of the Annual Accounts, 2016/17		15
5-18	Approval of the Management Representation Letter, 2016/17		16
5-19	**To consider any other business**		
5-20	**To receive any questions from members of the public**		
5-21	To approve the motion that in pursuance of the Public Bodies (Admission to Meetings) Act 1960, representatives of the press and public now be excluded from the meeting by reason of the confidential nature of the business to be transacted	Chair	Verbal

Date of next meetings:

- 28th June 2017, 10.30am, The Education Centre, Tunbridge Wells Hospital
- 19th July 2017, 10.30am, Academic Centre, Maidstone Hospital
- 7th September 2017 (time TBC, Academic Centre, Maidstone Hospital). N.B. Please note change of date from 27th September
- 18th October, 10.30am, Venue TBC
- 29th November, 10.30am, The Education Centre, Tunbridge Wells Hospital
- 20th December, 10.30am, The Education Centre, Tunbridge Wells Hospital

David Highton,
Chair of the Trust Board

MINUTES OF THE TRUST BOARD MEETING (PART 1) HELD ON WEDNESDAY 26TH APRIL 2017, 10.30A.M AT TUNBRIDGE WELLS HOSPITAL

NHS Maidstone and Tunbridge Wells NHS Trust

FOR APPROVAL

Present:	Kevin Tallett	Chair of the Trust Board	(KT)
	Glenn Douglas	Chief Executive	(GD)
	Sarah Dunnett	Non-Executive Director	(SDu)
	Angela Gallagher	Chief Operating Officer	(AG)
	Alex King	Non-Executive Director	(AK)
	Peter Maskell	Medical Director	(PM)
	Claire O'Brien	Interim Chief Nurse	(COB)
	Steve Orpin	Director of Finance	(SO)
In attendance:	Richard Hayden	Director of Workforce	(RH)
	Jim Lusby	Deputy Chief Executive	(JL)
	Sara Mumford	Director of Infection Prevention & Control	(SM)
	Kevin Rowan	Trust Secretary	(KR)
Observing:	Annemieke Koper	Staff Side representative	(AKo)
	Darren Yates	Head of Communications	(DY)
	Nick Anastasiou	Telefonica O2 UK Ltd	(NA)
	Pam Croucher	Healthwatch Kent Representative	(PC)
	David East	Member of the public	(DE)
	Jason Roberts	Cymbio Ltd	(JR)

4-1 To receive apologies for absence

There were no apologies.

4-2 To declare interests relevant to agenda items

No interests were declared.

4-3 Minutes of the Part 1 meeting of 29th March 2017

The minutes were agreed as a true and accurate record of the meeting, subject to the following amendment:

- Item 3-1, page 1 of 9: Replace: "Apologies were received from Sara Dunnett…" with "Apologies were received from Sarah Dunnett …".

Action: Amend the minutes of the Part 1 Trust Board meeting of 29th March 2017 (Trust Secretary, April 2017)

4-4 To note progress with previous actions

The circulated report was noted. The following actions were discussed in detail:

- **12-8iii ("Arrange for the next Trust Board 'Away Day' to discuss the 'new normal' levels of clinical activity seen at the Trust away day)**. KT asked for an update on the scheduling of the 'Away Day'. KR reported that the arrival of the new Chair of the Trust Board, David Highton, on 08/05/17, was awaited before arranging a date.

4-5 Safety moment

COB reported that the focus of the month was patient and staff safety, & highlighted the following:

- Incident reporting had been the focus of week 1, whilst week 2 focused on the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations (RIDDOR)
- Week 3 of the month was dedicated to Serious Incidents (SIs), and the classification of when an incident became an SI. Information had been issued regarding this, and also clarifying what constituted a Never Event. Finally, week 4 focused on learning from incidents

- The Safety calendar for May focused on dementia, to coincide with Dementia Awareness Week

SDu asked whether there was a plan to repeat the programme for the staff that may have been on Leave during April. COB confirmed that the information provided during the month was publicised via the intranet and the Chief Executive's weekly email, and was therefore still available to all staff. RH added that the Trust was also exploring the introduction of a staff engagement 'App', which could include such information. KT welcomed the intention to introduce this 'App', and also asked that consideration be given to assessing the impact of the Safety Moments. COB agreed this needed to be considered, and noted she had asked for feedback on the Safety Moments at the most recent meeting of the Trust Management Executive (TME). COB added that the Divisions each had their own approach to Safety Moments.

4-6 Chairman's report

KT confirmed he had nothing to report.

4-7 Chief Executive's report

GD referred to the circulated report and highlighted the following points:

- The end of March was a useful time to reflect on 2016/17, and it was important to note that the Trust had survived the winter period reasonably intact. This was of particular relevance when considering the impact on some neighbouring Trusts. GD thanked AG and all of those involved
- The Trust's rate of Clostridium difficile had improved from 2015/16, and sustaining the seismic improvements that had occurred in the previous 2 years was a remarkable achievement
- The Trust had also treated significantly more people than the previous year. Therefore, overall, the Trust had done as well as could have reasonably have expected
- It was clear that the NHS was facing a 'new norm' in relation to patient demand, and the contract levers now in place enabled the Trust to have more influence over the relevant factors for the first time
- It would be remiss of GD to not acknowledge the Trust's year-end financial deficit and non-achievement of key access targets, but GD believed the financial performance over the last 6 months of 2016/17 had been excellent, and staff should be commended for their efforts
- The Trust did not operate within a zero sum game, and the key issue was direction of travel, so the improvement seen during the year was important

KT concurred with GD's points. GD then referred to point 3, which related to the 'Mouth Care Matters' initiative, and stated he was pleased that a large step had been taken towards addressing an important aspect of patient care.

GD also referred to point 4, and noted the Trust was one of the few national pilots for Maternity services, and the region was seen as one of the best in the country. GD continued that Jenny Cleary (Head of Midwifery & Women's Health) should be thanked for her leadership, and there were many positive signs, including the progress made at Crowborough Birth Centre. GD added that the Maternity service was a starring light of the Trust's services and should be supported.

4-8 Year-end review of the Board Assurance Framework, 2016/17 / Agreement of key objectives for 2017/18

KR referred to the circulated report and highlighted the following points:

- There were 3 aspects to the report, the first of which was the year-end position against the objectives for 2016/17. The overall position was summarised in the table on page 1, and hopefully did not contain any surprises, in relation to the information submitted to the Trust Board and sub-committees throughout the year. The Finance Committee had reviewed the information relating to objectives 4.a and 4.b, and agreed with the year-end ratings
- The second aspect of the report was the proposed objectives for 2017/18, and all of the proposals had been discussed and agreed with the relevant member of the Executive Team
- The third aspect related to the format of the 2017/18 Board Assurance Framework (BAF), and it was proposed that the "Are the actions that had been planned for this point been taken?" rating be removed

SDu expressed support for the proposed objectives but queried whether there should be another, relating to elective activity, given the importance of this to the Trust's plans. KT stated that he agreed with SDu's logic. GD noted that he also agreed, but believed there needed to be a counterbalance, to reflect overall activity levels. It was therefore agreed to develop an activity-related objective.

Action: Liaise with the Chief Operating Officer and Chief Executive to agree the wording for an activity-related key objective for the 2017/18 Board Assurance Framework, and submit this to the Trust Board, for approval (Trust Secretary, May 2017)

GD then referred to proposed objective 4, and suggested that the wording be amended so that the objective was "To deliver the control total for 2017/18 (of a pre-STF deficit of no more £4.5m, or otherwise agreed by NHS Improvement)". This was agreed.

The other proposed objectives were approved as circulated.

The Trust Board also approved the proposals to remove the "Are the actions that had been planned for this point been taken?" rating from the 2017/18 BAF.

SDu then referred to page 5, and queried whether the risk that "The Trust does not have the correct level of substantive workforce for effective delivery" was truly "Fully achieved", given the work still required for the Lord Carter-related efficiency metrics. KR clarified that the "Fully achieved" rating pertained to the objective "To reduce the vacancy rate to 8.5%", and not to the risk. The point was acknowledged, but the importance of the Lord Carter-related work regarding workforce metrics was emphasised, and RH proposed that he submit a report to the June 2017 Workforce Committee meeting, and then report back to the Trust Board. PM pointed out that the Lord Carter-related work only represented a possible opportunity, but the questions posed by the Lord Carter data needed to be answered, and such work was continuing. PM therefore proposed that output from that work would be more appropriately reported and discussed at the Finance Committee, as was currently the case. This was agreed. It was therefore clarified that the report RH had offered to submit to the Workforce Committee was not required.

4-9 Integrated Performance Report for March 2017

KT referred to the circulated report and invited colleagues to highlight any issues arising.

Effectiveness / Responsiveness (incl. DTOCs)

AG highlighted the following points:

- The Trust had agreed a revised A&E 4-hour waiting time performance target with NHS Improvement (NHSI), of 87%, and 87.1% had been achieved, despite the huge increase in non-elective demand
- Planning for winter 2017 had commenced, and needed to reflect the aforementioned 'new norm'. Capacity and workforce (both internal and external) requirements needed to be considered as part of the planning
- The A&E 4-hour waiting time target remained a national NHS Constitutional target, and the Home First initiative remained the key infrastructure of the Trust's approach, in addition to pathways for frail elderly patients
- Performance on the 18-week Referral to Treatment (RTT) target was below the national requirement, but this was directly related to the inability to admit patients due to non-elective demand and the inability to discharge patients in a timely manner
- Delayed Transfers of Care (DTOCs) remained high
- The focus of performance for the Cancer 62-day waiting time target was on lower Gastrointestinal (GI) and Urology. There had been a small reduction in the waiting list backlog, but treating patients on the backlog (i.e. who had already waited over 62 days) would mean that performance on the target would not improve. However, the Cancer 2-week waiting time target had been met for 9 months in succession, and performance on the 31-day waiting time target was also good.
- Stroke performance had been strong recently, particularly in relation to the proportion of inpatients spending 90% of their time on a Stroke Unit

SDu referred to page 4, and asked for further comment on the RTT performance in Cardiology. AG reminded Trust Board Members that no Cardiology Day Case activity had been undertaken in Quarter 4 of 2015/16, but this had not been the case for Quarter 4 of 2016/17, so there should be a recovery of Cardiology-related RTT performance.

GD noted that Stroke performance had improved significantly, and looked very favourable when compared to neighbouring Trusts. GD also noted that the Trust had previously considered the development of a Hyper Acute Stroke Unit (HASU), and the Kent and Medway Sustainability and Transformation Plan (STP) had expressed a desire to include this aspect at the forefront of the public consultation that would take place in relation to the future of Stroke services.

Safe / Effectiveness / Caring

COB then highlighted the following points:

- The year-end pressure ulcer rate was 2.6 per 1000 admissions, which compared to a planned rate of 3.0. This was an improvement, but there was a desire to reduce the rate further
- The year-end falls rate was 6.07 per 1000 occupied bed days, and the achievement required effort from staff across the Trust. The number of falls-related SIs also reduced, but again there was a desire to reduce these further. A review meeting on falls was scheduled for 27/04/17, to consider the action taken, and the action that could be taken in the future, which included doing more to prevent falls in patients with dementia
- There had been 12 single sex accommodation breaches during the year, which predominantly related to an episode on the Maidstone Short Stay Surgical Unit (MSSU). However, the issue on MSSU had now been resolved, and there had been no breaches for the year thus far
- The number of complaints received had reduced slightly, but more action was required to improve the response rate. There had been some recruitment challenges within the Central Complaints Team, and these had been compounded by the recent withdrawal of a candidate who had been offered a position
- The response rate for the Friends and Family Test (FFT) had been good, particularly for A&E, who had worked very hard in March. The Trust had discussed its rate with the company who supported the Trust on FFT, and they had confirmed the Trust's A&E response rate was better than all of their other Trusts. However, the response rate for the Maternity FFT needed work, as many mothers had selected the 'don't know' option. The Maternity team were however completely engaged in the need to identify a solution.

KT commended the FFT rate in A&E, given the demand pressures faced by the Department.

Safe (infection control)

SM then highlighted the following points:

- The Trust breached its Clostridium difficile trajectory by 1 case, but the rate (per 100,000 Bed days) was 10.5%, which was below the target rate of 11.5%. The provisional national rate was 13.5%, whilst the rate in Kent, Surrey and Sussex was 12.6%. All but 3 of the Trusts in Kent, Surrey and Sussex had breached their trajectory by number, whilst 7 had breached their trajectory by rate. The Trust's 2017/18 Clostridium difficile trajectory was again a limit of 27 cases, and the target rate was expected to again be 11.5%
- The Trust still only had 2 MRSA bacteraemia cases in 2016/17, but there was still a desire to assign 1 of the cases to another Trust
- Performance on MRSA screening continued to be strong
- New data collection was required in relation to the target to reduce gram-negative bloodstream infections by 2020, and a baseline data collection would take place soon

Well-Led (finance)

SO then highlighted the following points:

- The draft Accounts for 2016/17 had been submitted on 25/04/17 and the year-end deficit was £11.918m. This should be considered in the context of the £23.4m deficit in 2015/16, and the original planned deficit for 2016/17 of £23.1m. Performance on a range of other financial metrics had also been maintained, so overall, the year-end position represented a significant positive change

- The impact of elective and non-elective activity had been better than expected in March, and March had also been the second lowest pay month in 2016/17
- The focus on Workforce Transformation would continue

KT commended the financial performance during the latter part of 2016/17, but acknowledged the size of the challenge in 2017/18, particularly in relation to the Cost Improvement Programme (CIP).

SDu drew attention to the increase in the use of Agency staff in the last Quarter of 2016/17, which needed to be monitored closely. SO noted this was specifically related to Nursing Agencies and in particular, cover for vacancies, as vacancy rates among Nursing staff had increased. SO did however report that the provisional data for April 2017 showed that the use of non-Framework Agencies had started to reduce.

Well-led (workforce)

RH then highlighted the following points:
- There had been an increase in staff turnover over the last 2 months. Although 9 of the top 10 areas were in corporate services, work was required in relation to Nursing staff, particularly given the national shortage of Nurses
- Sickness absence had reduced slightly from previous months, and the Trust's rate for 2016/17 was below the national average (of 4.3%). However, the need for further work was acknowledged

Safe / Effectiveness (incl. Mortality)

PM noted that mortality-related performance would be covered under item 4-10.

Quality Items

4-10 Outcome of the current investigations regarding mortality / increased HSMR

PM referred to the circulated report and highlighted the following points:
- Hospital Standardised Mortality Ratio (HSMR) and Summary Hospital-level Mortality Indicator (SHMI) were routinely reported to the Trust Board, and both measures were related to observed deaths compared to expected deaths
- When PM joined the Trust, the SHMI was 1.10. However, it had now been established that the true figure was 1.07, which was as expected. The Trust had been using the SHMI generated by Dr Foster, and not that produced by NHS Digital, which was calculated slightly differently (using an over-dispersion model, which Dr Foster did not use). Under the Dr Foster SHMI, the Trust was rated as 'red', whilst under the NHS Digital SHMI the Trust was rated as 'green'. The NHS Digital SHMI would therefore only be reported from now on, and the Trust Performance Dashboard would be changed. However, it was acknowledged that the difference between the 'red' and 'green' ratings was slight, so investigatory work would continue. SHMI was updated every 3 months, but also had a 3-month time lag. Dr Foster therefore produced a SHMI each month (as they did for HSMR). PM could produce a written report that described this particular situation, if the Board wished to receive this
- On a separate matter, a new national mortality review model had been published, and would be discussed at the 'main' Quality Committee on 03/05/17. A new mortality dashboard would need to be submitted to the Trust Board each Quarter containing certain mortality indicators, including the identification of any "deficits in care"
- The Trust's monthly HSMR trend was below 100, but the 12-monthly trend was still adversely affected by the high HSMR seen in April and May 2016. PM was optimistic that the 12-month rolling average will therefore be rated 'green' once the rate no longer included those months
- The Medical review of deaths for patients with a fractured neck of femur had not yet been completed, but the most recent GMC Junior Doctor survey had identified a need for additional Orthogeriatric support. The surgical review of deaths for patients with a fractured neck of femur had however been completed, and it was noted that circa 36% of such patients were not receiving surgery within the recommended timeframe. A Business Case was therefore being developed to address this via the use of Theatre 6 (at Tunbridge Wells Hospital (TWH))

SO referred to section 3 of page 3, which stated that "…the Trust admits significantly more non elective patients than elective compared to our regional peers…", and asked whether this related to absolute numbers or proportionate percentage. PM confirmed it was the latter, but added that he still did not consider the Trust's Clinical Coding to be good as it could be, which was supported by the lower number of comorbidities that were coded. PM also stated that SO's query usefully highlighted the point that more patients aged over 85 were being admitted to the Trust than at peer organisations. GD remarked that this situation reflected a healthier, wealthier, population, as patients were living longer and therefore experiencing more complex health issues. AK opined that this would undoubtedly have an impact on Social Care.

KT then referred to PM's offer to produce a written report, and stated that he did not think this was required, as any updates would be reported via the Quality Committee. This was agreed.

4-11 Planned and actual Ward staffing for March 2017

COB referred to the circulated report and drew attention to the following points:

- Care Hours Per Patient Day (CHPPD) was slightly higher at TWH, due to the increased use of additional hours on that site. CHPPD was required to be reported, but the value of the metric, when considered independently, was questionable
- There had been some over-usage on a number of Wards, which mainly related to the need for Enhanced Care
- The report included Bank and Agency staffing, so did not reflect vacancies
- The overall 'RAG' rating was shown in the last column of the table, and this arose following a discussion with Senior Nurses in each area. Five areas had been rated as 'amber' from the culmination of several factors, and these areas continued to be monitored

KT asked for confirmation that the requests for Enhanced Care were scrutinised, to confirm the need. COB noted a similar query had prompted a discussion at the last Trust Board meeting, and the new Policy and 'reasonable assurance' Internal Audit report had been discussed then, but confirmed she had confidence that the requests were warranted.

4-12 Board members' hospital visits

KT referred to the circulated report and encouraged all Trust Board Members to continue to undertake visits, although the current shortage of Non-Executive Directors was evident. KR then pointed out a typographical error on page 1, in relation to the inclusion of the words "(see below)".

Planning and strategy

4-13 Next steps on the NHS five year forward view

JL referred to the circulated report and highlighted the following points:

- The aforementioned 'new norm' was reflected in the document, and the focus of STPs was on urgent care in particular
- Accountable Care Systems (ACS) had now entered the NHS vernacular, and represented a new way of thinking. ACS may be a useful subject for discussion at a future Trust Board 'Away Day', but JL believed that the Trust was well positioned for the future operation of an ACS, given the aligned incentives contract for 2017/18

KT agreed it would be useful to discuss ACS at a Board 'Away Day', ideally in the near future.

GD commented that this was the first time a document had outlined that not all commitments could be achieved without additional funding, and also included the assumption that waiting times for elective care would not get any better. KT acknowledged the starkness of the latter statement.

Reports from Board sub-committees (and the Trust Management Executive)

4-14 Quality Committee, 10/04/17

SDu referred to the circulated report, and added that she had attended a meeting earlier that day in which formal feedback from the South East London, Kent and Medway (SELKaM) Network

Review visit had been given. SDu elaborated that this had confirmed the Trust was in a good position, but an issue had been raised as to the relationship between existing networks & the STP.

4-15 Trust Management Executive (TME), 19/04/17 (incl. approval of the Sustainable Development Management Plan (SDMP))

JL referred to the circulated report, and pointed out that it included a Sustainable Development Management Plan (SDMP), which the Board was asked to approve. JL then highlighted the good work that had been undertaken to reduce the Trust's carbon footprint.

KT asked how the SDMP would be fully integrated with other issues. JL agreed this needed to occur, and stated this would be primarily achieved via the new Performance Management Framework. JL continued, and commended the approach to the new Framework taken by Estates & Facilities, which had enabled the Executive Team to have a more balanced view of performance.

KT also expressed his interest in seeing how the implementation of the SDMP progressed.

The Trust Board approved the Sustainable Development Management Plan as circulated.

4-16 Finance Committee, 24/04/17

SDu referred to the circulated report and stated that the Committee had received an interesting report on the Workforce Transformation programme, and, notwithstanding the remarks PM had made under item 4-8 regarding Lord Carter-related efficiencies, it was clear that the 'prize' on offer was significant. SDu continued that the Committee had acknowledged the labour-intensive nature of the programme, and the likely need to invest in order to achieve the potential savings. SDu confirmed that the Finance Committee had therefore recommended such investment be considered. AK expressed his support. KT also confirmed his support, and asked how the matter would be taken forward. SO replied that the Executive Team would consider this by assessing the resources currently in place. It was therefore confirmed that the Executive Team would consider the matter, having acknowledged the Finance Committee and Trust Board's view.

SDu then continued, and stated that a report on IT had raised some concern in relation to the replacement PAS and A&E Symphony IT system. KT noted this had been considered at the 'Part 2' Trust Board meeting on 29/03/17, and therefore proposed that any further discussion take place in the 'Part 2' Board meeting to be held later that day. This was agreed.

4-17 To consider any other business

No other business was reported.

4-18 To receive any questions from members of the public

There were no questions.

4-19 To approve the motion that in pursuance of the Public Bodies (Admission to Meetings) Act 1960, representatives of the press and public now be excluded from the meeting by reason of the confidential nature of the business to be transacted

The motion was approved.

Trust Board Meeting – May 2017

NHS Maidstone and Tunbridge Wells NHS Trust

5-4 Log of outstanding actions from previous meetings — Chair of the Trust Board

Actions due and still 'open'

Ref.	Action	Person responsible	Original timescale	Progress [1]
4-8 (April 17)	Liaise with the Chief Operating Officer and Chief Executive to agree the wording for an activity-related key objective for the 2017/18 Board Assurance Framework, and submit this to the Trust Board, for approval	Trust Secretary	May 2017	Liaison has not yet occurred, but is intended to submit a proposed objective to the Trust Board in June 2017

Actions due and 'closed'

Ref.	Action	Person responsible	Date completed	Action taken to 'close'
4-3 (April 17)	Amend the minutes of the Part 1 Trust Board meeting of 29th March 2017	Trust Secretary	April 2017	The minutes were amended before being presented to the Chair of the Trust Board for signature

Actions not yet due (and still 'open')

Ref.	Action	Person responsible	Original timescale	Progress
12-8iii (Dec 16)	Arrange for the next Trust Board 'Away Day' to discuss the 'new normal' levels of clinical activity seen at the Trust	Trust Secretary	spring 2016	The issue will be added to the agenda of the next 'Away Day', which has now been scheduled for 09/06/17

[1] Not started | On track | Issue / delay | Decision required

Trust Board meeting – May 2017

NHS
Maidstone and Tunbridge Wells NHS Trust

5-7 Chief Executive's report Chief Executive

I wish to draw the points detailed below to the attention of the Board:

1. Our intense and on-going focus on emergency admissions continues to remain an absolute priority for our Trust and our patients in the face of further increases in unplanned demand for hospital care.

   MTW's hospital admissions through A&E have continued to increase at pace since February. Our clinical teams saw and admitted more patients in April than in any of the three preceding months of 2017.

   Following a small (3%) fall in February, A&E admissions increased (month on month) by 8% in March and 10% in April. If we look back a year, our emergency admissions are 18% higher for April 2017 than in April 2016 and attendances are up 10% for the same period.

   This continues to impact on our ability to see all of our planned patients as quickly as both we and they would want, and remains the reason why we continue to devote our time and focus on enhancing patient flow through our hospitals, covering both our emergency and elective pathways.

   Our staff deserve a huge amount of praise on a daily basis for providing high standards of care for so many patients in a safe environment, and their efforts have already been recognised at the highest level this year. Thanks to their skills, commitment and determination our performance on the four hour A&E waiting time standard has improved by around 10% since January. This has attracted the praise of the Secretary of State for Health, after our teams achieved the most improved A&E performance for the whole of South of England between January and February.

   It is clear though that we need to help support our staff keep pace with, and wherever possible get ahead of, the changing health needs of our patients.

   That is why we are supporting our staff to quickly identify and deliver improvements they believe will make the biggest difference to our patients' experience. We will be bringing the full force of our organisation to bear over the coming weeks and months to deliver the changes our staff want to see for the benefit of the many patients they treat.

2. Since our last Trust Board meeting I have promoted our overriding objectives for the year ahead with colleagues throughout the Trust. I have also helped highlight our key quality improvements. There is a clear link between our objectives and the challenges that I have just described.

   Some of the other messages that I have recently shared with our colleagues have helped promote the open and honest culture that we want at MTW, through shared learning and improvement.

   Following the death of Edna Thompson in 2015 and the subsequent inquest, we reviewed the way we use the drug Mannitol, which Mrs Thompson was given when she was in hospital and contributed to her death. Mrs Thompson's family also asked us to share our learning with other hospitals and healthcare professionals.

   The Trust contacted the National Network of Medication Safety Officers (MSO) and NHS Improvement (NHSI), and at the end of April, a presentation was given, via webinar, to explain what we had learnt from the incident. As well as our involvement, NHSI gave an

introduction and a representative from the Medicines and Healthcare Regulatory Authority (MHRA) commented on the manufacturer's information sheets listing the adverse effects and monitoring of Mannitol.

Additionally, the lead for the MSO network had also done a short survey of MSOs across the country and asked other nursing staff about the use/monitoring of Mannitol, which showed that information around its use is not well-known and adverse effects may be under-recognised.

A local GP contacted us to explain that one of his patients had been pre-assessed for cardiac catheterisation. The patient was told he would be contacted with advice on the anticoagulation pre-procedure, as he is on warfarin for multiple DVT's (Deep Vein Thrombosis) in the past. The patient wasn't contacted so rang the clinic who directed him to his GP to get his bridging anti-coagulation. The GP contacted the Cardiac Catheter Lab for instruction but it wasn't a straight-forward process to establish exactly what was required.

As a result of the GP providing this feedback, we reviewed the situation and established that the procedure booking form had not contained any instructions to the pre-assessment nurses about the use of warfarin or the need for bridging anti-coagulation. We have altered the process so now, nurses will no longer accept booking forms if the medication management section has not been completed. It's so important that we report incidents, and act on our experiences and the information given to us to make

3. I would like to commend the actions of colleagues from MTW who have once again shown us all what it truly means to be a healthcare professional.

   Two of our Respiratory Clinical Nurse Specialists recently provided lifesaving care at the scene of an accident as they travelled between Maidstone and Tunbridge Wells hospitals. They performed CPR and were joined by an anaesthetist and nurse who were also travelling to Maidstone Hospital. They combined their skills to act as a resus team until paramedics and police arrived and the casualty was taken to hospital. They then continued on to work caring for our patients for the rest of the day. I would like to echo the words of their colleagues in saying that we have some truly wonderful, dedicated healthcare professionals in our Trust.

Which Committees have reviewed the information prior to Board submission?

- N/A

Reason for submission to the Board (decision, discussion, information, assurance etc.) [1]

Information and assurance

[1] All information received by the Board should pass at least one of the tests from 'The Intelligent Board' & 'Safe in the knowledge: How do NHS Trust Boards ensure safe care for their patients': the information prompts relevant & constructive challenge; the information supports informed decision-making; the information is effective in providing early warning of potential problems; the information reflects the experiences of users & services; the information develops Directors' understanding of the Trust & its performance

Trust Board meeting – May 2017

NHS Maidstone and Tunbridge Wells NHS Trust

5-8 Integrated performance report for April 2017 — Chief Executive

The enclosed report includes:

- The 'story of the month' for April 2017 (including a commentary on the A&E 4-hour waiting time target, Delayed Transfers of Care (DTOCs), Referral to Treatment (RTT), and Cancer 62 day First Definitive Treatment)
- A workforce commentary
- The Trust performance dashboard
- An explanation of the Statistical Process Control charts which are featured in the "Integrated performance charts" section
- Integrated performance charts
- The review of latest financial performance and Board finance pack

Which Committees have reviewed the information prior to Board submission?

- Trust Management Executive (TME), 17/05/17 (Trust performance dashboard)

Reason for receipt at the Board (decision, discussion, information, assurance etc.) [1]

Discussion and scrutiny

[1] All information received by the Board should pass at least one of the tests from 'The Intelligent Board' & 'Safe in the knowledge: How do NHS Trust Boards ensure safe care for their patients': the information prompts relevant & constructive challenge; the information supports informed decision-making; the information is effective in providing early warning of potential problems; the information reflects the experiences of users & services; the information develops Directors' understanding of the Trust & its performance

The 'story of the month' for April 2017

The key areas of focus remain as previously reported, emergency 4 hour standard, RTT and Cancer 62 day target.

1. Emergency Performance (4 hour standard)

Performance for the Trust for April was 87.03% narrowly missing the Trust recovery plan of 87.30% by 34 breaches. 16/17 came in at 87.1%, which was in line with what was agreed as possible with NHSI. This year, we will be monitored against a new set of targets, where Q1, Q2 and Q3 must score 90% or above, then 95% in March 2018. The directorate management team and the Information Department have agreed a set of monthly targets to facilitate how we monitor and track this. The May target is set at 90.84%. Demand and capacity planning for 2017-18 (including winter resilience planning) is based on the new normal for non-elective activity using the parameters of attendances, admissions, age-profile and reason for admission as basis for planning.

a. The key issues for April are:

- A&E Attendances remain higher than plan and higher than last year, conforming very closely to the MTW activity model.
- Non-Elective Activity was 13.0% higher than plan for April and 18.5% higher than April last year.
- There were 1,208 bed-days lost (5.62% of occupied bed-days) due to delayed transfers of care.
- Non-elective LOS was 7.34 days for April discharges after spiking at 8.68 in Jan. Average occupied bed days dropped to 713 in April, down from March's 733.

Focus remains on improving length of stay for all patients and establishing practice that is aimed at reducing the volume of patients that are admitted to inpatient beds and these are:

- Acute assessment facilities
- Ambulatory pathways across all specialties
- Frail elderly facilities & pathway

2. Delayed Transfers of Care

Count of Hospital ID																									
Row Labels	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17
A : Awaiting Assessment	15	6	15	21	15	17	15	10	5	7	3	8	1	6	25	15	7	5	5	12	20	22	32	14	14
B : Awaiting Public Funding	2		1	1	4	8	7	3	1			1	1	1	8	12	25	21	5	3	6		4	3	1
C : Awaiting Further Non-Acute NHS Care	32	34	39	48	33	30	20	6	3	8	15	18	17	13	11	10	8	10	14	6	23	8	13	16	17
Di : Awaiting Residential Home	18	1	11	27	28	26	22	16	21	15	15	27	32	20	37	21	33	43	34	19	21	30	24	35	21
Dii : Awaiting Nursing Home	40	21	38	90	57	52	56	40	73	53	80	73	58	67	65	67	69	83	69	63	112	78	77	76	57
E : Awaiting Care Package	7	7	20	16	27	17	32	26	43	28	36	36	28	24	39	41	41	76	58	51	89	49	30	38	35
F : Awaiting Community Adoptions	1	11	2	1		1	13	9	8	14	5	13	8	7	12	4	6	10	8	5	7	9	10	13	6
G : Patient of Family Choice	60	44	44	45	16	43	26	22	31	12	12	22	13	9	19	19	10	16	20	16	14	9	19	28	6
H : Disputes	2	1			1	3	1	1		1				3	1	1				1			1	1	1
I : Housing	3	4	3	1		1	13	12	9	3	5	1			5	5	2	3	2	4	8	3	5	4	3
Grand Total	180	129	173	250	181	198	205	145	194	141	171	199	158	150	222	195	201	267	215	180	300	208	215	228	161
Trust delayed transfers of care	5.5%	4.8%	6.8%	7.9%	7.1%	7.9%	6.6%	5.7%	6.0%	5.0%	5.8%	5.6%	5.5%	5.3%	6.2%	6.7%	6.7%	7.2%	7.9%	6.3%	8.1%	6.7%	7.1%	6.2%	5.6%

The number of bed days lost fell from 1,409 in March to 923 in April. For 16/17, there were 17,781 bed days lost equating to a rate of 6.67 compared to 6.19 on 15/16.

- There has been some improvement in the availability of packages of care and Social Services (KEAH – Kent Enablement at Home). Large double handed calls remain an issue and Social Services are continuing a piece of work at trying to reduce ongoing dependency levels of discharged patients.
- Progress made with the implementation of Home First Pathway 1 using HILTON.

- The capacity for Home First Pathway 3 of 10 beds at the Westbank Nursing Home has become fully utilised within the month
- Costs at local nursing homes have seen a rise in the period since Christmas with occupancy remaining high.
- Poor access to EMI capacity at nursing home level has been an issue.

3. Elective Activity / Referral to Treatment.

Performance: April performance shows the Trust continues to forecast non-compliance with the Incomplete RTT standards at an aggregate level – 87.7%. This is mainly due to the impact of non-elective activity on our ability to undertake all the planned elective work.

Key non-compliant specialties are T&O, Gynae, ENT, Surgery, Cardiology and Urology and the majority of the backlog is concentrated in these five; all of which are being carefully monitored against action plans put in place to reduce their longest waiters.

All these specialties are trying to continue to reduce their backlogs despite cancellations by moving lists to Maidstone and focusing capacity on booking patients within the backlog to all available lists. Extra Saturday sessions are being planned when current escalation reduces.

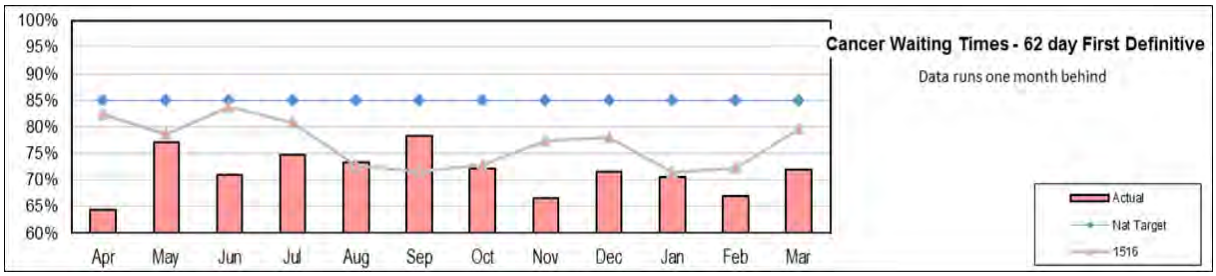
The Trust is required to deliver compliance at an aggregate level by November 2017.

	Apr-17	Apr-17 Trajectory	Variance from trajectory
RTT Backlog Incomplete	3032	2310	-722
RTT Waiting List	24709	23957	-752
RTT Incomplete performance %	87.7%	90.36%	-2.66

4. Cancer 62 day First Definitive Treatment

Performance for 62 day First Definitive Treatment (data runs a month behind) for March 2017 is 71.9%, for Q4, this is 69.7%, whilst for the full year was 71.5%: which is below the national target of 85%.

62 FDT for March: 28 patients were treated who had waited over 62 days and 14 of these were MTW only patients. 16 patients were referred to MTW from other Trusts and 12 patients from MTW to elsewhere (1 patient = 0.5 breach). MTW received breaches: 5 patients from Medway, 3 patients from Darent Valley and 8 patients from East Kent (Patients shared across Trusts = 0.5 of a breach).



There are a number of remedial actions in place to achieve a sustainable improved performance.

- Straight to test triage clinics are now well established for colorectal referrals with increasing numbers of clinics per week and increasing numbers of patients being sent straight to test. This is reducing the interval between referral and initial diagnostic and OP appointments for these patients and will eventually enable the number of breaches to be reduced.

- The weekly cancer PTL meeting is being further revised to include administrative staff responsible for booking inpatient and outpatient appointments. This will enable real time changing of appointments and for dates to be pre-booked for patients when a next key event is known (e.g. likely for surgery).
- Improvements in administrative processes will enable better performance especially for Urology (rollout of the Endoview reporting system in Tunbridge Wells to reduce the number of letters dictated and appropriate patients to be removed earlier from the pathway) and clinic outcome pro forma (again to reduce the number of letters dictated and to remove the patient earlier).
- The TCI form for surgery is being updated to provide a reminder to clinicians to record the data needed to apply waiting time adjustments where appropriate.

Oncology has implemented a new process to identify patients referred after day 38 where breaches can be avoided if the patient is treated within 24 days. Oncologists will reserve one new patient appointment per week and the process is being piloted to book the 24 day patients in to these.

Workforce commentary

As at the end of April 2017, the Trust employed 5,090.3 whole time equivalent substantive staff, a 23.7 WTE rise from the previous month. However since the start of the calendar year, the employed whole time equivalent substantive staff has reduced by 27.2 WTE. Overall temporary staffing decreased significantly from March 2017.

Sickness absence in the month (March) reduced by 0.4% to 3.8% compared to the previous month and represented a 0.4% improvement on the same period last year. However, sickness absence management remains a key area of focus for the HR and operational management teams.
Statutory and mandatory training compliance has reduced slightly to 86.8%, but has remained consistently above the target percentage.

While Turnover has remained at 11.5% in April, this is higher than the target. A detailed analysis of trust Turnover is being prepared for consideration at the June Workforce Committee.

The ‘Recommended Place to Work’ indicator from the last quarterly pulse survey has fallen by 10% from the consistent response that the Trust has received over the past few years (circa 60%). This reduction was not mirrored in the recent published annual staff survey (February 2017) result of 63% for the Trust. However over the past 12 months the Trust has seen a similar reduction in the ‘Recommended for Care’ indicator.

TRUST PERFORMANCE DASHBOARD **Position as at:** **30 April 2017**

Delivering or Exceeding Target	
Underachieving Target	
Failing Target	

Please note a change in the layout of this Dashboard to the Five CQC/TDA Domains

******A&E 4hr Wait monthly plan is Trust Recovery Trajectory

	Safe	Latest Month Prev Yr	Latest Month Curr Yr	Year to Date Prev Yr	Year to Date Curr Yr	YTD Variance From Prev Yr	YTD Variance From Plan	Year End Plan/ *Limit*	Year End Forecast	Bench Mark
1-01	*Rate C-Diff (Hospital only)	9.26	9.3	9.3	9.3	0.1	- 4.7	11.5	9.8	
1-02	Number of cases C.Difficile (Hospital)	2	2	2	2	0	- 1	27	2	
1-03	Number of cases MRSA (Hospital)	0	0	0	0	0	0	0	0	
1-04	Elective MRSA Screening	93.0%	98.0%	93.0%	98.0%		0.0%	98.0%	98.0%	
1-05	% Non-Elective MRSA Screening	98.0%	96.5%	98.0%	96.5%		1.5%	95.0%	96.5%	
1-06	**Rate of Hospital Pressure Ulcers	2.9	2.7	2.9	2.7	- 0.2	- 0.4	*3.0*	2.8	3.0
1-07	***Rate of Total Patient Falls	6.7	5.49	6.7	5.49	- 1.2	- 0.5	*6.00*	5.33	
1-08	***Rate of Total Patient Falls Maidstone	6.0	4.9	4.9	4.9	-			4.5	
1-09	***Rate of Total Patient Falls TWells	7.2	5.9	5.9	5.9	-			5.9	
1-10	Falls - SIs in month	1	1	1	1	-				
1-11	Number of Never Events	-	-	-	-	-	-	-	-	
1-12	Total No of SIs Open with MTW	22	27			5				
1-13	Number of New SIs in month	8	7	8	7	- 1	- 3			
1-14	**Serious Incidents rate	0.37	0.33	0.37	0.33	- 0.04	0.27	*0.0584 - 0.6978*	0.33	*0.0584 - 0.6978*
1-15	Rate of Patient Safety Incidents - harmful	0.58	0.87	0.58	0.87	0.29	- 0.36	*0 - 1.23*	0.87	*0 - 1.23*
1-16	Number of CAS Alerts Overdue	0	0			0	0	*0*		
1-17	VTE Risk Assessment	95.5%	95.4%	95.5%	95.4%	-0.1%	0.4%	95.0%	95.4%	95.0%
1-18	Safety Thermometer % of Harm Free Care	96.4%	96.0%	96.4%	96.0%	-0.4%	1.0%	95.0%		93.4%
1-19	Safety Thermometer % of New Harms	3.64%	3.74%	3.64%	3.74%	0.10%	0.7%	*3.00%*	3.74%	
1-20	C-Section Rate (non-elective)	12.9%	12.6%	15.1%	12.6%	-2.59%	-2.4%	*15.0%*	12.6%	

	Effectiveness	Latest Month Prev Yr	Latest Month Curr Yr	Year to Date Prev Yr	Year to Date Curr Yr	YTD Variance From Prev Yr	YTD Variance From Plan	Year End Plan/ *Limit*	Year End Forecast	Bench Mark
2-01	Hospital-level Mortality Indicator (SHMI)******	Prev Yr: July 14 to June 15		1.0	1.0762	0.1	- 98.9	Band 2	Band 2	100.0
2-02	Standardised Mortality HSMR	Prev Yr: Oct 14 to Sept 15		103.0	110.0	7.0	10.0	Lower confidence limit		100.0
2-03	Crude Mortality	1.5%	1.5%	1.5%	1.3%	-0.2%		to be <100		
2-04	****Readmissions <30 days: Emergency	11.4%	11.0%	11.4%	11.4%	0.0%	-2.2%	*13.6%*	11.4%	14.1%
2-05	****Readmissions <30 days: All	10.7%	6.3%	10.7%	10.9%	0.2%	-3.8%	*14.7%*	10.9%	14.7%
2-06	Average LOS Elective	3.33	2.69	3.33	2.69	- 0.64	- 0.51	*3.20*	2.69	
2-07	Average LOS Non-Elective	7.83	7.34	7.83	7.34	- 0.49	0.54	*6.80*	7.34	
2-08	******FollowUp : New Ratio	1.64	1.56	1.64	1.56	- 0.08	0.04	*1.52*	1.56	
2-09	Day Case Rates	85.9%	87.5%	85.9%	87.5%	1.6%	7.5%	80.0%	87.5%	82.2%
2-10	Primary Referrals	9,632	7,484	9,632	7,484	-22.3%	-6.4%	109,314	103,529	
2-11	Cons to Cons Referrals	3,281	2,864	3,281	2,864	-12.7%	-11.1%	40,621	39,619	
2-12	First OP Activity	11,676	12,474	11,676	12,474	6.8%	-9.9%	165,756	165,756	
2-13	Subsequent OP Activity	22,838	26,530	22,838	26,530	16.2%	-8.8%	356,602	356,602	
2-14	Elective IP Activity	614	468	614	468	-23.8%	-29.8%	8,144	8,144	
2-15	Elective DC Activity	3,449	3,118	3,449	3,118	-9.6%	-19.6%	43,859	43,859	
2-16	Non-Elective Activity	4,114	4,877	4,114	4,877	18.5%	13.2%	48,889	48,889	
2-17	A&E Attendances (Inc Clinics. Calendar Mth)	12,434	13,669	12,434	13,669	9.9%	6.9%	167,456	167,456	
2-18	Oncology Fractions	6,302	4,853	6,302	4,853	-23.0%	-24.5%	72,321	72,321	
2-19	No of Births (Mothers Delivered)	1,462	470	502	470	-6.4%	-5.6%	5,977	5,640	
2-20	% Mothers initiating breastfeeding	80.8%	80.8%	82.9%	80.8%	-2.1%	2.8%	78.0%	80.8%	
2-21	% Stillbirths Rate	0.4%	0.42%	0.00%	0.42%	*0.4%*	*0.0%*	*0.47%*	0.42%	0.47%

	Caring	Latest Month Prev Yr	Latest Month Curr Yr	Year to Date Prev Yr	Year to Date Curr Yr	YTD Variance From Prev Yr	YTD Variance From Plan	Year End Plan/ *Limit*	Year End Forecast	Bench Mark
3-01	Single Sex Accommodation Breaches	0	0	0	0	0	0	0	0	
3-02	*****Rate of New Complaints	1.25	1.35	1.69	1.35	-0.3	0.03	*1.318-3.92*	1.35	
3-03	% complaints responded to within target	73.0%	93.8%	74.3%	93.8%	19.4%	18.8%	75.0%	93.8%	
3-04	****Staff Friends & Family (FFT) % rec care	87.2%	76.6%	87.2%	76.6%	-10.6%	-2.4%	79.0%	79.0%	
3-05	*****IP Friends & Family (FFT) % Positive	96.8%	95.3%	96.8%	95.3%	-1.6%	0.3%	95.0%	95.3%	95.8%
3-06	A&E Friends & Family (FFT) % Positive	89.5%	91.4%	89.5%	91.4%	1.9%	4.4%	87.0%	91.4%	85.5%
3-07	Maternity Combined FFT % Positive	94.1%	94.2%	94.1%	94.2%	0.1%	-0.8%	95.0%	95.0%	95.6%
3-08	OP Friends & Family (FFT) % Positive	82.5%	83.9%	82.5%	83.9%	1.5%			83.9%	

* Rate of C.Difficile per 100,000 Bed days, ** Rate of Pressure Sores per 1,000 admissions (excl Day Case), *** Rate of Falls per 1,000 Occupied Beddays, **** Readmissions run one month behind, ***** Rate of Complaints per 1,000 occupied beddays.

***** New :FU Ratio is only for certain specialties -plan still being agreed so currently last year plan

***** *IP Friends and Family includes Inpatients and Day Cases* ******SHMI is at Band 2 "As Expected"*

	Responsiveness	Latest Month Prev Yr	Latest Month Curr Yr	Year/Quarter to Date Prev Yr	Year/Quarter to Date Curr Yr	YTD Variance From Prev Yr	YTD Variance From Plan	Year End Plan/ *Limit*	Year End Forecast	Bench Mark
4-01	******Emergency A&E 4hr Wait	91.6%	87.0%	91.6%	87.0%	-4.5%	-0.3%	90.1%	90.0%	77.6%
4-02	Emergency A&E >12hr to Admission	0	0	0	0	0	0	0	0	
4-03	Ambulance Handover Delays >30mins	New	326	New						
4-04	Ambulance Handover Delays >60mins	New	20	New						
4-05	RTT Incomplete Admitted Backlog	1,632	2,313	1,632	2,313	681	747	1,259	1,259	
4-06	RTT Incomplete Non-Admitted Backlog	818	718	818	718	- 100	- 67	631	631	
4-07	RTT Incomplete Pathway	90.4%	87.7%	90.4%	87.7%	-2.7%	-2.1%	92%	92.0%	
4-08	RTT 52 Week Waiters	0	0	0	0	-	0	*0*	0	
4-09	RTT Incomplete Total Backlog	2,383	3,031	2,383	3,031	648	680	1,890	3,031	
4-10	% Diagnostics Tests WTimes <6wks	99.55%	99.8%	99.6%	99.8%	0.3%	0.8%	99.0%	99.0%	
4-11	*Cancer WTimes - Indicators achieved	4	4	4	1	- 3	- 8	9	1	
4-12	*Cancer two week wait	92.5%	94.9%	95.2%	95.2%	0.0%	2.2%	93.0%	95.2%	
4-13	*Cancer two week wait-Breast Symptoms	87.8%	87.7%	88.0%	88.0%	0.0%	-5.0%	93.0%	88.0%	
4-14	*Cancer 31 day wait - First Treatment	98.1%	99.0%	95.7%	95.7%	0.0%	-0.3%	96.0%	95.7%	
4-15	*Cancer 62 day wait - First Definitive	79.6%	71.9%	69.7%	69.7%	0.0%	-2.8%	85.0%	69.7%	
4-16	*Cancer 62 day wait - First Definitive - MTW	84.9%	82.5%	79.5%	76.5%	-3.0%		85.0%		
4-17	*Cancer 104 Day wait Accountable	7.5	11.5	43.5	112.5	69.0	112.5	*0*	112.5	
4-18	*Cancer 62 Day Backlog with Diagnosis	New	81	New	81					
4-19	*Cancer 62 Day Backlog with Diagnosis - MTW	New	59	New	59					
4-20	Delayed Transfers of Care	5.5%	5.6%	5.5%	5.6%	0.2%	2.1%	3.5%	3.5%	
4-21	% TIA with high risk treated <24hrs	90.9%	72.7%	90.9%	81.7%	-9.2%	21.7%	60%	81.7%	
4-22	*******% spending 90% time on Stroke Ward	88.5%	87.5%	88.5%	88.5%	0.0%	8.5%	80%	88.5%	
4-23	*******Stroke:% to Stroke Unit <4hrs	58.6%	67.3%	58.6%	53.9%	-4.7%	-6.1%	60.0%	60.0%	
4-24	*******Stroke: % scanned <1hr of arrival	62.7%	76.4%	62.7%	59.0%	-3.7%	11.0%	48.0%	59.0%	
4-25	*******Stroke:% assessed by Cons <24hrs	67.8%	83.6%	67.8%	68.2%	0.4%	-11.8%	80.0%	80.0%	
4-26	Urgent Ops Cancelled for 2nd time	0	0	0	0	0	0	*0*	0	
4-27	Patients not treated <28 days of cancellation	2	5	2	5	3	5	*0*	5	

RTT Incomplete Pathway Monthly Plan is Trust Recovery Trajectory

**CWT run one mth behind, YTD is Quarter to date, Monthly Plan for 62 Day Wait First Definitive is Trust Recovery Trajectory*

**** Contracted not worked includes Maternity /Long Term Sick* **** Staff FFT is Quarterly therefore data is latest Quarter*

	Well-Led	Latest Month Prev Yr	Latest Month Curr Yr	Year to Date Prev Yr	Year to Date Curr Yr	YTD Variance From Prev Yr	YTD Variance From Plan	Year End Plan/ *Limit*	Year End Forecast	Bench Mark
5-01	Income	33,191	36,968	33,191	37,074	11.7%	2.6%	436,666	436,666	
5-02	EBITDA	(955)	1,308	(955)	1,415	-248.1%	-3.6%	38,055	38,055	
5-03	Surplus (Deficit) against B/E Duty	(3,693)	(1,261)	(3,693)	(1,155)			6,673	6,673	
5-04	CIP Savings	1,267	1,086	1,267	1,086	-14.3%	-5.1%	31,558	31,558	
5-05	Cash Balance	9,162	13,564	9,162	13,564	48.0%	4%	1,000	1,000	
5-06	Capital Expenditure	79	37	79	37	-53.2%	-95.5%	*17,398*	17,398	
5-07	Establishment WTE	5,735.4	5,605.4	5,735.4	5,605.4	-2.3%	0.0%	5,605.4	5,605.4	
5-08	Contracted WTE	5,145.1	5,090.3	5,145.1	5,090.3	-1.1%	-0.5%	5,116.5	5,116.5	
5-09	Vacancies WTE	590.3	515.1	590.3	515.1	-12.7%	24.8%	412.9	412.9	
5-11	Vacancy Rate (%)	10.3%	9.2%	10.3%	9.2%	-10.7%	5.4%	8.7%	8.7%	
5-12	Substantive Staff Used	4,978.9	4,949.3	4,978.9	4,949.3	-0.6%	-3.3%	5,116.5	5,116.5	
5-13	Bank Staff Used	333.3	404.0	333.3	404.0	21.2%	21.2%	333	333.3	
5-14	Agency Staff Used	242.8	133.8	242.8	133.8	-44.9%	-14.0%	155.6	155.6	
5-15	Overtime Used	62.8	41.7	62.8	41.7	-33.7%				
5-16	Worked WTE	5,617.9	5,528.8	5,617.9	5,528.8		-1.4%	5,605.4	5,605.4	
5-17	Nurse Agency Spend	(865)	(608)	(865)	(608)	-29.7%				
5-18	Medical Locum & Agency Spend	(1,364)	(1,365)	(1,364)	(1,365)	0.0%				
5-19	Temp costs & overtime as % of total pay bill	17.0%	15.2%	17.0%	15.2%	-1.8%				
5-20	Staff Turnover Rate	9.9%	11.5%	10.5%	11.5%	1.6%	1.0%	*10.5%*	10.5%	11.05%
5-21	Sickness Absence	4.3%	3.8%	4.2%	3.8%	-0.5%	0.5%	*3.3%*	3.3%	4.3%
5-22	Statutory and Mandatory Training	89.2%	86.8%	90.8%	86.8%	-2.4%	1.8%	85.0%	86.8%	
5-23	Appraisal Completeness	Data not reported for Quarter 1.								
5-24	Overall Safe staffing fill rate	103.6%	98.2%	103.6%	98.2%	-5.4%		93.5%	98.2%	
5-25	****Staff FFT % recommended work	64.2%	53%	64.2%	53%	-11.7%	-9.5%	62.0%	62%	
5-26	***Staff Friends & Family -Number Responses	664	619	664	619	-45				
5-27	*****IP Resp Rate Recmd to Friends & Family	18.8%	23.7%	18.8%	23.7%	4.9%	-1.3%	25.0%	25.0%	25.7%
5-28	A&E Resp Rate Recmd to Friends & Family	4.6%	21.4%	4.6%	21.4%	16.8%	6.4%	15.0%	21.4%	12.7%
5-29	Mat Resp Rate Recmd to Friends & Family	30.0%	44.7%	30.0%	44.7%	14.8%	19.7%	25.0%	44.7%	24.0%

Explanation of Statistical Process Control (SPC) Charts

In order to better understand how performance is changing over time, data on the Trusts performance reports are often displayed as SPC Charts. *A*n SPC chart looks like this:

SPC is a type of charting that shows the variation that exists in the systems that are being measured. When interpreting SPC charts there are 4 rules that help to identify what the system is doing. If one of the rules has been broken, this means that 'special cause ' variation is present in the system. It is also perfectly normal for a process to show no signs of special cause. This means that only 'common cause ' variation is present.

Rule 1: Any point outside one of the control limits. Typically this will be some form of significant event, for example unusually severe weather. However if the data points continue outside of the control limits then that significant change is permanent. When we are aware of a significant change to a service such as Tunbridge Wells Hospital opening, then we will recalculate the centre and control lines. This is called a step change.

Rule 2: Any unusual pattern or trends within the control limits. The most obvious example of a cyclical pattern is seasonality but we also see it when looking at daily discharges where the weekends have low numbers. To qualify as a trend there must be at least 6 points in a row. This is one of the key reasons we use SPC charts as it helps us differentiate between natural variation & variation due to some action we have taken.

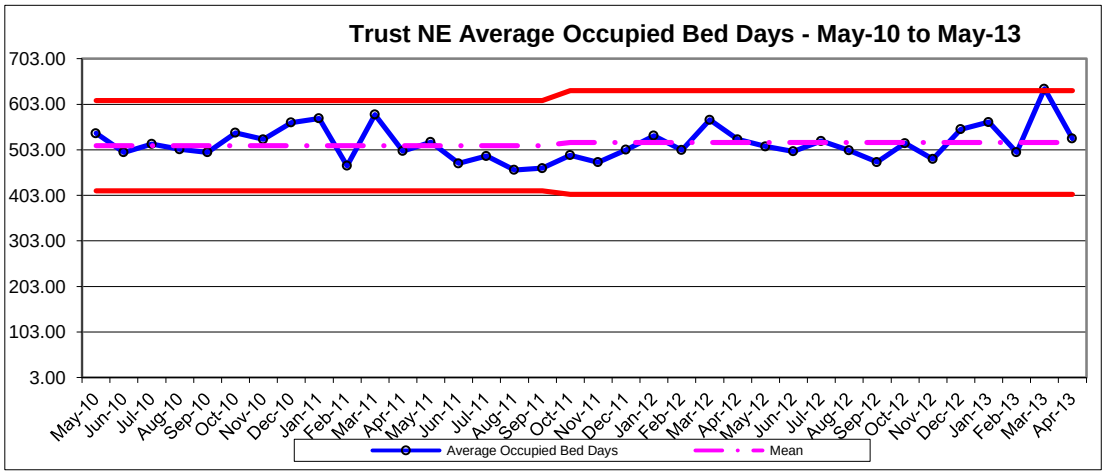
Rules 1 and 2 are the main reason for displaying SPC charts on our performance reports as it makes abnormally high or low values and trends immediately obvious. However there are two other rules that are also used to interpret the graphs.

Rule 3: A run of seven points all above or all below the centre line, or all increasing or decreasing. This shows some longer term change in the process such as a new piece of equipment that allows us to perform a procedure in an outpatient setting rather than admitting them. However alternating runs of points above the line then points below the line can also invoke rule 3.

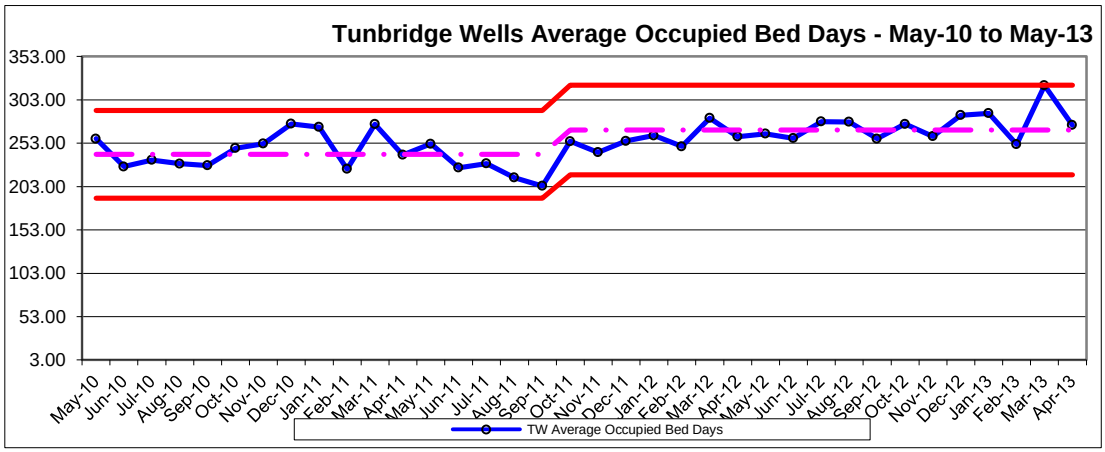
Rule 4: The number of points within the middle third of the region between the control limits differs markedly from two -thirds of the total number of points. This gives an indication of how stable a process is. If controlled variation (common cause) is displayed in the SPC chart, the process is stable and predictable, which means that the variation is inherent in the process. To change performance you will have to change the entire system.

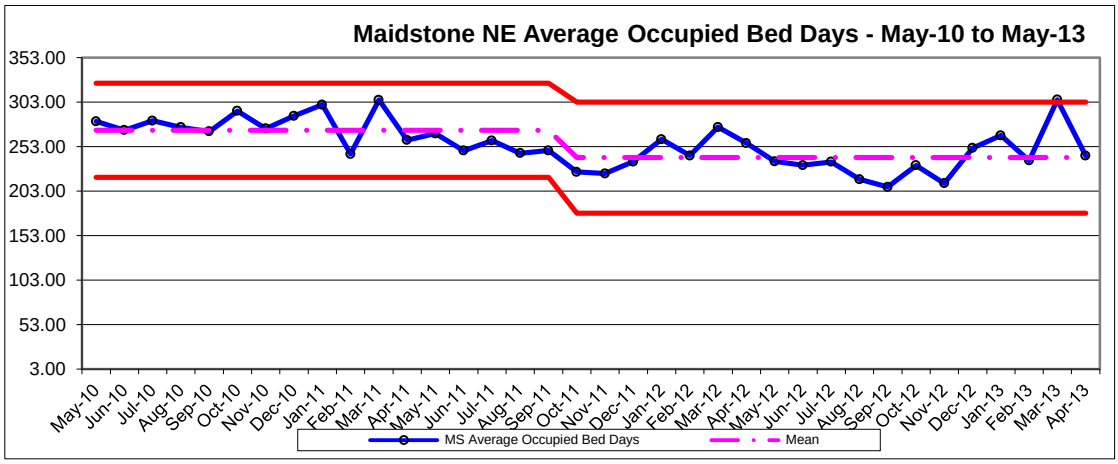
Changes to Control Lines

When there are known changes to the services we provide we reset the calculations as at the date of that change. For example you will see in the graph below that we have re-calculated the control lines from October 2011 onwards. This is to reflect the move of services to the new Tunbridge Wells Hospital in late September.



The change is not immediately obvious in the graph above if you look at just the blue line, but we know there were major changes to our inpatient beds. Looking at site level the change is more obvious:

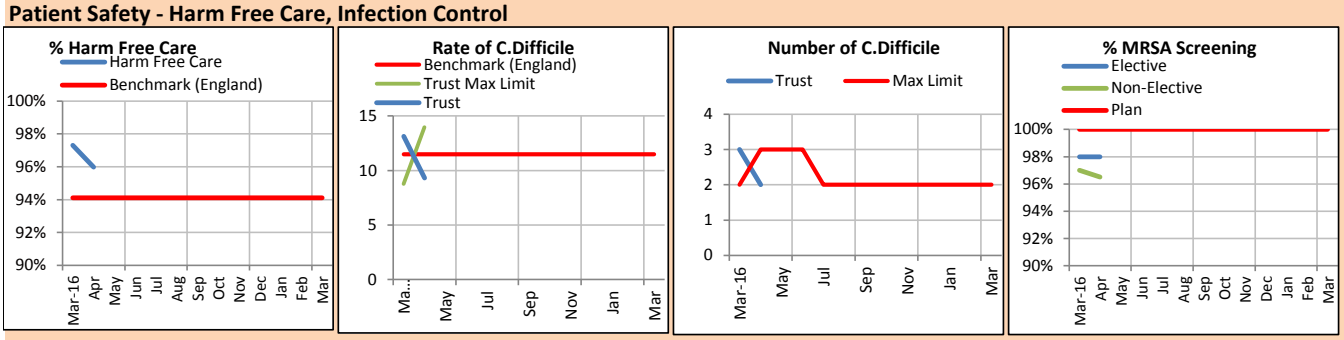




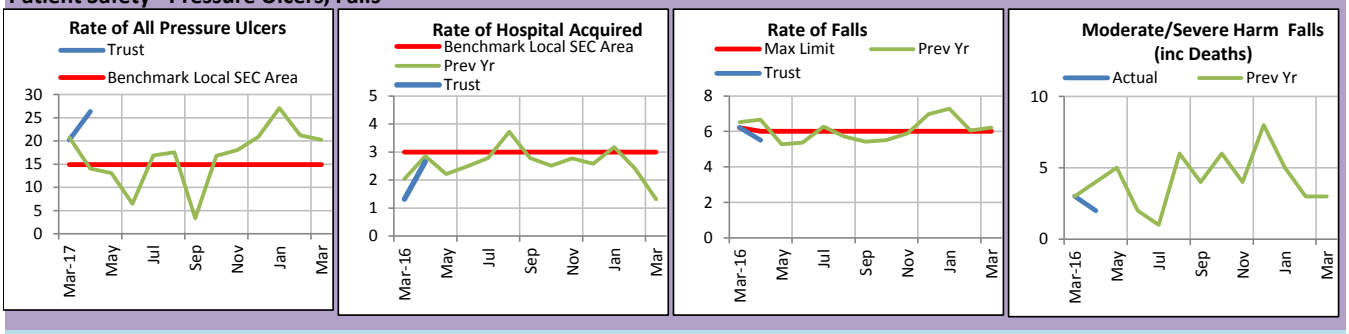
So in the examples given we have calculated a mean and control limits based on the data for May 2010 to September 2011 and then calculated them based on the period October 2011 to April 2013. The lines are all a result of the SPC calculations, only the date of the change is decided by the Information team based on a real life changes in process or service.

INTEGRATED PERFORMANCE REPORT ANALYSIS - PATIENT SAFETY & QUALITY

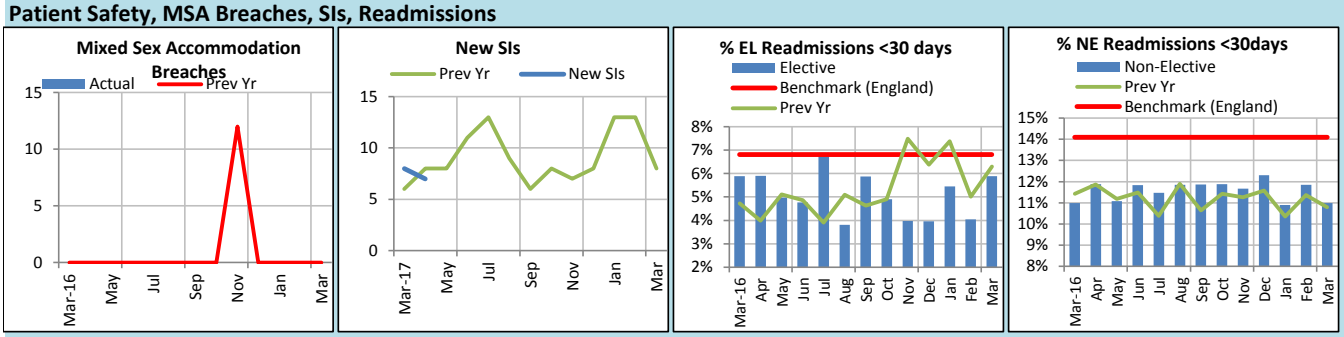
Patient Safety - Harm Free Care, Infection Control



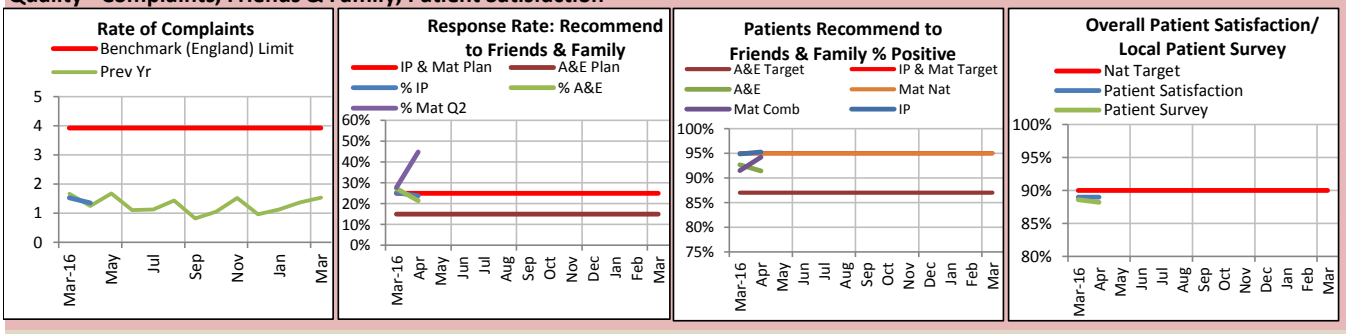
Patient Safety - Pressure Ulcers, Falls



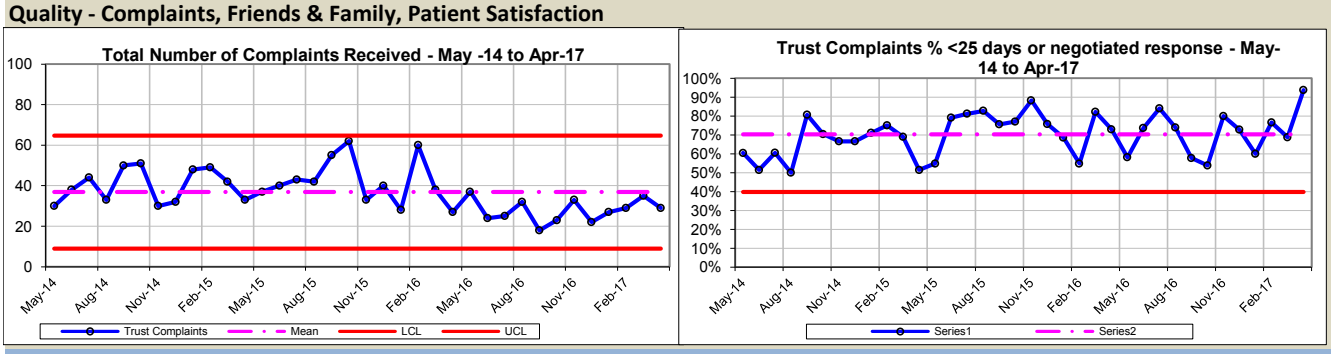
Patient Safety, MSA Breaches, SIs, Readmissions



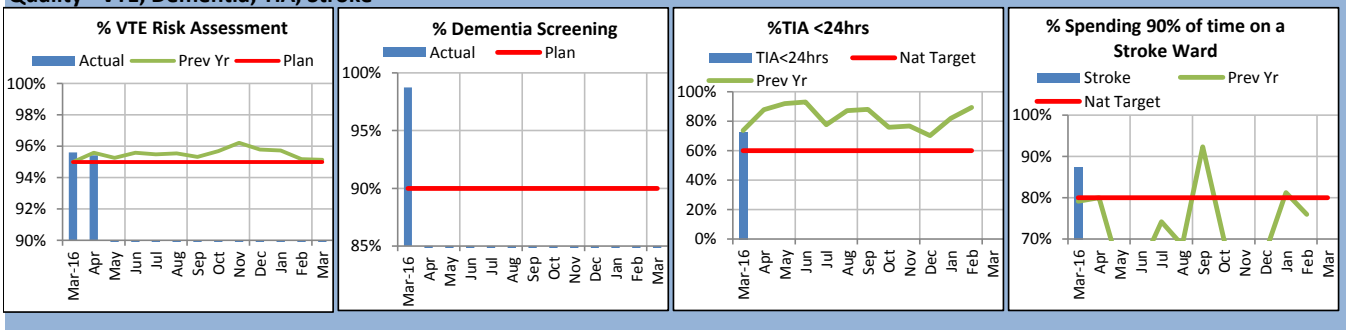
Quality - Complaints, Friends & Family, Patient Satisfaction



Quality - Complaints, Friends & Family, Patient Satisfaction

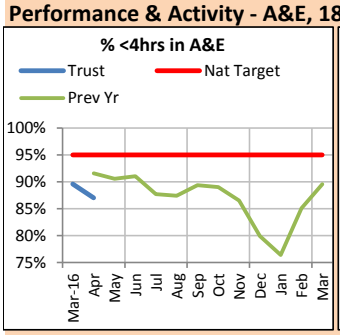


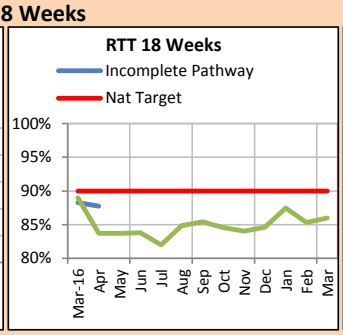
Quality - VTE, Dementia, TIA, Stroke

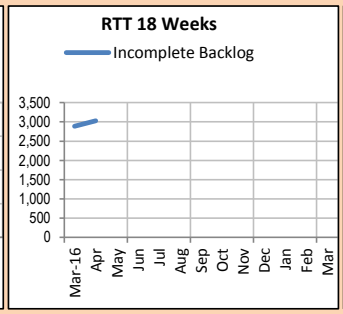


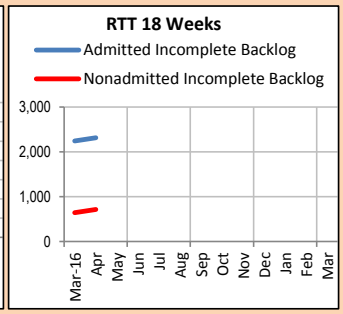
INTEGRATED PERFORMANCE REPORT ANALYSIS - PERFORMANCE & ACTIVITY

Performance & Activity - A&E, 18 Weeks

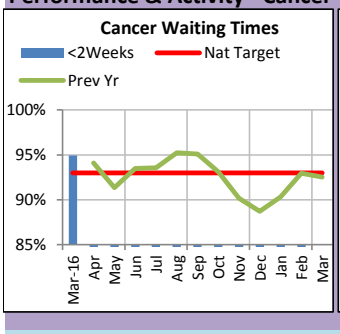


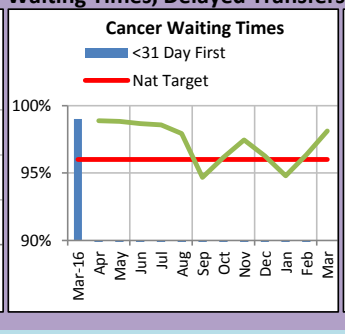


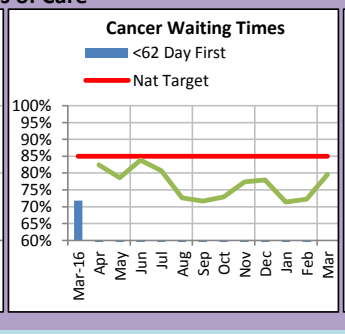


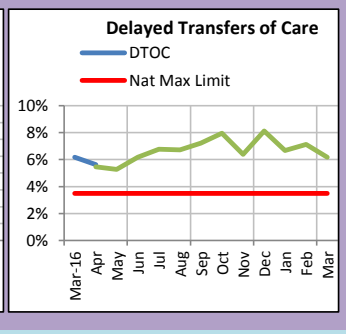


Performance & Activity - Cancer Waiting Times, Delayed Transfers of Care

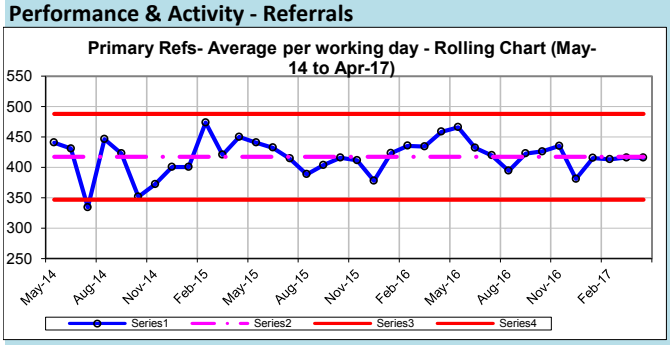


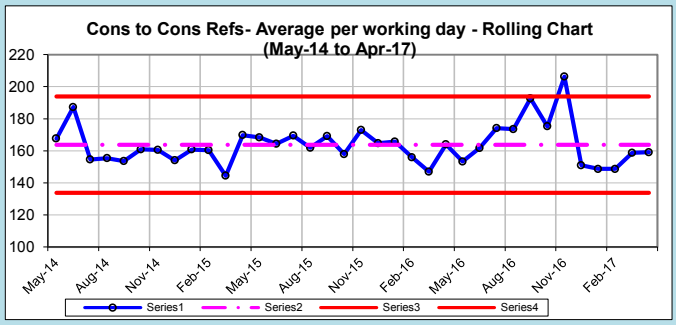




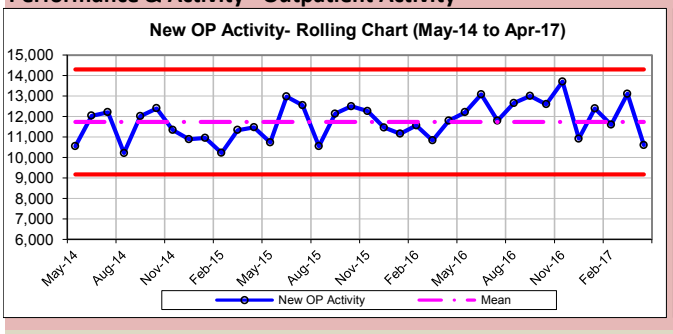


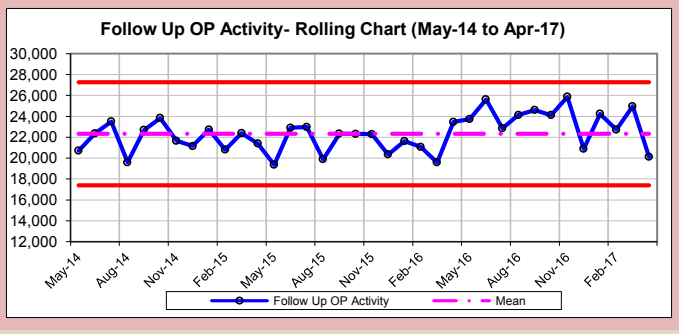
Performance & Activity - Referrals



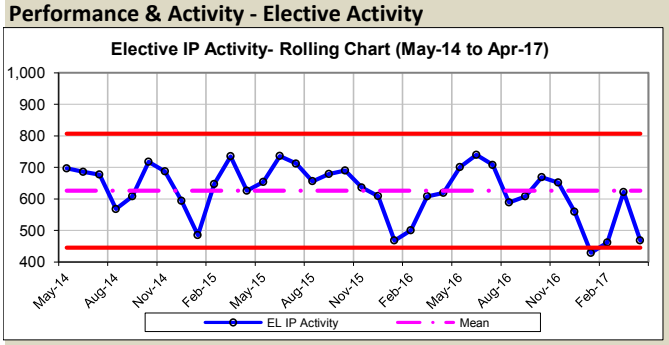


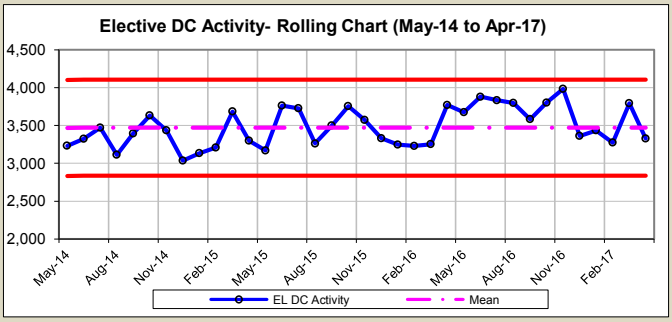
Performance & Activity - Outpatient Activity



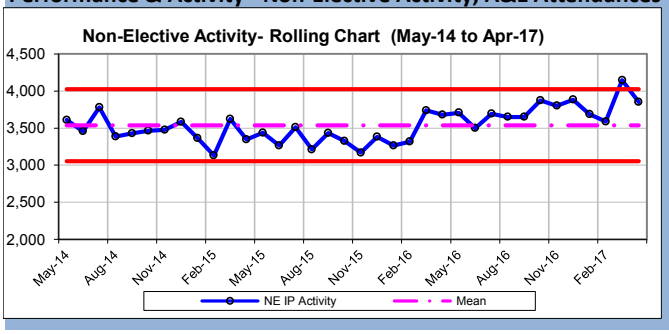


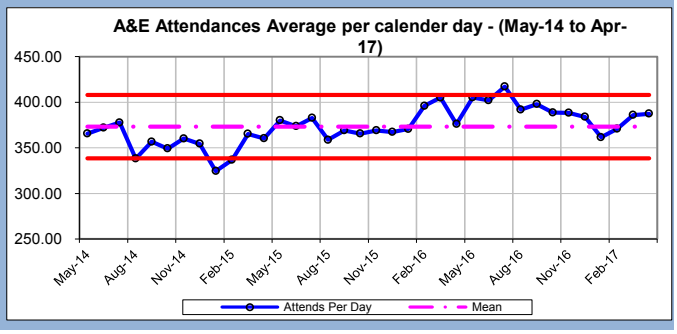
Performance & Activity - Elective Activity





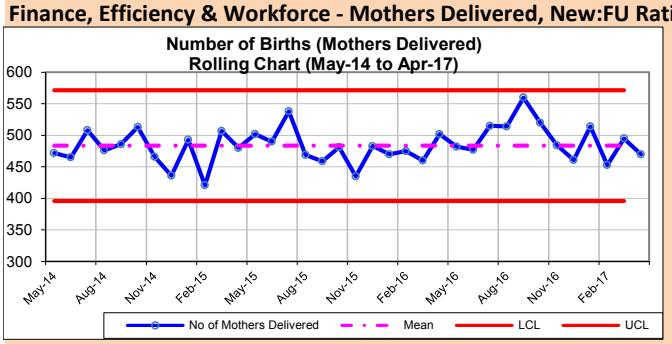
Performance & Activity - Non-Elective Activity, A&E Attendances

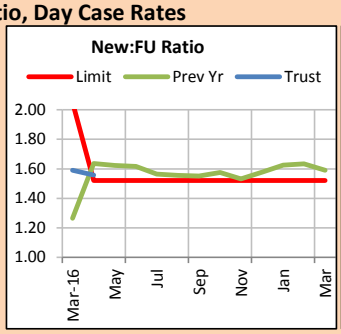


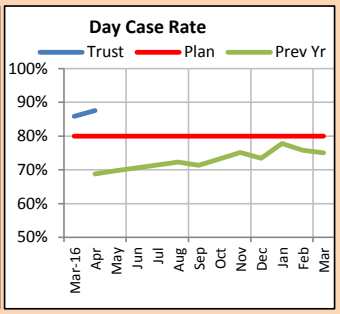


INTEGRATED PERFORMANCE REPORT ANALYSIS - FINANCE, EFFICIENCY & WORKFORCE

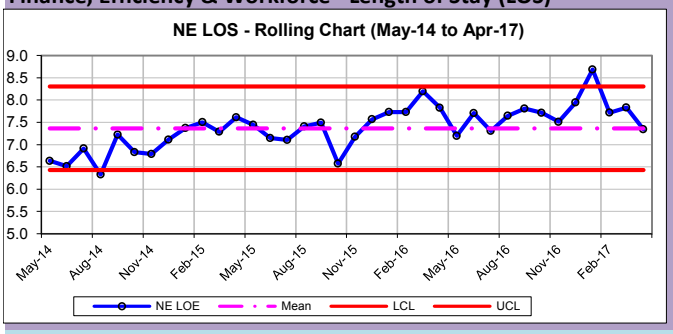
Finance, Efficiency & Workforce - Mothers Delivered, New:FU Ratio, Day Case Rates

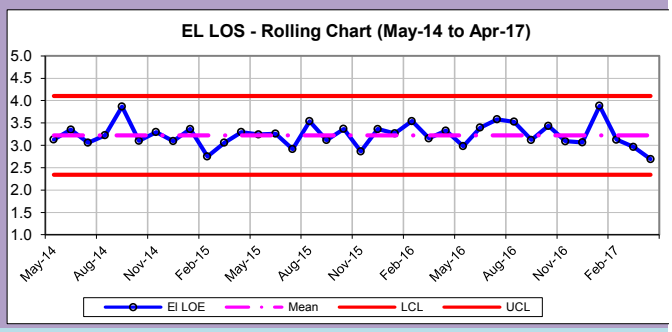




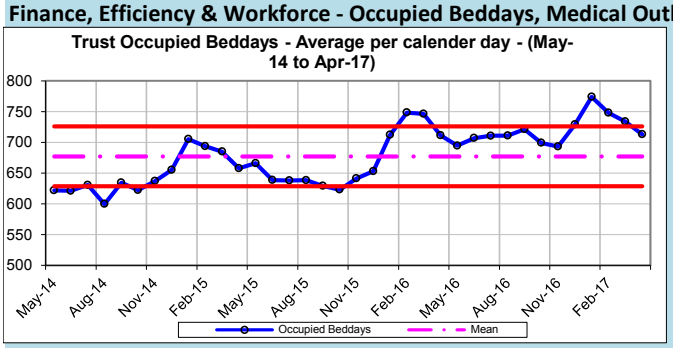


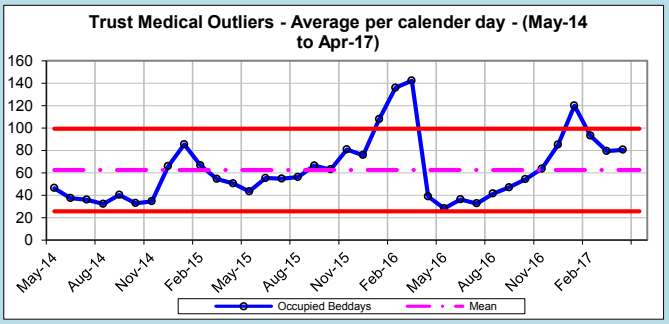
Finance, Efficiency & Workforce - Length of Stay (LOS)



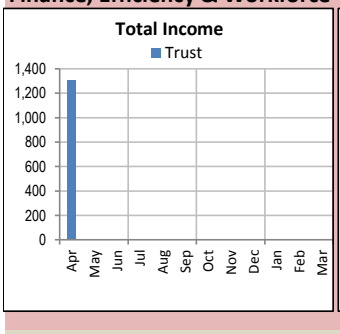


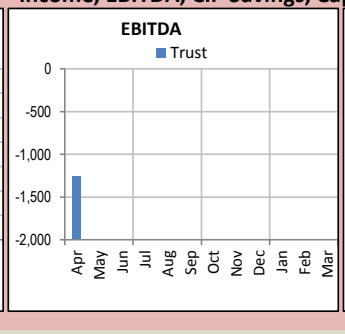
Finance, Efficiency & Workforce - Occupied Beddays, Medical Outliers

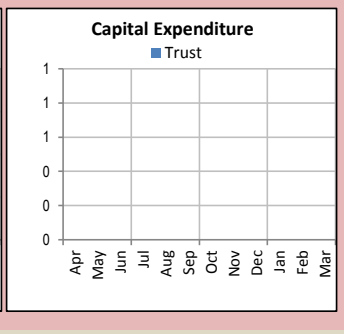




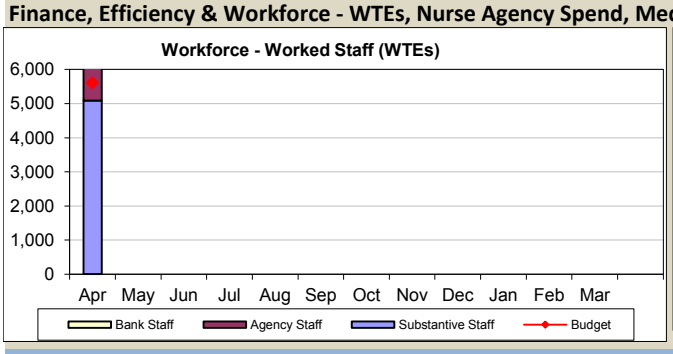
Finance, Efficiency & Workforce - Income, EBITDA, CIP Savings, Capital Expenditure

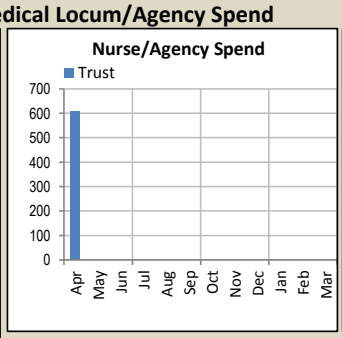


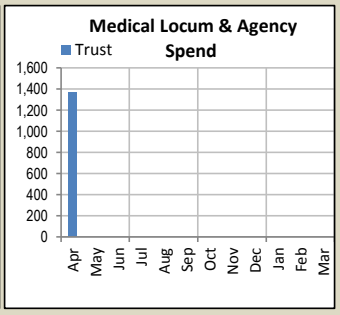




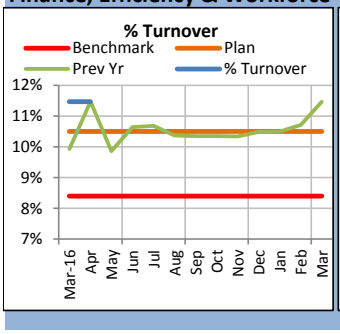
Finance, Efficiency & Workforce - WTEs, Nurse Agency Spend, Medical Locum/Agency Spend

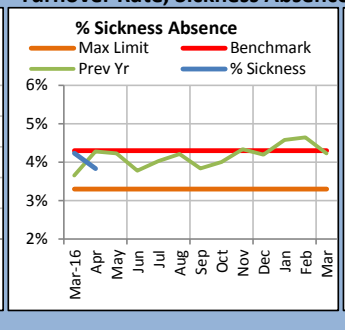


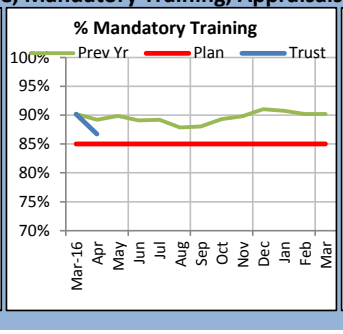


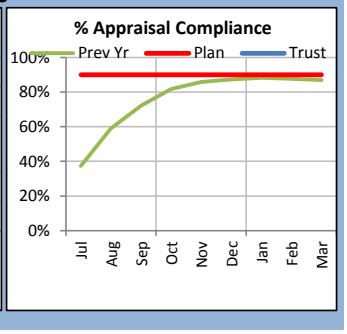


Finance, Efficiency & Workforce - Turnover Rate, Sickness Absence, Mandatory Training, Appraisals









Review of latest financial performance

- The Trust had an adverse variance against plan in April 2017 of £0.2m including STF, this is due to £0.2m shortfall against STF relating to non-achievement of the A&E trajectory target in April.
- The Trust's net deficit (including technical adjustments) is £1.3m against a planned deficit of £1.1m, therefore £0.2m adverse to plan.
- In April the Trust operated with an EBITDA surplus of £1.3m which was £0.2m adverse to plan.
- The key variances in the month are as follows:
    - Total income was £0.8m favourable in the month, Clinical Income was breakeven which included an Aligned Incentive adjustment of £1.8m, STF was £0.2m adverse in April due to missing the A&E trajectory for April and other operating income was £1m favourable, £1.25m favourable relating to STP (£1m) and PAS Allscripts (£0.25m) which is offsetting costs incurred, Private Patient income was £0.2m adverse to plan.
    - Pay was £0.1m favourable, Medical staffing was the only staff group overspent (£0.1m adverse) which was within Diagnostics (£33k), T&O (£27k) and Emergency and Acute (£31k).
    - Non Pay was overspent by £1.2m in the month which was mainly due to the STP (£1m) and Pas All Scipts (£0.25m) however this was offset by additional non clinical income.
- The CIP performance in April delivered efficiencies of £1.1m which was £0.1m adverse to plan.
- The Trust held £13.6m of cash at the end of April which is in line with the forecast value of £13.1m. Within April the Trust received double block SLA income from WK CCG, High Weald CCG and Medway CCG totalling £22.5m, along with the remaining balance of £0.8m quarter 3 STF funding. Key payments made in April by the Trust were to NHS Supply Chain c£1.7m in respect of the Linac machine, repayment of the uncommitted loan and associated interest totalling £2.5m, £2.5m paid to various Agencies to ensure the Trust didn't breech IR35 rules.

Maidstone and Tunbridge Wells NHS Trust

Trust Board Finance Pack

Month 1
2017/18

Content

Maidstone and Tunbridge Wells NHS Trust

Trust Board Finance Pack for April 2017

mtw

1.Executive Summary

Maidstone and Tunbridge Wells NHS Trust

1a. Executive Summary April 2017

Key Variances £m

	April		Headlines
Total Surplus (+) / Deficit (-)	(0.2)	Adverse	The Trusts deficit including STF was £1.3m in April which was £0.2m adverse to plan due to £0.2m slippage against STF income relating to the non achievement of the April A&E trajectory. The Trust was breakeven compared to the pre STF plan.
Clinical Income	0.0	Breakeven	Clinical Income was breakeven in the month, which included £1.8m aligned incentive adjustment. The key adverse areas in April were Regular attenders (including Chemotherapy) (£391k) and Out Patients (£239k) offset by favourable variances within High Cost Drugs (£258k), Non Elective (net of threshold adjustment) £124k, A&E £117k favourable, and Elective activity £56k favourable to plan. A number of assumptions have been made when producing the income position for month 1. Please see activity and income slides.
Other Operating Income	1.0	Favourable	Other Operating Income £1m favourable in the month , £1m relating to STP costs (offset by additional costs), £0.25m PAS Allscripts income (offset by additional costs) and £0.2m adverse variance relating to private patient income (£0.15m relating to PPU).
Pay	0.1	Favourable	Pay was £0.1m favourable in the month, Medical Staffing was the only staff group overspent in the month (£0.1m adverse), the main overspending directorates were Diagnostics (£33k), T&O (£27k) and Emergency and Acute (£31k). Nursing was breakeven in the month, the main directorate adverse in the month was Surgery which was £87k adverse, £67k adverse within Short Stay Surgical Ward at TWH due escalation, offset by £80k underspend within Specialist Medicine.
Non Pay	(1.2)	Adverse	Non Pay was overspent by £1.2m, £1m relating to STP costs offset by income and £0.25m relating to PAS AllScripts which was also offset by income.
Elective IP	(0.7)	Adverse	Elective Income was £0.7m adverse to plan in April, the Aligned Incentive contract adjustment relating to Elective activity was £0.6m therefore a net £0.1m adverse variance in April.
Sustainability and Transformation Fund	(0.2)	Adverse	The Sustainability and Transformation fund is weighted 70% towards achieving the financial plan and 30% towards A&E access targets. The trust achieved the financial target in April but missed the A&E access trajectory.
CIP / FRP	(0.1)	Adverse	The Trust achieved £1.1m savings in April, this was £0.1m adverse to plan.

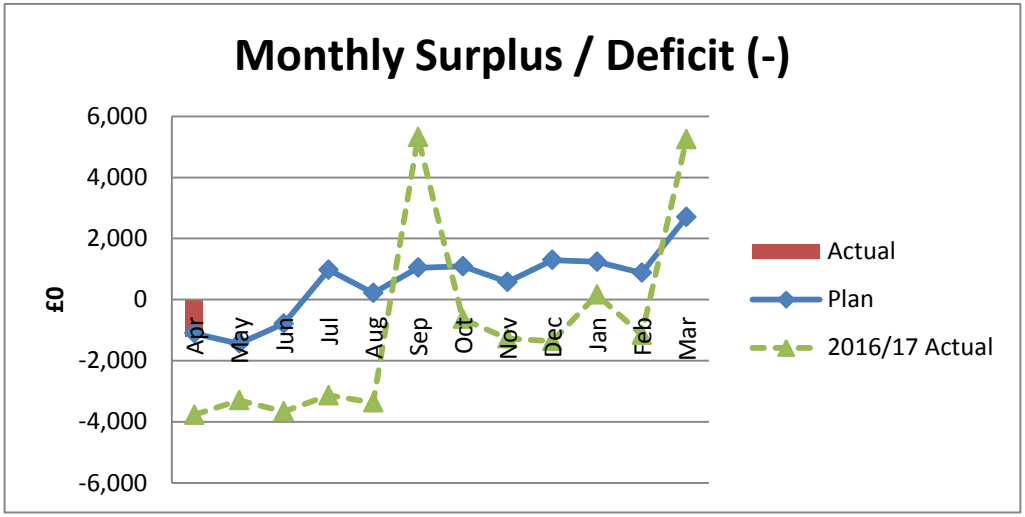
Risks:

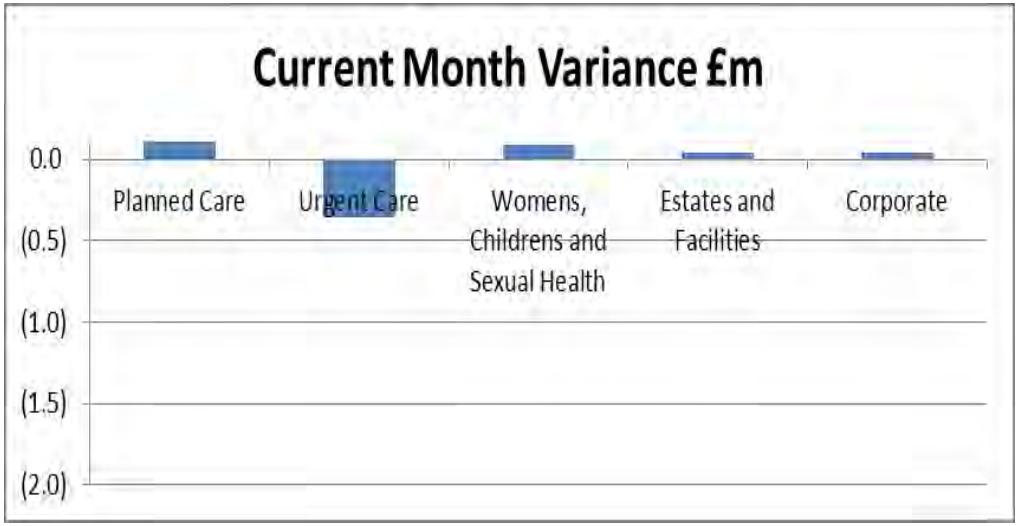
- The Trust has assumed over performance on a PbR basis for West Kent CCG relating to the cost risk share bucket. Further discussion is required with the CCG about the application of the access and use of the risk reserve, this will be reflected in the month 2 financial position.

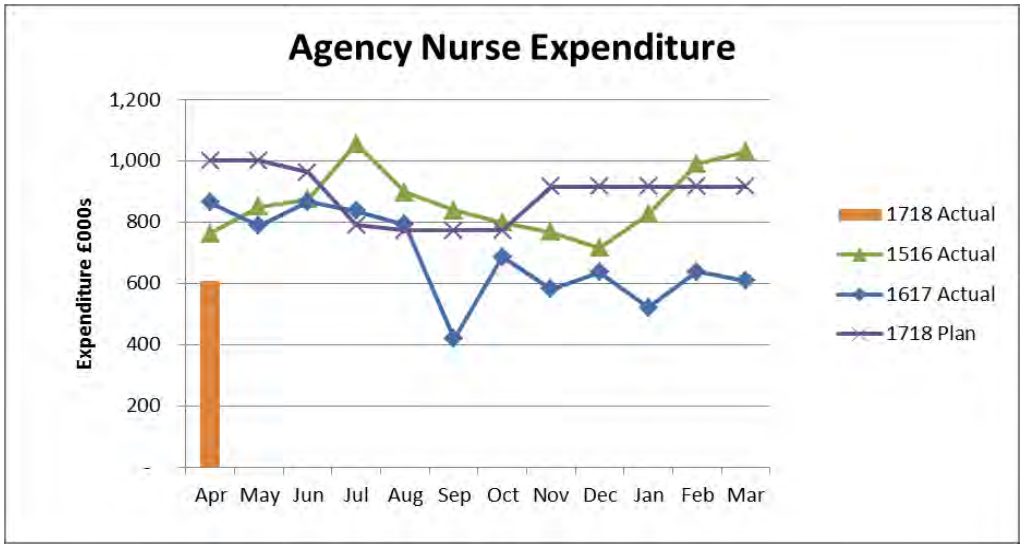
CQUINS: An assessment on system control totals and national risk profile will be made by NHS Improvement and NHS England on a quarterly basis, it is expected that the funds will be released and the Trust will be in a position to recognise the full 0.5%. Consideration of the Aligned Incentives contract impact will need to take place to ensure application of the national CQUIN guidance adhered to in full.

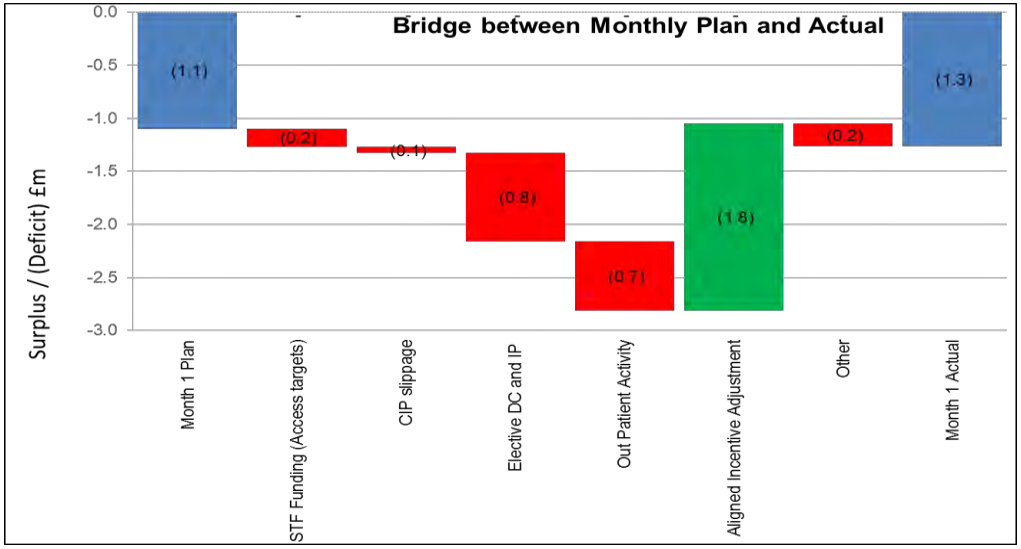
Maidstone and Tunbridge Wells NHS Trust

1b. Executive Summary KPI's April 2017









2.Income and Expenditure

Maidstone and Tunbridge Wells NHS Trust

2a. Income & Expenditure

Income & Expenditure April 2017/18

		Current Month			Annual Forecast		
		Actual £m	*Plan* £m	*Variance* £m	*Forecast* £m	*Plan* £m	*Variance* £m
Revenue							
	Clinical Income	31.9	31.9	0.0	381.9	381.9	0
	STF	0.4	0.6	(0.2)	11.2	11.2	0
	Other Operating Income	4.6	3.6	1.0	43.6	43.6	0
	Total Revenue	37.0	36.1	0.8	436.7	436.7	0
Expenditure							
	Substantive	(17.9)	(18.3)	0.4	(215.3)	(215.3)	0
	Bank	(0.9)	(0.6)	(0.3)	(6.1)	(6.1)	0
	Locum	(1.4)	(0.9)	(0.4)	(10.2)	(10.2)	0
	Agency	(0.8)	(1.3)	0.4	(13.4)	(13.4)	0
	Pay Reserves	(0.2)	(0.3)	0.0	(3.0)	(3.0)	0
	Total Pay	(21.3)	(21.4)	0.1	(248.1)	(248.1)	0
	Drugs & Medical Gases	(4.2)	(4.3)	0.1	(50.9)	(50.9)	0
	Blood	(0.2)	(0.2)	(0.0)	(2.5)	(2.5)	0
	Supplies & Services - Clinical	(2.6)	(2.3)	(0.3)	(23.7)	(23.7)	0
	Supplies & Services - General	(0.4)	(0.4)	(0.0)	(5.1)	(5.1)	0
	Services from Other NHS Bodies	(0.8)	(0.6)	(0.1)	(7.6)	(7.6)	0
	Purchase of Healthcare from Non-NHS	(0.5)	(0.9)	0.4	(7.9)	(7.9)	0
	Clinical Negligence	(1.7)	(1.7)	(0.0)	(20.6)	(20.6)	0
	Establishment	(0.3)	(0.3)	0.1	(3.7)	(3.7)	0
	Premises	(2.0)	(1.9)	(0.2)	(21.5)	(21.5)	0
	Transport	(0.1)	(0.1)	0.0	(1.4)	(1.4)	0
	Other Non-Pay Costs	(1.5)	(0.4)	(1.1)	(4.9)	(4.9)	0
	Non-Pay Reserves	(0.1)	(0.0)	(0.1)	(0.8)	(0.8)	0
	Total Non Pay	(14.4)	(13.2)	(1.2)	(150.5)	(150.5)	0
	Total Expenditure	(35.7)	(34.7)	(1.0)	(398.6)	(398.6)	0
EBITDA	**EBITDA**	1.3	1.5	(0.2)	38.1	38.1	0
		0.0	*0.0*	*(0.0)*	*8.7%*	*8.7%*	
Other Finance Costs							
	Depreciation	(1.2)	(1.2)	(0.0)	(14.8)	(14.8)	0
	Interest	(0.1)	(0.1)	(0.0)	(1.3)	(1.3)	0
	Dividend	(0.1)	(0.1)	0.0	(1.5)	(1.5)	0
	PFI and Impairments	(1.2)	(1.2)	(0.0)	(14.9)	(14.9)	0
	Total Finance Costs	(2.6)	(2.6)	(0.0)	(32.4)	(32.4)	0
Net Surplus / Deficit (-)	**Net Surplus / Deficit (-)**	(1.3)	(1.1)	(0.2)	5.7	5.7	0
Technical Adjustments	**Technical Adjustments**	0.0	0.0	0.0	1.0	1.0	0
Surplus/ Deficit (-) to B/E Duty	**Surplus/ Deficit (-) to B/E Duty Incl STF**	(1.3)	(1.1)	(0.2)	6.7	6.7	0.0
	Surplus/ Deficit (-) to B/E Duty Excl STF	(1.7)	(1.7)	0.0	(4.5)	(4.5)	0.0

Commentary

The Trusts deficit including STF was £1.3m in April which was £0.2m adverse to plan due to £0.2m slippage against STF income relating to the non achievement of the April A&E trajectory. The Trust was breakeven compared to the pre STF plan.

Clinical Income (Excluding STF) was breakeven in the month, which included £1.8m aligned incentive adjustment. The key adverse areas in April were Regular attenders (including Chemotherapy) (£391k) and Out Patients (£239k) offset by favourable, variances within High Cost Drugs (£258k), Non Elective (net of threshold adjustment) £124k, A&E £117k favourable, and Elective activity £56k favourable to plan.

STF income £0.2m adverse in month relating to non achievement of the April A&E trajectory.

Other Operating Income £1m favourable in the month , £1m relating to STP costs (offset by additional costs), £0.25m PAS Allscripts income (offset by additional costs) and £0.2m adverse variance relating to private patient income (£0.15m relating to PPU).

Pay was £0.1m favourable in the month, Medical Staffing was the only staff group overspent in the month (£86k adverse), the main overspending directorates were Diagnostics (£33k), T&O (£27k) and Emergency and Acute (£31k). Nursing was breakeven in the month, the main directorate adverse in the month was Surgery which was £87k adverse, £67k adverse within Short Stay Surgical Ward at TWH due to escalation, offset by £80k underspend within Specialist Medicine.

Non Pay was overspent by £1.2m, £1m relating to STP costs offset by income and £0.25m relating to PAS AllScripts which was also offset by income.

The Trust delivered £1.1m savings in April compared to a plan of £1.1m, Urgent Care Division was £0.3m adverse to plan with favourable variances within all the other Divisions. The majority of the variances within Urgent Care relate to a plan CIP phasing change, compared to the current 'live' plan the division was £53k adverse in April.

3. Expenditure Analysis

Maidstone and Tunbridge Wells NHS Trust

3a. Run Rate Analysis

Analysis of 13 Monthly Performance (£m's)

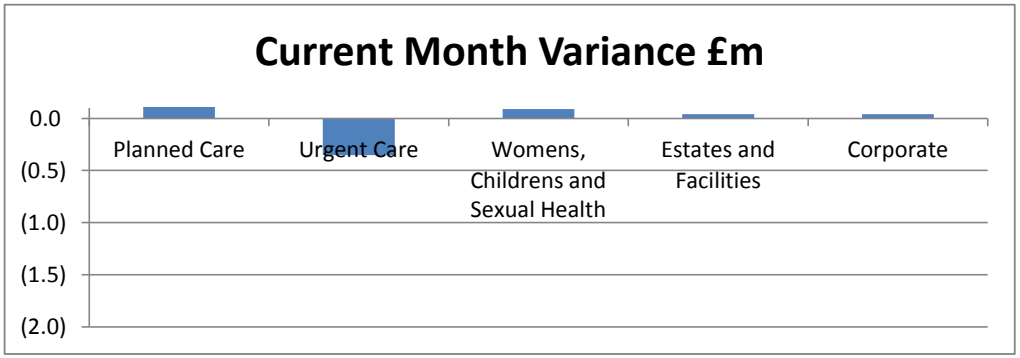
		Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	Change between Months
Revenue	Clinical Income	25.9	27.0	27.8	27.0	27.2	32.0	28.5	28.6	28.1	27.5	27.0	29.1	31.9	2.9
	STF	0.7	0.7	0.7	0.7	0.7	2.7	0.9	0.7	0.6	(0.0)	0.0	0.8	0.4	(0.4)
	High Cost Drugs	2.8	2.6	2.8	2.6	2.7	2.9	2.9	2.8	3.8	3.1	2.7	3.2	(0.1)	(3.3)
	Other Operating Income	3.2	3.2	2.9	3.3	2.9	1.0	3.2	3.2	3.3	4.5	3.9	7.6	4.7	(2.9)
	Total Revenue	**32.5**	**33.5**	**34.1**	**33.6**	**33.4**	**38.6**	**35.4**	**35.3**	**35.7**	**35.1**	**33.5**	**40.7**	**37.0**	**(3.7)**
Expenditure	Substantive	(17.8)	(17.9)	(18.1)	(17.9)	(17.9)	(18.1)	(18.0)	(18.1)	(18.1)	(17.6)	(17.8)	(17.3)	(17.9)	(0.6)
	Bank	(0.9)	(0.8)	(0.8)	(0.7)	(0.9)	(0.8)	(0.8)	(0.8)	(1.0)	(1.1)	(0.8)	(1.0)	(0.9)	0.0
	Locum	(1.2)	(0.9)	(1.0)	(1.1)	(1.1)	(0.8)	(0.9)	(0.5)	(1.9)	(1.1)	(0.9)	(1.6)	(1.4)	0.2
	Agency	(1.3)	(1.6)	(1.7)	(1.5)	(1.3)	(1.2)	(1.4)	(1.6)	(0.1)	(0.8)	(0.9)	(1.0)	(0.8)	0.1
	Pay Reserves	0	0	0	0	0	0	0	0	0	0	0	0	(0.2)	(0.2)
	Total Pay	(21.2)	(21.2)	(21.6)	(21.3)	(21.2)	(20.9)	(21.1)	(20.9)	(21.1)	(20.5)	(20.5)	(20.8)	(21.3)	(0.5)
Non-Pay	Drugs & Medical Gases	(4.3)	(4.1)	(4.4)	(3.8)	(4.0)	(4.5)	(3.9)	(4.8)	(4.6)	(4.2)	(4.0)	(5.1)	(4.2)	0.9
	Blood	(0.2)	(0.2)	(0.2)	(0.2)	(0.2)	(0.2)	(0.2)	(0.2)	(0.2)	(0.2)	(0.2)	(0.2)	(0.2)	(0.0)
	Supplies & Services - Clinical	(2.2)	(2.7)	(2.7)	(2.7)	(3.0)	(2.7)	(2.7)	(2.6)	(2.8)	(2.7)	(2.5)	(3.1)	(2.6)	0.5
	Supplies & Services - General	(0.4)	(0.5)	(0.5)	(0.4)	(0.5)	(0.4)	(0.5)	(0.5)	(0.5)	(0.4)	(0.4)	(0.6)	(0.4)	0.2
	Services from Other NHS Bodies	(0.7)	(0.7)	(0.8)	(0.6)	(0.6)	(0.7)	(0.7)	(0.6)	(0.7)	(0.6)	(0.7)	(0.5)	(0.8)	(0.3)
	Purchase of Healthcare from Non-NHS	(0.8)	(0.7)	(0.8)	(0.9)	(0.9)	(0.6)	(0.8)	(0.7)	(0.7)	(0.8)	(0.5)	(0.5)	(0.5)	0.0
	Clinical Negligence	(1.5)	(1.5)	(1.5)	(1.5)	(1.5)	(1.5)	(1.5)	(1.5)	(1.5)	(1.5)	(1.5)	(1.5)	(1.7)	(0.2)
	Establishment	(0.2)	(0.3)	(0.3)	(0.4)	(0.3)	(0.4)	(0.3)	(0.3)	(0.3)	(0.3)	(0.3)	(0.3)	(0.3)	0.0
	Premises	(2.1)	(1.7)	(1.9)	(1.9)	(1.7)	(1.2)	(1.7)	(1.4)	(1.8)	(1.8)	(1.7)	(1.7)	(2.0)	(0.4)
	Transport	(0.1)	(0.2)	(0.2)	(0.1)	(0.1)	(0.2)	(0.1)	(0.1)	(0.1)	(0.1)	(0.1)	(0.1)	(0.1)	0.0
	Other Non-Pay Costs	(0.2)	(0.7)	(0.6)	(0.4)	(0.2)	(0.3)	(0.3)	(0.9)	(0.9)	(1.2)	(0.7)	(0.5)	(1.5)	(1.0)
	Non-Pay Reserves	(0.2)	(0.2)	(0.4)	(0.4)	(0.4)	0.4	0.0	0	0	0	0	1.3	(0.1)	(1.4)
	Total Non Pay	(12.9)	(13.4)	(14.1)	(13.3)	(13.4)	(12.3)	(12.9)	(13.6)	(14.1)	(13.8)	(12.7)	(12.9)	(14.4)	(1.5)
	Total Expenditure	(34.1)	(34.6)	(35.7)	(34.6)	(34.6)	(33.1)	(34.0)	(34.5)	(35.2)	(34.3)	(33.2)	(33.7)	(35.7)	(2.0)
EBITDA	EBITDA	(1.6)	(1.2)	(1.5)	(1.1)	(1.2)	5.5	1.4	0.9	0.6	0.8	0.3	7.0	1.3	(5.7)
		-5%	*-3%*	*-4%*	*-3%*	*-3%*	*14%*	*4%*	*2%*	*2%*	*2%*	*1%*	*17%*	*4%*	
Other Finance Costs	Depreciation	(1.4)	(1.4)	(1.4)	(1.4)	(1.4)	(1.4)	(1.4)	(1.4)	(0.8)	0.8	(1.0)	(1.2)	(1.2)	0.0
	Interest	(0.1)	(0.1)	(0.1)	(0.1)	(0.1)	(0.1)	(0.1)	(0.1)	(0.1)	(0.0)	(0.2)	(0.1)	(0.1)	(0.0)
	Dividend	(0.3)	(0.3)	(0.3)	(0.2)	(0.3)	(0.3)	(0.3)	(0.3)	(0.3)	(0.3)	0.7	0.1	(0.1)	(0.2)
	PFI and Impairments	(1.1)	(1.1)	(1.1)	(1.1)	(1.1)	(1.1)	(1.1)	(1.1)	(1.2)	(1.1)	(42.3)	(1.2)	(1.2)	0.0
		(2.9)	**(2.8)**	**(2.8)**	**(2.8)**	**(2.8)**	**(2.9)**	**(2.9)**	**(2.9)**	**(2.4)**	**(0.7)**	**(42.7)**	**(2.4)**	**(2.6)**	**(0.2)**
Net Surplus / Deficit (-)	Net Surplus / Deficit (-)	(4.5)	(4.0)	(4.4)	(3.8)	(4.0)	2.6	(1.5)	(2.0)	(1.8)	0.1	(42.4)	4.6	(1.3)	(5.9)
Technical Adjustments	Technical Adjustments	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	(0.0)	0.1	40.3	(0.1)	0	0.1
Surplus/ Deficit (-) to B/E Duty Incl STF	Surplus/ Deficit (-) to B/E Duty	(4.4)	(3.9)	(4.2)	(3.7)	(3.9)	2.7	(1.4)	(1.9)	(1.9)	0.3	(2.0)	4.5	(1.3)	(5.7)
Surplus/ Deficit (-) to B/E Duty Excl STF	Surplus/ Deficit (-) to B/E Duty	(5.0)	(4.5)	(4.9)	(4.4)	(4.6)	(0.0)	(2.3)	(2.6)	(2.5)	0.3	(2.0)	3.7	(1.7)	(5.3)

4. Cost Improvement Programme

Maidstone and Tunbridge Wells NHS Trust

4a. Curent month savings by Directorate

	In Month		
	Actual	*Plan*	*Variance*
	£m	£m	£m
Cancer and Haematology	0.0	0.1	(0.0)
Critical Care	0.1	0.1	0.0
Diagnostics	0.1	0.1	0.0
Head and Neck	0.0	0.0	0.0
Surgery	0.1	0.1	0.0
Trauma and Orthopaedics	0.4	0.3	0.1
Patient Admin	0.0	0.0	0.0
Private Patients Unit	0.0	0.0	0.0
Total Planned Care	**0.7**	**0.6**	**0.1**
Urgent Care	**0.1**	**0.4**	**(0.4)**
Womens, Childrens and Sexual Health	**0.1**	**0.0**	**0.1**
Estates and Facilities	**0.0**	**0.0**	**0.0**
Corporate	**0.1**	**0.1**	**0.0**
Total	**1.1**	**1.1**	**(0.1)**



Comment

The Trust achieved £1.1m savings in April which was £0.1m adverse to plan.

The plan value is based upon the Trusts submitted plan to NHSI in December 16 and March 17. The Trust has a 'live' plan for monitoring the actuals and phasing of the CIP programme. Based upon the 'live plan the savings achieved in April were £149k below plan.

Planned Care: £0.1m favourable compared to original CIP planned phasing, however £70k slippage in April when compared to the 'live' plan. The main areas of slippage relate to Diagnostics (£50k adverse) due to the delay in the new MLS contract for Pathology.

Urgent Care: £0.4m adverse compared to the original plan however when compared to the 'live' plan the directorate are £50k adverse in the month which is mainly due to slippage against procurement savings.

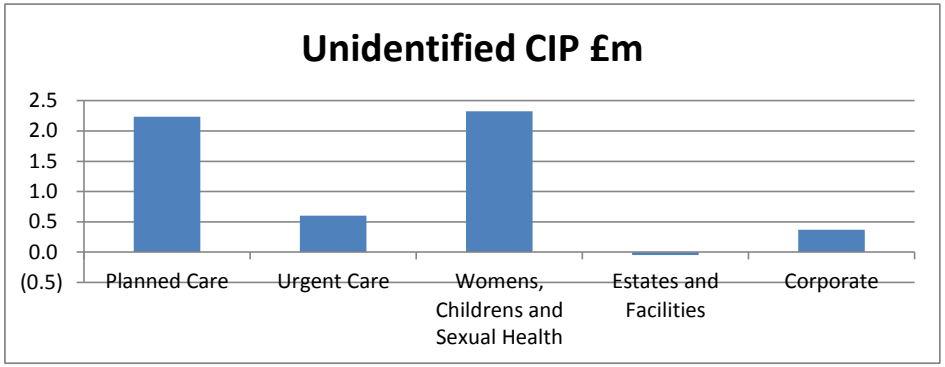
Womens, Childrens and Sexual Health: The main saving delivered in april related to the reduction of outsourcing (£50k).

Maidstone and Tunbridge Wells NHS Trust

6b. Forecast savings by Directorate

Directorate Performance

	Forecast Savings					
	Actual Identified	*Unidentified*	*Forecast*	*Plan*	*Variance*	*% Unidentified*
	£m	£m	£m	£m	£m	
Cancer and Haematology	1.6	0.4	2.0	2.0	0.0	18%
Critical Care	1.5	0.6	2.2	2.2	0.0	29%
Diagnostics	2.2	(0.1)	2.2	2.2	0.0	-3%
Head and Neck	1.1	(0.1)	1.0	1.0	0.0	-13%
Surgery	1.4	0.4	1.8	1.8	0.0	20%
Trauma and Orthopaedics	4.1	1.0	5.1	5.1	0.0	20%
Patient Admin	0.0	0.1	0.1	0.1	0.0	78%
Private Patients Unit	0.2	(0.0)	0.2	0.2	0.0	-26%
Total Planned Care	**12.2**	**2.2**	**14.5**	**14.5**	**0.0**	**15%**
Urgent Care	**8.3**	**0.6**	**8.9**	**8.9**	**0.0**	**7%**
Womens, Childrens and Sexual Health	**1.3**	**2.3**	**3.7**	**3.7**	**0.0**	**64%**
Estates and Facilities	**2.9**	**(0.1)**	**2.9**	**2.9**	**0.0**	**-2%**
Corporate	**1.5**	**0.4**	**1.9**	**1.9**	**0.0**	**20%**
Total	**26.2**	**5.5**	**31.7**	**31.7**	**0.0**	17%



The Trust has a £31.7m CIP plan for 2017/18 and has identified £26.2m (non risk adjusted) , £5.5m unidentified. The current forecasted risk adjusted identified savings is £19.5m, a shortfall of £12.2m.

Womens, Childrens and Sexual Health Division have the largest shortfall to the target, £2.3m unidentified (64%).

Estates and Facilities are the only Division who have fully identified their savings target (2% favourable). The main scheme relate to an asset sale of £1.1m. The directorate have been asked to collate further opportunities to mitigate potential shortfalls elsewhere in the Trust wide CIP programme.

5. Balance Sheet and Liquidity

Maidstone and Tunbridge Wells NHS Trust

5a. Balance Sheet

April 2017

The Trust Balance Sheet is produced on a monthly basis and reflects changes in the asset values, as well as movement in liabilities.

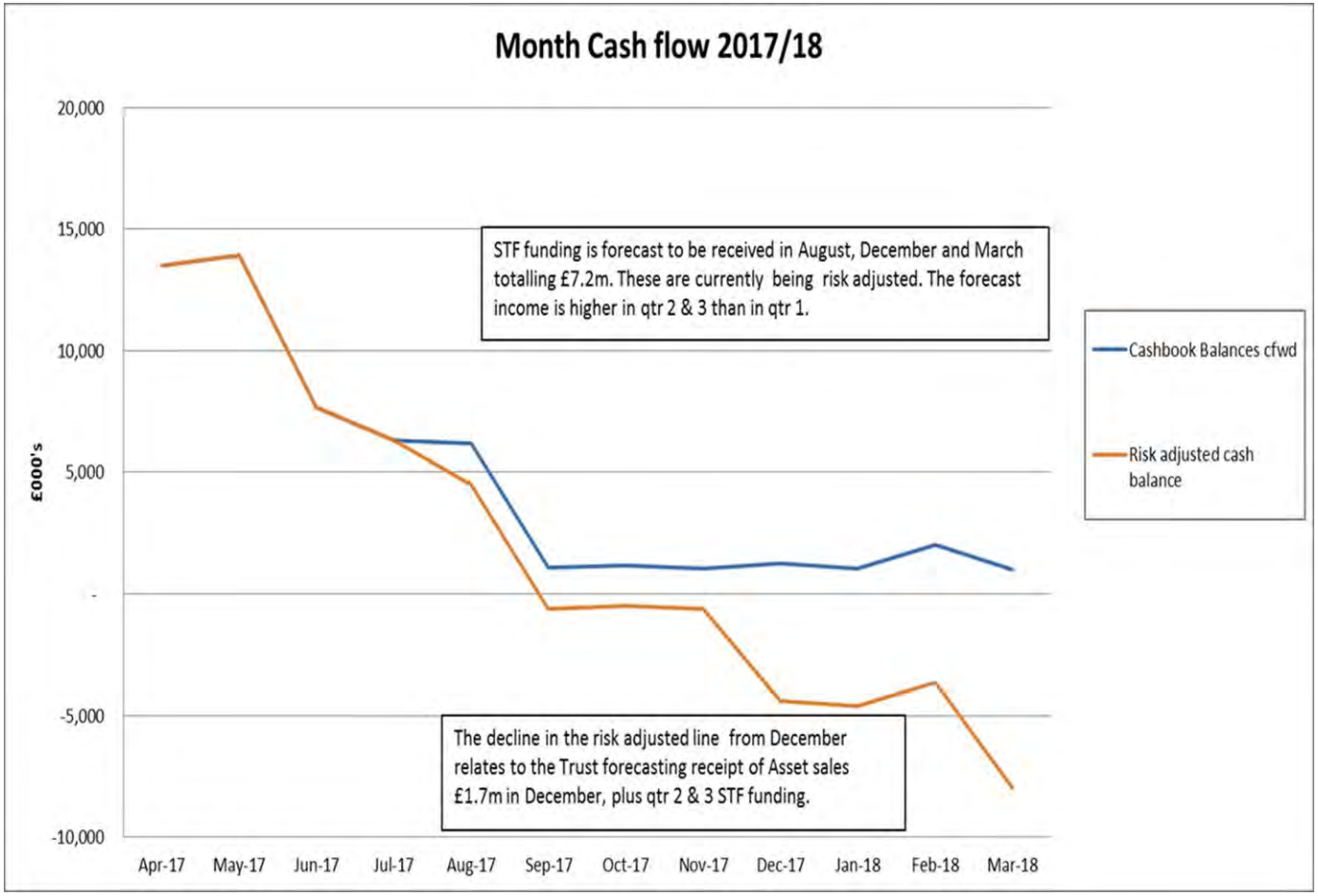
	April			March	Full year	
£m's	**Reported**	**Plan**	**Variance**	**Reported**	**Plan**	**Forecast**
Property, Plant and Equipment (Fixed Assets)	279.1	275.3	3.8	280.2	282.1	282.1
Intangibles	3.1	2.8	0.3	3.2	2.1	2.1
PFI Lifecycle	0.0	0.0	0.0	0.0	0.0	0.0
Debtors Long Term	1.5	1.2	0.3	1.5	1.2	1.2
Total Non-Current Assets	**283.7**	**279.3**	**4.4**	**284.9**	**285.4**	**285.4**
Current Assets						
Inventory (Stock)	8.1	8.3	(0.2)	7.9	8.3	8.3
Receivables (Debtors) - NHS	37.0	23.6	13.4	35.3	21.0	21.0
Receivables (Debtors) - Non-NHS	16.3	9.5	6.8	11.1	9.5	9.5
Cash	13.6	13.1	0.5	1.4	1.0	1.0
Assets Held For Sale	1.7	0.0	1.7	1.7	0.0	0.0
Total Current Assets	**76.7**	**54.4**	**22.3**	**57.5**	**39.8**	**39.8**
Current Liabilities						
Payables (Creditors) - NHS	(4.4)	(4.5)	0.0	(4.5)	(4.5)	(4.5)
Payables (Creditors) - Non-NHS	(73.9)	(35.1)	(38.8)	(51.6)	(13.6)	(13.6)
Capital & Working Capital Loan	(2.2)	(2.2)	0.0	(4.6)	(19.1)	(19.1)
Temporary Borrowing	0.0	0.0	0.0	0.0	0.0	0.0
Borrowings - PFI	(5.0)	(5.0)	(0.0)	(5.0)	(5.5)	(5.5)
Provisions for Liabilities and Charges	(1.8)	(1.1)	(0.7)	(1.7)	(1.3)	(1.3)
Total Current Liabilities	**(87.3)**	**(47.8)**	**(39.4)**	**(67.5)**	**(44.0)**	**(44.0)**
Net Current Assets	(10.5)	6.6	(17.1)	(10.0)	(4.2)	(4.2)
Finance Lease - Non- Current	(197.8)	(198.2)	0.5	(198.2)	(192.7)	(192.7)
Capital Loan - (interest Bearing Borrowings)	(12.3)	(12.3)	0.0	(12.3)	(10.2)	(10.2)
Interim Revolving Working Capital Facility	(29.0)	(29.0)	0.0	(29.0)	(16.1)	(16.1)
Provisions for Liabilities and Charges	(1.2)	(0.7)	(0.6)	(1.3)	(0.4)	(0.4)
Total Assets Employed	**32.8**	**45.6**	**(12.8)**	**34.1**	**61.8**	**61.8**
Financed By						
Capital & Reserves						
Public dividend capital	(205.0)	(205.0)	(0.0)	(205.0)	(208.6)	(208.6)
Revaluation reserve	(30.3)	(30.3)	0.0	(30.3)	(36.2)	(36.2)
Retained Earnings Reserve	202.5	189.7	12.8	201.2	182.9	182.9
Total Capital & Reserves	**(32.8)**	**(45.6)**	**12.8**	**(34.1)**	**(61.8)**	**(61.8)**

Commentary:
The balance sheet is £12.8m or 30% less than plan, primarily due to significant variations in current assets and current liabilities. Key movements to April are in working capital where receivables increase by 60% and payables increased by 100% over plan. The teams are continuing to focus on reducing the aged debtors and creditors and reviewing current processes to ensure improvement in working capital going forward.
Non-Current Assets (PPE)- The value of PPE has increased from the March's position as assets which were under construction have been capitalised and brought into use. The in-year capital programme has been prioritised and business cases are currently being prepared.
Current Assets - Inventory has increased slightly from the reported March's position, mainly due to increase in pharmacy stock from £3.3m to £3.6m. Materials management stock remains at £1m, whilst cardiology stocks decreased £1.3m to £1.2m. Inventory reduction is a cash management strategy.
NHS Receivables have increased since March, remaining significantly higher than the plan value. Of the £37m balance, £17.6m relates to invoiced debt of which £3.3m is aged debt over 90 days. Debt over 90 days has increased since March mainly relating to Medway FT SLA and East Kent FT consultant uplift. Due to the financial situation of many neighbouring NHS organisations regular communication is continuing and "like for like" arrangements are being actioned.
Trade receivables has increased by £5.2m from March's position, and is above plan by £6.8m. Included within this balance is trade invoiced debt of £2.2m and private patient invoiced debt of £0.7m which is fairly consistent with £0.8m in March.
Current Liabilities -NHS trade payables has remained consistent with the March reported position and the plan of £4.5m. Non-NHS trade payables has increased by £22.3m, still remaining significantly above plan.

Of the £73.9m trade creditor balances, £21.9m relates to invoices, £28.8m is deferred income primarily relating to double block from West Kent CCG, High Weald CCG and Medway CCG, and other funding for PAS AllScript and LDA. The remaining £23.2m relates to accruals, including TAX, NI, Superannuation, PDC and deferred income.

Maidstone and Tunbridge Wells NHS Trust

5b. | Cash Flow



Commentary

The blue line shows the Trust's cash position from the start of April, after receiving a double block from West Kent CCG, High Weald CCG and Medway CCG.

For 17/18 the Trust is assuming no receipt of external Revenue financing compared to 2016/17 where the Trust received £12.1m IRWCF.

The Trust repaid the remaining £2.458m of uncommitted loan in April, with £68k associated interest.

STF funding of £0.8m was received in April, which related to the Qtr 3 16/17 appeal.

The risk adjusted items on the graph relate to STF funding for qtrs 1,2 and 3, along with £1.7m asset sales forecast for receipt in December. If this income is not received these will be mitigated by proposed strategies.

The other two risk adjusted items relate to capital funding for 2 linacs £3.6m and capital loan of £4m, these are mitigated by reducing the in year capital spend.
The cash flow is based on the Income and Expenditure plan along with working capital adjustments.

A number of large payments were made in April, which include £2.5m agency invoices paid 3rd April to ensure the Trust met the IR35 rules, capital payment of £1.6m for a linac machine and the monthly £2.3m PFI unitary payment .

Trust Board meeting – May 2017

NHS Maidstone and Tunbridge Wells NHS Trust

5-9 Planned and actual ward staffing for April 2017 — Chief Nurse

The enclosed report shows the planned v actual nursing staffing as uploaded to UNIFY for the month of April 2017. This data is also published via the NHS Choices website and the Trust website as directed by NHS England and the National Quality Board.

Which Committees have reviewed the information prior to Board submission?
- N/A

Reason for submission to the Board (decision, discussion, information, assurance etc.) [1]
Assurance

[1] All information received by the Board should pass at least one of the tests from 'The Intelligent Board' & 'Safe in the knowledge: How do NHS Trust Boards ensure safe care for their patients': the information prompts relevant & constructive challenge; the information supports informed decision-making; the information is effective in providing early warning of potential problems; the information reflects the experiences of users & services; the information develops Directors' understanding of the Trust & its performance

Care Hours Per Patient Day (CHPPD)
CHPPD is calculated by adding the hours of available registered nurses to the hours of available healthcare support workers during each 24 hour period and dividing the total by every 24 hours of in-patient admissions, or approximating 24 patient hours by counts of patients at midnight. NHS England have recommended the latter for the purposes of the UNIFY upload and subsequent publication.

The Carter report indicated a range for CHPPD between 6.3 and 15.48. The median was 9.13.
Overall CHPPD for both sites has remained static at 7.6 for Maidstone Hospital, and 9.7 for Tunbridge Wells.

Planned vs. Actual
The fill rate percentage is the actual hours used compared to the hours set in the budgeted establishment. That is, the budgeted establishment sets out the numbers of Registered Nurses and Clinical Support Workers based on an average acuity and dependency (or planned case mix for elective units). When units are faced with increased acuity and/or dependency, in escalation or undergo a service change that is not currently reflected in the budget, this is represented by an 'overfill'. Financial and key nurse-sensitive indicators have also been included as an aid to triangulation of both efficient and effective use of staff.

This is evident in a number of areas where there has been an unplanned increase in dependency. A number of wards have required additional staff, particularly at night, to manage patients with altered cognitive states, increased clinical dependency or with other mental health issues.

Wards in this category during April were Edith Cavel, Wards 10, 11 and 20.

All enhanced care needs are supported by an appropriate risk assessment, reviewed and approved by the Matron.

Escalation areas account for over-fill on Maidstone AMU (UMAU), and TWH AMU, and Hedgehog.

Ward 21 had a variation in the RN/CSW ratio. This was an accepted risk as unable to fill all shifts via bank/framework agency. The CSW numbers were increased to ensure overall numbers of staff on the ward were sufficient to respond to patient need. This was a considered decision based on acuity and skill mix with oversight by the directorate matron and the site practitioners.

Maternity manage staffing as a 'floor' with support staff moving between areas as required. Midwifery needs are assessed regularly by the Labour Ward Coordinator with midwives following women from delivery through to post-natal. This ensures that all women in established labour received 1:1 care from a Registered Midwife.

A number of wards will cross-cover each other. This enables a more efficient use of staff, and allows for safe redeployment of staff to escalated areas. For example Short Stay Surgery at Tunbridge Wells Hospital provide support to the escalated beds in Recovery. The ITUs will move staff between sites according to the acuity levels on each site. Cross-cover support was also provided to wards 2, 21, 22 and Whatman.

When the fill rate is only marginally over 100% by +/- 5% this is normally related to working patterns which required staff to work an additional shift periodically as long shifts result in a staff member either working over or under their contracted hours in any given month.

The RAG rating for the fill rate is rated as:
Green: Greater than 90% but less than 110%
Amber: Less than 90% OR greater than 110%
Red: Less than 80% OR greater than 130%

The principle being that any shortfall below 90% may have some level of impact on the delivery of care. However this is dependent on both acuity and dependency. Acuity is the term used to describe the clinical needs of a patient or group of patients, whilst dependency refers to the support a patient or group of patients may need with activities such as eating, drinking, or washing.

High fill rates (those greater than 110%) would indicate significant changes in acuity and dependency. This results in the need for short notice additional staff and as a consequence may have a detrimental impact on the quality of patient care.

The exception reporting rationale is overall RAG rated according to professional judgement against the following expectations:

- The ward maintained a nurse to patient ratio of 1:5 – 1:7
- Acuity and dependency within expected tolerances
- Workforce issues such as significant vacancy
- Quality & safety data
- Overall staffing levels
- Risks posed to patients as a result of the above

The **overall** RAG status gives an indication of the safety levels of the ward, compared to professional judgement as set out in the Staffing Escalation Policy. The arrow indicates improvement or deterioration when compared to the previous month. The thresholds for the overall rating are set out below:

RAG	Details
	Minor or No impact: Staffing levels are as expected and the ward is considered to be safely staffed taking into consideration workloads, patient acuity and skill mix. RN to patient ratio of 1:7 or better Skill mix within recommended guidance Routine sickness/absence not impacting on safe care delivery Clinical Care given as planned including clinical observations, food and hydration needs met, and drug rounds on time. OR Staffing numbers not as expected but reasonable given current workload and patient acuity.
	Moderate Impact: Staffing levels are not as expected and minor adjustments are made to bring staffing to a reasonable level. OR Staffing numbers are as expected, but given workloads, acuity and skill mix additional staff may be required. Requires redeployment of staff from other wards RN to Patient ratio >1:8 Elements of clinical care not being delivered as planned
	Significant Impact: Staffing levels are inadequate to manage current demand in terms of workloads, patient acuity and skill mix. Key clinical interventions such as intravenous therapy, clinical observations or nutrition and hydration needs not being met. Systemic staffing issues impacting on delivery of care. Use of non-ward based nurses to support services RN to Patient ratio >1:9 Need to instigate Business Continuity

April '17		Day		Night			Nurse Sensitive Indicators						Financial review		
Hospital Site name	Ward name	Average fill rate registered nurses/midwives	Average fill rate care staff (%)	Average fill rate registered nurses/midwives	Average fill rate care staff (%)	Overall Care Hours per pt day	FFT Response Rate	FFT Score % Positive	Falls	PU ward acquired	Overall RAG Status	Comments	Budget £	Actual £	Variance £ (overspend)
MAIDSTONE	Acute Stroke	91.3%	102.5%	99.2%	106.7%	7.1	46.0%	100.0%	3	0			132,328	142,946	-10,618
MAIDSTONE	Foster Clark	92.0%	99.2%	98.9%	98.3%	6.4	9.8%	92.3%	3	0			109,824	88,591	21,233
MAIDSTONE	Cornwallis	94.4%	86.7%	91.1%	90.0%	7.5	69.8%	97.7%	1	0		CSW fill rate an accepted risk. RN support provided to Whatman on three occasions.	72,057	72,839	-782
MAIDSTONE	Coronary Care Unit (CCU)	98.3%	86.7%	98.3%	N/A	10.3	0.0%	0.0%	0	0		CSW fill rate an accepted risk. Unit collocated with Culpepper.	103,725	105,989	-2,264
MAIDSTONE	Culpepper	105.0%	95.0%	100.0%	103.3%	7.1	56.3%	94.4%	0	0					
MAIDSTONE	John Day	89.4%	104.4%	100.0%	103.3%	6.8	38.5%	100.0%	4	1		10 RN shifts unfilled. Bank/agency unable to fill. Gaps due to combination of vacancy and sickness.	127,486	124,942	2,544
MAIDSTONE	Intensive Treatment Unit (ITU)	98.3%	N/A	97.1%	N/A	27.7	100.0%	100.0%	1	0			174,246	168,277	5,969
MAIDSTONE	Pye Oliver	90.6%	96.0%	100.0%	100.0%	7.3	33.7%	93.1%	2	0			100,557	113,887	-13,330
MAIDSTONE	Chaucer	99.2%	96.7%	100.0%	99.2%	6.0	30.2%	92.3%	5	2			135,000	119,875	15,125
MAIDSTONE	Lord North	98.0%	111.8%	101.1%	100.0%	7.0	44.4%	100.0%	2	1		Additional support worker to support ward attenders. Fill from within existing budget.	101,913	101,268	645
MAIDSTONE	Mercer	105.0%	94.2%	98.9%	96.7%	6.7	32.4%	100.0%	8	3			101,227	102,400	-1,173
MAIDSTONE	Edith Cavell (MOU)	94.9%	114.3%	100.0%	123.1%	8.1	93.3%	96.4%	2	0		Enhanced care/special required for 9 days/nights (mental health patient)	75,054	63,280	11,774
MAIDSTONE	Urgent Medical Ambulatory Unit (UMAU)	89.8%	91.7%	122.2%	183.3%	11.6	9.0%	94.4%	4	0		Low RN fill rate due to short notice sickness. Priority given to ensuring nights covered for escalation/additional capacity beds.	87,685	109,975	-22,290
TWH	Stroke/W22	82.2%	99.3%	90.7%	94.4%	9.4	108.3%	100.0%	11	0		Reduced RN fill rate due to inability to fill from bank/framework agency. Support provided by CNS and neighbouring wards.	163,074	139,328	23,746
TWH	Coronary Care Unit (CCU)	99.0%	93.3%	96.7%	N/A	11.8	45.0%	100.0%	0	0			61,501	58,265	3,236
TWH	Gynaecology/ Ward 33	94.9%	94.6%	100.0%	100.0%	7.9	29.4%	92.9%	0	0			74,602	81,564	-6,962
TWH	Intensive Treatment Unit (ITU)	96.3%	100.0%	97.5%	80.0%	29.3	0.0%	0.0%	0	0		Reduced CSW fill rate at night an accepted risk. Low dependency in month.	192,154	180,240	11,914
TWH	Medical Assessment Unit	87.8%	102.5%	118.0%	185.4%	8.3	66.8%	97.0%	9	0		Low fill rate during the day. Unable to fill via bank. Priority given to cover at night to meet escalation/additional capacity demand.	178,200	168,991	9,209
TWH	SAU	97.8%	100.0%	100.0%	96.7%	10.8			0	0			54,119	63,572	-9,453
TWH	Ward 32	89.4%	93.3%	98.9%	102.5%	7.3	22.2%	100.0%	9	2		RN fill rate due to inability to fill from bank/framework agency.	126,956	130,263	-3,307
TWH	Ward 10	96.1%	98.3%	75.0%	181.7%	7.4	0.0%	0.0%	0	1		19 nights required enhanced care. 10 of these were cohorted (patients with cognitive impairment). RN:CSW ratio an accepted risk in light of this.	112,453	121,258	-8,805
TWH	Ward 11	95.2%	111.1%	90.8%	116.7%	6.8	0.0%	0.0%	1	0		Additional CSW support required to enable RN to cover tracheostomy patient for 3 days.	110,018	122,805	-12,787
TWH	Ward 12	93.5%	95.0%	94.4%	99.2%	6.8	12.5%	100.0%	7	0			122,915	108,898	14,017
TWH	Ward 20	94.4%	116.7%	96.7%	148.3%	4.3	7.7%	33.3%	7	1		Increased number of cognitively impaired patients requiring enhanced care. Cohort approach used.	106,679	112,324	-5,645
TWH	Ward 21	96.7%	96.7%	81.3%	131.7%	6.1	19.4%	100.0%	1	2		RN:CSW ratio shift due to lack of available RNs on bank or agency.	133,012	133,058	-46
TWH	Ward 2	89.2%	99.3%	95.6%	102.5%	6.8	15.6%	100.0%	8	0		RN fill rate due to vacancy and bank/agency unable to fill.	124,028	111,270	12,758
TWH	Ward 30	91.5%	95.5%	97.5%	103.3%	6.5	25.5%	100.0%	9	0			108,041	115,865	-7,824
TWH	Ward 31	102.2%	100.7%	98.3%	97.8%	7.8	52.6%	86.7%	5	0			129,736	133,691	-3,955
Crowborough	Birth Centre	98.3%	76.7%	86.7%	100.0%				0	0		Fill rate an accepted risk. Unit collocated with another facility so CSW during day mitigated. On-call system in place for night.	85,997	71,602	14,395
TWH	Ante-Natal	100.0%	93.3%	96.7%	83.3%		44.7%	94.2%	0	0		CSW fill rate an accepted risk. All women in established labour received 1:1 care.	615,756	686,037	-70,281
TWH	Delivery Suite	96.3%	100.0%	93.7%	100.0%				0	0					
TWH	Post-Natal	97.1%	88.9%	98.3%	83.3%				0	0					
TWH	Gynae Triage	100.0%	100.0%	98.3%	100.0%				0	0			11,974	11,909	65
TWH	Hedgehog	102.8%	53.3%	115.3%	83.3%	9.6	5.7%	94.7%	3	0		Day fill rate for unregistered an accepted risk. Additional RNs at night for additional capacity.	214,824	172,456	42,368
MAIDSTONE	Birth Centre	108.3%	90.0%	100.0%	100.0%				0	0			63,527	69,329	-5,802
TWH	Neonatal Unit	100.0%	83.3%	104.4%	70.0%	11.5			0	0		CSW fill rate at night an accepted risk.	167,377	167,284	93
MAIDSTONE	MSSU	104.7%	102.4%	76.5%	N/A				0	0		RN fill rate at night low against plan, as acuity and capacity allowed.	40,769	33,650	7,119
MAIDSTONE	Peale	121.1%	42.9%	106.7%	66.7%	8.0	26.0%	100.0%	0	0		variation in fill rate against plan due to over establishment of RNs since agreed review. 3 RNs moving in next few months.	70,239	70,860	-621
TWH	SSSU	100.0%	61.5%	100.0%	100.0%	10.0			5	0		Reduced fill rate for CSWs an accepted risk. Unable to fill via bank.	60,469	125,883	-65,414
MAIDSTONE	Whatman	98.9%	98.9%	98.9%	100.0%	4.1	22.5%	88.9%	8	0			90,070	84,086	5,984
MAIDSTONE	A&E	98.3%	93.3%	98.9%	100.0%		14.8%	90.0%	3	0			209,586	188,799	20,787
TWH	A&E	91.7%	95.6%	97.3%	91.7%		28.0%	92.2%	2	0			274,758	291,053	-16,295
												Total Establishment Wards	**5,023,936**	**5,068,610**	**(44,674)**
												Additional Capacity beds	39,307	54,075	-14,768
												Other associated nursing costs	2,555,985	2,490,902	65,083
												Total	7,619,228	7,613,588	5,640

RAG Key

Under fill

Over fill

Trust Board meeting – May 2017

NHS Maidstone and Tunbridge Wells NHS Trust

5-10	**Update on the implementation of the PAS+ (incl. the outcome of the 3 assurance programmes)**	**Chief Operating Officer**

During the 6-monthly "Update on IT strategy and related matters" at the Finance Committee on 24/04/17, it was noted that the outcome of the 3 assurance programmes being undertaken in relation to the implementation of the PAS+ would be submitted to the PAS Programme Board, Trust Management Executive (TME) and Trust Board. The enclosed report includes the outcomes, and provides an overview of the latest situation regarding the implementation.

Which Committees have reviewed the information prior to Board submission?

- Trust Management Executive, 17/05/17

Reason for submission to the Board (decision, discussion, information, assurance etc.) [1]

Information and assurance

[1] All information received by the Board should pass at least one of the tests from 'The Intelligent Board' & 'Safe in the knowledge: How do NHS Trust Boards ensure safe care for their patients': the information prompts relevant & constructive challenge; the information supports informed decision-making; the information is effective in providing early warning of potential problems; the information reflects the experiences of users & services; the information develops Directors' understanding of the Trust & its performance

Introduction

The purpose of this report is to update the Trust Board on the latest position with our PAS Programme.

Project Status – 11th May 2017

The programme remains at a RED status.

The PAS Programme Board met on 10th May 2017 and received a revised implementation plan that includes a number of key governance checkpoints that will ensure that project does not progress until key criteria have been met. This new plan is currently being risk assessed by the RTT, Order Communications and PAS Implementation Groups. Revised Test, Training and Communications Plans are also being reviewed with progress reported at the last PAS Programme Board meeting.

The Live environment has now been upgraded with CU8 in advance of the next round of testing, UAT Cycle 5. The testing will start with Pre-Validation testing that will be conducted between 15th and 19th May. The Testing will focus on the basic sanity testing of the PAS and the testing of CU8 fixes. If this testing is successful and meets the agreed criteria then full regression UAT will commence on 25th May.

A Communications task and finish group has been established to ensure that key messages are agreed and relayed to stakeholder groups across the Trust at key decision points. This group will meet weekly.

Additionally, the Business Continuity Task and Finish Group will now be resurrected to ensure that all Business Continuity procedures are in place in preparation for Cut Over and Go Live.

Commercials and Legal

The Deputy Chief Executive, Chief Operating Officer and the Director of Health Informatics have had several meetings with the senior management of Allscripts to seek a swift resolution to these difficulties and deliver a clinically sound solution. Alongside of these discussions, Capsticks has been commissioned to provide legal advice about the mechanism for securing delay payments due to the contractual Testing milestone not being met.

The contractual User Acceptance Testing (UAT) milestone was not met in February 2017 as previously reported. A non-conformance letter has been issued to Allscripts outlining which contractual Output Based Specification (OBS) requirements could not be successfully tested during UAT and the full Test report identifying the fails and passes.

Allscripts has refuted that they have defaulted on the contract. A meeting with Allscripts is currently being scheduled to take place in the next couple of weeks.

Programme Assurance

As the Trust has not yet achieved a successful go-live and the project is now showing a >1 year delay, it is important that the Trust receives assurance that the PAS Programme Board has explored all options and opportunities to achieve a clinically safe go-live at the earliest opportunity; understanding the risks and issues and taken timely action to rectify them.

Assurance has been sought on three fronts:

- Allscripts Commercial Discussions
- Trust Internal Review
- Independent Audits by NHS Digital

Allscripts Commercial Discussions

During the Commercial meeting with Allscripts on 16th February 2017, the Trust shared suggested tasks and activities that could be undertaken by Allscripts to rebuild confidence and provide additional assurance to the Trust on the deliverability of a new go-live plan. Allscripts has considered these suggestions and has responded well in delivering a 'believable' plan and covers additional go/no go checkpoints before proceeding onto the next phase of implementation.

Trust Internal Review

The Chair of the PAS Programme Board requested that an internal review of how the board has operated since early 2016 and how it has interacted with Allscripts. The PAS Programme Board confirmed that the review needed to focus on:

> *'Following significant delays in the planned go live date of the new Allscripts PAS system, was there anymore that the programme board could have done to expose the recently experienced capability issues of the supplier to deliver the procured functionality, to the agreed timeline'.*

A review of key board documents, i.e. highlight reports, governance structure, risks and issue logs, decision logs, minutes, readiness assessment documents, project plan, procurement documentation, various correspondence between the Trust and Allscripts, was undertaken.

The scope covered 5 key areas:

- Functionality
- Implementation Plan
- Risk Management
- Governance
- Lessons Learned

This review concluded the following. The Programme Board has always reacted appropriately in challenging Allscripts and its own project management team in identifying future risks and issues and the available information demonstrates that they reacted promptly to the issues raised.

Early assurance from Allscripts has not been delivered and solutions have taken longer to resolve than they initially thought. The Programme Board has always assessed the time line for go-live against the operational needs of the Trust, particularly during the winter period.

The findings of the review shows that the Programme Board had secured a good understanding of the problems as they arose, their interdependencies and engaged with Allscripts in a positive way to secure there timely resolution. They had initiated informal and formal escalation procedures appropriately ad in a timely way, when resolution was not forthcoming. Advice has been sought from the legal contractual aspect as well as from the NHS Digital.

There was nothing more that the Programme Board could have done to expose the recently experienced capability issues of the supplier to deliver the procured functionality, to the agreed timeline.

Independent Audits by NHS Digital

Healthcheck Report

NHS Digital was asked to undertake a health check on the current status of the project and identifying risk and issues which may jeopardise the delivery of the new PAS at the Trust. The NHS Digital team comprised deployment subject matter experts with backgrounds in commercial, implementation and clinical settings. They reviewed key project documentation and spent 3 days on-site conducting interviews. Interviews were held with key members of staff and included Clinicians, General Managers and the project team with the aim of capturing a broad range of experiences, concerns and the current perception of the programme.

This particular review attracted an AMBER RED rating from NHS Digital. Taken directly from the NHS Digital report, AMBER RED is described as:

> *'Successful delivery of the project/programme is in doubt with major risks or issues apparent in a number of key areas. Urgent action is needed to ensure these are addressed, and whether resolution is feasible.'*

The report stated 12 recommendations, all of which have an action plan.

Review of User Acceptance Testing

This review primarily focussed on the efficacy of our Order Communication user acceptance testing. NHS Digital has been requested to undertake this review. This will focus on determining if our planned user acceptance testing of the proposed software release 'CU8' is fit-for-purpose and secondly provide feedback on the clinical safety of the Order Communications module.

This assurance review assessed the following categories:

- Trust UAT Test Process – **Green**
- Defect Management - **Green**
- Quality Gateways - **Amber**
- Test Obligations v Actuals – **Amber**

The RAG status of each category is shown above. This was assigned by NHS Digital based on impact to the overall programme.

The review concluded that the Trust's test preparation, planning, execution and defect process followed good practice and was robust. However, during the review the following areas were identified needing to be addressed:

- Entry and Exit Criteria – this needs to be clear defined and agreed
- Supplier Testing – this needs to be included in the Entry Criteria to UAT

Both of these areas have been addressed in the Test Plan.

SAcP Collaboration with East Kent

The next meeting with East Kent is scheduled for Thursday, 18th May 2017 at which time current progress, risks and issues will be discussed.

Trust Board meeting - May 2017

NHS Maidstone and Tunbridge Wells NHS Trust

5-11 NHS Provider licence: Self-certification for 2016/17 Trust Secretary

The Health and Social Care Act 2012 made changes to the way NHS service providers were regulated, and gave Monitor new duties and powers. The changes include the introduction of a Licence for providers of NHS services. The NHS Provider License was subsequently introduced by Monitor in February 2013 as the new main tool with which providers of NHS services would be regulated. Foundation Trusts were licensed from April 2013, with other providers being licensed from April 2014. It was later confirmed that the Licence would not apply to NHS Trusts, but in April 2017, NHS Improvement (NHSI) confirmed that NHS Trusts must undertake a self-certification against the NHS Provider Licence, on the basis that, despite their exemption from needing to hold the Licence, directions from the Secretary of State required the NHS Trust Development Authority (legal entity i.e. NHSI) to ensure that NHS Trusts comply with conditions equivalent to the Licence, as it deems appropriate. As NHSI's Single Oversight Framework (SOF) bases its oversight on the Licence, NHS Trusts are legally subject to the equivalent of certain Provider Licence conditions, and must self-certify under these licence provisions.

NHS Trusts are therefore required to self-certify for 2016/17 that:

1. They can 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
2. They have complied with governance requirements.

Specifically, providers need to self-certify, after the financial year-end, the Licence conditions that:

- "The provider has taken all precautions necessary to comply with the licence, NHS Acts and NHS Constitution" (Condition G6(3)); and
- "The provider has complied with required governance arrangements" (Condition FT4(8))

The aim of self-certification is for providers give assurance that they are compliant with the conditions. Providers are free to self-certify however they choose, but to aid the process, NHSI have provided templates which Boards can use if they wish.

The Board must sign off on self-certification no later than 31st May 2017 (for condition G6) and 30th June 2017 (for condition FT4). Providers must then publish their G6 self-certification within 1 month following the deadline for sign-off. NHS Trusts are not required to submit their self-certification declarations to NHSI. Instead, from July 2017 NHSI will contact a select number of NHS Trusts (and Foundation Trusts) to ask for evidence that they have self-certified.

The proposed self-certification, which uses the template provided by NHSI, is enclosed. The Trust Board is asked to review, and approve, the content. Trust Board Members will be aware that the Board has also received the Annual Report for 2016/17 (under item 5-16, Attachment 14), which contains the Governance Statement. The Annual Report and Governance Statement is considered to provide sufficient information and supporting evidence to enable the Board to self-certify that the Trust has been compliant with the relevant Licence conditions. Therefore, rather than provide a brief response to each of the requirements within the template (which would force brevity) Board Members are encouraged to refer to the full Annual Report and Governance Statement for a more comprehensive overview.

Which Committees have reviewed the information prior to Board submission?

- N/A

Reason for receipt at the Board (decision, discussion, information, assurance etc.) [1]

Review and approval of the proposed self-certification

[1] All information received by the Board should pass at least one of the tests from 'The Intelligent Board' & 'Safe in the knowledge: How do NHS Trust Boards ensure safe care for their patients': the information prompts relevant & constructive challenge; the information supports informed decision-making; the information is effective in providing early warning of potential problems; the information reflects the experiences of users & services; the information develops Directors' understanding of the Trust & its performance

Worksheet "FT4 declaration"

Corporate Governance Statement (FTs and NHS trusts)

The Board are required to respond "Confirmed" or "Not confirmed" to the following statements, setting out any risks and mitigating actions planned for each one

1	Corporate Governance Statement	Response	Risks and Mitigating actions
1	The Board is satisfied that the Licensee applies those principles, systems and standards of good corporate governance which reasonably would be regarded as appropriate for a supplier of health care services to the NHS.	Confirmed	Please refer to the Annual Report (including Governance Statement) for 2016/17 (item 5-16, Attachment 14 at the May 2017 Trust Board meeting) for full details.
2	The Board has regard to such guidance on good corporate governance as may be issued by NHS Improvement from time to time	Confirmed	Please refer to the Annual Report (including Governance Statement) for 2016/17 (item 5-16, Attachment 14 at the May 2017 Trust Board meeting) for full details.
3	The Board is satisfied that the Licensee has established and implements: (a) Effective board and committee structures; (b) Clear responsibilities for its Board, for committees reporting to the Board and for staff reporting to the Board and those committees; and (c) Clear reporting lines and accountabilities throughout its organisation.	Confirmed	Please refer to the Annual Report (including Governance Statement) for 2016/17 (item 5-16, Attachment 14 at the May 2017 Trust Board meeting) for full details.
4	The Board is satisfied that the Licensee has established and effectively implements systems and/or processes: (a) To ensure compliance with the Licensee's duty to operate efficiently, economically and effectively; (b) For timely and effective scrutiny and oversight by the Board of the Licensee's operations; (c) To ensure compliance with health care standards binding on the Licensee including but not restricted to standards specified by the Secretary of State, the Care Quality Commission, the NHS Commissioning Board and statutory regulators of health care professions; (d) For effective financial decision-making, management and control (including but not restricted to appropriate systems and/or processes to ensure the Licensee's ability to continue as a going concern); (e) To obtain and disseminate accurate, comprehensive, timely and up to date information for Board and Committee decision-making; (f) To identify and manage (including but not restricted to manage through forward plans) material risks to compliance with the Conditions of its Licence; (g) To generate and monitor delivery of business plans (including any changes to such plans) and to receive internal and where appropriate external assurance on such plans and their delivery; and (h) To ensure compliance with all applicable legal requirements.	Confirmed	Please refer to the Annual Report (including Governance Statement) for 2016/17 (item 5-16, Attachment 14 at the May 2017 Trust Board meeting) for full details.
5	The Board is satisfied that the systems and/or processes referred to in paragraph 4 (above) should include but not be restricted to systems and/or processes to ensure: (a) That there is sufficient capability at Board level to provide effective organisational leadership on the quality of care provided; (b) That the Board's planning and decision-making processes take timely and appropriate account of quality of care considerations; (c) The collection of accurate, comprehensive, timely and up to date information on quality of care; (d) That the Board receives and takes into account accurate, comprehensive, timely and up to date information on quality of care; (e) That the Licensee, including its Board, actively engages on quality of care with patients, staff and other relevant stakeholders and takes into account as appropriate views and information from these sources; and (f) That there is clear accountability for quality of care throughout the Licensee including but not restricted to systems and/or processes for escalating and resolving quality issues including escalating them to the Board where appropriate.	Confirmed	Please refer to the Annual Report (including Governance Statement) for 2016/17 (item 5-16, Attachment 14 at the May 2017 Trust Board meeting) for full details.
6	The Board is satisfied that there are systems to ensure that the Licensee has in place personnel on the Board, reporting to the Board and within the rest of the organisation who are sufficient in number and appropriately qualified to ensure compliance with the conditions of its NHS provider licence.	Confirmed	Please refer to the Annual Report (including Governance Statement) for 2016/17 (item 5-16, Attachment 14 at the May 2017 Trust Board meeting) for full details.

Signed on behalf of the Board of directors, and, in the case of Foundation Trusts, having regard to the views of the governors

Signature	Signature
Name Glenn Douglas	Name

Further explanatory information should be provided below where the Board has been unable to confirm declarations under FT4.

A: N/A

Worksheet "G6 & CoS7"

Declarations required by General condition 6 and Continuity of Service condition 7 of the NHS provider licence

The board are required to respond "Confirmed" or "Not confirmed" to the following statements (please select 'not confirmed' if confirming another option). Explanatory information should be provided where required.

1 & 2 General condition 6 - Systems for compliance with license conditions (FTs and NHS trusts)

1	Following a review for the purpose of paragraph 2(b) of licence condition G6, the Directors of the Licensee are satisfied that, in the Financial Year most recently ended, the Licensee took all such precautions as were necessary in order to comply with the conditions of the licence, any requirements imposed on it under the NHS Acts and have had regard to the NHS Constitution.	Confirmed	OK

Signed on behalf of the board of directors, and, in the case of Foundation Trusts, having regard to the views of the governors

Signature		**Signature**	
Name	Glenn Douglas	**Name**	
Capacity	Chief Executive	**Capacity**	[job title here]
Date	24 May 2017	**Date**	

Further explanatory information should be provided below where the Board has been unable to confirm declarations under G6.

A	N/A

Trust Board meeting - May 2017

NHS Maidstone and Tunbridge Wells NHS Trust

5-12	Summary report from Audit and Governance Committee, 04/05/17 & 24/05/17	Committee Chair (Non-Executive Director)

The Audit and Governance Committee met on 4th May 2017

1. The key matters considered at the meeting were as follows:

- A review of the progress with actions from previous meetings included confirmation to proceed with the planned evaluation/survey of the Internal Audit service, despite the fact that the Trust has given notice to its current Internal Audit supplier, Tiaa Ltd.
- Under the Safety Moment, the Trust Secretary reported that the theme for May was Dementia, and described the activities planned over the 4 weeks
- The year-end review of the Board Assurance Framework (BAF) was discussed (this was the same report submitted to the Board in April), and it was agreed not to set in-year milestones for the key objectives, but to ensure that performance against any existing in-year milestones/trajectories was captured within the BAF reports during 2017/18
- The Internal Audit Annual Report for 2016/17 was reviewed, which included the draft Head of Internal Audit Opinion. A report on progress with actions from previous Internal Audit reviews was also reviewed, and during the ensuing discussion, it was agreed that the Trust Secretary would identify and report the processes in place for ensuring the return of valuable hospital property and equipment after patient discharge
- The Counter Fraud Annual Report for 2016/17 was reviewed, and the Counter Fraud Work Plan for 2017/18 was approved
- A 'Progress and emerging issues report' was received from the External Auditors, which included the usual annual report on 'Understanding how the Committee gains assurance from management', as well as a report from the Director of Finance on providing assurance over the management processes in place for 2016/17. The Committee was informed by External Audit that Trust would likely receive an 'except for' Value for Money conclusion for 2016/17, but it was agreed that the External Auditors would provide further narrative on the rationale for this, within their Annual Findings Report
- A Benchmarking report for Trust's Annual Report for 2015/16 (which compared the content with the Annual Reports of the External Auditor's other clients), and it was agreed that the Trust Secretary would review the ratings for reporting on 'Leadership, people and culture – Board evaluation' and identify actions to improve practice in areas where the Trust's performance was considered to be below 'reasonable'
- The Trust's draft Annual Report for 2016/17 (including the Governance Statement) was reviewed, and some minor amendments agreed. The draft Annual Accounts for 2016/17 were also reviewed. Following the conclusion of the External Audit both would be subjected to final review at the Committee, and Trust Board, on 24/05/17
- The Audit and Governance Committee Annual Report for 2016/17 was approved. The NHS Audit Committee Handbook recommends that this Report be issued to all members of the Trust Board in advance of the meeting to agree the Annual Report and Accounts. The Report is therefore enclosed, in Appendix 1
- The Associate Director of Procurement attended for the review of the latest Single Tender Waivers data
- The Trust Secretary submitted the latest details of gifts, hospitality and sponsorship declared, which included an update on progress with implementing NHS England's latest Conflicts of Interest guidance
- The Risk and Compliance Manager attended to present the revised 'Risk Management Policy', which had been submitted for comment as part of the current consultation before the Policy is submitted to the Trust Board for ratification

2. The Committee received details of the following Internal Audit reviews:

- "Critical Financial Assurance - Payroll" (which received a "Reasonable Assurance" conclusion)

- "Use of Temporary Staff" (which received a "Reasonable Assurance" conclusion)
- "Follow Up Review of Health Records" (which received a "Reasonable Assurance" conclusion)
- "Follow Up Review of Clinic Management in the Outpatients Department" (which received a "Reasonable Assurance" conclusion)
- "Assurance Framework and Risk Management Processes" (which received a "Reasonable Assurance" conclusion)
- "Review of Enhanced Care Policy (Use of Nurse Specials)" (which received a "Reasonable Assurance" conclusion)
- "Critical Financial Assurance – Financial Accounting and Non Pay Expenditure" (which received a "Reasonable Assurance" conclusion)
- "Activity and Income Recording" (which received a "Limited Assurance" conclusion)
- "Information Governance Toolkit" (which received a "Limited Assurance" conclusion)
- "Active Directory" (which received a "Limited Assurance" conclusion)

3. The Committee was also notified of the following "Urgent" priority outstanding actions from Internal Audit reviews:

- "Prevention of Never Events (Advisory Review)" (1 outstanding action)
- "Clinical Activity Recording" (1 outstanding action)
- "Local Registration Authority" (1 outstanding action)

4. The Committee agreed that (in addition to any actions noted above):

- The Head of Internal Audit agreed to forward a summary of relevant material from other organisations relating to VTE prevention to the Trust Secretary for onward circulation to Committee members; and to confirm with other organisations if they were willing for detailed reports to be shared in full with the Trust (on the basis of reciprocal sharing)
- The Local Counter Fraud Specialist agreed to make the necessary amendments to ensure that the Trust's legal name was accurately reflected in the Counter Fraud Annual Report for 2016/17
- The Director of Finance agreed to consider establishing a marker/trigger date (e.g. August 2017) by which schemes totalling the full value of the Trust's CIP must have been identified, or consider an alternative approach

5. The issues that need to be drawn to the attention of the Board are as follows:

- The Committee considered whether all Trust Board Members should be invited to the Committee meeting on 24/05/17, at which the final Annual Report and Accounts would be reviewed in detail, to be able to participate in the detailed discussion at first hand (a model which operates in some other Trusts). However, it was agreed to instead continue with the model applied in the past few years (i.e. that only Audit and Governance Committee review the Annual Report and Accounts and recommend a position to the Board)
- The Committee was informed that External Audit will need to issue another section 30 referral to the Secretary of State for Health (under the Local Audit and Accountability Act 2014) for 2016/17, because the Trust had not recovered the cumulative deficit from previous years within the required timescale. The Committee was also informed that it was likely the Trust would receive an 'except for' conclusion in its Value for Money statement until circa 2020, based on the application of current guidance
- The Audit and Governance Committee will meet on 24/05/17, before the Trust Board, to review the final Annual Report and Accounts, and consider the findings from the external audit. A verbal update on the outcome will be reported to the Trust Board on 24/05/17

Which Committees have reviewed the information prior to Board submission?

- N/A

Reason for receipt at the Board (decision, discussion, information, assurance etc.) [1]

Information and assurance

[1] All information received by the Board should pass at least one of the tests from 'The Intelligent Board' & 'Safe in the knowledge: How do NHS Trust Boards ensure safe care for their patients': the information prompts relevant & constructive challenge; the information supports informed decision-making; the information is effective in providing early warning of potential problems; the information reflects the experiences of users & services; the information develops Directors' understanding of the Trust & its performance

Audit and Governance Committee Annual Report 2016/17

NHS Maidstone and Tunbridge Wells NHS Trust

1. Introduction

This report summarises the key work areas of the Audit and Governance Committee during the period from April 2016 to March 2017. The report supports the primary role of the Committee in ensuring the adequacy and effective operation of the organisation's overall internal control system. The format of the report is informed by the guidance contained with the NHS Audit Committee Handbook (2014), and highlights work and outcomes in the following areas: Meetings and administration; Governance, Risk Management and Internal Control; Internal Audit; External Audit, Audit and Governance Committee assessment; Auditor Panel; Adding value/'making a difference'; and Audit and Governance Committee statement/declaration.

2. Meetings and administration

During 2016/17, the Audit and Governance Committee met 5 times in its usual form, on: 05/05/16, 25/05/16 (to recommend the approval of the Annual Accounts for 2015/16), 10/08/16, 03/11/16 and 02/02/17. The Committee met a further 3 times as the Trust's 'Auditor Panel'[2], and these meetings took place immediately after the main Committee meetings, on 25/05/16, 10/08/16, and 03/11/16.

All of the Trust's Non-Executive Directors (apart from the Chairman of the Trust Board) are members of the Committee. The membership of the Committee during 2016/17 was as follows:

- Sylvia Denton, Non-Executive Director (until the end of February 2017, when she left the Trust Board)
- Sarah Dunnett, Non-Executive Director
- Alex King, Non-Executive Director
- Kevin Tallett, Non-Executive Director. Mr Tallett was the Chairman of the Committee throughout 2016/17
- Steve Tinton, Non-Executive Director (until the end of September 2016, when he left the Trust Board)

Attendance at each Audit and Governance Committee meeting in 2016/17, including those as Auditor Panel, is shown below:

	Meetings in 2016/17							
Member	**05/05/16**	**25/05/166** (main meeting)	**25/05/16** (Auditor Panel)	**10/08/16** (main meeting)	**10/08/16** (Auditor Panel)	**03/11/16** (main meeting)	**03/11/16** (Auditor Panel)	**02/02/17**
Kevin Tallett, Non-Executive Director (Chair)	✓	Apologies	Apologies	✓	✓	✓	✓	✓
Sylvia Denton, Non-Executive Director[3]	Apologies	✓	✓	✓	✓	Apologies	Apologies	✓
Sarah Dunnett, Non-Executive Director	✓	✓	✓	✓	✓	✓	✓	Apologies
Alex King, Non-Executive Director	✓	✓	✓	✓	✓	✓	✓	Apologies
Steve Tinton[4], Non-Executive Director	Apologies	✓	✓	Apologies	Apologies			

The Committee's Terms of Reference were reviewed and agreed at the Committee meeting on 03/11/15, and approved by the Trust Board on 30/11/16. The Terms of Reference will next be reviewed at the November 2017 Audit and Governance Committee meeting (and then be submitted for approval to the Trust Board in the same month).

[2] The Trust Board has appointed the Audit and Governance Committee as the Trust's Auditor Panel in accordance with Schedule 4, Paragraph 1 of the Local Audit and Accountability Act 2014.
[3] Sylvia Denton left the Trust Board at the end of February 2017
[4] Steve Tinton left the Trust Board at the end of September 2016

The Terms of Reference deliberately do not incorporate clinical audit processes, as this is left to the oversight of the Quality Committee and Trust Clinical Governance Committee.

3. Governance, Risk Management and Internal Control

a. Board Assurance Framework (BAF) and Risk management

The BAF is the document through which the Trust Board is apprised of the principal risks to the Trust meeting its objectives, and to the controls in place to manage those risks. The 2016/17 BAF was reviewed at the Committee meetings on 03/11/16 and 02/02/17, whilst a year-end review report for the 2015/16 objectives was received at the meeting on 05/05/16. The Committee also received the Trust's full Risk Register on 02/02/17, whilst at the meeting on 05/05/17, a discussion regarding 'risk appetite' was held, and the agreed approach will be reflected in a revised Risk Management Policy. The annual Internal Audit review of "Assurance Framework and Risk Management", undertaken at the end of 2016/17, resulted in a "reasonable assurance" conclusion, noting that "The Board Assurance Framework and Risk Management processes have been subject to regular review by the Trust, including at the Trust Board, Audit and Governance Committee and the Trust Management Executive"; "Clear processes are in place within the Trust to support the identification and management of risks"; and "A robust reporting structure to the Trust Board is in place". The small number of recommendations made (and accepted) will be implemented during 2017/18.

b. Counter fraud

The Committee has reviewed activity relating to counter fraud measures in 2016/17, via reports from the Local Counter Fraud Specialist (LCFS). The 2016/17 Counter Fraud Work Plan was approved at the meeting held on 05/05/16, whilst the Annual Report of Counter Fraud Activity for 2015/16 was received at the meeting on 25/05/16.

c. Relationship with the Trust Board

The reporting from the Committee to the Trust Board takes place via a written summary report of each meeting, presented by the Committee Chair. The report is based on a template, and covers the key matters considered at the meeting; details of the Internal Audit reviews that were discussed; any "high" priority outstanding actions from Internal Audit reviews; the actions agreed at the Committee; and any issues that need to be drawn to the attention of the Board.

A written report from the Audit and Governance Committee as Auditor Panel was also submitted to each Trust Board (in its 'Part 2'/non-public form) following each Panel meeting.

d. Head of Internal Audit Opinion (HoIA)

The Head of Internal Audit Opinion for 2016/17 states that "Except for the Trust's ability to deliver their planned financial control total 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".

e. Governance Statement

The Governance Statement for 2016/17 was reviewed at the Audit and Governance Committee on 03/05/17, as part of the draft Annual Report and Accounts for 2016/17.

Based on this, the detailed work of the Audit and Governance Committee summarised above, and its Internal and External Auditor work programme, the Governance Statement is consistent with the view of the Audit and Governance Committee on the Trust's system of Internal Control, and the Committee supports the Trust Board's approval of the Statement, which is scheduled to take place on 24/05/17.

4. Internal Audit

The 2016/17 Internal Audit plan was agreed by the Audit and Governance Committee at its meeting on 22/02/16. The output from the plan is listed below.

System	Assurance Level			
	Substantial	Reasonable	Limited	No
Achievement of Best Practice Tariffs[5]		✓		
Additional Consultant Payments[5]			✓	
Consultant Job Plans[5]			✓	
Cash Collection Processes[5]			✓	
Cost Improvement Plans[5]		✓		
Data Quality of Key Performance Indicators[5]		✓		
Review of Retrospective Never events		✓		
Heath Records			✓	
Health Records (Follow Up)		✓		
Pharmacy			✓	
NHS In-House Information Governance Toolkit: Training Material Checklist	Fully Comprehensive (NHS Connecting for Health rating)			
Information Management Framework			✓	
Audiology Stock Management			✓	
Never Events (Advisory Review)	N/A (Assurance levels do not apply to Advisory Reviews)			
Clinic Management in the Outpatient Department			✓	
Clinic Management in the Outpatient Department (Follow Up)		✓		
Nurse Revalidation		✓		
Information Governance Toolkit Part 1	N/A (Assurance level will be allocated following completion of part 2 of the work – see below)			
Procurement		✓		
Implementation of E-Rostering	N/A (it was agreed that this audit will be postponed until 2017/18 due to slippage in the project timeline)			
Activity and Income			✓	
Critical Financial Assurance – Payroll		✓		
Critical Financial Assurance – Financial Accounting & Non Pay Expenditure		✓		
Use of Temporary Staff		✓		
Use of Nurse Specials Follow Up (carried forward from 2015/16)		✓		
Assurance Framework and Risk Management		✓		
Data Quality[6]	TBC	TBC	TBC	TBC
Information Governance Toolkit Part 2		✓		
Active Directory (was Strategic Planning for ICT)			✓	
Head of Internal Audit Opinion and Annual Report		✓		

In 2017/18, the Committee intends to undertake a formal assessment of the performance of the Trust's Internal Auditors.

The Committee reviews the reliability and quality of clinical information systems via the Internal Audit process. In particular, as can be seen from the above table, the audit of "Data Quality of Key Performance Indicators" from the 2015/16 Plan resulted in a "reasonable assurance" conclusion, and an audit of "Data Quality" was included in the 2016/17 Plan, as part of a commitment to undertake such audits annually.

[5] These reviews were actually from the 2015/16 Audit Plan, but the draft reports were not issued until after the Head of Internal Audit Opinion in 2015/16, and will be reported in the 2016/17 Opinion and Internal Audit Annual Report

[6] This review had not been completed at the time of this Annual Report

5. External Audit

On 10/08/16, the Committee received the Annual Audit Letter for 2015/16. The key issues reported were as follows:

- An unqualified opinion on the Trust's financial statements was given on 27/05/16
- The Auditors were satisfied that the Trust put in place proper arrangements to ensure economy, efficiency and effectiveness in its use of resources except for 'sustainable resource deployment', on the basis that the Trust delivered a £23.4m deficit in 2015/16 and is forecasting a deficit of £22.9m in 2016/17. The Auditors therefore qualified their value for money conclusion in their report on the financial statements on 27/05/16
- The consolidation schedules submitted to the Department of Health with the audited financial statements were concluded to be consistent
- The Auditors referred a matter to the Secretary of State, as required by section 30 of the Local Audit and Accountability Act 2014, on 18/05/16 because the Trust has not recovered the cumulative deficit from 2013/14 within the required three years, as set out in the Department of Health's "Guidance on breakeven duty and provisions"
- The Auditors certified that they completed the audit of the accounts of the Trust in accordance with the requirements of the Code of Audit Practice
- The Auditors completed a review of the Trust's Quality Accounts and issued their report on 30/06/16. They concluded the Quality Accounts and the indicators they reviewed were prepared in line with the Regulations and guidance

The 'overall value for money conclusion' within the Letter was that "We are satisfied that, in all significant respects, except for the matter we identified below, the Trust had proper arrangements to secure economy, efficiency and effectiveness in its use of resources for the year ending 31 March 2016. Our review highlighted the following issues which gave rise to a qualified 'except for' VFM conclusion:

- the Trust delivered £23.4m deficit in 2015/16; and
- the Trust is forecasting a deficit of £22.9m in 2016/17"

The External Audit plan and fee for 2016/17 was approved by the Committee on 02/02/17.

In 2017/18, the Committee intends to undertake a formal assessment of the performance of the Trust's External Auditor.

6. Auditor Panel

As noted above, the Trust Board has appointed the Committee as the Trust's Auditor Panel in accordance with Schedule 4, Paragraph 1 of the Local Audit and Accountability Act 2014. The Auditor Panel advises the Trust Board on the selection, appointment and removal of external auditors (for appointments for 2017/18 onwards), and on the maintenance of independent relationships with such auditors. Specifically, this includes the following:

- Agreeing and overseeing a robust process for selecting the External Auditors in accordance with the Trust's normal procurement rules
- Making a recommendation to the Trust Board as to who should be appointed (ensuring that any conflicts of interest are dealt with effectively)
- Advising the Trust Board on the maintenance of an independent relationship with the appointed External Auditor
- Advising (if asked) the Trust Board on whether or not any proposal from the External Auditor to enter into a liability limitation agreement as part of the procurement process is fair and reasonable
- Advising on (and approving) the contents of the Trust's policy on the purchase of non-audit services from the appointed External Auditor
- Advising the Trust Board on any decision about the removal or resignation of the External Auditor

The Chair and Vice-Chair of the Audit and Governance Committee also act as Chair and Vice-Chair (respectively) of the Auditor Panel, and when undertaking the role of the Auditor Panel,

the membership shall comprise the entire membership of the Audit and Governance Committee, with no additional appointees. This means that all members of the Auditor Panel are independent, Non-Executive Directors. Ordinarily, the Committee is quorate when two Non-Executive members are present (including either the Committee Chair or Vice Chair). However, when the Committee is undertaking the role of the Trust's "Auditor Panel", the Committee shall be quorate when three Non-Executive members are present (including either the Committee Chair or Vice Chair)[7]. The Chair may also invite others to attend when the Committee is meeting as the Auditor Panel, but these invitees are not members of the Auditor Panel.

As a general rule, the Auditor Panel will meet on the same day as the Audit and Governance Committee. However, Auditor Panel business shall be identified via a separate agenda, and members shall deal with these matters as Auditor Panel members, not as Audit and Governance Committee members. The Auditor Panel's Chair shall formally state (and this shall be formally recorded) when the Auditor Panel is meeting in that capacity.

The Chair must report to the Trust Board on how the Auditor Panel has discharged its responsibilities, and that requirement is fulfilled by this Annual Report, as well as the summary reports submitted to each Trust Board meeting ('Part 2') following each Auditor Panel meeting.

At the Auditor Panel meeting on 03/11/16, an update was received on the terms and outcome of the solo tender process to appoint the Trust's External Auditor, from 2017/18 onwards. The tender evaluation panel proposed that the Auditor Panel recommended to the Trust Board the appointment of Grant Thornton UK LLP as the Trust's External Auditor, with a contract start date of 01/04/17. The Auditor Panel supported this proposal and subsequently recommended the appointment of Grant Thornton UK LLP to the Trust Board. The Trust Board then approved that appointment at its 'Part 2' meeting on 30/11/16.

7. Audit and Governance Committee assessment

At the Committee meeting on 04/11/15, it was agreed that the Trust Secretary should propose a self-assessment process reflecting the Committee's agreed approach, which would allow for:

- Initial assessment, through completion of a checklist of fact-based questions, by the Trust Secretary and
- Individual, evaluative feedback by Committee members.

Following liaison with the Chair of the Committee, two forms were developed:

1. A fact-based, check list for completion by the Trust Secretary
2. A self-assessment / evaluation form for Committee members, which each member was invited to complete (individually). This form was also completed by the Director of Finance.

Both forms were based on examples provided within the NHS Audit Committee Handbook (2014) and were closely linked to the Committee's Terms of Reference. The findings from the 2 forms of evaluation were considered at the Committee meeting on 10/08/16, and the 2 specific actions that were proposed (to evaluate the Internal Audit Service for 2016/17, and defer an evaluation of the External Audit service pending the appointment of an External Auditor with effect from 2017/18) were agreed.

8. Adding value/'making a difference'

The following are examples of where the Audit and Governance Committee added value/'made a difference' during 2016/17:

- The Committee had a useful discussion, at its meeting on 05/05/17, about the Trust's approach to 'risk appetite'. The discussion had been prompted by Tiaa Ltd's 'client briefing' on "Developments in Risk Management and Defining Risk Appetite at NHS Organisations" that was circulated by to Committee members in March 2016. The Committee agreed an

[7] Independent members of the Auditor Panel must be in the majority and there must be at least two independent members present or 50% of the auditor panel's total membership, whichever is the highest

approach, which has been reflected in the revised Risk Management Policy (which will be ratified during 2017/18). The discussion also agreed that the "Safety Moments" at Trust Board and sub-committee meetings should be better structured, and this, in turn, resulted in the agreement to have a set number of pre-set 'themes' for Safety Moments, that could be used to promote a discussion on a number of subjects within that theme (which then developed into the Trust's current 'Safety Calendar')

- The Committee has prompted the review and revision of a number of risks within the Risk Register, and the content of the BAF. The format of the BAF has also been subject to some beneficial amendments as a result of review at the Committee.
- The Committee has requested that other Trust Board sub-committees review the findings from work undertaken by Internal Audit and/or Counter Fraud in more detail. For example, at the August 2016 meeting, it was agreed to arrange for the Medical Director to present a report on the issue of Consultant Job Plans at the next Workforce Committee, in response to the issues raised in the most recent Internal Audit. The November 2016 meeting also requested that the Finance Committee undertake a review of Medical Productivity, and this ultimately developed into the current "Workforce transformation" programme that is reported to each Finance Committee meeting
- A number of challenges have been posed which has increased the scrutiny, and strengthened the oversight applied to Single Tender Waivers, Losses and compensations, and Gifts, Hospitality and Sponsorship
- The Committee requested that the Director of Finance arrange via the Executive Team, for a process to be developed to keep track of external reports (as notified by Internal and External Audit) and to ensure that matters arising from such reports can be identified and referred for appropriate scrutiny as required
- The Committee used its authority to invite the owners of some Outstanding Audit Recommendations to attend meetings unless the actions were completed. The invitations had the desired effect of prompting action, and all the invitations made were able to be withdrawn
- The Committee made some beneficial changes to the Standing Orders, Standing Financial Instructions and Reservation of Powers and Scheme of Delegation, in November 2016

9. Audit and Governance Committee statement / declaration

The Audit and Governance Committee can confirm that:

- The Trust's Governance Statement for 2016/17 is consistent with the view of the Audit and Governance Committee on the Trust's system of internal control, and the Committee supports the Trust Board's approval of the Statement
- The Committee has reviewed and used the Board Assurance Framework and believes that it is fit for purpose and that the 'comprehensiveness' of the assurances and the reliability and integrity of the sources of assurance are sufficient to support the Trust Board's decisions and declarations
- The system of risk management in the Trust is adequate in identifying risks and allowing the Trust Board to understand the appropriate management of those risks
- There are no areas of significant duplication or omission in the systems of governance in the Trust that have come to the Committee 's attention and not been adequately resolved
- There has been no major breakdown in internal control that has led to a significant loss in one form or another for 2016/17; and that
- There have been no major weakness in the governance systems that has exposed, or continues to expose, the Trust to an unacceptable risk

Kevin Tallett,
Chair, Audit and Governance Committee
Maidstone and Tunbridge Wells NHS Trust
May 2017

Trust Board Meeting – May 2017

NHS Maidstone and Tunbridge Wells NHS Trust

5-13 Summary report from Quality C'ttee, 03/05/17 C'ttee Chair (Non-Executive Director)

The Quality Committee has met once since the last Board meeting, on 3rd May (a 'main' meeting).

1. **The key matters considered at the meeting were as follows:**
   - A review of the **progress with actions** from previous meetings included the intention to hold a 'lessons learned' exercise once the Trust had exited Financial Special Measures. The Chief Nurse reported on **quality matters arising from the Financial Recovery Plan**, and stated that a number of Quality Impact Assessments had now been received, for review
   - The Chief Operating Officer again reported on the **work being undertaken to reduce Length of Stay**. The Committee was particularly interested in the plans for an Acute Frailty Unit, initially at Maidstone Hospital, and it was noted that a trial of the 'proof of concept' would be held during the 'Rapid Improvement Week' scheduled at the end of May
   - The Chief Nurse gave a verbal update on the work to provide an **updated assurance report on the "Summary of findings" within the CQC's Quality Report for the Trust**, including the actions required to achieve an overall rating of "Good" at the next inspection. It was noted that a written report would be submitted to the Quality Committee in July
   - A report of recent **Trust Clinical Governance Committee** meetings was discussed, & the Committee was notified that a new Never Event had been declared, following discussions with West Kent CCG. It was confirmed that the incident had occurred earlier in 2016/17. Each Directorate then highlighted their key issues, which included the following:
     - Specialist Medicine & Therapies first main concern was the completion of Mortality Reviews, but the situation was improving, and compliance at both sites was now circa 57%. The risk for staff turnover and vacancies was also rated 'red' (the vacancy rate for Registered Nurses on the Stroke Units was over 50%). It was noted that a full-page colour advertisement would appear in the Kent and Sussex Courier, and the Directorate was working closely with the Trust's Nurse Recruitment Lead
     - Acute and Emergency reported that their main concerns also included staff vacancies, and staff were being transferred between Wards daily, to address shortages and ensure patient safety. The A&E 4-hour waiting time target was challenging but the year-end target had been achieved. It was also noted that the supplier of the Symphony A&E IT system had agreed to provide support for a further 12 months after August 2017, so the risk had been downgraded to a 'green' rating
     - Surgery reported that performance on the 62-day Cancer waiting time target remained problematic, particularly for the Lower GI and Urology tumour sites, but a new Lower GI pathway had been established which was expected to considerably shorten the time involved. It was also noted that the escalation of Surgical areas continued, including in the Short Stay Surgical Unit. Attention was also drawn to a forthcoming Coroner's Inquest (which related to the incident reported to the 'Part 2' Trust Board on 26/04/17).
     - Head and Neck reported that the pressure on beds had been partly assisted by altering how tonsillectomies were performed, to enable these to be done as Day Cases; and also reported that a successful 'Getting It Right First Time' meeting had been held
     - For Trauma & Orthopaedics, the key risks including staffing on Wards 30 & 31, whilst one Serious Incident (SI) related to alleged abuse of a patient by a member of staff, which was currently being investigated by the Police. The worsening waiting list for elective surgery, which was now at 6 to 9 months, was also noted, and this prompted a discussion regarding Trauma Theatre capacity (and beds)
     - Critical Care reported some recent appointments that had been made, and noted that the death of Mrs Frances Cappuccini had been discussed at a joint Clinical Governance meeting with Obstetrics. It was noted that the Clinical Director was scheduled to meet with Mrs Cappuccini's family in the near future, at their request, as they wished to understand what action the Trust had taken to prevent a recurrence of the incident. It was also reported that the deterioration in Laparotomy mortality reported at the last 'main' Quality Committee had been investigated and no concerns had been identified
     - Cancer & Haematology, reported that the performance on the Cancer waiting time standards was their top risk, but also highlighted some key vacancies. It was noted that

for Radiotherapy staffing, some Medical Dosimetrists had recently been appointed, but some Medical Physicists had left. It was also noted that the Chemotherapy service had been adversely affected by vacancies, and all Chemotherapy was now being dispensed from Maidstone Hospital and then transferred to Tunbridge Wells Hospital. However, it was noted that the situation was not expected to last for long, and assurance was given that the change had only been made following a risk assessment.
    - Diagnostics & Pharmacy reported that Pharmacy staffing was a concern, but the Chief Pharmacist had achieved some success in recruitment, and they were also reviewing the structure, to try to be more resilient in the face of any future changes in personnel. It was also noted that the second phase of the 'Bloodhound' IT system had been approved, which would address the issues regarding the traceability of blood products (fating). It was reported that the risk re blood science staffing shortages also remained
    - Women's & Sexual Health reported the continuing issues regarding IT for Community Midwifery clinics but it was noted that that a capital bid for IT had been submitted. It was also noted that the staffing requirements for a second Obstetric Theatre (to enable 2 consecutive cases to be performed) were under review
    - Paediatrics reported that their main concern was Medical staffing, and 2 Consultants would be taking a sabbatical to undertake additional training overseas (but approval had been given to appoint Locum replacements). A shortage of Registrars was also reported, which adversely affected compliance with the new Junior Doctors' night rota
- A letter from NHSI & CQC in relation to **Learning from Deaths** outlined what was being asked regarding Mortality Reviews, which included having Executive & NED leads for mortality; training (in Structured Judgement Reviews); and the quarterly publication of mortality data. It was noted that an action plan had been developed, and the first quarterly mortality data was expected to be reported to the Board in June. An **update on response to the increase in the Trust's HSMR** was also given, which included notification that the report submitted to the Board in April contained incorrect data (this pertained to "Figure 1.0 - Monthly Trend" of Attachment 6). Frustration was expressed at the continued absence of an accurate understanding of the specific reasons for the increased mortality.
- The Chief Nurse gave a verbal report regarding the implementation of the changes from the **Nursing establishment review in autumn 2016**, and stated that the next review was about to commence. It was noted that a written report would be submitted to the July meeting
- The latest **SIs** were reported, & it was noted that a meeting with West Kent CCG identified that the Trust was not declaring SIs quickly enough, so an approach had been agreed
- The response to the recommendations within the **Preventing Future Deaths (PFD) report following the Inquest into the death of Mrs Cappuccini** was received (the same report received at the 'Part 2' Board on 29/03/17), & prompted a discussion on the actions being taken to improve the quality of record keeping (which was 1 of the points in the PFD report)
- The **draft Quality Accounts 2016/17** were reviewed, which included the quality priorities for 2017/18. The **minutes of the Quality Committee 'deep dive' meeting** on 10/04/17, & summary report from the **Patient Experience Committee** on 08/03/17 were also noted.
- Finally, the Chief Nurse reported that a **tender document for overseas recruitment**, which had been agreed in conjunction with several other local Trusts, was due to be awarded soon (a Business Case had already been approved for the Trust to recruit 40 overseas Nurses, with a further 40 to be recruited in the future, should this be necessary)

2. In addition to the agreements referred to above, the Committee agreed that:

- N/A

3. The issues that need to be drawn to the attention of the Board are as follows:

- N/A

Which Committees have reviewed the information prior to Board submission?

- N/A

Reason for receipt at the Board (decision, discussion, information, assurance etc.) [1]

Information and assurance

[1] All information received by the Board should pass at least one of the tests from 'The Intelligent Board' & 'Safe in the knowledge: How do NHS Trust Boards ensure safe care for their patients': the information prompts relevant & constructive challenge; the information supports informed decision-making; the information is effective in providing early warning of potential problems; the information reflects the experiences of users & services; the information develops Directors' understanding of the Trust & its performance

Trust Board Meeting – May 2017

NHS Maidstone and Tunbridge Wells NHS Trust

5-14	Summary of the Trust Management Executive (TME) meeting, 17/05	Deputy Chief Executive

The TME has met once since the last Board meeting. The key items covered were as follows:

- In the **safety moment**, the Chief Nurse highlighted the work taking place to mark the safety theme for the month, which was Dementia
- A request for a **replacement Consultant Histopathologist post** was approved. A request for a **replacement Obstetrician and Gynaecologist** was provisionally approved, subject to this being discussed further the Director of Finance and Chief Operating Officer
- The Director of Operations for Planned Care gave an update on the **operational impact of the plans regarding the use of Theatre 6 at Tunbridge Wells Hospital** (for which the Business Case was currently being finalised, for likely review by the Finance Committee & Board in June)
- The **new service model for Diabetes** was presented and discussed, which highlighted the potential for similar collaborative redesigns of other services
- The **Performance for month 1,** 2017/18 was discussed, which included an update on the latest mortality rates, and the work to address the issues relating to the recent higher than expected Hospital Standardised Mortality Ratio (HSMR). The decline in Referral to Treatment (RTT) performance was also acknowledged, as was the size of the waiting list backlog (of over 3000 patients, 1000 of which were for Orthopaedics). The recent decline in the proportion of staff who would recommend the Trust as a place to work (as shown by the latest staff 'Impressions' survey) was also discussed, and it was agreed that the Head of Communications should liaise with the Director of Workforce to promote awareness of the possible reasons for the decline. It was also agreed that the Head of Communications should liaise with the Chief Operating Officer and Directors of Operations to raise awareness of the forthcoming 'Rapid Improvement Week'
- The agreed **performance trajectories for 2017/18** for Cancer, A&E and Referral to Treatment (RTT) were noted
- The latest **infection prevention and control** position was reported, which confirmed that the case of MRSA bacteraemia seen in February has been formally removed from the Trust's data and assigned to a third party by Public Health England
- The **reports from Divisions** highlighted that for Women's, Children's & Sexual Health, the key issues were the significant gap in relation to their Cost Improvement Programme (CIP), and concerns regarding medical staffing at night (which would be subject to a risk assessment). For Planned Care, it was noted that the Division would be split into 2 sub-Divisions, for operational purposes, and the key issues related to vacancies and staffing, as well as a forthcoming review of Trauma & Orthopaedics by Health Education Kent, Surrey and Sussex (HEKSS). The recent dramatic price increases for 2 particular medications was also raised, and it was agreed that the Chief Pharmacist would liaise with the relevant staff at NHS England and/or the Central Medicines Unit to ascertain the reasons for the increases. For Urgent Care, a possible reason for the increase in Ambulance attendances in the evening was discussed, and it was suggested it may be beneficial for the Clinical Director for Acute and Emergency to attend a meeting of the Urgent Care Delivery Board, to discuss this
- The key issues discussed at the latest **Clinical Directors' Committee** and **Executive Team meetings** were reported, which included the announcement of the appointment of the 3 new Deputy Medical Directors (for each Division) - Sharon Beesley, Paul Sigston and Sarah Flint. It was noted that Dr Beesley's appointment would therefore require a new Clinical Director to be appointed for Cancer and Haematology.
- The latest position on the **national 7 day service programme** was reported, which included the plans for the 'Challenge Day' with the National Team and West Kent CCG on 19/05/17
- A presentation was given on the **'Listening into Action' (LiA) programme**, which emphasised that LiA was about fundamentally shifting how the Trust worked and was an attempt to connect better with all employees to deliver the best outcomes for patients, staff and the whole team. A LiA document ("The best medicine – powerful stories of staff-led change from the 5th biggest employer in the world") was agreed to be circulated

- An update on the **Kent and Medway Sustainability and Transformation Plan (STP)** was given, and a discussion was held in relation to a **proposed Trust strategy**, which highlighted the likely future importance of Accountable Care Systems, and drew attention to the need for senior clinical engagement in their development.
- The Director of Workforce gave an **update on the 2016 new Junior Doctor contract**
- The summary report from the **Trust Clinical Governance Committee** was received, and it was agreed that a new, briefer, format (which was trialled), should continue for future meetings. However, the need for a review of the relationships and reporting processes between the Trust Clinical Governance Committee and Quality Committee was acknowledged.
- The **recently-approved Business Cases** were noted, which included £1.3m of Backlog Maintenance for 2017/18 (although the programme of works consists of various projects that are aggregated together with no individual project exceeding £500k)
- An update on the **implementation of the replacement PAS+** was given
- Formal updates were received on the recent activity of the TME's main **sub-committees** (MTW Programme Committee, Clinical Operations & Delivery Committee, Information Governance Committee and Policy Ratification Committee)

Which Committees have reviewed the information prior to Board submission?
N/A

Reason for receipt at the Board (decision, discussion, information, assurance etc.) [1]
Information and assurance

[1] All information received by the Board should pass at least one of the tests from 'The Intelligent Board' & 'Safe in the knowledge: How do NHS Trust Boards ensure safe care for their patients': the information prompts relevant & constructive challenge; the information supports informed decision-making; the information is effective in providing early warning of potential problems; the information reflects the experiences of users & services; the information develops Directors' understanding of the Trust & its performance

Trust Board Meeting – May 2017

NHS Maidstone and Tunbridge Wells NHS Trust

5-15 Summary report from Finance C'ttee, 22/05 Committee Chair (Non-Exec. Director)

The Finance Committee met on 22nd May 2017. The meeting was regrettably not quorate (apart from 2 items) as only one Executive Director was in attendance for the whole meeting.

1. The key matters considered at the meeting were as follows:

- Under the review of actions from previous meetings, the scope of a post-tender review of service tenders/developments was agreed i.e. that the process should cover tenders/service developments resulting in a material financial change (defined as in excess of £100k revenue), but that this £100k threshold should be reviewed in February 2018
- Under the "Safety Moment", the Trust Secretary reported that May's theme was Dementia
- The month 1 performance was discussed, and a report on the Cost Improvement Plan (CIP) was reviewed. The £0.2m adverse variance to plan, which was essentially as a result of not receiving the performance-related Sustainability and Transformation Fund (STF) monies, prompted a discussion on patient flow, & the C'ttee agreed its role should expand to include oversight of performance-related issues (& that those attending the meeting be reconsidered accordingly). It was noted that the Terms of Reference were due for review in June 2017.
- The review of the month 1 position also led to a discussion of the planned levels of elective activity for 2017/18, and the opportunity to undertake increased elective activity during the summer of 2017 (for activity covered via Payment by Results contracts) was acknowledged
- The monthly update on the Workforce Transformation programme noted that progress was proceeding according to plan, and the Job Planning Policy had now been completed, but need to be agreed at the Joint Medical Consultative Committee (JMCC)
- An update was given on the work to prepare for the Financial Special Measures Review Meeting with NHS Improvement (NHSI) in June, and it was noted that a more detailed discussion would take place at the 'Part 2' Trust Board on 24/05/17
- The usual monthly update on the Lord Carter efficiency review was discussed, and the latest quarterly progress update on the Procurement Transformation Plan was reported (the same report has been submitted to the Trust Board, as a separate Attachment)
- The Business Case for the Radiotherapy modernisation program – Linear Accelerator (LinAc) replacements in 2017-2020 was reviewed, and the Committee agreed to recommend that the Trust Board approve the Case (which has been submitted as a separate Attachment)
- The usual monthly report on breaches of the external cap on the Agency staff pay rate was reviewed, and it was agreed to request that the June 2017 meeting of the Workforce Committee consider and discuss the recent increase in the use of Agency staffing (and of non-Framework Agencies in particular)
- The Committee received details of the agreed reclassification of expenditure as charitable funds for the full 2016/17 year, and confirmed it was content with the reclassification

2. In addition the agreements referred to above, the Committee agreed that:

- The labels used in future reports to the Committee should clearly distinguish between the values in the plan submitted to NHSI in December 2016 and the adjusted plan
- The Director of Finance and Deputy Director of Finance (Financial Performance) should liaise with the Deputy Chief Executive to relay the Committee's request that the work being undertaken to strengthen communications highlight the importance of the Trust achieving its planned financial position each month, in light of the limited opportunity (under the aligned incentives contract) to recover any shortfall in subsequent months

3. The issues that need to be drawn to the attention of the Board are as follows:

- The Committee agreed to recommend that the Trust Board approve the Business Case for LinAc replacements in 2017-2020
- The Committee recommended that its role expand to include oversight of performance-related issues (and that the individuals attending the meeting be reconsidered accordingly)

Which Committees have reviewed the information prior to Board submission?

- N/A

Reason for receipt at the Board (decision, discussion, information, assurance etc.)

Information and assurance

Trust Board meeting – May 2017

NHS Maidstone and Tunbridge Wells NHS Trust

5-15	Finance Cttee, 22/05/17 (incl. approval of the Business Case to replace 2 Linear Accelerators)	Chair of Finance Committee / Director of Finance

In the autumn of 2016 NHS England announced a capital fund of £130m had been made available to support replacement of ageing or technologically obsolescing linear accelerators. They identified a number of machines that fitted the criteria for MTW, and invited bids in the first place for capital PDC funding in 2016/17. The Trust was successful in its initial bid and purchased a replacement machine for LA1at Maidstone Hospital to be commissioned in 2017/18. The Trust has recently submitted its application to NHS England for the replacement of 3 further machines to be funded from central PDC capital in 2017/18 (2 machines) and 2018/19 (1 machine).

The enclosed Business Case sets out the preferred option for the linear accelerator replacement programme from 2017 to 2020 explaining the rationale for the selection of machines, the financial implications, the arrangements for ensuring that SLA patient activity is maintained during the replacement phase, and the overall project management.

The Trust's Reservation of Powers and Scheme of Delegation (2.6) stipulate that "Acquisition, disposal or change of use of land and/or buildings, involving capital expenditure in excess of £1,000,000" is a function reserved for decision by the Trust Board. The Case has therefore been submitted for consideration by the Finance Committee on 22nd May 2017, before the Trust Board is asked to approve the Case. The outcome of the Finance Committee's consideration will be reported to the Trust Board as part of the summary report from that Committee (which will be issued after the meeting).

Which Committees have reviewed the information prior to Board submission?

- Finance Committee, 22/05/17

Reason for submission to the Board (decision, discussion, information, assurance etc.) [1]

Review and approval

[1] All information received by the Board should pass at least one of the tests from 'The Intelligent Board' & 'Safe in the knowledge: How do NHS Trust Boards ensure safe care for their patients': the information prompts relevant & constructive challenge; the information supports informed decision-making; the information is effective in providing early warning of potential problems; the information reflects the experiences of users & services; the information develops Directors' understanding of the Trust & its performance

Maidstone and Tunbridge Wells NHS Trust

Business Case

The radiotherapy modernisation program – linac replacements in 2017-2020

Issue date	May 2017
Department	Kent Oncology Centre
Directorate	Cancer & Haematology
Author	Stephen Duck
Clinical lead	Dr Sharon Beesley
Executive Sponsor	Jim Lusby
ID reference	ID 490

Approved by	Name	Signature	Date
General Manager	David Fitzgerald		
Finance manager	Gemma Paling		
Clinical Director	Dr Sharon Beesley		
Executive sponsor	Jim Lusby		
Supported by	**Name**	**Signature**	**Date**
Director Estates & Facilities	Jeanette Rooke		
Director of Informatics	Donna Jarrett		
HR Business Partner	Angie Collison		
Approved by	**Name**	**Minute**	**Date**
Directorate Board			
Investment Appraisal Group	IAG		17.5.17
Finance Committee			
Trust Board			

Maidstone and Tunbridge Wells NHS Trust

The Business Case Summary

Strategic context

The Trust is falling behind with the radiotherapy linac replacement program which is pushing the projected age of the machines out to between 12-15 years on current timescales – well beyond the national recommendation that treatment units should be replaced once they reach 10 years[1].

Whilst benefiting from the NHS England Modernising Radiotherapy program to replace 1 linac in 2017, the Trust will still have a further 5 out of a complement of 9 linacs that will be obsolescent by the end of 2017.

NHS England commissioners have indicated that the Trust may be allocated access to the Modernising Radiotherapy fund[2] to purchase 3 further linacs in 2018-2019.

The Trust's capital program also schedules a further linac for 2019/2020.

This linac should be considered in conjunction with the 3 modernisation program linacs to close the gap on the obsolescence that the Kent Oncology Centre is facing by providing a robust replacement program for 2017-2020 that is responsive to the uncertainties in the timescales for the proposed TWH satellite radiotherapy centre and the future of the Kent and Canterbury Hospital site (both the subject of separate strategic cases).

The case recommends that the enabling works for the first linac should be undertaken in 2017/18 to minimise further delays to the overall replacement program and proposes how this could be achieved.

This business case is about maintaining current activity and is not a case for the growth of the radiotherapy service.

[1] NHS Standard Contract for Radiotherapy (all ages)
[2] Transforming Radiotherapy Services – letter from NHS England

Maidstone and Tunbridge Wells NHS Trust

Objectives of the investment and the problems with the status quo

1. *Continue with the linac replacement program outlined in the earlier agreed business case for the replacement of LA1M in 2016/17.*
2. *Replace four end-of-life, obsolete, radiotherapy linear accelerators (linacs) during 2017-2020 which are not compliant with the NHSE specification for the provision of radiotherapy, with modern units that provides a safer, higher-quality treatment that will deliver better patient outcomes and which meet the radiotherapy specification.*
3. *Take advantage of the Transforming Radiotherapy Services Capital Investment Programme's proposed allocation of two linacs to Maidstone and Tunbridge Wells NHS Trust for the financial years 2017/18 and one linac for 2018/19 to develop our services.*
4. *Continue with the Trust's capital replacement program for 2020.*
5. *Maintain existing radiotherapy activity during the replacement programme.*
6. *This is not a case for increasing radiotherapy activity.*

The main benefits expected from the investment

1. *Improve access to modern radiotherapy techniques for our patients – increasing access to dose-painting techniques (IMRT), image guided radiotherapy (IGRT) and stereotactic ablative/body radiotherapy (SABR/SBRT).*
2. *Provide continuity for the radiotherapy service, maintaining standards for patients living in Kent, Medway and parts of East Sussex.*
3. *Improve patient care through better treatment outcomes.*
4. *Improve capability for transferring patients between linacs during breakdowns and servicing which could otherwise result in patient delays and additional staff overtime.*
5. *Protect market share.*

The main risks associated with the investment

1. *The loss of 11% of linac capacity during the replacement of the treatment unit and the need to maintain business continuity.*
2. *The aging linac at Canterbury (LA3C) is prone to high failure rates that may result in extended down-times that would reduce linac capacity by a further 11%.*
3. *Knock-on delays (due to enabling works or equipment issues for example) may incur additional storage charges as the installations of subsequent linacs are delayed.*
4. *Funding may not be allocated if there is no agreement over the Trust's control target with NHS Improvement.*
5. *Funding may not be allocated if the Trust does not sign up to participate in the local radiotherapy network.*

Available options

A. *Do nothing – do not replace a linac at the KOC in 2017-2020.*

B. *Replace 4 linacs in 2017-2020, identifying the priority as Maidstone but continuing to review both the strategic position at Canterbury and the TWH satellite, with a view to substituting LA3C at Canterbury for a scheduled Maidstone replacement as service/strategical reasons dictate.*

Maidstone and Tunbridge Wells NHS Trust

Preferred Option

Option B Replace 4 linacs in 2017-2020 according to operational and strategic demands

1. *Replace 4 obsolescent linacs with state-of-the-art Varian Truebeam linear accelerators similar to that which was installed at Canterbury in 2015 and which is currently being installed at Maidstone. The linacs will provide additional dose-painting techniques (IMRT), image guided radiotherapy (IGRT) and stereotactic ablative/body radiotherapy (SABR/SBRT) in accordance with modern radiotherapy delivery.*

2. *Identify the priority as the Maidstone linacs that are over 10 years old – subject to the outcome of the review on the strategic case for the disposition of linacs in east Kent.*

3. *Utilise access to the Modernising Radiotherapy PDC funding for 3 of these replacements, with the 4th funded in-line with the Trust's capital program.*

4. *Begin the enabling works for the first replacement in January 2018 to minimise potential delays in the linac replacement program.*

Funding, affordability

Revenue – net additional costs [no extra activity or income assumed)

Year	*Recurrent*	*Non-recurrent*	*Total net additional costs*
2017/18	*(£8.5k)*	*£90.3k*	*£81.8k*
2018/19	*£46.2k*	*£153.6k*	*£199.8k*
2019/20	*£302.8k*	*£102.7k*	*£405.5k*
2020/21	*£693.2k*	*£28.2k*	*£721.4k*
2021/22	*£888.9k*	*£0k*	*£888.9k*
2022/23	*£987.7k*	*£0k*	*£987.7k*

The additional revenue costs arising from the replacement of the linac machines relate to higher capital charges (new machines/enabling works approx. twice the cost of the predecessor machines) and the full preventative maintenance contracts after the 2yr warranty expires. The case does not assume additional activity or income changes.

Capital

Year	*Linac machines*	*Enabling works, commissioning & other equip*	*Total Capex*	*Bids for PDC funding*
2017/18	*£3.68m*	*£0.00m*	*£3.68m*	*£3.68m*
2018/19	*£1.84m*	*£1.10m*	*£2.94m*	*£1.84m*
2019/20	*£1.84m*	*£1.39m*	*£3.23m*	*£0.00m*

The Trust has submitted bids to the DH for 3 linac replacements funded from central PDC, 2 to be funded in 2017/18 and 1 in 2018/19. All other costs for enabling build works, commissioning and ancillary equipment are financed from Trust capital which is not available until 2018/19 onwards, which will mean the Trust will incur off site storage (as for the first funded linac in 2016/17). The 2019/20 linac is currently planned for replacement from Trust capital.

Management arrangements

The project will be managed by an internal MTW team from procurement, Estates & Facilities and Medical Physics. Work-streams to manage the various tasks will be formed under an umbrella Project Group that will report into the Maidstone Program Board and the Cancer and Haematology Directorate Board (see below for further details).

Maidstone and Tunbridge Wells NHS Trust

The Business Case

Strategic Context	*Strategic Case*

Current status

The Maidstone and Tunbridge Wells NHS Trust hosts the regional Kent Oncology Centre (KOC) that provides specialised cancer services – including radiotherapy – to the 1.9M population in Kent, Medway and parts of East Sussex.

The KOC radiotherapy service is based at Maidstone General Hospital (MGH) and the Kent and Canterbury Hospital (KCH). Delivering over 69,000 fractions/year, the service is one of the top 5 Cancer Centres in England for radiotherapy delivery.

The radiotherapy department at MH is relatively new and purpose built while the facilities at KCH are older and were not originally designed for linacs (being built in 1937), albeit the area has been recently refurbished.

NHSE have published, in conjunction with Cancer Research UK, a vision for radiotherapy services [3]where "All patients will receive advanced and innovative radiotherapy that has been shown to be clinically and cost effective" and that "aging equipment prevents centres from keeping pace with innovation and provide advanced techniques to agreed levels of good practice…Trusts should have appropriate replacement plans for these machines to ensure they continue to meet national standards[4]."

The NHS standard contract for radiotherapy recommends that treatment units should be replaced once they reach 10 years to ensure that the advanced and innovative radiotherapy technology present on modern treatment units is implemented in cancer centres to improve patient outcome[4].

The Kent Oncology Centre has a fleet of 9 linacs (6 at MGH and 3 at KCH). Of the 9 linacs, 5 are in need of replacement in 2017 because they are already at the end of their 10-year lifetime. Being older generation linear accelerators they are unable to meet the current minimum specification for radiotherapy treatment delivery and are not capable of meeting the future developments envisaged by the KOC in the 5 year plan.

There is a published linac replacement program for the Kent Oncology Centre that calls for a replacement of a linac every year (Appendix A) but this program has already been delayed with projected replacement ages now between 2 and 5 years higher than when the original business case to replace LA2C was written in 2013.

As a consequence, the replacement program now extends the lifetime of each linac significantly beyond the recommended 10 years– with planned replacement ages now upwards of 12- 15 years which are well beyond NHS England's recommended age for linacs .

Further delay in the replacement program would push all of the linear accelerators well beyond the recommended lifetime (unless there are options to replace 2 linacs in a single year over a number of years) and would, therefore, place significant strain on the KOC's ability to provide modern radiotherapy. Ultimately, this could challenge the viability of the KOC service as other providers seize the opportunity to enter the market, because the NHS radiotherapy contract specifies that commissioners are free to engage with other suppliers, who presumably are able to provide a modern radiotherapy service, where the provider has not agreed a timely replacement program, "Commissioners may divert activity where this is breached without agreement".

[3] Vision for Radiotherapy 2014-2024, Cancer Research UK and NHSE, 2014
[4] NHS standard contract for radiotherapy (all ages) Section B Part 1 – Service Specifications, NHS England B01/S/9, 2013

In 2016/2017, NHS England announced funding through the Modernising Radiotherapy program to support the replacement of obsolete and aged (10 years or older) linacs as a priority[5,6].The Trust was subsequently allocated access to this funding and is currently replacing a linac at Maidstone which is due to return to clinical use in October 2017.

Access to the recently announced second tranche of central funding would continue to allow the KOC to partially catch-up on a delayed replacement schedule and improve the Trust's position. NHS England commissioners have indicated that the Trust may be allocated two linac replacements in 2017/18 and one more in 2018/19.

Failure to take advantage of this funding to purchase the latest generation of radiotherapy treatment units into the Trust will significantly impact not only the potential outcomes for our patients but also the Kent Oncology Centre's radiotherapy income as commissioners choose to use those providers who are able to offer better access to modern treatments[1].

Regarding the proposed satellite centre at TWH, the Trust's capital program identifies that this may come on-line in 2020 with the TWH Radiotherapy Bunker Capacity Project Outline Business Case[7]identifying the diversion of a Maidstone replacement linac to equip the TWH facility. The replacement program needs to take this development into account and provide a solution should TWH be delayed.

The replacement program also needs to be able to respond to the current uncertainties around the future of the Kent and Canterbury Hospital site, which is owned by East Kent Hospitals University Foundation Trust (EKHUFT), and to manage the difficulties in installing replacement linacs on this site given the buildings are not purpose built for radiotherapy machines and suffer the inherent infrastructure issues often present in buildings which are over 80 years old. These considerations are particularly acute given the oldest linac in the KOC fleet, LA3C, is based at Canterbury.

The Trust is engaging at executive level with EKHUFT to understand their plans for the site and the future configuration of the KOC at Canterbury is the subject of a separate strategic case.

The NHS England commissioners are aware of the position regarding KCH and have indicated that the replacement of an obsolete linac at Maidstone instead of Canterbury is acceptable under the Modernising Radiotherapy program should this be necessary.

The Trust's capital program includes a linac replacement in 2020 (and further replacements in subsequent years). This linac should be considered in this business case in conjunction with the 3 Modernising Radiotherapy program linacs to demonstrate that the proposed replacement program is robust, achievable and able to respond to the uncertainties and risks described above.

This business case is, therefore, proposing to replace 4 linacs in 2017-2020 (3 under the Modernising Radiotherapy program and 1 from the capital program) to significantly address the current need to replace 5 obsolete linacs at the KOC.

This business case is about maintaining the capability of the KOC fleet and is not proposing growth in radiotherapy activity. There is, therefore, no need for recurrent staffing resources as a consequence of this replacement program (staffing for the TWH satellite facility is the subject of a separate case).

[5] Transforming Radiotherapy Services – letter from NHS England
[6] It should be noted that the funding is Public Dividend Capital for equipment only – monies for any bunker enabling works would need to be allocated from Trust capital.
[7] Outline Business Case: MTW Radiotherapy Bunker Capacity Project, 2015

Advances in radiotherapy technology

Significant technological progress has been made in both treatment unit design and radiotherapy techniques that have contributed to improved patient outcomes since the older generation units were installed over 10 years ago, including:

- *RapidArc for dose painting that concentrates the dose on the target lesion whilst minimising the dose to surrounding critical structures.*
- *On-board imaging that provides near diagnostic quality images with the patient in the treatment position on the linear accelerator to improve the accuracy of dose delivery,*
- *Image acquisition during treatment to monitor target position in real-time which is important when targeting lesions that can vary position throughout treatment,*
- *High-dose rate modes for stereotactic radiotherapy techniques to significantly reduce treatment times and improve accuracy when irradiating small, highly mobile, lesions.*

The first 2 of these advances opens the way for 4D image guided adaptive radiotherapy that should be the standard of care for many patients[8,9] and the last 2 would improve the accuracy of the techniques such as stereotactic ablative radiotherapy/stereotactic body radiotherapy (SABR/SBRT) which are in the KOC business plan and significantly reduce treatment delivery time and improve outcomes for some patients.

Current linac status

The table below lists the current location of the linac fleet within the Kent Oncology Centre and indicates whether they meet the NHS specification for maximum age (in 2017) and the ability to deliver modern radiotherapy, including 4D Adaptive and SABRE/SBRT.

The Kent Oncology Centre has 5 linacs that need immediate replacement if the Centre is comply with the NHS specification.

The table also indicates the anticipated replacement dates for the linacs, assuming access to the second tranche of the Modernising Radiotherapy fund (3 linacs) and the Trust's capital replacement program (see Appendix A).

Even with access to this funding, the KOC will not meet the NHS Specification for equipment replacement without additional investment in both linacs and decant bunker capacity (see Appendix B) for further details.

[8] NHS standard contract for radiotherapy (all ages) Section B Part 1 – Service Specifications, NHS England B01/S/9, 2013
[9] National Radiotherapy Implementation Group Report Image Guided Radiotherapy (IGRT) Guidance for implementation and use, 2012

Current status of the treatment units at the Kent Oncology Centre.

Location	Linac	Within 10y Age (2017)	Capable of modern RT	Replacement date		Anticipated age at replacement	Comments
				Due	Expected		
Canterbury	LA1C	Yes	Yes	2020	2023	13	
Canterbury	LA2C	Yes	Yes	2025	2025	10	
Canterbury	LA3C	No	No	2014	2019	15	Delayed due to uncertainty of the east Kent site.
Maidstone	LA1M	Currently being replaced					
Maidstone	LA2M	Yes	Yes	2019	2022	14	
Maidstone	LA3M	No	Yes	2017	2021	14	
Maidstone	LA4M	No	No	2015	2018	13	
Maidstone	LA5M	No	Yes	2016	2018	12	
Maidstone	LA6M	No	Yes	2016	2020	14	Upgraded to 4D adaptive in 2013 under government "Innovations" program.

The case for the replacement of a treatment unit

The drivers for replacing a radiotherapy treatment unit include: equitability of access to modern radiotherapy facilities for our patients, improving patient care through improved outcomes[10] and the protection of market share.

Providing the best care for our patients requires providers to keep up with technological advances that improve outcomes by replacing treatment units regularly. The NHS standard contract for radiotherapy states that "The provider should ensure that each Linear Accelerator is in operation for a maximum of 10 years and that the replacements are planned in a timely manner." This is echoed through the Modernisation of Radiotherapy Services Program[11] where priority is given to "Replacement of linacs that have reached or are reaching the age of ten years or older, as these are considered obsolete".

The NHS standard contract for radiotherapy also identifies "Access to technologies such as Image Guided Radiotherapy (IGRT), which together with intensity modulated therapy forms the basis of 4-D Adaptive Radiotherapy, should be the standard of care for many patients". These techniques require imaging equipment that is not available on older generation treatment units.

The delivery of the best care to our patients also requires providers to increase access to IMRT. The current national target of 24% has been achieved by the Kent Oncology Centre (currently access to IMRT at the KOC is around 34%), but the latest national guidance recommends 50% by 2020[12] and there is already an expectation that "incentives to

[10] Vision for Radiotherapy 2014-2024, Cancer Research UK and NHSE, 2014
[11] Specialised Services Circular, £130m capital fund to modernise radiotherapy services in England – Next Steps, 2016
[12] Radiotherapy Board – Intensity Modulated Radiotherapy (IMRT) in the UK: Current access and predictions of future access rates, 2015

promote IMRT being driven through tariff[13]. In order to meet future targets and increase income the Kent Oncology Centre will need the additional dose-painting and on-board imaging capability that comes as standard on modern units.

The proposed linac would be the make and model (Varian, Truebeam recently installed at Canterbury), with the same standard features necessary to deliver innovative radiotherapy including IMRT, IGRT and SABR/SBRT.

Case for Change - Business Needs

The objective/s of the proposed investment

- *To improve access to modern radiotherapy techniques and better outcomes for our patients,*
- *To provide continuity of the radiotherapy service,*
- *To protect income and market share.*

Case for change -Benefits

The Economic Case

The measurable benefits associated with the investment objectives listed above are summarised below.

To improve access to modern radiotherapy techniques and better outcomes for our patients

- *Provide additional capability to deliver more advanced radiotherapy so that more patients are offered innovative radiotherapy techniques that will contribute to better outcomes.*

To provide continuity of the radiotherapy service

- *Maintain the radiotherapy service activity during subsequent linac replacements and minimise patient delays and gaps in treatment by standardising linac energies (6MV and 10 MV) across the fleet so as to allow patients to be transferred seamlessly between linacs during failures and downtime.*

To protect income and market share

- *Provide additional capability to deliver advanced radiotherapy that meets the National Standard Contract for Radiotherapy, assuring commissioners and patients that the KOC should remain the Cancer Centre of choice within Kent.*

Case for change –Risks

The Economic Case

List and description (category and grading) of the potential risks associated with the investment

Risk	*Category*	*Grading (Consequence x Likelihood)*	*Mitigation*
Loss of linac capacity during the replacement resulting in loss of activity and patient delays.	*Financial, Clinical Outcome, Quality*	*4 x 2= 8 Green*	*The KOC has recently undertaken a similar project successfully with no loss of activity.* *Select an obsolescent linac for replacement that is least able to support the activity of the KOC during the replacement project (and not necessarily the oldest).* *Business continuity arrangements will be in place.* *Major servicing and quality assurance will be undertaken out of hours and, where possible, before the project starts.* *The number of linacs being replaced in any one year will not impact on activity or waiting times because only one unit is out for replacement at any one time.* *A delay in the completion of a linac replacement will impact on the program for a subsequent linac, which*

[13] Improving outcomes: a strategy for cancer, Department of Health, January 2011

			may result in additional storage charges & contractor costs (see "unforeseen occurrences" below).
Incomplete knowledge of bunker structure and supporting services resulting in additional costs and delay in the project.	*Financial* *Maidstone replacements*	*3 x 2 =6 Green*	*The bunker is a purpose built facility. Services/bunker inspected as part of developing the Contractor's proposals and contingency costs allocated where appropriate.* *Advice from the Estates Department is that HVAC is sufficient.* *Core samples (which are standard) will be required for additional assurance.*
	Financial *Canterbury replacement*	*3 x 4 =12 Amber*	*Whilst the existing bunker is relatively new, the surrounding infrastructure is poor and deteriorating.* *Early engagement with EKHUFT estates and the design team (with the support of the MTW estates team) is essential to formally agree and document roles and responsibilities, design derogations and timescales.* *LA3C is programmed for later in the program which will further minimise the risk to the overall replacement program.*
Unforeseen occurrences, including unavailability of contractors and equipment failures, resulting in delay in the overall program.	*Financial*	*3 x 3 = 9 Green*	*Early engagement with the Turn-key contractors to secure their commitment to the enabling works dates proposed in this business case.* *Major equipment failures resulting in long-term commissioning delays are rare. Overtime would be required to catch up where possible.* *Regular communication with the equipment suppliers and the Turn-key contractors would be required to manage additional knock-on effects and minimise costs (such as additional storage charges of contractor costs).*
Insufficient staffing or expertise to successfully commission the linac resulting in project delays.	*Workforce*	*4 x 2= 8 Green*	*The team have successfully commissioned a similar unit at Canterbury in 2015 and this expertise is still available within the centre.* *Maintenance of the routine service during the replacement may require staff to agree to work overtime.* *Commissioning times are expected to be shorter as the replacement linac will match the Canterbury linac and, therefore, data collection and analysis will be a sub-set of what is undertaken normally.*

Constraints

1. *To maintain activity during the replacement program any enabling works that may affect the operation of the other linacs will need to be carried out outside of the radiotherapy service working hours.*
2. *To meet our obligations under the Modernising Radiotherapy program, the Trust must take ownership of the 2 linacs by 31st March 2018 and 1 linac by 31st March 2019 – either delivered to site or to a bonded warehouse.*
3. *Availability of capital to fund the enabling works could restrict the program to the financial calendar introducing delay.*

Dependencies

1. *Timescales for the delivery of the project are dependent on the following external factors:*
   a. *Confirmation of allocation of funding for the linac from NHSE – so that an order can be provided for the enabling works and the linac.*
   b. *Availability of the Turn-key contractors to carry out the enabling works (the Modernisation Program has already significantly increased demand for their services).*

2. *Trust capital funding is required for the bunker enabling works, commissioning costs and additional equipment to support the clinical use of the linac.*

The short list of options *The Economic Case*

Option A. The do nothing option - **Discounted.**

Do not replace linacs in 2017-2020.

SWOT Analysis – Do minimum	
Strengths	*Lower capital costs in the short term.* *a. No loss of radiotherapy capacity during the linac replacement.* *b. Sweating high value capital assets.*
Weaknesses	*Increased failure rates on aging equipment will result in delays in patient treatments.* *a. Increase in revenue in the instance of major breakdown as staff will need to work overtime at weekends to meet demand.* *b. There is an increased risk that a catastrophic failure will remove an older unit from clinical use for an extended period at very short notice, resulting in significant disruption, local and national media interest and consequent loss of income and reputation.* *c. Managing capacity during unscheduled long-term catastrophic breakdowns will not always be possible without compromising the outcome of treatment for some patients.* *d. Increasing pressure on other IMRT capable units to meet demand – extended working days and weekend working to cope – increase in revenue.* *e. Recruitment difficulties as it would be more attractive to work at other centres providing better facilities, working hours and advanced treatment techniques.* *f. Higher staff turnover due to unsatisfied staff.* *g. Increased staff stress and poorer morale due to workload and overtime with the potential of increased clinical incidents.*
Opportunities	*None identified given the age profile of the linac fleet.*
Threats	*Increasing loss of MTW market share and income:* *a. Significant extension to the projected lifetime of the KOC linacs damaging local and national reputation and questioning the strategic and operational viability of the cancer centre,* *b. commissioners may choose to redirect patients to other centres who are able to meet the NHS standard contract for radiotherapy delivery,* *c. patients may choose to have their treatment elsewhere where the provider is able to offer a modern radiotherapy service, and,* *d. other providers may be encouraged to enter the market and secure the business having assessed the age of the KOC fleet as significantly outside the 10 years specified in the NHSE Radiotherapy standard contract.*

Option B Replace 4 linacs during 2017-2020 - **Preferred Option**

Replace 4 linacs in 2017-2020, starting the enabling works for the first linac in January 2018 to minimise delay to the overall linac replacement program.

Key assumptions

a. *There is currently no capital allocation for enabling works in 2017/18 (£373,600 inclusive of vat and Estates fees) but capital has been allocated for 2018/19.*
b. *Beginning the enabling works in January 2018 removes the bottleneck created by the Modernisation linacs on the Trust's capital plan that would have created further delay in the linac replacement program.*
c. *The enabling works proceed in January 2018 on the basis that the Turn-key contractor accepts the deferral of payment until the completion of the works in 2018/19 or capital is secured in year from slippage / reallocation of estates/equipment funding (see below for further details).*

Proposed replacement program 2017 – 2020

Linac	*Funding*	*Linac purchase date*	*Linac accepted*	*Project completed*	*Proposed installation site*	*Alternative site*
LA4	*Modernisation*	*Nov 2017*	*30 Apr 2018*	*27 Aug 2018*	*Maidstone*	*X (Canterbury not resolved, TWH not available.)*
LA5	*Modernisation*	*Nov 2017*	*10 Dec 2018*	*15 Apr 2019*	*Maidstone*	*X (Canterbury not resolved, TWH not available.)*
LA6 or LA3C	*Modernisation*	*Mar 2019*	*5 Aug 2019*	*4 Nov 2019*	*Maidstone (LA6)* *East Kent (LA3C) – subject to strategic case*	*X* *X*

And then one of the linacs below (depending on whether it was LA3C or LA6 replaced earlier in the program)

LA3 or LA3C or LA6	*Trust capital*	*Oct 2019*	*23 Mar 2020*	*6 Jul 2020*	*TWH (LA3)* *East Kent (LA3C) – subject to strategic case* *TWH (LA6)*	*Maidstone (LA3)* *X (LA3C - unless to TWH)* *Maidstone (LA6)*

Mitigating the financial risks in starting the enabling works in January 2018

1. *The proposal is to begin the enabling works in January 2018 upon agreement with the Turn-key contractors that the liability to pay the contractors is only triggered upon satisfactory completion of the building works in 2018/19.*

2. *If the contractors decline, then funding, or part funding if the contractors are prepared to accept some of the financial risk, could be secured in year from slippage / reallocation of estates/equipment funding.*

3. *If no slippage funding was forthcoming, then the start date would need to be renegotiated with the contractor. But there would be no guarantee that the contractors could commit to a new start date in early 2018 which would put*

the replacement program even further behind and the Trust would also incur penalty costs for the subsequent delay.

4. *The alternative approach is to de-risk the LA4 enabling works completely by planning them for 2018/19 when capital funding has been allocated. This will create its own risks, however, because the Modernisation linacs will be pushed up against the Trust capital linac scheduled for 2019/2020. This will put the capital plan under pressure as the enabling works and linac acceptance (5% of linac cost) move from 2019/20 to 2020/21 – for LA3C this could require around £1,000,000 of additional capital to be found in 2020/21 which could stall the replacement program.*

SWOT Analysis – Replace 4 linacs 2017-2020 with enabling works beginning January 2018	
Strengths	*Modernises the linac fleet, secures local and national confidence in the future of the KOC.* *Accommodates the uncertainties regarding the TWH satellite centre and the future of the Canterbury site, by prioritising the aged linacs at Maidstone - all of which are beyond the 10 year lifetime recommended by NHS England.* *Minimises bottlenecks in the capital program and potential delays by bringing forward the enabling works for the first linac replacement (LA4) into the 2017/18 financial year.* *Options for the future configuration of the KOC at Canterbury and the subsequent disposition of the LA3C replacement in east Kent are the subject of a separate strategic case.* *Should the TWH satellite centre be delayed, subsequent linac replacements scheduled under the Trust's capital program (and not covered by the modernisation program or this business case) could be diverted from Maidstone to TWH to complete the proposed satellite configuration and achieve the objectives of the TWH Radiotherapy Satellite Business Case.*
Weaknesses	*There is little room for slippage in the program.* *The Turn-key operator may decline to accept full payment at the completion of the works or slippage money is not available.* *If LA3C is not replaced in 2019 and the TWH satellite centre comes on-line in 2020 - taking a replacement from Maidstone - then LA3C will be at least 17 years old before it is replaced.* *Reduction in linac capacity of 11% during the commissioning program.*
Opportunities	*Provides additional capability to deliver advanced radiotherapy, including IMRT, IGRT and SABRE/SBRT.*
Threats	*EKHUFT is currently undertaking a strategic review of the location of their hospital services and, therefore, the future of the Kent and Canterbury site is unclear which could impact on the future delivery of radiotherapy services and the disposition of linacs in east Kent.* *The lifetime of LA3C could as a consequence extend beyond 15 years which may encourage other providers to enter the east Kent market and secure business.* *MTW's strategy for the East Kent linacs needs to be resolved relatively quickly so as to facilitate the replacement of the oldest linac ASAP.*

Maidstone and Tunbridge Wells NHS Trust

Maintenance options – Truebeam Linac

Potential options for managing the maintenance of the Truebeam after the 2 year warranty include:

1. *No maintenance contract from the linac manufacturer – support is chargeable when required, spares not included.*
2. *Limited maintenance contract – telephone support and access to diagnostic tools but spare parts are not included.*
3. *Full-service maintenance contract, including all spares except "high-vacuum" items.*

The provision of manufacturer support and access to diagnostic tools is considered essential to ensuring that delays due to breakdowns are minimised. Proceeding without maintenance cover is, therefore, not recommended because the risks to the service are too high.

Selection of the most appropriate maintenance contract from the remaining options (limited cover and full-service cover) is essentially a question of the financial risk that the Trust wishes to take around the cost of the spare parts: all parts are chargeable under the limited contract but under a full-service contract spares are included – except items identified as "high vacuum" items which are typically x-ray tubes, and high energy valves etc.

Unfortunately, given that the Truebeam is a relatively new linac platform, with the Canterbury unit just out of warranty (early 2017), it is difficult to predict the spare-parts costs at this stage and therefore the relative merits of these options – except that the full-service contract places an upper limit on the likely spend on spare parts in a year.

We may be in a better positon to identify the best service contract option as theses linacs come out of warranty in 2 years because we will have several years of (non-warranty) maintenance experience on the Truebeam at Canterbury and Maidstone.

Summary of maintenance options.

Maintenance options	*Advice*	*Diagnostics*	*Spares*	*Service contract cost/year (£)*	*Comments*
No cover	*X*	*X*	*X*	*£0*	*Not recommended – business continuity risks are too high.*
Limited cover	*√*	*√*	*X*	*£18,500*	
Full-service	*√*	*√*	*√*	*£85,000*	*All spares covered excluding "high vacuum" items.*

The Preferred Option *The Economic Case*

Services and/or assets required

1. *This is a linac replacement into an existing bunker and will, therefore, connect into the existing services already being supplied to the current unit.*

Activity and service level agreement (SLA) implications. Commissioner involvement and input.

1. *There are no anticipated implications on activity and SLAs because the service will maintain business as usual during the linac replacement by extending the service's operating hours.*

2. *The replacement is supported by NHSE through the Modernising Radiotherapy program.*

3. *Radiotherapy services are fully commissioned.*

Workforce impact
1. *The service will extend operating hours during the replacement program which will require staff to work different shift patterns and some occasional weekend working and overtime –but additional staff will not be required to support the extended working day.* 2. *The linac commissioning will be undertaken utilising existing Radiotherapy Physics staff – this approach was successful when commissioning LA2 at Canterbury in 2015 and has been shown to be the most cost-effective approach[14]. These "business continuity" costs have been factored into the financial assessment.* 3. *Additional clinical staff will not be required to maintain existing activity once the linac facility has been returned to clinical use.*
Estates impact
1. *Enabling works are required within the bunker to increase the protection levels to meet the demands of the replacement machine and to bring the facility up to modern standards.* 2. *The enabling works and installation will be a turn-key project using the team that completed LA2 at Canterbury.* 3. *The Estates and Facilities team will be involved in the project management and delivery of the enabling works.* 4. *We are advised by Estates that there is sufficient power on-site to support the linac.* 5. *During the enabling works, noisy working and the movement of materials into and out of the work area will be undertaken out of hours to minimise any disruption.*
Impact on other directorates
1. *No impacts are anticipated on other directorates at any stage of the replacement process.* 2. *The Project Management arrangements described below will be used to manage communications should a problem arise that may impact on other directorates.*

Funding and affordability *The Financial Case*

[14] Business Case – Replacement linear accelerator at Canterbury (October 2014)

Capital costs of preferred investment option

1. *The Trust has bid for 3 further Linac replacement machines from DH capital PDC, with a 4th replacement funded from Trust capital resource. This is in line with the Trust 5 year capital programme submitted to NHSI in the 2017/18 planning submissions.*

2. *Only the machines are funded from PDC; the other necessary costs for build enabling, associated equipment and commissioning of the machines has to be found from Trust capital. In most cases the timings in this case accord with the latest plan submission but there are some mismatches that will need to be managed. The main initial issue is the desirability of commencing the enabling works for LA4 replacement at Maidstone at the back end of 2017/18, although the funding is not at present available until 2018/19. The two options currently under consideration are:*
   a) *Identify sufficient funding from the 17/18 programme from either slippage during the year or by redirecting currently allocated budgets to other areas. This is being explored.*
   b) *Commence the work in 17/18 but ensuring that it is not completed, or contractually liable until 18/19.*

If neither of these options becomes available then the work will need to be delayed until the 2018/19 financial year.

3. *There are risks on the cost of the enabling works for LA3C at Kent and Canterbury hospital given the infrastructure challenges of that site. The base case proposal is to delay replacement of that machine until clarity on issues around the future of the site are resolved, so it is not an immediate risk to resource in the next two financial years.*

4. *The costs are based on latest quotes from NHS Supply Chain and updated estimates of internal works costs.*

Capex £m inc. VAT	Machine	2017/18	2018/19	2019/20	2020/21	Funding	Plan position
Linacs	LA4M	1,839				DH PDC bid	2017/18
	LA5M	1,839				DH PDC bid	2017/18
	LA6M		1,839			DH PDC bid	2018/19
	LA3C			1,839		Trust Capital	2019/20
Enabling works	LA4M		374			Trust Capital	2018/19
	LA5M		374			Trust Capital	2018/19
	LA6M			374		Trust Capital	2018/19 not 2019/20
	LA3C			910		Trust Capital	2019/20 but only £700k
Associated equipment	LA4M		74			Trust Capital	2018/19
	LA5M		142			Trust Capital	2018/19
	LA6M		72			Trust Capital	2018/19
	LA3C			75		Trust Capital	2019/20
Commissioning	LA4M		31			Trust Capital	2018/19
	LA5M		31			Trust Capital	2018/19
	LA6M			31		Trust Capital	2018/19 not 2019/20
	LA3C				32	Trust Capital	2020/21
Totals £m incl. VAT		**3,677**	**2,936**	**3,228**	**32**		

Revenue costs of the preferred option

1. *The linacs are replacements to existing capacity. No assumptions of additional growth in patient activity and corresponding income and marginal costs have been factored into the case. The change in recurrent costs begins to impact significantly in 2019/20 with c£303k additional cost, and rises to £988k by 2022/23 when all the machines are out of warranty. There are two main drivers for the change in recurrent cost levels:*
   a) *The replacement linacs plus enabling works and other costs are more than twice the cost of the predecessor machines and thus generate higher capital charges across the asset lives (13 years for linacs and 5 for other equipment). This accounts for over 70% of the change in cost by 2022/23.*

b) *The case assumes at present the highest level of maintenance cover once the 2 year warranty expires – the cost is £85k per machine against a current cost of around £15k per machine amounting to a net change of £280k per annum by 2022/23. As stated in the discussion on maintenance cover this choice is subject to review with the experience from the Truebeam machine installed at Canterbury. The Directorate will need to finance the additional costs of the maintenance cover from within its existing budget resource.*

2. *Non recurrent costs have been assessed for:*
   a) *Storage costs for the linac machines until the enabling works' completion permits their onsite installation;*
   b) *Business continuity costs for existing staffing working on other machines to maintain contractual capacity;*
   c) *Disposal/write off costs of the replaced machines. The Trust policy on linac asset lives is 13 years, recognising the reality of use beyond the recommended 10 year span; the advent of the national funding will enable earlier replacement than at the end of the 13 years for some of the current machines.*

The analysis of both new costs, and avoided costs, by machine and by year is set out in the following table.

Maidstone and Tunbridge Wells NHS Trust

			2017/18	2018/19	2019/20	2020/21	2021/22	2022/23	Total
LA4M	Recurrent	New Depreciation		95,543	191,086	191,086	191,086	191,086	859,887
		New PDC	32,175	71,046	74,398	67,710	61,022	54,334	360,687
		Previous Depreciation		-79,097	-79,097	-79,097	-79,097	-79,097	-395,485
		Previous PDC (avg)		-18,263	-18,263	-18,263	-18,263	-18,263	-91,315
		Maintenance (Net)		-15,000	-15,000	70,000	70,000	70,000	180,000
		Total Recurrent	**32,175**	**54,229**	**153,124**	**231,436**	**224,748**	**218,060**	913,774
	Non Recurrent	Pay - Business Continuity	9,786	24,464					34,250
		Storage	1,411						1,411
		Asset Write off	79,098						79,098
		Total Non Recurrent	**90,295**	**24,464**	**0**	**0**	**0**	**0**	114,759
		Total Revenue	**122,469**	**78,693**	**153,124**	**231,436**	**224,748**	**218,060**	1,028,532
LA5M	Recurrent	New Depreciation			153,559	204,746	204,746	204,746	767,797
		New PDC	32,175	71,046	80,790	75,415	67,353	60,187	386,966
		Previous Depreciation		-35,871	-71,742	-71,742	-71,742	-71,742	-322,841
		Previous PDC			-19,649	-19,649	-19,649	-19,649	-78,598
		Maintenance (Net)		-3,750	-15,000	6,250	70,000	70,000	127,500
		Total Recurrent	**32,175**	**31,425**	**127,957**	**195,019**	**250,707**	**243,541**	880,824
	Non Recurrent	Pay - Business Continuity		28,250					28,250
		Storage		11,200	800				12,000
		Asset Write off		89,679					89,679
		Total Non Recurrent	**0**	**129,129**	**800**	**0**	**0**	**0**	129,929
		Total Revenue	**32,175**	**160,553**	**128,757**	**195,019**	**250,707**	**243,541**	1,010,753
LA6M	Recurrent	New Depreciation		0	47,711	190,846	190,846	190,846	620,249
		New PDC		33,442	73,129	76,035	69,355	62,676	314,636
		Previous Depreciation			-68,177	-90,903	-90,903	-90,903	-340,886
		Previous PDC				-20,110	-20,110	-20,110	-60,329
		Maintenance (Net)			-7,500	-15,000	27,500	70,000	75,000
		Total Recurrent		**33,442**	**45,163**	**140,868**	**176,688**	**212,509**	608,670
	Non Recurrent	Pay - Business Continuity			28,250				28,250
		Storage			5,500				5,500
		Asset Write off			68,178				68,178
		Total Non Recurrent	**0**	**0**	**101,928**	**0**	**0**	**0**	101,928
		Total Revenue	**0**	**33,442**	**147,091**	**140,868**	**176,688**	**212,509**	710,598
LA3C	Recurrent	New Depreciation				116,414	232,827	232,827	582,069
		New PDC			49,412	97,347	91,796	83,647	322,202
		Previous Depreciation	-59,380	-59,380	-59,380	-59,380	-59,380	-59,380	-356,283
		Previous PDC	-13,509	-13,509	-13,509	-13,509	-13,509	-13,509	-81,054
		Maintenance (Net)				-15,000	-15,000	70,000	40,000
		Total Recurrent	**-72,890**	**-72,890**	**-23,477**	**125,871**	**236,733**	**313,584**	506,933
	Non Recurrent	Pay - Business Continuity				28,250			28,250
		Storage							0
		Asset Write off							0
		Total Non Recurrent	**0**	**0**	**0**	**28,250**	**0**	**0**	28,250
		Total Revenue	**-72,890**	**-72,890**	**-23,477**	**154,121**	**236,733**	**313,584**	535,183
Total Revenue costs			**81,755**	**199,799**	**405,496**	**721,445**	**888,878**	**987,695**	3,285,067
Total Recurrent Revenue costs			*-8,540*	*46,206*	*302,768*	*693,195*	*888,878*	*987,695*	*2,910,201*
Total Non Recurrent Revenue costs			*90,295*	*153,593*	*102,728*	*28,250*	*0*	*0*	*374,866*

Procurement Route *The Commercial Case*

1. *The linacs and associated equipment will be procured through the DH approved NHS Supply Chain Framework with the supplier then providing a turn-key solution to the bunker upgrade and linac installation.*
2. *This approach has been implemented successfully on the previous linac replacements.*

Quality Impact Assessment *The Management Case*

Clinical Effectiveness

Have clinicians been involved in the service redesign? If yes, list who.

Dr Sharon Beesley, Clinical Director for Cancer and Haematology and Clinical Oncologist and Dr Mathilda Cominos, Lead Clinician for Radiotherapy and Clinical Oncologist.
Full discussion at the Cancer and Haematology Care Group meetings attended by all Consultants in oncology.
This has also been discussed at the Cancer and Haematology departmental governance meetings and is included in the Annual Business Plan.

Has any appropriate evidence been used in the redesign? (e.g. NICE guidance)

Yes, the national predicted patient demand for radiotherapy activity levels (known as MALTHUS modelling
Actual activity levels achieved in the last 5 years.
National trends in growth in oncology patients from a variety of sources including Macmillan and the Royal Colleges.
MTW has been nationally benchmarked with other radiotherapy centres in the UK.

Are relevant Clinical Outcome Measures already being monitored by the Directorate? If yes, list. If no, specify additional outcome measures where appropriate.

The radiotherapy department monitors a number of key performance indicators including efficacy of treatment, number of fractions of radiotherapy per patient, incidence of side effects (minimal).
The Directorate regularly audits radiotherapy practise and there are a number of regular annual clinical audits on radiotherapy treatments.
Complication rates are audited on a regular basis and discussed at the clinical governance meetings and monitored on the Trust Dashboards.
The directorate participates in Mortality and Morbidity meetings continually learn and improve on clinical outcomes.
Both the Radiotherapy and Physics departments are ISO 9001:2008 certified and CHKS accredited. Clinical Quality is a large part of the accreditation process.

Are there any risks to clinical effectiveness? If yes, list

Yes – 11% loss in capacity during the replacement program, potential failure of one of the remaining treatment units during this time – reducing capacity further.

Have the risks been mitigated?

Yes – there is a business continuity plan in place to manage the 11% loss in capacity during the linac replacement and to manage breakdowns during this period.

Have the risks been added to the departmental risk register and a review date set?

Yes.

Are there any benefits to clinical effectiveness? If yes, list

Yes – the replacement treatment unit will contribute to improved patient outcomes by supporting advanced radiotherapy

techniques, including dose painting of the target lesion and improved treatment accuracy through better image guidance.
Patient Safety
Has the impact of the change been considered in relation to:

Infection Prevention and Control?	Y/~~N~~
Safeguarding vulnerable adults/ children?	Y/~~N~~
Current quality indicators?	Y/~~N~~
Quality Account priorities?	Y/~~N~~
CQUINS?	Y/~~N~~

Are there any risks to patient safety? If yes, list
There are no known risks to patient safety at the time of writing as the radiotherapy service is highly governed and there are a number of inherent patient safety checks that are performed prior to administration of radiotherapy.
Have the risks been mitigated?
Yes, all of the existing risks have been mitigated appropriately.
Have the risks been added to the departmental risk register and a review date set?
Yes.
Are there any benefits to patient safety? If yes, list
Yes. Improved access to image guided, intensity modulated radiotherapy (IGRT/IMRT- dose painting) which may improve outcomes and reduce side-effects.
Patient experience
Has the impact of the redesign on patients/ carers/ members of the public been assessed? If no, identify why not.
Yes, the impact of the redesign has been assessed. There should be no impact on the patients/ carers or members of the public apart from the radiotherapy patients being offered a superior service to the one that is currently available within the existing resources.
Has the impact of the change been considered in relation to: • Promoting self-care for people with long-term conditions? • Tackling health inequalities?
Patients treated and consulted at the new radiotherapy centre will be managed by current MTW staff who will always promote self-care when applicable in addition to their treatment. **Tackling health inequalities?** *The radiotherapy department is open to all patients who access health services and can accommodate all types of patients as per the Trust's Access Policy.*
Does the redesign lead to improvements in the care pathway? If yes, identify
Yes, patients will be seen in a location closer to home and meet unmet patient need for treatment.
Are there any risks to the patient experience? If yes, list

No.
Have the risks been mitigated?
N/A.
Have the risks been added to the departmental risk register and a review date set?
N/A.
Are there any benefits to the patient experience? If yes, list
Yes – see above.
Equality & Diversity
Has the impact of redesign been subject to an Equality Impact Assessment?
Yes.
Are any of the 9 protected characteristics likely to be negatively impacted? (If so, please attach the Equality Impact Assessment)
No.
Has any negative impact been added to the departmental risk register and a review date set?
N/A.
Service
What is the overall impact on service quality? – please tick one box

Improves quality	✓	Maintains quality		Reduces quality	

Clinical lead comments

Management Arrangements

The Management Case

Project management arrangements

1. *The technical leadership and project management will be provided internally by MTW NHS Trust.*

2. *The project governance arrangements are covered by the Trust's Governance arrangements whereby the project group (see below) will report into the Cancer and Haematology Directorate Management Meeting which is chaired by the General Manager for the Directorate and the Maidstone Program Board which is chaired by the COO.*

   The main aims are to:

   - *Ensure the decision making can be integrated with MTW normal management processes as much as possible,*
   - *Clinical leadership and project management support can be targeted effectively and efficiently,*
   - *Best practice is applied in terms of project management and governance,*
   - *As part of the project, business assurance and benefits realisation key performance indicators along with risk and contingency plans have been developed and will be updated as the project develops.*

3. *The project group will ensure that the replacement of the linear accelerator is successfully delivered and the benefits realised and will oversee 4 work-streams that will manage contractor and site liaison, the team commissioning the unit and the associated treatment planning systems, the operational plan to maintain the service during the replacement period and the implementation of the new technology into routine clinical use.*

Group	*Role*	*Chair*	*Reporting to*
Project Group	*Oversee the implementation of the project, including the business planning process.*	*Director of Medical Physics*	*Cancer and Haematology Directorate Management Meeting* *Maidstone Program Board*
Operations work stream	*Implementation of the operational plan for maintaining business continuity during the replacement program*	*Cancer & Haematology Operations Manager*	*Project Group*
Contractor and site liaison team	*To ensure that the design meets the user's requirements and those of the wider Trust.* *To liaise with builders, Varian, MTW, operations and commissioning teams.*	*Estates Project Manager*	*Project Group*
Commissioning team	*To commission the treatment unit and the treatment planning systems*	*Lead Physicist*	*Project Group*
Radiotherapy Technique group	*To ensure that new treatment techniques/technology are introduced safely into clinical use.*	*Head of Radiotherapy Physics*	*Project Group*

Timetable

Milestone	*Indicative date*
Submission to Finance Committee.	*15th May 2017*
NHS England confirm award of PDC for 3 linacs	*15th May 2017*
Submission to the Trust Board.	
Linac ordered (minimum 12 week lead time)	*See table below for individual schedule for each linac.*
Formal instructions issued by the Trust to the Turn-key contractors	
Linac placed in storage until enabling works are completed.	
Close machine, move to business continuity arrangements.	
Enabling building works completed.	
Linac delivered, installation and acceptance commences.	
Treatment unit is accepted by the Trust and commissioning begins.	
Commissioning completed, staff training begins.	
Staff training completed and the treatment unit enters into clinical use. Centre returns to normal operating hours. Completion of the project.	

The timetable below shows the key installation and commissioning dates along with the key assumptions if the Trust is to install the 4 linacs in a timely manner.

Assuming that the enabling works for the first linac (LA4) start in January 2018

Linac	*Formal Instructions given to turn-key contractor*	*Linac purchased*	*Linac removed from clinical use*	*Storage (weeks)*	*Replacement linac installed/ enabling works complete*	*Replacement linac accepted*	*New linac Commissioned*	*Returned to clinical service*	*Comments*
LA4	*Jun 2017*	*Sep 2017*	*29 Jan 2018*	*2*	*02 Apr 2018*	*30 Apr 2018*	*20 Aug 2018*	*27 Aug 2018*	*Installation and acceptance timescales provided by Turn-key contractor and linac supplier. A 9 week build program (bunker shielding is up to specification), 4 week linac acceptance, a 16 week commissioning program (additional modalities require data collection) and 1 week of radiographer applications training.*
LA5	*Dec 2017*	*Sep 2017 (delivery Q4 2017/18)*	*10 Sep 2018*	*34*	*10 Nov 2018*	*10 Dec 2018*	*8 Apr 2019*	*15 Apr 2019*	*2 weeks to transfer patients onto the earlier replacement linac, 9 week build program (bunker shielding is up to specification), 4 week linac acceptance, a 16 week commissioning program, 1 week for public holidays, 1 week for radiographer applications training.*
LA6	*Aug 2018*	*Mar 2019 (delivery Q4 2018/19*	*6 May 2019*	*15*	*6 Jul 2019*	*5 Aug 2019*	*28 Oct 2019*	*4 Nov 2019*	*2 weeks to transfer patients onto the earlier replacement linac, 9 week build program, 4 week linac acceptance, a 12 week commissioning program (confirmatory measurements only and 1 week for radiographer applications training.*
LA3C	*Mar 2019*	*Jul 2019*	*18 Nov 2019*	*0*	*22 Feb 2020*	*23 Mar 2020*	*29 Jun 2020*	*6 Jul 2020*	*2 weeks to transfer patients onto the earlier replacement linac, 13 weeks build program, 1 week for public holidays, 4 week linac acceptance, a 14 week commissioning program and 1 week for radiographer applications training.*

Business assurance and benefits realisation arrangements
1. *The business benefits that will be realised upon the installation of the Truebeam linear accelerator include:* • *improved access for patients to modern radiotherapy techniques,* • *no additional loss in market share,* • *replacement linacs within recommended lifetime.* 2. *The benefits will be realised as soon as the replacement treatment unit is fully commissioned and put into routine clinical use.*
Training arrangements
1. *A Truebeam linear accelerator has been commissioned by the Medical Physics team and introduced into clinical use within the KOC at Canterbury. There is, therefore, scientific, clinical and technical expertise within the centre to successfully commission, operate and maintain the replacement Truebeam unit.* 2. *Additionally, to ensure that expertise is developed within the teams, Varian will provide on-site clinical training in the week leading up to go live and a radiotherapy engineer will attend the appropriate maintenance training courses.*
Risk Management and Contingency plans
1. *The Centre will maintain activity throughout the replacement program following the business continuity arrangements that were implemented successfully during the replacement of LA2 at Canterbury and which have now been implemented at Maidstone for the replacement of LA1.* 2. *The plan was developed by a multi-disciplinary team from the Kent Oncology Centre to ensure that it is robust and the necessary infrastructure will be in place to support the continuity arrangements.* 3. *The workload will be redistributed across the remaining Maidstone linacs by starting the treatment day a little earlier and continuing through until 8pm. To ensure that there are sufficient resources to meet the requirements for RapidArc and to deal with the inevitable fluctuations in patient numbers, some patients in the Ashford corridor may be transferred to Canterbury when there is spare capacity.* 4. *To manage the extended working days, some servicing and quality assurance of the treatment units will move to the weekends for which the costs have been readily identified because these are scheduled tasks that are normally completed regularly throughout the year.* 5. *It is likely that a treatment unit will break down occasionally during the replacement program. If the breakdown exceeds 1 hour (breakdowns totalling 1 hour is the most that can be tacked onto an already extended day) then patients may need to be treated during the weekends to catch up (for many patients a gap in radiotherapy must be avoided). Weekend planned maintenance and quality assurance programs may need to be moved to a subsequent weekend when a breakdown necessitates weekend working.* 6. *The business continuity planning team have estimated a contingency element to cover the staffing costs required to cover unscheduled weekend working using the current breakdown statistics for the units that will be treating during the replacement. These costs are obviously subject to variability because breakdowns can be unpredictable.* 7. *To mitigate the requirements for extended servicing on the linacs, the engineering team will arrange for the OEM servicing on the Maidstone linacs to be completed before the replacement program gets*

underway.

8. *The contingency plan assumes that radiotherapy activity will not increase significantly during the replacement period – this assumption is supported by the activity data from previous years and there being no evidence to suggest that a significant increase is anticipated.*

9. *The business continuity plan does not provide a model for managing activity across the Kent Oncology Centre on fewer linacs in the longer term because the extended working day is not sustainable (patient acceptance, staff good-will, recruitment and retention, over-reliance on equipment and staff support), the Centre will not be able to replace future linacs because capacity will be insufficient, limited access to IMRT, IGRT and SABR/SBRT will affect patient outcomes and choice which could impact on the Trust's market share.*

Arrangements for post project evaluation

1. *Post project evaluation will be monitored through the Cancer and Haematology Directorate Management Meeting and include;*
   a. *RPA reports from a critical examination of the radiation facility,*
   b. *Linac acceptance and commissioning reports,*
   c. *Treatment planning system commissioning reports,*
   d. *External dose audit reports,*
   e. *Monitoring of activity, including patient delays and IMRT uptake.*

Version history

Version	Issue date	Brief Summary of Change	Owner's Name

Pre- submission checklist

Item	Complete
Completed fully signed business case template	Yes/no
Revenue breakdown completed	Yes/no
Capital breakdown completed	Yes/no
Supporting statements from stakeholders attached	Yes/no
Quality impact assessment completed	Yes/no
Commissioner support agreed	Yes/no
Appendices attached	Yes/no
	Yes/no

Maidstone and Tunbridge Wells NHS Trust

Appendix A
Trust capital program

Capital Programme

Capital Spend	2017/18 £000	2018/19 £000	2019/20 £000	2020/21 £000	2021/22 £000
Estates					
Estates Projects - Backlog maintenance	1,300	900	900	850	850
Ward refurbishment/Decant ward	0	0	0	1,000	2,300
Estates Projects - other renewals	500	400	400	400	400
Electrical Substation/generator M	2,500				
Linac estates work	573	1,719	700	700	700
Subtotal - internally generated funds	**4,873**	**3,019**	**2,000**	**2,950**	**4,250**
ICT					
ICT - Infrastructure	1100	900	700	650	650
ICT - Clinical System	204				
ICT - Non-clinical systems	160	103	26	26	26
Core IT System Upgrade PAS (SaCP)	200				
Subtotal - internally generated funds	**1,664**	**1,003**	**726**	**676**	**676**
Equipment					
Linac replacement programme	207	621	1,900	1,900	1,900
Trustwide equipment	1,687	1,775	1,485	1,516	1,369
TWH closed theatre equipment	410				
Subtotal - internally generated funds	**2,304**	**2,396**	**3,385**	**3,416**	**3,269**
Externally financed projects					
TWH - Lifecycle (IFRIC 12 PFI capital)	495	457	575	939	1,186
Linac replacement programme	3,612	1,806			
New MRI Maidstone - build & equip		2,500			
Energy infrastructure/EPC	4,000				
TWH Satellite Radiotherapy Bunkers		4,056	3,244		
Maidstone Hospital Theatres' Renewal		3,000	12,000		
Subtotal - external finance	**8,107**	**11,819**	**15,819**	**939**	**1,186**
Total Capital Spend Plans	**16,948**	**18,237**	**21,930**	**7,981**	**9,381**

Comments:

The Trust is planning a rolling five year capital programme of £74m. This is inclusive of:

- £10m essential improvements in backlog estates
- Electrical substation at Maidstone to support future developments (£2.5m)
- Energy Performance capital of £4m from Salix loan application to support boiler, lighting and controls replacements
- Replacement equipment programme of £20m, including linear accelerators with 3 assumed from central DH PDC in addition to the one agreed for 2016/17
- £4.7m IM&T modernisation programme

The Trust is planning for capital investment loans to support the scale of the required estate renewal. The loans will support delivery of:

- Increase diagnostic capacity (£2.5m)
- Development of a satellite TWH radiotherapy facility (£7.3m)
- Theatre modernisation at Maidstone site (£15m)
- Salix loan application for an Energy Performance contract

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Appendix B

Linac replacement program

1. *The table below outlines the revised current proposed linac replacement program, taking into account potential funding from the Modernisation of Radiotherapy Services program and the Trust capital program (and assumes a LA3C replacement in 2019).*

2. *The table shows that even with access to central funding, the majority of the linacs are scheduled to be replaced between 12- 15 years - which is significantly beyond the 10 years recommended in the NHS specification.*

Linac replacement programme

Site	*Equipment*	*2015/16*	*2016/17*	*2017/18*	*2018/19*	*2019/20*	*2020/21*	*2021/22*	*2022/23*	*2023/24*	*2024/25*	*Age replaced*	*Note*
Canterbury	*LA1*									*R*		*12*	*1*
Canterbury	*LA2*										*R*	*10*	*2*
Canterbury	*LA3*					*R*						*15*	*3*
Maidstone	*LA1*		*R*		*Currently being replaced*							*--*	*4*
Maidstone	*LA2*								*R*			*14*	*5*
Maidstone	*LA3*							*R*				*14*	*6*
Maidstone	*LA4*				*R*							*13*	*7*
Maidstone	*LA5*				*R*							*12*	*8*
Maidstone	*LA6*						*R*					*14*	*9*
TWH	*Build bunker/s*						✓						*10*

Notes relating to linac replacement programme

Note 1: Canterbury LA1 10 years old in 2020
Note 2: Last replaced in 2015.
Note 3: LA3 moved back from 14/15 as a consequence of earlier LA2 delay (completed 11/2015) and now delayed due to discussions over the future of the KCH site.
Note 4: Currently being replaced
Note 5: 10 years old in 2019/20
Note 6: 10 years old in 2017/18
Note 7: 10 years old in 2015/16
Note 8: Delayed, due to knock-on from Canterbury. 10 years old 2016/17
Note 9: Extended replacement from 2016 due to Innovations upgrade.
Note 10: Option for bunker development at TWH which would allow the replacement program at Maidstone to continue whilst maintaining a full complement of treatment units in west Kent.

3. *There are a number of complexities with this replacement program that need to be managed:*

   a. *There is no bunker in which to house a replacement unit (at Maidstone or Canterbury) -which*

means that an existing linac would need to be removed from clinical use, reducing capacity by 11%.

b. *There is currently significant uncertainty within EKHUFT and the local healthcare economy regarding the future of the Kent & Canterbury site that houses the KOC at Canterbury – closure of the KCH site appears to be a real possibility.*

c. *Significant additional investment is required on the KOC at Canterbury site because the KCH is not designed to provide the infrastructure and shielding requirements of modern linear accelerator and the fabric of the building is also deteriorating, with water leaks throughout the department becoming common.*

d. *Each linac replacement is time-consuming, taking around 6-12 months to complete depending on the complexities of the estate (and involves removing the existing linac, upgrading the bunker, installing and commissioning the replacement unit and training the staff).*

e. *There is very little slack in the program which means that a delay in one replacement (due to funding or technical reasons) has a knock-on effect on the whole replacement program, pushing the age of the linacs ever upwards. The projected replacement age of the KOC linacs has already moved upwards by 2-5 years since the original business case was written to replace LA2C in 2013.*

Appendix C

Linac costs

The specification for all linacs is the same.

Truebeam Deal 3 specification.xlsx

NHS SC Quote - Varian Linac - Maidsto

Appendix D

Cost proposal – enabling works

The replacements of the Maidstone linacs (LA3, LA4, 5 and 6) are anticipated to require similar enabling works (and therefore costs) because these bunkers were designed and built to a similar specification.

Maidstone LA4 Proposed dwg for CP.

Maidstone LA4 Draft CP for budget.pdf

The enabling works for the Canterbury linac (LA3C) are much more complex given the age of the building and the additional shielding required bringing the bunker up to standard.

2186-215 LA3 Scheme plan revF.pdf

Canterbury LA3 Contractors Proposals

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Appendix E

Cost pro-formas for each linac replacement

Replacement of LA4 at Maidstone		
Capital requirements (excluding the linac)	Description	Costs (inc VAT)
Enabling works	Upgrade and refurbish linac bunker and control area to take the replacement linac.	£373,600
Commissioning equipment	Ionisation chambers Verification phantoms Verification film Winston Lutz kit OBI dosimetry equipment	£14,000 £20,000 £2,400 £2,700 £20,000
Dosimetry equipment	Dosimetry PC Instrumentation cabling	£1,600 £1,000
Patient equipment	Patient communications system Additional CCTV cameras Head and Neck overlay board	£2,400 £2,500 £7,000
Treatment planning equipment	FAS server Citrix server Advanced planner desktop and Rapid Arc license Upgrade to Advanced planner desktop	 (included in linac costs)
Commissioning workforce	Capitalisation of commissioning physicist, 0.5wte x B7 Overtime to meet the commissioning program	£23,000 £8,000
TOTAL (excluding linac)	Capital costs for enabling and commissioning works, equipment to commission and support the linac and business continuity (i.e. excludes cost of the linac)	£478,200
Linear accelerator	Varian Truebeam, operating at 6MV and 10MV x-rays only – includes Treatment Planning options described above	£1,838,556.73

Revenue requirements		Costs (inc VAT)
Storage and insurance costs	NHS England is proposing to allocate funding for the Trust to acquire the linac in Q4 of the 2017/18 financial year. The Trust will be able to install the linac early April if the enabling works begin in January 2018.	£700
Business continuity arrangements	To maintain the existing radiotherapy activity during the replacement program by extending the treatment day on the remaining linacs and moving servicing and major quality assurance to the weekends. Additional OEM costs Additional Physics-engineering staffing costs Additional Physics staffing costs Additional travel costs	 £9,750 £16,500 £4,000 £4,000
TOTAL		£34,250

Replacement of LA5 at Maidstone		
Capital requirements (excluding the linac)	Description	Costs (inc VAT)
Enabling works	Upgrade and refurbish linac bunker and control area to take the replacement linac.	£373,600
Commissioning equipment	Verification film	£2,400
Dosimetry equipment	Dosimetry PC Instrumentation cabling Replacement monitor unit checking software IMRT QA upgrade	£1,600 £1,000 £50,000 £75,000
Patient equipment	Patient communications system Additional CCTV cameras Head and Neck overlay board	£2,400 £2,500 £7,000
Treatment planning equipment	FAS server Citrix server Advanced planner desktop and Rapid Arc license Upgrade to Advanced planner desktop	 (included in linac costs)
Commissioning workforce	Capitalisation of commissioning physicist, 0.5wte x B7 Overtime to meet the commissioning program	£23,000 £8,000
TOTAL (excluding linac)	Capital costs for enabling and commissioning works, equipment to commission and support the linac and business continuity (i.e. excludes cost of the linac)	£546,500
Linear accelerator	Varian Truebeam, operating at 6MV and 10MV x-rays only – includes Treatment Planning options described above	£1,838,556.73

Revenue requirements		Costs (inc VAT)
Storage and insurance costs	NHS England is proposing to allocate funding for the Trust to acquire the linac in Q4 of the 2017/18 financial year. The Trust will be unable to install the linac at this point because capacity will already be restricted by the on-going replacement of LA4 at this juncture. Based on the proposed timescales storage is estimated as 34 weeks.	£12,000
Business continuity arrangements	To maintain the existing radiotherapy activity during the replacement program by extending the treatment day on the remaining linacs and moving servicing and major quality assurance to the weekends. Additional OEM costs Additional Physics-engineering staffing costs Additional Physics staffing costs Additional travel costs	 £9,750 £12,500 £3,000 £3,000
TOTAL		£40,250

Replacement of LA3 or LA6 at Maidstone		
Capital requirements (excluding the linac)	Description	Costs (inc VAT)
Enabling works	Upgrade and refurbish linac bunker and control area to take the replacement linac.	£373,600
Commissioning equipment	Verification phantoms Verification film	£20,000 £2,400
Dosimetry equipment	Dosimetry PC Instrumentation cabling Detectors Instrumentation	£1,600 £1,000 £10,500 £25,000
Patient equipment	Patient communications system Additional CCTV cameras Head and Neck overlay board	£2,400 £2,500 £7,000
Treatment planning equipment	FAS server Citrix server Advanced planner desktop and Rapid Arc license	 (included in linac costs)
Commissioning workforce	Capitalisation of commissioning physicist, 0.5wte x B7 Overtime to meet the commissioning program	£23,000 £8,000
TOTAL (excluding linac)	Capital costs for enabling and commissioning works, equipment to commission and support the linac and business continuity (i.e. excludes cost of the linac)	£477,000
Linear accelerator	Varian Truebeam, operating at 6MV and 10MV x-rays only – includes Treatment Planning options described above	£1,838,556.73

Revenue requirements		Costs (inc VAT)
Storage costs	Assumed 15 weeks of storage – will be 0 weeks (and hence no storage charges) if the replacement is after LA3C	£5,500
Business continuity arrangements	To maintain the existing radiotherapy activity during the replacement program by extending the treatment day on the remaining linacs and moving servicing and major quality assurance to the weekends. Additional OEM costs Additional Physics-engineering staffing costs Additional Physics staffing costs Additional travel costs	 £9,750 £12,500 £3,000 £3,000
TOTAL		£33,750

Replacement of LA3C at Canterbury		
Capital requirements (excluding the linac)	Description	Costs (inc VAT)
Storage costs	Assumed 15 weeks of storage – will be 0 weeks (and hence no storage charges) if the replacement is after LA6.	£5,500
Enabling works	Upgrade and refurbish linac bunker and control area to take the replacement linac. (includes an estimated uplift for inflation)	£910,000
Commissioning equipment	Verification phantoms Verification film	£20,000 £2,400
Dosimetry equipment	Dosimetry PC Instrumentation cabling Detectors Instrumentation	£1,600 £1,000 £15,000 £35,000
Treatment planning equipment	FAS server Citrix server Advanced planner desktop and Rapid Arc license	 (included in linac costs)
Commissioning workforce	Capitalisation of commissioning physicist, 0.5wte x B7 Overtime to meet the commissioning program	£23,000 £9,000
Business continuity arrangements	To maintain the existing radiotherapy activity during the replacement program by extending the treatment day on the remaining linacs and moving servicing and major quality assurance to the weekends. Additional OEM costs Additional Physics-engineering staffing costs Additional Physics staffing costs Additional travel costs	 £9,750 £12,500 £3,000 £3,000
TOTAL (excluding linac)	Capital costs for enabling and commissioning works, equipment to commission and support the linac and business continuity (i.e. excludes cost of the linac)	£1,007,000
Linear accelerator	Varian Truebeam, operating at 6MV and 10MV x-rays only – includes Treatment Planning options described above	£1,838,556.73

Revenue requirements		Costs (inc VAT)
Storage costs	Assumed 15 weeks of storage – will be 0 weeks (and hence no storage charges) if the replacement is after LA6.	£5,500
Business continuity arrangements	To maintain the existing radiotherapy activity during the replacement program by extending the treatment day on the remaining linacs and moving servicing and major quality assurance to the weekends. Additional OEM costs Additional Physics-engineering staffing costs Additional Physics staffing costs Additional travel costs	 £9,750 £12,500 £3,000 £3,000
TOTAL		£33,750

Trust Board meeting – May 2017

NHS Maidstone and Tunbridge Wells NHS Trust

5-11	Finance Committee, 22/05/17 (quarterly progress update on Procurement Transformation Plan)	Chair of Finance Committee / Director of Finance

The Procurement Transformation Plan (PTP) was approved by the Trust Board on the 19th October 2016 and submitted to NHSI by the deadline of 31st October 2016.

It was a requirement that every Trust should have a Procurement Transformation Plan. The PTP is a document which outlines the procurement function within the Trust and the key actions to deliver the Lord Carter targets set within the document.

NHSI published a review template in January 2017 for quarterly review by Trust Boards with a view that reporting would commence from February 2017. It was also intended that a dashboard would be published in April with data from January, February and March 2017 that will track and benchmark the Trust's progress. The dashboard has not been published as NHSI have issued further clarity on the definition of the metrics to allow Trusts the opportunity to resubmit their data.

This is the second report to the Finance Committee/Trust Board about progress against the PTP.

Which Committees have reviewed the information prior to Board submission?

- Finance Committee, 22/05/17

Reason for submission to the Board (decision, discussion, information, assurance etc.) [1]

Review

[1] All information received by the Board should pass at least one of the tests from 'The Intelligent Board' & 'Safe in the knowledge: How do NHS Trust Boards ensure safe care for their patients': the information prompts relevant & constructive challenge; the information supports informed decision-making; the information is effective in providing early warning of potential problems; the information reflects the experiences of users & services; the information develops Directors' understanding of the Trust & its performance

1. INTRODUCTION

1.1 The Procurement Transformation Plan (PTP) was approved by the Trust Board on the 19th October 2016 and then submitted to NHS Improvement by the 31st October 2016, which was the deadline for Board approved submissions.

1.2 The PTP guidance from NHSI states that "Trusts will be asked to provide regular progress updates on their PTPs to their Trust's board and NHS Improvement. These will take place quarterly"

2. DETAIL AND BACKGROUND

Background

2.1 The Procurement Transformation Plan was approved by the Trust Board on the 19th October 2016 and then submitted to NHSI by the 31st October, which was the deadline for Board approved submissions.

2.2 The Programme Lead – Carter Procurement has been reviewing the submitted plans and will provide feedback to individual trusts. To date the Trust has not received any feedback.

2.3 The Associate Director of Procurement has been attending the meeting of the National Health Service Procurement Alliance. Invitations to this meeting are based on trusts submitting their PTP and confirming agreement to the Nationally Contract Products Programme. The purpose of this meeting is to bring together procurement leaders from across England at regular intervals to discuss and agree joint strategies for improvement in operations and value for money. In doing so the Alliance is expected to support delivery of Lord Carter's recommendations 2016, the national e-procurement strategy and Get it Right First Time (GIRFT). These meetings have been held monthly since January.

Carter Metrics

2.4 The table, overleaf, is an update on the metrics reported to the Committee in October 2016.

METRICS		PERFORMANCE				COMMENTARY
		ACTUAL			TARGET	
		SEPTEMBER 2016	MARCH 2017	SEPTEMBER 2017	SEPTEMBER 2018	
1	Monthly cost of clinical and general supplies per 'WAU' (Weighted Activity Unit)	£339 per WAU	£280.99 per WAU	TBC by NHSI	TBC by NHSI	Outturn to be refreshed with model hospital data.
2	Total % **purchase order lines** through a catalogue (target 80%)	60%	99.07%	72%	80%	This metric relates to the proportion of Integra POs that utilise the approved e-catalogues. When Estates have moved fully from Shires to Integra this will dilute the metric, as they use a higher proportion of non-catalogue ordering. The purchasing team are able to monitor and intervene on any non-catalogue items. This is to ensure no items are requested as non-catalogue where the item is on the catalogue.
3a	Total % of **expenditure** through an electronic purchase order (target 80%) up to and including PO issue	43%	60%	60%	80%	The Trust has a No PO no Pay policy and this is strictly applied across the Trust. This has significantly improved the Trust's position in relation to the coverage of transactions. This improvement will be reflected in the coverage of spend levels when the 22 transactions related to the PFI and Negligence contracts are covered by a PO in 17/18. NB this data is Integra only, not including the Estates' Shires system.
3b	Total % of **transactions** through an electronic purchase order (target 80%) up to and including PO issue	74%	87%	80%	80%	

[1] The information related to WAU is based on the spend in 2015/16 and is a figure derived from the "Model Hospital" work by the Carter team.

METRICS		PERFORMANCE				COMMENTARY
		ACTUAL		TARGET		
		SEP 2016	MARCH 2017	SEPTEMBER 2017	SEPTEMBER 2018	
3c	Total % of expenditure through an electronic purchase order (target 80%) from requisition through to and including payment	5%	62.38%	50%	80%	The current payment system is not completely electronic with a number of invoices coming into the Trust as hard copy though in turn these may be processed using OCR technology. This indicator includes data from EME from shires as well as the data from Integra. The level of POs hasve increased as all Omnicell orders are covered by a PO now as well.
3d	Total % of transactions through an electronic purchase order (target 80%) from requisition through to and including payment	63%	92.9%	70%	80%	
4	% of spend on a contract (target 90%)	61%	43.91%	81%	90%	The Trust is reviewing this area and where there is no contract in place, this will form part of the 2017/18 work plan. Work is also being undertaken to negotiate with suppliers to tie them into a fixed term contract. There are instances were a product is ordered and there is no contract in place. Contracts are now being put in place for these areas.
5a	Inventory Stock Turns-static	Days	Days	Days	Days	The Trust is implementing an inventory management system which has supported getting this data.

METRICS		PERFORMANCE				COMMENTARY
		ACTUAL		TARGET		
		SEP 2016	MARCH 2017	SEPTEMBER 2017	SEPTEMBER 2018	
5b	Inventory Stock Turns-dynamic – stock managed through a system e.g.	Days	Days	Days	Days	No target has been set by NHSI for this indictor.
6	NHS Standards Self-Assessment Score (average total score out of max 3)	1.16	1.16	2	2	Peer review due in June 2017. It is likely this will be delayed as there are insufficient people trained as reviewers.
7	NHSI's Purchase Price Index Benchmarking (PPIB) Tool	N/A[2]	Variance to median[3] £534,652	TBC	TBC	The targets will be completed following the development of the CIP1718 planning with Regional HoPs across the STP footprint.

[2] PPIB tool was not published at this time. Please note that the PPIB tool currently relates to data from acute trusts only.
[3] Based on £20.7million of spend with 949 suppliers for 12000 products

RAG Rating Definitions:
Green = At, or better, than the target
Amber = Up to 10% less than target
Red = More than 10% below target

Action plan

2.5 A review of the action plan is in appendix one of the document. The action plan is confirmed below.

Procurement objective	Action
Procurement strategy	Staff qualifications. An internal target has been set for 50% of procurement team qualified. 100% of staff are qualified within category management.
Procurement workplan	Completion of 2017/18 and 2018/19 procurement workplan. These workplans will cover tail spend and improve the trust position on contract spend.
Procurement Savings	Achievement of agreed £5.3 million 2017/18 CIP.
Communication strategy	There has been wider engagement with divisions and procurement. Procurement is present at all division CIP meetings now. Communication to internal and external stakeholders. Focus on Trust policy to ensure adherence to spend restrictions as well as

Procurement objective	Action
	improved compliance. This is a key objective within the procurement strategy.
Policies, processes and systems	Policies are reviewed and updated annually or at times of significant change.
Spend controls	Percentage of invoiced expenditure captured electronically through Purchase orders (P2P systems). Re-launch of the Trust 'No Purchase Order, No Pay' policy.
People and Organisation	Achievement of the procurement standard level 1 and training programme to support level 2.
Collaboration	50% of expenditure on goods and services is channelled through collaborative arrangements by 2017/18, rising to 60% by 2019.
	Alignment of procurement work plans across the region
	Review of external options for transactional procurement
	Integra financial system – working groups for agreement and alignment for the use of the system
	Market management engagement – 2 supplier events per year.
	Shared learning and collaboration of the FOM across the region
	2 supplier surveys per year to be sent to support the review of the team's engagement with the market

3. Risks and issues

3.1 The previous report noted the risk of a shortage of procurement skills within the region. There are 2 vacancies within the category management team and this is a key risk to the delivery of the CIP saving for 17/18.

The Associate Director is working with an agency to support permanent recruitment to these roles as the numerous adverts for these roles have been unsuccessful. The Associate Director of Procurement has established regular meetings with the Heads of Procurement from the acute trusts in the STP footprint. This meeting has now widened to include the Heads of Procurement from non-acute trusts.

These meetings have led to seven areas of collaboration being agreed so that the skills and expertise across the region are focused for the benefit of all. This approach has proved to be helpful to the Trust given the recent resignation of a Category Manager and the unsuccessful recruitment campaigns to replace this officer, because the work that has been commenced by the current post holder has been agreed to continue in his role at another Trust within the STP footprint.

Maidstone and Tunbridge wells NHS Trust has also agreed to work closer with Medway Foundation Trust on some of the non-clinical areas to support each Trust with resource in this category.

An apprentice role has also been appointed to the team. This role is focused on supporting the systems team and documenting the team processes. The role will also negotiate with local suppliers to support the transactional team.

4. RECOMMENDATION

4.1 It is recommended that the Finance Committee note and review the information in the report.

Appendix 1: Update about the action plan

Procurement objective	Action	Update
Procurement strategy	Staff qualifications. An internal target has been set for 50% of procurement team qualified. Training matrix has been pulled together to identify the training requirements of all staff and link this to their role. This will support the Trust in achieving the level 2 procurement standard.	The procurement team has 40% of its staff with CIPS qualifications. The category management team is 100% CIPS qualified.
Procurement workplan	Completion of 2017/18 and 2018/19 procurement workplan. These workplans will cover tail spend and improve the trust position on contract spend.	The Purchasing team has a workplan that commenced in January 2017 to renegotiate with 100 suppliers by June 2017. The annual spend between these suppliers ranges from over £22,000 to £200,000 and a total spend of £3.77 million.
Procurement Savings	Achievement of agreed 2017/18 CIP	The detailed plans for the CIP which is £5.3 million of non-pay are being developed with directorates. The biggest area of support is planned care where their procurement saving alone is over £4,000,000. Seven areas of collaboration with STP partners have been identified and currently in progress.
Communication strategy	Communication to internal and external stakeholders. Focus on Trust policy to ensure adherence to spend restrictions as well as improved compliance. This is a key objective within the procurement strategy.	Planned actions for 2016/17 have been completed. Further communications plans for 2017/18 are set out in the sections below.
Policies, processes and systems	Policies are reviewed and updated annually or at times of significant change.	Policies and processes are being reviewed and these will be captured in a procurement manual. . The manual will be finalised by an intern over the summer following workshops with all three teams within the Department. Interviews for the intern take place on 18 May.
Spend controls	Percentage of invoiced expenditure captured electronically through Purchase orders (P2P systems). Re-launch of the Trust No Purchase Order, No Pay policy.	Integra is now live and supporting the re-launch of the Trust's No PO, No Pay policy. Metrics 3a and 3b demonstrate the progress in this regard.
People and Organisation	Achievement of the procurement standard level 1 and training programme to support level 2.	The Trust has invested in the procurement team to support achieving level 2. A peer review has been requested for June 2017.
Collaboration	50% of expenditure on goods and services is channelled through collaborative arrangements by 2016, rising to 60% by 2019.	52% of the Trust's spend is through collaborative arrangements.

Procurement objective	**Action**	**Update**
	Alignment of procurement work plans across the region	This is being progressed for 2017/18. The STP HoPs have all shared workplans and identified areas of duplication and assigned a lead for the STP to progress the work.
	Review of external options for transactional procurement	This is part of the STP corporate services workstream.
	Integra financial system – working groups for agreement and alignment for the use of the system	This is part of the STP corporate services workstream.
	Market management engagement – 2 supplier events per year.	A supplier event is planned for the first 6 months of the financial year. Once was planned for April but smaller events are being held with suppliers for the seven areas of STP collaboration. These events will be more focused on the specific category of spend.
	Shared learning and collaboration of the FOM across the region	Part of the National Health Service Procurement Alliance, they will be looking at how we can work together to deliver greater savings in advance of the FOM, with the expectation that the learning is taken back to respective STPs. Both MTW and East Kent Foundation Trust have attended the Alliance. The meetings are held monthly in London.
	2 supplier surveys per year to be sent to support the review of the team's engagement with the market	A survey of the attendees to the supplier event in September led to 13 responses. Given that this is not a statistically significant sample of the attendees, only the key messages from the responses are reported below: 1 The suppliers welcomed the opportunity to meet with the procurement teams and asked for more of the 121 meetings that were offered as part of the event 2 The suppliers would like themed events in the future to ensure that the event is focused on their business category.

Trust Board meeting - May 2017

NHS Maidstone and Tunbridge Wells NHS Trust

5-16	Annual Report 2016/17 (including Governance Statement)	Chair of the Audit and Governance Committee

NHS Trusts are required by statute[1] to produce an Annual Report for each accounting year, in such form as may be determined by the Secretary of State for Health. The minimum content for such Annual Reports is prescribed by the Department of Health (DH), through its 'Group Accounting Manual' (GAM). The GAM also states that "Beyond this [minimum context] however, the entity must take ownership of the document and ensure that additional information is included where necessary to reflect the position of the body within the community and give sufficient information to meet the requirements of public accountability". The Governance Statement is covered by the GAM, but is also subject to separate guidance, issued by NHS Improvement (NHSI) in February 2017.

The Annual Report (including Governance Statement) for 2016/17 was duly written to ensure compliance with the aforementioned guidance, and using the same template/format used for the 2015/16 Annual Report. The draft Annual Report is required to be reviewed by the Trust's External Auditors, as part of their Audit of the Financial Accounts. Certain information contained in the "Remuneration and Staff Report" section is subject to audit and will be referred to in the Audit Opinion. Other aspects of the Annual Report are reviewed by the Auditors to ensure consistency with the Financial Accounts. The draft Annual Report was duly provided to the Trust's External Auditors on 28th April 2017, in accordance with the required deadline.

The Governance Statement was reviewed (and endorsed) by the Trust Management Executive on 19th April. The draft Annual Report (including Governance Statement) was then reviewed by the Audit and Governance Committee on 4th May 2017. The minor amendments agreed at that meeting have been made. Since the meeting, the External Auditors have recommended a number of minor amendments and/or corrections, and these have also been made.

The enclosed Annual Report therefore represents the final version, and has been submitted for final review by the Audit and Governance Committee, which meets on 24th May, before the Trust Board. The Audit and Governance Committee will be asked to review the Report in detail, and recommend that the Trust Board approves the document. The outcome of the Audit and Governance Committee's review will be provided verbally at the Trust Board on 24th May.

The final document will include the "Independent auditor's report to the Directors of the Trust", and the Annual Report and Accounts will be combined (the full Accounts will be inserted at the end of the Annual Report). It should also be noted that there may be further minor layout/design changes between now and the date that printed versions will be produced (for the Trust's Annual General Meeting, 7th September 2016). However, such changes will be cosmetic, and the text will not be materially changed from that approved by the Board.

Once approved, a signed version of the Governance Statement is required to be emailed to NHSI, as a separate document, by 5pm on 1st June 2017. The Statement will be assessed by NHSI, and any significant issues identified that warrant attention at national level will be brought to the attention of the DH for their preparation of the overarching DH group Governance Statement.

Which Committees have reviewed the information prior to Board submission?

- Trust Management Executive (TME), 19/04/17 (Governance Statement)
- Audit and Governance Committee, 04/05/17 (earlier draft)
- Audit and Governance Committee, 24/05/17 (the enclosed draft)

Reason for receipt at the Board (decision, discussion, information, assurance etc.) [2]

To review and approve the Annual Report (including Governance Statement) for 2016/17

[1] The National Health Service and Community Care Act 1990

[2] All information received by the Board should pass at least one of the tests from 'The Intelligent Board' & 'Safe in the knowledge: How do NHS Trust Boards ensure safe care for their patients': the information prompts relevant & constructive challenge; the information supports informed decision-making; the information is effective in providing early warning of potential problems; the information reflects the experiences of users & services; the information develops Directors' understanding of the Trust & its performance

NHS

Maidstone and Tunbridge Wells

NHS Trust

Annual Report and Accounts 2016/17

taking pride

Patient First – Respect – Innovation – Delivery - Excellence

About this Annual Report

The National Health Service and Community Care Act 1990 requires NHS Trusts to produce an Annual Report. The content and format is required to follow the guidance issued by the Department of Health (in the form of a 'Manual for Accounts'). The specific requirements for Annual Reports for 2016/17 are that NHS bodies must publish, a single Annual Report and Accounts (ARA) document, comprising the following:

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

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

- "Performance Report for 2016/17", which is split into the following sections:
  - An overview. This includes an overview summary; the purpose and activities of the Trust; the Chair and Chief Executive's report; the 'story of the year' (month by month); the key issues and risks affecting delivery of the Trust's objectives; an explanation of the adoption of the going concern basis; and a Performance summary
  - A Performance analysis, which includes details of how the Trust measures performance; the Trust's development and performance in 2016/17; and a review of financial performance for 2016/17
  - A summary of the Trust's Quality Accounts for 2016/17
  - A Sustainability Report. This follows the standard reporting format from the NHS Sustainable Development Unit
- "Accountability Report for 2016/17", which is split into the following sections:
  - "Corporate Governance Report for 2016/17", which in turn is split into:
    - A Directors' report (which provides details of the Trust Board; a Statement as to disclosure to Auditors; attendance at Trust Board meetings; details of Directors' interests; the Trust's Management Structure; complaints performance and the Trust's application of the 'Principles for Remedy' guidance; disclosure of "incidents involving data loss or confidentiality breaches"; & details of Emergency Preparedness arrangements)
    - The "Statement of the Chief Executive's responsibilities as the Accountable Officer of the Trust"
    - The "Governance Statement for 2016/17"
  - "Remuneration and Staff Report for 2016/17" (including details of 'off-payroll' engagements)
- "Financial Statements for 2016/17", which includes Pension Liabilities, exit packages and severance payments; and staff sickness absence data
- Independent Auditor's report to the Directors of Maidstone and Tunbridge Wells NHS Trust

The Annual Report and Accounts were approved by the Trust Board of Maidstone and Tunbridge Wells NHS Trust on 24th May 2017.

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

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Performance Report for 2016/17: Overview

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Summary

The purpose of this overview is to give the reader sufficient, summarised information to understand the Trust, its purpose, the key risks to the achievement of its objectives, and an outline of its performance during the year 2016/17. For those wishing to read more about the Trust's achievements, the issues it faced and its detailed financial situation, further detail is provided in the rest of the Annual Report and Accounts.

The purpose and activities of Maidstone and Tunbridge Wells NHS Trust

Maidstone and Tunbridge Wells NHS Trust (the Trust) is a large acute hospital Trust in the south east of England. The Trust was legally established on 14th February 2000[2], and provides a full range of general hospital services and some areas of specialist complex care to around 560,000 people living in the south of West Kent and the north of East Sussex.

The Trust's core catchment areas are Maidstone and Tunbridge Wells and their surrounding boroughs, and it operates from three main clinical sites: Maidstone Hospital, Tunbridge Wells Hospital at Pembury and Crowborough Birth Centre. 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. The Trust employs a team of over 5000 full and part-time staff.

In addition, the Trust provides specialist Cancer services to circa 1.8 million people across Kent and Sussex, via the Kent Oncology Centre, which is sited at Maidstone Hospital and at Kent and Canterbury Hospital in Canterbury. The Trust also provides Outpatient and outreach clinics across a wide range of locations in Kent, Medway and East Sussex.

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 Hospital and Tunbridge Wells Hospital)
- Diagnostic and screening procedures (at Maidstone Hospital and Tunbridge Wells Hospital)
- Family planning services (at Maidstone Hospital and Tunbridge Wells Hospital)
- Maternity and midwifery services (at Maidstone Hospital, Tunbridge Wells Hospital and Crowborough Birth Centre)
- Surgical procedures (at Maidstone Hospital and Tunbridge Wells Hospital)
- Termination of pregnancies (at Tunbridge Wells Hospital only)
- Treatment of disease, disorder or injury (at Maidstone Hospital and Tunbridge Wells Hospital)

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

[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)

Chair's report

I feel proud and privileged to be appointed as the new Chair of the Trust Board, and I look forward to working with colleagues across all our hospitals and sites.

I would like to thank my predecessor, Anthony Jones, for all he did for the Trust, and to Kevin Tallett, for acting as Chair between Anthony's departure and my arrival. Also, I would like to thank Steve Tinton and Sylvia Denton CBE, who both served as Non-Executive Directors during the year 2016/17, for their contributions to the Trust. We will be seeking to recruit two replacement Non-Executive Directors over the summer of 2017.

The year 2016/17 was a difficult year for the Trust, as our Chief Executive, Glenn Douglas, will describe in his report. This level of challenge to the performance of the Trust will continue into 2017/18 with considerable financial and capacity pressures. The Board will continue to put patient safety at the top of the agenda in the face of these pressures and will strongly support the Executive Team as we work together to meet the challenge.

The Board will continue to engage with other health and social care entities as part of the Kent and Medway Health and Social Care Sustainability and Transformation Plan. I am sure we can achieve more in Kent and Medway by working together collaboratively and look forward to building strong and productive relationships with all stakeholders and partners of the Trust.

Signature
David Highton,

Chair of the Trust Board

24th May 2017

Chief Executive's report

Our Annual Report for 2016/17 reflects another difficult year for the Trust. Financial pressures, combined with unprecedented demand, created a uniquely testing environment. Increases of approximately 18,000 Accident and Emergency (A&E) attendances and around 4,000 hospital admissions than the previous year adversely affected our elective activity and placed tremendous strain on our staff and resources.

There is still much to do to get our A&E, 18-week Referral To Treatment (RTT) and Cancer 62-day waiting time performance back on track, but we have strong plans in place and a clear focus, and progress is being made. Despite the pressures, we performed well on some key performance standards (more can be read about this in the Performance Summary) and the Trust was named as one of the best performing in the UK in the 2016CHKS (Comparative Health Knowledge System) "Top Hospitals Awards". The award, which is based on the evaluation of 22 key indicators of safety, clinical effectiveness, efficiency, patient experience, quality of care and health outcomes, celebrates the success of healthcare and social care providers across the UK and internationally, and demonstrates the dedication of our staff.

The Trust was placed into Financial Special Measures in July 2016, and our aim to address this positively focussed the management of the Trust for the rest of 2016/17. At the start of 2016/17, we had planned for a year-end deficit of circa £23 million, but continued problems with increased emergency activity in the early months of the year put this plan in jeopardy. A range of improvement plans were already in place by July, but entering the Special Measures regime made it clear that we needed to accelerate these, and identify additional ways to reduce our expected financial deficit in safe and sustainable ways. Thanks to the hard work, ingenuity and determination of all staff, the Trust's year-end deficit was £10.9 million (once Sustainability and Transformation Fund monies were taken into account).

There can however be no easing of effort in 2017/18, as the Trust's Cost Improvement Programme (CIP) target for the year is £31.8m – one of the largest, if not the largest, savings targets in the Trust's 17 year history. Although achieving this will be extremely difficult, at the close of 2016/17, we had identified efficiency schemes covering the majority of the target value, and there is real optimism that we can make significant progress towards the aim of a financially sustainable Trust. This is now within our grasp.

There have been several changes in Trust Board Members over the past year, most notably the departure of the Chairman, Anthony Jones, who joined the Board in 2008 and oversaw huge improvements in quality and

safety during his eight years as Chairman. The Trust had one of the worst infection rates in the country when he started, but now has one of the best. The Trust Board, and myself in particular, are grateful for all that Anthony did for the Trust, and wish him the very best for the future. David Highton, the new Chair of the Board, starts in post in May 2017, and my Trust Board colleagues and I look forward to working with David during 2017/18 and beyond.

In the last week of 2016/17 an important milestone was reached in the journey to improve the way health and social care is delivered in the region, with the publication of the Kent and Medway Health and Social Care Sustainability and Transformation Plan's (STP) "case for change" document. The case underpins the thinking and ambition set out in the draft STP that was published in late 2016, and critically sets out where we need to make changes to the way we work. As has been widely reported in the national, and local, media, NHS and Social Care services are under increasing pressure, and the adverse impact of this on the Trust that I discussed earlier will, I'm sure, be reflected within the Annual Reports of other local health and social care organisations. Regrettably, despite the best efforts of all involved, the expected standards are not being delivered in some areas. We all believe that health and social care services in Kent and Medway could and should be better, and the Trust therefore looks forward to playing its part in making that happen, to ensure our services are fit for the future.

Glenn Douglas,

Chief Executive

24th May 2017

The story of the year

The story of 2016/17 is largely one of achievement over adversity. Despite an unrelenting backdrop of unprecedented demand and financial pressure, the pace and scope of activity and initiative within the Trust was undaunted. A sample of that achievement throughout the year is given below.

April 2016

On 1st April, the Trust took over the management of Crowborough Birth Centre and welcomed both a team of 20-plus Midwives and Maternity Support Workers who joined the Trust as part of the transfer, as well as its first birth at 10.02am that day. With this expansion of its Maternity services, the Trust became one of very few Trusts nationally able to provide women with the widest possible range of birth choices.

Work to improve the flow of patients through the Trust's hospitals continued throughout the month. The Trust welcomed confirmation that 10 of the beds vacated at Tonbridge Cottage Hospital by the transfer of patients to Ward 22 at Tunbridge Wells Hospital, would be funded by West Kent Clinical Commissioning Group (CCG) and used to provide stepdown care for patients who did not need to be in an acute hospital environment. This was a theme that was to continue as the year progressed.

Other initiatives to improve patient flow included the launch of a new 'Breakfast Club' in the Trust's discharge lounges, aimed to ensure that patients were able to leave hospital early having had a proper meal. 'Perfect Discharge Week', launched mid-month, involved staff from multiple teams working together to get patients properly treated and home as soon as possible (aiming for 10 by 10 – 10 patients discharged by 10am each day). Wards were encouraged to address the issues blocking patients ready for discharge, supported by a clinical champion in each area.

Later in the month, the first of a series of Health and Wellbeing events took place for patients that had completed or were nearing completion of active cancer treatment. The event was part of a collaborative programme between Kent Oncology Centre and Macmillan Cancer Support and aimed at supporting individuals in the transition from treatment to 'normal' life.

In other collaborative initiatives, staff from Derby Hospital visited Maidstone Hospital to see its Dementia Activities / Keyworker role in operation. The visit was arranged after hearing Liz Champion, the Trust's Dementia Lead, describing this important role at a dementia event, and the visitors left inspired to get a similar role 'up and running' at Derby Hospital.

The impact of the Junior Doctors' industrial action in April was met with positive engagement across the Trust and the high levels of advance planning served the Trust well for all future eventualities potentially affecting continuity of patient care. In a similar vein, the Trust took part in a no-notice emergency exercise. Staff responded with crews from Kent Police, Kent Fire & Rescue Service and South East Coast Ambulance Service (SECAmb) to a radiation contamination incident. Volunteer casualties were decontaminated and treated, while managers were put through their paces with commanders from the emergency services.

May 2016

May saw the opening of a dedicated children's A&E unit at Tunbridge Wells Hospital, the first of its kind in Kent. The unit's first patient, a six month old baby, arrived just minutes after it opened. Additional paediatric trained Nurses, Nursery Nurses and five Consultant Paediatricians were appointed to work within the A&E department. The launch of the unit was the culmination of much hard work by directorate staff.

An important plan setting out how the Trust would deliver quality and safety for the next three to five years achieved approval in May. The Safety Improvement Plan (SIP) aimed to reduce harm by improving safety and set out 4 focus areas for improvement:

- Improving communication during escalation and handover
- Improving the quality of patient involvement in decision making and informed consent
- Improving the effectiveness of identifying and acting upon deviations from normal during labour & birth
- Reducing the number of inpatient falls.

The SIP was intended to be discussed and used at all levels of the organisation from Ward to Board and could equally be shared with those needing to scrutinise the Trust's safety activity including regulators such as the CQC and NHS Improvement (NHSI).

During the month, the Trust marked Dying Matters Awareness Week. The focus of the year's event was `The Big Conversation' with an emphasis on 'Talking about dying won't make it happen!'. The Trust's End of Life Care Clinical Nurse Specialist, members of the Chaplaincy team and Trust Ethicist manned a stall in the main entrance at Maidstone Hospital to provide an opportunity for staff, patients and visitors to consider and discuss these important issues.

Elsewhere, the generosity of external parties allowed the provision of 15 brand new wheelchairs, donated by the Maidstone Hospital League of Friends, and a state-of-the-art bladder scanner for Kent Oncology Centre, gifted by the Prostate Cancer Support Association (PCSA) Kent.

Finally, the Trust was selected to take part in a national Financial Improvement Programme, contracted and run by NHSI, and designed to speed up financial recovery. NHSI identified 16 Trusts around the country believed to have the potential to deliver good return on investment from some external consultancy support. The Trust appointed an experienced team, including an Improvement Director, from KPMG LLP as its partners in this process. The external team was on site initially for several weeks fact-finding, sharing best practice from other Trusts and working alongside staff making recommendations to support the push for financial sustainability.

June 2016

The introduction of a new interpreter and translation service in June was aimed at providing a more responsive and safer service for all of the Trust's patients. The service enabled staff to contact foreign language interpreters by telephone, reducing the amount of notice required for most services. British Sign Language (BSL) interpretation was also introduced as a readily available service.

Later in the month, the UK's vote to leave the European Union (EU) saw the Trust reassuring its staff of its commitment to support and fully engage with its EU colleagues regarding future changes to the UK's membership of the EU, and to continue with recruitment drives within the UK, EU and elsewhere overseas to help continue to provide the highest possible quality services.

In other developments, the results of the National Adult Inpatient Survey for 2015 showed that patients continued to rate the Trust's hospitals highly at a time of exceptional demand for NHS services. Based on their overall patient reviews, hospitals were given marks out of 10 for each standard. The Trust achieved the following scores for 8 of the key standards:

- The hospital and ward – 8.4 out of 10 (8.2 in 2014)
- Doctors – 8.7 out of 10 (8.4 in 2014)
- Nurses - 8.6 out of 10 (8.5 in 2014)
- Care and treatment – 8 out of 10 (7.7 in 2014)
- Operations and procedures – 8.2 out of 10 (8.2 in 2014)
- Leaving hospital – 7.3 out of 10 (7.3 in 2014)
- Overall view of care and service – 5.6 out of 10 (5.6 in 2014)
- Overall experience – 8.2 out of 10 (8.1 in 2014)

An overall good response was achieved from patients rating over 70 areas of their care across the key standards. Patients rated their care and staff highly and found the Trust hospitals to be clean and safe. The majority of patients said they felt well looked after while in hospital locally, and had trust and confidence in the doctors and nurses, who treated them with respect and dignity. The full survey results are available at: www.cqc.org.uk/provider/RWF/surveys.

On a further positive note, the Trust, alongside partners NHS West Kent CCG and NHS High Weald Lewes and Havens CCG, was chosen as Maternity Choice and Personalisation Pioneers by NHS England. This made it one of 7 areas across the country to be successful in spearheading new ways of opening up choice in maternity care. In practice it meant the introduction over the following 18 months of notional budgets for pregnant women living in West Kent and the Crowborough area to be able to choose who provided their care while they were expecting and when they gave birth.

July 2016

July saw the launch of a range of developments and new services across the Trust, starting on the first of the month with the introduction of a new patient transport service, provided across Kent and Medway by G4S (and commissioned by West Kent CCG). With this came tough new measures on the provider to raise standards, and greater emphasis on customer care and getting patients home from hospital promptly. Performance measures against a Patient Charter were introduced, developed by users of patient transport services in Kent and Medway. There were also tighter timescale targets for collecting and dropping off patients before and after their appointments, or when going home after an inpatient stay.

The same week, a new Virtual Fracture Clinic (VFC) Service was launched across the Trust, aimed at improving patient experience and ensuring a more streamlined service. The service introduced a new process for dealing with the first initial assessment of all patients referred to fracture clinic, helping to reduce the number of patients requiring a face to face appointment and allowing individuals to be seen by the correct Consultant at the right time.

Ambulatory Emergency Care was relaunched in July on the Acute Medical Unit at Tunbridge Wells Hospital. This new facility, intended to address the significant rise in demand for emergency care in West Kent, offered same day emergency care to patients, including assessment, diagnosis, treatment and discharge, avoiding an overnight admission - good for patients, and for the Trust too.

Other developments during the month saw the installation of automated ultraviolet (UV) environmental decontamination systems at Maidstone and Tunbridge Wells hospitals to enhance quick and effective deep cleaning and decontamination of clinical areas using UV radiation. A pilot exercise demonstrated significant improvement in environmental cleanliness and decontamination when compared with existing methods.

Hedgehog Ward at Tunbridge Wells Hospital received a generous donation from local charity, Megan's Wish List, set up by the family and friends of 17-year-old Megan Fox, who passed away in March 2014, after she was diagnosed with a brain tumour in October 2013. The donation allows the children's unit to continue to sponsor 'Beads of Courage' – an initiative to help children receiving treatment for childhood cancer. Each time a young person has a procedure, test, or treatment for their illness, they are given a bead. The colour of the bead signifies what has happened – for example, white beads relate to having chemotherapy, light green beads to scans such as x-rays and MRIs, and yellow beads to an overnight stay in hospital. The beads help children to make sense of the experience they are going through and research has shown that the programme has helped to decrease illness-related stress and increases the use of positive coping strategies.

Late in the month, the Trust was placed in to Financial Special Measures (FSM) by NHSI to address its underlying financial deficit. More on this is reported under the 'story of the month' for August 2016.

August 2016

On confirmation of Financial Special Measures, an NHSI-selected and funded Finance Improvement Director was appointed to support the development of the Trust's Financial Recovery Plan. This process started in August with briefings of around 400 key individuals, to identify the next steps in shaping the Plan. As part of this process all staff were requested to ask themselves the following questions:

- Do you know what Financial Special Measures is and how this affects our Trust or you in your role?
- Do you know the financial position of your ward, department, or service and Financial Recovery Plan?
- Do you know how to add your ideas to our Financial Recovery Plan?

Authorised signatory limits and the Trust's Standing Financial Instructions were also reviewed. The need to balance the 3 areas of quality, finance and performance was identified as critical in delivering benefits for the Trust and its patients in the longer term. Hundreds of ideas were generated by staff and colleagues, highlighting ways in which the Trust might make better use of its finite resources. More information on the Financial Special Measures framework and timetable for the Trust is available at: https://tinyurl.com/MTWFSM

In spite of these financial challenges, it was reported in August by The Royal College of Anaesthetists that more patients with life-threatening conditions were surviving emergency bowel surgery at the Trust's hospitals and no other hospital in the South East, outside of London, was providing better outcomes for patients with life-threatening conditions such as bowel obstruction, perforation or a bleed. Mortality rates ranged from 3% to over 20% in the 186 hospitals taking part in a national audit of emergency laparotomy surgery, and the Trust saw its mortality rate fall from 9.9% to 7.2% as part of a quality improvement project to save 1,000 more lives over 2 years across the South of England.

On another positive note, staff in cervical screening accomplished a successful Quality Assurance meeting with NHS England. This was part of a review undertaken every 3 years to ensure appropriate standards in cervical screening, and involved a detailed review of diagnostic standards, waiting times, treatment standards, patient communications, failsafe policies and many other areas.

September 2016

The beginning of the month saw the launch of the Trust's new Safety Calendar with a key patient theme identified each month. September's theme was improving patient communication and the adoption of the 'Hello my name is' campaign was a central to this. The campaign was founded by Dr Kate Granger MBE, a renowned Geriatrician, who sadly passed away in 2016. It was during her own battle with cancer that she was saddened to find how poor her colleagues were at introducing themselves to patients, and as a result she launched this, now national, initiative. Just taking the extra time to smile and say 'Hello my name is' is proven to put patients at ease and make them feel welcome and valued. Trust staff were encouraged to extend the same principle to their own colleagues.

Both Tunbridge Wells and Maidstone hospitals received very encouraging feedback in September following patient-led assessments to review cleanliness of Wards, general building maintenance; quality of patient food and how the environment supports a patient's privacy and dignity. Annual Patient-Led Assessments of

the Care Environment (PLACE) inspections take place at every hospital in the country and during the month it was confirmed that both of the Trust's hospitals had achieved results which exceeded the national average scores in all categories.

Good food in hospitals can help patients to eat well, giving them the nutrients they need to recover from surgery or illness. September saw the launch of a revised policy for adult patient mealtimes, which included the promotion of protected mealtimes, periods of time when routine activity on the Ward is reduced so that Nurses, Ward based teams and catering staff can serve and supervise meals and give assistance to those patients who need help to eat and drink.

The month also saw the Infection Prevention and Control Team hold its annual infection prevention conference. The event, held at Maidstone Hospital, was well attended by internal and external stakeholders who listened to a range of presentation subjects including the Trust's own infection control journey since 2006, the Zika virus and influenza.

In other developments, members of the Paediatric Diabetic Team at Maidstone Hospital, along with some of their patients, received a cheque for £500, from the Kent Police Property Fund. The money was for the Maidstone Area Parents Support group (MAPS), set up for parents who have children with diabetes. MAPS hosts events throughout the year which allow children with Type 1 Diabetes, and their parents, to meet others in the same position to share advice, experiences and offer support to each other. The events provide a great opportunity for the Trust's team to deliver Diabetes education in a relaxed, friendly environment.

Directorates across the Trust finalised their first draft Financial Recovery Plans ready for the Trust's Financial Special Measures meeting with NHSI mid-month. Following the meeting, NHSI recognised the effort that had contributed to completing the Recovery Plan in a short space of time, was supportive of the Trust's approach to date and asked for its thanks to be passed on to staff for their hard work. A further Review meeting was scheduled for November (see the 'story of the month' for November 2016).

October 2016

Breaking news at the beginning of the month confirmed that Maternity services in West Kent, which were predominantly provided by the Trust, had been rated the best in the country. Following a review of over 200 NHS Maternity services, the provision was the only service deemed as top performing. The Ofsted-style ratings examined stillbirth and neonatal mortality, maternal smoking at the time of delivery, women's experience of Maternity services and women's choice. Baroness Cumberlege, the Independent Chair of the 2016 'National Maternity Review' commissioned by NHS England to assess current provision and help shape future services, also visited the Trust's Maternity services during the month to help mark the fifth anniversary of integrated Maternity care.

Application of important preparatory works to support the Trust's clinically-led winter resilience plan began early in October. The plan's key aims were: to avoid queueing ambulances where patients could not be cared for in an Emergency Department cubicle; to avoid cancelling elective patients who required urgent treatment, or cancer treatment, and avoidance of 12 hour trolley breaches.

In further preparations for the winter, the Trust launched its flu clinics for staff, with the Chief Executive and Executive team leading the way towards hitting the target of an uptake of 75% for the year and, in doing so, helping to maintain a healthy, resilient workforce.

The re-launch in October of the Trust's partnership with "iWantGreatCare", the largest independent source of healthcare reviews, enabled all patients to leave real-time feedback about their care and ensured an ongoing source of information for the Trust, both about excellent care from its staff, as well as where improvements might be needed.

In other developments, Healthcare professionals and patients attended a 'Lung Awareness Day' at Maidstone Hospital. The event was organised by the Trust's Respiratory Research and Respiratory Medicine departments in partnership with the charity, 'Kent Lung Awareness'. Simon Denegri, National Director for Patients and Public at the National Institute for Health Research (NIHR) gave a key note speech and Dr Syed Arshad Husain, Chest Consultant at Maidstone Hospital, gave a series of talks on the range of various lung illnesses in people and how to best manage lung conditions. The event also showcased a new device to help identify irregular breathing patterns in patients.

The Trust's Emergency department at Tunbridge Wells Hospital hosted a visit by pupils from Oakley School, which caters for pupils aged 4-18 years with severe and or complex needs, and associated communication and learning difficulties. Nine pupils and 3 teachers came along to meet staff, look around the department and even try out some first-aid. The visit was arranged as part of the Trust's ongoing campaign to make the Department a less daunting place. The pupils thoroughly enjoyed their visit & left with a really positive view.

November 2016

The Trust submitted its draft 2 year operational plan late in the month, which was closely aligned to the emerging Kent and Medway STP, and the Executive team met with NHSI to provide an update on its progress against the Financial Recovery Plan. This was the second such progress meeting and NHSI again acknowledged the efforts made by the Trust and recognised the progress that had been delivered. The rate of progress and pace with which some actions had been implemented did not completely satisfy NHSI and a further meeting in January 2017 was arranged to assess progress and delivery. Following the meeting, the Trust's Executive team presented update sessions to staff on the latest position.

More encouragingly, the results of the Trust's second quarterly Staff Impressions Survey showed that 93% of staff who responded would recommend the Trust as a place to receive treatment, with quality of care being the top reason for this. 60% of staff said they would recommend the Trust as a great place to work, with job role and colleagues being the top ranking reasons for recommending.

The efforts of many of the Trust's committed staff were recognised at the year's Annual Staff Awards in November. Winners and Runners-Up included the Trust's Teenage Pregnancy Midwives who provide a personalised service for young pregnant teenagers and Dr Jenny Weeks, famous for using mathematics, namely subtraction, to distract her patients undergoing stressful biopsy procedures. Carol Kinsella, Clinical Manager, Outpatient Physiotherapy, was the Trust's "Employee of the Year", and was rewarded for her consistently outstanding approach and exceptional professionalism over many years of service.

Sister Sandra Wakelin, a Macmillan Lung Clinical Nurse Specialist, won the Innovation Award for her work setting up a clinic which assessed patients and prescribed supportive medications to help them manage side effects from chemotherapy. Winner of the Excellence Award was the Linear Accelerator (1) Oncology team, nominated by a patient who described the 'kindness, consideration and compassion' shown by the team and recorded how 'it has been a pleasure to come every day and not a chore'.

December 2016

As part of the year's winter plans (see October), the 12-bed Maidstone Orthopaedic Unit (MOU) was recommissioned a week before Christmas. The Unit was initially scheduled to operate until the end of March 2017, with the intention being to make a long-term decision regarding its future. The theatre, with a laminar flow unit to maintain a working area free of contaminants, was for use for elective Orthopaedic conditions, such as hip and knee replacements.

'Home First', a new scheme to help patients get home from the Trust's hospitals sooner was also launched in December. A critical element of the scheme, which is part of the Kent and Medway STP, was close working between the Trust, Kent Community Health NHS Foundation Trust and Kent County Council, as well as more effective involvement with voluntary and community sector partners. 'Home First' aims to make home the first choice for all medically stable patients and further stages of this programme were due to be rolled out over the months ahead.

The appointment of Dr Peter Maskell as the Trust's new Medical Director was announced in December, along with the establishment of three new roles of Deputy Medical Directors for Planned Care; Urgent Care and Women's, Children's & Sexual Health. This reorganisation was in recognition of the scale of the operational and financial challenges faced by the Trust and the need to build the strongest clinical leadership possible.

In the lead up to Christmas, the Trust held tea parties at both of its main sites to thank the many volunteers whose tireless dedication and support proved invaluable at both hospitals throughout the year. The 26th annual Christmas coffee morning, run by the Tunbridge Wells Hospital League of Friends, raised £4,300 and attracted over 150 attendees.

Over the Christmas period, NHSI's Chairman (Ed Smith) and Director of Nursing for Professional Leadership (Jacqueline McKenna) visited Tunbridge Wells Hospital to see staff in action and to view Accident & Emergency, Maternity and the Acute Medical Unit, as well as some wards. The visitors were impressed with what they saw, commenting specifically on how helpful and friendly the staff were.

January 2017

Between Christmas and the New Year over 4,000 people were seen and treated in the Trust's Emergency Departments. Heightened demand for unplanned care continued throughout January and saw both sites in full escalation. The cancellation of some non-urgent elective activity was a regrettable, but inevitable outcome of this surge in demand.

The roll out of the 'Home First' scheme for Kent continued to get patients in the county's hospitals home sooner, to carry on with their recovery safely at home. For patients unable to manage at home, short-term rehabilitation was offered in a community hospital and an 8-bed therapy ward was opened for this purpose at Tonbridge Cottage Hospital.

The findings of Healthwatch Kent's 'Enter and View' visits to Outpatients clinics at both main Trust sites, published in January 2017 (http://healthwatchkent.co.uk/outpatients), showed patient satisfaction levels to be high at both hospitals and aspects of the waiting areas' environment to be satisfactory to excellent. However, many patients noted that they experienced a delay before being seen, signage to clinics and waiting areas was limited and parking needed to be improved. The feedback received instigated a number of improvements.

Elsewhere during the month, young patients at Tunbridge Wells Hospital were given access to a new therapy play room in the Woodlands Unit, funded by the charity, 'Emilia's Little Heart'. The charity was set up in memory of Emilia, a young girl who sadly passed away following her third open heart surgery, and aims to ensure that every child in hospital should be helped to cope with the hospital environment through play and pain distraction. The £2,000 project featured a bespoke sea-life themed wall mural, toys, books, an arts and crafts area and comfortable seating.

In Maidstone Hospital in January, Mark Cynk, Consultant Urological Surgeon, and his team performed their 1000th laser prostate operation. Originally developed in New Zealand, the first local procedures were performed in Tunbridge Wells by Mr Cynk in 2003. The advantages of the laser surgery are that the risk of bleeding is much reduced, leading to a safer operation and a shorter hospital stay, with advantages both for patients and for the hospital. Over half of patients are now treated as day cases. Based on this pioneering experience, Maidstone Hospital is now a venue for laser training courses, which are attended by surgeons from across the world.

At the end of the month, the final Review meeting for the year was held between the Trust and NHSI to take stock of the latest situation under the Financial Special Measures regime. The meeting was positive with acknowledgement of the extent to which staff had clearly taken responsibility for spending money carefully and wisely as was clearly reflected in the figures. The challenge was recognised as maintaining the momentum already built, delivering in the same way for the remainder of the year and establishing a robust plan for 2017/18.

February 2017

The first week of February saw the highest ever number of patients through the doors of the Discharge Lounge at Tunbridge Wells Hospital with 31 patients using the service, a welcome development at a time when demand for hospital beds and services were at very high levels.

Mid-month, the Trust and its health and social care partners, were focussed on improving the emergency care pathway as part of a dedicated 'Rapid Improvement Week'. The aim of the week was to support delivery of safer, faster, better urgent and emergency care. Increases in Emergency Department attendances, and challenges in discharging patients had resulted in poor patient flow and necessitated a number of escalation areas to maintain patient safety, improve patient flow and produce a step-change in performance, safety and patient experience.

The month's Safety Calendar focus was on venous thromboembolism (VTE). Whilst the Trust has enjoyed a good record in relation to VTE prevention, the need to continue to implement all necessary actions to prevent patients from developing VTE was recognised and February's initiatives included educating patients about this issue.

The CHKS (Comparative Health Knowledge System) inspection for Kent Oncology Centre (KOC), which took place towards the end of February, was very successful. Overall comments on the findings concluded, "The Kent Oncology Centre remains an outstanding centre and it is recommended that they continue to be in receipt of their ISO certification". This was testament to the ongoing hard work and commitment from all KOC staff.

The month closed with the announcement of the appointment of David Highton, the new Chair of the Trust Board, with effect from 8th May 2017. Further details of David's background and extensive experience are included in the Corporate Governance Report. Anthony Jones retired as Chairman on 28th February, after serving two full terms of office. Anthony's significant contribution to the Trust over the past 9 years was acknowledged at the Trust Board meeting in February. Also stepping down from the Trust Board after 9 years was Non-Executive Director, Sylvia Denton. During her service, Sylvia made an excellent and invaluable contribution, and was hugely supportive to the Trust's Chief Nurses with her wealth of experience as a senior nurse.

March 2017

The announcement in March that the Trust had been awarded £1.8 million of national funding to help modernise radiotherapy, meant that it was one of only 15 Trusts across England to benefit from this first wave of investment by NHS England. The funding was to ensure the Trust could continue to provide optimum treatment, care and support to its cancer patients. The money funded the replacement

of one Linear Accelerator (LinAc) and the planning for the pre-installation works for the new equipment is advancing well. The new LinAc would allow Radiotherapy staff to target tumours which can vary in position during treatment, and would help to deliver treatment quickly and accurately while avoiding healthy tissues and organs.

The Trust marked National Apprenticeship Week in March with a visit of more than 180 students from 18 different local schools to a Trust hosted careers event. The event, put on by the Trust's Learning and Development team in partnership with Health Education England and Education Business Partnership Kent, highlighted the diverse range of careers within the NHS and opportunities for traineeships all the way through to higher and degree apprenticeships. Students were able to speak to members of staff from across the Trust and other health-related organisations, such as Pharmacy and the ambulance service, as well as to try their hand at some simulation exercises.

In other developments, the Trust exceeded its annual research recruitment target for 2016/17 in March, with 1,300 people having consented to take part in clinical trials during the year. This surpassed the Trust's target of 1,250. As well as more Trust patients than ever before offered innovative treatments, this achievement also secured future research funding for the Trust.

Delayed Transfers of Care (DTOCs) within the Trust accounted for around 1,500 lost bed days in March. Close working with Social Services and a new approach to patient discharge was introduced in the month by the Integrated Discharge Team, (an amalgamation of Social Services, Community Liaison and Discharge Liaison teams) working collaboratively with Kent Community Health NHS Foundation Trust and Social Services. This new way of working, facilitated by improved technology and strong communication between providers, was intended to provide a more seamless healthcare approach for the patient and their relatives; to reduce delays in discharge and misinformation; as well as allowing better use of staff time and increasing elective activity – all themes that would continue beyond the year-end.

To monitor the impacts of the Trust's initiatives in this area, the first of 10 Enter and View visits by Healthwatch Kent, to gather feedback from patients about their experience of being discharged from hospital in West Kent, took place at the end of the month. As part of this enterprise, there were plans to visit both Maidstone and Tunbridge Wells Hospitals, along with other places that Trust patients were discharged to, like Tonbridge Cottage Hospital and various care homes. The scheme would also elicit feedback from Home First patients.

The story of the year: Kent and Medway Sustainability and Transformation Plan

The review of the year would not be complete without proper reference to the work undertaken as part of the development of a Kent and Medway Health and Social Care Sustainability and Transformation Plan (STP). This initiative saw all the NHS organisations in Kent and Medway, Kent County Council and Medway Council working in partnership for the first time on plans for the future provision of health and social care services to the county's growing population of over 1.8 million people. The work recognises that changes are needed because the current health and social care system isn't set up to meet the needs of today's population. With the Trust's Chief Executive acting as Senior Responsible Officer (SRO) for the STP, the Trust has been at the forefront of this ground-breaking initiative during the course of the year.

This initiative resulted in two key publications in 2016/17:

- The draft Sustainability and Transformation Plan (STP) for Kent and Medway ("Transforming health and social care in Kent and Medway"), published in November 2016, explains the vision for the future, a key theme of which is putting local people at the heart of services, helping people to stay well and independent in their own homes and communities and avoid being admitted to hospital, and
- The 'case for change', published in March 2017, set out why services need to change to meet the needs of local people and explains in more detail the thinking behind the draft plans in the Kent and Medway Sustainability and Transformation Plan (STP)

The STP is work in progress. It describes what needs to be done differently to bring about better health and wellbeing, better standards of care, and better use of staff and funds. Engagement and consultation with local communities in Kent and Medway is ongoing and will play a critical part in deciding on any future changes to services.

Further information on the Kent and Medway STP and access to the documents referenced above is available at:
http://kentandmedway.nhs.uk/stp/caseforchange/

Amongst the intended benefits arising from the STP for the people of Kent and Medway are:

- joined-up services to treat and care for people in their own home and support for them to leave hospital as soon as they are medically fit to leave
- quality hospital care when needed – and more care, treatment and support out of hospital if it isn't
- health and social care professionals coming together to work as a single team for the local area
- a modern approach to health and social care services using the best technology, from booking appointments online to virtual (but secure) consultations and diagnostic systems
- timely appointments with the right professional
- care for the individual as a whole, for both physical and mental health
- more support from voluntary and charitable organisations.

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

The Trust Board agreed the following objectives for 2016/17:

- To reduce the falls rate to less than 6.2 per 1,000 occupied bed days
- To achieve an average maximum Length of Stay for elective care of 3.2 days and an average maximum Length of Stay for non-elective care of 6.8 days
- To reduce the vacancy rate to 8.5%
- To maintain operational liquidity whilst reducing working capital (from the planned level for 2016/17) and to deliver the control total for 2016/17[4]
- To deliver the Trust's 2016/17 agreed trajectory regarding the 62-day Cancer waiting time target

The key issues and risks affecting delivery of these (as described in the Trust's Board Assurance Framework – see the "Governance Statement for 2016/17") are outlined below. Details of how the Trust actually performed in response to these can be found in the "Performance analysis" section below.

To reduce the falls rate to less than 6.2 per 1,000 occupied bed days

In order to achieve this, it was known that the following risks needed to be managed effectively: insufficient senior leadership and commitment; insufficient clarity of the performance required by each Ward, & the monitoring of such performance; insufficient engagement by Wards and staff; and falls-related documentation not being fit for purpose.

To achieve an average maximum Length of Stay for elective care of 3.2 days and to achieve an average maximum Length of Stay for non-elective care of 6.8 days

In order to achieve this, it was known that the following risks needed to be managed effectively: insufficient senior leadership and commitment; insufficient engagement by clinical staff; insufficient clarity over the performance required; insufficient framework to drive patient flow; poorly designed ambulatory pathways; insufficient 'pull' of patients from outside of Wards; insufficient incentives for good performance; insufficient awareness of the action required; a lack of capability & capacity re complex discharges; a lack of optimal use of community hospitals; insufficient capacity for non-elective patients; and insufficient change in discharge management out of the Trust (i.e. inability to deliver system-wide).

To reduce the vacancy rate to 8.5%

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

[4] The Trust Board approved this objective on 30th November 2016 as an alternative to the original wording: "To improve on the Trust's Income and Expenditure plan for 2016/17"

To maintain operational liquidity whilst reducing working capital (from the planned level for 2016/17); and to deliver the control total for 2016/17

In order to achieve this, it was known that the following risks needed to be managed effectively: a lack of senior leadership and commitment; poor financial controls and/or their application; a lack of urgency/commitment by managers; a lack of capability and capacity in key areas; deficiency in consideration of best practice elsewhere in the development of the Financial Recovery Plan; non-acceptance of the Financial Recovery Plan by NHSI; and insufficient engagement with external stakeholders.

To deliver the Trust's 2016/17 agreed trajectory regarding the 62-day Cancer waiting time target

In order to achieve this, it was known that the following risks needed to be managed effectively: insufficient engagement by clinical staff outside of the Cancer and Haematology Directorate; that pathways may not be optimal in relation to achieving the required performance; insufficient communication of the performance required outside of the Cancer and Haematology Directorate (only $^{1}/_{3}$ of the delivery is within the control of the Cancer and Haematology Directorate – the remainder is within Diagnostics, Surgery and Medicine).

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

Adoption of the 'going concern' basis

The Department of Health Group Accounting Manual 2016-17 states that '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. Department of Health group bodies should therefore prepare their accounts on a going concern basis unless informed by the relevant national body or Department of Health sponsor of the intention for dissolution without transfer of services or function to another entity'.

The Trust has compiled the 2016/17 accounts on a "going concern" basis on consideration of the following:-

- There has been no expectation raised in the public arena that healthcare services will not continue to be provided from the two hospital sites
- The Trust has submitted business plans to NHSI in December 2016 setting out its plans for the following two operating years (2017/18 and 2018/19). These plans include acceptance of the nationally set revenue "control total" to which the Trust has confirmed sign up
- The Trust has fully participated in the STP planning process including the submission of the forward 5 year financial and operating plans on a going concern basis. The Trust's Chief Executive is the SRO for the STP, and the Trust is leading some of the significant workstream areas
- The Trust has agreed/signed contracts for provision of healthcare services for 2017/18 including a new "aligned objectives" approach with its main CCG
- The Trust has prepared and submitted cash-flow forecasts for 2017/18 and 2018/19 which do not include assumptions of additional required working capital finance
- The Trust is in financial special measures and is working with its Financial Improvement Director and NHSI support to deliver an outturn as close as possible to the control total (pre-Sustainability and Transformation Fund (STF) funding)
- There are no plans to dissolve the Trust or to cease services without transfer to any other NHS body.

Performance summary for 2016/17

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

Overall performance for the year was again mixed. Performance against the Trust's agreed objectives, including the delivery of the financial plan, is described in detail in the "Development and performance in 2016/17" section on the following pages.

The Trust achieved successes in the areas of Stroke, patient falls and pressure ulcers, with: an 88.3% rate (unvalidated) of Stroke patients spending 90% or more of their time on a Stroke ward against a target of 80% and 58.8% (unvalidated) of patients receiving a CT scan within 1 hour against a target of 48%. The Trust was successful in exceeding its target to reduce patient falls to a maximum rate of 6.2 per 1,000 bed days, achieving a rate of 6.07 for the year.

Similarly, the rate of pressure ulcers was 2.6 per 1,000 admissions against a threshold of 3 per 1,000 admissions. Progress in these areas is encouraging given the increased operational pressures which resulted from significantly higher levels of attendances and admissions. Also positive was the reduction in the number of complaints - a rate of 1.25 complaints per 1,000 occupied bed days for the year.

The Trust maintained its robust performance in the field of infection prevention and control - as well as meeting its target for Clostridium difficile in terms of rate (10.5% per 100,000 bed days, against a target of 11.5%), it also outperformed both regional (12.6%) and national averages (13.5%) in this field. The Trust just exceeded (by 1 case) its maximum limit of 27 cases of Clostridium difficile for the year. This is set against a background where all but 3 of the Trusts in Kent, Surrey and Sussex breached their trajectory by number, and 7 breached their trajectory by rate. There was also only 1 case of MRSA bacteraemia for the year.

Elsewhere, the Trust underperformed on several targets, including those relating to Cancer, Access to treatment & Length of Stay. More details are provided in the "Governance Statement" section later.

Performance standards for quality of care can be found in the trust's Quality Accounts found also on the Trust website at www.mtw.nhs.uk

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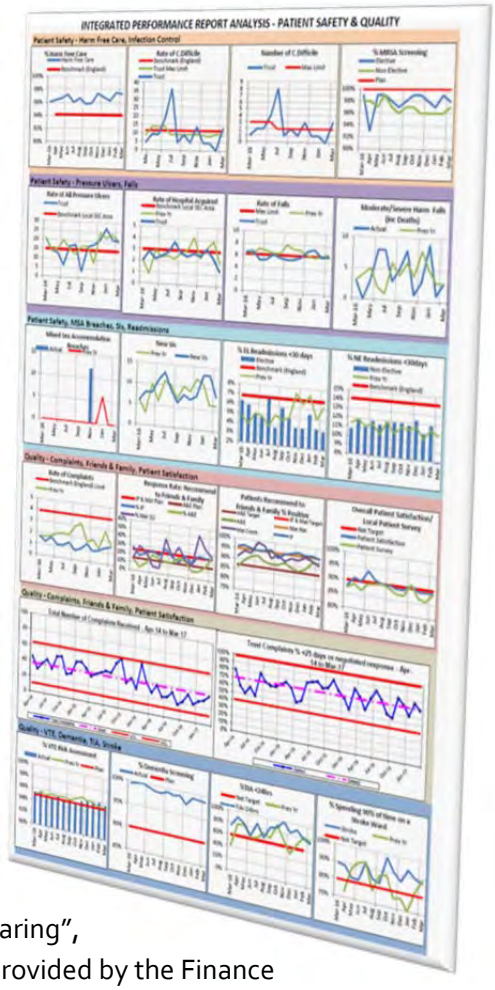
Performance Report for 2016/17: Performance analysis

taking pride

How the Trust measures performance

To ensure that its information is appropriately validated from a wide range of data sources, the Trust launched a new performance management framework in the autumn of 2016. The framework is based upon the national Single Oversight Framework and reinforces accountability for delivery at Divisional level. As part of this new system, a 'Ward to Board' approach has been adopted and is monitored through a sign-off process at Directorate, then Divisional level before presentation at monthly Executive Performance Review meetings and ultimately, the Trust Board.



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

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

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

Performance against the Trust's agreed objectives is measured and monitored via the Board Assurance Framework, which is described in more details in the "Governance Statement" later in the Report.

The Trust also uses nationally-published information (where available), to compare performance. This includes national staff and patient surveys (which are described elsewhere in this Report); and national clinical audits.

Development and performance in 2016/17

The 'key issues and risks affecting delivery of the Trust's objectives' were described earlier in the Report. The Trust's actual performance against each of its 2016/17 objectives is described below.

To reduce the falls rate to less than 6.2 per 1,000 occupied bed days

This was fully achieved, with performance for the year at 6.07 per 1000 bed days against the threshold of 6.2 and compared to 6.69 for 2016/17.

To achieve an average maximum Length of Stay for elective care of 3.2 days and to achieve an average maximum Length of Stay for non-elective care of 6.8 days

This was achieved in part. The average Length of Stay (LOS) for elective care for the year was 3.28 days and the average Length of Stay for non-elective care for the year was 7.74 days. However there were mitigating circumstances, including December 2016 seeing the highest level of Delayed Transfers of Care (DTOCs), at 8%. Ambulatory pathways (where some conditions may be treated without the need for an overnight stay in hospital) were rolled out at Tunbridge Wells Hospital in July 2016, but due to high escalation these were not been optimised. Similar pathways are in place at Maidstone Hospital but these require embedding further. Therefore although the actions taken and/or planned are felt to have been the correct actions required to address this objective, achieving the target average LOS targets may not be achieved until mid-2017/18. This level of confidence is affected by the fact that there has been no reduction in non-elective demand. However, despite this, there are continuing measures in place to assist patient flow.

To reduce the vacancy rate to 8.5%

This was fully achieved, with the vacancy rate for the year standing at 8.3% (which compared to 9.3% for 2015/16). This was the result of implementation of the Trust Workforce Strategy 2015-20 ("Recruitment & Retention" is the first of 6 workforce priorities); through the operation of a Nurse Recruitment and Retention Group; through increased recruitment staffing resource and various Task and Finish Groups focussed on the issue.

To maintain operational liquidity whilst reducing working capital (from the planned level for 2016/17); and to deliver the control total for 2016/17

Maintenance of operational liquidity whilst reducing working capital was fully achieved, as the Trust managed its liquidity during the financial year through the delivery of the actions within its Financial Recovery Plan. This meant that no significant additional borrowing was necessary, while the Trust also significantly reduced its 90 days and over aged debt profile.

In relation to the control total for 2016/17 (which was to achieve a surplus, after Sustainability and Transformation Fund (STF) monies, of £4.7m), the Trust ended 2016/17 with a deficit of £10.9m, which meant the Trust did not meet its control total for the year. A significant factor in the size of the deficit was the fact that the Trust was not allowed to undertake the Capital to Revenue Transfer (of £4.2m) it had planned.

To deliver the Trust's 2016/17 agreed trajectory regarding the 62-day Cancer waiting time target

The 2016/17 performance on the 62-day Cancer waiting time target was 71.5% (which compares to the standard of 85%). The key issue to address is with the Lower Gastrointestinal (GI) pathway (which has the lowest performance among all Tumour Sites).

A detailed report on Cancer performance was considered by the Trust Management Executive (TME) and Trust Board in March 2017, which described the resources in place, the actions that had been taken, and those planned to be taken, and noted that a recovery trajectory to achieve the 62-day standard had been submitted to NHS Improvement which anticipated achievement in September 2017.

Financial performance in 2016/17

The year has proven extremely challenging financially. The Trust was placed in Financial Special Measures (FSM) in July 2016 as a consequence of not agreeing to the control total set by NHSI and being significantly at variance to that control total. The Trust remained in FSM at the year-end and a further checkpoint meeting was scheduled for late May 2017, with the Trust's main aim being to exit FSM at this time.

The Trust reported a deficit of £10.9m, post Sustainability and Transformation Funding (STF), which was £15.6m adverse to the control total set at the beginning of the financial year (a £4.7m surplus). The scale of this achievment against a 2015/16 deficit of £23.4m, and an original planned deficit for 2016/17 of £23.1m, whilst maintaining performance on a range of other financial metrics, is noteworthy. The key drivers of the adverse variance reported were:

- Significant use of Agency staff and the associated premium, particularly in Medical to cover vacancies (£1.2m)
- The need to open escalation areas during the winter period (£0.3m)
- The impact on the Trust's ability to deliver elective activity due to the increasing demand of non-elective activity, Length of Stay and Delayed Transfers of Care (£4.5m)
- Inclusion within the Financial Recovery Plan of a number of high risk income schemes (£4.3m) which were unable to be delivered
- Part-delivery of the STF performance and financial targets (£3.7m) (the financial target was not delivered in the last quarter of the year only)

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	2016/17 (revised Plan)	2016/17 (Actual)	Variance
Income	£440.8m	£430.5m	(£10.3m)
Expenditure	(£403.1m)	(£411.6m)	(£8.5m)
EBITDA (deficit):	£37.7m	£18.9m	(£18.8m)
EBITDA %	9%	4%	-5%
Depreciation & other	(£15.7m)	(£13.2m)	£2.5m
Net interest	(£14.6m)	(£14.6m)	(£0.0m)
PDC dividend	(£3.4m)	(£1.9m)	£1.5m
Impairments	(£13.5m)	(£41.3m)	(£27.8m)
	(£47.2m)	(£71.0m)	(£23.8m)
(Deficit) before technical adjustments	(£9.5m)	(£52.1m)	(£42.6m)
Technical adjustments	£14.2m	£41.1m	£26.9m
(Deficit) after technical adjustments	£4.7m	(£10.9m)	(£15.6m)

Income

The Trust's income was below plan by £10.3m by the end of the financial year. Clinical income was £9.6m adverse to plan and other income £0.7m adverse which included £1m non recurrent support funding from NHS Improvement. The Trust had a challenging winter period where it faced an increasing demand of non-elective activity during quarter four of 2016/17. This led to a significant reduction in elective and day case activity during this period (£4.5m). The Financial Recovery Plan included a number of high risk income schemes (£4.3m) which were unable to be delivered. STF income was adverse by £3.7m, high cost drug income was favourable by £2.4m (it should be noted that the high cost drug income is a pass through cost). The majority (82%) of the Trust's income is from Clinical Commissioning Groups (CCGs) or NHS England.

Expenditure

The Trust's operating expenses were dominated by pay. Pay costs for 2016/17 were 61% of total operating expenses. Pay was £1.5m adverse to plan at the end of the financial year. This was partly due to an unidentified Financial Recovery Plan target relating to pay, which was offset by a small underspend within Nursing. Non-pay was £7m adverse to the Trust's plan. The main driver of this was medication of £3.4m, clinical supplies (£1.5m) & a further unidentified Financial Recovery Plan target relating to non-pay (£2.1m).

Of the £3.4m medication over-spend, £2.4m was recoverable from either NHS England or CCGs.

Cost Improvement Plan (CIP)

The Trust had a CIP and Financial Recovery Plan (FRP) of £32m during 2016/17. The Trust delivered a CIP of £14.6m against a plan of £15.9m. The FRP delivered additional savings of £9.9m against a plan of £16.2m. Full year delivery against this plan was £24.5m, with an adverse variance of £7.4m. The full details are shown in the following table:

CIP programme by workstream	2016/17 Plan £'000	2016/17 Actual £'000	Variance £'000
Cancer & Haematology (Planned Care)	£2,734	£3,182	£448
Critical Care (Planned Care)	£1,466	£1,393	(£73)
Diagnostics (Planned Care)	£2,833	£2,511	(£322)
Head and Neck (Planned Care)	£1,313	£1,077	(£236)
Surgery (Planned Care)	£2,157	£1,706	(£451)
Trauma & Orthopaedics (Planned Care)	£2,242	£1,840	(£402)
Patient Admin (Planned Care)	£45	£33	(£12)
Private Patients Unit (Planned Care)	£210	£238	£28
Total for Planned Care	£13,000	£11,980	(£1,021)
Urgent Care	£11,783	£5,836	(£5,947)
Women's, Children's & Sexual Health	£2,408	£1,912	(£496)
Estates & Facilities	£3,269	£2,169	(£1,100)
Corporate	£1,605	£2,657	£1,052
Total across all workstreams	£32,065	£24,554	(£7,511)

Capital Expenditure plan

During the year, the Trust made capital investments totalling £9.5m, including £0.4m of assets funded from donated or charitable fund sources. A significant part of the Trust's capital programme in year was the purchasing of equipment (£3.4m, of which £1.7m was the purchase of a Linear Accelerator), IT equipment (£3m) and Estates (£2.4m which mostly relates to backlog schemes).

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.

Capital Cost Absorption Duty

The Trust is required to achieve a rate of return on capital employed of 3.5% and met that target, achieving a return of 3.5% for the year to March 2017.

External Finance Limit (EFL)

The Trust is required to demonstrate that it has managed its cash resources effectively by staying below an agreed limit on the amount of cash drawn from the Department of Health (DH). In 2016/17, the Trust met its target by managing the year-end position to an under shoot against the EFL of £0.4m, actual closing cash balance £1.4m.

Capital Resource Limit

The Trust is expected to manage its capital expenditure within its agreed Capital Resource Limit (CRL). For 2016/17, the Trust's CRL was £12.53m, which was underspent by £3.36m. This underspend was part of the Trust's Financial Recovery Plan agreed with NHSI in the year.

Capital Investment Financing

The Trust did not take out any additional capital investment loans in 2016/17, but was successful in an application for £1.7m of central Public Dividend Capital (PDC) to replace a Linear Accelerator machine at Maidstone Hospital.

Break-even duty

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

The Trust's latest 3 year break-even cycle commenced in 2013/14 and was not met by the end of the period in 2015/16. The Trust's break-even period has therefore been extended with the plans submitted for 2017/18 and 2018/19 aimed at reducing the accumulated deficit towards the target of formal cumulative break-even by 2020/21.

Accounting Issues

The Accounts have been prepared in accordance with guidance issued by the DH and in line with International Financial Reporting Standards (IFRS) as applied in the DH Group Accounting Manual. The accounts were prepared under the "Going Concern" concept in line with the DH 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 £85,069 excluding VAT (in 2015/16 this was £85,069 excluding VAT) which includes the audit of the Quality Accounts. Grant Thornton UK LLP did not undertake any non-audit work for the Trust in 2016/17.

Looking forward to 2017/18

- The Trust has set a planned surplus of £6.7m which includes receipt of £11.2m STF during 2017/18. To deliver this surplus the Trust will need to deliver a £32m CIP. The overall plan shows that 2017/18 will continue to be financially challenging. The table below sets out the Trust's 2 year financial plan submitted to NHSI.

Statement of Comprehensive Income	2017/18 (Plan) £m	2018/19 (Plan) £m
Income	£436.6m	£446.5m
Expenditure	(£398.6m)	(£402.8m)
EBITDA (deficit):	£38.0m	£43.7m
EBITDA %	9%	10%
Depreciation & other	(£14.8m)	(£15.6m)
Net interest	(£15.1m)	(£15.2m)
PDC dividend	(£1.5m)	(£2.0m)
Impairments	(£1.0m)	(£1.0m)
	(£32.4m)	(£33.8m)
Deficit (before technical adjustments)	£5.6m	£10.0m
Technical adjustments	£1.0m	£1.2m
Deficit (after technical adjustments)	£6.6m	£11.2m

- The key movements from 2016/17 to 2017/18 are: Clinical Negligence Scheme for Trusts (CNST) and rates inflation (£3.4m), PFI indexation change (£0.6m), inflationary factors such as pay awards, incremental drift, apprentice levy and non pay (£6.1m) and a contingency plan of (£3.7m). The plan includes additional STF funding of £5.6m. The 2016/17 financial position also included non recurrent items of £8.8m. This is offset by the planned £32m CIP, full year effect of 2016/17 FRP (£5.6m) and NHS tariff inflation and demographic growth.
- The Trust's overall baseline income plan assumes the same level of non-elective and elective activity as per demand during 2016/17 increased for demographic growth. The Trust has moved from a 'Payment by Results' contract with its host commissioner, West Kent Clinical Commissioning Group (CCG), to an 'Aligned Incentives' contract for the next 2 years. This contract is designed to deliver efficient and robust patient pathways across the local health economy.
- The Trust is planning a rolling 5-year capital programme of £74m. This is inclusive of the following:
  - £14m essential improvements in backlog estates and planned lifecycle replacement
  - £6.5m of electrical substation and energy peformance infrastructure
  - Renewal of a main theatre block at Maidstone Hospital (£15m)
  - Replacement equipment programme of £20m, including LinAcs (with £4.4m of build work related to the LinAc replacements)
  - £4.7m Information Management &Technology (IM&T) modernisation programme
  - Tunbridge Wells Hospital Satellite radiotherapy bunkers £7.4m
- The Trust is planning for capital investment loans to support the scale of the required estate renewal including Salix[5] funding. The Trust has also included the expectation of further national PDC funding for linear accelerator replacements and is working with the NHS England team on this programme.

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

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Performance Report for 2016/17: Summary of Quality Accounts

taking pride

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

This section contains a summary of the Quality Accounts for 2016/17, but the full Quality Accounts can be found on the Trust's website (www.mtw.nhs.uk), or the Trust's pages on the NHS Choices website (www.nhs.uk/Services/Trusts/Overview/DefaultView.aspx?id=1178).

Performance against selected key priorities for 2016/17

Performance against some of the 2016/17 priorities, as stated in the 2015/16 Quality Accounts, is detailed below.

Patient Safety: To improve the dissemination of learning from serious incidents and complaints to drive improvement across the organisation

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

- "Improvements as a result of learning from all Serious Incidents and Red Complaints to be shared in a staff monthly newsletter and on the intranet and website (100% where disclosable)": The Governance Gazette was published monthly within the Trust throughout the year with each edition dedicating a section to learning from complaints and serious incidents. The Annual Complaints report is published on Trust website (www.mtw.nhs.uk)
- "Implement improvements to in-hospital falls prevention with a reduction in falls rates to a target of less 6.2 per 1000 occupied bed-days by end of March 2017": As noted above, the target was achieved with the year-end position standing at 6.07 per 1000 occupied bed days
- "Implement improvements as a result of learning from the review of in-hospital mortalities": The year-end percentage achieved for hospital mortality reviews undertaken was 43% against a plan of 75%. This action was therefore not achieved, but sustained improvement was demonstrated across the year

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

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

- "Friends & Family results to be clearly and consistently displayed within departments, including actions and improvements as a result of qualitative feedback". A project group was formed to lead and facilitate the new contract with the "iWantGreatCare" company which supports the Trust with collation of reports from our Friends and Family Test (FFT) questions. A Roadshow was held in October 2016 which provided opportunities for the group to consider its methodology for patient feedback in all areas of the Trust. The issue was a monthly agenda item for Nurse Engagement and Learning Forum meetings, with ward managers sharing their FFT results, along with learning and best practice
- "Positive feedback / plaudits to be gathered and shared in a more robust way with staff to ensure good practices are acknowledged and become drivers for improvement": A section for feedback/plaudits has been integrated within Directorate reports and collaboration with the Trust's Communications team ensures that these are also publicised in the Chief Executive's weekly update; "iWantGreatCare" are supporting the Trust to undertake a case study on successes within its Emergency Departments, which will then be shared across the Trust to promote learning
- "Work with Healthwatch Kent to consider and implement different ways of listening to staff and service users to drive improvements (such as listening events, better use of social media and technology)": Patient representatives from Healthwatch support the Trust in a number of patient focussed initiatives,

including participation in the Trust's Internal Assurance visits to wards and departments. As also mentioned earlier in the Report, they also completed 'Enter and view' visits to Outpatient services at Maidstone and Tunbridge Wells Hospitals, and the results are available at http://healthwatchkent.co.uk/outpatients. A new project focussed around the discharge experience of patients is also in progress

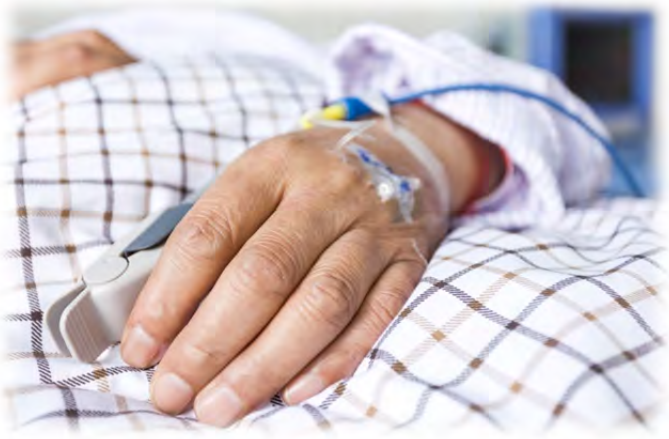
Clinical Effectiveness: To improve the management of patient flow

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

- "Sustained reduction in length of stay achieved through (but not exclusively) the full implementation of Senior review, Anticipate, Flow, Early discharges, React to delays & waits (SAFER) Discharge Bundle. To achieve the outputs and timeframes agreed at the Timely Effective Safe (TES) Steering Group": The average non-elective Length of Stay for the year was 7.74 days against a target of 6.8 days (see also Development and Performance in 2016/17). The Trust saw a significant increase in escalated beds, bed occupancy and attendances during the winter period. Work is ongoing in three specific areas: Emergency Department Recovery; SAFER implementation and Home First (see pages 16 and 17). Within the SAFER implementation, there is focus on increase in Discharge Lounge referrals (these increased in January 2017 to the highest yet level of 15.5%) and engagement with junior doctors.
- "Sustain 1 ring-fenced bed for Stroke patients at Maidstone at all times and 2 on the Tunbridge Wells Hospital site (90% by March 2017). Sustain 1 ring-fenced bed on Ward 31 at Tunbridge Wells Hospital for fractured neck of femur patients at all times (90% by March 2017)": The availability of ring-fenced beds for Stroke and fractured neck of femur are reported at each site meeting. If ring-fenced beds are not available, this becomes a priority for the Clinical Site team to achieve before the next site meeting. The Sentinel Stroke National Audit Programme (SSNAP) also records the timeliness of admission to a Stroke Unit, and the percentage of patients having direct admission to Stroke Unit in less than 4 hours was 54.2% for the Trust (an increase of 5.7% compared to 2015/16)
- "Embed new ambulatory pathways on the Acute Medical Unit (AMU) at Tunbridge Wells Hospital to achieve a 10% reduction (minimum) from the March 2016 baseline in admitted patients from the medical take each day, by March 2017": As part of the Emergency Department recovery group, new ambulatory pathways within Respiratory and Cardiology were devised and were trialled during a Rapid Improvement Event in February 2017. A Trauma & Orthopaedics 'task and finish' group was established to divert admissions into ambulatory pathways within the AMU. However, the Trust was unable to achieve the planned reduction in patients admitted, due to the 4.2% increase in attendances that were experienced

Quality improvement priorities for 2017/18

The Trust's quality improvement priorities are only ever a small sample of the quality improvement work undertaken across the organisation in any one year. The initiatives selected in previous years will almost always continue into subsequent years, although the focus may change according to need. Selecting new initiatives each year ensures that a wide breadth of areas are covered and prioritised. The Trust has chosen 3 quality priorities for 2017/18:



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

The key objectives involve: A demonstrable, embedded safety culture within all departments undertaking invasive procedures with compliance with the WHO surgical safety methodology; improved reporting of medication errors within the Trust and reduction of the number of inappropriate omissions of doses of medication; reduction of observed rates of mortality to be in line with expected rates according to speciality; consistent recognition and rapid treatment of sepsis in both Emergency and Inpatient departments and an ultimate reduction in the number of avoidable deaths; improvement in the outcomes for expectant mothers and their babies in line with the Maternal and Neonatal Health Safety Collaborative.

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

The key objectives include: Implementation of the revised Friends & Family methodology to provide a more targeted focus on 5 questions relating to the patient's overall experience; consistent monthly response rates to the Friends and family test; Identification, through work with external partners such as Healthwatch, NHSI, CQC and the CCG, of key themes of good practice and emerging issues that may give cause for concern; development of a framework to report and monitor the incidence of harm affecting those with cognitive impairment (dementia).

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

The key objectives include: Avoidance of unnecessary admissions to hospital through the increased use of ambulatory pathways of care for patients who attend the Trust's Emergency departments; reduction in the number of frequent attendances of patients in crisis attending the Trust's Emergency departments through work with mental health partners; improvement of access to ring-fenced beds for Stroke and Fractured Neck of Femur patients; development of pathways that will support the timely discharge of patients

Progress against these subjects will be monitored through Directorate and Trust-level governance structures. Assurance of progress against the above objectives will be presented at the Trust Management Executive (TME), Quality Committee and the Patient Experience Committee.

NHS
Maidstone and Tunbridge Wells
NHS Trust

Performance Report for 2016/17: Sustainability Report

taking pride

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

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

Policies

In order to embed sustainability within the Trust's business it is important to explain where sustainability features in its process and procedures. Sustainability is considered in relation to Travel, Procurement (environmental), Procurement (social impact) and Suppliers' impact, but not in relation to Business Cases. One of the ways in which an organisation can embed sustainability is through the use of a Sustainability Development Management Plan (SDMP), which the Trust has. As an organisation that acknowledges its responsibility towards creating a sustainable future, the Trust also helps to achieve that goal by running awareness campaigns that promote the benefits of sustainability to its staff.

Climate change brings new challenges to the Trust's business 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. The Trust's plans address the potential need to adapt the delivery of the organisation's activities and infrastructure to climate change and adverse weather events.

Partnerships

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

Performance

Organisation

Since the 2007 baseline year, the NHS has undergone a significant restructuring process, 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	2007/08	2014/15	2015/16	2016/17
Floor space (m^2)	109,896	138,533	138,533	138,533
Number of staff (WTE)	3,969	4,800	4,678	5,130

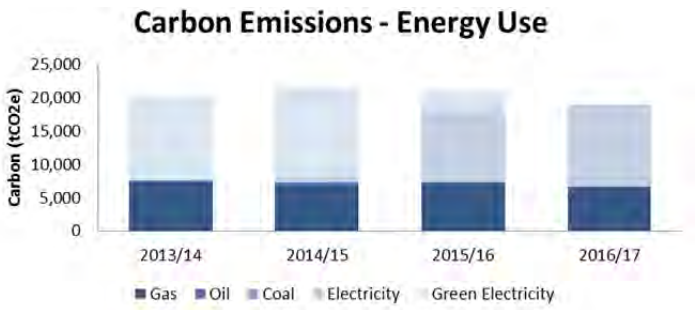
In 2014 the national Sustainable Development Strategy outlined an ambition to reduce the carbon footprint of the NHS by 28% (from a 2013 baseline) by 2020. The Trust has supported this ambition as detailed below:

Energy

The Trust spent £3,835,790 on energy in 2016/17, which was a 2.1% decrease on energy spend from 2015/16. The Trust is pleased to report a reduction in its total energy use and associated carbon emissions in the reporting period, particularly following 2 years of increase versus the baseline. The Trust has embarked on an ambitious program to reduce its energy consumption to ensure it meets its target and has identified a range of programmes and activities to enable this. None of the Trust's electricity came from a dedicated green tariff[7] within the period as the tariff was cancelled due to a financial review undertaken in 2015. However, this is under review from 2017/18 with the intention being to re-evaluate the financial impact versus the environmental and ethical benefit of purchasing certified green energy.

Resource[6]		2013/14	2014/15	2015/16	2016/17
Gas	Use (kWh)	34,135,656	32,905,482	34,139,781	31,546,328
	tCO_2e	7,242	6,904	7,145	6,593
Oil	Use (kWh)	955,973	1,110,958	635,113	532,926
	tCO_2e	305	356	203	147
Coal	Use (kWh)	0	0	0	0
	tCO_2e	0	0	0	0
Electricity	Use (kWh)	224,551	1,331,564	18,564,756	23,801,508
	tCO_2e	126	825	10,673	12,301
Green Electricity	Use (kWh)	22,477,329	21,816,665	4,892,105	0
	tCO_2e	12,585	13,512	2,813	0
Total energy CO_2e		20,258	21,597	20,834	18,941
Total energy spend		£4,039,990	£3,814,599	£3,919,681	£3,835,790

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.



Within the reporting period, a program of review and optimisation of Heating, Ventilation and Air Conditioning (HVAC) set points and operating hours has been conducted. This will be further enhanced in the year ahead with a complete revision of the HVAC strategy being employed within the Trust to ensure that the equipment is used to the optimum without compromising stakeholder comfort or patient

[6] Data for energy resource usage before 2016/17 was reviewed and revalidated in 2016/17
[7] A green supply tariff means that some or all of the electricity bought by the user is 'matched' by purchases of renewable energy that the energy supplier makes on their behalf. These could come from a variety of renewable energy sources such as wind farms and hydroelectric power stations.

experience. A large scale upgrade of external LED lighting has been commenced at Maidstone Hospital and this will be followed by a comprehensive program of internal LED upgrade in the 2017/18 period. The Trust is working in partnership with Interserve FM at Tunbridge Wells Hospital to identify and implement similar programmes in 2017/18 and is also in the detailed planning phase for the installation of a Combined Heat and Power unit to Tunbridge Wells, and at the feasibility stage for a similar installation to Maidstone.

Travel

The Trust can improve local air quality and improve the health of its community by promoting active travel – to the staff and to the patients and public that use its services. Every action counts and the Trust is a lean organisation trying to realise efficiencies across the board for cost and carbon (CO_2e) reductions. The Trust supports a culture for active travel to improve staff wellbeing and reduce sickness. Air pollution, accidents and noise all cause health problems for the local population, patients, staff and visitors and are caused by cars, as well as other forms of transport. Increased patient and staff numbers have resulted in an increase in business travel. The Trust bus service between the major sites is still active and transporting more people than ever before and so reducing reimbursed car mileage.

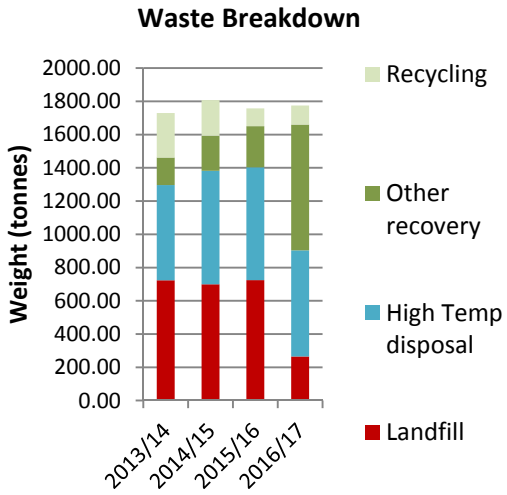
Category	Mode	2013/14	2014/15	2015/16	2016/17
Patient & visitor travel	Miles	160,990,704	166,216,506	171,390,938	178,975,901
	tCO_2e	59,481	61,072	61,981	64,683
Business travel & fleet	Miles	1,665,175	1,170,280	1,319,789	1,037,636
	tCO_2e	615	430	477	375
Staff commute	Miles	4,419,865	4,610,964	4,493,769	4,927,968
	tCO_2e	1,633	1,694	1,625	1,781

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.

Waste

The Trust has entered into a new total waste management contract as a member of the South East NHS Total Waste Management Consortium. The contract has been bedding in and the intention is to use 2017/18 to drive efficiencies in waste disposal costs and also in performance. It is intended to increase the level of recycling being removed from the hospital sites through better segregation at the point of production and the more proactive separation of waste within the hospital loading areas.

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



Water

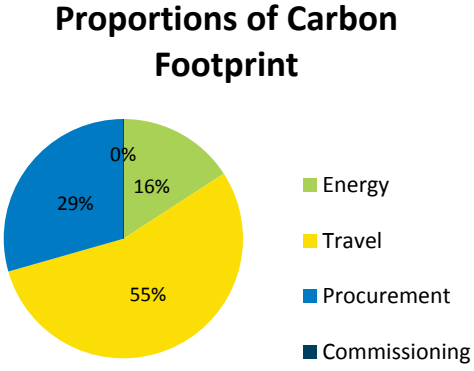
The Trust recognises that its water consumption is increasing on an annual basis, within the acute hospitals and the laundry operations. The acute sites are completely linked to patient attendances and the laundry is due to the increased throughput at the sites and the extension of laundry services to other NHS Trusts. The Trust has partnered with Aquafund to allow capital investment into water saving infrastructure and processes across the Trust. It is anticipated that the partnership, at no cost to the Trust, will allow it to realise its water reduction target of 20% by 2020 against a baseline of 2013.

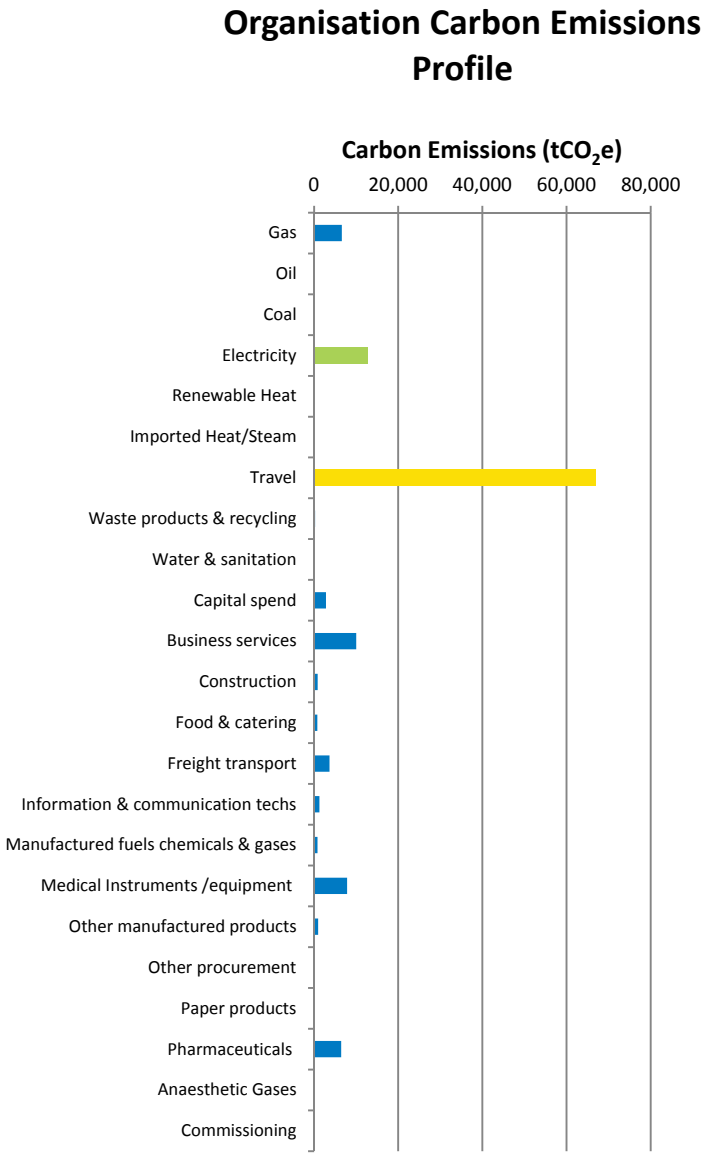
Water		2013/14	2014/15	2015/16	2016/17
Mains	m^3	186,570	186,441	205,246	209,205
	tCO_2e	170	170	187	190
Water & Sewage Spend		£684,307	£539,538	£582,869	£661,990

Modelled Carbon Footprint

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

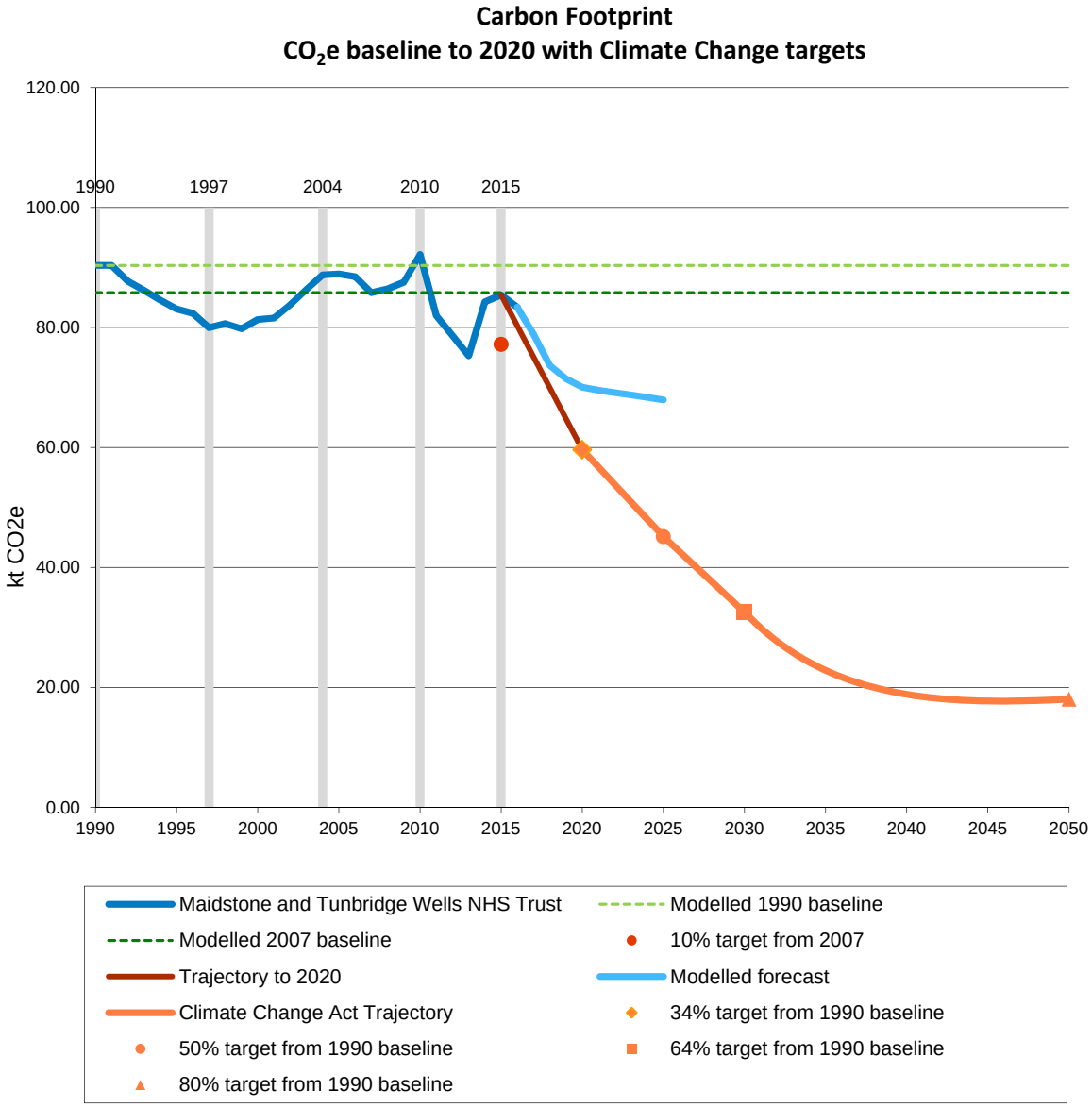
The application of this model results in an estimated total carbon footprint of 122,197 tonnes of carbon dioxide equivalent emissions (tCO_2e). The Trust's carbon intensity per pound is 268 grams of carbon dioxide equivalent emissions per pound of operating expenditure (gCO2e/£). Average emissions for acute services is 200 grams per pound.





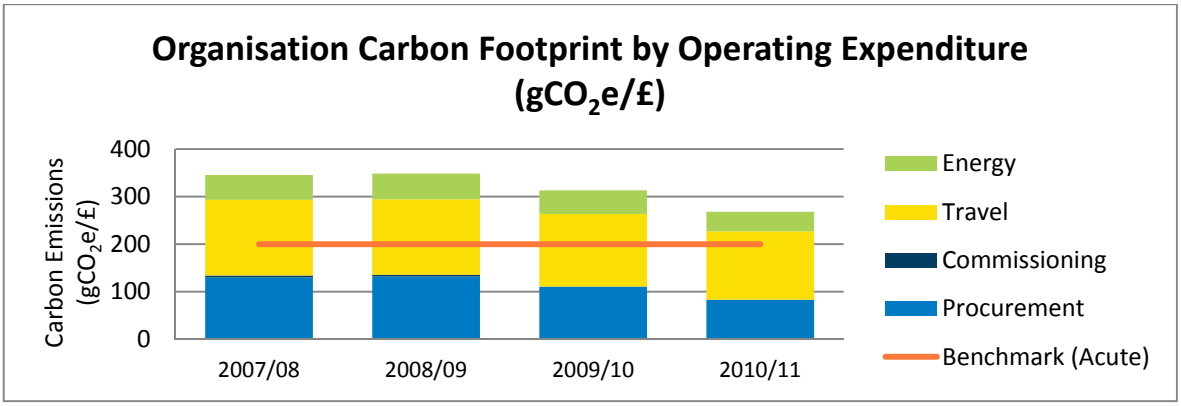
Modelled trajectory

The Trust is currently above the 'trajectorised' emissions level and, with an increasing and aging population, and most of the emissions caused by scope 3 items (mainly pharmacy products, Medical equipment and travel emissions), it recognises that the task in hand is formidable. The Trust is committed to engaging with supply chain partners, other NHS organisations and the wider care providing community within Kent to identify areas of opportunity for reduction of scope 3 emissions.



Modelled benchmark

The Trust recognises that the scope modelled carbon footprint is higher than the benchmark for acute providers and further appreciates that this is largely related to travel. By way of mitigation, the Trust has a large catchment area and hosts the Kent Oncology Centre which leads to an increased level of patient contact and subsequent transport related emission.



Adaptation

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

The Trust recognises that the process of climate change is leading to the normal patterns of weather changing and severe weather events becoming more frequent and prolonged. These include heatwaves, drought and water shortage, extreme cold events and associated snowfall, extreme rainfall and associated fluvial (surface water) flooding, changes to groundwater levels and associated groundwater flooding, severe storms and high winds.

The Trust will prepare plans for the risks identified and will integrate the process of planning with the existing processes for Emergency Planning and Business Continuity.

NHS
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Accountability Report for 2016/17: Corporate Governance report

taking pride

Directors' report

The Trust Board

The role of the Trust Board is to determine strategy and policy for the Trust, to monitor in-year performance against plans, to ensure accountability by holding the organisation to account for the delivery of strategy and to ensure the Trust is well managed and governed. The Trust Board comprises the roles of Chair (Non-Executive), 5 other Non-Executive Directors (voting members), the Chief Executive, and 4 Executive Directors (voting members). Other Directors (non-voting) also attend the Board, and contribute to its deliberations and decision-making. The Non-Executive Directors (NEDs) bring a range of skills and expertise from outside the NHS; their role is to hold Executive Directors to account. The Trust used an executive search facility to ensure that one Non-Executive Director vacancy which arose during the year was widely advertised to attract the broadest range of appropriately skilled candidates. The Trust Board meets monthly, except in August, in public. The times and venues of these meeting are advertised on the Trust's website, which also contains the agendas, minutes & reports (see www.mtw.nhs.uk/about-us/trust-board/). The 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.

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 2016/17, the Trust Board had the following members:

David Highton

Chair (from) 8th May 2017*

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

Kevin Tallett

Non-Executive Director [8] * ♎

Kevin joined the Trust Board in June 2008, and in addition to his role on the Trust Board (for which he is the Vice-Chair), Kevin attends several other Trust Board sub-committees, one of which he chairs (the Audit and Governance Committee). He is also the Trust's "Senior Independent Director" and "Speak Out Safely Guardian". Kevin has had a highly successful career at a senior level in the energy industry and was previously Enterprise IT Strategy, Architecture and Change Director at EDF Energy (which included looking after corporate and enterprise-wide change projects). Prior to that, his roles include Director of IT Operations at EDF, leading a team of 550 people and with a multi-million pound budget.

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

[8] Kevin Tallett also acted as Chair of the Board from 1st March to 7th May 2017, to cover the period between the departure of the previous Chair, Anthony Jones, and the arrival of David Highton

Trust Board Members (continued)

Glenn Douglas

Chief Executive*∑

As the Trust's "Accountable Officer", Glenn is responsible for the overall development and performance of the Trust. In addition to being a Board member, he attends several Board sub-committees. Glenn has previously been Chief Executive at Ashford and St Peters Hospitals and Eastbourne Hospitals NHS Trusts, and is currently a member of the Independent Reconfiguration Panel (IRP). Glenn is also the Senior Responsible Officer (SRO) for the Kent and Medway Sustainability and Transformation Plan (STP). His career is mainly NHS, having worked finance and operational management in a number of other Trusts and Health Authorities in Sussex, Kent and Manchester. He is a qualified accountant and member of the Institute of Health Services Managers, and is also a governor of a local school. Glenn became Chief Executive in October 2007

Sarah Dunnett OBE

Non-Executive Director*♎

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

Angela Gallagher

Chief Operating Officer*∑

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

Richard Hayden

Director of Workforce∑

Richard joined the Trust Board in March 2016, and is accountable for the development of the Trust's workforce strategy, Organisational Development and Human Resource (HR) management. In addition to his role on the Board, Richard attends a number of Board sub-committees. Richard joined the Trust in January 2008, to focus on organisational development and learning, and since 2011 was the Deputy Director of Workforce. Richard has held various management and HR positions in a NHS career spanning over 14 years. Richard holds a BSc honours degree in Geography from Aberdeen University, an MA in Human Resources Management, a postgraduate diploma in Health and Social Care Management, is a qualified coach and mentor, and is a Chartered Fellow of the CIPD (Chartered Institute of Personnel and Development). Richard is also a Non-Executive Director for the Valley Invicta Academies Trust.

Alex King MBE

Non-Executive Director*♎

Alex Joined the Trust Board in September 2014. Alex has a strong business background, and has worked in the local health service before in a Non-Executive capacity. He is also one of the longest serving Councillors on Kent County Council. Alex was Deputy Leader of the County Council for a number of years and is currently Chairman of their Policy and Resources Cabinet Advisory Committee. His business background is in management consultancy, specialising in Human Resources, general management and organisation and business development. Alex lives in Hawkhurst with his wife, Susan. In addition to his role on the Board, Alex chairs one of the Board's sub-committees (the Workforce Committee).

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

Trust Board Members (continued)

Jim Lusby

Deputy Chief Executive[Σ]

Jim joined the Trust Board in April 2015 and leads on the development of strategy. Before joining the Trust Jim was a Portfolio Director at the NHS Trust Development Authority (TDA), with responsibility for oversight of NHS Trusts in the South East. During his final five months with the TDA he acted into the position of Director of Delivery & Development for the South of England. Jim joined the TDA from King's Health Partners where he was Director of Integrated Care. He previously held senior positions in South East London Strategic Health Authority, the Department of Health and the Prime Minister's Delivery Unit.

Peter Maskell

Medical Director[*Σ]

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

Sara Mumford

Director of Infection Prevention and Control

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

Claire O'Brien

Interim Chief Nurse[*Σ]

Claire has worked in the NHS for over 37 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's Corporate Nursing team 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 is keen to ensure that the Trust continues to actively engage patients in shaping its services. Claire also has a particular interest in engaging with staff and supporting them in their development, recognising the relationship between staff and patient experience, and feels it is vital that staff are valued and supported to provide the best possible care at all times

Steve Orpin

Director of Finance[*Σ]

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

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

The following persons also served on the Trust Board during 2016/17:

- Avey Bhatia, Chief Nurse (joined the Board in July 2013, and left, via a secondment to St George's University Hospitals NHS Foundation Trust, on 31st January 2017)

- Sylvia Denton, Non-Executive Director (joined the Board in March 2008, and left on 28th February 2017)
- Anthony Jones, Chairman of the Board (joined the Board in March 2008, appointed Chairman in January 2009, and left on 28th February 2017)
- Paul Sigston, Medical Director (joined the Board in March 2010, and left on 8th February 2017)
- Steve Tinton, Non-Executive Director (joined the Board in April 2013, and left on 28th September 2016)

With effect from the confirmation of Financial Special Measures in July 2016, Simon Worthington was appointed Finance Improvement Director, but was not a member of the Trust Board and did not attend Trust Board meetings. Mr Worthington's formal relationship with the Trust ended after the Financial Special Measures Review meeting on 30/01/17. Similarly, as part of the Trust's participation in Phase 1 of the Financial Improvement Programme in May 2016, Jane Hurst was appointed Improvement Director, but again, was not a member of the Trust Board, although Ms Hurst attended Trust Board meetings in June and July 2016, before leaving the Trust on 5th August 2016.

Statement as to disclosure to auditors

Each Director can confirm that as far as they are aware there is no relevant audit information of which the Trust's auditors are unaware; and that they have taken all the steps that they ought to have taken as a Director in order to make themself aware of any relevant audit information, and to establish that the Trust's auditors are aware of that information.

Attendance at Trust Board meetings

There were 12 formal Trust Board meetings in 2016/17. Attendance at each meeting is shown below:

Trust Board Member (see above for the time served on the Board during 2016/17)	April 2016	May 2016	June 2016	July 2016	Sept (15th) 2016	Sept.(28th) 2016	Oct. 2016	Nov. 2016	Dec 2016	Jan 2017	Feb 2017	March 2017
Anthony Jones, Chairman	Apologies	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	N/A[9]
Glenn Douglas, Chief Executive	✓	✓	Apologies	✓	✓	✓	✓	✓	Apologies	✓	✓	✓
Avey Bhatia, Chief Nurse	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	N/A[10]	
Sylvia Denton, Non-Executive Director	✓	✓	✓	✓	Apologies	✓	✓	✓	✓	✓	✓	N/A[11]
Sarah Dunnett, Non-Executive Director	✓	✓	✓	✓	Apologies	✓	✓	✓	✓	✓	✓	Apologies
Angela Gallagher, Chief Operating Officer	✓	✓	✓	✓	✓	✓	Apologies	✓	✓	✓	Apologies	✓
Richard Hayden, Director of Workforce	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Alex King, Non-Executive Director	✓	✓	Apologies	Apologies	✓	✓	Apologies	Apologies	Apologies	✓	✓	✓[12]
Jim Lusby, Deputy Chief Executive	✓	✓	Apologies	✓	✓	✓	✓	✓	✓	✓	✓	✓
Peter Maskell, Medical Director					N/A[13]						✓	✓
Sara Mumford, Director of Infection Prevention & Control	✓	✓	✓	✓	✓	✓	✓	Apologies	✓	✓	Apologies	✓
Claire O'Brien, Interim Chief Nurse					N/A[14]						✓	✓
Steve Orpin, Director of Finance	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Paul Sigston, Medical Director	✓	✓	✓	✓	✓	Apologies	✓	✓	✓	✓	N/A[15]	
Kevin Tallett, Non-Executive Director	✓	Apologies	✓	✓		✓	✓	Apologies	✓	✓	✓	✓
Steve Tinton, Non-Executive Director	✓	✓	✓	Apologies	✓	✓	N/A[16]					

[9] Anthony Jones left the Board on 28th February 2017
[10] Avey Bhatia left the Board on 31st January 2017
[11] Sylvia Denton left the Board on 28th February 2017
[12] Alex King was in attendance by teleconference only for matters requiring decision by the Trust Board on 29th March 2017
[13] Peter Maskell joined the Board on 8th February 2017
[14] Claire O'Brien joined the Board on 1st February 2017 as Acting Chief Nurse, and was formally appointed as Interim Chief Nurse on 27th February 2017
[15] Paul Sigston left the Board on 8th February 2017
[16] Steve Tinton left the Board on 28th September 2016

Appointment and evaluation of Trust Board Members' performance

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

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

Members of the Trust Board also undertake a self-assessment in line with fit and proper persons requirements (FPPR[17]). No issues or concerns have been raised in relation to this.

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 2016/17 for those on the Board at the end of that year were as follows:

Director (see above for the time served on the Board during 2016/17)	**Details of notifiable interest**
Glenn Douglas, Chief Executive	▪ Director 4P Consultants Ltd (company no: 09998884)[18] ▪ Senior Responsible Officer (SRO) for the Kent and Medway Sustainability and Transformation Plan
Sarah Dunnett, Non-Executive Director	▪ Trustee of The Sevenoaks Almhouse Charity (charity number: 226418) ▪ Governor of Sevenoaks School (**www.sevenoaksschool.org** / charity number: 1101358; company number: 04908949)
Angela Gallagher, Chief Operating Officer	None
Richard Hayden, Director of Workforce	▪ Trustee of Valley Invicta Academies Trust (company number: 07559256)
Alex King, Non-Executive Director	▪ Member of Kent County Council – Councillor for Tunbridge Wells Rural (Wards: Brenchley & Horsmonden, Capel, Goudhurst & Lamberhurst, Paddock Wood) (ceased 08/05/17) ▪ Chairman of Kent County Council Policy and Resources Committee (ceased 08/05/17) ▪ Chairman of Paddock Wood Community Advice Centre (company number: 08006468) ▪ Trustee of Cranbrook School (charity number: 290237) ▪ President Tunbridge Wells Conservatives ▪ President Kent Conservatives ▪ Chairman of The King Partnership Ltd (**www.kingpartnership.com** / company number: 02202346), which provides management & human resource consultancy services to clients in the UK & overseas
Jim Lusby, Deputy Chief Executive	None
Peter Maskell, Medical Director	None
Sara Mumford, Director of Infection Prevention & Control	None
Claire O'Brien, Interim Chief Nurse	None
Stephen Orpin, Director of Finance	▪ Director NHS Innovations South East Limited (company number: 05210174) – serves as a Director as a result of the Trust acting as Guarantor
Kevin Tallett, Non-Executive Director	▪ Owner/Director Discidium Ltd (company number: 10042570) ▪ Engaged with Medway NHS Foundation Trust via Discidium Ltd to deliver PMO Services, signed a confidentiality agreement to protect both Trusts' commercial interests (engagement ended 31/03/17)

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 2016/17 can also be obtained from the Trust Secretary.

[17] As introduced by The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014
[18] The Company has never traded since incorporation

Pension Liabilities

Details of how the Trust treats Pension Liabilities are outlined in the Principal Financial Statements (within Note 10.3).

Board sub-committees

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

The Trust's Management Structure

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

Division	Directorate
Urgent Care	▶ Acute and Emergency ▶ Specialist Medicine and Therapies
Planned Care	▶ Surgery ▶ Head and Neck ▶ Trauma and Orthopaedics ▶ Critical Care ▶ Cancer and Haematology ▶ Diagnostics and Pharmacy
Women's, Children's and Sexual Health	▶ Women's and Sexual Health ▶ Children's Services

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

Complaints: Ready to listen, ready to learn

The Trust aims to provide the best possible care and treatment but sometimes, despite the best efforts of staff, things can go wrong. In such circumstances, patients and relatives are encouraged to tell a member of staff on the Ward or in the clinic as soon as they can, to enable their concerns to be responded to as soon as possible. However, for circumstances where concerns cannot be resolved in this way, the Trust has a formal complaints process.

In 2016/17, the Trust received 326 formal complaints (in 2015/16, this was 513), and 69% of complaints received were responded to within the agreed timescale.

The Trust's Complaints and Patient Advice and Liaison Service (PALS) – Annual Report (due for publication in June 2017) (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 Manager and senior Directorate management team, with input from Legal Services as required. During 2016/17, the Trust offered financial remedy in 3 cases, totalling £1,640[19]. Financial redress was also recommended by the PHSO in a further 4 cases, at a total of £10,600[20]. This process excludes any claims for clinical negligence, which are pursued under the Trust's Claims Management Policy.

Disclosure of personal data-related incidents

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

Date (month)	Nature of incident	Nature of data involved	No. of people potentially affected	Notification steps
February 2017	Non-secure disposal - paperwork	NHS Number Name Date of Birth	3	Individuals notified
Further action on information risk	As a result of this incident, a Root Cause Analysis was undertaken and staff members have been reminded of their responsibilities relating to confidentiality and data protection under the principles of the Data Protection Act 1998. The Information Commissioner's Office confirmed that no further action would be taken.			

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

Category	Nature of Incident	Total
A	Corruption or inability to recover electronic data	1
B	Disclosed in error	38
C	Lost in transit	0
D	Lost or stolen hardware	3
E	Lost or stolen paperwork	13
F	Non-secure disposal – hardware	0
G	Non-secure disposal – paperwork	1
H	Unloaded to website in error	1
I	Technical security failing (including hacking)	0
J	Unauthorised access/disclosure	6
K	Other	4

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.

[19] This is based on complaints received between 01/4/16 and 31/03/17 inclusive, though some complaints received towards the end of that period are still open at the time of this report, so further financial redress may be offered

[20] This is based on recommendations made by the Parliamentary and Health Service Ombudsman between 01/04/16 and 31/03/17, but not all of the relevant complaints were received within that time span

Emergency preparedness

During the year the Emergency Preparedness team continued to increase the resilience of the Trust, foster and enhance partnerships across the county and develop innovative training for those involved in emergency response. As a Category One responder under the Civil Contingencies Act 2004, the Trust has specific statutory duties in relation to emergency planning and response. In addition, the Trust has other obligations as required by contracts and performance standards set by NHS England and Clinical Commissioning Groups (CCGs), and throughout the year a continuous process of exercising, testing, training, assurance took place. In 2016, the Trust self-assessed itself and was rated fully compliant against NHS England's Core Standards for Emergency Preparedness, Resilience and Response (EPRR).

Incidents that took place during the year

- As noted earlier in the Report, during 2016 the British Medical Association was engaged in dispute with the Government and industrial action was taken by Junior Doctors leading, in April, to activation of business continuity plans. A table-top exercise was also held with key departments to ensure all contingencies were planned for
- Heavy traffic, roadworks and road traffic collisions led to gridlock at Maidstone Hospital on several occasions during the year. This trapped traffic on the site and caused delays for staff, patients, ambulances and deliveries. Meetings were held with Highways and Police, resulting in the issue being escalated to the Kent Resilience Forum for resolution with partner agencies. It is recognised that the situation will become more acute as more housing is built in the area. The importance of maintaining helicopter landing facilities at Maidstone Hospital is therefore critical.
- Maidstone Hospital experienced failure of paging services which required activation of business continuity plans to maintain services
- The construction of the A21 dual carriageway at Pembury closed the Tonbridge Road & multi-agency working resulted in 'Operation Radiate' to maintain access to Tunbridge Wells Hospital in an emergency
- In the late summer, a number of heat wave alerts were issued for the South East which required activation of the Trust's heatwave plan.

Multi-agency cooperation & training

In 2016 the Trust was asked to support East Kent Hospitals NHS Foundation Trust in their emergency planning and response after a recent CCG audit. This resulted in a partnership between the Trusts and the sharing of a team and good practice across the two acute organisations.As well as working closely with other local Trusts, there was constructive collaboration with a range of multi-agency partners during the year. The Trust's innovative Command Accreditation Scheme continued, with the launch of Gold Strategic Level training in addition to Silver Tactical Training. The Trust has enjoyed representation from a number of other NHS Trusts, NHS England and CCGs from around the country on these courses.

The Trust has continued to foster good relationships with its helicopter providers and partnership working has allowed Coastguard Paramedics to train in the Trust's hospitals and Trust staff to receive live in-flight training to transfer patients to hospitals by air. The Trust has maintained an effective Chemical, Biological, Radiological and Nuclear (CBRN) & hazmat Training scheme and the number of staff being trained, including those from other local Trusts, increased.

Training exercises during the year included:

- 'Exercise Reach' at Maidstone Hospital in November 2016 involved Kent Fire & Rescue Service and a live rescue from the plant rooms on the roof. This tested communications, command & control and multi-agency working. It also enabled Kent Fire Brigade to test new rescue equipment.
- 'Exercise Spring Day' was held in April 2016 in pouring rain at Maidstone Hospital to test plans for a Radiation Incident and involved Kent Police, Kent Fire Brigade & South East Coast Ambulance Service. The live exercise included loggists, clinical staff, estates & facilities and managers and tested procedures learned on command courses including dynamic risk assessments and media training
- 'Exercise Polar' was a tabletop exercise held in Tunbridge Wells in October to test winter preparedness. This took into account the feedback from last winter's debrief and involved partners from other NHS Trusts, South East Coast Ambulance Service NHS Foundation Trust and Local Authorities.

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

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

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

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

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

I confirm that the Annual Report and Accounts as a whole is fair, balanced and understandable and that I take personal responsibility for the Annual Report and Accounts and the judgments required for determining that it is fair, balanced and understandable.

Glenn Douglas, Chief Executive,

24th May 2017

Governance Statement for 2016/17

1. Scope of responsibility

As Accountable Officer and Chief Executive of Maidstone and Tunbridge Wells NHS Trust, I have responsibility for maintaining a sound system of internal control and governance that supports the achievement of the Trust's policies, aims and objectives whilst safeguarding quality standards and public funds. I acknowledge these and my other responsibilities, as set out in the Accountable Officer Memorandum for Chief Executives of NHS Trusts[21].

This statement describes the internal control and governance framework that has been in place at Maidstone and Tunbridge Wells NHS Trust for the period 1st April 2016 to 31st March 2017.

2. The governance framework of the organisation

The Trust Board

The Trust Board meets in public every month (with the exception of August), although the Board met twice in September 2016, in order to consider its Financial Recovery Plan (FRP). The agenda for Board meetings is mainly focussed around the key aspects of operational performance; quality; planning and strategy; assurance and policy; and reports from its sub-committees. A separate ('Part 2') meeting is held on the same day as the meeting held in public, to consider confidential matters, in accordance with the Public Bodies (Admission to Meetings) Act 1960. A 12-month rolling forward programme of agenda items is actively managed to ensure the Board receives the information, and considers the matters it requires to perform its duties efficiently and effectively.

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

In 2016/17, the following changes in personnel occurred within the Trust Board:

- Steve Tinton (NED) left the Trust Board on 28/09/16
- Avey Bhatia (Chief Nurse) went on secondment to St Georges NHS Foundation Trust on 31/01/17. Claire O'Brien then started in post as Acting Chief Nurse on 01/02/17, and was formally appointed as Interim Chief Nurse on 27/02/17
- Paul Sigston's tenure as Medical Director ended on 08/02/17, and Peter Maskell's tenure as Medical Director started on 08/02/17
- Anthony Jones' (Chairman of the Trust Board) term of office expired on 28/02/17. Kevin Tallett then acted as Chair of the Trust Board from 01/03/17 to 07/05/17 (as the newly-appointed Chair, David Highton, started his term of office on 08/05/17)
- Sylvia Denton's (NED) term of office expired on 28/02/17

Board sub-committees and other key forums

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

- The Audit and Governance Committee. This supports the Trust Board by critically reviewing the governance and assurance processes on which the Board places reliance. This therefore incorporates reviewing Governance, Risk Management and Internal Control (including the Board Assurance

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

Framework); oversight of the Internal and External Audit, and Counter Fraud functions. The Committee also undertakes detailed review of the Trust's Annual Report and Accounts, and has been appointed (by the Trust Board) as the Trust's Auditor Panel, in accordance with Schedule 4, Paragraph 1 of the Local Audit and Accountability Act 2014. The Auditor Panel advises the Trust Board on the selection, appointment and removal of external auditors (for appointments for 2017/18), and on the maintenance of independent relationships with such auditors, and carried out this role for the appointment of the Trust External Auditor, which the Trust Board approved in November 2016. The Audit and Governance Committee is chaired by a NED, and meets 5 times each year (including a specific meeting to review the Annual Report and Accounts prior to the Trust Board being asked to approve these). All other NEDs (apart from the Chair of the Trust Board) are members.

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

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

Although not a Board sub-committee, the Trust Management Executive (TME) is the senior management committee within the Trust. Its purpose is to oversee and direct: the effective operational management of

the Trust, including achievement of standards, targets and other obligations; the delivery of safe, high quality, patient-centred care; the development of Trust strategy, culture and policy; and the identification, mitigation and escalation of assurance and risk issues. The TME meets monthly, and is chaired by the Deputy Chief Executive.

In addition to focussing on internal governance and risk, the Trust, and Board, has continued to engage fully with the work of the Kent & Medway STP. I am the Senior Responsible Officer (SRO) for the STP, whilst the Trust's Medical Director is the Chair of the STP's Clinical Board, and the Director of Finance is the Chair of the STP Productivity workstream. In November 2016, the Trust Board received the draft STP ("Transforming health and social care in Kent and Medway"), and confirmed its support for the 'direction of travel' described in the Plan. Then, in March 2017, the Board received, and agreed to support, the case for change for the STP.

Reports from Board sub-committees

The Trust Board receives a written summary report from each meeting of its main sub-committees (and the TME) in a timely manner, supplemented by a verbal report from each sub-committee Chair, which highlights the main subjects discussed, and draws attention to any matters requiring the Board's consideration and/or action (there is a specific section for this within the reporting template). The Audit and Governance Committee also submits an Annual Report to the Board, in May, to inform the Board's consideration of the Annual Report and Accounts. The issues specifically drawn to the attention of the Board by its sub-committees in 2016/17 included the following:

- Significant progress had been made in Critical Care since the Care Quality Commission (CQC) inspection in October 2014, but a number of challenges remained, particularly in relation to the recruitment of Consultant Intensivists (from the Quality Committee, 13/04/16)
- The strategic and financial significance to the Trust of cancelled and missed appointments (from the Patient Experience Committee, 16/06/16)
- The concerns that had been raised by the Chief Nurse from West Kent Clinical Commissioning Group (CCG) at the level of Disclosure and Barring Scheme (DBS) checks undertaken at the Trust (from the Quality Committee, 06/07/16) (N.B. The Trust Board was subsequently given assurance on DBS checks at its 'Part 2' meeting on 20/07/16)
- That the outcome of the current review of bed configuration/capacity should be submitted to the 'Part 2' Trust Board meeting in September 2016, whilst the detailed response to the recommendations from the Lord Carter-led operational productivity and performance review should be submitted to the Trust Board in September 2016 (from the Finance Committee, 18/07/16)
- The agreement obtained from the Specialist Palliative Care Team that all appropriate patients would be on an Integrated Care Pathways (ICPs) by 01/08/17 (to fully support the Trust's claims that it managed its End of Life Care patients in an appropriate way) (from the Quality Committee, 01/08/16)
- The outcome of the Quality Committee's review of the draft Financial Recovery Plan (from the Quality Committee, 14/09/16)
- The Patient Experience Committee's highlighting of the positive nature of the Patient-led Assessment of the Care Environment ('PLACE') findings - particularly the significant improvement that had been recognised in the "Condition, Appearance and Maintenance" category, following the major investment in Maidstone Hospital in 2015, and the fact that the results achieved by the Trust for 2016 were above the national average across the board (from the Patient Experience Committee, 06/09/16)
- The Finance Committee's recommendation to replace objective 4.b within the Board Assurance Framework (BAF) ("To improve on the Trust's Income and Expenditure plan for 2016/17") with an alternative objective ("To deliver the control total for 2016/17"); and the Committee's recommendation that the Agency self-certification checklist required to be submitted to NHSI be approved by the Trust Board (from the Finance Committee, 28/11/16)

- The Charitable Funds Committee's agreement that the Director of Finance would report to the Trust Board in January 2017 on the findings from his review of expenditure for the current year, with a view to identifying items that might be retrospectively classified as Charitable Funds expenditure (from the Charitable Funds Committee, 28/11/16)
- The Finance Committee's review of the Business Case to replace a Linear Accelerator (LinAc) at Maidstone Hospital, and the agreement to recommend that the Board approve the Case (from the Finance Committee, 19/12/16)
- The Finance Committee concern at the recent formal request by West Kent CCG for the Trust to reduce non-elective activity, the unsatisfactory arrangements for the management of backlog and the need for the Trust Board to consider a formal written response; and the Committee's notification of the unpaid invoices to CCGs in respect of the Trust's costs for hosting the Sustainability and Transformation Plan (STP), as well as raising the wider issue of the governance of expenditure on STP (from the Finance Committee, 23/01/17)
- The Audit and Governance Committee's concern about the 'red' status of BAF objective 5a (62 day cancer waiting time target) (from the Audit and Governance Committee, 02/02/17)
- The Charitable Funds Committee's agreement to support the establishment of a fundraiser role, linked to a strategic appeal and as part of a wider engagement strategy within the Trust, and that the Trust Board should be invited to approve the establishment of the post (from the Charitable Funds Committee, 20/02/17)
- The Workforce Committee's review of the first quarterly Guardian for Safe Working Report (from the Workforce Committee, 09/03/17)
- The Quality Committee's concern that the Symphony A&E IT system would be unsupported in August 2017, and the version currently being used had not had the last circa 9 updates applied (from the Quality Committee, 15/03/17) (N.B. The Trust Board then discussed this issue at its 'Part 2' meeting on 29/03/17)

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

In addition, two Board 'away day' meetings were held, in June and November 2016. These enabled discussion of the Trust's future strategy, particularly in light of the Kent & Medway STP. The Trust's FRP draft planning submissions for 2017/18 and 2018/19 were also reviewed at the November 2016 'Away Day'.

Assessment of the Trust's Corporate Governance

The Board assesses its effectiveness, and that of its sub-committees, via a range of methods. The Terms of Reference of the Board and its sub-committees are reviewed annually, to ensure the role and function of each reflects the Board's wishes. The Terms of Reference of the Trust Board and all its sub-committees were reviewed and approved in 2016/17. Formal self-evaluations were undertaken in the year by the Trust Board, Audit and Governance Committee, Finance Committee, and Quality Committee, with the findings discussed at those meetings (in May 2016, August 2016, December 2016 and January 2017 respectively).

To support the Trust's corporate governance framework, a Chartered Secretary is employed, as Trust Secretary. The post-holder supports the Trust Board in the discharge of its statutory functions and duties, and ensures that any issues regarding legal compliance, as well as best practice in corporate governance, are drawn to the Board's attention. To the best of my knowledge, the Trust Board, and the wider organisation, has complied with its legal obligations during 2016/17, and is, in general, compliant with those aspects of the UK Governance Code considered to be relevant to the Trust.

Arrangements for the discharge of statutory functions

I can confirm that the Trust's arrangements in place for the discharge of statutory functions have been checked for any irregularities, and that, to the best of my knowledge, they are legally compliant

Quality Governance

The Trust's Quality Governance arrangements are managed via the Trust Clinical Governance Committee (and its sub-committees); and via a number of associated systems and processes. As noted above, the Quality Committee then aims to seek and obtain assurance on the effectiveness of these structures, systems and processes. The arrangements are described in detail within the Trust's annual Quality Accounts, which are reviewed by the Quality Committee, approved by the Trust Board, and published as a separate document. The Trust's Quality Accounts are also independently assessed by External Audit, with regards to whether the performance information reported therein is reliable and accurate. The audit of the 2015/16 Quality Accounts (which was concluded in 2016/17) resulted in an unqualified limited assurance report. The External Audit of the 2016/17 Quality Accounts will be available in the summer of 2017.

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

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

Regrettably, 4 'Never Events' occurred at the Trust in 2016/17, which were subject to Board-level scrutiny to ensure that lessons were learnt.

One of the key areas of focus for quality during the year has been the increased Hospital Standardised Mortality Ratio (HSMR), which stands at 110 for the latest 12-month period (to December 2016). The Trust Board and Quality Committee have reviewed the progress of the work to understand the reason/s for the increase, which has been led by the Medical Director, and this will continue to be closely monitored during 2017/18.

In May 2016, the TME and Trust Board received a report that enabled the Trust's Quality Improvement Plan that had been developed in response to the CQC's inspection in October 2014 to be formally closed. However, it was agreed at the Trust Board ('Part 2') meeting on 22/02/17 that the Quality Committee should receive a report confirming whether each issue described in the bullet points in the "Summary of findings" within the CQC's Quality Report that related to the inspection (that was published in February 2015) had been addressed. The Quality Committee duly considered the requested report in March 2017.

3. Risk assessment

Risks are identified, analysed and controlled in accordance with the Trust's Risk Management Policy. The Trust has a BAF and a Risk Register. The BAF is the document through which the Trust Board is apprised of the principal risks to the Trust meeting its objectives, and to the controls in place to manage those risks. In addition to the Trust Board, the BAF and Risk Register are reviewed at the Audit and Governance Committee and TME, whilst the financial aspects of both are reviewed at the Finance Committee.

As is the case every year, the BAF and Risk Register are subject to an Internal Audit review. The review for 2016/17, gave a "Reasonable Assurance" conclusion, and the report's "key findings" included the statements that "The Board Assurance Framework and Risk Management processes have been subject to regular review by the Trust, including at the Trust Board, Audit and Governance Committee and the Trust

Management Executive", "Clear processes are in place within the Trust to support the identification and management of risks" and "A robust reporting structure to the Trust Board is in place".

A number of new risks were identified in-year, which were considered and overseen by the process described above. The 4 'red-rated' risks on the Risk Register in September 2016 (which included the costs involved in the use of temporary staff; the failure to meet Cancer waiting time targets; and the Trust's long-term financial viability) were reviewed in detail by the TME in that month. The TME was asked, for each risk, whether further action should be taken to reduce the risk; whether the risk score/rating should be moderated (on the basis of a collective assessment of the actual risk); or whether the risk should be accepted as rated in the short-term (as the actions currently taken and/or planned are expected to enable the risk to be mitigated). The TME also agreed to a proposal that red-rated risks should be subjected to regular review at Executive Team meetings, rather than this review being undertaken at the TME.

In July 2016, the Trust Board agreed the key risks faced by the Trust for 2016/17, and how these should be reflected in the Trust's objectives. The Trust Board also approved the proposal to focus on a deliberately small number of higher-level objectives to act as proxy indicators (i.e. a 'litmus test') for broader performance. The 5 key risks were agreed as follows:

1. The Trust fails to improve key aspects of clinical care and safety
2. The Trust is unable to manage (either clinically or financially) during the winter period
3. The Trust does not have the correct level of substantive workforce for effective delivery
4. The Trust fails to demonstrate an ability to achieve future financial viability
5. The Trust fails to maintain and improve its reputation as a Cancer provider

The associated objectives that were agreed were as follows:
1.a. To reduce the falls rate to less than 6.2 per 1,000 occupied bed days
2.a. To achieve an average Length of Stay for elective care of 3.2 days
2.b. To achieve an average Length of Stay for non-elective care of 6.8 days2
3.a. To reduce the vacancy rate to 8.5%
4.a. To maintain operational liquidity whilst reducing working capital (from the planned level for 2016/17)
4.b. To improve on the Trust's Income and Expenditure plan for 2016/17 (as noted above, this objective was subsequently amended, in November 2016, to "To deliver the control total for 2016/17")
5.a. To deliver the Trust's 2016/17 agreed trajectory regarding the 62-day Cancer waiting time target

The Trust Board received formal updates on the performance of each objective, and the management of risks to non-achievement, via the BAF, at its meetings in September and November 2016 and February 2017. A BAF 'closure' report for the objectives is scheduled to be received in April 2017.

The Trust had one notifiable Information Governance Serious Incident Requiring Investigation (SIRI) in 2016/17, which related to the discovery of some patient identifiable information in Pembury village. The Trust's Senior Risk Information Owner (SIRO) and Caldicott Guardian were involved in the response. The Information Commissioner's Office (ICO) confirmed that no action would be taken against the Trust, but the Trust has accepted that there needs to be learning from the incident, and processes may need to be reviewed.

4. The risk and control framework

The Trust has in place a range of systems to prevent, deter, manage and mitigate risks and measure the associated outcomes. Some of these systems are described in the "The governance framework of the organisation" and "Risk assessment" sections above, and in addition to the Trust's Risk Management Policy, a full range of risk management policies and guidance is made available to staff. This includes the procedures for incident reporting, managing complaints, risk assessment, 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 Governance Department includes clinical risk management; clinical governance; clinical audit; complaints; PALS; staff health and safety; medico-legal service and claims handling; research and

development; and the management of all clinical and non-clinical incident reporting. In addition, Directorates and sub-specialities have identified 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.

In addition, a number of specific risk-related roles are held by Trust Board Members. The Vice-Chair of the Trust Board is also the Senior Independent Director and "Freedom to Speak Up Guardian"; the Chief Nurse is the SIRO; the Medical Director is the Caldicott Guardian and the Responsible Officer (for Medical Revalidation); whilst the Chief Operating Officer is the Board Level Director (with fire safety responsibility), the Accountable Emergency Officer for Emergency Preparedness, Resilience & Response (EPRR), and the Security Management Director.

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

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

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

- The Trust has a "Patient Access to Treatment Policy and Procedure", which encompasses Standard Operational Procedures for waiting list management at all stages of a referral to treatment pathway. The Policy also states the responsibilities of key staff, including those for auditing data quality. The Policy is also currently being reviewed to ensure it is aligned with the Trust's new Patient Administration System (PAS) (see the "Significant issues" section below)
- The Trust also has an "Information Lifecycle Management Policy and Procedure", which describes the Trust's general approach to data quality, including the role of the Data Quality Steering Group
- There is a weekly validation process involving operational, management and information leads, to assure the quality of local and national waiting times reporting/data
- Compliance with the above Policies and processes is audited annually by Internal Audit (TIAA Ltd). At the time of writing this Annual Report, this audit was not completed, but Internal Audit had been able to report that testing of Referral to Treatment (RTT) data had not highlighted any issues with the processes or the data used for reporting purposes, which is consistent with previous year. [N.B. The final findings of the 2016/17 Audit will be included here when available]

5. Review of the effectiveness of risk management and internal control

As Accountable Officer, I have responsibility for reviewing the effectiveness of the system of risk management and internal control. My review is informed in a number of ways. The Head of Internal Audit provides me with an opinion on the overall arrangements for gaining assurance through the BAF and on the controls reviewed as part of the work of Internal Audit. The Head of Internal Audit Opinion for 2016/17 states that "In my opinion, there is "reasonable" assurance that Maidstone and Tunbridge Wells NHS Trust has a generally sound system of internal control, designed to meet the organisation's objectives and that controls are generally being applied consistently. However, some weaknesses in the design and/or inconsistent application of control put the achievement of particular objectives at risk".

Executive managers within the Trust who have responsibility for the development and maintenance of the system of internal control also provide me with assurance, via regular meetings and submission of reports to the Committees referred to above. The BAF and Risk Register processes also provide me with evidence that the effectiveness of controls to manage the risks to the organisation have been reviewed, and scrutinised appropriately. Further evidence is provided by a range of sources including reports from Internal Audit

(including Counter Fraud) and External Audit, and reports from external agencies, following inspections and/or accreditation visits.

The Audit and Governance Committee approves the Internal Audit plan for the year and receives details of the findings from each of the Internal Audit reviews that are undertaken. Summary reports of relevant Internal Audit reviews are also submitted to the TME and Quality Committee during the year. Although a number of the Internal Audit reviews completed in 2016/17 resulted in a 'Reasonable assurance' conclusion, a number also led to a conclusion of 'Limited assurance'. These latter reviews have, or will be, considered at the Audit and Governance Committee, and actions to address the weaknesses identified in controls have been taken (or will be taken during 2017/18).

6. Significant issues

In addition to those referred to earlier in the Governance Statement, the following issues are considered significant, and warrant disclosure:

- In May 2016, the Trust was one of 16 NHS Trusts selected to participate in Phase 1 of a national Financial Improvement Programme operated by NHSI. As part of the Programme, KPMG LLP was appointed to provide intensive financial support, and an Improvement Director attended meetings of the Finance Committee and Trust Board. The Trust's participation in the Programme ended in July 2016, as limited opportunities were identified to warrant the Trust proceeding to Phase 2
- In July 2016, NHSI placed the Trust into Financial Special Measures (FSM), to help improve its financial position and reduce its expected year-end deficit. As part of the FSM regime, NHSI appointed a Financial Improvement Director, Simon Worthington, to work with the Trust, as Mr Worthington had been successful in supporting a financial turnaround at his own organisation, Bolton NHS Foundation Trust (where he was the Deputy Chief Executive and Director of Finance). The Trust has been involved in a number of formal FSM review meetings with NHSI, and although significant progress has been made, it is recognised that more is needed ahead of the next review meeting, in May/June 2017. The Trust therefore remained in the FSM regime at the end of the year, but the engagement of the Financial Improvement Director was ended by NHSI after the FSM review meeting on 30/01/17.
- The Trust ended 2016/17 with a deficit of £10.9m (once Sustainability and Transformation Fund (STF) monies were taken into account), which meant the Trust did not meet its control total for the year (which was to achieve a surplus, after STF monies, of £4.7m). A significant factor in the size of the deficit was the fact that the Trust was not allowed to undertake the Capital to Revenue Transfer (of £4.2m) it had planned. The Finance Committee and Trust Board have closely monitored the financial position across the year, and the year-end deficit is in accordance with that forecast in January 2017. NHSI have also, via the FSM regime, monitored and overseen the Trust's position, and the remedial action being taken, which will continue into 2017/18
- Although the Trust successfully achieved its planned performance on a number of important indicators, including reducing the rate of patient falls and pressure ulcers, it failed to meet a number of key access targets for the year, including that for 62-day first definitive treatment for Cancer. The Trust Board has closely monitored this, and received a detailed report on performance at its 'Part 2' meeting in March 2017. The Board has made it clear that performance needs to improve, but has been assured, in part, by the approach taken, which has included holding 3 Cancer summits over the past 18 months. Improvement is expected in 2017/18
- The Trust also failed to achieve the access targets relating to A&E 4-hour waits and 18-week Referral to Treatment (RTT). The Trust Board has again closely followed the situation with both throughout the year, and although the performance is not regarded as acceptable, the Board has recognised that a number of external factors have had a significant adverse effect. In particular, attendances to the A&E department and non-elective admissions increased markedly during the year, a significant proportion of bed-days were lost as a result of Delayed Transfers of Care (DTOC), which were 6.7% for the year (compared the national maximum limit of 3.5%), and a number of staffing-related issues (such as the restrictions on the use of temporary staffing, and shortages within particular medical specialities) caused specific challenges. All of these factors have had a significant adverse effect on patient flow,

which has in turn affected the Trust's ability to reduce patient's average Length of Stay (which was one of the Trust's key objectives for 2016/17)

- In January 2017, the Coroner's Inquest into the death of Mrs Frances Cappuccini in October 2012 was concluded. HM Coroner issued a narrative verdict, and also issued a 'Report to Prevent Future Deaths' under paragraph 7, Schedule 5, of The Coroners and Justice Act 2009 and regulations 28 and 29 of the Coroners (Investigations) Regulations 2013. The Trust's response to this report was considered by the Trust Board at its ('Part 2') meeting on 29/03/17, and subsequently sent to HM Coroner.

Glenn Douglas, Chief Executive

24th May 2017

Maidstone and Tunbridge Wells NHS Trust

Accountability Report for 2016/17: Remuneration and Staff Report

taking pride

Our staff

The Trust understands that maintaining a highly skilled and engaged workforce is fundamental to its ability to provide the highest, consistent, quality care to its patients. This is particularly critical during times of increasingly high demand for the Trust's services and financial constraint. In 2016, the Trust took part in the 14th annual National NHS Staff Survey. The results remained in line with the 2015 scores. Importantly, the Trust remains above the national average yet again as a place to work or receive treatment and as many of its staff thought patient care was the Trust's top priority in 2016, as they did in 2015. The Trust continued with its strong performance for the percentage of staff who felt they had been appraised (94%) and scored within the top 20% of acute trusts for this finding. The Trust's score of 3.82 (out of a maximum score of 5) for staff engagement was in line with Trusts of a similar type. Other results included:

- Percentage of staff believing that the organisation provides equal opportunities for career progression or promotion: 90% (National Average 87%)
- Effective use of patient / service user feedback : 3.79 (National Average 3.72)
- Percentage of staff / colleagues reporting the most recent experience of harassment, bullying or abuse: 49% (National Average 45%)
- Percentage of staff experiencing physical violence from patients, relatives or the public in the last 12 months : 13% (National Average 15%)

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

- Staff health and wellbeing
- Quality of non-mandatory training and development
- Encouraging staff to report incidences of violence

The full survey results are available at: https://tinyurl.com/MTWstaffsurvey

Employee benefits

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

Staff numbers and costs

Average[22] staff numbers	Permanently employed (WTE)[23]	Other (WTE)	Permanently employed (expenditure) (£000s)	Other (expenditure) (£000s)
Medical and dental	621	101	60,165	15,004
Ambulance staff	0	0	0	0
Administration and estates	1091	64	32,716	2,107
Healthcare assistants and other support staff	1195	121	29,632	3,339
Nursing, midwifery and health visiting staff	1424	238	60,774	13,724
Nursing, midwifery and health visiting learners	13	0	244	0
Scientific, therapeutic and technical staff	511	44	22,066	3,411
Social Care Staff	0	0	0	0
Healthcare Science Staff	188	0	8,975	0
Other	0	0	0	0
Total	5043	568	214,571	37,585
Staff engaged on capital projects (excluded from above)	23	14	789	1,434

[22] 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.
[23] This excludes any staff on unpaid leave (and therefore does not equate to the WTE reported within the Sustainability Report)

Exit packages

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	25	£82,156	25	£82,156	None	0
£10,000 - £25,000	None	N/A	2	£25,769	2	£25,769	None	0
£25,001 - £50,000	None	N/A	0	0	None	0	None	0
£50,001 - £100,000	None	N/A	0	0	None	0	None	0
£100,001 - £150,000	None	N/A	0	0	None	0	None	0
£150,001 - £200,000	None	N/A	0	0	None	0	None	0
>£200,000	None	N/A	0	0	None	0	None	0
Total	N/A	N/A	27	£107,925	27	£107,925	N/A	N/A

Other Exit packages – disclosures (excluding compulsory redundancies)	Number of exit package agreements	Total Value of agreements (£)	Number of exit package agreements	Total Value of agreements (£)
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	27	£108,000	12	£63,000
Exit payments following Employment Tribunals or court orders	0	0	0	0
Non contractual payments requiring HMT approval *	0	0	0	0
Total	27	£108,000	12	£63,000

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.

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

The Trust meets with local Trade Union representatives formally, via the Joint Consultative Forum and the Joint Medical Consultative Committee. A quarterly Open Staff Meeting system also operates, to cascade information to all staff, which involves a face-to-face meeting with two Executive Directors (including the Chief Executive) at both hospital sites. A weekly Chief Executive's update ("Glenn's update") is issued to all staff via email, enabling key messages to be given on matters of note. The Trust also conducts 'Impressions' surveys throughout the year to help it gauge the level of satisfaction and engagement amongst staff. The Trust has a range of support mechanisms for staff, beyond that provided by their line manager. This includes a comprehensive Employee Assistance Programme providing 24 hour support and a full Occupational Health service.

Following the introduction of Financial Special Measures during the year, staff across the Trust have been consulted on and engaged with, through surveys, meetings and day to day line management, on the development and delivery of the Financial Recovery Plan, and regular communications are issued to update the Trust's workforce on progress against the Plan.

Education and Development

The Trust takes the ongoing development of its staff very seriously. Each hospital site has an Education Centre, giving dedicated teaching space to staff, and a library. Staff can expect to have an annual appraisal with a plan of personal development and access to education teams to support them with advice and guidance about their development needs. Over the past year the Trust recorded over 200 different in-house learning activities such as, courses on Time Management or Leadership Skills; Effective Minute-Taking; Microsoft Word and Excel skills; e-learning passes for subjects e.g. Safe Use of Insulin or Supporting Breastfeeding and competency assessments on various Medical Devices. Funding is also available for staff to access external training and over 700 staff benefitted from this in the past year. In 2016/17 the Trust continued its investment in additional training equipment (for example Skin and Vein Kits for IV Therapy and resus training equipment), improved the access to local schools for work experience opportunities, and ran training exercises for staff with HM Coastguard Rescue.

Equal opportunities

As demonstrated by the encouraging results in the staff survey, the Trust is committed to the equality agenda and continues to support the delivery of the Workforce Strategy, 2015-2010. The strategy demonstrates a commitment to creating a culture that promotes equality & embraces diversity in all its functions as both an employer and a service provider. The Trust's aim is to provide a safe environment, free from discrimination, and a place where all individuals are valued, treated fairly and accepted for who they are without exception. The Trust is in the first year of a new approach to embedding and mainstreaming equality into everything it does, which is spearheaded by a dedicated Staff Engagement and Equality lead.

In June 2016, the Trust implemented a new translation service, providing a one stop shop for all translation requirements. Provision includes written translation, face to face language translation, British Sign Language (BSL), Deaf/Blind services and telephone interpreting. Telephone interpreting is available 24 hours a day, 7 days a week, 365 days a year. Requests for face to face and BSL interpreting may be made both in-an-out-of-hours through an online portal.

A Cultural Diversity network was set up in late 2016 with the purposes of ensuring that the Trust continually improves equality in the provision of healthcare, other services and employment. It will ensure the Trust complies with equality, non-discrimination and human rights law & raise awareness of cultural diversity in the workplace through events, diversity days & initiatives. The Network will act as a forum for staff of different cultures to come together, share experiences and find support for the issues that affect them.

A survey in 2016, created in collaboration with Great Ormond Street Hospital, assessed how members of the Trust's Lesbian, Gay, Bisexual and Transgender (LGBT) community are treated at the Trust and the results will be used as a basis for creating an inclusive environment for its LGBT community as patients and staff within the organisation. The Trust works with Stonewall, a charity which supports people from the LGBT communities, and is pleased to be a Diversity Champion. The programme is an excellent framework for creating a workplace that enables LGBT staff to reach their potential.

The gender, age and ethnic group distribution of staff and Trust Board Members (Senior Managers) at the end of 2016/17 is set out below (the 2015/16 equivalent is in brackets):

Gender	Staff [head count]		Trust Board Members [24]	
Male	1548 (1874)	24.3% (24%)	7 (9)	63.6% (64%)
Female	4819 (5933)	75.7% (76%)	4 (5)	36.4 % (36%)

Age (age at 31/03/17)	Staff [head count]		Trust Board Members [25]	
16-30	1329 (1932)	20.9% (26.0%)	0 (0)	0% (0%)
31-40	1363 (1732)	21.4% (23.0%)	1 (1)	9.1% (7.0%)
41-50	1670 (1908)	26.2% (25.5%)	3 (3)	27.3% (21.0%)
51-60	1394 (1532)	21.9% (20.5%)	6 (6)	54.6% (43.0%)
61 and over	611 (361)	9.6% (5.0%)	1 (4)	9.1% (29.0%)

Ethnic group [26]	Staff [head count]		Trust Board Members [24]	
Asian/Asian British: Any other Asian background	360 (376)	5.7% (4.8%)	0 (0)	0% (0%)
Asian/Asian British: Bangladeshi	7 (14)	0.1% (0.2%)	0 (0)	0% (0%)
Asian/Asian British: Indian	342 (379)	5.4% (4.9%)	0 (1)	0% (7%)
Asian/Asian British: Pakistani	52 (84)	0.8% (1.1%)	0 (0)	0% (0%)
Black/African/Caribbean/Black British: African	148 (183)	2.3% (2.3%)	0 (0)	0% (0%)
Black/African/Caribbean/Black British: Any other Black/African/Caribbean background	14 (23)	0.2% (0.3%)	0 (0)	0% (0%)
Black/African/Caribbean/Black British: Caribbean	18 (30)	0.3% (0.4%)	0 (0)	0% (0%)
Mixed/Multiple ethnic groups: Any other Mixed/Multiple ethnic background	36 (40)	0.6% (0.5%)	0 (0)	0% (0%)
Mixed/Multiple ethnic groups: White and Asian	39 (40)	0.6% (0.5%)	0 (0)	0% (0%)
Mixed/Multiple ethnic groups: White and Black African	9 (16)	0.1% (0.2%)	0 (0)	0% (0%)
Mixed/Multiple ethnic groups: White and Black Caribbean	19 (16)	0.3% (0.2%)	0 (0)	0% (0%)
White: Any other White background	578 (739)	9.1% (9.5%)	0 (1)	0% (7%)
White: English/Welsh/Scottish/Northern Irish/British	4213 (5045)	66.2% (64.6%)	10 (11)	91% (79%)
White: Irish	73 (105)	1.2% (1.3%)	1 (1)	9 % (7%)
Any other ethnic group	199 (232)	3.1% (3.0%)	0 (0)	0% (0%)
Not known / not stated / undefined	260 (485)	4.1% (6.2%)	0 (0)	0% (0%)

Staff sickness absence

The staff sickness absence for 2016/17 (and 2015/16) is reported below:

	2016/17	2015/16
Total days lost (adjusted to the Cabinet Office measure)	47,119	43,757
Total staff years (WTE)	5,197	5,054
Average working days lost	9.1	8.7

N.B. This data is provided via the Department of Health (DH) (as it is necessary to reconcile NHS Electronic Staff Record data with the 'Cabinet Office' data reported by central Government, to permit aggregation across the NHS). The sickness absence figures reported for 2016/17 are actually for the calendar year 2016 (i.e. January to December 2016), whilst the figures for 2015/16 are for the calendar year 2015. However, the DH considers the figures for the calendar year to be a reasonable proxy for the financial year.

[24] Includes non-voting Board Members (refer to the 'Trust Board' section later in the Report for details). The definition of "Senior Manager" only applies to Trust Board Members, all of whom are on "Very Senior Manager" contracts.
[25] Includes non-voting Board Members (refer to the 'Trust Board' section later in the Report for details). The definition of "Senior Manager" only applies to Trust Board Members, all of whom are on "Very Senior Manager" contracts.
[26] Recommended Office of National Statistics (ONS) Ethnicity Classifications, 2012

Disabled employees

The Disability Confident Scheme, launched by the Government in July 2016, replaced the Positive about Disability "Two Ticks" scheme. The Trust has achieved Level 2 – Disability Confident Employer status, demonstrating that it actively seeks out and hires skilled disabled people helping to positively change attitudes, behaviours and cultures. In 2016/17 the Trust has:

- Actively looked to attract and recruit disabled people
- Provided a fully inclusive and accessible recruitment process
- Offered an interview to disabled people who met the minimum criteria for the job
- Been flexible when assessing people so disabled job applicants have the best opportunity to demonstrate they can do the job
- Made reasonable adjustments as required
- Encouraged suppliers to be Disability Confident

"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).

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

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

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

The Directors are normally on permanent contracts and subject to a minimum of 6 months' notice period; the Chief Executive's notice period is 6 months. Contract, interim and seconded staff will all have termination clauses built into their letters of engagement, which will be broadly in line with the above.

Termination arrangements are applied in accordance with statutory regulations as modified by Trust or National NHS conditions of service agreements, and the NHS pension scheme. The Remuneration and Appointments Committee will agree any severance arrangements following appropriate approval from NHSI and HM Treasury as appropriate.

The figures included in the tables below show details of salaries, allowances, pension entitlements and any other remuneration of the Trust's 'Senior Managers' i.e. non-recurrent awards etc.

Salaries and allowances for the year ending 31st March 2017 (subject to audit)

Comparatives for the year ending 31st March 2016 are shown in brackets below the figure for 2016/17.

Name and title (alphabetical by surname) N.B. Dates of service are for the full 2016/17 year unless otherwise disclosed	**(a) Salary** (bands of £5,000) £000	**(b) Taxable expense payments, and other benefits in kind, to the nearest £100** £00 Λ	**(c) Annual performance-related pay and bonuses** (bands of £5,000) £000	**(d) Long-term performance-related pay and bonuses** (bands of £5,000) £000	**(e) Other remuneration for other offices held alongside Senior Manager role** (bands of £5,000) £000	**(f) All pension-related benefits** (bands of £2,500) £000	**(g) TOTAL (columns a - f)** (bands of £5.000) £000	**(h) Payments or compensation for loss of office** £000
Avey Bhatia, Chief Nurse (until 31/01/17)	90-95 (105-110)	0 (0)	0 (0)	0 (0)	0 (0)	25-27.5 (2.5-5)	115-120 (115-120)	N/A (N/A)
Sylvia Denton, Non-Executive Director (until 28/02/17)	5-10 (5-10)	0 (0)	0 (0)	N/A (N/A)	N/A (N/A)	N/A (N/A)	5-10 (5-10)	N/A (N/A)
Glenn Douglas, Chief Executive	200-205 (200-205)	70∑ (70)	0 (0)	0 (0)	N/A (N/A)	0 (0)	205-210 (205-210)	N/A (N/A)
Sarah Dunnett, Non-Executive Director	5-10 (5-10)	0 (0)	0 (0)	N/A (N/A)	N/A (N/A)	N/A (N/A)	5-10 (5-10)	N/A (N/A)
Angela Gallagher, Chief Operating Officer	120-125 (115-120)	0 (0)	0 (0)	N/A N/A	N/A (N/A)	2-5-5.0 (0)	125-130 (115-120)	N/A (N/A)
Richard Hayden, Director of Workforce	110-115 (5-10)	0 (0)	0 (0)	N/A (0)	N/A (N/A)	132.5-135 (N/A)	170-175 (5-10)	N/A (N/A)
Anthony Jones, Chair of the Trust Board (until 28/02/17)	40-45 (40-45)	0 (5)	0 (0)	N/A (N/A)	N/A (N/A)	N/A (N/A)	40-45 (40-45)	N/A (N/A)
Alex King, Non-Executive Director	5-10 (5-10)	0 (0)	0 (0)	N/A (N/A)	N/A (N/A)	N/A (N/A)	5-10 (5-10)	N/A (N/A)
Jim Lusby, Deputy Chief Executive	85-90 (115-120)	0 (0)	0 (0)	0 (0)	N/A (5-10)	85-87.5 (10-12.5)	170-175 (140-145)	N/A (N/A)
Peter Maskell, Medical Director Ψ (from 08/02/17)	35-40 (N/A)	0 (N/A)	0 (N/A)	0 (N/A)	0 (N/A)	0 (N/A)	35-40 (N/A)	N/A (N/A)
Sara Mumford, Director of Infection Prevention and Control Ψ	15-q20 (15-20)	0 (2)	0 (0)	0 (0)	135-140 (115-120)	57.5-60 (5-7.5)	210-215 (140-145)	N/A (N/A)
Claire O'Brien, Interim Chief Nurse (from 28/02/17)	5-10 (N/A)	0 (N/A)	0 (N/A)	0 (N/A)	0 (N/A)	0 (N/A)	5-10 (N/A)	N/A (N/A)
Steve Orpin, Director of Finance	125-130 (125-130)	0 (0)	0 (0)	0 (0)	N/A (N/A)	27.5-30 (77.5-80)	155-160 (205-210)	N/A (N/A)
Paul Sigston, Medical Director Ψ (until 08/02/17)	205-210 (230-235)	0 (0)	0 (0)	0 (0)	5-10 (10-15)	0 (0)	210-215 (245-250)	N/A (N/A)
Kevin Tallett, Non-Executive Director	5-10 (5-10)	0 (0)	0 (0)	N/A (N/A)	N/A (N/A)	N/A (N/A)	5-10 (5-10)	N/A (N/A)
Steve Tinton, Non-Executive Director (until 28/09/16)	0-5 (5-10)	0 (0)	0 (0)	N/A (N/A)	N/A (N/A)	N/A (N/A)	0-5 (5-10)	N/A (N/A)

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

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

∑ This relates to a lease vehicle

Pension benefits for the year ending 31st March 2017 (subject to audit)

Name and title Ψ (alphabetical by surname) N.B. Dates of service are for the full 2016/17 year unless otherwise disclosed	**(a) Real increase in pension at pension age (bands of £2,500)** £000	**(b)** Real increase in pension lump sum at pension age **(bands of £2,500)** £000	**(c)** Total accrued pension at pension age at 31st March 2017 **(bands of £5,000)** £000	**(d)** Lump sum at pension age related to accrued pension at 31st March 2017 **(bands of £5,000)** £000	**(e)** Cash Equivalent Transfer Value Λ at 1st April 2016 £000	**(f)** Cash Equivalent Transfer Value Λ at 31st March 2017 £000	**(g)** Real increase in Cash Equivalent Transfer Value Σ £000	**(h)** Employer's contribution to stakeholder pension £000
Glenn Douglas, Chief Executive Ω	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Avey Bhatia, Chief Nurse (until 31/01/17)	0-2.5	0-2.5	35-40	95-100	558	594	31	0
Angela Gallagher, Chief Operating Officer	0-2.5	2.5-5.0	45-50	140-145	889	935	46	0
Richard Hayden, Director of Workforce	5-7.5	7.5-10	20-25	50-55	189	244	55	0
Jim Lusby, Deputy Chief Executive	2.5-5.0	0-2.5	30-35	85-90	450	513	63	0
Peter Maskell, Medical Director (from 08/02/17))Ж	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Sara Mumford, Director of Infection Prev. and Control	2.5-5	0-2.5	45-50	70-75	585	649	64	0
Claire O'Brien, Interim Chief Nurse (from 28/02/17)	0-2.5	0-2.5	30-35	100-105	692	704	1	0
Steve Orpin, Director of Finance	0-2.5	0-2.5	40-45	115-120	578	617	39	0
Paul Sigston, Medical Director (until 08/02/17)Ж	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A

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

Λ A Cash Equivalent Transfer Value (CETV) is the actuarially assessed capital value of the pension scheme benefits accrued by a member at a particular point in time. The benefits valued are the member's accrued benefits and any contingent spouse's (or other allowable beneficiary's) pension payable from the scheme. CETVs are calculated in accordance with the Occupational Pension Schemes (Transfer Values) Regulations 2008

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

Ω Mr Douglas ceased payments into the NHS Pensions scheme in 2012/13

Ж Drs Sigston and Maskell did not make any contributions into the NHS Pensions scheme in 2016/17

Pay multiples (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.

The banded remuneration of the highest paid director in the financial year 2016-17 was £200,000 to £205,000 (in 2015/16 this was £230,000 to £235,000). This was 7.1 times (in 2015/16, this was 8.3 times) the median remuneration of the workforce, which was £28,462 (2015-16, £28,159). The reduction is due to a change in post holder.

In 2016-17, 11 employees (2015-16, 2) received remuneration in excess of the highest-paid Director (these were all Medical staff.) Remuneration ranged from £6,042 to £279,930 (in 2015/16 the range was from £11,413 to £240,132). The highest paid Director in the financial year 2016/17 was the Chief Executive (in 2015/16 this was the Medical Director).

Total remuneration includes salary, non-consolidated performance-related pay, benefits-in-kind, but not severance payments. It does not include employer pension contributions and the cash equivalent transfer value of pensions. The calculations of the median pay included in this analysis is based on the month 12 remuneration on an annualised basis (remuneration divided by whole time equivalent multiplied by 12) and therefore is not necessarily the actual remuneration received by those individuals in the financial year.

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

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

All off-payroll engagements as of 31st March 2017, for more than £220 per day and lasting for longer than 6 months

	Number
Number of existing engagements as of 31st March 2017	2
Of which, the number that have existed…	
for less than 1 year at the time of reporting =	1
for between 1 and 2 years at the time of reporting =	0
for between 2 and 3 years at the time of reporting =	1
for between 3 and 4 years at the time of reporting =	0
for 4 or more years at the time of reporting =	0

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

New off-payroll engagements between 1st April 2016 and 31st March 2017, for more than £220 per day that last longer than 6 months

	Number
Number of new engagements, or those that reached 6 months in duration, between 1st April 2016 and 31st March 2017	1
Number of new engagements which include contractual clauses giving the Trust the right to request assurance in relation to income tax and National Insurance obligations	0
Number for whom assurance has been requested	0
Of which…	
Assurance has been received	0
Assurance has not been received	0
Engagements terminated as a result of assurance not being received	0

Number of off-payroll engagements of Board members and/or senior officers 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	16 Σ

Σ This includes the Board members that left the Trust Board during 2016/17. Please refer to the 'Directors' Report' for further details.

Expenditure on consultancy staff

The Trust's expenditure on consultancy staff for 2016/17 was £468,000, a reduction of £532,700 from 2015/16.

NHS
Maidstone and Tunbridge Wells
NHS Trust

Accountability and audit report for 2016/17: Independent Auditor's report to the Directors of the Trust

taking pride

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

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Darren Wells

for and on behalf of Grant Thornton UK LLP, Appointed Auditor

Fleming Way

Manor Royal

Crawley RH10 9GT

xx May 2017

NHS
Maidstone and Tunbridge Wells
NHS Trust

Financial Statements for 2016/17

taking pride

Glossary of NHS terms

Term	Definition/explanation
Ambulatory (Care)	A service where some conditions may be treated without the need for an overnight stay in hospital
Care Quality Commission (CQC)	The body that regulates all health and social care services in England. The CQC ensures the quality and safety of care in hospitals, dentists, ambulances, and care homes, and the care given in people's own homes. CQC is an executive non-departmental public body, sponsored by the Department of Health.
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.' (DoH 1998)
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 2016/17, and for which they will be held directly accountable
Cost Improvement Plan/ 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
Delayed Transfer of Care (DTOC)	According to NHS England, a 'delayed transfer of care' occurs when an adult inpatient in hospital is ready to go home or move to a less acute stage of care but is prevented from doing so. Sometimes referred to in the media as 'bed-blocking', delayed transfers of care are a problem as they reduce the number of beds available to other patients who need them, as well as causing unnecessarily long stays in hospital for patients
Elective treatment	Treatment that is not urgent and can be planned
Escalation	The term used to describe circumstances when clinical areas of the Trust, not ordinarily designated for non-elective inpatient care, are required to be used for that purpose due to non-elective demand
Financial Special Measures (FSM)	The Financial Special Measures programme, was launched by NHSI in July 2016 to provide a rapid turnaround package for Trusts which had either not agreed savings targets, or planned to make savings but deviated significantly from this plan
Friends and Family Test (FFT)	A feedback tool, launched in April 2013, that supports the fundamental principle that people who use NHS services should have the opportunity to provide feedback on their experience. It asks people if they would recommend the services they have used and offers a range of responses. When combined with supplementary follow-up questions, the FFT provides a mechanism to highlight both good and poor patient experience
Length of Stay (LOS)	The period of time a patient remains in hospital or other healthcare facility as an inpatient

Term	Definition/explanation
NHS England	An executive non-departmental public body, sponsored the Department of Health, 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
Patient Advice and Liaison Service (PALS)	A service within an NHS Trust offering confidential advice, support and information on health-related matters. It provides a point of contact for patients, their families and their carers
Patient Experience	A term used for individual and collective feedback. (1) Individual patient's feedback about their experiences of care or a service e.g. whether they understood the information they were given, their views on the cleanliness of the hospital where they were treated. (2) A combination of all the intelligence held about what patients experience in services, drawing on a range of sources including complaints, compliments, etc.
Patient flow	The course of patients between staff, departments and organisations along a pathway of care
Patient Pathhway	The route that a patient will take from entry into a hospital or other healthcare seeting until the patient leaves. A template pathway can be created for common services and operations (e.g. emergency care pathway)
Ring-fenced beds	Beds allocated for a specific category of patient / treatment (e.g. stroke or elective orthopaedic beds), not used for general medical patients when the hospital is busy
Serious Incident (SI)	Events in health care where the potential for learning is so great, or the consequences to patients, families and carers, staff or organisations are so significant, that they warrant using additional resources to mount a comprehensive response. SIs can extend beyond incidents which affect patients directly and include incidents which may indirectly impact patient safety or an organisation's ability to deliver ongoing healthcare
Single Oversight Framework (SOF)	A framework which applies to all NHS Trusts and is designed to help providers attain, and maintain, CQC ratings of 'Good' or 'Outstanding'. The framework replaced the Monitor 'Risk Assessment Framework' and the NHS Trust Development Authority 'Accountability Framework' in October 2016
Sustainability and Transformation Fund (STF)	A fund allocated to support and incentivise the sustainable provision of efficient, effective and economic care by NHS Trusts, paid subject to the achievement of stipulated targets. The general element of the STF is allocated primarily to Trusts providing acute emergency care, as they remain under the greatest financial and operational pressure
Sustainability and Transformation Plan (STP)	STPs are 5 year plans for the future of health and care services in local areas. STPs cover all areas of NHS England activity and include better integration with local authority services, as well as outlining how they will deliver the national NHS Mandate, plans will to address a series of 'national challenges', which fall broadly into three themes: improving health and wellbeing, improving quality and developing new models of care, and improving efficiency to achieve financial balance.

Thank you for your support

Signature

Glenn Douglas, Chief Executive

David Highton, Chair of the Trust Board

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

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

Maidstone and Tunbridge Wells NHS Trust

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01622 729000

01622 226 416

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Patient First – Respect – Innovation – Delivery - Excellence

Trust Board meeting - May 2017

NHS Maidstone and Tunbridge Wells NHS Trust

5-17 Approval of Annual Accounts, 2016/17 Chair of the Audit and Governance C'ttee

The Annual Accounts for 2016/17 are enclosed.

The Accounts, along with the External Auditors' findings, will be reviewed in detail at the Audit and Governance Committee on 24th May (before the Trust Board).

The Audit and Governance Committee will be asked to recommend that the Trust Board approves the Accounts, and a verbal update on the outcome of the Committee's review will be given at the Trust Board meeting.

Once approved, the Accounts will be signed, and submitted to the External Auditors, who will in turn submit them to Department of Health, by the required deadline (1st June 2017).

Which Committees have reviewed the information prior to Board submission?

- Audit and Governance Committee, 04/05/17 (pre-audit draft)
- Audit and Governance Committee, 24/05/17

Reason for receipt at the Board (decision, discussion, information, assurance etc.) [1]

To review and approve the Annual Accounts for 2016/17

[1] All information received by the Board should pass at least one of the tests from 'The Intelligent Board' & 'Safe in the knowledge: How do NHS Trust Boards ensure safe care for their patients': the information prompts relevant & constructive challenge; the information supports informed decision-making; the information is effective in providing early warning of potential problems; the information reflects the experiences of users & services; the information develops Directors' understanding of the Trust & its performance

Data entered below will be used throughout the workbook:

Trust name	Maidstone and Tunbridge Wells NHS Trust
This year	2016-17
Last year	2015-16
This year ended	31 March 2017
Last year ended	31 March 2016
This year commencing:	1 April 2016
Last year commencing:	1 April 2015

Accounts 2016-17

Statement of Comprehensive Income for year ended 31 March 2017

	NOTE	2016-17 £000s	2015-16 £000s
Gross employee benefits	10.1	**(252,156)**	(246,792)
Other operating costs	8	**(213,965)**	(173,267)
Revenue from patient care activities	5	**384,413**	361,792
Other operating revenue	6	**46,089**	39,138
Operating surplus/(deficit)		**(35,619)**	(19,129)
Investment revenue	12	**34**	47
Other gains and (losses)	13	**17**	1
Finance costs	14	**(14,647)**	(14,349)
Surplus/(deficit) for the financial year		**(50,215)**	(33,430)
Public dividend capital dividends payable		**(1,851)**	(3,882)
Net Gain/(loss) on transfers by absorption		**0**	0
Retained surplus/(deficit) for the year		**(52,066)**	(37,312)

Other Comprehensive Income

	2016-17 £000s	2015-16 £000s
Impairments and reversals taken to the revaluation reserve	**(24,643)**	(22,820)
Net gain/(loss) on revaluation of property, plant & equipment	**1,161**	13,986
Net gain/(loss) on revaluation of intangibles	**0**	0
Net gain/(loss) on revaluation of available for sale financial assets	**0**	0
Total comprehensive income for the year	**(75,548)**	(46,146)

Financial performance for the year

Retained surplus/(deficit) for the year	**(52,066)**	(37,312)
Prior period adjustment to correct errors and other performance adjustments	**0**	0
IFRIC 12 adjustment (including IFRIC 12 impairments)	**39,832**	8,609
Impairments (excluding IFRIC 12 impairments)	**1,461**	5,444
Adjustments in respect of donated gov't grant asset reserve elimination	**(145)**	(154)
Adjusted retained surplus/(deficit)	**(10,918)**	(23,413)

The IFRIC 12 adjustment relates to impairments of the PFI assets charged to the Statement of Comprehensive Income (SoCI) of £39.8m. Impairments on non PFI assets charged to the SoCI were £1.5m.

The notes on pages 7 to 42 form part of this account.

Statement of Financial Position as at 31 March 2017

	NOTE	31 March 2017 £000s	31 March 2016 £000s
Non-current assets:			
Property, plant and equipment	16	**280,190**	350,397
Intangible assets	17	**3,219**	3,253
Investment property	19	**0**	0
Other financial assets		**0**	0
Trade and other receivables	22.1	**1,496**	1,200
Total non-current assets		**284,905**	354,850
Current assets:			
Inventories	21	**7,945**	8,286
Trade and other receivables	22.1	**46,419**	31,969
Other financial assets	24	**0**	0
Other current assets	25	**0**	0
Cash and cash equivalents	26	**1,420**	1,197
Sub-total current assets		**55,784**	41,452
Non-current assets held for sale	27	**1,742**	0
Total current assets		**57,526**	41,452
Total assets		**342,431**	396,302
Current liabilities			
Trade and other payables	28	**(56,099)**	(43,038)
Other liabilities	29	**0**	0
Provisions	35	**(1,744)**	(2,331)
Borrowings	30	**(5,028)**	(4,774)
Other financial liabilities	31	**0**	0
DH revenue support loan	30	**0**	0
DH capital loan	30	**(4,632)**	(2,174)
Total current liabilities		**(67,503)**	(52,317)
Net current assets/(liabilities)		**(9,977)**	(10,865)
Total assets less current liabilities		**274,928**	343,985
Non-current liabilities			
Trade and other payables	28	**0**	0
Other liabilities	29	**0**	0
Provisions	35	**(1,260)**	(1,401)
Borrowings	30	**(198,233)**	(203,261)
Other financial liabilities	31	**0**	0
DH revenue support loan	30	**(29,040)**	(16,908)
DH capital loan	30	**(12,328)**	(14,502)
Total non-current liabilities		**(240,861)**	(236,072)
Total assets employed:		**34,067**	107,913
FINANCED BY:			
Public Dividend Capital		**204,966**	203,264
Retained earnings		**(201,203)**	(149,151)
Revaluation reserve		**30,304**	53,800
Other reserves		**0**	0
Total Taxpayers' Equity:		**34,067**	107,913

The notes on pages 7 to 42 form part of this account.

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

Chief Executive: Date: 25 May 2017

Statement of Changes in Taxpayers' Equity
For the year ending 31 March 2017

	Public Dividend capital	Retained earnings	Revaluation reserve	Other reserves	Total reserves
	£000s	£000s	£000s	£000s	£000s
Balance at 1 April 2016	**203,264**	**(149,151)**	**53,800**	**0**	**107,913**
Changes in taxpayers' equity for 2016-17					
Retained surplus/(deficit) for the year	**0**	**(52,066)**	**0**	**0**	**(52,066)**
Net gain / (loss) on revaluation of property, plant, equipment	**0**	**0**	**1,161**	**0**	**1,161**
Net gain / (loss) on revaluation of intangible assets	**0**	**0**	**0**	**0**	**0**
Net gain / (loss) on revaluation of financial assets	**0**	**0**	**0**	**0**	**0**
Net gain / (loss) on revaluation of available for sale financial	**0**	**0**	**0**	**0**	**0**
Impairments and reversals	**0**	**0**	**(24,643)**	**0**	**(24,643)**
Other gains/(loss) (provide details below)	**0**	**0**	**0**	**0**	**0**
Transfers between reserves	**0**	**14**	**(14)**	**0**	**0**
Reclassification Adjustments					
On disposal of available for sale financial assets	**0**	**0**	**0**	**0**	**0**
Reserves eliminated on dissolution	**0**	**0**	**0**	**0**	**0**
Originating capital for Trust established in year	**0**	**0**	**0**	**0**	**0**
Temporary and permanent PDC received - cash	**1,702**	**0**	**0**	**0**	**1,702**
Temporary and permanent PDC repaid in year	**0**	**0**	**0**	**0**	**0**
PDC written off	**0**	**0**	**0**	**0**	**0**
Other movements	**0**	**0**	**0**	**0**	**0**
Net actuarial gain/(loss) on pension	**0**	**0**	**0**	**0**	**0**
Other pensions remeasurement	**0**	**0**	**0**	**0**	**0**
Net recognised revenue/(expense) for the year	**1,702**	**(52,052)**	**(23,496)**	**0**	**(73,846)**
Balance at 31 March 2017	**204,966**	**(201,203)**	**30,304**	**0**	**34,067**
Balance at 1 April 2015	199,548	(111,941)	62,736	0	150,343
Changes in taxpayers' equity for the year ended 31 March 2016					
Retained surplus/(deficit) for the year	0	(37,312)	0	0	(37,312)
Net gain / (loss) on revaluation of property, plant, equipment	0	0	13,986	0	13,986
Net gain / (loss) on revaluation of intangible assets	0	0	0	0	0
Net gain / (loss) on revaluation of financial assets	0	0	0	0	0
Net gain / (loss) on revaluation of assets held for sale	0	0	0	0	0
Impairments and reversals	0	0	(22,820)	0	(22,820)
Other gains / (loss)	0	0	0	0	0
Transfers between reserves	0	102	(102)	0	0
Reclassification Adjustments					
On disposal of available for sale financial assets	0	0	0	0	0
Originating capital for Trust established in year	0	0	0	0	0
New PDC received - cash	3,716	0	0	0	3,716
PDC repaid in year	0	0	0	0	0
Other movements	0	0	0	0	0
Net actuarial gain/(loss) on pension	0	0	0	0	0
Other pension remeasurement	0	0	0	0	0
Net recognised revenue/(expense) for the year	3,716	(37,210)	(8,936)	0	(42,430)
Balance at 31 March 2016	203,264	(149,151)	53,800	0	107,913

Information on reserves

1 Public dividend capital

Public dividend capital (PDC) is a type of public sector equity finance based on the excess of assets over liabilities. Additional PDC may also be issued to NHS Trusts by the Department of Health. A charge, reflecting the cost of capital utilised by the NHS foundation trust, is payable to the Department of Health as the public dividend capital dividend.

2 Income and expenditure reserve

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

3 Revaluation Reserve

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

4 Other reserves

The Trust has no other reserves

5 Charitable Funds Reserve

The Trust has not consolidated the charity accounts within the main exchequer accounts so this note is not used.

Statement of Cash Flows for the Year ended 31 March 2017

	NOTE	2016-17 £000s	2015-16 £000s
Cash Flows from Operating Activities			
Operating surplus/(deficit)		**(35,619)**	(19,129)
Depreciation and amortisation	8	**13,255**	13,816
Impairments and reversals	18	**41,293**	13,369
Other gains/(losses) on foreign exchange	13	**0**	0
Donated Assets received credited to revenue but non-cash	6	**0**	0
Government Granted Assets received credited to revenue but non-cash		**0**	0
Release of PFI/deferred credit		**0**	0
(Increase)/Decrease in Inventories		**341**	(1,767)
(Increase)/Decrease in Trade and Other Receivables		**(14,436)**	2,006
(Increase)/Decrease in Other Current Assets		**0**	0
Increase/(Decrease) in Trade and Other Payables		**11,216**	13,745
(Increase)/Decrease in Other Current Liabilities		**0**	0
Provisions utilised	35	**(907)**	(1,136)
Increase/(Decrease) in movement in non cash provisions		**133**	486
Net Cash Inflow/(Outflow) from Operating Activities		**15,276**	21,390
Cash Flows from Investing Activities			
Interest Received	12	**34**	47
(Payments) for Property, Plant and Equipment		**(6,834)**	(18,294)
(Payments) for Intangible Assets		**(902)**	(843)
(Payments) for Investments with DH		**0**	0
Proceeds of disposal of assets held for sale (PPE)		**0**	0
Proceeds of disposal of assets held for sale (Intangible)		**0**	0
Net Cash Inflow/(Outflow) from Investing Activities		**(7,702)**	(19,090)
Net Cash Inflow / (outflow) before Financing		**7,574**	2,300
Cash Flows from Financing Activities			
Gross Temporary and Permanent PDC Received		**1,702**	3,716
Gross Temporary and Permanent PDC Repaid		**0**	0
Loans received from DH - New Capital Investment Loans		**0**	0
Loans received from DH - New Revenue Support Loans		**14,840**	29,408
Other Loans Received		**0**	0
Loans repaid to DH - Capital Investment Loans Repayment of Principal		**(2,174)**	(2,174)
Loans repaid to DH - Working Capital Loans/Revenue Support Loans		**(250)**	(12,500)
Other Loans Repaid		**0**	0
Capital Element of Payments in Respect of Finance Leases and On-SoFP PFI and LIFT		**(4,774)**	(4,776)
Interest paid	14	**(14,641)**	(14,343)
PDC Dividend (paid)/refunded		**(2,054)**	(4,273)
Capital grants and other capital receipts (excluding donated / government granted cash receipts)		**0**	43
Net Cash Inflow/(Outflow) from Financing Activities		**(7,351)**	(4,899)
NET INCREASE/(DECREASE) IN CASH AND CASH EQUIVALENTS	**26**	**223**	(2,599)
Cash and Cash Equivalents (and Bank Overdraft) at Beginning of the Period		**1,197**	3,796
Effect of exchange rate changes in the balance of cash held in foreign currencies		**0**	0
Cash and Cash Equivalents (and Bank Overdraft) at year end	**26**	**1,420**	1,197

NOTES TO THE ACCOUNTS

1. Accounting Policies

The Secretary of State for Health has directed that the financial statements of NHS trusts shall meet the accounting requirements of the Department of Health Group Manual for Accounts, which shall be agreed with HM Treasury. Consequently, the following financial statements have been prepared in accordance with the DH Group Accounting Manual (GAM) 2016-17 issued by the Department of Health. The accounting policies contained in that manual 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 Manual for Accounts permits a choice of accounting policy, the accounting policy which 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 by the trust are described below. They have been applied consistently in dealing with items considered material in relation to the accounts.

1.1 Accounting convention

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

Going Concern

These accounts have been prepared on a going concern basis

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

'For non-trading entities in the public sector, the anticipated continuation of the provision of a service in the future, as evidenced by inclusion of financial provision for that service in published documents, is normally sufficient evidence of going concern. DH group bodies should therefore prepare their accounts on a going concern basis unless informed by the relevant national body or DH sponsor of the intention for dissolution without transfer of services or function to another entity.'

The Trust has prepared its 2016/17 accounts on a "going concern" basis following consideration of the following:-

- There has been no expectation raised in the public arena that healthcare services will not continue to be provided from the two hospital sites.
- The Trust submitted business plans to NHSI in December 2016 (refreshed for some specific updates in March 2017) setting out its plans for the following two operating years (2017/18 and 2018/19). These plans include acceptance of the nationally set revenue "control total" to which the Trust has confirmed sign up. Achievement of these plans would return the Trust into revenue breakeven.
- The Trust has fully participated in the Kent & Medway Sustainability and Transformation Plan (STP) process including the submission of the forward 5 year financial and operating plans on a going concern basis.
- The Trust has agreed/signed contracts for provision of healthcare services for 2017/18 including a new "aligned incentives" approach with its main CCG.
- The Trust has prepared and submitted cash-flow forecasts for 2017/18 and 2018/19 which do not include assumptions of additional required working capital finance.

The Trust does not consider that there are any material uncertainties that affect this judgement of going concern.

1.2 Acquisitions and discontinued operations

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

1.3 Movement of assets within the DH Group

Transfers as part of reorganisation fall to be accounted for by use of absorption accounting in line with the Treasury Financial Reporting Manual (FReM). The FReM does not require retrospective adoption, so prior year transactions (which have been accounted for under merger accounting) have not been restated. Absorption accounting requires that entities account for their transactions in the period in which they took place, with no restatement of performance required when functions transfer within the public sector. Where assets and liabilities transfer, the gain or loss resulting is recognised in the SOCI, and is disclosed separately from operating costs.

Other transfers of assets and liabilities within the Group are accounted for in line with IAS 20 and similarly give rise to income and expenditure entries.

1.4 Charitable Funds

Under the provisions of IAS 27 Consolidated and Separate Financial Statements, those Charitable Funds that fall under common control with NHS bodies are consolidated within the entity's financial statements. In accordance with IAS 1 Presentation of Financial Statements, restated prior period accounts are presented where the adoption of the new policy has a material impact.

The Charitable Funds for this trust are not material for 2016-17 and have not been consolidated. See policy note 1.32

NOTES TO THE ACCOUNTS

1.5 Pooled Budgets

The Trust does not have any pooled budgets

1.6 Critical accounting judgements and key sources of estimation uncertainty

In the application of the NHS Trust's accounting policies, management is required to make judgements, estimates and assumptions about the carrying amounts of assets and liabilities that are not readily apparent from other sources. The estimates and associated assumptions are based on historical experience and other factors that are considered to be relevant. Actual results may differ from those estimates and the estimates and underlying assumptions are continually reviewed. Revisions to accounting estimates are recognised in the period in which the estimate is revised if the revision affects only that period or in the period of the revision and future periods if the revision affects both current and future periods.

1.6.1 Critical judgements in applying accounting policies

The following are the critical judgements, apart from those involving estimations (see below 1.6.2) that management has made in the process of applying the NHS trust's accounting policies and that have the most significant effect on the amounts recognised in the financial statements.

For 2016/17 the Trust has identified the following critical judgements that are required to be disclosed under IAS1 paragraph 122. All other material judgements within this financial year relate to estimations and are disclosed in the relevant notes (see 1.6.2)

Material areas of critical judgements within the 2016/17 accounts are as follows:

The financial statements have been prepared on a going concern basis as set out in note 1.1. In preparing the financial statements the directors have considered the Trust's overall financial position and expectation of future contractual income, cost improvements and Sustainability and Transformation Funding (STF). The Trust has submitted a two year financial plan for 2017/18 and 2018/19 to NHS Improvement which delivers agreed control totals and, including planned STF funding, £6.7m surplus for 2017/18 and £11.1m surplus for 2018/19. Note 5 (Revenue) contains a reference in respect of future STF Funding.

The Trust has applied the concept of Modern Equivalent Asset (MEA) to estimate the valuation of its property assets, as applicable, under the guidance of the DH GAM and its independent professional valuers. Please see note 16.3 for further information.

Charitable Funds are not material for the Trust and have not been consolidated (see note 1.4).

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

1.6.2 Key sources of estimation uncertainty

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

Material areas including estimations within the 2016/17 accounts are as follows:
Property, Plant and Equipment valuation including PFI infrastructure assets (see note 16.3)
Pension fund valuation (see note10.3).

1.7 Revenue

Revenue in respect of services provided is recognised when, and to the extent that, performance occurs, and is measured at the fair value of the consideration receivable. The main source of revenue for the Trust is from commissioners for healthcare services. Revenue relating to patient care spells that are part-completed at the year end are apportioned across the financial years on the basis of length of stay at the end of the reporting period compared to expected total length of stay.

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

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

NOTES TO THE ACCOUNTS

The NHS Trust receives income under the NHS Injury Cost Recovery Scheme, designed to reclaim the cost of treating injured individuals to whom personal injury compensation has subsequently been paid e.g. by an insurer. The NHS Trust recognises the income when it receives notification from the Department of Work and Pension's Compensation Recovery Unit that the individual has lodged a compensation claim. The income is measured at the agreed tariff for the treatments provided to the injured individual, less a provision for unsuccessful compensation claims and doubtful debts.

1.8 Employee Benefits

Short-term employee benefits
Salaries, wages and employment-related payments are recognised in the period in which the service is received from employees, except for bonuses earned but not yet taken which, like leave earned but not yet taken is not accrued for at the year end, on the grounds of immateriality.

Retirement benefit costs
Past and present employees are covered by the provisions of the NHS Pension Schemes. These schemes are unfunded, defined benefit schemes that cover NHS employers, General Practices and other bodies, allowed under the direction of the Secretary of State in England and Wales. The schemes 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, the schemes are accounted for as though they were defined contribution schemes: the cost to the NHS body of participating in a scheme is taken as equal to the contributions payable to the scheme for the accounting period.

For early retirements other than those due to ill health the additional pension liabilities are not funded by the scheme. The full amount of the liability for the additional costs is charged to expenditure at the time the NHS 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, currently 1%.

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

1.9 Other expenses

Other operating expenses are recognised when, and to the extent that, the goods or services have been received. They are measured at the fair value of the consideration payable.

1.10 Property, plant and equipment

Recognition
Property, plant and equipment is capitalised if:
- it is held for use in delivering services or for administrative purposes;
- it is probable that future economic benefits will flow to, or service potential will be supplied to the NHS Trust;
- it is expected to be used for more than one financial year;
- the cost of the item can be measured reliably; and either
- the item cost at least £5,000; or
- Collectively, a number of items have a total cost of at least £5,000 and individually have a cost of more than £250, where the assets are functionally interdependent, they had broadly simultaneous purchase dates, are anticipated to have simultaneous disposal dates and are under single managerial control; or
- Items form part of the initial equipping and setting-up cost of a new building, ward or unit, irrespective of their individual or collective cost.

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

Valuation

NOTES TO THE ACCOUNTS

All property, plant and equipment are measured initially at cost, representing the cost directly attributable to acquiring or constructing the asset and bringing it to the location and condition necessary for it to be capable of operating in the manner intended by management. Assets that are held for their service potential and are in use are measured subsequently at their current value in existing use. Assets that were most recently held for their service potential but are surplus are measured at fair value where there are no restrictions preventing access to the market at the reporting date.

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

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

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

HM Treasury has adopted a standard approach to depreciated replacement cost valuations based on modern equivalent assets and, where it would meet the location requirements of the service being provided, an alternative site can be valued.

The financial year 2016/17 is the second year in the current 5 year cyclical valuation period. A full valuation was undertaken in September 2014 with a desktop valuation at 31st March 2015. In keeping with the Trust's policies the Trust commissioned professional valuers, Montagu Evans LLP, to carry out a desktop valuation of the Trust's Land, Building and Dwelling assets at 30th September 2016 and the Trust have reviewed values at year end in the light of overall movements in BCIS indices. The lead relationship partner from Montagu Evans LLP is qualified to BSc MRICS. The results are recorded in the property plant and equipment note 16.3.

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

IT equipment, transport equipment, furniture and fittings, and plant and machinery that are held for operational use are valued at depreciated historic cost where these assets have short useful economic lives or low values or both, as this is not considered to be materially different from current value in existing use. The Trust annually 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. For 2016/17 the Trust reviewed all plant and machinery (P&M) assets to ensure the accurate assessment of remaining asset lives. IT assets are also subject to annual review.

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

Subsequent expenditure

Where subsequent expenditure enhances an asset beyond its original specification, the directly attributable cost is capitalised. Where subsequent expenditure restores the asset to its original specification, the expenditure is capitalised and any existing carrying value of the item replaced is written-out and charged to operating expenses.

1.11 Intangible assets

Recognition

Intangible assets are non-monetary assets without physical substance, which are capable of sale separately from the rest of the trust's business or which arise from contractual or other legal rights. They are recognised only when it is probable that future economic benefits will flow to, or service potential be provided to, the trust; where the cost of the asset can be measured reliably, and where the cost is at least £5000.

NOTES TO THE ACCOUNTS

Intangible assets acquired separately are initially recognised at cost. Software that is integral to the operation of hardware, for example an operating system, is capitalised as part of the relevant item of property, plant and equipment. Software that is not integral to the operation of hardware, for example application software, is capitalised as an intangible asset. Expenditure on research is not capitalised: it is recognised as an operating expense in the period in which it is incurred. Internally-generated assets are recognised if, and only if, all of the following have been demonstrated:

- the technical feasibility of completing the intangible asset so that it will be available for use;
- the intention to complete the intangible asset and use it;
- the ability to sell or use the intangible asset;
- how the intangible asset will generate probable future economic benefits or service potential;
- the availability of adequate technical, financial and other resources to complete the intangible asset and sell or use it; and

- the ability to measure reliably the expenditure attributable to the intangible asset during its development

Measurement
The amount initially recognised for internally-generated intangible assets is the sum of the expenditure incurred from the date when the criteria above are initially met. Where no internally-generated intangible asset can be recognised, the expenditure is recognised in the period in which it is incurred.

Following initial recognition, intangible assets are carried at current value in existing use by reference to an active market, or, where no active market exists, at the lower of amortised replacement cost (modern equivalent assets basis) and value in use where the asset is income generating. Internally-developed software is held at historic cost to reflect the opposing effects of increases in development costs and technological advances.

1.12 Depreciation, amortisation and impairments

Freehold land, assets under construction or development, and assets held for sale are not depreciated/amortised.

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

At each financial year-end, the NHS Trust checks whether there is any indication that its property, plant and equipment or intangible non-current assets have suffered an impairment loss. If there is indication of such an impairment, the recoverable amount of the asset is estimated to determine whether there has been a loss and, if so, its amount. Intangible assets not yet available for use are tested for impairment annually at the financial year end.

Estimated useful lives for non current assets are adopted as follows:	Years
Buildings & Dwellings	1 - 60
Plant and Machinery	5 -15
Furniture and Fittings	10
Information Technology Hardware	3 - 5
Vehicles	5 -15
X ray Tubes	2
Software Licences (intangibles)	3 - 5
IT - In House and Third Party Software (intangibles)	2 - 7

At each reporting period end, the NHS Trust checks whether there is any indication that any of its tangible or intangible non-current assets have suffered an impairment loss. If there is indication of an impairment loss, the recoverable amount of the asset is estimated to determine whether there has been a loss and, if so, its amount. Intangible assets not yet available for use are tested for impairment annually.

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 are taken to expenditure. Where an impairment loss subsequently reverses, the carrying amount of the asset is increased to the revised estimate of the recoverable amount but capped at the amount that would have been determined had there been no initial impairment loss. The reversal of the impairment loss is credited to expenditure to the extent of the decrease previously charged there and thereafter to the revaluation reserve.

NOTES TO THE ACCOUNTS

Impairments are analysed between Departmental Expenditure Limits (DEL) and Annually Managed Expenditure (AME). This is necessary to comply with Treasury's budgeting guidance. DEL limits are set in the Spending Review and Departments may not exceed the limits that they have been set.

1.13 Donated assets

Donated non-current assets are capitalised at current value in existing use, if they will be held for their service potential, or otherwise at value on receipt, with a matching credit to income. They are valued, depreciated and impaired as described above for purchased assets. Gains and losses on revaluations, impairments and sales are treated in the same way as for purchased assets. Deferred income is recognised only where conditions attached to the donation preclude immediate recognition of the gain.

1.14 Government grants

Government grant funded assets are capitalised at current value in existing use, if they will be held for their service potential, or otherwise at fair value on receipt, with a matching credit to income. Deferred income is recognised only where conditions attached to the grant preclude immediate recognition of the gain.

1.15 Non-current assets held for sale

Non-current assets are classified as held for sale if their carrying amount will be recovered principally through a sale transaction rather than through continuing use. This condition is regarded as met when the sale is highly probable, the asset is available for immediate sale in its present condition and management is committed to the sale, which is expected to qualify for recognition as a completed sale within one year from the date of classification. Non-current assets held for sale are measured at the lower of their previous carrying amount and fair value less costs to sell. Fair value is open market value including alternative uses.

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.

Property, plant and equipment that is to be scrapped or demolished does not qualify for recognition as held for sale. Instead, it is retained as an operational asset and its economic life is adjusted. The asset is de-recognised when it is scrapped or demolished.

1.16 Leases

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

The Trust as lessee

Property, plant and equipment held under finance leases are initially recognised, at the inception of the lease, at fair value or, if lower, at the present value of the minimum lease payments, with a matching liability for the lease obligation to the lessor. Lease payments are apportioned between finance charges and reduction of the lease obligation so as to achieve a constant rate of interest on the remaining balance of the liability. Finance charges are recognised in calculating the trust's surplus/deficit.

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

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

Where a lease is for land and buildings, the land and building components are separated and individually assessed as to whether they are operating or finance leases.

The NHS Trust as lessor

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

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

1.17 Private Finance Initiative (PFI) transactions

NOTES TO THE ACCOUNTS

HM Treasury has determined that government bodies shall account for infrastructure PFI schemes where the government body controls the use of the infrastructure and the residual interest in the infrastructure at the end of the arrangement as service concession arrangements, following the principles of the requirements of IFRIC 12. The Trust therefore recognises the PFI asset as an item of property, plant and equipment together with a liability to pay for it. The services received under the contract are recorded as operating expenses.

The annual unitary payment is separated into the following component parts, using appropriate estimation techniques where necessary:

a) Payment for the fair value of services received;
b) Payment for the PFI asset, including finance costs; and
c) Payment for the replacement of components of the asset during the contract 'lifecycle replacement'.

Services received
The fair value of services received in the year is recorded under the relevant expenditure headings within 'operating expenses'

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.

1.18 Inventories
Inventories are valued at the lower of cost and net realisable value using the first-in first-out cost formula. This is considered to be a reasonable approximation to fair value due to the high turnover of stocks.

NOTES TO THE ACCOUNTS

1.19 Cash and cash equivalents

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

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

1.20 Provisions

Provisions are recognised when the NHS Trust has a present legal or constructive obligation as a result of a past event, it is probable that the Trust will be required to settle the obligation, and a reliable estimate can be made of the amount of the obligation. The amount recognised as a provision is the best estimate of the expenditure required to settle the obligation at the end of the reporting period, taking into account the risks and uncertainties. Where a provision is measured using the cash flows estimated to settle the obligation, its carrying amount is the present value of those cash flows using HM Treasury's discount rates.

Early retirement provisions are discounted using HM Treasury's pension discount rate of positive 0.24% (2015-16: positive 1.37%) in real terms. All other provisions are subject to three separate discount rates according to the expected timing of cash flows from the Statement of Financial Position date:

- A short term rate of negative 2.70% (2015-16: negative 1.55%) for expected cash flows up to and including 5 years
- A medium term rate of negative 1.95% (2015-16: negative 1.00%) for expected cash flows over 5 years up to and including 10 years
- A long term rate of negative 0.80% (2015-16: negative 0.80%) for expected cash flows over 10 years.

All percentages are in real terms.

When some or all of the economic benefits required to settle a provision are expected to be recovered from a third party, the receivable is recognised as an asset if it is virtually certain that reimbursements will be received and the amount of the receivable can be measured reliably.

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

A restructuring provision is recognised when the NHS Trust has developed a detailed formal plan for the restructuring and has raised a valid expectation in those affected that it will carry out the restructuring by starting to implement the plan or announcing its main features to those affected by it. The measurement of a restructuring provision includes only the direct expenditures arising from the restructuring, which are those amounts that are both necessarily entailed by the restructuring and not associated with ongoing activities of the entity.

1.21 Clinical negligence costs

The NHS Litigation Authority (NHSLA) operates a risk pooling scheme under which the Trust pays an annual contribution to the NHSLA, which in return settles all clinical negligence claims. The contribution is charged to expenditure. Although the NHSLA is administratively responsible for all clinical negligence cases the legal liability remains with the NHS Trust. The total value of clinical negligence provisions carried by the NHSLA on behalf of the trust is disclosed at Note 35.

1.22 Non-clinical risk pooling

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

1.23 Carbon Reduction Commitment Scheme (CRC)

CRC and similar allowances are accounted for as government grant funded intangible assets if they are not expected to be realised within twelve months, and otherwise as other current assets. They are valued at open market value. As the NHS Trust makes emissions, a provision is recognised with an offsetting transfer from deferred income. The provision is settled on surrender of the allowances. The asset, provision and deferred income amounts are valued at fair value at the end of the reporting period.

1.24 Contingencies

NOTES TO THE ACCOUNTS

A contingent liability is a possible obligation that arises from past events and whose existence will be confirmed only by the occurrence or non-occurrence of one or more uncertain future events not wholly within the control of the NHS Trust, or a present obligation that is not recognised because it is not probable that a payment will be required to settle the obligation or the amount of the obligation cannot be measured sufficiently reliably. A contingent liability is disclosed unless the possibility of a payment is remote.

A contingent asset is a possible asset that arises from past events and whose existence will be confirmed by the occurrence or non-occurrence of one or more uncertain future events not wholly within the control of the NHS Trust. A contingent asset is disclosed where an inflow of economic benefits is probable.

Where the time value of money is material, contingencies are disclosed at their present value.

1.25 Financial assets

Financial assets are recognised when the NHS Trust becomes party to the financial instrument contract or, in the case of trade receivables, when the goods or services have been delivered. Financial assets are derecognised when the contractual rights have expired or the asset has been transferred.

Financial assets are classified into the following categories: financial assets at fair value through profit and loss; held to maturity investments; available for sale financial assets, and loans and receivables. The classification depends on the nature and purpose of the financial assets and is determined at the time of initial recognition.

Financial assets at fair value through profit and loss

Embedded derivatives that have different risks and characteristics to their host contracts, and contracts with embedded derivatives whose separate value cannot be ascertained, are treated as financial assets at fair value through profit and loss. They are held at fair value, with any resultant gain or loss recognised in calculating the NHS Trust's surplus or deficit for the year. The net gain or loss incorporates any interest earned on the financial asset.

Held to maturity investments

Held to maturity investments are non-derivative financial assets with fixed or determinable payments and fixed maturity, and where there is a positive intention and ability to hold to maturity. After initial recognition, they are held at amortised cost using the effective interest method, less any impairment. Interest is recognised using the effective interest method.

Available for sale financial assets

Available for sale financial assets are non-derivative financial assets that are designated as available for sale or that do not fall within any of the other three financial asset classifications. They are measured at fair value with changes in value taken to the revaluation reserve, with the exception of impairment losses. Accumulated gains or losses are recycled to surplus/deficit on de-recognition.

Loans and receivables

Loans and receivables are non-derivative financial assets with fixed or determinable payments which are not quoted in an active market. After initial recognition, they are measured at amortised cost using the effective interest method, less any impairment. Interest is recognised using the effective interest method.

Financial assets are initially recognised at fair value. Fair value is determined by reference to quoted market prices where possible, otherwise by valuation techniques. The Trust has issued no loans, receivables are held at cost as this is believed to be not materially different to the initial fair value of the financial asset.

1.26 Financial liabilities

Financial liabilities are recognised on the statement of financial position when the NHS Trust becomes party to the contractual provisions of the financial instrument or, in the case of trade payables, when the goods or services have been received. Financial liabilities are de-recognised when the liability has been discharged, that is, the liability has been paid or has expired.

Loans from the Department of Health are recognised at historic cost. Otherwise, financial liabilities are initially recognised at fair value. The Trust's liabilities are held at cost as this is not believed to be materially different to fair value in respect of current liabilities.

Financial guarantee contract liabilities

The Trust has no financial guarantee contract liabilities

Financial liabilities at fair value through profit and loss

NOTES TO THE ACCOUNTS

Embedded derivatives that have different risks and characteristics to their host contracts, and contracts with embedded derivatives whose separate value cannot be ascertained, are treated as financial liabilities at fair value through profit and loss. They are held at fair value, with any resultant gain or loss recognised in the NHS Trust's surplus/deficit. The net gain or loss incorporates any interest payable on the financial liability.

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

Other financial liabilities
After initial recognition, all other financial liabilities are measured at amortised cost using the effective interest method, except for loans from Department of Health, which are carried at historic cost. The effective interest rate is the rate that exactly discounts estimated future cash payments through the life of the asset, to the net carrying amount of the financial liability. Interest is recognised using the effective interest method.

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

1.28 Foreign currencies
The NHS Trust's functional and presentational currency is sterling. Transactions denominated in a foreign currency are translated into sterling at the exchange rate ruling on the dates of the transactions. At the end of the reporting period, monetary items denominated in foreign currencies are retranslated at the spot exchange rate on 31 March. Resulting exchange gains and losses for either of these are recognised in the Trust's surplus/deficit in the period in which they arise.

1.29 Third party assets
Assets belonging to third parties (such as money held on behalf of patients) are not recognised in the accounts since the Trust has no beneficial interest in them. Details of third party assets are given in Note 45 to the accounts.

1.30 Public Dividend Capital (PDC) and PDC dividend
Public dividend capital represents taxpayers' equity in the NHS Trust. At any time the Secretary of State can issue new PDC to, and require repayments of PDC from, the trust. PDC is recorded at the value received. As PDC is issued under legislation rather than under contract, it is not treated as an equity financial instrument.

An annual charge, reflecting the cost of capital utilised by the trust, is payable to the Department of Health as public dividend capital dividend. The charge is calculated at the real rate set by HM Treasury (currently 3.5%) on the average carrying amount of all assets less liabilities (except for donated assets and cash balances with the Government Banking Service). The average carrying amount of assets is calculated as a simple average of opening and closing relevant net assets.

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

1.31 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 NHS trust not been bearing its own risks (with insurance premiums then being included as normal revenue expenditure). However the note on losses and special payments is compiled directly from the losses and compensations register which is prepared on an accruals basis.

1.32 Subsidiaries
Material entities over which the NHS Trust has the power to exercise control are classified as subsidiaries and are consolidated. The NHS Trust has control when it is exposed to or has rights to variable returns through its power over another entity. The income and expenses; gains and losses; assets, liabilities and reserves; and cash flows of the subsidiary are consolidated in full into the appropriate financial statement lines. Appropriate adjustments are made on consolidation where the subsidiary's accounting policies are not aligned with the NHS Trust or where the subsidiary's accounting date is not co-terminus.

NOTES TO THE ACCOUNTS

Subsidiaries that are classified as 'held for sale' are measured at the lower of their carrying amount or 'fair value less costs to sell'.

Following Treasury's agreement to apply IAS 27 to NHS Charities from 1st April 2013, the Trust has established that as the trust is the corporate trustee of the linked NHS charity - Maidstone and Tunbridge Wells NHS Charitable Fund (Charity registration 1055215), it effectively has the power to exercise control so as to obtain economic benefit. However the transactions are immaterial in the context of the group and transactions have not been consolidated. Details of the transactions with the charity are included in the related parties' notes.

The Trust has no subsidiaries.

1.33 Associates

Material entities over which the NHS Trust has the power to exercise significant influence so as to obtain economic or other benefits are classified as associates and are recognised in the NHS Trust's accounts using the equity method. The investment is recognised initially at cost and is adjusted subsequently to reflect the NHS trust share of the entity's profit/loss and other gains/losses. It is also reduced when any distribution is received by the NHS Trust from the entity.

Associates that are classified as 'held for sale' are measured at the lower of their carrying amount or 'fair value less costs to sell'

The Trust has no associates.

1.34 Joint arrangements

Material entities over which the NHS Trust has joint control with one or more other entities are classified as joint arrangements. Joint control is the contractually agreed sharing of control of an arrangement. A joint arrangement is either a joint operation or a joint venture. The Trust has no joint arrangements.

A joint operation exists where the parties that have joint control have rights to the assets and obligations for the liabilities relating to the arrangement. Where the NHS Trust is a joint operator it recognises its share of, assets, liabilities, income and expenses in its own accounts. The Trust has no joint operations.

A joint venture is a joint arrangement whereby the parties that have joint control of the arrangement have rights to the net assets of the arrangement. Joint ventures are recognised as an investment and accounted for using the equity method. The Trust has no joint ventures.

1.35 Research and Development

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

1.36 Accounting Standards that have been issued but have not yet been adopted

The HM Treasury FReM does not require the following Standards and Interpretations to be applied in 2016-17. These standards are still subject to HM Treasury FReM interpretation, with IFRS 9 and IFRS 15 being for implementation in 2018-19, and the government implementation date for IFRS 16 still subject to HM Treasury consideration.

● IFRS 9 Financial Instruments – Application required for accounting periods beginning on or after 1 January 2018, but not yet adopted by the FReM: early adoption is not therefore permitted

● IFRS 15 Revenue from Contracts with Customers - Application required for accounting periods beginning on or after 1 January 2018, but not yet adopted by the FReM: early adoption is not therefore permitted

● IFRS 16 Leases – Application required for accounting periods beginning on or after 1 January 2019, but not yet adopted by the FReM: early adoption is not therefore permitted.

1.37 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.

2. Pooled budget

Maidstone and Tunbridge Wells NHS Trust does not have any pooled budgets.

3. Operating segments

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

The Trust's income is predominantly from contracts for the provision of healthcare with Clinical Commissioning Groups (CCGs) and NHS England. This accounts for 86% of the Trust's total income.

4. Income generation activities

The Trust undertakes income generation activities with an aim of achieving profit, which is then used in patient care. The following provides details of income generation activities whose full cost exceeded £1m.

Summary Table - aggregate of all schemes	**2016-17 £000s**	2015-16 £000s
Income	**4,247**	4,062
Full cost	**(2,913)**	(2,993)
Surplus/(deficit)	**7,160**	7,055
Car Parking		
Income	**2,324**	2,232
Full cost	**(1,795)**	(1,811)
Surplus/(deficit)	**529**	421
Catering		
Income	**1,280**	1,315
Full cost	**(648)**	(753)
Surplus/(deficit)	**632**	562

5. Revenue from patient care activities

	2016-17 £000s	2015-16 £000s
NHS Trusts	**1,940**	1,407
NHS England	**79,154**	74,541
Clinical Commissioning Groups	**290,681**	270,212
Foundation Trusts	**1,511**	1,405
Department of Health	**8**	0
NHS Other (including Public Health England and Prop Co)	**505**	718
Additional income for delivery of healthcare services	**0**	0
Non-NHS:		
Local Authorities	**4,602**	4,799
Private patients	**4,799**	6,935
Overseas patients (non-reciprocal)	**321**	504
Injury costs recovery	**762**	1,167
Other Non-NHS patient care income	**130**	104
Total Revenue from patient care activities	**384,413**	361,792

Injury cost recovery income is subject to a provision for impairment of receivables which the trust has estimated using historical information for each main site. The provision rates are 21.93% for Maidstone Hospital and 16.25% for Tunbridge Wells Hospital (19% Maidstone Hospital and 14.28% Tunbridge Wells Hospital in 2015/16). This provision reflects expected rates of collection.

Included within revenue from NHS England for 2016-17 is £8.0m of central PFI financial support (2015-16 £12m). The local support concluded in 2015/16. The Trust's 2017-18 plan includes £8m recurrent central PFI support.

	2016-17 £000s	2015-16 £000s
Central Support for PFI scheme (excluding inflation)	**8,000**	8,000
NHS England local support for PFI scheme	**0**	4,000
	8,000	12,000

6. Other operating revenue

	2016-17 £000s	2015-16 £000s
Recoveries in respect of employee benefits	**0**	0

Patient transport services	**0**	0
Education, training and research	**13,080**	11,388
Charitable and other contributions to revenue expenditure - NHS	**0**	0
Charitable and other contributions to revenue expenditure -non- NHS	**0**	0
Receipt of charitable donations for capital acquisitions	**361**	610
Support from DH for mergers	**0**	**0**
Receipt of Government grants for capital acquisitions	**0**	0
Non-patient care services to other bodies	**20,159**	15,553
Sustainability & Transformation Fund Income	**5,677**	0
Income generation (Other fees and charges)	**4,247**	4,062
Rental revenue from finance leases	**0**	0
Rental revenue from operating leases	**23**	23
Other revenue	**2,542**	7,502
Total Other Operating Revenue	**46,089**	39,138
Total operating revenue	**430,502**	400,930

Other Operating Revenue included £7.8m income in 2015/16 for the Health Informatics Service that was hosted by the Trust until 31st March 2016.

Included within other operating income for 2016-17 is £5.677m of Sustainability and Transformation Funding (STF). The Trust's 2017-18 plan includes £11.177m of STF funding.

	2016-17 £000s	2015-16 £000s
NHS England STF funding	**5,677**	0

7. Overseas Visitors Disclosure

	2016-17 £000s	2015-16 £000s
Income recognised during 2016-17 (invoiced amounts and accruals)	**321**	**504**
Cash payments received in-year (re receivables at 31 March 2016)	**25**	**18**
Cash payments received in-year (re invoices issued 2016-17)	**95**	**361**
Amounts added to provision for impairment of receivables (re receivables at 31 March 2016)	**27**	**0**
Amounts added to provision for impairment of receivables (re invoices issued 2016-17)	**138**	**120**
Amounts written off in-year (irrespective of year of recognition)	**0**	**30**

8. Operating expenses

	2016-17 £000s	2015-16 £000s
Services from other NHS Trusts	**246**	299
Services from CCGs/NHS England	**18**	12
Services from other NHS bodies	**338**	193
Services from NHS Foundation Trusts	**7,071**	6,155
Total Services from NHS bodies*	**7,673**	6,659
Purchase of healthcare from non-NHS bodies	**8,643**	7,752
Purchase of Social Care	**0**	**0**
Trust Chair and Non-executive Directors	**75**	80
Supplies and services - clinical	**86,531**	78,755
Supplies and services - general	**5,618**	5,761
Consultancy services	**3,839**	1,001
Establishment	**3,778**	3,997
Transport	**1,633**	1,591
Service charges - ON-SOFP PFIs and other service concession arrangements	**4,268**	4,120
Total charges - Off-SOFP PFIs and other service concession arrangements	**0**	0
Business rates paid to local authorities	**3,353**	1,590
Premises	**12,717**	13,473
Hospitality	**0**	0
Insurance	**384**	342
Legal Fees	**249**	843
Impairments and Reversals of Receivables	**(421)**	378
Inventories write down	**0**	0
Depreciation	**12,303**	12,973
Amortisation	**952**	843
Impairments and reversals of property, plant and equipment	**41,293**	13,369
Impairments and reversals of intangible assets	**0**	0
Impairments and reversals of financial assets	**0**	0
Impairments and reversals of non current assets held for sale	**0**	0
Internal Audit Fees	**151**	171
Audit fees	**89**	90
Other auditor's remuneration**	**13**	13
Clinical negligence	**18,231**	16,573
Research and development (excluding staff costs)	**0**	0
Education and Training	**937**	1,060
Change in Discount Rate	**40**	(3)
Capital Grants in Kind	**0**	0
Other	**1,616**	1,836
Total Operating expenses (excluding employee benefits)	**213,965**	173,267
Employee Benefits		
Employee benefits excluding Board members	**250,818**	245,713
Board members	**1,338**	1,079
Total Employee Benefits	**252,156**	246,792
Total Operating Expenses	**466,121**	420,059

*Services from NHS bodies does not include expenditure which falls into a category below
**this relates to the quality audit which has not previously been separated from the audit fees

9. Operating Leases

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

Danwood - lease of photocopiers and printers under a managed service arrangement £875k (£696k 2015-16). This arrangement was renegotiated within the terms of the contract during 2016/17. The contract is expected to complete in June 2021

Ash Corporate Finance - lease of the laundry land, buildings and equipment £323k (£323k 2015-16). The lease is for a 25 year term and contains a break clause in December 2020.

Roche Diagnostic Limited - lease of equipment to support the pathology and clinical chemistry managed service £253k (£253k 2015-16). This arrangement completes in June 2017 with an option to extend for up to a further 3 years.

There are no purchase options or escalation clauses and there are no restrictions imposed by the lease arrangements.

9.1. Maidstone and Tunbridge Wells NHS Trust as lessee

	Land £000s	Build £000s	Other £000s	2016-17 Total £000s	2015-16 £000s
Payments recognised as an expense					
Minimum lease payments				**2,104**	2,256
Contingent rents				**0**	0
Sub-lease payments				**0**	0
Total				**2,104**	2,256
Payable:					
No later than one year		539	1,573	**2,112**	1,824
Between one and five years		1,956	6,059	**8,015**	3,698
After five years		1,300	0	**1,300**	1,692
Total	**0**	**3,795**	**7,632**	**11,427**	7,214
Total future sublease payments expected to be received:				0	0

9.2. Maidstone and Tunbridge Wells NHS Trust as lessor

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

	2016-17 £000s	2015-16 £000s
Recognised as revenue		
Rental revenue	23	23
Contingent rents	0	0
Total	**23**	23
Receivable:		
No later than one year	29	29
Between one and five years	147	115
After five years	206	230
Total	**382**	374

10. Employee benefits

10.1. Employee benefits

	2016-17 Total £000s	2015-16 Total £000s
Employee Benefits - Gross Expenditure		
Salaries and wages	**212,997**	212,514
Social security costs	**18,526**	14,350
Employer Contributions to NHS BSA - Pensions Division	**22,850**	22,310
Other pension costs	**6**	3
Termination benefits	**0**	478
Total employee benefits	**254,379**	249,655
Employee costs capitalised	**(2,223)**	(2,863)
Gross Employee Benefits excluding capitalised costs	**252,156**	246,792

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

10.2. Retirements due to ill-health

	2016-17 Number	2015-16 Number
Number of persons retired early on ill health grounds	**7**	5
	£000s	£000s
Total additional pensions liabilities accrued in the year	**413**	76

10.3. 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 are accepted as providing suitably robust figures for financial reporting purposes. The valuation of scheme liability as at 31 March 2017, is based on valuation data as 31 March 2016, updated to 31 March 2017 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 scheme actuary report, which forms part of the annual NHS Pension Scheme (England and Wales) Pension 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 their recent demographic experience), and to recommend contribution rates payable by employees and employers.

The last published actuarial valuation undertaken for the NHS Pension Scheme was completed for the year ending 31 March 2012. The Scheme Regulations allow for the level of contribution rates to be changed by the Secretary of State for Health, with the consent of HM Treasury, and consideration of the advice of the Scheme Actuary and appropriate employee and employer representatives as deemed appropriate.

The next actuarial valuation was due to be carried out as at 31 March 2016. This will set the employer contribution rate payable from April 2019 and will consider the cost of the Scheme relative to the employer cost cap. There are provisions in the Public Service Pension Act 2013 to adjust member benefits or contribution rates if the cost of the Scheme changes by more than 2% of pay. Subject to this 'employer cost cap' assessment, any required revisions to member benefits or contribution rates will be determined by the Secretary of State for Health after consultation with the relevant stakeholders.

The Trust participates in the National Employees Savings Trust (NEST) scheme as an alternative to those employees who are not eligible to join the NHS Pension Scheme. This came into effect in July 2013 for this Trust as part of the auto enrolment requirements introduced by the Government. NEST is a defined contribution scheme with a phased employer contribution rate, currently 1%. Trust contributions under the NEST scheme for the 2016/17 financial year totalled £6k (£3k 2015/16).

11. Better Payment Practice Code

11.1. Measure of compliance

	2016-17 Number	2016-17 £000s	2015-16 Number	2015-16 £000s
Non-NHS Payables				
Total Non-NHS Trade Invoices Paid in the Year	**103,549**	**175,490**	113,947	179,686
Total Non-NHS Trade Invoices Paid Within Target	**59,344**	**105,628**	77,717	134,047
Percentage of NHS Trade Invoices Paid Within Target	**57.31%**	**60.19%**	68.20%	74.60%
NHS Payables				
Total NHS Trade Invoices Paid in the Year	**2,775**	**32,678**	2,473	**27,339**
Total NHS Trade Invoices Paid Within Target	**990**	**21,653**	1,459	**20,508**
Percentage of NHS Trade Invoices Paid Within Target	**35.68%**	**66.26%**	59.00%	75.01%

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 a valid invoice, whichever is later.

11.2. The Late Payment of Commercial Debts (Interest) Act 1998

	2016-17 £000s	2015-16 £000s
Amounts included in finance costs from claims made under this legislation	**0**	0
Compensation paid to cover debt recovery costs under this legislation	**8**	0
Total	**8**	0

The Trust made 8 late payment charge totalling £3.5k and 12 interest charges of £4.5k (£75.33 total of charges and interest in 2015/16) during the year under the Late Payment of Commercial Debt Act.

12. Investment Revenue

	2016-17 £000s	2015-16 £000s
Rental revenue		
PFI finance lease revenue (planned)	**0**	0
PFI finance lease revenue (contingent)	**0**	0
Other finance lease revenue	**0**	0
Subtotal	**0**	0
Interest revenue		
Bank interest	**34**	47
Other loans and receivables	**0**	0
Impaired financial assets	**0**	0
Subtotal	**34**	47
Total investment revenue	**34**	47

13. Other Gains and Losses

	2016-17 £000s	2015-16 £000s
Gain/(Loss) on disposal of assets other than by sale (PPE)	**17**	**1**
Gain/(Loss) on disposal of assets other than by sale (intangibles)	**0**	**0**
Gain (Loss) on disposal of assets held for sale	**0**	**0**
Gain/(loss) on foreign exchange	**0**	**0**
Total	**17**	1

14. Finance Costs

	2016-17 £000s	2015-16 £000s
Interest		
Interest on loans and overdrafts	**1,094**	**710**
Interest on obligations under finance leases	**0**	**0**
Interest on obligations under PFI contracts:		
- main finance cost	**10,912**	**11,161**
- contingent finance cost	**2,635**	**2,472**
Interest on late payment of commercial debt	**0**	**0**
Total interest expense	**14,641**	14,343
Other finance costs	**0**	**0**
Provisions - unwinding of discount	**6**	**6**
Total	**14,647**	14,349

15. Finance Costs

15.1. Other auditor remuneration

	2016-17 £000s	2015-16 £000s
Other auditor remuneration paid to the external auditor:		
1. Audit of accounts of any associate of the trust	**0**	0
2. Audit-related assurance services	**13**	13
3. Taxation compliance services	**0**	0
4. All taxation advisory services not falling within item 3 above	**0**	0
5. Internal audit services	**0**	0
6. All assurance services not falling within items 1 to 5	**0**	0
7. Corporate finance transaction services not falling within items 1 to 6 above	**0**	0
8. Other non-audit services not falling within items 2 to 7 above	**0**	0
Total	**13**	13

The £13k reported in note 15.1 relates to the audit of the Trust's quality accounts. As the Trust does not consolidate its charitable funds (see note 1.4) 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 42 as a related party.

15.2. Limitation on auditor's liability

There is no limitation on auditor's liability for external audit work carried out for the financial years 2016/17 or 2015/16.

16.1. Property, plant and equipment

2016-17	Land	Buildings excluding dwellings	Dwellings	Assets under construction & payments on account	Plant & machinery	Transport equipment	Information technology	Furniture & fittings
Cost or valuation:								
At 1 April 2016	**18,275**	**297,231**	**4,085**	**3,016**	**79,024**	**960**	**19,009**	**2,755**
Additions of Assets Under Construction	**0**	**0**	**0**	**3,830**	**0**	**0**	**0**	**0**
Additions Purchased	**0**	**2,400**	**22**	**0**	**1,705**	**0**	**310**	**9**
Additions - Non Cash Donations (i.e. physical assets)	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
Additions - Purchases from Cash Donations & Government Grants	**0**	**0**	**0**	**0**	**361**	**0**	**0**	**0**
Additions Leased (including PFI/LIFT)	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
Reclassifications	**0**	**0**	**0**	**(662)**	**603**	**0**	**43**	**0**
Reclassifications as Held for Sale and reversals	**(525)**	**(525)**	**(700)**	**0**	**0**	**0**	**0**	**0**
Disposals other than for sale	**0**	**0**	**0**	**0**	**(741)**	**(102)**	**0**	**0**
Revaluation	**609**	**516**	**36**	**0**	**0**	**0**	**0**	**0**
Impairments/reversals charged to operating expenses	**0**	**(41,175)**	**0**	**0**	**0**	**0**	**(118)**	**0**
Impairments/reversals charged to reserves	**(4,863)**	**(23,126)**	**37**	**0**	**0**	**0**	**0**	**0**
At 31 March 2017	**13,496**	**235,321**	**3,480**	**6,184**	**80,952**	**858**	**19,244**	**2,764**
Depreciation								
At 1 April 2016	**0**	**0**	**161**	**0**	**56,941**	**924**	**14,524**	**1,408**
Reclassifications	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
Reclassifications as Held for Sale and reversals	**0**	**(3)**	**(5)**	**0**	**0**	**0**	**0**	**0**
Disposals other than for sale	**0**	**0**	**0**	**0**	**(733)**	**(102)**	**0**	**0**
Revaluation	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
Impairment/reversals charged to reserves	**0**	**(3,309)**	**0**	**0**	**0**	**0**	**0**	**0**
Impairments/reversals charged to operating expenses	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
Charged During the Year	**0**	**5,993**	**139**	**0**	**4,308**	**22**	**1,640**	**201**
At 31 March 2017	**0**	**2,681**	**295**	**0**	**60,516**	**844**	**16,164**	**1,609**
Net Book Value at 31 March 2017	**13,496**	**232,640**	**3,185**	**6,184**	**20,436**	**14**	**3,080**	**1,155**
Asset financing:								
Owned - Purchased	**13,496**	**90,619**	**3,185**	**6,184**	**18,830**	**14**	**3,065**	**1,155**
Owned - Donated	**0**	**29**	**0**	**0**	**1,606**	**0**	**15**	**0**
Owned - Government Granted	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
Held on finance lease	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
On-SOFP PFI contracts	**0**	**141,992**	**0**	**0**	**0**	**0**	**0**	**0**
PFI residual interests	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
Total at 31 March 2017	**13,496**	**232,640**	**3,185**	**6,184**	**20,436**	**14**	**3,080**	**1,155**

Revaluation Reserve Balance for Property, Plant & Equipment

	Land	Buildings	Dwellings	Assets under construction & payments on account	Plant & machinery	Transport equipment	Information technology	Furniture & fittings
	£000's	£000's	£000's	£000's	£000's	£000's	£000's	£000's
At 1 April 2016	**9,346**	**42,191**	**1,693**	**0**	**759**	**13**	**0**	**2**
Movements	**(4,254)**	**(19,300)**	**73**	**0**	**(216)**	**(3)**	**0**	**0**
At 31 March 2017	**5,092**	**22,891**	**1,766**	**0**	**543**	**10**	**0**	**2**

Additions to Assets Under Construction in 2016-17

	£000's
Land	**0**
Buildings excl Dwellings	**1**
Dwellings	**0**
Plant & Machinery	**3,829**
Balance as at YTD	**3,830**

16.2. Property, plant and equipment prior-year

2015-16	Land	Buildings excluding dwellings	Dwellings	Assets under construction & payments on	Plant & machinery	Transport equipment	Information technology	Furniture & fittings
Cost or valuation:								
At 1 April 2015	**38,580**	**299,498**	**3,033**	**6,758**	**81,875**	**960**	**16,323**	**2,694**
Additions of Assets Under Construction				**2,110**				
Additions Purchased	**0**	**9,132**	**46**	**0**	**1,171**	**0**	**1,344**	**61**
Additions - Non Cash Donations (i.e. Physical Assets)	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
Additions - Purchases from Cash Donations & Government Grants	**0**	**0**	**0**	**0**	**606**	**0**	**4**	**0**
Additions Leased (including PFI/LIFT)	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
Reclassifications	**0**	**529**	**0**	**(5,852)**	**2,839**	**0**	**1,669**	**0**
Reclassifications as Held for Sale and Reversals	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
Disposals other than for sale	**0**	**0**	**0**	**0**	**(7,467)**	**0**	**0**	**0**
Revaluation	**82**	**13,176**	**728**	**0**	**0**	**0**	**0**	**0**
Impairment/reversals charged to reserves	**(566)**	**(21,827)**	**0**	**0**	**0**	**0**	**(331)**	**0**
Impairments/reversals charged to operating expenses	**(19,821)**	**(3,277)**	**278**	**0**	**0**	**0**	**0**	**0**
At 31 March 2016	**18,275**	**297,231**	**4,085**	**3,016**	**79,024**	**960**	**19,009**	**2,755**
Depreciation								
At 1 April 2015	**0**	**3,010**	**53**	**0**	**60,107**	**882**	**12,614**	**1,134**
Reclassifications	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
Reclassifications as Held for Sale and Reversals	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
Disposals other than for sale	**0**	**0**	**0**	**0**	**(7,460)**	**0**	**0**	**0**
Revaluation	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
Impairments/reversals charged to operating expenses	**0**	**(9,355)**	**0**	**0**	**0**	**0**	**0**	**0**
Impairment/reversals charged to reserves	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
Charged During the Year	**0**	**6,345**	**108**	**0**	**4,294**	**42**	**1,910**	**274**
At 31 March 2016	**0**	**0**	**161**	**0**	**56,941**	**924**	**14,524**	**1,408**
Net Book Value at 31 March 2016	18,275	297,231	3,924	3,016	22,083	36	4,485	1,347
Asset financing:								
Owned - Purchased	**18,275**	**97,687**	**3,924**	**3,016**	**20,599**	**36**	**4,456**	**1,347**
Owned - Donated	**0**	**31**	**0**	**0**	**1,446**	**0**	**29**	**0**
Owned - Government Granted	**0**	**0**	**0**	**0**	**38**	**0**	**0**	**0**
Held on finance lease	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
On-SOFP PFI contracts	**0**	**199,513**	**0**	**0**	**0**	**0**	**0**	**0**
PFI residual interests	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
Total at 31 March 2016	**18,275**	**297,231**	**3,924**	**3,016**	**22,083**	**36**	**4,485**	**1,347**

Total
£000's
424,355
3,830
4,446
0
361
0
(16)
(1,750)
(843)
1,161
(41,293)
(27,952)
362,299
73,958
0
(8)
(835)
0
(3,309)
0
12,303
82,109
280,190
136,548
1,650
0
0
141,992
0
280,190

	Total
	£000's
	54,004
	(23,700)
	30,304

Total
£000's
449,721
2,110
11,754
0
610
0
(815)
0
(7,467)
13,986
(22,724)
(22,820)
424,355
77,800
0
0
(7,460)
0
(9,355)
0
12,973
73,958
350,397
149,340
1,506
38
0
199,513
0
350,397

16.3. Property, plant and equipment

The Trust spent £8.3m on tangible assets from its capital resource in 2016/17. The main items were: £1.7m linear accelerator machine funded from central PDC; £2.4m of backlog estates and renewal schemes; £3.1m on Information Technology projects; and £1.7m on medical and other equipment. In addition £247k of lifecycle capital was recognised as undertaken by the Trust's PFI partner in the year and accounted for under IFRIC 12.

Within the financial year 2016/17 the Trust purchased medical equipment totalling £362k from charitable funds. The largest single item was £151k spent on a cardiac ultrasound machine for Tunbridge Wells hospital funded from a legacy to the Cardiology department. A grant of £56k from NHS England was spent on gastro fibroscan equipment, and £49k on respiratory ventilators funded by the Maidstone League of Friends.

The Trust's depreciation on tangible assets in the year was £12.3m. Disposals were transacted for assets with £8k of remaining net book value which generated a profit on disposal of £17k.

The financial year 2016/17 is the second year in the current five year cyclical valuation period. A full valuation was undertaken in September 2014 with a desktop valuation at 31st March 2015 and 31st March 2016. In keeping with the Trust policies the Trust has commissioned independent professional valuers, Montagu Evans, to carry out a desktop valuation of the Trust Land, Building and Dwelling assets at 30th September 2016. The Trust has reviewed the movements in Building Cost Indices for the period from the valuation to the 31st March 2017 and has assessed the movements as immaterial.

Specialist properties (main hospitals) have been valued on Depreciation Replacement Cost (DRC) using the Modern Equivalent Assets (MEA) valuation concept. Non specialised buildings and land have been valued on an Existing Use Value (EUV) basis and key worker accommodation has been valued on an EUV - Social housing basis in line with RICS guidelines. In December 2016 the Trust Board approved the disposal of two residential properties (Hillcroft and the Spring) that had previously been identified as surplus to the Trust's requirements and valued in line with IFRS 13 at best and highest alternative use. These assets were reclassified to "non current assets held for sale" as they met the conditions for such classification and retained at the current carrying value (£1.742m).

During 2015/16 national guidance and best practice in the application of the Modern Equivalent Asset concept for the valuation of NHS specialist property was shared across the NHS community, including some elements that were clarified by the DH late in the 2015/16 reporting period. In consultation with its Valuers the Trust applied the MEA (Modern Equivalent Asset) approach in the light of this emerging application guidance as far as it was practicable in the given timeframes, with a view to reviewing the best practice and extant guidance further in the 2016/17 valuation. The main elements that have therefore been incorporated into the valuation exercise for 2016/17 are:
1. Application of the option on estimation set out in the DH Group Accounting Manual allowing the exclusion of VAT from the valuation of assets procured under a PFI contract and likely to be replaced under a similar contract; this has therefore been applied to the PFI assets at the Tunbridge Wells Hospital;
2. Application of the modern re-build concept to the Maidstone site to incorporate the likely design solution in any re-provision, reducing the land required;
3. Review of the appropriate treatment of car parking and office space accommodation in terms of both size and value for any modern equivalent asset;
4. Retention of the approach to alternative site application, using the range of values as previously applied by the Valuers.

The 30th September 2016 valuation resulted in an overall reduction in the carrying value of the Trust's Land and Property assets of £65.8m, of which £41.2m was charged as impairments (net of any reversals) to operating expenses and £24.6m to any existing credit on the revaluation reserve. The main components of this reduction were:
1. Operating expense impairments - £38.8m related to the Tunbridge Wells Hospital building and £1.1m the TWH hard landscaping, primarily in respect of the PFI VAT exclusion and the replacement approach to car parking facilities. For the Maidstone Hospital the impairment was £1.3m relating mainly to BCIS movements around plant room values.
2. Reserve impairments - £14.8m related to the TWH hospital build in respect of the PFI VAT exclusion and the replacement approach to car parking facilities. For the Maidstone site the building values reduced overall by £3.6m of which £2.6m related to office accommodation that could be re-provided offsite in any modern equivalent replacement. A further £1.5m related to the review of car parking facilities and reproviding the most efficient replacement layout and sizing. Land values at Maidstone reduced by £3.6m as a consequence of the application of the re-build concept on a multi-storey basis, requiring less space than the existing footprint. Land values reduced by £1.2m at TWH as a result of the car parking conceptually efficient reprovision.

There was an upward revaluation of £1.2m across the sites relating to movements in the underlying BCIS indices for the period.

Fixtures and equipment are carried at depreciated historic cost as this is not considered to be materially different from fair value. The Trust has reviewed its plant and machinery assets to ensure that both the value and the remaining lives are held at the correct values. A fair value assessment of IT tangible assets has been carried out based on a valuation model as advised by Trust experts, this is in accordance with the Trust's policy 1.10.

17. Intangible non-current assets

Sub Analysis columns Source Data

17.1. Intangible non-current assets

2016-17	IT - in-house & 3rd party software	Computer Licenses	Licenses and Trademarks	Patents	Development Expenditure - Internally Generated	Intangible Assets Under Construction	Total
							£000's
At 1 April 2016	**6,749**	**458**	**0**	**0**	**0**	**0**	**7,207**
Additions of Assets Under Construction						0	**0**
Additions Purchased	**781**	**121**	**0**	**0**	**0**	**0**	**902**
Additions Internally Generated	**0**	**0**	**0**	**0**	**0**	**0**	**0**
Additions - Non Cash Donations (i.e. physical assets)	**0**	**0**	**0**	**0**	**0**	**0**	**0**
Additions - Purchases from Cash Donations and Government Grants	**0**	**0**	**0**	**0**	**0**	**0**	**0**
Additions Leased (including PFI/LIFT)	**0**	**0**	**0**	**0**	**0**	**0**	**0**
Reclassifications	**16**	**0**	**0**	**0**	**0**	**0**	**16**
Reclassified as Held for Sale and Reversals	**0**	**0**	**0**	**0**	**0**	**0**	**0**
Disposals other than by sale	**0**	**0**	**0**	**0**	**0**	**0**	**0**
Upward revaluation/positive indexation	**0**	**0**	**0**	**0**	**0**	**0**	**0**
Impairments/reversals charged to operating expenses	**0**	**0**	**0**	**0**	**0**	**0**	**0**
Impairments/reversals charged to reserves	**0**	**0**	**0**	**0**	**0**	**0**	**0**
At 31 March 2017	**7,546**	**579**	**0**	**0**	**0**	**0**	**8,125**
Amortisation							
At 1 April 2016	**3,588**	**366**	**0**	**0**	**0**	**0**	**3,954**
Reclassifications	**0**	**0**	**0**	**0**	**0**	**0**	**0**
Reclassified as Held for Sale and Reversals	**0**	**0**	**0**	**0**	**0**	**0**	**0**
Disposals other than by sale	**0**	**0**	**0**	**0**	**0**	**0**	**0**
Upward revaluation/positive indexation	**0**	**0**	**0**	**0**	**0**	**0**	**0**
Impairment/reversals charged to reserves	**0**	**0**	**0**	**0**	**0**	**0**	**0**
Impairments/reversals charged to operating expenses	**0**	**0**	**0**	**0**	**0**	**0**	**0**
Charged During the Year	**887**	**65**	**0**	**0**	**0**	**0**	**952**
At 31 March 2017	**4,475**	**431**	**0**	**0**	**0**	**0**	**4,906**
Net Book Value at 31 March 2017	**3,071**	**148**	**0**	**0**	**0**	**0**	**3,219**
Asset Financing: Net book value at 31 March 2017 comprises:							
Purchased	**3,071**	**148**	**0**	**0**	**0**	**0**	**3,219**
Donated	**0**	**0**	**0**	**0**	**0**	**0**	**0**
Government Granted	**0**	**0**	**0**	**0**	**0**	**0**	**0**
Finance Leased	**0**	**0**	**0**	**0**	**0**	**0**	**0**
On-balance Sheet PFIs	**0**	**0**	**0**	**0**	**0**	**0**	**0**
Total at 31 March 2017	**3,071**	**148**	**0**	**0**	**0**	**0**	**3,219**
Revaluation reserve balance for intangible non-current assets							
	£000's	**£000's**	**£000's**	**£000's**	**£000's**	**£000's**	**£000's**
At 1 April 2016	**0**	**0**	**0**	**0**	**0**	**0**	**0**
Movements	**0**	**0**	**0**	**0**	**0**	**0**	**0**
At 31 March 2017	**0**	**0**	**0**	**0**	**0**	**0**	**0**

17.2. Intangible non-current assets prior year

2015-16	IT - in-house & 3rd party software	Computer Licenses	Licenses and Trademarks	Patents	Development Expenditure - Internally Generated	Intangible assets under construction	Total
	£000s	£000s	£000s	£000s	£000s	£000s	£000's
Cost or valuation:							
At 1 April 2015	**5,049**	**458**	**0**	**0**	**0**	**0**	**5,507**
Additions - purchased	**885**	**0**	**0**	**0**	**0**	**0**	**885**
Additions - internally generated	**0**	**0**	**0**	**0**	**0**	**0**	**0**
Additions - donated	**0**	**0**	**0**	**0**	**0**	**0**	**0**
Additions - government granted	**0**	**0**	**0**	**0**	**0**	**0**	**0**
Additions Leased (including PFI/LIFT)	**0**	**0**	**0**	**0**	**0**	**0**	**0**
Reclassifications	**815**	**0**	**0**	**0**	**0**	**0**	**815**
Reclassified as held for sale	**0**	**0**	**0**	**0**	**0**	**0**	**0**
Disposals other than by sale	**0**	**0**	**0**	**0**	**0**	**0**	**0**
Upward revaluation/positive indexation	**0**	**0**	**0**	**0**	**0**	**0**	**0**
Impairments/reversals charged to operating expenses	**0**	**0**	**0**	**0**	**0**	**0**	**0**
Impairments/reversals charged to reserves	**0**	**0**	**0**	**0**	**0**	**0**	**0**
At 31 March 2016	6,749	458	0	0	0	0	7,207
Amortisation							
At 1 April 2015	**2,857**	**254**	**0**	**0**	**0**	**0**	**3,111**
Reclassifications	**0**	**0**	**0**	**0**	**0**	**0**	**0**
Reclassified as held for sale	**0**	**0**	**0**	**0**	**0**	**0**	**0**
Disposals other than by sale	**0**	**0**	**0**	**0**	**0**	**0**	**0**
Upward revaluation/positive indexation	**0**	**0**	**0**	**0**	**0**	**0**	**0**
Impairments/reversals charged to operating expenses	**0**	**0**	**0**	**0**	**0**	**0**	**0**
Impairments/reversals charged to reserves	**0**	**0**	**0**	**0**	**0**	**0**	**0**
Charged during the year	**731**	**112**	**0**	**0**	**0**	**0**	**843**
At 31 March 2016	**3,588**	**366**	**0**	**0**	**0**	**0**	**3,954**
Net book value at 31 March 2016	**3,161**	**92**	**0**	**0**	**0**	**0**	**3,253**
Asset Financing: Net book value at 31 March 2016 comprises:							
Purchased	**3,161**	**92**	**0**	**0**	**0**	**0**	**3,253**
Donated	**0**	**0**	**0**	**0**	**0**	**0**	**0**
Government Granted	**0**	**0**	**0**	**0**	**0**	**0**	**0**
Finance Leased	**0**	**0**	**0**	**0**	**0**	**0**	**0**
On-balance Sheet PFIs	**0**	**0**	**0**	**0**	**0**	**0**	**0**
Total at 31 March 2016	**0**	**0**	**0**	**0**	**0**	**0**	**0**

17.3. Intangible non-current assets

During 2016/17 the Trust spent £902k on intangible software and licences, and recognised £16k of assets under construction as completed in the period.
The intangible assets relate to purchase of software and licences and the Trust considers the carrying value to represent fair value
The Trust has no intangible assets with indefinite lives.
The asset lives are set out in policy number 1.12

18. Analysis of impairments and reversals recognised in 2016-17

	Property Plant and Equipment	Intangible Assets	Financial Assets	Non-Current Assets Held for Sale	Total
	£000s	£000s	£000s	£000s	£000s
Impairments and reversals taken to SoCI					
Loss or damage resulting from normal operations	0	0	0	0	**0**
Over-specification of assets	0	0	0	0	**0**
Abandonment of assets in the course of construction	0	0	0	0	**0**
Total charged to Departmental Expenditure Limit	**0**	**0**	**0**	**0**	**0**
Unforeseen obsolescence	0	0	0	0	**0**
Loss as a result of catastrophe	0	0	0	0	**0**
Other	0	0	0	0	**0**
Changes in market price	41,293	0	0	0	**41,293**
Total charged to Annually Managed Expenditure	**41,293**	**0**	**0**	**0**	**41,293**
Total Impairments of Property, Plant and Equipment changed to SoCI	**41,293**	**0**	**0**	**0**	**41,293**

Donated and Gov Granted Assets, included above	**£000s**
PPE - Donated and Government Granted Asset Impairments: amount charged to SOCI - DEL	**0**
Intangibles - Donated and Government Granted Asset Impairments: amount charged to SOCI - DEL	**0**

Changes in market price in respect of the Modern Equivalent Asset revaluation of Property, Plant and Equipment generated net impairments of £41.175m charged to the SoCI following the desktop valuation at 30th September 2016. The balance of £0.118m represents the fair value assessment of IT equipment assets based on a valuation model as advised by Trust experts in the relevant asset class.

These impairments are taken to the SoCI where either no applicable revaluation reserve exists for the component asset, or has been previously exhausted. Impairments disclosed through the Statement of Financial Position for reserve adjustments totalled £24.6m.

Further information in respect of the valuation is contained in Note 16.3.

19. Investment property

The Trust has no investment properties.

20. Commitments

20.1. Capital commitments

Contracted capital commitments at 31 March not otherwise included in these financial statements:

	31 March 2017 £000s	31 March 2016 £000s
Property, plant and equipment	710	115
Intangible assets	0	9
Total	710	124

20.2. Other financial commitments

The Trust has no non-cancellable contracts not disclosed elsewhere under PFI contracts or leases.

21. Inventories

	Drugs £000s	Consumables £000s	Work in Progress £000s	Energy £000s	Loan Equipment £000s	Other £000s	Total £000s	Of which held at NRV £000s
Balance at 1 April 2016	**3,787**	**976**	**0**	**51**	**0**	**3,472**	**8,286**	0
Additions	**40,379**	**0**	**63**	**0**	**0**	**13,081**	**53,523**	0
Inventories recognised as an expense in the period	**(40,830)**	**(88)**	**0**	**0**	**0**	**(12,946)**	**(53,864)**	0
Write-down of inventories (including losses)	**0**	**0**	**0**	**0**	**0**	**0**	**0**	0
Reversal of write-down previously taken to SOCI	**0**	**0**	**0**	**0**	**0**	**0**	**0**	0
Balance at 31 March 2017	**3,336**	**888**	**63**	**51**	**0**	**3,607**	**7,945**	**0**

22.1. Trade and other receivables

	Current		Non-current	
	31 March 2017 £000s	31 March 2016 £000s	**31 March 2017 £000s**	31 March 2016 £000s
NHS receivables - revenue	**35,171**	22,511	**0**	0
NHS receivables - capital	**107**	0	**0**	0
NHS prepayments and accrued income	**0**	0	**0**	0
Non-NHS receivables - revenue	**2,976**	2,594	**0**	0
Non-NHS receivables - capital	**0**	0	**0**	0
Non-NHS prepayments and accrued income	**4,730**	3,700	**308**	0
PDC Dividend prepaid to DH	**683**	480	**0**	0
Provision for the impairment of receivables	**(797)**	(1,273)	**0**	0
VAT	**2,068**	2,317	**0**	0
Current/non-current part of PFI and other PPP arrangements prepayments and accrued income excluding PFI lifecycle	**0**	0	**158**	138
Interest receivables	**0**	0	**0**	0
Finance lease receivables	**0**	0	**0**	0
Operating lease receivables	**0**	0	**0**	0
Other receivables	**1,481**	1,640	**1,030**	1,062
Total	**46,419**	31,969	**1,496**	1,200
Total current and non current	**47,915**	33,169		
Included in NHS receivables are prepaid pension contributions:	**0**			

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

22.2. Receivables past their due date but not impaired

	31 March 2017 £000s	31 March 2016 £000s
By up to three months	**5,202**	7,256
By three to six months	**1,603**	2,536
By more than six months	**1,178**	3,708
Total	**7,983**	13,500

The Trust does not hold any collateral against receivable balances.

22.3. Provision for impairment of receivables

	2016-17 £000s	2015-16 £000s
Balance at 1 April 2016	**(1,273)**	(971)
Amount written off during the year	**55**	76
Amount recovered during the year	**0**	0
(Increase)/decrease in receivables impaired	**421**	(378)
Balance at 31 March 2017	**(797)**	(1,273)

The provision of receivables includes provision for all non-NHS invoices over 120 days overdue plus any other invoices that are deemed to be a specific risk. In addition Injury cost recovery debt is provided for in accordance with the approach set out in note 5.

23. NHS LIFT investments

The Trust does not have any LIFT investments.

24.1. Other Financial Assets - Current

The Trust does not have any current financial assets.

24.2. Other Financial Assets - Non Current

The Trust does not have any non-current financial assets.

25. Other current assets

The Trust does not have any other current assets.

26. Cash and Cash Equivalents

	31 March 2017 £000s	31 March 2016 £000s
Opening balance	**1,197**	3,796
Net change in year	**223**	(2,599)
Closing balance	**1,420**	1,197
Made up of		
Cash with Government Banking Service	**1,366**	1,125
Commercial banks	**40**	33
Cash in hand	**14**	39
Liquid deposits with NLF	**0**	0
Current investments	**0**	0
Cash and cash equivalents as in statement of financial position	**1,420**	1,197
Bank overdraft - Government Banking Service	**0**	0
Bank overdraft - Commercial banks	**0**	0
Cash and cash equivalents as in statement of cash flows	**1,420**	1,197
Third Party Assets - Bank balance (not included above)	**1**	3
Third Party Assets - Monies on deposit	**0**	0

27. Non-current assets held for sale

	Land	Buildings, excl. dwellings	Dwellings	Asset Under Construction and Payments on Account	Plant and Machinery	Transport and Equipment	Information Technology	Furniture and Fittings	Intangible Assets	Financial Assets	Total
	£000s	£000s	£000s	£000s	£000s	£000s	£000s	£000s	£000s	£000s	£000s
Balance at 1 April 2016	0	0	0	0	0	0	0	0	0	0	**0**
Plus assets classified as held for sale in the year	525	522	695	0	0	0	0	0	0	0	**1,742**
Less assets sold in the year	0	0	0	0	0	0	0	0	0	0	**0**
Less impairment of assets held for sale	0	0	0	0	0	0	0	0	0	0	**0**
Plus reversal of impairment of assets held for sale	0	0	0	0	0	0	0	0	0	0	**0**
Less assets no longer classified as held for sale, for reasons other than disposal by sale	0	0	0	0	0	0	0	0	0	0	**0**
Balance at 31 March 2017	**525**	**522**	**695**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**1,742**
Liabilities associated with assets held for sale at 31 March 2017	0	0	0	0	0	0	0	0	0	0	**0**
Balance at 1 April 2015	0	0	0	0	0	0	0	0	0	0	**0**
Plus assets classified as held for sale in the year	0	0	0	0	0	0	0	0	0	0	**0**
Less assets sold in the year	0	0	0	0	0	0	0	0	0	0	**0**
Less impairment of assets held for sale	0	0	0	0	0	0	0	0	0	0	**0**
Plus reversal of impairment of assets held for sale	0	0	0	0	0	0	0	0	0	0	**0**
Less assets no longer classified as held for sale, for reasons other than disposal by sale	0	0	0	0	0	0	0	0	0	0	**0**
Balance at 31 March 2016	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
Liabilities associated with assets held for sale at 31 March 2016	0	0	0	0	0	0	0	0	0	0	**0**

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

28. Trade and other payables

	Current		Non-current	
	31 March 2017 £000s	31 March 2016 £000s	**31 March 2017 £000s**	31 March 2016 £000s
NHS payables - revenue	**4,453**	4,949	**0**	0
NHS payables - capital	**2**	23	**0**	0
NHS accruals and deferred income	**5,094**	0	**0**	0
Non-NHS payables - revenue	**23,574**	15,133	**0**	0
Non-NHS payables - capital	**3,408**	1,584	**0**	0
Non-NHS accruals and deferred income	**12,898**	10,767	**0**	0
Social security costs	**2,751**	4,459	**0**	0
PDC Dividend payable to DH	**0**	0	**0**	0
Accrued Interest on DH Loans	**105**	36	**0**	0
VAT	**0**	0	**0**	0
Tax	**2,409**	4,717	**0**	0
Payments received on account	**0**	0	**0**	0
Other	**1,405**	1,370	**0**	0
Total	**56,099**	43,038	**0**	0
Total payables (current and non-current)	**56,099**	**43,038**		
Included above:				
to Buy Out the Liability for Early Retirements Over 5 Years	**0**	0		
number of Cases Involved (number)	**0**	0		
outstanding Pension Contributions at the year end	**3,159**	3,191		

29. Other liabilities

The Trust does not have any other liabilities

30. Borrowings

	Current		Non-current	
	31 March 2017 £000s	31 March 2016 £000s	**31 March 2017 £000s**	31 March 2016 £000s
Bank overdraft - Government Banking Service	**0**	0	**0**	0
Bank overdraft - commercial banks	**0**	0	**0**	0
Loans from Department of Health	**4,632**	2,174	**41,368**	31,410
Loans from other entities	**0**	0	**0**	0
PFI liabilities - main liability	**5,028**	4,774	**198,233**	203,261
Finance lease liabilities	**0**	0	**0**	0
Other	**0**	0	**0**	0
Total	**9,660**	**6,948**	**239,601**	234,671
Total other liabilities (current and non-current)	**249,261**	**241,619**		

Included within the current loans from Department of Health is an uncommitted term loan for £2.458m which has been repaid in April 2017.

Borrowings / Loans - repayment of principal falling due in:

	31 March 2017		
	DH £000s	**Other £000s**	**Total £000s**
0-1 Years	4,632	5,028	**9,660**
1 - 2 Years	2,174	5,284	**7,458**
2 - 5 Years	34,736	16,178	**50,914**
Over 5 Years	4,458	176,771	**181,229**
TOTAL	**46,000**	**203,261**	**249,261**

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

The PFI liabilities relate to the PFI contract that the Trust signed in March 2008. The contract is a standard form PFI contract with a concession that completes in 2042, when the building reverts to the Trust. Further information is set out in note 38.

The Trust has received a revenue working capital loan of £16.9m in March 2016 consolidating previous interim revolving facilities. The loan is interest bearing at 1.5% per annum and the principal falls due in February 2019. During 2016/17 the Trust utilised its interim revolving working capital facility to the extent of £12.1m, this is due for repayment in October 2020. The Trust also took out a short term Uncommitted Term Loan of 6% from the DH in advance of receipt of quarter 3 STF payment. This latter loan was repaid in full on 18 April 2017.

31. Other financial liabilities

The Trust does not have any other financial liabilities

32. Deferred income

	Current		Non-current	
	31 March 2017 £000s	31 March 2016 £000s	**31 March 2017 £000s**	31 March 2016 £000s
Opening balance at 1 April 2016	**2,111**	4,695	**0**	0
Deferred revenue addition	**39,953**	35,453	**0**	0
Transfer of deferred revenue	**(36,319)**	(38,037)	**0**	0
Current deferred Income at 31 March 2017	**5,745**	2,111	**0**	0
Total deferred income (current and non-current)	**5,745**	2,111		

Deferred income for 2016/17 includes an item for the maternity pathway arrangement agreed with West Kent CCG of £2m.

33. Finance lease obligations as lessee

The Trust has not entered into any finance lease arrangement as lessee.

34. Finance lease receivables as lessor

The Trust has not entered into any finance lease arrangement as lessor.

35. Provisions

		Comprising:						
	Total	**Early Departure Costs**	**Legal Claims**	**Restructuring**	**Continuing Care**	**Equal Pay (incl. Agenda for Change**	**Other**	**Redundancy**
	£000s	**£000s**	**£000s**	**£000s**	**£000s**	**£000s**	**£000s**	**£000s**
Balance at 1 April 2016	**3,732**	420	412	0	0	0	2,313	587
Arising during the year	**190**	17	173	0	0	0	0	0
Utilised during the year	**(907)**	(23)	(115)	0	0	0	(182)	(587)
Reversed unused	**(57)**	0	(57)	0	0	0	0	0
Unwinding of discount	**6**	6	0	0	0	0	0	0
Change in discount rate	**40**	40	0	0	0	0	0	0
Balance at 31 March 2017	**3,004**	**460**	**413**	**0**	**0**	**0**	**2,131**	**0**
Expected Timing of Cash Flows:								
No Later than One Year	**1,744**	23	413	0	0	0	1,308	0
Later than One Year and not later than Five Years	**914**	91	0	0	0	0	823	0
Later than Five Years	**346**	346	0	0	0	0	0	0

Amount Included in the Provisions of the NHS Litigation Authority in Respect of Clinical Negligence Liabilities:

As at 31 March 2017	164,886
As at 31 March 2016	149,922

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

Other includes the provision for dilapidations of leased properties/equipment £1,786k and onerous contract provision £362k.

36. Contingencies

	31 March 2017	31 March 2016
	£000s	£000s
Contingent liabilities		
NHS Litigation Authority legal claims	**(57)**	**(65)**
Employment Tribunal and other employee related litigation	**0**	**0**
Redundancy	**0**	**0**
Other	**0**	**0**
Net value of contingent liabilities	**(57)**	**(65)**
Contingent assets		
Contingent assets	**0**	**0**
Net value of contingent assets	**0**	**0**

37. Analysis of charitable fund reserves

The Trust has not consolidated the charity accounts within the main exchequer accounts so this note is not used.

38. PFI and LIFT - additional information

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 2016/17 year was 1.29%.

The information below is required by the Department of Heath for inclusion in national statutory accounts

Charges to operating expenditure and future commitments in respect of ON and OFF SOFP PFI

	2016-17 £000s	2015-16 £000s
Total charge to operating expenses in year - Off SoFP PFI	**0**	0
Service element of on SOFP PFI charged to operating expenses in year	**4,268**	4,120
Total	**4,268**	4,120

Payments committed to in respect of off SOFP PFI and the service element of on SOFP PFI

No Later than One Year	**4,696**	4,394
Later than One Year, No Later than Five Years	**20,832**	19,462
Later than Five Years	**159,100**	161,471
Total	**184,628**	185,327

The estimated annual payments in future years will vary according to published RPI rates but are not expected to be materially different from those which the Trust is committed to make during the next year.

Imputed "finance lease" obligations for on SOFP PFI contracts due

	2016-17 £000s	2015-16 £000s
No Later than One Year	**15,686**	15,686
Later than One Year, No Later than Five Years	**61,316**	62,060
Later than Five Years	**291,071**	306,013
Subtotal	**368,073**	383,759
Less: Interest Element	**(164,812)**	(175,724)
Total	**203,261**	208,035

Present Value Imputed "finance lease" obligations for on SOFP PFI contracts due Analysed by when PFI payments are due	**2016-17 £000s**	2015-16 £000s
No Later than One Year	**5,028**	4,774
Later than One Year, No Later than Five Years	**21,462**	21,088
Later than Five Years	**176,771**	182,173
Total	**203,261**	208,035

Number of on SOFP PFI Contracts

Total Number of on PFI contracts	**1**
Number of on PFI contracts which individually have a total commitments value in excess of £500m	**0**

39. Impact of IFRS treatment - current year

The information below is required by the Department of Heath for budget reconciliation purposes	2016-17 Income £000s	2016-17 Expenditure £000s	2015-16 Income £000s	2015-16 Expenditure £000s
Revenue costs of IFRS: Arrangements reported on SoFP under IFRIC12 (e.g. PFI / LIFT)				
Depreciation charges	0	**3,165**	0	3,424
Interest Expense	0	**10,912**	0	13,633
Impairment charge - AME	0	**39,832**	0	7,925
Impairment charge - DEL	0	**0**	0	0
Other Expenditure	0	**6,903**	0	4,122
Revenue Receivable from subleasing	0	0	0	0
Impact on PDC dividend payable	0	**(1,216)**	0	(494)
Total IFRS Expenditure (IFRIC12)	0	**59,596**	0	28,610
Revenue consequences of PFI / LIFT schemes under UK GAAP / ESA95 (net of any sublease revenue)	0	**(20,013)**	0	(20,001)
Net IFRS change (IFRIC12)	**0**	**39,583**	0	8,609
Capital Consequences of IFRS : LIFT/PFI and other items under IFRIC12				
Capital expenditure 2015-16		**247**		274
UK GAAP capital expenditure 2015-16 (Reversionary Interest)		**3,235**		3,084

	2016-17 Income/ Expenditure IFRIC 12 YTD **£000s**	**2016-17** Income/ Expenditure ESA 10 YTD **£000s**	2015-16 Income/ Expenditure IFRIC 12 YTD **£000s**	2015-16 Income/ Expenditure ESA 10 YTD **£000s**
Revenue costs of IFRIC12 compared with ESA10				
Depreciation charges	**3,165**	**0**	3,424	0
Interest Expense	**10,912**	**0**	13,633	0
Impairment charge - AME	**39,832**	**0**	7,925	0
Impairment charge - DEL	**0**	**0**	0	0
Other Expenditure				
Service Charge	**4,268**	**20,013**	4,120	20,001
Contingent Rent	**2,635**	**0**	0	0
Lifecycle	**0**	**0**	2	0
Impact on PDC Dividend Payable	**(1,216)**	**0**	(494)	0
Total Revenue Cost under IFRIC12 vs ESA10	**59,596**	**20,013**	28,610	20,001
Revenue Receivable from subleasing	**0**	**0**	0	0
Net Revenue Cost/(income) under IFRIC12 vs ESA10	**59,596**	**20,013**	28,610	20,001

40. Financial Instruments

40.1. Financial risk management

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

The Trust's treasury management operations are carried out by the finance department, within parameters defined formally within the Trust's standing financial instructions and policies agreed by the board of directors. The Trust's treasury activity is subject to review by the Trust's internal auditors.

Currency risk

The Trust is principally a domestic organisation with the great majority of transactions, assets and liabilities being in the UK and sterling based. The Trust has no overseas operations. The Trust therefore has low exposure to currency rate fluctuations.

Interest rate risk

The Trust borrows from government for capital expenditure, subject to affordability as confirmed by NHS Improvement. The borrowings are for 1 – 25 years, in line with the life of the associated assets, and interest is charged at the National Loans Fund rate, fixed for the life of the loan. The Trust therefore has low exposure to interest rate fluctuations.

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

The Trust therefore has low exposure to interest rate fluctuations.

Credit risk

Because the majority of the Trust's revenue comes from contracts with other public sector bodies, the Trust has low exposure to credit risk. The maximum exposures as at 31 March 2017 are in receivables from customers, as disclosed in the trade and other receivables note.

Liquidity risk

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

40.2. Financial Assets

	At 'fair value through profit and loss'	Loans and receivables	Available for sale	Total
	£000s	£000s	£000s	£000s
Embedded derivatives	0	0	0	**0**
Receivables - NHS	0	33,278	0	**33,278**
Receivables - non-NHS	0	6,400	0	**6,400**
Cash at bank and in hand	0	1,420	0	**1,420**
Other financial assets	0	0	0	**0**
Total at 31 March 2017	**0**	**41,098**	**0**	**41,098**
Embedded derivatives	0	0	0	0
Receivables - NHS	0	22,512	0	22,512
Receivables - non-NHS	0	5,293	0	5,293
Cash at bank and in hand	0	1,197	0	1,197
Other financial assets	0	0	0	0
Total at 31 March 2016	0	29,002	0	29,002

40.3. Financial Liabilities

	At 'fair value through profit and loss'	Other	Available for sale	Total
	£000s	£000s	£000s	£000s
Embedded derivatives	0	0	0	0
NHS payables	0	4,455	0	4,455
Non-NHS payables	0	40,334	0	40,334
Other borrowings	0	46,000	0	46,000
PFI & finance lease obligations	0	203,261	0	203,261
Other financial liabilities	0	0	0	0
Total at 31 March 2017	**0**	**294,050**	**0**	**294,050**
Embedded derivatives	0	0	0	0
NHS payables	0	4,972	0	4,972
Non-NHS payables	0	25,165	0	25,165
Other borrowings	0	33,584	0	33,584
PFI & finance lease obligations	0	208,035	0	208,035
Other financial liabilities	0	0	0	0
Total at 31 March 2016	0	271,756	**0**	271,756

41. Events after the end of the reporting period

The Trust has no events after the reporting period to report.

42. Related party transactions

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

The Department of Health is regarded as a related party. During the year 2016/17 the Trust has received £14.9m working capital financing, £1.7m capital PDC and the Trust also has loans with the DH, interest paid within the year £1.1m, principal repayment of £2.4m and the balance outstanding for the working capital loans is £31.5m. The Trust has also had a significant number of material transactions with the Department, and with other entities for which the Department is regarded as the parent Department. The following entities with material transactions of more than £1m are listed below:

Ashford CCG
Medway CCG
West Kent CCG
High Weald Lewes Havens CCG
Dartford, Gravesham and Swanley CCG
Swale CCG
Hastings and Rother CCG
Wessex Specialised Commissioning Hub
South East Specialised Commissioning Hub
Kent Community Foundation Trust
East Kent University Hospitals Foundation Trust
Medway NHS Foundation Trust
NHS England
Dartford and Gravesham NHS Trust
Kent and Medway NHS and Social Care Partnership Trust
Health Education England
HMRC
NHS Pension Authority
NHS Litigation Authority
NHS Supply Chain
Kent County Council
NHS Blood and Transplant
Maidstone Borough Council
Tunbridge Wells Borough Council

The Trust has also received revenue and capital payments from the Charitable Funds that it controls, the trustees for which are also members of the Trust Board. The Trust has not consolidated the Charitable Funds on the grounds of materiality to the Trust (see policy notes 1.4 and 1.32). 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.

	2016-17	2015-16
	£000s	£000s
Total charitable resources expended with the Trust	**866**	795 *
Closing creditor (monies owed to the Trust by the charity)	**477**	365 *
Total income received by the Charity in the reporting period	**291**	1,474 *
Total Charitable Funds at end of the reporting period	**1,151**	1,726 *

* prior year comparators have been restated following the completion of charitable funds accounts.

43. Losses and special payments

The total number of losses cases in 2016-17 and their total value was as follows:

	Total Value of Cases £s	**Total Number of Cases**
Losses	47,271	54
Special payments	26,647	40
Gifts	0	0
Total losses and special payments and gifts	73,918	94

The total number of losses cases in 2015-16 and their total value was as follows:

	Total Value of Cases £s	**Total Number of Cases**
Losses	75,916	44
Special payments	17,917	48
Total losses and special payments	93,833	92

Details of cases individually over £300,000
The Trust had no cases exceeding £300,000

44. Financial performance targets

The figures given for periods prior to 2009-10 are on a UK GAAP basis as that is the basis on which the targets were set for those years.

44.1. Breakeven performance

	2006-07 £000s	2007-08 £000s	2008-09 £000s	2009-10 £000s	2010-11 £000s	2011-12 £000s	2012-13 £000s	2013-14 £000s	2014-15 £000s	2015-16 £000s	2016-17 £000s
Turnover	243,218	272,939	297,888	311,889	322,176	345,101	367,391	375,714	403,310	400,930	430,502
Retained surplus/(deficit) for the year	(4,932)	131	143	(17,077)	(20,474)	(27,113)	(4,704)	(30,946)	(14,954)	(37,312)	(52,066)
Adjustment for:											
Timing/non-cash impacting distortions:											
Pre FDL(97)24 agreements	0	0	0	0	0	0	0	0	0	0	0
Prior Period Adjustments	0	(5,441)	0	0	0	0	0	0	0	0	0
Adjustments for impairments	0	0	0	17,266	21,430	23,646	2,610	17,175	14,250	13,369	41,293
Adjustments for impact of policy change re donated/government grants assets	0	0	0	0	0	324	182	57	0	(154)	(145)
Consolidated Budgetary Guidance - adjustment for dual accounting under IFRIC12*	0	0	0	0	754	3,443	2,041	1,340	861	684	0
Other agreed adjustments	0	0	4,952	0	0	0	0	0	0	0	0
Break-even in-year position	**(4,932)**	**(5,310)**	**5,095**	**189**	**1,710**	**300**	**129**	**(12,374)**	**157**	**(23,413)**	**(10,918)**
Break-even cumulative position	**(3,045)**	**(8,355)**	**(3,260)**	**(3,071)**	**(1,361)**	**(1,061)**	**(932)**	**(13,306)**	**(13,149)**	**(36,562)**	**(47,480)**

* Due to the introduction of International Financial Reporting Standards (IFRS) accounting in 2009-10, NHS Trust's financial performance measurement needs to be aligned with the guidance issued by HM Treasury measuring Departmental expenditure. Therefore, the incremental revenue expenditure resulting from the application of IFRS to IFRIC 12 schemes (which would include PFI schemes), which has no cash impact and is not chargeable for overall budgeting purposes, is excluded when measuring Breakeven performance. Other adjustments are made in respect of accounting policy changes (impairments and the removal of the donated asset and government grant reserves) to maintain comparability year to year.

	2006-07 %	2007-08 %	2008-09 %	2009-10 %	2010-11 %	2011-12 %	2012-13 %	2013-14 %	2014-15 %	2015-16 %	2016-17 %
Materiality test (I.e. is it equal to or less than 0.5%):											
Break-even in-year position as a percentage of turnover	-2.03	-1.95	1.71	0.06	0.53	0.09	0.04	-3.29	0.04	-5.84	-2.54
Break-even cumulative position as a percentage of turnover	-1.25	-3.06	-1.09	-0.98	-0.42	-0.31	-0.25	-3.54	-3.26	-9.12	-11.03

The amounts in the above tables in respect of financial years 2005/06 to 2008/09 inclusive have **not** been restated to IFRS and remain on a UK GAAP basis.

44.2. Capital cost absorption rate

The dividend payable on public dividend capital is based on the actual (rather than forecast) average relevant net assets based on the pre audited accounts and therefore the actual capital cost absorption rate is automatically 3.5%.

44.3. External financing

The Trust is given an external financing limit which it is permitted to undershoot.

	2016-17 £000s	2015-16 £000s
External financing limit (EFL)	9,541	16,470
Cash flow financing	9,121	16,316
Finance leases taken out in the year	0	0
Other capital receipts	0	(43)
External financing requirement	**9,121**	16,273
Under/(over) spend against EFL	**420**	197

44.4. Capital resource limit

The Trust is given a capital resource limit which it is not permitted to exceed.

	2016-17 £000s	2015-16 £000s
Gross capital expenditure	9,539	15,359
Less: book value of assets disposed of	(8)	(7)
Less: capital grants	0	0
Less: donations towards the acquisition of non-current assets	(362)	(609)
Charge against the capital resource limit	**9,169**	14,743
Capital resource limit	12,529	14,795
(Over)/underspend against the capital resource limit	**3,360**	52

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

45. Third party assets

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

	31 March 2017 £000s	31 March 2016 £000s
Third party assets held by the Trust	**1**	3

The third party assets are all patients' monies held by the Trust.

Trust Board meeting – May 2017

NHS Maidstone and Tunbridge Wells NHS Trust

5-18	Approval of the Management Representation Letter, 2016/17	Chair of the Audit and Governance Committee

The approval of the Letter of Representation from the Trust (management) is a formal part of the Annual Accounts process.

The Letter is drafted by the Trust's External Auditors, using standard wording, following the completion of their Audit of the Annual Accounts.

The enclosed Letter is scheduled to be reviewed and agreed at the Audit and Governance Committee on 24th May (before the Trust Board meeting), with the intention that the Committee recommend that the Board approve the Letter. A verbal update on the outcome of the Committee's review will be given at the Board on 24th May.

If the Audit and Governance Committee agrees, the Trust Board is asked to approve the Letter. If approved, the Letter will be signed, on behalf of the Trust Board, by the Chief Executive (as Accountable Officer), on 25th May 2017, and submitted to the External Auditors.

Which Committees have reviewed the information prior to Board submission?
- Audit and Governance Committee, 24/05/17

Reason for submission to the Board (decision, discussion, information, assurance etc.) [1]
Review and approval

[1] All information received by the Board should pass at least one of the tests from 'The Intelligent Board' & 'Safe in the knowledge: How do NHS Trust Boards ensure safe care for their patients': the information prompts relevant & constructive challenge; the information supports informed decision-making; the information is effective in providing early warning of potential problems; the information reflects the experiences of users & services; the information develops Directors' understanding of the Trust & its performance

Maidstone and Tunbridge Wells NHS Trust

Grant Thornton UK LLP
Grant Thornton House
Melton Street
Euston
London NW1 2EP

25th May 2017

Dear Sirs

Maidstone and Tunbridge Wells NHS Trust - Financial Statements for the year ended 31st March 2017.

This representation letter is provided in connection with the audit of the financial statements of Maidstone and Tunbridge Wells NHS Trust for the year ended 31st March 2017 for the purpose of expressing an opinion as to whether the financial statements give a true and fair view in accordance with International Financial Reporting Standards and the accounting policies directed by the Secretary of State with the consent of the Treasury as relevant to the National Health Service in England.

We confirm that to the best of our knowledge and belief having made such inquiries as we considered necessary for the purpose of appropriately informing ourselves:

Financial Statements

i As Trust Board members, we have fulfilled our responsibilities under the National Health Services Act 2006 for the preparation of the financial statements in accordance with the Department of Health Group Accounting Manual 2016-17 (GAM) and International Financial Reporting Standards which give a true and fair view in accordance therewith.

ii We have complied with the requirements of all statutory directions affecting the Trust and these matters have been appropriately reflected and disclosed in the financial statements.

iii The Trust has complied with all aspects of contractual agreements that could have a material effect on the financial statements in the event of non-compliance. There has been no non-compliance with requirements of the Care Quality Commission or other regulatory authorities that could have a material effect on the financial statements in the event of non-compliance.

iv We acknowledge our responsibility for the design, implementation and maintenance of internal control to prevent and detect fraud.

v Significant assumptions used by us in making accounting estimates, including those measured at fair value, are reasonable.

vi We are satisfied that the material judgements used in the preparation of the financial statements are soundly based, in accordance with International Financial Reporting Standards and the GAM, and adequately disclosed in the financial statements. There are no other material judgements that need to be disclosed.

vii Except as disclosed in the financial statements:
   a. there are no unrecorded liabilities, actual or contingent
   b. none of the assets of the Trust has been assigned, pledged or mortgaged
   c. there are no material prior year charges or credits, nor exceptional or non-recurring items requiring separate disclosure.

viii Related party relationships and transactions have been appropriately accounted for and disclosed in accordance with the requirements of International Financial Reporting Standards and the GAM.

ix All events subsequent to the date of the financial statements and for which International Financial Reporting Standards and the GAM requires adjustment or disclosure have been adjusted or disclosed.

x We have considered the adjusted misstatements, and misclassification and disclosures changes schedules included in your Audit Findings Report. The financial statements have been amended for these misstatements, misclassifications and disclosure changes and are free of material misstatements, including omissions.

xi In calculating the amount of income to be recognized in the financial statements from other NHS organisations we have applied judgement, where appropriate, to reflect the appropriate amount of income expected to be received by the Trust in accordance with the International Financial Reporting Standards and the GAM.

xii Actual or possible litigation and claims have been accounted for and disclosed in accordance with the requirements of International Financial Reporting Standards and the GAM.

xiii We acknowledge our responsibility to participate in the Department of Health's agreement of balances exercise and have followed the requisite guidance and directions to do so. We are satisfied that the balances calculated for the Trust ensure the financial statements and consolidation schedules are free from material misstatement, including the impact of any disagreements.

xiv We have no plans or intentions that may materially alter the carrying value or classification of assets and liabilities reflected in the financial statements.

Information Provided

xv We have provided you with:
   a. access to all information of which we are aware that is relevant to the preparation of the financial statements such as records, documentation and other matters;
   b. additional information that you have requested from us for the purpose of your audit; and
   c. unrestricted access to persons within the Trust from whom you determined it necessary to obtain audit evidence.

xvi We have communicated to you all deficiencies in internal control of which management is aware.

xvii All transactions have been recorded in the accounting records and are reflected in the financial statements.

xviii We have disclosed to you the results of our assessment of the risk that the financial statements may be materially misstated as a result of fraud.

xix We have disclosed to you all our knowledge of fraud or suspected fraud affecting the Trust involving:
   a. management;
   b. employees who have significant roles in internal control; or
   c. others where the fraud could have a material effect on the financial statements.

xx We have disclosed to you all our knowledge of any allegations of fraud, or suspected fraud, affecting the Trust's financial statements communicated by employees, former employees, regulators or others.

xxi We have disclosed to you all known instances of non-compliance or suspected non-compliance with laws and regulations whose effects should be considered when preparing financial statements.

xxii We have disclosed to you the identity of all of the Trust's related parties and all the related party relationships and transactions of which we are aware.

xxiii We have disclosed to you all known actual or possible litigation and claims whose effects should be considered when preparing the financial statements.

Annual Report

xxiv The disclosures within the Annual Report fairly reflect our understanding of the Trust's financial and operating performance over the period covered by the financial statements.

Annual Governance Statement

xxv We are satisfied that the Annual Governance Statement (AGS) fairly reflects the Trust's risk assurance framework and we confirm that we are not aware of any significant risks that are not disclosed within the AGS.

Approval

The agreement of this letter of representation was minuted by the Trust's Audit and Governance Committee at its meeting on 24th May 2017. The approval of this letter of representation was minuted by the Trust Board at its meeting on 24th May 2017.

Yours faithfully

Glenn Douglas
Chief Executive

25th May 2017

Signed on behalf of the Trust Board