MTW
Exceptional people, outstanding care

NHS
Maidstone and Tunbridge Wells
NHS Trust

Annual report and accounts

2021-2022

About this Annual Report

The National Health Service and Community Care Act 1990 requires NHS Trusts to produce an Annual Report. Its content and format must follow the guidance issued by the Department of Health and Social Care (in the form of a 'Group Accounting Manual'). The specific requirements for Annual Reports for 2021/22 are that NHS bodies must publish a single Annual Report and Accounts (ARA) document, comprising the following:

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

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

- "Performance Report for 2021/22", which is split into:
  - An overview. This includes an overview summary; the purpose and activities of the Trust; the Chair and Chief Executive's report; a 'snapshot of the year'; key developments; the key issues and risks affecting delivery of the Trust's objectives; an explanation of the adoption of the going concern basis; and a Performance summary
  - A Performance analysis, which includes details of how the Trust measures performance; the Trust's development and performance in 2021/22; and a review of financial performance for 2021/22
  - A summary of the Trust's Quality Accounts for 2021/22
  - A Sustainability Report. This follows the standard reporting format from the NHS Sustainable Development Unit.
- "Accountability Report for 2021/22", which is divided into the following sections:
  - "Corporate Governance Report for 2021/22", which includes:
    - A Directors' report (providing details about the Trust Board; a Statement regarding Directors' disclosure to auditors; attendance at Trust Board meetings; Directors' interests; the Trust's Management Structure; complaints performance and the Trust's application of the 'Principles for Remedy' guidance; disclosure of "incidents involving data loss or confidentiality breaches"; & details of Emergency Preparedness arrangements)
    - The "Statement of the Chief Executive's responsibilities as the Accountable Officer of the Trust"
    - A "Statement of Directors' responsibilities in respect of the accounts"
    - The "Annual Governance Statement for 2021/22"
  - "Remuneration and Staff Report for 2021/22" (including details of 'off-payroll' engagements)
  - The "Parliamentary Accountability and Audit Report"
- "Financial Statements for 2021/22", including details of Pension Liabilities, exit packages and severance payments; and staff sickness absence data
- Independent Auditor's report to the Directors of Maidstone and Tunbridge Wells NHS Trust.

The Annual Report and Accounts were approved by the Trust Board of Maidstone and Tunbridge Wells NHS Trust on 16th June 2022.

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

Contents

Performance report for 2021-2022:
Overview

The purpose of the overview section

This overview aims to equip the reader with a broad understanding of the Trust, its purpose, the key risks to the achievement of its objectives, and an outline of its performance during 2021/22. For those wishing to read in more detail about the Trust's achievements, the issues it faced and its financial situation, further detail is provided in the rest of the Annual Report and Accounts.

The purpose and activities of Maidstone and Tunbridge Wells NHS Trust

Maidstone and Tunbridge Wells NHS Trust (the Trust) is a large acute hospital Trust in the south east of England. The Trust was legally established on 14th February 2000[2], for the purposes specified in section 5(1) of the National Health Service and Community Care Act 1990 i.e. to be responsible for the ownership, provision and management of hospitals or other establishments or facilities. The Trust's mission, as defined in its Strategy, is to be there for our patients and their families in their time of need, and to empower our staff so that they can feel proud and fulfilled in delivering the best care for our community; while the Trust's vision is "Exceptional people, outstanding care". The Trust provides a full range of general hospital services and some areas of specialist complex care to around 600,000[3] people living in West Kent and East Sussex; and also provides some aspects of specialist care to a wider population.

The Trust's core catchment areas are Maidstone and Tunbridge Wells and their surrounding boroughs. It employs over 6,900 full and part-time staff, and operates from three main sites (Maidstone Hospital, Tunbridge Wells Hospital and the Crowborough Birth Centre), but also manages services at Kent and Canterbury Hospital and outpatient services at several community locations.

In September 2021 the Trust Board approved a Business Case for the provision of a Community Diagnostic Centre (CDC), by the Trust, on behalf of West Kent Integrated Care Partnership (ICP), following approval of 'early adopter' status by NHS England / Improvement.

In September 2021 the Trust Board approved the centralisation of complex inpatient medical and surgical gastroenterology at Tunbridge Wells Hospital, to enable the development of a dedicated Digestive Diseases Unit (DDU).

In February 2022, following a 14-week engagement period, the Trust Board approved the centralisation of the inpatient cardiology service and the cardiac catheter laboratories at Maidstone Hospital to enable the

[2] See The Maidstone and Tunbridge Wells National Health Service Trust (Establishment) Order 2000
[3] Based on the population for which the Trust would be the default service provider for a blue-light ambulance response; the Trust's population 'footprint' is subject to variation dependent on specific service provisions.

delivery of a 7-day service which provides improved quality of care, service efficiencies, minimised waits and enhanced patient experience (subject to the approval of a Full Business Case in 2022/23).

Tunbridge Wells Hospital is a Private Finance Initiative (PFI) hospital[4] and the majority of the site provides single bedded en-suite accommodation for inpatients in a modern, state of the art environment. It is a designated Trauma Unit, undertakes the Trust's emergency surgery and is the main site for Women's and Children's, and Orthopaedic services.

Maidstone Hospital benefits from its central county location. It hosts the Kent Oncology Centre, providing specialist Cancer services to around 1.9 million people across Kent and East Sussex, the fourth largest oncology service in the country. The Trust offers PET/CT (Positron Emission Tomography – Computed Tomography) services in a dedicated building and has a rolling programme to upgrade its Linear Accelerator radiotherapy machines. The Trust also provides sexual health services to the population of Kent and Medway. The Maidstone site also has a state-of-the-art Birth Centre, a dedicated ward for respiratory services and an Academic Centre with a 200-seat auditorium. The Education Centre at Tunbridge Wells Hospital, with its full resuscitation simulation suite, enables the Trust to offer excellent clinical training. The Trust has strong clinical, academic and research links with London hospitals, including joint appointments. Many staff are nationally recognised for excellence in their fields.

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

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

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

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

[4] The PFI Project Company is "Kent and East Sussex Weald Hospital Ltd" (KESWHL)

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

For all of us 2021/22 has been a year of achievement and dedication but also one of shock and horror as we learnt about the appalling crimes committed by David Fuller. The families of his victims have been unimaginably hurt by his crimes and our apologies and heartfelt sympathies are with each of them. We remain committed to supporting the independent inquiry into the mortuary offences committed by Fuller and will make any improvements it may recommend.

Over the last 12 months we have continued to respond to the impact of COVID-19 and have also faced a fresh set of challenges – treating the thousands of people whose care has been disrupted by pandemic pressures. It has been an incredibly difficult year in so many ways but also a year which has showcased what our exceptional staff at MTW excel at; an unwavering commitment to providing outstanding patient care.

The country is learning to live with COVID-19 but while the virus circulates in our communities important safety measures remain in place to keep our patients and staff safe. These infection prevention protocols and the impact of the Covid virus on our staff have directly affected the number of patients we can care for. With the additional increase in hospital attendances and the pressures on social care impacting our ability to discharge patients, across the NHS we face major challenges.

But throughout this year the hard work, resilience and care shown by our staff has been exceptional and we are immensely proud of all they have achieved. Across MTW we have sustained our levels of performance, continuing to be one of the best performing Trusts for emergency care, providing our patients with some of the fastest access to cancer treatment in England and reducing the large number of patients waiting for planned care.

Despite the many impacts of the pandemic we would like to highlight a number of achievements:

- Organisational development - in May last year we launched our MTW story, sharing the strategic priorities we will be focusing on to take MTW to outstanding. These are based on staff feedback and what we have learnt from other excelling Trusts. This was followed by the launch of our Exceptional Leaders development programme for 300 senior leaders - a key step in helping us deliver our Exceptional People, Outstanding Care vision and based on staff feedback on what good leadership looks like.

- Staff engagement - almost 3,500 MTW staff completed the annual survey and MTW scored above the national average for acute trusts in five out of the seven NHS People Promise themes. These positive results demonstrate the improvements we are making as a Trust while continuing to respond to the pandemic challenges. Some of the most encouraging themes in the results are: staff recognising our compassion and inclusivity and recommending MTW as a place to work and to receive treatment.

- Performance – continued delivery of the 62-day cancer access standard, consistently in the top 10 nationally for Emergency Department performance, a reduction in the number of long waiting patients from almost 1,000 to zero.

- Finance – achieved the financial plan for 2021/22 and delivered a significant capital programme, investing in the infrastructure and services of the Trust. Looking forward, the changes to the financial regime in 2022/23 will require additional focus to ensure we continue to deliver the financial plan and restore elective care

- Service developments – at Tunbridge Wells Hospital the Trust built a new Paediatric Emergency Department, upgraded the facilities within the Pharmacy Aseptic Unit and began work on a new academic teaching and accommodation building for medical students and trainee doctors. At Maidstone Hospital work began on a Barn Theatres project which will expand elective theatre capacity for both the Trust and the wider health system. Diagnostic capacity was increased with the opening of a new Community Diagnostic Centre close to Maidstone Hospital and this will be expanded further in 2022/23.

- Digital developments – the introduction of a new electronic bed management system has seen the time a hospital bed is empty more than half and also reduced the time it takes to get a patient from the Emergency Department (ED) into a bed. A new Electronic Patient Record system was also introduced across the Trust in the summer of 2021. This system demonstrates our enthusiasm and energy in embracing change and technology to provide better outcomes for our patients and introduces a number of key benefits. These include saving staff time, improving the uniformity of notes and ensuring a smoother patient experience.

Looking ahead we will continue to prioritise the health and wellbeing of staff, building on the psychological and practical support introduced in 2021/22. We will focus on recruitment – launching a dedicated recruitment website and a number of major recruitment campaigns to attract people who share our values. The Trust will continue to develop a Digestive Diseases Unit with surgery and medicine working together to increase the range and quality of services for patients. We will also design complex cardiology services, with dedicated cardiac wards, a Coronary Care Unit and Cardiac Catheter laboratories, improving the access of complex cardiology services. As we develop these plans collaboration is crucial across the health and care sector and we will continue to develop our partnerships with health, local authority and the voluntary and community sectors.

We look forward with confidence to the year ahead and would like to take this opportunity to thank all our staff and volunteers for their incredible efforts. There is of course more to do but we have a great deal to be proud of and by working together we will take MTW to outstanding.

Miles Scott, Chief Executive

16th June 2022

David Highton, Chair of the Trust Board

16th June 2022

Snapshot of 2021/22

April 2021

MTW was delighted to announce the appointment of Jo Haworth as the Trust's new Chief Nurse. Jo previously held the post of Deputy Chief Nurse at King's College Hospital in London and has held a number of senior nursing leadership roles in the NHS. She has a commitment to outstanding care which delivers the best possible experience for patients and staff and is a powerful advocate for partnership working. Jo took over from Claire O'Brien, who retired after five years at MTW and more than 41 years working in the NHS.

May 2021

In May we launched our MTW story, sharing with colleagues the strategic priorities we will focus on to take our Trust to outstanding. These are based on staff feedback and what we have learnt from other excelling Trusts. This was followed by the launch of our Exceptional Leaders development programme for 300 senior leaders - a key step in helping us deliver our Exceptional People, Outstanding Care vision and based on staff feedback on what good leadership looks like.

June 2021

Emergency Department staff celebrated the roll out of a new Electronic Patient Record (EPR) system to support joined up patient care across the Trust. Within the first three weeks the EPR system created 21,000 documents, made nearly 40,000 orders for tests and referrals, collected nearly 30,000 specimens and received 170,000 results. This system ensures staff have access to records in one place which saves time and duplication and marks a significant step in our journey to going paperless.

July 2021

New state-of-the-art technology is helping MTW to deliver outstanding care by ensuring patients get the right care, in the right place, at the right time. Thanks to a wall of computer screens in the Care Co-ordination Centre (CCC) at Maidstone Hospital, a team of specialist staff can see in real time how many beds need cleaning or are clean and ready for patients as well as those where people are being discharged. The bed management system has enormous benefits for both staff and patients, reducing the time a hospital bed is empty and the time it takes to get a patient from the Emergency Department into a bed. Time is also given back to nurses and ward staff to care for patients.

August 2021

Ground-breaking work began on the construction of a new medical student accommodation and academic building at Tunbridge Wells Hospital. The new state-of-the-art six storey building will provide teaching facilities and high-quality accommodation for 144 medical students and trainee doctors a year. Once fully established, it will place 120 additional Kent and Medway Medical School students with MTW every 12 months – a 315% increase in the total number of students the Trust currently takes.

September 2021

Two milestones were celebrated in September – Tunbridge Wells Hospital marked 10 years of being fully operational and Maidstone Birth Centre celebrated 10 years since it first opened its doors. Over the last decade Tunbridge Wells Hospital has cared for 742,000 people through its Emergency Department, carried out 142,000 operations, delivered 1,874,000 outpatient appointments and delivered 53,000 babies.

October 2021

Cancer patients at MTW are receiving some of the fastest access to treatment in the UK as the Trust achieved the national standard for treating patients within 62 days for 24 months in a row. Against the backdrop of the COVID-19 pandemic MTW continued all cancer treatments, quickly moving many face to face appointments to video and telephone consultations and only bringing in patients to site who were urgently required. The Trust also introduced a number of changes to improve its cancer waiting times and respond to the rise in demand, including investing in staff, upskilling more nurses to be able to deliver chemotherapy treatment, improving diagnostic equipment and facilities and introducing new treatment pathways.

November 2021

As part of a staff winter wellbeing programme MTW invested in additional resources to support colleagues with their mental health and wellbeing. Staff wellbeing lounges were refurbished on each site to provide welcoming and restful spaces for staff to relax and recharge. Wellbeing partners were recruited to work alongside the divisions to offer support and signposting to wellbeing services to managers and staff. Food wagons made regular visits, delivering lunch to both hospitals, and events including acupuncture, massage sessions and art therapy proved popular with staff. Alongside the Winter Wellbeing programme, we also launched the #OnlyHuman campaign, with tips and tools aimed at encouraging staff to look after themselves and also actively look out for the wellbeing of their colleagues.

December 2021

The cranes moved in and work began on the new Paediatric Emergency Department at Tunbridge Wells Hospital. The department is co-located with our main Emergency Department (ED) and will provide easy access to support from adult ED staff and resus facilities. The unit is also located within close proximity to radiology and theatres. Once fully operational, the new unit will offer a child friendly environment with appropriate facilities for parents, children and carers alongside separate red and green triage rooms to support infection prevention and control protocols. Our teams and patients will also have access to two high dependency rooms, seven examination cubicles and a minor injuries room.

January 2022

Thanks to an innovative new pilot programme which checks for signs of certain types of cancer MTW can quickly tell patients if they do or do not have the disease. The Trust is the only organisation across Kent and Medway taking part in the two-year pilot where patients swallow a tiny camera, known as a colon capsule endoscopy, to check for signs of cancer and provide a diagnosis within hours. Since the launch of the programme in June 2021, the Trust has performed colon capsule endoscopies on 147 patients and has been able to tell 100 people they do not have cancer much earlier than would have previously been possible.

February 2022

Prime Minister Boris Johnson and Chancellor of the Exchequer Rishi Sunak met staff and patients during a visit to the Kent Oncology Centre at Maidstone Hospital. The Trust, which runs the centre, provides specialist cancer services to around 1.9 million people across Kent, Medway and East Sussex. The Prime Minister praised the staff who provide cancer patients at the centre with some of the fastest access to treatment in England. The country's senior politicians were joined by local MPs Helen Grant, Tracey Crouch and Helen Whately. The group talked to radiographers and medical physicists in the new multi-million-pound CT and Linear Accelerator (LinAc) suites, hearing first-hand about the importance of these machines in diagnosing and treating cancer.

March 2022

Different. Not Less – a campaign that aims to improve care for patients with learning disabilities or autism, was launched across our hospitals. The campaign promotes a better understanding of autism and learning disabilities and supports the delivery of equality in care for all patients. It encourages staff to avoid making assumptions about autistic patients or those with learning disabilities and to listen to them and their families. MTW has organised autism reality experience training for staff to help increase understanding of the hypersensitivity that can be caused by the actions of others and by the hospital environment. The training provides the experience of what autism is like and how simple changes to clinical practice and the hospital environment can improve the hospital experience for autistic patients or those with learning disabilities.

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

The Trust Board agreed the following key Vision Goals / Targets; and associated Breakthrough objectives for 2021/22:

- To increase the percentage of staff that recommended the Trust as a good place to work, as per the findings of the Quarterly Climate Survey.
  - To increase the Quarterly Climate Survey response rates to provide a larger sample base to be able to assess those that recommend the Trust as a place to work
- To reduce the number of incidents resulting in patient harm by March 2022.
  - To reduce the number of slips, trips and falls (rate per 1,000 occupied bed days)
- To ensure that no patient waits longer than 52 weeks for treatment by April 2022; and,
- To achieve the Referral To Treatment (RTT) standard by April 2022.
  - To ensure activity levels for Theatres match those pre-COVID-19
  - To ensure activity levels for first outpatient appointments match those pre-COVID-19
  - To ensure activity levels for follow up outpatient appointments match those pre-COVID-19
  - To ensure activity levels for Magnetic Resonance Imaging (MRI) diagnostics match those pre-COVID-19
  - To ensure activity levels for computerised tomography (CT) diagnostics match those pre-COVID-19
  - To ensure activity levels for Non-Obstetric Ultrasound (NOUS) diagnostics match those pre-COVID-19
- To maintain the national Friends and Family Test (FFT) positive response rate for inpatients.
  - To implement 'Always Events' which will include a focus on seeing an increase in response rates across all FFT domains to meet the national response rate target for inpatients.
- To maintain the national Friends and Family Test (FFT) positive response rate for Accident and Emergency (A&E) patients.
  - To implement 'Always Events' which will include a focus on seeing an increase in response rates across all FFT domains to meet the national response rate target for Accident and Emergency (A&E) patients
- To maintain the national Friends and Family Test (FFT) positive response rate for Maternity Services.
  - To increase response rates across all the Trust's FFT domains to meet the national target response rate for Maternity Services
- To maintain the national Friends and Family Test (FFT) positive response rate for outpatients.
  - To increase response rates across all the Trust's FFT domains to meet the national target response rate for Outpatients
- To reduce the number of non-elective bed days to a monthly average of less than 550, which represents approximately a 10% reduction on the current number of non-elective bed days.
  - To reduce the average non-elective bed days relating to patients with high and very high acuity ambulatory emergency care (AEC) conditions by 10%
- To deliver the Trust's financial plan for 2021/22, including operational delivery of the Trust's capital investment plan.
- To reduce the amount of money the Trust spends on premium workforce spend from c.£48m to target level by April 2022.

The key issues and risks affecting delivery of these objectives are described in the monthly Integrated Performance Report and primarily within the top contributors section of the Counter Measures Summaries for the Breakthrough Objectives (as described in the Trust's Strategy Deployment Review (SDR) process, and monitored by the Trust Board through the Integrated Performance Report – see the "Annual Governance Statement for 2021/22" (pages 54 to 65)). These are summarised below. Details of how the Trust actually performed against these objectives are provided in the "Performance analysis" section (pages 18 to 27).

To increase the percentage of staff that recommended the Trust as a good place to work, as per the findings of the Quarterly Climate Survey

The key recognised risks to delivery of the associated breakthrough objectives were:

- People, which included sufficient capacity for staff to complete the Climate Survey.
- Process, which included concerns from Trust staff in relation to the anonymity of responses.
- Equipment, which included access issues for non-desk-based staff due to the Climate Survey being conducted online.
- Management, which included lack of communication to Trust staff of the actions which had been implemented in response to the findings from previous Climate surveys.

To reduce the number of incidents resulting in patient harm by March 2022

The key recognised risks to delivery of the objective were:

- Education, which included non-elective radiology diagnostic errors; and insufficient National Early Warning Score (NEWS) 2 training.
- Equipment, which included clinical observation machines not being digitally linked to the 'Sunrise' Electronic Patient Record (EPR).
- Process, which included inconsistent COVID-19 screening during admission; inconsistent enhanced care assessments; and inconsistent falls risk screening during admission.
- Workforce, which included nursing and midwifery staffing shortages; and staff 'burnout'.
- Clinical Pathways, which included insufficient mental health pathway capacity for patients with acute care needs.
- Patient profile, which included increased frailty and acuity of acute medical and surgical patients; and high levels of non-elective activity.
- Environment, which included the requirement for bathroom environments to be optimised for fall reduction; and the challenges associated with the provision of visual observations in ward areas with an increased number of side rooms.

To ensure that no patient waits longer than 52 weeks for treatment by April 2022

The key recognised risks to delivery of this objective were:

- Environment, such as the temporary closure of two surgical theatres at Tunbridge Wells Hospital
- People / Patients, which included the Trust's vacancy rate; cancellation of appointments at short notice due to patient sickness; the impact of COVID-19 on the Trust's sickness absence rate
- Process, which included under utilisation of surgical theatre capacity; and late commencement of surgical theatre operating lists

However, it should be noted that the number of patients waiting longer than 52 weeks for treatment was reported as zero as of the March 2022 Trust Board meeting and therefore the objective was fully delivered ahead of the original timescale.

To achieve the Referral To Treatment (RTT) standard by April 2022

The key recognised risks to delivery of the associated breakthrough objective/s were:

- Environment, which included reduced theatre capacity at Tunbridge Wells Hospital due to staffing shortages and increased non-elective activity; and reduced outsourcing of activity to the Independent Sector due to COVID-19 sickness absence and lack of capacity.
- People, which included staffing vacancies and sickness absence rates.
- Equipment, which included reduced capacity for Pathway 3 patients resulting in an increased length of stay.
- Communication, which included an increased rate of 'Did Not Attend' outpatient appointments.
- Process, which included reduced theatre utilisation and under booking of available capacity.

To maintain the national Friends and Family Test (FFT) positive response rate for Inpatients, Accident and Emergency Patients; Maternity Services; and Outpatients[5]

The key recognised risks to delivery of this objective were:

- Environment, which included a reduction in the display of FFT information; and the lack of a centralised storage for FFT feedback cards.
- Measurement, which included the lack of availability of baseline data; that the Netcall and IQVIA data and associated management resided with sperate teams within the Trust; and insufficient resources to establish action drivers.
- People, which included the impact of operational pressures on the capacity for staff to provide and advertise the FFT; and poor engagement with the FFT process.
- Equipment, which included a lack of hardware for the provision of FFTs.
- Policy / Communication, which included staff awareness of the FFT; the lack of a standardised approach for the display of information for staff; and a lack of consistent messaging.
- Process / methods, which included issues associated with the upload of historic data; delays in postal submissions; loss of paper FFTs; lack of clarity regarding the ordering process for FFTs.

To reduce the number of non-elective bed days to a monthly average of less than 550, which represents approximately a 10% reduction on the current number of non-elective bed days

The key recognised risks to delivery of this objective were the COVID-19 pandemic; delays in discharging medically optimised for discharge patients; and staffing vacancies.

[5] It should be noted that the four key Friends and Family Test (FFT) Vision Goals / Targets were grouped into one heading, due to the overlap of the key recognised risks to the delivery of the associated Breakthrough objectives.

To deliver the Trust's financial plan for 2021/22, including operational delivery of the Trust's capital investment plan

The key recognised risk to delivery of this objective were failure to deliver the savings outlined within the Trust's Cost Improvement programme (CIP); failure to maintain a sufficient cash balance; and increased capital expenditure beyond that which was outlined within the Trust's capital programme for 2021/22, although the impact of additional capital funding beyond the original forecast should be acknowledged.

Adoption of the 'going concern' basis

The DHSC Group Accounting Manual (GAM) requires the management of the Trust to consider the following public sector interpretation of IAS 1 in respect of applying the going concern assumption when preparing its accounts. In para 4.18 it states: "For non-trading entities in the public sector, the anticipated continuation of the provision of a service in the future, as evidenced by inclusion of financial provision for that service in published documents, is normally sufficient evidence of going concern. DHSC group bodies must therefore prepare their accounts on a going concern basis unless informed by the relevant body or DHSC sponsor of the intention for dissolution without transfer of services of function to another entity. A trading entity needs to consider whether it is appropriate to continue to prepare its financial statements on a going concern basis where it is being, or is likely to be, wound up".

The Executive Team Meeting and Finance and Performance Committee have assessed the Trust's ability to continue for the foreseeable future in the light of the GAM guidance and have prepared the 2021/22 accounts on a "going concern" basis following consideration of the following:

- There has been no expectation raised in the public arena that healthcare services will not continue to be provided from the two hospital sites. There are no plans to dissolve the Trust or to cease services without transfer to any other NHS body.
- National NHS Provider/Commissioner Planning guidance has been published by NHSE/I that outlines the process and framework for funding arrangements within which NHS Commissioners and Providers will operate during 2022/23.
- The Trust has submitted its 5-year capital plan to the Kent and Medway Integrated Care System (ICS) which manages the overall resource level within the system in April 2022.
- The Trust is an active participant and fully engaged in financial planning with both Kent and Medway ICS/ Integrated Care Board (ICB) designate leads as well as locally within the West Kent Health and Care Partnership (HCP) locality.
- The Trust will have signed contracts in place for the provision of healthcare services in 2022/23. The Trust contracts will be held with the local commissioning bodies for patient care in Kent & Medway, Sussex, Surrey Heartlands and South East London. In addition, regional contracts for Specialised Commissioning, Public Health and Health and Justice will be agreed, signed and effective from April 2022 with NHS England. The planned financial regime provides certainty for income and cash flows for the full financial year 2022/23.

- The Trust has no working capital loans and is not anticipating requiring support in 2022/23.
- The Trust does not consider that there are any material uncertainties to the going concern basis.

For these reasons, the Trust has prepared its 2021/22 annual accounts using the going concern basis in line with the GAM guidance.

Performance summary for 2021/22

Performance against the Trust's agreed objectives, including the delivery of the financial plan, is described in detail in the "Development and performance in 2021/22" section (pages 20 to 21). The Trust's performance activities can be found in full within the monthly Trust Board reports, which are available for review at https://tinyurl.com/MTWTBReports. Further details on the performance standards for quality of care can be found in the Trust's Quality Accounts for 2021/22, which will be made available in full on the Trust website (www.mtw.nhs.uk).

Performance report for 2021-2022:
Performance analysis

The purpose of the performance analysis section and its structure

This purpose of the performance analysis section is to detail the mechanisms which are employed by the Trust to measure performance and to outline the Trust's performance during 2021/22 against key objectives. The performance analysis section is structured to cover "How the Trust measures performance"; "Development and performance in 2021/22"; "Equality and Peformance in 2021/22"; "Financial performance in 2021/22"; and "Sustainability Report".

How the Trust measures performance

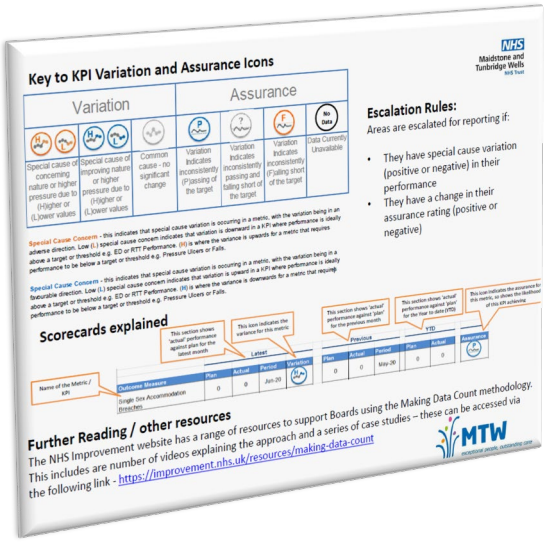
The Trust's Performance Management framework recognises that a high-performance culture will only be achieved when performance is managed in a positive and non-punitive way. The framework aims to ensure that striving for excellence is an integral part of organisational culture. The key focus areas for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

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

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

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

The monthly Integrated Performance Report encapsulates the result of these processes and provides the Board with a rich source of information that has been reviewed and substantiated at all levels of the Trust. The dashboard contains details of all key aspects of performance, under the CQC domains of "Safety", "Effectiveness", "Caring", "Responsiveness" and "Well-Led" and also the Trust's Strategic Themes of "People", "Patient Safety & Clinical Effectiveness", "Patient Access", "Patient Experience", "Systems", and "Sustainability". The Trust uses Statistical process control (SPC) methods to monitor and direct performance improvements. 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 Integrated Performance Report is discussed at meetings of the Executive Team Meeting and Trust Board. At the latter, the person responsible for each domain is asked to highlight key issues of note, and explain areas of under/failing performance. Performance against the Trust's agreed objectives is

measured and monitored via the Strategy Deployment Review process, which is described in more detail in the "Annual Governance Statement for 2021/22" later in this Annual Report. In addition to this, the Trust continues to use nationally-published information (where available), to compare performance. This includes national staff and patient surveys and national clinical audits.

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

Details of the Trust's accountability issues are outlined within the "Annual Governance Statement for 2021/22" (pages 54 to 65) which includes any significant internal control issues reported for the financial year; details of any personal data-related incidents are included within the "Corporate Governance Report for 2021/22" section (pages 37 to 66) ; and details of any finance related accountability issues would be reported via the "Financial Performance 2021/22" section (pages 23 to 27) where applicable (however there were no such issues for 2021/22).

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

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

Development and performance in 2021/22

The 'key issues and risks affecting delivery of the Trust's objectives' were described earlier in the Report (pages 13 to 16). The Trust's actual performance against each of its 2021/22 objectives is described below.

To increase the percentage of staff that recommended the Trust as a good place to work, as per the findings of the Quarterly Climate Survey

This objective was not met as the year-end position reported at the April 2022 Trust Board meeting was 64.4% (against a target of 80%). However a number of actions were developed to support the attainment of the Trust's target which included the introduction of a QR code to increase accessibility for Trust staff; the introduction of a Lead Recruitment and Retention Matron to address staffing vacancies and reduce the Trust's turnover rate; the approval of a Business Case for the recruitment of international nurses (in March 2022); and the development of a dedicated recruitment website in conjunction with a number of major recruitment campaigns.

To reduce the number of incidents resulting in patient harm by March 2022

This objective was not met as 188 incidents of harm were reported at the end of 2021/22 (against a target of 100 incidents of harm). However, a range of actions were taken during 2021/22, which included a robust

focus on the recruitment and retention of nursing and midwifery staff to increase support of safe staffing levels; the introduction of the Trust's Health and Wellbeing offering to reduce staff fatigue in light of the COVID-19 pandemic; and the establishment of a Trust-wide Falls Quality Improvement workstream.

To ensure that no patient waits longer than 52 weeks for treatment by April 2022

 This objective was met as the Trust reduced the number of patients waiting longer than 52 to weeks to zero, as reported to the March 2022 Trust Board meeting.

To achieve the Referral To Treatment (RTT) standard by April 2022

 This objective was not met as the Trust's position at the end of 2021/22 was 70.8% (against an internal target of 79% and a national target of 92%); the failure to obtain the target was associated with an increase in the backlog of outpatient appointments due to the COVID-19 pandemic; a reduction in the utilisation of clinic appointments due to an increased 'did not attend' rate; an increase in patient length of stay due to a lack of Pathway 3 capacity and a reduction in internal activity due to the closure of an operating theatre at Tunbridge Wells Hospital as a result of staffing shortages and increased non-elective activity. However, a number of actions have been developed to improve the Trust's performance, which includes the implementation of a flow improvement week and the increase of activity to 110% of pre-COVID-19 levels.

To maintain the national Friends and Family Test (FFT) positive response rate for Inpatients, Accident and Emergency Patients; Maternity Services; and Outpatients[6]

 This objective was met as the Friends and Family Test (FFT) positive response rate for Inpatients was 97.7% (against a target of 95%); the positive response rate for Accident and Emergency (Emergency Department (ED)) was 93.7% (against a target of 87.0%); the positive response rate for Maternity Services was 100% (against a target of 95.0%) and the positive response rate for Outpatients was 86.4% (against a target of 84.0%).

To reduce the number of non-elective bed days to a monthly average of less than 550, which represents approximately a 10% reduction on the current number of non-elective bed days

 This objective was not met as a monthly average of less than 550 non-elective bed days was not achieved for six consecutive months during 2021/22. This was due to a lack of available Pathway 3 capacity for Medically Optimised for Discharge (MOFD) patients; staffing vacancies and sickness absence rates; an increase in 'open' escalation capacity, including escalation into Same Day Emergency Care (SDEC) areas; and a sustained increase in ED attendances.

To deliver the Trust's financial plan for 2021/22, including operational delivery of the Trust's capital investment plan.

 This objective was met as the Trust has delivered its financial plan for 2021/22 (subject to audit).

Equality and performance in 2021/22

Public Sector Equality Duty

The Trust is committed to the development of a culture of inclusion where all people are valued and respected for their individual differences. We positively contribute to the advancement of equality and good relations within the design of our policies; in the support of our staff networks; and the goals designed using

[6] It should be noted that the four key FFT Vision Goals / Targets were grouped into one heading, due to the overlap of the key recognised risks to the delivery of the associated Breakthrough objectives.

performance against the Workforce Race Equality Standard, the Workforce Disability Equality Standard and the Gender Pay Gap to meet the Public Sector Equality Duty.

Equality, Diversity and Human Rights

The Trust's activity and policies in this area are explained in the Accountability Report (page 37 onwards).

Equality of service delivery

The Trust has carried out analysis of patients waiting over 18, 40 and 52 weeks for treatment (as part of the Referral to Treatment standard) using various characteristics such as age, gender, ethnicity and deprivation[7] (IMD) to look for any outliers. This analysis has been carried out at speciality level and the results are shared with operational colleagues to factor into their service planning and operational delivery. The Trust intends to repeat this work for other standards within the NHS Constitution, such as access to treatment in our Emergency Departments, Cancer Services and Diagnostics. This information will be regularly refreshed and incorporated into operational planning and service monitoring processes.

The Trust will also endeavour to collaborate with partners across the West Kent Health and Care Partnership (HCP) to identify any unwarranted variation in terms of access to services and outcomes in relation to equality.

Activities the Trust is undertaking to promote equality of service delivery

The Trust has developed a three stage process for addressing health inequalities, which is outlined below:

- Stage one (completed): Develop a baseline position of the Trust's current position using quantitative data analysis; with a descriptive analysis of health inequalities which included race, sex, age and deprivation, in conjunction with a statistical analysis to adjust for any confounding variables.
- Stage two (in progress): Identify and target 'at risk' populations for qualitative analysis in conjuction with partner organisations including the Kent and Medway Clinical Commissioning Group (CCG) and local government organisations to reach and discuss the challenges with local communities; development of a revised Patient Experience Strategy which helps adddress health inequalities; and engagement with 'hard to reach' communities.
- Stage three (to commence on completion of stage two): Development of Corporate and Divisional action plans supported by individual initiatives.

Patient feedback and protected characteristics

The Trust received a total of 22,461 Friends and Family Test (FFT) survey responses during 2021/22. The overall percentage of respondents that reported a 'very good' or 'good' experience of care was 96.5% and with 1.3% respondents reporting a 'poor' or 'very poor' experience of care.

From the responses received 25.8% were from men, 45% from women, >0.1% identified as transgender and 28.7% did not confirm their gender identity. Almost 4% of responses were from representatives from a Black Asian and Minority Ethnic (BAME) background, however almost 28% of respondents did not declare their ethnicity.

Less than 0.01% of respondents identified a disability, long-term health or mental health condition.

The majority of submissions (62%) were provided by people aged 16 to 54 and 65 to 84. Under 16s, the 55 to 64 age group and those over 85 had a lower response rate during 2021/22.

[7] Using the Indices of multiple deprivation (IMD), which are widely-used datasets within the UK to classify the relative deprivation of small geographical areas

Financial performance in 2021/22

For the financial year 2021/22 the Trust reported a surplus of £0.2m, which was £0.2m better than plan. The finance regime for 2021/22 was different to previous years in response to the COVID-19 pandemic. The Trust had to work within the Kent and Medway system funding envelope; the year was split into two halves (H1 and H2) and a plan was required for each half.

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

- Clinical Supplies was underspent by £1.7m.
- A legal case provision of £2.3m.
- Public Dividend Capital (PDC) was higher than planned by £0.6m.
- Additional income received for trade and education £1.4m.

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	2021/22 (plan) £m	2021/22 (actual) £m	Variance £m
Income	595.7	623.9	28.2
Operating expenses	(579.6)	(591.50)	(11.9)
Operating surplus / (deficit):	**16.1**	**32.4**	**16.3**
Finance income	0.0	0.0	0.0
Finance expense	(14.5)	(14.5)	0.0
PDC dividend charge	(2.8)	(3.4)	(0.6)
Net finance costs	**(17.3)**	**(17.9)**	**(0.6)**
Other gains / (losses)	0.0	0.0	0.0
Surplus / (deficit) for the year before technical adjustments	(1.2)	14.5	15.7
Technical adjustments	1.2	(14.3)	(15.5)
Surplus / (deficit) for the year after technical adjustments	**0.0**	**0.2**	**0.2**

The Trust incurred additional expenditure pressures arising in the year after the plan was set. The Trust also received funding to support these pressures. The main pressures were the employers' NHS pension contribution increase of £13.8m, pay award £4.2m and COVID-19 PPE costs of £2.0m. These were funded by NHS England/NHS Improvement. There were also additional services agreed after the plan was set which came to £11.0m which were funded by commissioners.

Income

The Trust's income was £623.9m which was above plan by £28.2m by the end of the financial year. The main variances relate to centrally received income of £20.0m and commissioning income agreed after plan of £11.0m. There was an over achievement of pathology trade income and education income of £0.7m, this was offset by a reduction in clinical income of £2.7m in line with underspends in expenditure.

The majority (91%) of the Trust's income is from CCGs or NHS England.

Operating expenses

The Trust's expenditure was £591.5m which was £11.9m adverse to plan. The Trust incurred expenditure that was not in the original plan. This related to £21.4m of central national transactions (COVID-19 PPE £3.4m; pay award £4.2m; employer's pension contribution £13.8m) funded by associated national income; and additional NHSE commissioned and funded services of £11.0m. There was an increase in legal provision costs of £2.3m which was offset by underspends in clinical supplies of £1.7m. The expenditure included an additional £2.1m of costs to respond to COVID-19 which was in line with plan. This was offset by the impact of a net reversal of previous impairments of £16.8m arising from the increase in property valuations.

Finance costs

The Public Dividend Charge (3.5% on net average assets) was higher than planned by £0.6m. This was principally driven by a higher than planned year end property valuation.

Technical adjustments

There was a nationally provided stock adjustment for PPE usage of £1.4m offset by an impairment of £16.8m.

Cost Improvement Programme (CIP)

The Trust had an external (NHSE/I) savings target for 2021/22 of £3.7m which consisted of £0.8m in H1 (April to September) and £2.9m in H2 (October to March 22). The Trust delivered savings of £2.6m which was £1.1m adverse to plan.

Capital expenditure plan

During the year the Trust made capital investments of £26.6m including £0.4m of assets funded from donated or charitable fund sources. Significant elements of the programme were:

- £10m on building and estates backlog projects, including £1.4m on the new Paediatric Emergency Department at TWH; £1.2m of infrastructure works at TWH to support the Kent and Medway Medical School Accommodation project; £1.1m on the Oncology Outpatients' Unit at Maidstone; £1.0m on additional office accommodation at Maidstone; £2.5m enabling works for the proposed Barn Theatre development at Maidstone; and £1.2m on enabling works for major diagnostic and radiotherapy equipment. The PFI company invested £0.8m of lifecycle capital in maintaining TWH.
- £1.6m invested in the ongoing EPR and EPMA (electronic prescribing) programme; £1.6m from national funds on ICT schemes to support elective recovery (patient tracking, referral management and digital theatre systems, audio-visual facilities including a video consultation platform); £0.9m for digital diagnostic and maternity systems; £1m on device replacement (PCs/laptops) and £0.7m on network and telephony infrastructure. In addition £0.3m was invested in further cyber resilience.
- Equipment replacement and investment schemes included: £4.6m invested in two replacement Linear Accelerators at Maidstone, including ancillary equipment. The main machines were funded from NHSE national capital. Spending of £1.2m on Barn Theatre equipment; £2.0m of Diagnostic replacement equipment including £0.7m Single-Photon Emission Computerised Tomography (SPECT) and £0.2m Community Diagnostic Centre equipment; £0.4m on Imaging and Endoscopy Academy equipment; £1.8m of replacement or additional equipment for wards, theatres, ITU and emergency services, including £0.4m of donated equipment.

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

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

External Finance Limit (EFL)

The Trust is required to demonstrate that it has managed its cash resources effectively by staying within an agreed limit on the amount of cash it can borrow and spend. In 2021/22 the Trust met its target with a year-end position of a balanced EFL.

Capital Resource Limit (CRL)

The Trust is expected to manage its capital expenditure within its agreed CRL. For 2021/22 the Trust's CRL was £26.63m and the Trust spent £26.18m.

Break-even duty

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

The Trust's last formal three-year break-even cycle commenced in 2013/14 and was not met by the end of the period in 2015/16. The Trust has achieved break even surpluses and met its NHSEI control totals in each of the last three financial years. The Trust is not in any financial recovery regime relating to its historic accumulated deficit but is required to achieve the in-year break-even position agreed as part of the Kent and Medway ICS system control totals. The Trust has achieved an in-year break-even duty surplus in 2021/22 of £0.2m which was slightly better than plan and its system control total requirement.

Accounting Issues

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

External Auditors

The Trust's External Auditors are Grant Thornton UK LLP. Their charge for the year was £86,600 excluding VAT (in 2020/21 this was £82,100 excluding VAT). No audit of the Quality Accounts has been required in 2021/22. Grant Thornton UK LLP did not undertake any non-audit work for the Trust in 2021/22.

Looking forward to 2022/23

The business planning process has been reinstated both nationally and internally this year following a shortened version in previous years in response to COVID-19. The Trust will have signed contracts in place for the provision of healthcare services in 2022/23. The Trust contracts will be held with the local commissioning bodies for patient care in Kent & Medway, Sussex, Surrey Heartlands and South East London. In addition, regional contracts for Specialised Commissioning, Public Health and Health and Justice will be agreed, signed and effective from April 2022 with NHS England. The planned financial regime provides certainty for income and cash flows for the full financial year 2022/23.

The Trust is planning to deliver a breakeven position in 2022/23.The plan includes £9.5m of income and expenditure to support COVID-19. There is a Cost Improvement Programme of £20m and a contingency of £2.2m. The plan includes increased funding for inflation, in particular energy and the PFI contract. There are also increased costs in depreciation and Public Dividend Capital (PDC) as a result of national capital funding received in recent years and the increase in the property valuation.

Statement of Comprehensive Income	2022/23 (Plan) £m
Income	630.6
Operating expenses	-609.5
Operating surplus / (deficit):	**21.1**
EBITDA%	7.5%
Finance income	0.0
Finance expense	-16.5
PDC dividend charge	-5.8
Net finance costs	**-22.3**
Other gains / (losses)	0.0
Surplus / (deficit) for the year (before technical adjustments)	**-1.2**
Technical adjustments	1.2
Surplus / (deficit) for the year (after technical adjustments)	**0.0**

Capital allocations and expenditure are managed at the ICS system level. For 2022/23 the Trust's agreed initial control total is £10.58m comprising £8.63m of internally generated and financed resource and £1.95m of system PDC relating to the Hyper Acute Stroke Unit. In addition the Trust will be funded for the PFI Lifecycle costs (£1.3m). The Trust's plan also includes £29m anticipated national funding to support the Barn Theatre Development (subject to full business case approval) and £27.8m of in-year IFRS 16 new lease capital resource, which is also subject to approval. This includes the costs of the Kent and Medway Medical School Accommodation building on the TWH site that the Trust will be leasing.

Countering fraud, bribery and corruption

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

Quality Accounts 2021/22

The Trust's Quality Accounts for 2021/22, which are scheduled to be approved by the Trust Board in June 2022, can be found on the Trust's website at http://www.mtw.nhs.uk/wp-content/uploads/2022/06/Quality-Accounts-2021-2022-FINAL.pdf.

Performance report for 2021-2022:
Sustainability report

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

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

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

The pandemic and the increased activity associated with it has had a significant impact on the emissions associated with the supply chain and procurement activities of the Trust, and has seen a reduction in recycling performance. We are pleased to report that many data sets are returning to pre-pandemic levels and we are committed to maintaining this reduction where operationally possible.

Policies

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

One of the ways which we embed sustainability is through the use of a Green Plan within the Trust. Our Green Plan has been reviewed in the last 12 months and approved by the Trust Board. We are establishing a Green Committee to drive our sustainability performance in the next 12 months, the Committee will be representative of all departments and services and will be led by a member of the Trust Executive.

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

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

We comply with the Public Services (Social Value) Act by ensuring that at least 10% of our tenders relates to social and environmental impact of the services being procured. If they are critical to that service, then they will be included within the KPIs for ongoing monitoring and management.

We are proud to have recruited a sustainability / net zero buyer to our procurement team who will take a lead in ensuring that all procured services deliver value for money and align to our net zero trajectory and commitments.

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

Adaptation

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

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

Green space and biodiversity

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

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

Partnerships

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

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

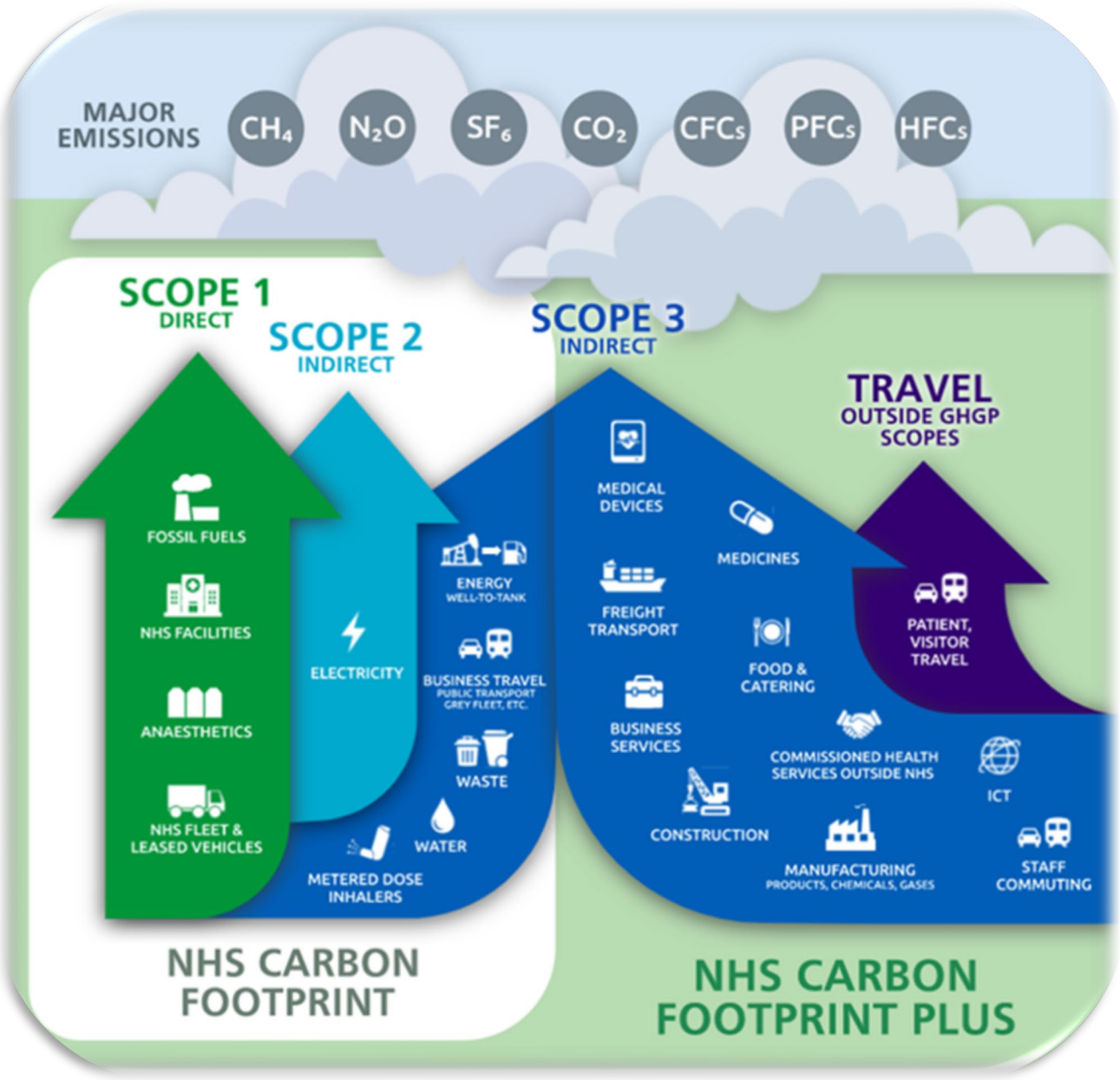
Performance

Organisation

Since the 2007 baseline year, the NHS has undergone a significant restructuring process and one which is still on-going. In the last year the Trust has commissioned 3 new areas which has resulted in a larger operational footprint.

Context info	2007/8	2015/16	2016/17	2017/18	2018/19	2019/20	2020/21	2021/22
Floor space (m^2)	109,896	138,533	138,533	138,533	138,533	134,083	133,111	134,371
Number of staff (WTE)	3,969	4,678	5,130	5,022	5,153	5,313	5,866	6,220[8]

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

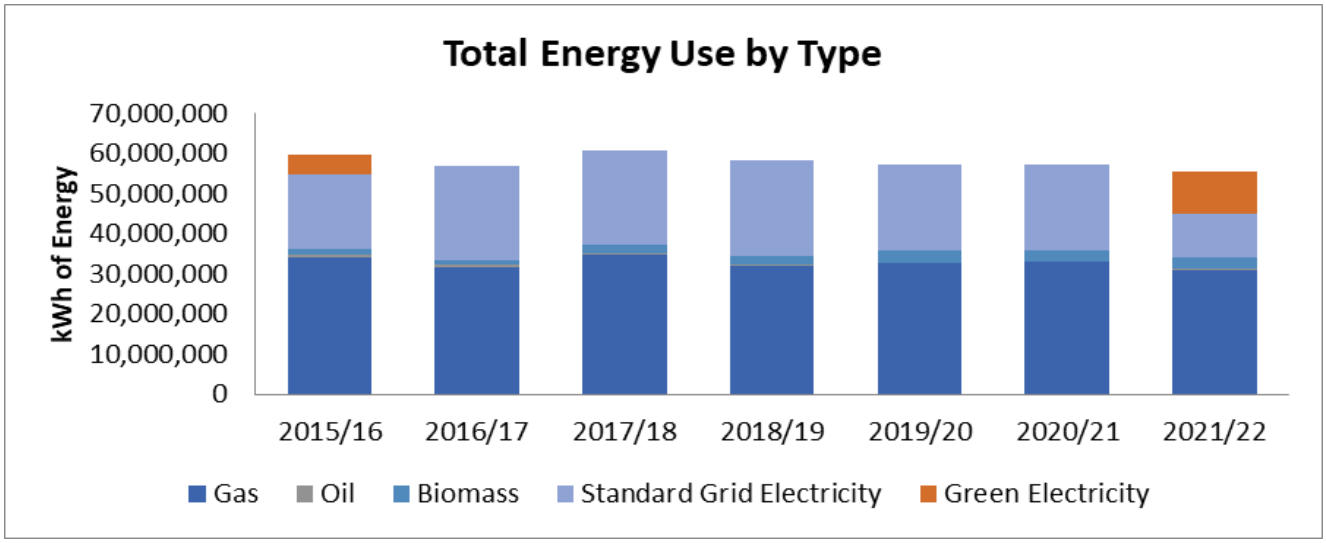


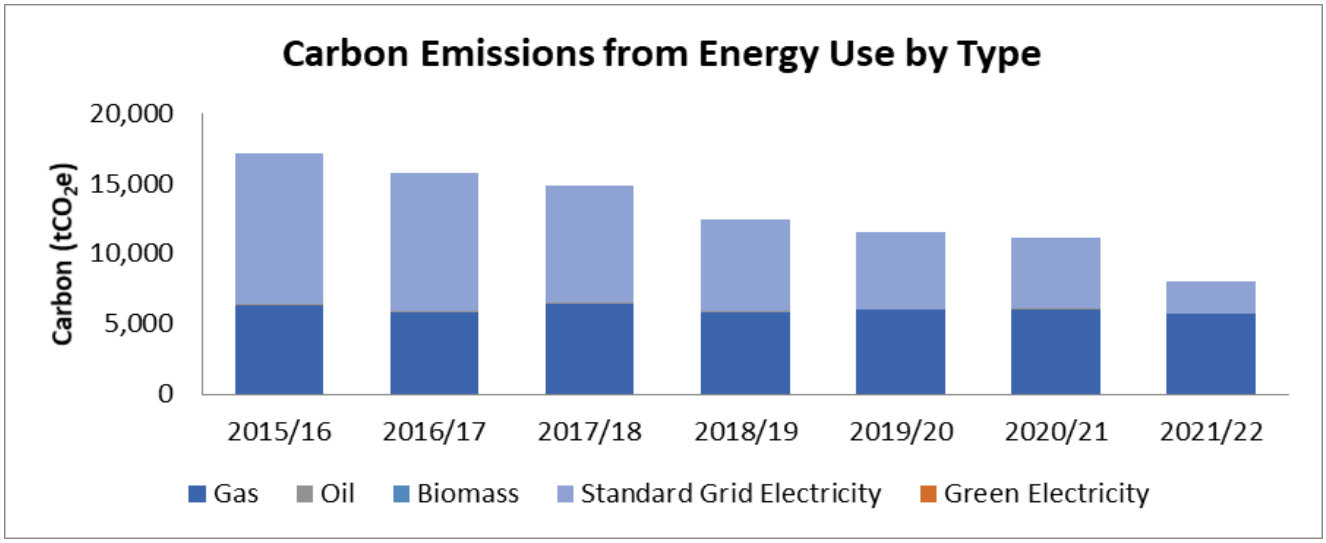
[8] Readers will note that this figure is different to the WTE figure reported in the "Staff numbers and costs" table within the "Remuneration and Staff Report". This difference arises because there is a difference between "contracted", "worked" and "paid" staff; and the figure in the "Staff numbers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

Energy

Managing energy is one aspect of reducing carbon emissions. Maidstone and Tunbridge Wells NHS Trust has spent £7,025,269 on energy in 2021/22, which is a 65% increase on energy spend from last year. We recognise that this is significant and reflects that the Trust's energy contracts expired in October 2021 and we were forced to reprocure during a very volatile time in the international energy markets.

The Trust used the opportunity to procure new contracts to move to a 100% renewable energy contract for electricity, allowing us to report a zero emissions factor for electricity used since 1st October 2021.





The Trust has continued to drive down energy consumption with a 0.49% reduction in electricity consumption and a 5.74% reduction in gas consumption against last year. Total energy consumption is down 3.6% against last year.

Resource		2015/16	2016/17	2017/18	2018/19	2019/20	2020/21	2021/22
Gas	Use (kWh)	34,139,781	31,605,108	34,671,340	31,855,591	32,475,249	32,920,550	31,032,244
	tCO_2e	6,284	5,804	6,385	5,860	5,971	6,053	5,684
Oil	Use (kWh)	635,116	532,926	313,362	280,800	273,640	224,294	230,310
	tCO_2e	172	147	86	78	70	58	59
Biomass	Use (kWh)	1,301,508	1,092,859	2,044,204	2,362,000	3,029,000	2,701,000	2,677,000
	tCO_2e	0	0	0	0	0	0	0
Electricity	Use (kWh)	18,564,756	23,456,861	23,799,662	23,661,820	21,578,000	21,452,491	10,917,054
	tCO_2e	10,673	9,748	8,319	6,482	5,515	5,001	2,318
Green Electricity	Use (kWh)	4,892,105	0	0	0	0	0	10,437,727
	tCO_2e	0	0	0	0	0	0	0
Total energy kWh		59,533,266	56,687,754	60,828,568	58,160,211	57,355,889	57,298,335	55,294,335
Total Energy tCO_2e		17,129	15,699	14,790	12,420	11,556	11,112	8,061
Total energy spend		£ 3,919,681	£3,835,790	£4,535,611	£4,912,381	£4,762,269	£4,263,339	£7,025,269

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

Paper

The movement to a paperless NHS can be supported by staff reducing the use of paper at all levels, this reduces the environmental impact of paper, reducing cost of paper to the NHS and can help improve data security. The progress made in the last year has been significant and we are proud to have reduced our paper use by 29% from 2020/21 levels.

Paper		2017/18	2018/19	2019/20	2020/21	2021/22
Volume used	Tonnes	61	90	62	68	48
Carbon emissions	tCO_2e	58	85	58	64	45

Travel

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

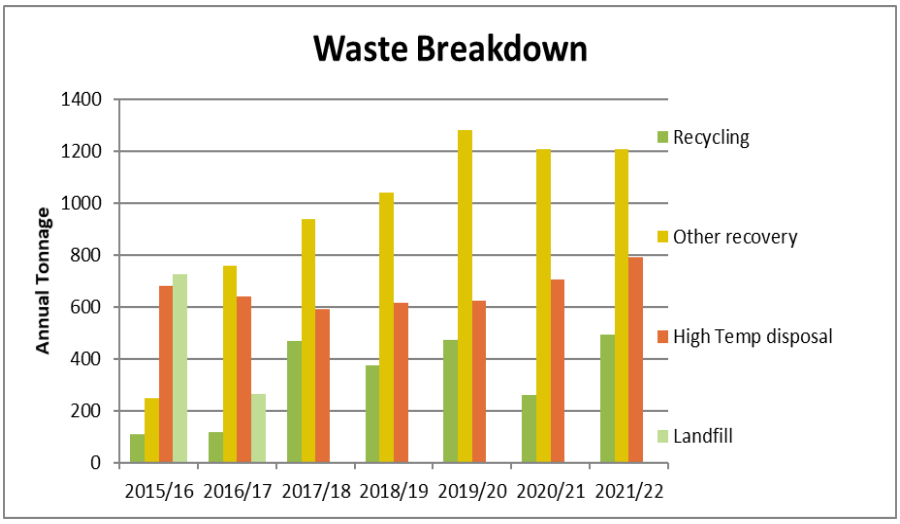
Every action counts and we are a lean organisation trying to realise efficiencies across the board for cost and carbon (CO2e) reductions. We support a culture for active travel to improve staff wellbeing and reduce sickness. Air pollution, accidents and noise all cause health problems for our local population,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

Category	Mode	2015/16	2016/17	2017/18	2018/19	2019/20	2020/21	2021/22
Patient & visitor travel	Miles ♌	107,404,988	112,158,231	115,563,332	121,747,529	118,743,943	110,617,477	120,604,241
	Miles	38,841.48	40,535.15	41,178.09	44,890	41,040	38,232	33,282
Business travel & fleet	Miles	1,319,789	1,037,636	1,059,360	0	569,989	265,695	735,082
	tCO_2e	477	375	377	0	197	92	243
Staff commute	Miles	4,493,769	4,927,968	4,824,221	4,824,221	5,105,793	5,637,226	5,977,420
	tCO_2e	1,625	1,781	1,719	1,779	1,765	1,948	1,650

N.B. tCO2e = Tonnes of CO2 equivalent. This is used to measure the equivalent CO2 concentration which causes the same level of absorption in the atmosphere for other greenhouse gases.
♌ Totals for previous years have been re-stated due to patient & visitor travelled mileages and associated carbon footprint being automatically calculated using externally provided intensity figures

Waste

We are pleased to report that the recycling rate has increased significantly in the last year and is now sitting at pre-pandemic levels, giving us a firm foundation to improve upon next year.



N.B. High temperature ("High Temp") disposal is the incineration of clinical waste. There is no energy recovery from this process at the current time.

The Trust sends domestic waste to an 'energy from waste' facility, and this is classed as "Other recovery". Energy from waste cannot be classed as recycling, as that refers to taking a used item, turning it into a raw material and using that as a basis to manufacture a new product. 'Energy from waste' is about recovering the embedded energy within a product and is lower down the waste hierarchy, this being: reduce (the amount of waste being produced); reuse (items in their existing form); recycle (into new products); recover (the embedded energy); or dispose (through landfill).

Waste		2015/16	2016/17	2017/18	2018/19	2019/20	2020/21	2021/22
Recycling	(tonnes)	107	115	468	372	472	258	494
	tCO_2e	2	2	7	8	8	5	10
Other recovery	(tonnes)	248	756	937	1040	1281	1206	1208
	tCO_2e	16	16	15	15	27	25	25
High Temp disposal	(tonnes)	679	639	592	614	621	704	792
	tCO_2e	149	141	190	192	137	155	175
Landfill	(tonnes)	724	265	0	0	0	0	0
	tCO_2e	177	82	0	0	0	0	0
Total Waste (tonnes)		1758	1775	1997	2026	2374	2168	2494
Total Waste tCO_2e		333	241	211	215	174	186	211
Recycling (% all waste)		6%	6%	23%	18%	20%	12%	20%

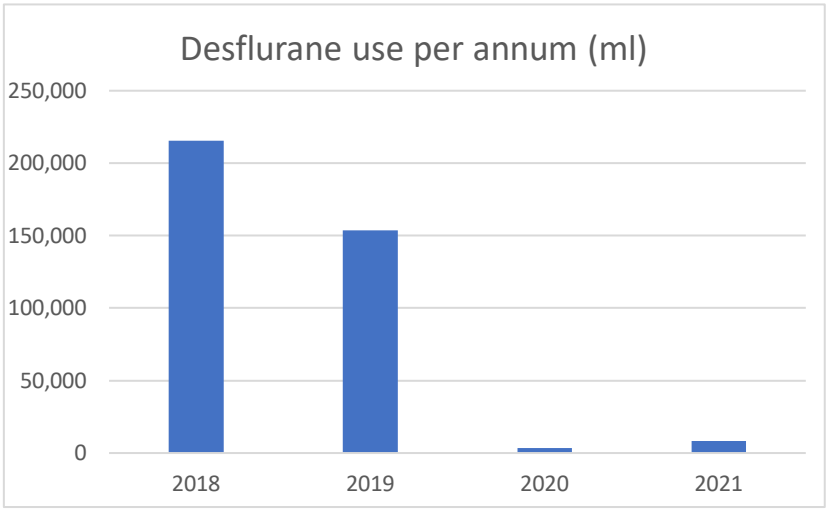
Finite resource use - water

The water consumption has now returned to pre-pandemic levels, this is partially due to the increased footfall when compared to last year.

Water		2015/16	2016/17	2017/18	2018/19	2019/20	2020/21	2021/22
Mains	m^3	205,246	209,205	225,383	211,936	237,616	218,494	234,048
	tCO_2e	187	190	205	193	216	199	213
Water & Sewage Spend		£582,869	£661,990	£761,100	£758,895	£959,889	£768,234	£835,040

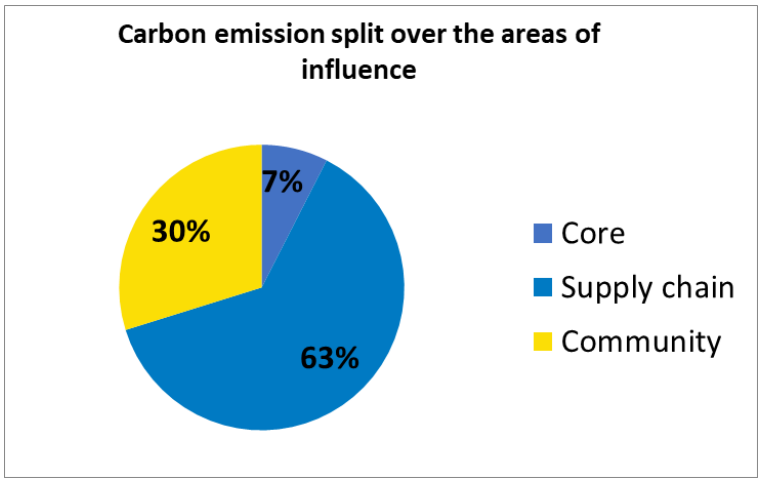
Anaesthetic Gases

As a Trust we recognise that anaesthetic gases are significant contributors to climate change, and that some gasses are much more harmful than others. Desflurane is the most harmful and we are proud to have reduced the usage of the gas by 96% against our levels in 2018/19. We are committed to maintaining this level of reduction and eliminating desflurane use as much as possible in the Trust.



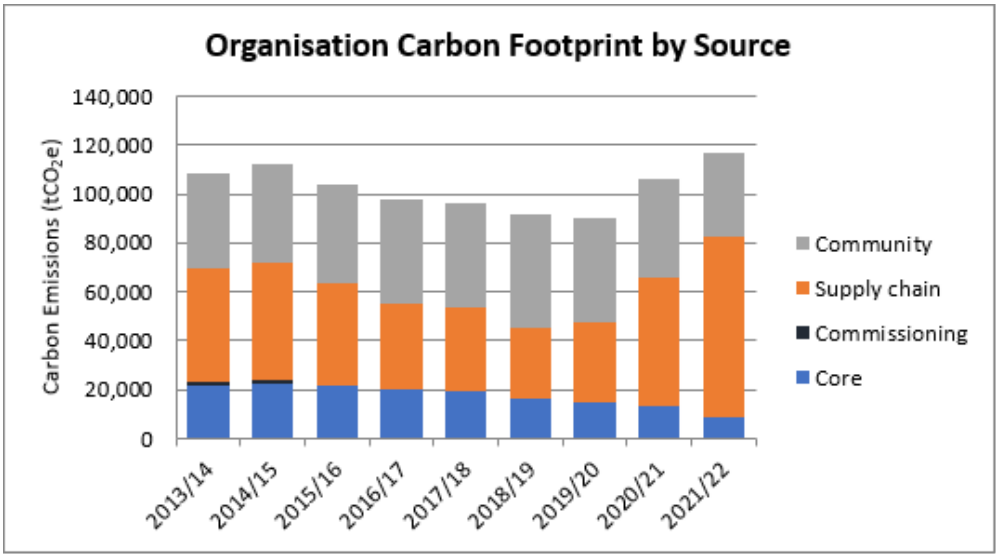
Modelled Carbon Footprint

The data presented so far in this report largely refers to the sources responsible for the "NHS Carbon Footprint", however we recognise that the "NHS Carbon Foorptint Plus" produces a significantly larger footprint and this has been calculated below.

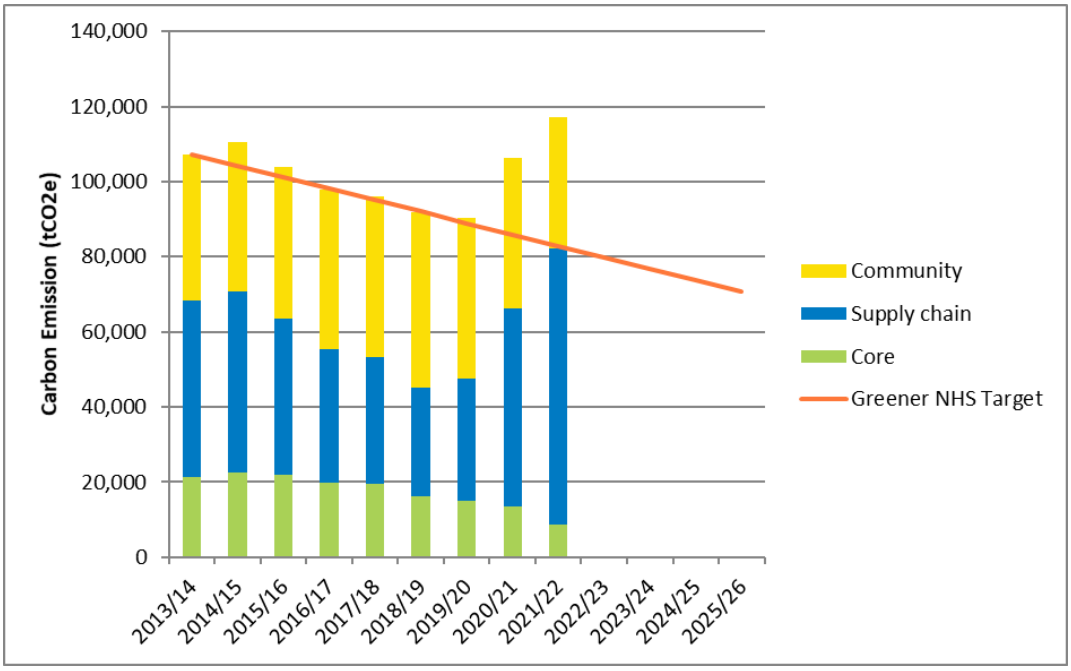


The measurement of supply chain emissions is not a precise art and the methodologies used are evolving on an annual basis as more and more data becomes available. This means that the figures being reported are always indicative and not precise however the proportions of the total footprint are largely accurate.

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



Modelled trajectory



We are committed to meeting both the legal requirements of the climate change act and the targets established by Greener NHS by reducing our emissions in line with the trajectory above.

We acknowledge that emissions associated with our supply chain have grown in recent years. This is partially due to increased operational output and expenditure and partially attributed to new data being available for analysis.

Declaration

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

Miles Scott, Chief Executive 16th June 2022

Accountability report for 2021-2022:
Corporate governance report

Directors' report

The Trust Board

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

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

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

- Sue Steen, Chief People Officer, joined the Trust Board on 01/04/21
- Claire O'Brien, Chief Nurse, left the Trust Board on 25/06/21
- Gemma Craig joined the Trust Board as Acting Chief Nurse on 26/06/21, and left the Trust Board on 22/07/21
- Jo Haworth, Chief Nurse, joined the Trust Board on 03/08/21
- Sarah Dunnett OBE, Non-Executive Director, left the Trust Board on 31/12/21
- Wayne Wright, Non-Executive Director, joined the Trust Board on 13/01/22

The Trust Board also held two 'away days' in the year, in June 2021 (which focused on Exceptional People, Outstanding Care (EPOC) programme, including the Strategy Deployment Review (SDR) process and the development of the Trust's Estates Strategy) and December 2021 (which focused on the Trust Reverse Mentoring programme and the governance arrangements associated with the development of an Integrated Care System (ICS) / Integrated Care Board (ICB)). The programme of Trust Board Seminars that was established in 2017/18 was temporarily suspended during 2021/22, as such no Trust Board Seminars were held within the reporting period.

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 2021/22, the Trust Board had the following members:

David Highton

Chair of the Trust Board*

David joined the Trust Board on 8th May 2017. Prior to this he was Ministerial Advisor on Private Sector Involvement and Public Private Partnership to the Minister of Public Health in Qatar. Since 2011 he has been Executive Director of Corporate Development at Hamad Medical Corporation, the main public hospital provider in Qatar. Over that time he has also been Chair of Sussex Health Care Audiology Ltd, a business delivering age-related hearing assessments in the community in Surrey, Sussex and Berkshire, and a Director of Clearview Healthcare, a Delhi-based company providing operator managed equipment services to the growing private hospital market in India. Prior to moving to Qatar, David worked in the independent health sector, including being director of his own consulting company and heading up Business Development for Medihome Ltd, a successful acute home healthcare provider. David was an NHS Chief Executive from 1991 to 2003, including the Chelsea and Westminster Hospital NHS Trust and the Oxford Radcliffe Hospitals NHS Trust. Originally a Chartered Accountant, David worked in publishing, property services, the brewing industry, an industrial starches business and in the City, before joining the NHS as a Finance Director in 1990. David, who is married and has a grown-up family, has strong links with Kent, having spent his childhood in Meopham and Sittingbourne, and currently lives in Whitstable.

Miles Scott

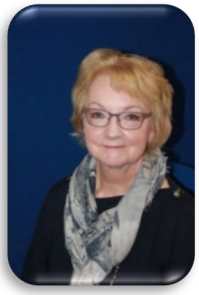
Chief Executive*Σ

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

Sean Briggs

Chief Operating Officer*Σ

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



Maureen Choong

Non-Executive Director*

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

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

Karen Cox

Associate Non-Executive Director

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

Richard Finn

Associate Non-Executive Director

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

Neil Griffiths

Non-Executive Director*

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

Jo Haworth

Chief Nurse*∑

Jo joined the Trust Board in August 2021. Jo has been qualified as a Registered General Nurse for over 20 years. She initially specialised in Emergency Nursing at The Royal London Hospital where she worked for over 15 years. Jo has since held a number of senior nursing leadership positions in a wide range of clinical services, including community and mental health services across London. Latterly she has been the Deputy Chief Nurse at King's College Hospital NHS Foundation Trust. Jo has a particular interest in the connection between mental and physical health and is passionate about improving this for patients.

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

Amanjit Jhund

Director of Strategy, Planning and Partnerships[Σ]

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

Peter Maskell

Medical Director[*Σ]

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

David Morgan

Non-Executive Director[*]

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

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 Deputy Medical Director. Sara joined the Trust in 2007, and has previously worked as Consultant Microbiologist at East Kent Hospitals University NHS Foundation Trust, and as a Consultant in Communicable Disease Control (CCDC) at Kent Health Protection Unit.

Steve Orpin

Deputy Chief Executive / Chief Finance Officer[*Σ]

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

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

Emma Pettitt-Mitchell

Non-Executive Director*

Emma joined the Trust Board in June 2018 as an Associate Non-Executive Director and was appointed as a substantive Non-Executive Director in August 2019. Emma is a highly experienced senior executive with over 21 years' experience with one of the largest retailers (UK and globally) and FTSE 100 company. Uniquely Emma has worked extensively as a Director in both the private and public sector, previously working for Kent County Council. Emma is also an experienced executive and team coach. Emma lives in Kent with her husband and 3 children. In addition to her role on the Trust Board, Emma chairs the People and Organisational Development Committee., is Vice Chair of the Patient Experience Committee and is a member of the Audit and Governance Committee and Remuneration and Appointments Committee.

Sue Steen

Chief People Officer∑

Sue joined the Trust in April 2021. She has over 25 years' experience of working in the public and not for profit sector, starting her career as a trainee in Coventry City Council. She was previously Deputy Chief Executive, People and Organisational Strategy, at St John in New Zealand where she lived for four years. Prior to this she was the Director of Corporate Services at the National Crime Agency and previously Director of Human Resources and Governance at South Western Ambulance NHS Foundation Trust. Sue has a Human Resources background and is passionate about employee engagement, building highly motivated teams and positive working environments where people can thrive. She is driven by working in community and health related services that make a difference in people's lives. Sue is married to Steve, and between them they have four grown children. She loves travelling, theatre and spending time with family and friends

Jo Webber

Associate Non-Executive Director

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

Wayne Wright

Non-Executive Director*

Wayne joined the Trust Board in January 2022. Wayne has worked in some of the most celebrated corporate entities as well as fast growing medium sized businesses at senior and board levels. His experience is in the building of businesses from the bottom up with a clear understanding of the strategic elements essential in driving successful growth. With a scientist background he is named on nine patents. Wayne has investments in healthcare businesses in the UK and US, and for the last 20 years has led [W]sq solutions, a small boutique entrepreneur coaching organisation that works with fast growing businesses in accelerating growth and profitability. His corporate and turnaround experience for venture capitalists and the serving of those high growth businesses, have created learning and principles that have been packaged into his new book, 'The Ten Commandments of Business Growth' and discussed in depth through his new breakthrough online course for business leaders and their executive teams 'Business Growth, Strategy and Execution Course'. Wayne is active in the Maidstone community where he has lived for over 20 years with his wife and grown up family. He currently owns Maidstone Warriors Basketball Club, the largest youth basketball club in the Kent region and is active in his local church, The Vine, which has a strong reputation in the Maidstone community and schools for supporting those in financial and physical need. In addition to his role on the Trust Board, Wayne is a member of the Quality Committee, and Remuneration and Appointments Committee.

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

Gemma Craig, Acting Chief Nurse (who joined the Trust Board on 26th June 2021, and left the Trust Board on 22nd July 2021) also served on the Trust Board during 2021/22.

Sarah Dunnett OBE, Non-Executive Director (who left the Trust Board on 31st December 2021) also served on the Trust Board during 2021/22.

Claire O'Brien, Chief Nurse (who left the Trust Board on 25th June 2021) also served on the Trust Board during 2021/22.

Statement regarding Directors' disclosure to auditors

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

Attendance at Trust Board meetings

There were 11 formal and 2 extraordinary Trust Board meetings in 2021/22. Attendance at each meeting is shown below:

Trust Board Member	April 2021	May 2021	June 2021	8th July 2021	29th July 2021	September 2021	October 2021	11th November 2021	25th November 2021	December 2021	January 2022	February 2022	March 2022
David Highton, Chair of the Trust Board	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Miles Scott, Chief Executive	✓	✓	✓	✓	✓	✓	✓	✓	✓	Apologies	✓	✓	✓
Sean Briggs, Chief Operating Officer	✓	Apologies	✓	Apologies	✓	Apologies	✓	✓	✓	✓	✓	✓	✓
Maureen Choong, Non-Executive Director	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Karen Cox, Associate Non-Executive Director	✓	✓	✓	Apologies	✓	✓	✓	Apologies	✓	✓	✓	✓	✓
Gemma Craig, Acting Chief Nurse	N/A	N/A	N/A	✓	✓	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Sarah Dunnett, Non-Executive Director	✓	Apologies	✓	✓	✓	✓	✓	✓	✓	✓	N/A	N/A	N/A
Richard Finn, Associate Non-Executive Director	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Neil Griffiths, Non-Executive Director	✓	✓	✓	✓	✓	Apologies	Apologies	✓	✓	✓	Apologies	✓	✓
Jo Haworth, Chief Nurse	N/A	N/A	N/A	N/A	N/A	✓	✓	Apologies	✓	✓	✓	✓	✓
Amanjit Jhund, Director of Strategy, Planning and Partnerships	✓	✓	Apologies	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Peter Maskell, Medical Director	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	Apologies	✓	✓
David Morgan, Non-Executive Director	✓	✓	✓	✓	✓	✓	Apologies	✓	✓	✓	✓	✓	✓
Sara Mumford, Director of Infection Prevention & Control	✓	✓	✓	✓	Apologies	✓	✓	✓	Apologies	Apologies	✓	✓	✓
Claire O'Brien, Chief Nurse	✓	✓	✓	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Steve Orpin, Deputy Chief Executive / Chief Finance Officer	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Emma Pettitt-Mitchell, Non-Executive Director	✓	✓	✓	✓	✓	✓	✓	Apologies	✓	✓	✓	✓	✓
Sue Steen, Chief People Officer	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Jo Webber, Associate Non-Executive Director	✓	✓	Apologies	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Wayne Wright, Non-Executive Director	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	✓	✓	✓

Appointment and evaluation of Trust Board Members' performance

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

- The Chair of the Trust Board is appraised via a national framework operated by NHSE/I;
- Non-Executive Directors and the Chief Executive are appraised by the Chair of the Trust Board; and
- Members of the Executive Team are appraised by the Chief Executive.

Trust Board Members are also subject to an annual self-assessment in accordance with the fit and proper persons requirements (FPPR[9]) for Directors. No concerns have been raised in relation to this in 2021/22.

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 2021/22 for those on the Board at the end of that year were as follows:

Trust Board Member	Details of notifiable interest
David Highton, Chair of the Trust Board	▪ Strategic Health Industry Adviser for Servita Group Ltd ▪ Chairman, Demelza House Children's Hospice ▪ Owner and Director, Hyperium Ltd ▪ Director of ACG Lettings Limited; a property lettings business bequeathed to Demelza by legacy ▪ Chair of Buckinghamshire Healthcare NHS Trust
Miles Scott, Chief Executive	▪ Chair of the Kent and Medway Cancer Alliance ▪ Chair of the Kent and Medway Elective Care Programme Board ▪ Chair of the Kent and Medway Pathology Network ▪ Chair of the Kent and Medway Imaging Network
Sean Briggs, Chief Operating Officer	None
Maureen Choong, Non-Executive Director	▪ Special Advisor: Care Quality Commission (CQC)
Karen Cox, Associate Non-Executive Director	▪ Vice Chancellor and President, University of Kent ▪ Board Member and Trustee, Nursing and Midwifery Council ▪ Royal College of Nursing Member ▪ Member of University of Kent Multi Academy Trust ▪ Member Universities UK membership Committee ▪ Board Member Kent, Surrey and Sussex Applied Research Collaborative ▪ Director of South East Local Enterprise Partnership ▪ Board Director of Universities and Colleges Employers Association (UCEA)
Richard Finn, Associate Non-Executive Director	▪ Director of Richard Finn Ltd ▪ Director of Goring Place ▪ Director of Detling Community Interest Company
Neil Griffiths, Non-Executive Director	▪ Managing Director of TeleTracking Technologies ▪ Advisory Council Member, Staff College
Jo Haworth, Chief Nurse	▪ Trustee of Mosaic Clubhouse
Amanjit Jhund, Director of Strategy, Planning and Partnerships	▪ Member of UK Labour Party
Peter Maskell, Medical Director	None
David Morgan, Non-Executive Director	▪ Chairman Nova Pangea Technologies Limited ▪ Chairman and Non-Executive Director of AMTE Power PLC ▪ Chairman, Piazza Barnaloft Management Limited ▪ Son works for Grant Thornton UK LLP
Sara Mumford, Director of Infection Prevention & Control	None
Steve Orpin, Deputy Chief Executive / Chief Finance Officer	▪ Non-Executive Director of NHS Innovations South East
Emma Pettitt-Mitchell, Non-Executive Director	▪ Director of ELM Business Consultancy Ltd ▪ Associate for Bridgethorne Ltd
Sue Steen, Chief People Officer	None
Jo Webber, Associate Non-Executive Director	▪ Chair of "In Control Partnerships" Charity ▪ Daughter in Law is Non-Executive Director of East Sussex Hospitals Trust ▪ Daughter in Law is Non-Executive Director of 2-gether Support Solutions ▪ Daughter in Law is Non-Executive Director of Westfield Health Insurance
Wayne Wright, Non-Executive Director	▪ Limited Liability Partnership Designated Member of [w]sq International LLP ▪ Director of Kytappo Health Technologies Limited ▪ Director of PayPill LLC

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

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

(or see www.mtw.nhs.uk/about-the-trust/trust-board.asp). The interests of Trust Board Members who left the Board during 2021/22 can also be obtained from the Trust Secretary.

Pension Liabilities

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

Trust Board sub-committees

The Trust Board has a number of sub-committees, to assist it in meeting its role and duties. Further details are provided in the "Annual Governance Statement for 2021/22" section later in the Annual Report.

The Trust's Management Structure

The Trust is organised into a number of corporate and clinical Divisions. The former includes Corporate Nursing, Emergency Planning and Response, Communications, Estates and Facilities, IT, Finance, Human Resources, Security, and Trust Management. The latter comprise 24 Clinical Directorates, as follows:

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

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

Complaints: Ready to listen, ready to learn

The Trust strives to deliver the highest standards of care and treatment for all our patients, but despite the best efforts of staff, we do not always get things right. In order to learn and improve our services, we encourage patients and relatives to tell a member of staff as soon as they can, to allow us to put things right as soon as possible. However, for circumstances where concerns cannot be resolved in this way, the Trust has a formal complaints process. In 2021/22, the Trust received 614 formal complaints (in 2020/21, this was 389), and 57.9% of complaints received were responded to within the agreed timescale (in 2020/21, this was 71.3%).

The Trust's Complaints and Patient Advice and Liaison Service (PALS) – Annual Report (which is due for publication in summer 2022) (www.mtw.nhs.uk/patients-visitors/talk-to-us/making-a-complaint/) provides further detail on: the number of complaints received; the number of complaints which were well founded (upheld); the number of complaints referred to the Parliamentary and Health Service Ombudsman (PHSO); the subject matter of the complaints received; any matters of general importance arising from those complaints or the way in which the complaints were handled; any matters where action has been or is to be taken to improve services as a consequence of those complaints.

'Principles for Remedy'

The Trust applies the 'Principles for Remedy' guidance issued by the PHSO as part of its Policy and Procedure for Management of Concerns and Complaints. Under the Trust's Policy, financial remedy is only considered when a complaint is upheld and the complainant has clearly suffered a financial loss as a result of a service failure or breach of a Trust policy. In such circumstances, the Trust will consider paying a sum that restores the person to the position they would have been in prior to the circumstances which necessitated the complaint. The amount of financial remedy is agreed between the Complaints and PALS Manager and senior Directorate management team, with input from Legal Services as required. During 2021/22, the Trust offered financial remedy in one case, totalling £55.00 (for a taxi fare). 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 three Serious Incident Requiring Investigation involving personal data that met the criteria for reporting to the Information Commissioner's Office (ICO) (i.e. a 'Level 2' severity incident) as follows.

Date of incident (month)	Nature of incident	Number affected	How patients were informed	Lessons learned
July 2021	Technical failure – failure of images to transfer between short and long data term storage	One thousand six hundred	The affected individuals were contacted by telephone and letter	The Trust notified this breach to the ICO who considered the case in light of the technical and organizational measures in place to ensure the security of personal data. The ICO decided not to take action.
June 2021	Unauthorised disclosure	One	The affected individual was contacted by telephone	The Trust notified this breach to the ICO who considered the case and were satisfied that appropriate disciplinary measures were taken in this instance.
May 2021	Non-secure disposal - Paperwork	Seventy		The Trust notified this breach to the ICO who considered the case and concluded that no further action was necessary on this occasion. The reasons for the ICO decision included: • The document was located by a responsible individual employed by a partner organization and therefore the likelihood of data misuse was limited; • Appropriate actions were taken to retrieve the documentation and therefore the breach was contained • Appropriate disciplinary procedures were followed

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	129
C	Lost in transit	11
D	Lost or stolen hardware	0
E	Lost or stolen paperwork	16
F	Non-secure disposal – hardware	1
G	Non-secure disposal – paperwork	1
H	Unloaded to website in error	0
I	Technical security failing (including hacking)	0
J	Unauthorised access/disclosure	9
K	Other	1

Policy on setting charges

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

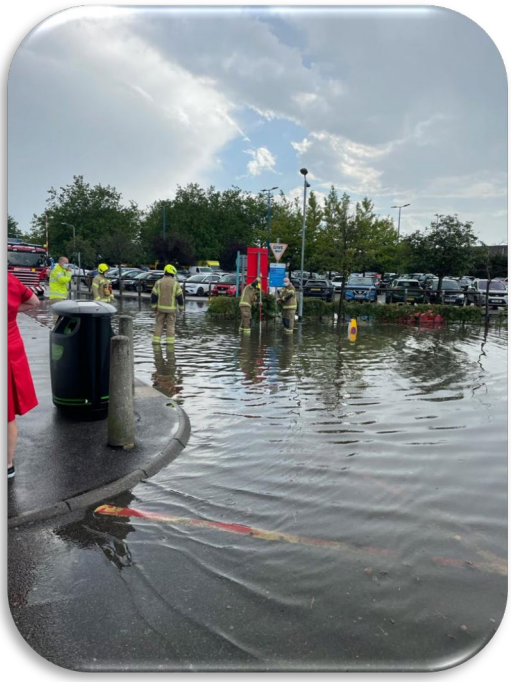
Emergency planning, response and recovery

As a Category One responder under the Civil Contingencies Act 2004, the Trust has specific statutory duties in relation to emergency planning and response. In addition the Trust has other obligations as required by contracts and performance standards set by NHS England. The following section describes the key areas of focus during 2021/22.

The Emergency Planning and Response Team have been heavily involved in the Trust's response to Operation Sandpiper as well as monitoring and responding to new challenges.

Incident Co-ordination Centre (ICC)

The Incident Co-ordination Centre (ICC) was developed in response to the command and control requirements of the COVID-19 pandemic to ensure rapid decision making and it is intended that the ICC be continued into "business as usual". The Trust has recognised the benefits provided by the ICC and it will continue as the new Trust Care Coordination Centre. A new build is under development at Maidstone Hospital which will open early in 2022/23 to provide bespoke facilities for utilisation in conjunction with the Central Operations Team.



Staffing

The Emergency Planning & Response team recruited additional staff in 2021/22 and in 2022/23 will host two students for yearlong placements helping to develop the next generation of NHS Emergency Planning Officers.

Business Continuity

During 2021/22 focus was afforded to Business Continuity plans including the development of new templates in conjunction with the provision of further training and awareness materials to support the Trust's Divisions. The Trust's Business Continuity plans were instrumental in the implementation of the 'Sunrise' Electronic Patient Record (EPR). Additional work in relation to Communications Resilience and the provision of public helplines was also undertaken in 2021/22.

Exercises and training

Despite the impact of the COVID-19 restrictions and the associated social distancing guidelines several training exercises were conducted in 2021/22 which included a Paediatric Surge Capacity event and a Multi-agency alerting exercise.

A comprehensive range of training was provided within the reporting period, both in a face to face / in-person setting and virtually via e-learning packages.

Additional training material, including videos, was produced in 2021/22.

Adverse Weather and Winter Preparedness

The Emergency Planning & Response team continued to work with partner organisations on the development of seasonal planning and contingencies for adverse weather conditions.

Assurance

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

Helicopters

The Emergency Planning and Response team continue to operate the Trust's two helipads, working closely with the various helicopter service provides to ensure the provision of safe 24-hour facilities.

Safety Advisory Groups (SAGs)

The Trust continued to offer advice and guidance to any events that came under Sevenoaks District Council, Tonbridge & Malling Borough Council, Maidstone Borough Council and Tunbridge Wells Borough Council. The focus of the guidance was directed at adequate medical cover and Emergency Department admission avoidance.

Incidents

There were three fire incidents in this reporting period where the team were involved for advice including a minor fire in an ambulance on the Emergency Department (ED) Ambulance bay; smoke reported in WHSmith in September 2021; and a skip fire in October 2021. All incidents were effectively and rapidly dealt with.

A thunderstorm caused very heavy rainfall in July 2021 causing flooding outside Maidstone ED requiring the attendance of Kent Fire & Rescue Service.

On the 30th of July 2021 a major incident was declared by the South East Coast Ambulance Service (SECAmb) in response to a chemical incident in Aylesford. The Trust plan was effectively activated using the Everbridge Alerting platform. Through close liaison between the Emergency Planning & Response team, Site Management and SECAmb Incident Commanders plans were made that enabled the incident to be rapidly stood down to a local response. It is always impressive to see how Trust staff respond to these calls.

In December 2021 flooding affected services that MTW provide at Sevenoaks Hospital. The Emergency Planning & Response team supported the Division to provide services at alternative locations.

It should be acknowledged that throughout the reporting period the Trust continued to respond to the challenges associated with the COVID-19 pandemic. The Emergency Planning & Response also provided support for the response to Operation Sandpiper as part of the Trust Tactical Team.

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

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

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

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

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

Miles Scott,

Chief Executive

16th June 2022

Statement of Directors' responsibilities in respect of the accounts

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

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

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

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

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

By order of the Trust Board

Miles Scott, Chief Executive

16th June 2022

Steve Orpin, Chief Finance Officer

16th June 2022

Annual Governance Statement for 2021/22

Scope of responsibility

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

The purpose of the system of internal control

The system of internal control is designed to manage risk to a reasonable level rather than to eliminate all risk of failure to achieve policies, aims and objectives; it can therefore only provide reasonable and not absolute assurance of effectiveness. The system of internal control is based on an ongoing process designed to identify and prioritise the risks to the achievement of the policies, aims and objectives of Maidstone and Tunbridge Wells NHS Trust, to evaluate the likelihood of those risks being realised and the impact should they be realised, and to manage them efficiently, effectively and economically. The system of internal control has been in place in Maidstone and Tunbridge Wells NHS Trust for the year ended 31st March 2022 and up to the date of approval of the annual report and accounts.

Capacity to handle risk

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

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

- The Chief Nurse is the Senior Information Risk Owner (SIRO).
- The Medical Director is the Caldicott Guardian and the Responsible Officer (for Medical Revalidation).
- The Chief Executive is the Board Level Director (with fire safety responsibility)[10].
- The Chief Operating Officer is the Security Management Director[11] and the Accountable Emergency Officer for Emergency Preparedness, Resilience & Response (EPRR)[12].

[10] Required by "Firecode – fire safety in the NHS. Health Technical Memorandum 05-01: Managing healthcare fire safety"
[11] Required by the "Secretary of State Directions to NHS Bodies on Security Management Measures 2004 (amended 2006)"
[12] Required by The Health and Social Care Act 2012

- The Chair of the Audit and Governance Committee is the security management Non-Executive Director (NED) champion[10].
- The Chair of the Quality Committee is Maternity board safety champion.

The Trust has a Risk Register in place, which is subject to an annual review by the Trust's Internal Audit function (which is provided by TIAA Ltd). The review for 2021/22 gave an overall assessment of TBC *[N.B. the outcome is not available at the time this Statement was drafted]*.

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

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

Trust staff are involved in risk management processes in a variety of ways, including raising any concerns they may have (anonymously, if they so wish) via a range of methods, including via the Freedom to Speak Up Guardian or their Deputy; being aware of their responsibility to report and act upon any incidents that occur; being involved in risk assessments; and attending regular training updates.

The Trust's mandatory induction and ongoing training programme for all staff reflects the need for staff to have a sound basis in managing risks relating to Information Governance, Infection Prevention and Control, fire safety, Safeguarding, Health and Safety and Moving and Handling. Non-mandatory training is also available to staff on a wide range of issues relating to risk management, both general (e.g. risk assessment) and in response to specific risks (e.g. falls prevention), whilst in-house support and advice on risk management is also available (which includes advice relating to patient safety, health and

safety, Emergency Planning & Response and information governance. Certain types of risk are also addressed via the engagement of external expertise. For example, the risk of fraud is managed and deterred via the appointment of a Local Counter Fraud Specialist (LCFS).

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

The risk and control framework

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

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

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

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

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

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

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

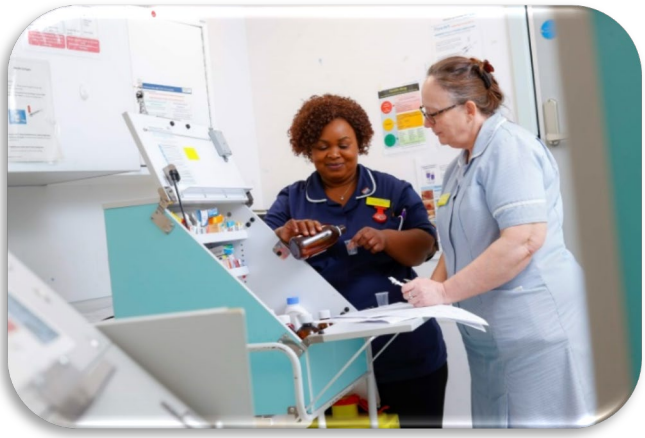
Compliance with CQC registration requirements is ultimately assessed via inspections by the CQC, and the Trust was subject to such inspections in the latter part of 2017 (which resulted in an overall assessment of "Requires Improvement"). However, regular engagement events have taken place with the CQC during 2021/22. Although such engagement events do not affect the Trust's formal assessment rating, the CQC have provided positive feedback on the areas that have been covered by these events.

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

How risks to data security are being managed and controlled

Risks to data security are managed and controlled via a range of methods, and the Trust undertakes an assessment against the National Data Guardian's ten data security standards. That assessment is primarily done via the Data Security and Protection Toolkit, and the Trust made a "Standards Met" Toolkit submission for the 2020/21 year in June 2021. The Trust is required to make its submission for the 2021/22 Toolkit by the end of June 2022.

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



The objectives for 2021/22 were approved by the Trust Board in April 2021, and were grouped under six "strategic themes": People; Patient Safety & Clinical Effectiveness; Patient Access; Patient Experience; Systems; and Sustainability. Each theme had a "Problem Statement", "Vision statement", and "Target and goal" (which later evolved into "Breakthrough objectives").

The main risks to the achievement of these key objectives (i.e. the issues that could prevent the objectives being achieved) are described within the monthly Integrated Performance Report (IPR), the format of which underwent a significant transformation during 2021/22. In addition, a number of risks were rated as 'red' in 2021/22. Red-rated risks are reviewed and validated at the ETM (see below) each quarter. The underlying risks have been discussed at the Trust Board and its sub-committees throughout 2021/22, and each associated risk assessment describes the efforts being made and/or planned to manage and mitigate the risk, and the Trust's Risk and Compliance Manager oversees the regular reviews of the assessments with the relevant risk leads.

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

The CQC inspection in 2017 that was referred to above rated the Trust as "Good" for the Well-led domain. It is likely that the Trust will be assessed again by the CQC during 2022/23.

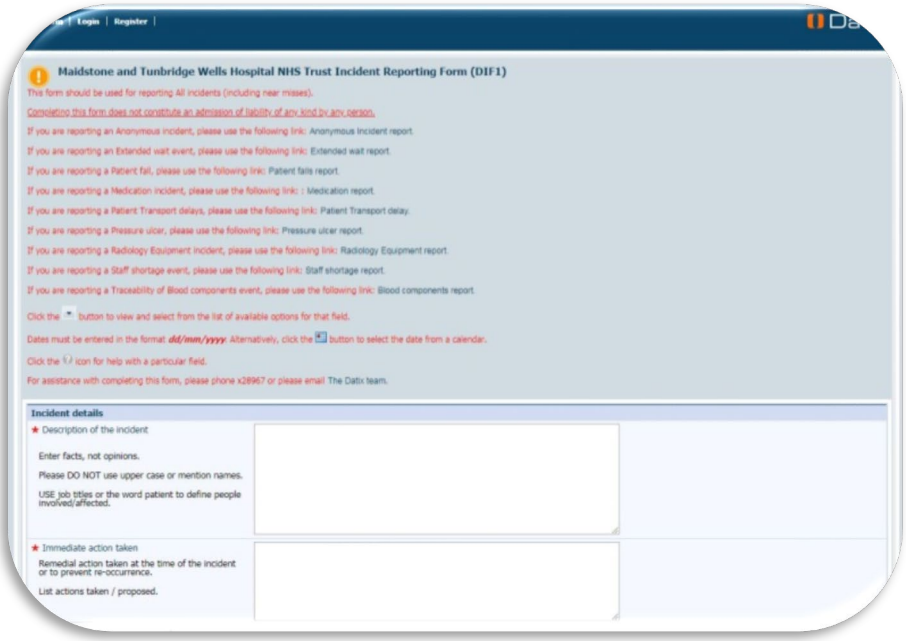
The principal risks to compliance with the NHS provider licence, condition 4, and actions identified to mitigate these risks

In May 2021, the Trust Board completed the required self-certification (for 2020/21) that the Trust could meet the obligations set out in the NHS Provider Licence (which itself includes requirements to comply with the National Health Service Act 2006, the Health and Social Care Act 2008, the Health Act 2009 and the Health and Social Care Act 2012, and to have regard to the NHS Constitution); and that it complied with governance requirements (condition FT4(8)). The Trust Board confirmed full compliance, on the basis of the content of the Trust's Annual Report, and Annual Governance Statement for 2020/21. The Trust Board will be asked to undertake the required self-certification for 2021/22 at its meeting in May 2022, and it will again be proposed that full compliance be confirmed.

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

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

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



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

The Trust complies with the "Developing Workforce Safeguards"[14] recommendations via the following methods:

- A bi-annual review of safe staffing levels is led by the Chief Nurse, using a combination of historical data, professional judgement and reference to quality outcomes. The reviews follow the National Quality Board's 2016 guidance[15] cover the necessary three components (i.e. evidence-based tools, professional judgement and outcomes).
- The Trust has a workforce plan that is submitted to NHS England/Improvement (NHSE/I) along with the annual financial and activity plans. The Trust Board discusses all of these plans before submission.
- The ETM received regular updates during 2021/22 on progress against the Trust's recruitment plan.
- Service changes including those related to skill mix and the introduction of new roles are subject to a QIA process led by the Medical Director and Chief Nurse.
- The Trust Board reviews workforce metrics on each month, via the IPR, to ensure that workforce challenges and risks are understood as part of the wider context of service delivery.
- Where there are critical service risks in relation to staffing and the safe delivery of care these, along with their associated mitigations are escalated to the Trust Board and external regulators as required.

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

Care Quality Commission (CQC) registration

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

Register of interests

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

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

under the "Gifts, hospitality, sponsorship and interests policy and procedure") has however been kept informed of the Trust's plans regarding the guidance, which the Trust intends to implement in full in 2022/23.

NHS Pension scheme

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

Obligations under equality, diversity and human rights legislation

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

Obligations under the Climate Change Act and the Adaptation Reporting requirements

The Trust has undertaken risk assessments and has plans in place which take account of the "Delivering a Net Zero Health Service" report under the Greener NHS programme. This is primarily driven via the Trust's Green Plan, which was approved by the Trust Board in May 2021, and is scheduled to be approved next in June 2022.

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

A range of processes are applied to ensure that the Trust's resources are used economically, efficiently and effectively. The monitoring of this is primarily overseen by the Trust Board, Finance and Performance Committee and Audit and Governance Committee, although the People and Organisational Development Committee, Quality Committee and Remuneration and Appointments Committee have all participated in this oversight during 2021/22. The Trust's annual Internal Audit plan for 2021/22 included a range of reviews relating to this area, including "Critical Financial Assurance – Financial Accounting and Non Pay Expenditure", and "Critical Financial Assurance – Payroll", which achieved overall assessment of "Reasonable Assurance".

Information governance

The Trust had three serious incidents involving personal data that met the criteria for reporting to the Information Commissioner's Office (ICO), as described within NHS Digital's Data Security and Protection Toolkit, during 2021/22. All three were subject to an internal investigation and remedial action was taken. The ICO confirmed it was satisfied that appropriate measures were taken for all three incidents.

Data quality and governance

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

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

- The Trust has a Data Quality Steering Group, chaired by the Deputy Chief Executive/Chief Finance Officer.
- The Trust has a "Patient access to elective care policy", which covers the management of waiting lists at all stages of a referral to treatment pathway. The Policy also states the responsibilities of key staff, including those relating to data quality.

- The Trust also has an "Information Lifecycle Management Policy and Procedure", which describes the Trust's general approach to data quality; and a Data Quality Strategy, which has been developed by the Data Quality Steering Group to ensure alignment with NHS Digital's Provider Data Quality Assurance Framework.
- There is a validation process involving operational, management and information leads, to assure the quality of local and national waiting times reporting/data.

The quality of performance information is primarily assessed via the Internal Audit programme, and in particular via the review of "Data Quality of Key Performance Indicators", which forms part of the Internal Audit plan each year. The "Data Quality of Key Performance Indicators" that was undertaken as part of the 2020/21 Internal Audit plan (and which was issued in July 2021) covered clinic cancellations less than 6 weeks and 18 Weeks Referral to Treatment (RTT) incomplete pathway indicators, and gave an overall assessment of "Reasonable Assurance".

In addition, the Trust's contract with the Clinical Commissioning Group (CCG) includes a requirement to have a Data Quality Improvement Plan (DQIP). The governance processes defined in the contract mean that any data quality issues relating to our RTT or cancer waiting times can be raised and resolved via that route. The Trust's commissioners receive copies of the Trust's performance reports, as well as information provided to them via NHSE/I, to support the performance management of the Trust's services (with the aim of ensuring the achievement of key targets such as the RTT and cancer waiting time standards). Any associated data quality issues are raised as part of this dialogue and are managed via the technical groups established under the contract and documented in the DQIP. Furthermore, all trusts now have to submit a weekly copy of their RTT waiting list (Patient Tracking List, or PTL) to NHSE/I and they have developed a Data Quality assurance report that is linked to this called "LUNA". All Trusts had the target to reach an RTT PTL confidence level of 95% by December 2021. The Trust achieved this standard and at the end of 2021/22 the confidence level stands at 99.38%.

Review of effectiveness

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

The Head of Internal Audit Opinion for 2021/22 states that "TIAA is satisfied that, for the areas reviewed during the year, Maidstone and Tunbridge Wells NHS Trust has reasonable and effective risk management, control and governance processes in place. This opinion is based solely on the matters that came to the attention of TIAA during the course of the internal audit reviews carried out during the year and is not an

opinion on all elements of the risk management, control and governance processes or the ongoing financial viability or your ability to meet financial obligations which must be obtained by Maidstone and Tunbridge Wells NHS Trust from its various sources of assurance".

The Audit and Governance Committee approves the Internal Audit plan for the year and receives details of the findings from each of the Internal Audit reviews that are undertaken. Summary reports of relevant Internal Audit reviews are also submitted to the Trust Management Executive (TME), Finance and Performance Committee, People and Organisational Development Committee, and 'main' Quality Committee during the year.
Although a number of the Internal Audit reviews completed in 2021/22 resulted in an overall 'Reasonable assurance' assessment, one led to an assessment of 'Limited assurance'. This related to Estates Procurement, and the Director of Estates and Facilities was invited to attend the Audit and Governance Committee meeting on 03/11/21 to respond to the review.

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

The Trust Board meets every month (with the exception of August) in public (a 'Part 1' meeting). All but one of Trust Board's meetings in 2021/22 were held 'virtually', as a result of the COVID-19 pandemic, and the requirement to meet in public was met via the Trust Board's meetings being broadcast live on the internet, via the Trust's YouTube channel. The agenda and reports for all 'Part 1' Trust Board meetings are available via the Trust's website.

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

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

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

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

- The Audit and Governance Committee. This supports the Trust Board by critically reviewing the governance and assurance processes on which the Board places reliance. This therefore incorporates reviewing Governance, Risk Management and Internal Control; oversight of the Internal and External Audit, and Counter Fraud functions. The Committee also undertakes detailed review of the Trust's Annual Report and Accounts, is the Trust's Auditor Panel (in accordance with Schedule 4, Paragraph 1, of the Local Audit and Accountability Act 2014). The Committee is chaired by a Non-Executive Director, and meets five times each year (including a specific meeting to review the Annual Report and Accounts prior to the Trust Board being asked to approve these). All other Non-Executives Directors (apart from the Chair of the Trust Board) are members.
- The Charitable Funds Committee. This aims to ensure that the Maidstone and Tunbridge Wells NHS Trust Charitable Fund is managed efficiently and effectively in accordance with the directions of the Charity Commission, relevant NHS legislation and the wishes of donors, which includes reviewing, and agreeing the Charitable Fund Annual Report and financial accounts, for approval by the Trust Board. The Committee is chaired by a Non-Executive Director, and usually meets three times per year, although it met five times during 2021/22.
- The Finance and Performance Committee. This aims to provide the Trust Board with: assurance on the effectiveness of financial management, treasury management, investment and capital expenditure and financial governance; an objective assessment of the financial position and standing of the Trust; and advice and recommendations on all key issues of financial management and financial performance. In addition, the Committee receives assurance on informatics (including Information Technology) strategies and plans, and on plans and proposals for major development and investment in Information Technology. The Committee is chaired by a Non-Executive Director, and meets monthly.
- The Patient Experience Committee. This considers the effectiveness of the Trust's progress in utilising the learning from patient and service users experience of Trust services in order to improve, and identify the level of inclusion achieved for patients and service users by Trust operations. The Committee is chaired by a Non-Executive Director, and meets quarterly. In addition to Trust staff, its membership includes representatives from the Trust's catchment area, Healthwatch Kent, and from Leagues of Friends of Maidstone and Tunbridge Wells Hospitals.
- The People and Organisational Development Committee. This provides assurance to the Board in the areas of people development, planning, performance and employee engagement; and works to assure the Trust Board that the Trust has the necessary strategies, policies and procedures in place to ensure a high performing and motivated workforce that supports success. The Committee is chaired by a Non-Executive Director and meets monthly.
- The Quality Committee. This aims to seek and obtain assurance on the effectiveness of the Trust's structures, systems and processes to enable delivery of the Trust's objectives relating to quality of care. The Committee is chaired by a Non-Executive Director and meets monthly. On alternate months, the Committee meets in the form of a 'deep dive', with a reduced membership, to enable a small number of subjects to be scrutinised in greater detail.
- The Remuneration and Appointments Committee. This reviews, on behalf of the Trust Board, the appointment of members of the Executive Team, to ensure such appointments have been undertaken in accordance with Trust Policies. It also reviews the remuneration, allowances and terms of service of such staff; reviews (with the Chief Executive) the performance of members of the Executive Team; oversees

appropriate contractual arrangements for such staff (including the proper calculation and scrutiny of termination payments, taking account of such national guidance, as appropriate); and considers and approves, on behalf of the Trust Board, proposals on issues which represent significant change. The Committee is chaired by the Chair of the Trust Board, and meets on an ad-hoc basis (although it met three times during 2021/22).

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

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

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

Significant internal control issues

The following significant internal control issues[16] have been identified in 2020/21:

1. Four "Never Events" were declared at the Trust in 2021/22. These related to a wrong side nerve block in theatres; a mis-placed nasogastric (NG) tube within Medicine and Emergency Care; a retained swab following a caesarean section in the delivery theatres; and a retained guide wire in surgery / Intensive Care Unit (ICU). The incidents were subject to scrutiny through the SI investigation process, and the Quality Committee, to aim to ensure that lessons were learnt to prevent recurrence.
2. In December 2021, HM Coroner issued the Trust with a Regulation 28 ("Report to Prevent Future Deaths") report, following the Inquest into the death (in October 2021) of one of the Trust's patients. HM Coroner identified some factors that they regarded as a "gross failure to provide basic medical care that would have prolonged but probably would not have saved [the patient's] life". The Trust duly wrote to HM Coroner in January 2021 to explain the actions that had been taken, and would be taken in the future, to learn from the incident, and prevent it from recurring.

[16] The Trust considered the following criteria when identifying if any significant internal control issues had occurred during 2021/22: Might the issue prejudice achievement of priorities? Could the issue undermine the integrity or reputation of the NHS? What view does the Audit and Governance Committee take on this point? What advice has internal or external audit given? Could delivery of the standards expected of the Accountable Officer be at risk? Has the issue made it harder to resist fraud or other misuse of resources? Did the issue divert resources from another significant aspect of the business? Could the issue have a material impact on the accounts? Might national or data security or integrity be put at risk?

3. On 15/12/20, Kent Police notified the Trust of their inquiries relating to a former Trust/Interserve/Mitie employee, David Fuller, committing offences under the Sexual Offences Act 2003 in the mortuary at Tunbridge Wells Hospital. Fuller subsequently pleaded guilty, on 08/10/21, to a range of offences against 78 identified deceased persons within the mortuaries at Tunbridge Wells Hospital and the now-closed Kent and Sussex Hospital. Fuller's mortuary-related offences were made public on 01/11/21 and on 08/11/21, in an Oral Statement to Parliament, the Secretary of State for Health and Social Care announced an independent inquiry into the issues raised by the actions of David Fuller. That Inquiry was formally launched on 18/01/22, and its Terms of Reference were published on 23/02/22. The Trust is cooperating fully with the Inquiry, and although a range of actions have been taken in response to Fuller's criminal activity, the Trust will respond to the Inquiry's findings once published.

Conclusion

The Trust has maintained a sound system of internal control during 2021/22, and has identified only three significant internal control issues during the year. These are described above, in the body of the Annual Governance Statement.

Miles Scott, Chief Executive

16th June 2022

Accountability Report for 2021-2022:
Remuneration and staff report

Our staff

NHS national staff survey

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

Making sure our staff are happy and healthy at work is a top priority for the Trust and we're delighted that our latest NHS Staff Survey results reflect this.

Our 2021 NHS National staff survey saw 52% of staff sharing their views with us (3385 staff). With the national average response rate for acute Trusts being 46% and with the continuing challenges of COVID-19, we're really pleased to see that more staff are happy with the standard of care provided and would be happy for friends and family to be cared for by our teams. Our levels of staff engagement and morale scored higher than the national average for other acute trusts too.

But our highest score compared to the national average was achieved under the theme "We are always learning', showing that we have a strong learning ethos with staff feeling they have opportunities to develop their careers and improve their knowledge and skills, and felt supported to develop their potential.

We know there is still more work to do to sustain these improvements and address the areas that we need to focus on and improve. These include how we recognise and reward staff, involve staff in making decisions about work and people's experience of compassion at work. Work is already underway in some of these areas with the development of our Exceptional Leaders programme which focuses on compassionate and inclusive leadership, and a programme of work to deliver our inclusion and diversity strategy.

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

Employee benefits

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

Staff numbers and costs (subject to audit)

Average[17] staff numbers	Permanently employed (WTE) [18]	Other (WTE)	Permanently employed (expenditure) (£000s)	Other (expenditure) (£000s)
Medical and dental	890	78	97,968	11,055
Ambulance staff	9	0	571	0
Administration and estates	1213	46	47,025	3,451
Healthcare assistants and other support staff	1907	4	55,993	285
Nursing, midwifery and health visiting staff	1788	125	91,551	7,816
Nursing, midwifery and health visiting learners	0	0	0	0
Scientific, therapeutic and technical staff	571	30	29,874	2,157
Healthcare Science Staff	215	0	11,647	19
Social Care Staff	0	0	0	0
Other	0	0	0	0
Apprenticeship levy	0	0	1,376	0
Employers Pension Contribution 6.3%	0	0	13,854	0
Total	6593	283	349,860	24,783
Staff engaged on capital projects (excluded from above)	1	0	117	1

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

The analysis of staff costs by main elements of costs:

Analysis of staff costs	2021/22 Permanently employed (£000s)	2020/21 Permanently employed (£000s)
Salaries and wages	275,015	255,636
Social security costs	27,959	26,419
Apprenticeship levy	1,376	1,277
Pension cost - employer contributions to NHS pension scheme	31,738	29,422
Pension cost - employer contributions paid by NHSE on provider's behalf (6.3%)	13,854	12,824
Pension cost - other*	35	76
Total	349,977	325,654

Exit packages (subject to audit)

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

[17] 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.
[18] This excludes any staff on unpaid leave (and therefore does not equate to the WTE reported within the Sustainability Report)

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	£000s	Whole numbers only	£000s	Whole numbers only	£s
Less than £10,000	None	0	20	60	20	60	None	0
£10,000 - £25,000	None	0	3	44	3	44	None	0
£25,001 - £50,000	None	0	0	0	None	0	None	0
£50,001 - £100,000	None	0	0	0	None	0	None	0
£100,001 - £150,000	None	0	0	0	None	0	None	0
£150,001 - £200,000	None	0	0	0	None	0	None	0
>£200,000	None	0	0	0	None	0	None	0
Total	None	0	23	104	23	104	None	0

Exit packages – disclosures (excluding compulsory redundancies)	Number of exit package agreements 2021/22	Total Value of agreements (£000s)	Number of exit package agreements 2020/21	Total Value of agreements (£000s)
Voluntary redundancies including early retirement contractual costs	0	0	0	0
Mutually agreed resignations (MARS) contractual costs	0	0	0	0
Early retirements in the efficiency of the service contractual costs	0	0	0	0
Contractual payments in lieu of notice	23	104	16	65
Exit payments following Employment Tribunals or court orders	0	0	0	0
Non-contractual payments requiring HMT approval *	0	0	0	0
Total	23	104	16	65
Non-contractual payments made to individuals where the payment value was more than 12 months of their annual salary	0	0	0	0

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

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

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

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

The Trust's Freedom to Speak Up Guardian (FTSUG) submitted reports to the Trust Board each quarter during 2021/22. The FTSUG aims to ensure that patients are cared for in a safe way and that staff are able to raise

concerns that they feel are not being heard or are unable to raise with management. It is also the Guardian's role to listen in confidence, note concerns and raise issues through the appropriate channels.

Exceptional People, Outstanding Care programme

The Trust launched its Exceptional People Outstanding Care cultural and leadership programme during 2021. The programme recognises the importance of culture and leadership in an organisation's success.

The programme, built on a foundation of compassionate leadership and coaching, emphasises staff wellbeing. This is key to supporting our staff as we continue to adjust to providing acute care in an environment where we are adapting to live with COVID-19.

Initially delayed due to the COVID-19 pandemic, the programme launched in June 2021 and the third cohort of leaders are currently going through the programme in Spring 2022. Evaluation of the programme is underway.

The next phase of leadership development is in design. This will evolve the rollout of leadership development to all people leaders in the Trust and is designed in three phases. It aims to launch in September 2022, aligned to the ambitions of the Trust's People and Culture Strategy 2022.

Education and Development

The Trust is committed to the ongoing development of its staff. There is an Academic Centre on both sites, including the newly built centre at Tunbridge Wells Hospital, providing a dedicated teaching space and library for all staff to utilise.

By working with colleagues in Equality, Diversity and Inclusion, Wellbeing, Occupational Health, Organisational Development, Medical Education, Nursing, Allied Health Professionals and many others we have been able to develop opportunities for students and staff, enabling them to support the Trust to develop as a clinically led organisation. Knowing that Trusts with a strong learning and educational ethos are safer, have better clinical outcomes, retain staff, and become an employer of choice for applicants, we are committed to continuing to create a supportive and engaging environment in which our staff can develop and grow.

There has been a significant amount of work focused on developing apprenticeship opportunities within the Trust. This has resulted in the Trust meeting and then exceeding the national 2.3% target for the first time and are currently at 2.73% with a 45/55 split between existing staff and new recruits respectively, following an apprenticeship development pathway. The Career Development team managing apprenticeships won an award in 2021 for Public Sector Employer for Apprenticeships in recognition of their ongoing work to provide apprenticeship opportunities for current staff as well as at the point of recruitment.

MTW-Learning is a learning platform utilised by all staff to support their training needs - both online learning and the booking of face to face sessions. It has been significantly developed to meet the growing requirements of the Trust as well as supporting staff to access training, development and wellbeing opportunities. The annual appraisal has been enhanced in line with the Trust promoting regular wellbeing conversations between staff and managers and nurturing the development staff career aspirations.

As part of the journey for the Trust becoming a well led organisation there has been significant investment in the leadership development of senior staff within the organisation. Over 300 senior leaders have attended the MTW Exceptional Leaders training programme with many more scheduled. Following this success, there are plans in place to develop and create leadership programmes for all staff, at all levels so that we can continue to develop high quality leadership across the organisation.

Equal opportunities

We are committed to providing services and employment to our diverse community. To do this effectively it is essential that we promote equity, embrace diversity and treat all of our patients, relatives, staff and service users with civility, dignity and respect. This means that we treat people as individuals and ensure that everyone is given the opportunities they deserve by identifying barriers and removing them.

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

Black, Asian and Minority Ethnic (BAME) employees

Launched in March 2021 by the NHSE/I Equality, Diversity and Inclusion (EDI) team, the Six National Actions are set to focus the attention of NHS organisations on race disparity within the workforce. The focus on overhauling recruitment seeks to give form to the target set by Sir Simon Stevens in 2020 of achieving 19% BAME representation across all staff pay bands by 2025.

The work undertaken by MTW over the past year has set the foundations of success and created a platform to launch the Six National Actions.

We successfully delivered our first Reverse Mentoring programme which saw the whole Trust Board being mentored by BAME staff from a wide range of roles.

Eight staff from the BAME community at MTW entered the Kent and Medway ICS BAME mentoring programme in September 2021. Matched with mentors across the system, the focus for the individuals was on their career development.

We piloted an innovative de-biased recruitment process and trained 25 EDI Recruitment Representatives to support recruiting panels in understanding how to run de-biased shortlisting and interviews.

Our White Ally programme launched supporting the See ME First badge scheme; we have delivered training on race equality and developed an EDI module drawing on both our Trust data and the lived experiences of our BAME staff for our ongoing Exceptional Leaders programme.

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

- Introducing values based recruitment practices
- Implementing a robust and de-biased talent and succession planning process
- Providing resources to educate all staff on race equality

LGBT+ employees

Restrictions on events have continued to take their toll on this vibrant network but it didn't stop them launching the very first MTW Pride event in July 2021. With members of the network and their allies, they visited all the main MTW sites with stands and goodie bags at each and a further 100 staff signed up to the NHS Rainbow Badge pledge.

Work continues with teams on developing inclusive environments for our staff and patients, ensuring that appropriate language is used in documentation and inclusive representation in our imagery. The maternity team are following in the footsteps of Brighton NHS Trust by implementing a Gender Inclusive toolkit that supports trans and non binary birthing people.

MTW have also been invited to join an extended pilot of the NHS Rainbow Badge Phase 2 assessment scheme. Over the coming months, we will be assessed on:

- How inclusive our HR policies are
- Training and confidence levels of our staff when providing care for LGBT+ patients and their carers
- Training and confidence levels of our staff when providing support for LGBT+ colleagues
- The inclusive behaviours of our staff towards patients
- How inclusive are services are
- How inclusive we are as an employer

Disabled employees

The DisAbility network has continued to grow in size and have held monthly meetings hosting activities related to disabilities open to the whole Trust including the support provided by Occupational Health with reasonable adjustments, introduction of the staff health passport and supporting staff with autism in the workplace.

Three peer support networks have launched from the Disability network including a carer's network, autism support group and chronic pain support group. The networks play active roles as subject matter experts to the Trust in developing services, developing our senior leadership training programmes and supporting campaigns such as Different Not Less, which focuses on our patients and colleagues with autism.

We have launched the Staff Health Passport which helps to guide conversations between staff and managers about health conditions and adjustments required; launched the Disability Leave policy providing staff with additional leave to support appointments connected to their long term health conditions and became the second NHS Trust in Kent to obtain Disability Confident Leader status demonstrating our commitment and leadership skills in:

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

Fair and inclusive recruitment

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

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

Gender	Staff [head count]		Trust Board Members	
Male	1653 (1568)	23.8% (23.9%)	10 (9)	58.8% (52.9%)
Female	5298 (4983)	76.2% (76.1%)	7 (8)	41.2% (47.1%)
Grand total	6951 (6551)	-	17 (17)	-

Ethnic group	Staff [head count]		Trust Board Members	
A White – British	3960 (3928)	57.0% (60.0%)	14 (15)	82.4% (88.2%)
B White – Irish	53 (55)	0.8% (0.8%)	1 (1)	5.9% (5.9%)
C White - Any other White background	478 (476)	6.9% (7.3%)	0 (0)	0% (0%)
C2 White Northern Irish	1 (2)	> 0.1% (>0.1%)	0 (0)	0% (0%)
C3 White Unspecified	1 (1)	> 0.1% (> 0.1%)	0 (0)	0% (0%)
CA White English	1 (0)	> 0.1% (> 0.1%)	0 (0)	0% (0%)
CF White Greek	3 (3)	> 0.1% (> 0.1%)	0 (0)	0% (0%)
CK White Italian	1 (1)	> 0.1% (> 0.1%)	0 (0)	0% (0%)
CP White Polish	6 (8)	0.1% (0.1%)	0 (0)	0% (0%)
CU White Croatian	1 (1)	> 0.1% (> 0.1%)	0 (0)	0% (0%)
CX White Mixed	1 (0)	> 0.1% (0%)	0 (0)	0% (0%)
CY White Other European	14 (16)	0.2% (0.2%)	0 (0)	0% (0%)
D Mixed - White & Black Caribbean	17 (15)	0.2% (0.2%)	0 (0)	0% (0%)
E Mixed - White & Black African	21 (15)	0.3% (0.2%)	0 (0)	0% (0%)
F Mixed - White & Asian	38 (32)	0.5% (0.5%)	0 (0)	0% (0%)
G Mixed - Any other mixed background	43 (31)	0.6% (0.5%)	0 (0)	0% (0%)
GA Mixed - Black & Asian	1 (1)	> 0.1% (> 0.1%)	0 (0)	0% (0%)
GC Mixed - Black & White	1 (1)	> 0.1% (>0.1%)	0 (0)	0% (0%)
GD Mixed - Chinese & White	0 (0)	0% (0%)	0 (0)	0% (0%)
GE Mixed - Asian & Chinese	1 (1)	> 0.1% (> 0.1%)	0 (0)	0% (0%)
GF Mixed - Other/Unspecified	3 (1)	> 0.1% (> 0.1%)	0 (0)	0% (0%)
H Asian or Asian British - Indian	662 (594)	9.5% (9.1%)	1 (1)	5.9% (5.9%)
J Asian or Asian British - Pakistani	93 (67)	1.3% (1.0%)	0 (0)	0% (0%)
K Asian or Asian British - Bangladeshi	29 (22)	0.4% (0.3%)	0 (0)	0% (0%)
L Asian or Asian British - Any other Asian background	347 (328)	5.0% (5.0%)	0 (0)	0% (0%)
LA Asian Mixed	5 (5)	0.1% (0.1%)	0 (0)	0% (0%)
LB Asian Punjabi	0 (1)	0% (>0.1%)	0 (0)	0% (0%)
LE Asian Sri Lankan	1 (0)	> 0.1% (0%)	0 (0)	0% (0%)
LF Asian Tamil	2 (2)	> 0.1% (>0.1%)	0 (0)	0% (0%)
LH Asian British	2 (3)	> 0.1% (> 0.1%)	0 (0)	0% (0%)
LJ Asian Caribbean	2 (1)	> 0.1% (>0.1%)	0 (0)	0% (0%)
LK Asian Unspecified	4 (3)	0.1% (>0.1%)	0 (0)	0% (0%)
M Black or Black British - Caribbean	31 (25)	0.4% (0.4%)	1 (0)	5.9% (0%)
N Black or Black British - African	243 (197)	3.5% (3.0%)	0 (0)	0% (0%)
P Black or Black British - Any other Black background	20 (14)	0.3% (0.2%)	0 (0)	0% (0%)
PB Black Mixed	0 (0)	0% (0%)	0 (0)	0% (0%)
PC Black Nigerian	13 (9)	0.2% (0.1%)	0 (0)	0% (0%)
PD Black British	1 (4)	> 0.1% (0.1%)	0 (0)	0% (0%)
PE Black Unspecified	0 (1)	0% (>0.1%)	0 (0)	0% (0%)
R Chinese	47 (31)	0.7% (0.5%)	0 (0)	0% (0%)
S Any Other Ethnic Group	164 (149)	2.4% (2.3%)	0 (0)	0% (0%)
SA Vietnamese	0 (1)	0% ((>0.1%)	0 (0)	0% (0%)
SB Japanese	4 (4)	0.1% (0.1%)	0 (0)	0% (0%)
SC Filipino	25 (18)	0.4% (0.3%)	0 (0)	0% (0%)
SD Malaysian	3 (2)	> 0.1% (>0.1%)	0 (0)	0% (0%)
SE Other Specified	4 (4)	0.1% (0.1%)	0 (0)	0% (0%)
Z Not Stated / Undeclared	604 (476)	8.7% (7.3%)	0 (1)	0% (0%)
Total	6951 (6551)	-	17 (17)	-

Age	Staff [head count]		Trust Board Members	
Less than or equal to 20 years	63 (55)	0.9% (0.8%)	0 (0)	0% (0%)
21 to 25	501 (472)	7.2% (7.2%)	0 (0)	0% (0%)
26 to 30	869 (810)	12.5% (12.4%)	0 (0)	0% (0%)
31 to 35	1006 (852)	14.5% (13.0%)	1 (1)	5.9% (5.9%)
36 to 40	767 (668)	11.0% (10.2%)	0 (1)	0% (5.9%)
41 to 45	821 (851)	11.8% (13.0%)	2 (2)	11.8% (11.8%)
46 to 50	941 (882)	13.5% (13.5%)	1 (2)	5.9% (11.8%)
51 to 55	840 (832)	12.1% (12.7%)	6 (3)	35.3% (17.6%)
56 to 50	670 (672)	9.6% (10.3%)	2 (2)	11.8% (11.8%)
61 to 65	366 (355)	5.4% (5.4%)	2 (3)	11.8% (17.6%)
66 to 70	76 (75)	1.1% (1.1%)	2 (2)	11.8% (11.8%)
71 years or over	31 (27)	0.4% (0.4%)	1 (1)	5.9% (5.9%)

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

Staff sickness absence

The staff sickness absence for 2021/22 is reported below:[19]

Figures converted by the Department of Health and Social Care (DHSC) to best estimates of required data items		Statistics produced by NHS Digital from Electronic Staff Record (ESR) Data Warehouse		
Average Full Time Equivalent (FTE) 2021	Adjusted FTE days lost to Cabinet Office definitions	FTE-Days Available	FTE-Days Lost to Sickness Absence	Average Sick Days per FTE[20]
6,007	56,640	9.4	2,192,610	91,883

N.B. This data is provided via the Department of Health and Social Care (DHSC) (as it is necessary to reconcile NHS Electronic Staff Record data with the 'Cabinet Office' data reported by central Government, to permit aggregation across the NHS) [21]. The sickness absence figures reported for 2021/22 are actually for the calendar year 2021 (i.e. January to December 2021). However, the DHSC considers the figures for the calendar year to be a reasonable proxy for the financial year. It should be noted that the reporting requirement was suspended for 2020/21 due to the COVID-19 pandemic, however information for the previous reporting period is available on the NHS Digital website.

Health and Safety at Work

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

- The number of non-patient safety incidents reported increased to pre-pandemic levels. There were 2447 in 2021/22 compared with 2147 in 2020/21, an increase of around 14%.

[19] The Electronic Staff Record (ESR) does not hold details of the normal number of days worked by each employee. Data on days available and days recorded sick are based on a 365-day year.
[20] Average Annual Sick Days per FTE has been estimated by dividing the estimated number of FTE-days sick by the average FTE, and multiplying by 225 (the typical number of working days per year).
[21] There may be inconsistencies between this data and the statutory basis for accounts, in terms of the organisation against which staff are reported for a particular month.

- There was a significant increase in incidents of violence and harassment against staff. The incidents are largely attributable to patients diagnosed with dementia or those suffering from a mental health crisis. Work is ongoing to mitigate the risk.
- A security audit was carried out and the findings are being evaluated and actioned. Body worn video has been rolled out and the Security team have been encouraged to report all incidents via Datix.
- At the end of March 2022, the number of reports to the Health and Safety Executive under the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations (RIDDOR) 2013 remained at 22 in 2021/22, the same number as in 2020/21. This does not include COVID-19-related occupational disease RIDDOR reports.
- The Trust stance on reporting COVID workplace disease RIDDOR has changed. The continued vaccination programme and change in Government guidelines for the general public outside of hospital settings decreased the likelihood of workplace versus community transmission and the ability to accurately attribute workplace acquired COVID infection. As a result the number of COVID RIDDOR reports decreased significantly.
- 2022/23 will see a significant increase in construction on both sites, including the student medical accommodation at Tunbridge Wells Hospital and the barn theatres at Maidstone Hospital. The Safety Team are consulted in all relevant matters involved with the construction process.
- Significant work is being carried to make sites safer for patients with mental health issues. The Safety Team will be leading on a workstream aimed at addressing the issue of the increase in patients presenting with mental health issues on both sites.
- A new health and safety audit tool is operational to streamline the health and safety inspection process. In addition, the Risk module in Datix is being developed to provide a more robust sytem for monitoring health and safety management compliance than the package currently in place.
- QR codes are to be placed in prominent locations around the sites to allow for quick and easy recording and reporting of safety concerns. This will be primarily aimed at members of the public and those who would not normally report using the Trust Datix incident reporting system.

"Senior Managers" remuneration

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

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

The Trust Board has established a Remuneration and Appointments Committee to advise and assist in meeting its responsibilities to ensure appropriate remuneration, allowances and terms of service for the Chief Executive, Directors and other key senior posts (refer to the Annual Governance Statement for 2021/22 for further details of the Remuneration and Appointments Committee).

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

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

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

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

Salaries and allowances for the year ending 31st March 2022 (subject to audit)

Comparatives for the year ending 31st March 2021 are shown in brackets below the figure for 2021/22.

Name and title (alphabetical by surname) N.B. Dates of service are for the full 2021/22 year unless otherwise disclosed	(a) Salary (bands of £5,000)	(b) Taxable expense payments and other benefits in kind, to the nearest £100	(c) Annual performance-related pay and bonuses (bands of £5,000)	(d) Long-term performance-related pay and bonuses (bands of £5,000)	(e) All pension-related benefits (bands of £2,500)	(f) TOTAL (columns a - f) (bands of £5.000)	(g) Payments or compensation for loss of office
	£000	£ Λ	£000	£000	£000	£000	£000
Sean Briggs, Chief Operating Officer	145- 150 (135-140)	0 (0)	N/A (N/A)	N/A (N/A)	55.0-57.5 (30-32.5)	200-205 (165-170)	N/A (N/A)
Maureen Choong, Non-Executive Director	10-15 (10-15	0 (0)	N/A (N/A)	N/A (N/A)	0 (0)	10-15 (10-15)	N/A (N/A)
Karen Cox, Associate Non-Executive Director ±	0 (0)	0 (0)	N/A (N/A)	N/A (N/A)	0 (0)	0 (0)	N/A (N/A)
Gemma Craig, Acting Chief Nurse (between 26/06/21 – 22/07/21)	25-30 0	0 (0)	N/A (N/A)	N/A (N/A)	0 (0)	25-30 (0)	N/A (N/A)
Sarah Dunnett, Non-Executive Director (until 31/12/2021)	5-10 (10-15)	0 (0)	N/A (N/A)	N/A (N/A)	0 (0)	5-10 (10-15)	N/A (N/A)
Richard Finn, Associate Non-Executive Director	10-15 (10-15)	0 (0)	N/A (N/A)	N/A (N/A)	0 (0)	10-15 (10-15)	N/A (N/A)
Neil Griffiths, Associate Non-Executive Director	10-15 (10-15)	0 (0)	N/A (N/A)	N/A (N/A)	0 (0)	10-15 (10-15)	N/A (N/A)
Joanna Haworth, Chief Nurse (started 03/08/21)	85-90 (0)	0 (0)	N/A (N/A)	N/A (N/A)	130.0-132.5 (0)	220-225 (0)	N/A (N/A)
David Highton, Chair of the Trust Board	45-50 (35-40)	0 (0)	N/A (N/A)	N/A (N/A)	0 (0)	45-50 (35-40)	N/A (N/A)
Amanjit Jhund, Director of Strategy, Planning & Partnerships	115-120 (115-120)	0 (0)	N/A (N/A)	N/A (N/A)	27.5-30.0 (27.5-30.0)	140-145 (140-145)	N/A (N/A)
Peter Maskell, Medical Director Ψ	200-205 (200-205)	0 (0)	N/A (N/A)	N/A (N/A)	0 (20.0-22.5)	200-205 (225-230)	N/A (N/A)
David Morgan, Non-Executive Director	10-15 (10-15)[22]	0 (0)	N/A (N/A)	N/A (N/A)	0 (0)	10-15 (10-15)	N/A (N/A)
Sara Mumford, Director of Infection Prevention and Control Ψ	195-200 (195-200)	0 (0)	N/A (N/A)	N/A (N/A)	82.5-85.0 (75.0-77.5)	280-285 (270-275)	N/A (N/A)
Claire O'Brien, Chief Nurse µ (retired 25/06/21)	45-50 (130-135)	0 (0)	N/A (N/A)	N/A (N/A)	0 (12.5-15.0)	45-50 (145-150)	N/A (N/A)
Steve Orpin, Deputy Chief Executive / Chief Finance Officer	165-170 (155-160)	0 (0)	N/A (N/A)	N/A (N/A)	95.0-97.5 (32.5-35.0)	265-270 (190-195)	N/A (N/A)
Emma Pettitt-Mitchell, Non-Executive Director	10-15 (10-15)	0 (0)	N/A (N/A)	N/A (N/A)	0 (0)	10-15 (10-15)	N/A (N/A)
Miles Scott, Chief Executive	225-230 (225-230)	0 (0)	N/A (N/A)	N/A (N/A)	0 (0)	225-230 (225-230)	N/A (N/A)
Sue Steen, Chief People Officer (started 01/04/21)	140-145 (0)	0 (0)	N/A (N/A)	N/A (N/A)	152.5-155.0 (0)	290-295 (0)	N/A (N/A)
Jo Webber, Associate Non-Executive Director	10-15 (10-15)[23]	0 (0)	N/A (N/A)	N/A (N/A)	0 (0)	10-15 (10-15)	N/A (N/A)

Λ £ hundreds are used for taxable expense payments, and other benefits (column (b)). All other columns are in £ thousands

Ψ Drs Maskell and Mumford hold clinical roles in the Trust alongside their responsibilities as Senior Managers. In relation to Dr Maskell the nil value in the year for his pension relates to a salary sacrifice scheme being taken out within 2021/22 resulting in a small negative value.

± Karen Cox does not receive renumeration from the Trust

µ Claire O'Brien retired in June 2021 and took her pension, this results in a decrease between this years and the prior year

Pension benefits for the year ending 31st March 2022[24] (subject to audit)

Name and title Ψ (alphabetical by surname) N.B. Dates of service are for the full 2021/22 year unless otherwise disclosed	(a) Real increase in pension at pension age (bands of £2,500)	(b) Real increase in pension lump sum at pension age (bands of £2,500)	(c) Total accrued pension at pension age at 31st March 2022 (bands of £5,000)	(d) Lump sum at pension age related to accrued pension at 31st March 2022 (bands of £5,000)	(e) Cash Equivalent Transfer Value Λ at 1st April 2021	(f) Real increase in Cash Equivalent Transfer Value Σ	(g) Cash Equivalent Transfer Value Λ at 31st March 2022	(h) Employee's contribution to stakeholder pension
	£000	£000	£000	£000	£000	£000	£000	£000
Sean Briggs, Chief Operating Officer	2.5-5.0	0	25-30	0	218	18	259	**0**
Gemma Craig, Acting Chief Nurse ± (between 26/06/21 – 22/07/21)	0	0-2.5	20-25	45-50	0	87	363	**0**
Joanna Haworth, Chief Nurse ± (started 03/08/21)	5.0-7.5	10-12.5	45-50	110-115	0	120	939	**0**
Amanjit Jhund, Director of Strategy, Planning & Partnerships	0-2.5	0	5.0-10.0	0	79	7	103	**0**
Peter Maskell, Medical Director	0-2.5	0	30-35	60-65	589	0	594	**0**
Sara Mumford, Director of Infection Prevention and Control	5.0-7.5	2.5-5.0	70-75	90-95	1108	85	1223	**0**
Claire O'Brien, Chief Nurse µ (retired 25/06/21)	0	0	55-60	165-170	1378	0	0	**0**
Steve Orpin, Deputy Chief Executive / Chief Finance Officer	2.5-5.0	10-12.5	65-70	140-145	1028	98	1140	**0**
Miles Scott, Chief Executive¥	0	0	0	0	0	0	0	**0**
Sue Steen, Chief People Officer ± (started 01/04/21)	7.5-10.0	0	5-10.0	0	0	97	117	**0**

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

Λ A Cash Equivalent Transfer Value (CETV) is the actuarially assessed capital value of the pension scheme benefits accrued by a member at a particular point in time. The benefits valued are the member's accrued benefits and any contingent spouse's (or other allowable beneficiary's) pension payable from the scheme. CETVs are calculated in accordance with the Occupational Pension Schemes (Transfer Values) Regulations 2008. Please however note that the CETV values at 31/03/21 and 31/03/22 may have been calculated using different methodologies, and this may have impacted the "Real increase in Cash Equivalent Transfer Value" figure in the table

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

¥ Miles Scott did not make any contributions into the NHS Pension Scheme in 2021/22

µ Claire O'Brien retired in June 2021 and took her pension, this results in no closing CETV value at 31st March 2022

± Where new starters have joined throughout 2021-22 they will not have a CETV for the 1st April 2022 but will have a closing CETV value at 31st March 2022.

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

Fair pay disclosure (subject to audit)

The remuneration of the highest paid director has remained unchanged between years. The median pay of all other staff has increased due to pay awards and a greater proportion of expenditure being on agency staff. The table below shows the changes and analyses remuneration between salary and allowances and performance pay and bonus components.

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

Percentage change for the highest paid director:

2021-22	Percentage change for highest paid director	Percentage change for employees as a whole
Salary and allowances	0%	4.96%
Performance pay/bonuses	0%	0%

Reporting bodies are required to disclose the relationship between the remuneration of the highest-paid director in their organisation against the 25th percentile, median and 75th percentile of remuneration of the organisation's workforce. Total remuneration is further broken down to show the relationship between the highest paid director's salary component of their total remuneration against the 25th percentile, median and 75th percentile of salary components of the organisation's workforce.

The banded remuneration of the highest paid director in the financial year 2021/22 was £227,500 (2020/21 £227,500). The relationship to the remuneration of the organisation's workforce is disclosed in the pay ratio table below.

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 distinction between total remuneration and salary is performance related pay and bonuses. Bonuses and PRP were not paid to staff in the current year and therefore the figures are the same.

Pay Ratios – highest paid director compared with organisation workforce at 25th, Median and 75th percentile:

Year	25th percentile total remuneration ratio	25th percentile salary ratio	Median total remuneration ratio	Median salary ratio	75th percentile total remuneration ratio	75th percentile salary ratio
2021-22	9.9 : 1	9.9 : 1	7.0 : 1	7.0 : 1	4.9 : 1	4.9 : 1
2020-21	N/A	N/A	7.4 : 1	N/A	N/A	N/A

N/A items were not required for reporting in 2020/21

Annualised employee remuneration (including temporary staff):

2021-22 (£)	All employees £	Highest Paid Director £	Ratio
25th Percentile	23,059	227,500	**9.9**
Median (50th) percentile	32,306	227,500	**7.0**
75th percentile	46,031	227,500	**4.9**

2020-21 (£)	All employees	Highest Paid Director	Ratio
Median (50th) percentile	30,615	227,500	**7.4**

The ratio of the remuneration of the highest paid director to the median pay of all employees has reduced from 7.4:1 last year to 7.0:1 this year. The remuneration of the highest paid director has remained unchanged but the median pay of other staff increased due to a pay award and a greater proportion of expenditure being on agency staff.

In 2021/22, 0 (2020-21, 0) employees received remuneration in excess of the highest paid director. Remuneration (excluding the highest paid director) ranged from £13,909 to £225,459 (2020-21, £12,569 to £227,209).

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

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

All off-payroll engagements as of 31st March 2022, for more than £245 per day and lasting for longer than six months

	Number
Number of existing engagements as of 31st March 2022 Of which, the number that have existed…	6
for less than one year at the time of reporting =	3
for between one and two years at the time of reporting =	1
for between two and three years at the time of reporting =	1
for between three and four years at the time of reporting =	0
for four or more years at the time of reporting =	1

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 2021 and 31st March 2022, for more than £245 per day that last longer than six months

	Number
Number of new engagements, or those that reached six months in duration, between 1st April 2021 and 31st March 2022	6
Of which…	
Number not subject to off-payroll legislation	0
Number subject to off-payroll legislation and determined as in-scope of IR35	0
Number subject to off-payroll legislation and determined as out of scope of IR35	6
Number of engagements reassessed for compliance or assurance purposes during the year	4
Number of engagements that saw a change to IR35 status following the consistency review	0

Off-payroll Board member / Senior Official engagements

Number of off-payroll engagements of Board members and/or senior officials with significant financial responsibility, during the year	0
Number of individuals that have been deemed "Board members and/or senior officers with significant financial responsibility", during the financial year. This figure includes both off-payroll and on-payroll engagements	20

Expenditure on consultancy staff

The Trust's internal expenditure on consultancy staff for 2021/22 was £3,135k, a decrease of £720k from previous financial year (£3,855k in 2020/21). This decrease related to IT development projects including Electronic Patient Records implementation reducing consultancy required.

Declaration

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

Miles Scott, Chief Executive

16th June 2022

Accountability and audit report for 2021-2022:

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

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

Report on the Audit of the Financial Statements

Opinion on financial statements

We have audited the financial statements of Maidstone and Tunbridge Wells NHS Trust (the 'Trust') for the year ended 31 March 2022, which comprise the Statement of Comprehensive Income, the Statement of Financial Position, the Statement of Changes in Taxpayers Equity, the Statement of Cash Flows and notes to the financial statements, including a summary of significant accounting policies. The financial reporting framework that has been applied in their preparation is applicable law and international accounting standards in conformity with the requirements of the Accounts Directions issued under Schedule 15 of the National Health Service Act 2006, as interpreted and adapted by the Department of Health and Social Care Group accounting manual 2021 to 2022.

In our opinion, the financial statements:

- give a true and fair view of the financial position of the Trust as at 31 March 2022 and of its expenditure and income for the year then ended; and
- have been properly prepared in accordance with international accounting standards as interpreted and adapted by the Department of Health and Social Care Group accounting manual 2021 to 2022; and
- have been prepared in accordance with the requirements of the National Health Service Act 2006.

Basis for opinion

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

Conclusions relating to going concern

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

In our evaluation of the Directors' conclusions, and in accordance with the expectation set out within the Department of Health and Social Care Group accounting manual 2021 to 2022 that the Trust's financial statements shall be prepared on a going concern basis, we considered the inherent risks associated with the continuation of services provided by the Trust. In doing so we had regard to the guidance provided in Practice Note 10 Audit of financial statements and regularity of public sector bodies in the United Kingdom (Revised 2020) on the application of ISA (UK) 570 Going Concern to public sector entities. We assessed the reasonableness of the basis of preparation used by the Trust and the Trust's disclosures over the going concern period.

Based on the work we have performed, we have not identified any material uncertainties relating to events or conditions that, individually or collectively, may cast significant doubt on the Trust's ability to continue as a

going concern for a period of at least twelve months from when the financial statements are authorised for issue.

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

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

Other information

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

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

We have nothing to report in this regard.

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

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

We have nothing to report in this regard.

Opinion on other matters required by the Code of Audit Practice

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

- the parts of the Remuneration and Staff Report to be audited have been properly prepared in accordance with international accounting standards in conformity with the requirements of the Accounts Directions issued under Schedule 15 of the National Health Service Act 2006, as interpreted and adapted by the Department of Health and Social Care Group accounting manual 2021 to 2022; and
- based on the work undertaken in the course of the audit of the financial statements and our knowledge of the Trust, the other information published together with the financial statements in the annual report for the financial year for which the financial statements are prepared is consistent with the financial statements.

Matters on which we are required to report by exception

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

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

has begun to take a course of action which, if followed to its conclusion, would be unlawful and likely to cause a loss or deficiency; or
- we make a written recommendation to the Trust under Section 24 of the Local Audit and Accountability Act 2014 in the course of, or at the conclusion of the audit.

We have nothing to report in respect to the above matters except on 9 June 2022 we referred a matter to the Secretary of State under sections 30(b) and 30 (a) of the Local Audit and Accountability Act 2014 in relation to Maidstone and Tunbridge Wells NHS Trust's breach of its three-year break-even duty for the three year period ending 31 March 2022 and its planned ongoing breach in 2022/23.

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

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

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

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

Auditor's responsibilities for the audit of the financial statements

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

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

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

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

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

- We obtained an understanding of the legal and regulatory frameworks that are applicable to the Trust and determined that the most significant which are directly relevant to specific assertions in the financial statements are those related to the reporting frameworks (international accounting standards and the National Health Service Act 2006, as interpreted and adapted by the Department of Health and Social Care Group accounting manual 2021 to 2022).
- We enquired of management and the Audit and Governance Committee, concerning the Trust's policies and procedures relating to:
  - the identification, evaluation and compliance with laws and regulations;

  - the detection and response to the risks of fraud; and
  - the establishment of internal controls to mitigate risks related to fraud or non-compliance with laws and regulations.
- We enquired of management, internal audit and the Audit and Governance Committee, whether they were aware of any instances of non-compliance with laws and regulations or whether they had any knowledge of actual, suspected or alleged fraud.
- We assessed the susceptibility of the Trust's financial statements to material misstatement, including how fraud might occur, evaluating management's incentives and opportunities for manipulation of the financial statements. This included the evaluation of the risk of management override of controls, fraudulent revenue recognition and fraudulent expenditure recognition. We determined that the principal risks were in relation to:
  - journal entries which met a range of criteria defined as part of our risk assessment;
  - revenue recognition for material streams of non- Block contract / system envelope income and other operating revenue, due to the scale of financial pressures experienced by the Trust; and
  - expenditure recognition given the continued challenges of the pandemic in 2021-22.
- Our audit procedures involved:
  - evaluation of the design effectiveness of controls that management has in place to prevent and detect fraud;
  - journal entry testing, with a focus on journals meeting a range of criteria defined as part of our risk assessment;
  - evaluating the assumptions and judgements made by management in its recognition of revenue and expenditure at year-end; and
  - assessing the extent of compliance with the relevant laws and regulations as part of our procedures on the related financial statement item.
- These audit procedures were designed to provide reasonable assurance that the financial statements were free from fraud or error. The risk of not detecting a material misstatement due to fraud is higher than the risk of not detecting one resulting from error and detecting irregularities that result from fraud is inherently more difficult than detecting those that result from error, as fraud may involve collusion, deliberate concealment, forgery or intentional misrepresentations. Also, the further removed non-compliance with laws and regulations is from events and transactions reflected in the financial statements, the less likely we would become aware of it.
- The team communications in respect of potential non-compliance with relevant laws and regulations, including the breach of the Trust's break-even duty for the three-year period ending 31 March 2022 and the potential for fraud in revenue and expenditure recognition.
- Our assessment of the appropriateness of the collective competence and capabilities of the engagement team included consideration of the engagement team's.
  - understanding of, and practical experience with audit engagements of a similar nature and complexity through appropriate training and participation;
  - knowledge of the health sector and economy in which the Trust operates;
  - understanding of the legal and regulatory requirements specific to the Trust including; and
    - the provisions of the applicable legislation
    - NHS England's rules and related guidance

  - the applicable statutory provisions.

- In assessing the potential risks of material misstatement, we obtained an understanding of:
  - The Trust's operations, including the nature of its income and expenditure and its services and of its objectives and strategies to understand the classes of transactions, account balances, expected financial statement disclosures and business risks that may result in risks of material misstatement; and
  - The Trust's control environment, including the policies and procedures implemented by the Trust to ensure compliance with the requirements of the financial reporting framework.

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

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

Under the Code of Audit Practice, we are required to report to you if, in our opinion, we have not been able to satisfy ourselves that the Trust has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources for the year ended 31 March 2022.

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

Responsibilities of the Accountable Officer

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

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

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

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

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

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

Report on other legal and regulatory requirements – Certificate

We certify that we have completed the audit of the financial statements of Maidstone and Tunbridge Well NHS Trust in accordance with the requirements of the Local Audit and Accountability Act 2014 and the Code of Audit Practice.

Use of our report

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

John Paul Cuttle

John Paul Cuttle, Key Audit Partner

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

London

21 June 2022

Glossary of NHS terms

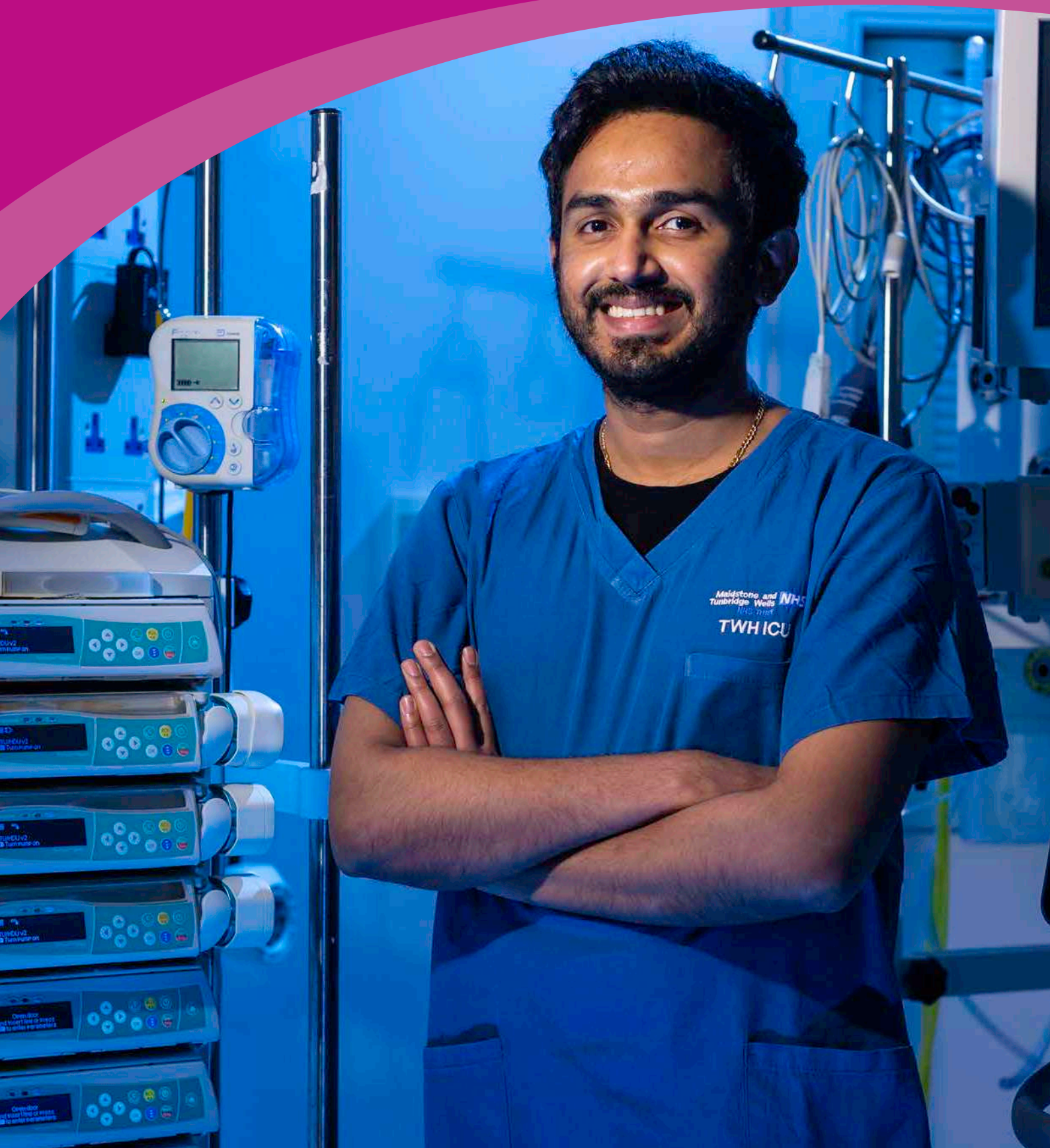
Term	Definition/explanation
Accident and Emergency (A&E)	Also referred to as Emergency Department (ED).
Acute Care	Acute care refers to the medical and surgical treatment provided by a hospital.
Acute Medical Unit (AMU)	An AMU is the first point of entry for patients referred to hospital as emergencies by their GP and those requiring admission from the Emergency Department.
Allied Health Professionals (AHPs)	AHPs is an umbrella term for therapists, chiropodists, dietitians, occupational therapists, orthoptists, paramedics, physiotherapists, prosthetists, psychologists, psychotherapists, radiographers, and speech and language therapists among others.
Ambulatory (Care)	A service where some conditions may be treated without the need for an overnight stay in hospital.
Acute Stroke Unit (ASU)	An acute neurological ward providing specialist services for people who have had a new suspected stroke.
Care Quality Commission (CQC)	A body that regulates all health & social care services in England. The CQC ensures the quality 7 safety of care in hospitals, dentists, ambulances, & care homes, and the care given in people's own homes. It is an executive non-departmental public body, sponsored by the Department of Health & Social Care.
Clinical Commissioning Group (CCG)	CCGs are clinically-led statutory NHS bodies, created following the Health and Social Care Act 2012, responsible for the planning and commissioning of health care services for their local area. CCGs are membership bodies, with local GP practices as the members.
Clinical Governance	Clinical Governance is the system through which NHS organisations are accountable for continuously improving the quality of their services and safeguarding high standards of care, by creating an environment in which clinical excellence can flourish.
Commissioning	The process of planning, agreeing and monitoring services, ranging from the health-needs assessment for a population, through the clinically based design of patient pathways, to service specification and contract negotiation or procurement, with continuous quality assessment.
Control total	A figure calculated by NHSI, on a Trust by Trust basis, which represents the minimum level of financial performance, against which the Trust's Board/ Governing Body and Chief Executives must deliver in 2021/22, and for which they will be held directly accountable.
Coronavirus disease	Coronavirus disease (COVID-19) is an infectious disease caused by a newly discovered coronavirus. The COVID-19 virus spreads primarily through droplets of saliva or discharge from the nose when an infected person coughs or sneezes.

Term	Definition/explanation
Cost Improvement Programme (CIP)	Sets out the savings that an NHS organisation plans to make to reduce its expenditure/increase efficiency. It is used to close the gap between the income received by the NHS body and expenditure incurred in any one year.
Commissioning for Quality and Innovation (CQUIN)	Introduced in 2009 to make a proportion of healthcare providers' income conditional on demonstrating improvements in quality and innovation in specified areas of patient care. The key aim of the CQUIN framework is to secure improvements in the quality of services and better outcomes for patients.
Datix	The Trust's incident reporting and risk management system.
Delayed Transfer of Care (DTOC)	According to NHS England, a 'delayed transfer of care' occurs when an adult inpatient in hospital is ready to go home or move to a less acute stage of care but is prevented from doing so. Sometimes referred to in the media as 'bed-blocking', delayed transfers of care are a problem as they reduce the number of beds available to other patients who need them, as well as causing unnecessarily long stays in hospital for patients.
Duty of Candour	The Duty of Candour makes it a statutory obligation for all NHS England organisations to be open and transparent with patients, their families, and their carers about the causes of any unexpected harm that results from a person's treatment.
Elective treatment	Treatment that is not urgent and can be planned.
Electronic Patient Record (EPR)	An EPR is the systematised collection of patient and population electronically-stored health information in a digital format. These records can be shared across different health and care settings.
Emergency Department (ED)	Also known as Accident and Emergency (A&E).
Escalation	The term used to describe circumstances when clinical areas of the Trust, not ordinarily designated for non-elective inpatient care, are required to be used for that purpose due to non-elective demand.
Freedom of Information	The Freedom of Information Act 2000 is an Act of Parliament of the United Kingdom that creates a public "right of access" to information held by public authorities.
Friends and Family Test (FFT)	A feedback tool, launched in April 2013, that supports the fundamental principle that people who use NHS services should have the opportunity to provide feedback on their experience. It asks people if they would recommend the services they have used and offers a range of responses. When combined with supplementary follow-up questions, the FFT provides a mechanism to highlight both good and poor patient experience.
Getting It Right First Time (GIRFT)	A national programme, led by frontline clinicians and designed to improve the quality of care within the NHS by reducing unwarranted variations. GIRFT tackles variations in the way services are delivered across the NHS, and shares best practice between trusts, identifying changes that will help improve care and patient outcomes, as well as delivering efficiencies such as the reduction of unnecessary procedures and cost savings.

Term	Definition/explanation
Hyper Acute Stroke Unit (HASU)	A dedicated Stroke unit bringing experts and equipment under one roof to provide world class treatment 24 hours a day.
Integrated Care System (ICS)	ICSs brings together local organisations to redesign care and improve population health, creating shared leadership and action to deliver the 'triple integration' of primary and specialist care, physical and mental health services, and health with social care.
Inpatient	A person who stays in hospital for one or more nights.
Length of Stay (LOS)	The period of time a patient remains in hospital or other healthcare facility as an inpatient.
Marginal Rate Emergency Tariff (MRET)	An adjustment made to the amount a provider of emergency services is reimbursed to encourage health economies to redesign emergency services and manage patient demand for those services. A provider is paid a percentage of the national price for each patient admitted as an emergency over and above a set threshold.
NHS England (NHSE)	An executive non-departmental public body, sponsored by the Department of Health and Social Care, which leads the NHS in England. It sets the priorities and direction of the NHS and encourages and informs the national debate to improve health and care.
NHS Improvement (NHSI)	The body responsible for overseeing NHS Trusts, and independent providers that provide NHS-funded care. It supports providers to give patients consistently safe, high quality, compassionate care within local health systems that are financially sustainable.
Non-elective treatment	Treatment that is not planned, but requires admission to hospital
Outpatient	A person who goes to a hospital for treatment or assessment, but does not stay overnight.
Patient Advice and Liaison Service (PALS)	A service within an NHS Trust offering confidential advice, support and information on health-related matters. It provides a point of contact for patients, their families and their carers.
Pandemic	An epidemic that has spread over several countries/continents, usually affecting a large number of people.
Patient experience	A term used for individual and collective feedback. (1) Individual patient's feedback about their experiences of care or a service e.g. whether they understood the information they were given, their views on the cleanliness of the hospital where they were treated. (2) A combination of all the intelligence held about what patients experience in services, drawing on a range of sources including complaints, compliments, etc.
Patient flow	The course of patients between staff, departments and organisations along a pathway of care.
Patient pathway	The route that a patient will take from entry into a hospital or other healthcare setting until the patient leaves. A template pathway can be created for common services and operations (e.g. emergency care pathway).

Term	Definition/explanation
Public Sector Equality Duty	The public sector equality duty (PSED) requires public bodies to have due regard to the need to eliminate discrimination, advance equality of opportunity and foster good relations between different people when carrying out their activities.
Provider Sustainability Fund (PSF)	A fund held by NHS England and NHS Improvement that is available to providers when they have met their control total.
Referral to Treatment (RTT)	The waiting time calculated from the date the Trust receives a referral, to the date the patient either receives treatment or a decision is made that no treatment is required.
Ring-fenced beds	Beds allocated for a specific category of patient / treatment (e.g. Stroke or elective orthopaedic beds), not used for general medical patients when the hospital is busy.
Social Distancing	Measures taken to reduce person-to-person contact in a given community, with a goal to stop or slow down the spread of a contagious disease.
Serious Incident (SI)	Events in health care where the potential for learning is so great, or the consequences to patients, families and carers, staff or organisations are so significant, that they warrant using additional resources to mount a comprehensive response. SIs can extend beyond incidents which affect patients directly and include incidents which may indirectly impact patient safety or an organisation's ability to deliver ongoing healthcare.
Sustainability and Transformation Partnership (STP)	STPs are 44 areas covering all of England, where local NHS organisations and councils have drawn up proposals to improve health and care in the areas they serve. STP can also stand for 'sustainability and transformation plan', plans drawn up in each of these areas setting out practical ways to improve NHS services and population health in every part of England. They aim to help meet a 'triple challenge' set out in the NHS Five Year Forward View – better health, transformed quality of care delivery, and sustainable finances.
Virtual Wards	Virtual Wards provide a community-based service using systems, processes and staffing similar to a hospital ward but without the physical building. Virtual Wards provide multi-disciplinary care to patients at high risk of unplanned hospital admission based on the forecasts of a predictive risk model. Using the staffing, systems and daily routines of a hospital ward with a social worker as a key member of the team, they deliver highly co-ordinated preventive care at home to people at high predicted risk.
Wellbeing	Wellbeing is broadly understood to be the state of being physically and mentally healthy and happy. Wellbeing also refers to how satisfied people feel with their lives as a whole, their sense of purpose, and how in control they feel about their lives, their employment and their social and professional relationships with others.

Financial statements:
2021-2022



Statement of Comprehensive Income

	Note	2021/22 £000	2020/21 £000
Operating income from patient care activities	3	580,855	496,048
Other operating income	4	43,036	68,148
Operating expenses	6, 8	-591,438	-550,300
Operating surplus from continuing operations		**32,453**	**13,896**
Finance income	11	18	9
Finance expenses	12	-14,528	-14,694
PDC dividends payable		-3,369	-1,285
Net finance costs		**-17,879**	**-15,970**
Other gains / (losses)	13	-37	16
Surplus / (deficit) for the year from continuing operations		**14,537**	**-2,058**
Surplus / (deficit) for the year		**14,537**	**-2,058**
Other comprehensive income			
Will not be reclassified to income and expenditure as taken to the Revaluation Reserve:			
Impairments	7	12,345	-2,778
Revaluations	17	4,842	1,930
Total comprehensive income / (expense) for the period		**31,724**	**-2,906**

Note - Adjusted financial performance (control total basis):

The Trust's surplus for 2021/22 was £14.5m. NHS England and Improvement excludes the impact of certain transactions - impairments, revaluations, capital grants and the net impact of "push stock" received from DHSC bodies - for the purpose of measuring NHS Trust's financial performance. After adjusting for these transactions, the Trust's adjusted financial performance surplus for the year is £0.2m as shown in the table below. The table does not form part of the Statement of Comprehensive Income and represents a note to the accounts.

Adjusted financial performance (control total basis):		
Surplus / (deficit) for the period	14,537	-2,058
Remove net impairments not scoring to the Departmental expenditure limit	-16,051	4,699
Remove I&E impact of capital grants and donations	268	-730
Remove net impact of inventories received from DHSC group bodies for COVID response	1,477	-1,581
Adjusted financial performance surplus	**231**	**330**

Statement of Financial Position

	Note	31 March 2022 £000	31 March 2021 £000
Non-current assets			
Intangible assets	14	11,332	10,658
Property, plant and equipment	15	339,794	298,452
Receivables	19	2,891	2,816
Total non-current assets		**354,017**	**311,926**
Current assets			
Inventories	18	9,158	9,988
Receivables	19	28,670	16,812
Cash and cash equivalents	20	11,838	26,221
Total current assets		**49,666**	**53,021**
Current liabilities			
Trade and other payables	21	-45,734	-48,934
Borrowings	23	-7,132	-6,830
Other financial liabilities	24	0	0
Provisions	25	-5,703	-3,226
Other liabilities	22	-3,647	-2,454
Total current liabilities		**-62,216**	**-61,444**
Total assets less current liabilities		**341,467**	**303,503**
Non-current liabilities			
Borrowings	23	-176,111	-183,152
Provisions	25	-2,421	-1,800
Total non-current liabilities		**-178,532**	**-184,952**
Total assets employed		**162,935**	**118,551**
Financed by			
Public dividend capital		274,005	261,345
Revaluation reserve		46,246	29,170
Income and expenditure reserve		-157,316	-171,964
Total taxpayers' equity		**162,935**	**118,551**

The notes on pages 6 to 49 form part of these accounts.

Name

Position Chief Executive Officer

Date 16th June 2022

Statement of Changes in Equity for the year ended 31 March 2022

	Public dividend capital	Revaluation reserve	Income and expenditure reserve	Total
	£000	£000	£000	£000
Taxpayers' and others' equity at 1 April 2021 - brought forward	**261,345**	**29,170**	**-171,964**	**118,551**
Surplus for the year	0	0	14,537	**14,537**
Other transfers between reserves	0	-111	111	**0**
Impairments	0	12,345	0	**12,345**
Revaluations	0	4,842	0	**4,842**
Public dividend capital received	12,660	0	0	**12,660**
Taxpayers' and others' equity at 31 March 2022	**274,005**	**46,246**	**-157,316**	**162,935**

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

	Public dividend capital	Revaluation reserve	Income and expenditure reserve	Total
	£000	£000	£000	£000
Taxpayers' and others' equity at 1 April 2020 - brought forward	**216,405**	**30,139**	**-170,027**	**76,517**
(Deficit) for the year	0	0	-2,058	**-2,058**
Impairments	0	-2,778	0	**-2,778**
Revaluations	0	1,930	0	**1,930**
Transfer to retained earnings on disposal of assets	0	-121	121	**0**
Public dividend capital received	44,940	0	0	**44,940**
Taxpayers' and others' equity at 31 March 2021	**261,345**	**29,170**	**-171,964**	**118,551**

Information on reserves

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

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

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

Statement of Cash Flows

	Note	2021/22 £000	2020/21 £000
Cash flows from operating activities			
Operating surplus		32,453	13,896
Non-cash income and expense:			
Depreciation and amortisation	6.1	17,777	13,828
Net impairments	7	-16,051	4,699
Income recognised in respect of capital donations	4	-377	-1,392
(Increase) / decrease in receivables and other assets		-20,242	19,286
(Increase) / decrease in inventories		830	-1,095
Increase / (decrease) in payables and other liabilities		5,251	7,208
Increase / (decrease) in provisions		3,103	1,624
Net cash flows from / (used in) operating activities		**22,744**	**58,054**
Cash flows from investing activities			
Interest received		18	9
Purchase of intangible assets		-3,004	-3,160
Purchase of PPE and investment property		-24,241	-27,636
Sales of PPE and investment property		42	16
Receipt of cash donations to purchase assets		290	251
Net cash flows from / (used in) investing activities		**-26,895**	**-30,520**
Cash flows from financing activities			
Public dividend capital received		12,660	44,940
Public dividend capital repaid		0	0
Movement on loans from DHSC		-974	-27,696
Movement on other loans		-361	-351
Capital element of PFI, LIFT and other service concession payments		-5,402	-5,349
Interest on loans		-240	-342
Other interest		-4	-5
Interest paid on PFI, LIFT and other service concession obligations		-14,291	-14,407
PDC dividend (paid) / refunded		-1,620	-1,458
Net cash flows from / (used in) financing activities		**-10,232**	**-4,668**
Increase / (decrease) in cash and cash equivalents		**-14,383**	**22,866**
Cash and cash equivalents at 1 April - brought forward		**26,221**	**3,355**
Cash and cash equivalents at 31 March	20.1	**11,838**	**26,221**

Notes to the Accounts

Note 1 Accounting policies and other information

Note 1.1 Basis of preparation

The Department of Health and Social Care has directed that the financial statements of the Trust shall meet the accounting requirements of the Department of Health and Social Care Group Accounting Manual (GAM), which shall be agreed with HM Treasury. Consequently, the following financial statements have been prepared in accordance with the GAM 2021/22 issued by the Department of Health and Social Care. The accounting policies contained in the GAM follow International Financial Reporting Standards to the extent that they are meaningful and appropriate to the NHS, as determined by HM Treasury, which is advised by the Financial Reporting Advisory Board. Where the GAM permits a choice of accounting policy, the accounting policy that is judged to be most appropriate to the particular circumstances of the Trust for the purpose of giving a true and fair view has been selected. The particular policies adopted are described below. These have been applied consistently in dealing with items considered material in relation to the accounts.

Accounting convention

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

Note 1.2 Going concern

These accounts have been prepared on a going concern basis. The financial reporting framework applicable to NHS bodies, derived from the HM Treasury Financial Reporting Manual, defines that the anticipated continued provision of the entity's services in the public sector is normally sufficient evidence of going concern.

Trust Management have assessed the Trust's ability to continue for the foreseeable future in the light of the GAM guidance. The Trust is planning to compile the 2021/22 accounts on a "going concern" basis following consideration of the following:-

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

- National NHS Provider/Commissioner Planning guidance has been published by NHSE/I that outlines the process and framework for funding arrangements within which NHS Commissioners and Providers will operate during 2022/23.

- The Trust submitted a draft 5 year capital plan to the ICS which manages the overall resource level within the patch with final plans expected to be submitted in April 2022.
- The Trust is an active participant and fully engaged in financial planning with both ICS/ICB designate leads as well as locally within the West Kent Health and Care Partnership (HCP) locality.

- The Trust will have signed contracts in place for the provision of healthcare services in 2022/23. The Trust contracts will be held with the local commissioning bodies for patient care in Kent & Medway, Sussex, Surrey Heartlands and South East London. In addition, regional contracts for Specialised Commissioning, Public Health and Health and Justice will be agreed, signed and effective from April 2022 with NHS England. The planned financial regime provides certainty for income and cash flows for the full financial year 2022/23.

- The Trust has no working capital loans and is not anticipating requiring support in 2022/23.

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

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

Note 1.3 Interests in other entities

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

Note 1.4 Revenue from contracts with customers

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

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

Revenue from NHS contracts

The main source of income for the Trust is contracts with commissioners for health care services. In 2021/22 and 2020/21, the majority of the Trust's income from NHS commissioners was in the form of block contract arrangements.

In 2021/22 the Trust received block funding from its main contracted commissioners, where funding envelopes were set nationally for all directly commissioned services and out of area commissioned services. Locally commissioned services were set at a local Integrated Care System level using national guidance. Block contract arrangements were set for individual NHS providers directly with the lead commissioners. The related performance obligation is the delivery of healthcare and related services during the period, with the trust's entitlement to consideration not varying based on the levels of activity performed.

The Elective Recovery Fund enabled systems to earn income linked to the achievement of elective activity targets including funding any increased use of independent sector capacity. Income earned by the system is distributed between individual entities by local agreement. Income earned from the fund has been accounted for as variable consideration.

Revenue from research contracts

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

NHS injury cost recovery scheme

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

Education Income

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

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

Note 1.6 Other forms of income

Grants and donations

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

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

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

Note 1.7 Expenditure on employee benefits

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

Pension costs

NHS Pension Scheme

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

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

The Trust participates in the National Employees Savings Trust (NEST) scheme as an alternative to those employees who are not eligible to join the NHS Pension Scheme. This came into effect in July 2013 for this Trust as part of the auto enrolment requirements introduced by the Government. NEST is a defined contribution scheme with a phased employer contribution rate which was 3% for 2021/22, the rate remains at 3% from April 2022.

Note 1.8 Expenditure on other goods and services

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

Note 1.9 Discontinued operations

The Trust does not have any discontinued operations.

Note 1.10 Property, plant and equipment

Recognition
Property, plant and equipment is capitalised where:

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

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

Subsequent expenditure:

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

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

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

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

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

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

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

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

The financial year 2021/22 is the second year following the five-year cyclical valuation period. In keeping with the Trust's policies, the Trust commissioned professional valuers, Montagu Evans LLP, to carry out a desk top valuation at 31st March 2022. The lead relationship partner from Montagu Evans LLP is qualified to BSc MRICS. The results are recorded in property, plant and equipment notes 15 and 17.

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

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

An increase arising on revaluation is taken to the revaluation reserve except when it reverses impairment for the same asset previously recognised in expenditure, in which case it is credited to expenditure to the extent of the decrease previously charged. 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. Gains and losses recognised in the revaluation reserve are reported as other comprehensive income in the Statement of Comprehensive Income. Any residual balance in the revaluation reserve in respect to an individual asset is transferred to the retained earnings reserve on disposal of the asset.

Depreciation

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

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

Revaluation gains and losses

Revaluation gains are recognised in the revaluation reserve, except where, and to the extent that, they reverse a revaluation decrease that has previously been recognised in operating expenses, in which case they are recognised in operating expenditure.

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

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

Impairments

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

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

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

De-recognition

Assets intended for disposal are reclassified as 'held for sale' once the criteria in IFRS 5 are met. The sale must be highly probable and the asset available for immediate sale in its present condition.

The sale must be probable i.e.:

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

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

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

Donated and grant funded assets

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

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

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

Note 1.11 Private Finance Initiative (PFI)

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

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

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

Service received

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

PFI Asset

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

PFI Liability

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

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

The element of the annual unitary payment that is allowed 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 in the contract, the difference is treated as a 'free' asset and a deferred income balance is recognised. The deferred income is released to operating income over the shorter of the remaining contract period or the useful economic life of the replacement component.

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

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

Other assets contributed by the NHS Trust to the operator

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

Useful lives of property, plant and equipment

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

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

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

Note 1.12 Intangible assets

Recognition

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

Internally generated intangible assets

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

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

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

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

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

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

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

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

Software

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

Measurement

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

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

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

Amortisation

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

Useful lives of intangible assets

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

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

Note 1.13 Inventories

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

In 2020/21 and 2021/22, the Trust received inventories including personal protective equipment from the Department of Health and Social Care at nil cost. In line with the GAM and applying the principles of the IFRS Conceptual Framework, the Trust has accounted for the receipt of these inventories at a deemed cost, reflecting the best available approximation of an imputed market value for the transaction based on the cost of acquisition by the Department.

Note 1.14 Cash and cash equivalents

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

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

Note 1.15 Financial assets and financial liabilities

Recognition

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

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

Classification and measurement

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

Financial assets and financial liabilities at amortised cost

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

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

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

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

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

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

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

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

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

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

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

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

Note 1.16 Leases

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

The Trust as a lessee

Finance leases

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

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

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

Operating leases

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

Leases of land and buildings

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

The Trust as a lessor

Finance leases

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

Operating leases

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

Note 1.17 Provisions

The Trust recognises a provision where it has a present legal or constructive obligation of uncertain timing or amount; for which it is probable that there will be a future outflow of cash or other resources; and a reliable estimate can be made of the amount. The amount recognised in the Statement of Financial Position is the best estimate of the resources required to settle the obligation. Where the effect of the time value of money is significant, the estimated risk-adjusted cash flows are discounted using HM Treasury's discount rates effective from 31 March 2022:

		Nominal rate	Prior year rate
Short-term	Up to 5 years	0.47%	Minus 0.02%
Medium-term	After 5 years up to 10 years	0.70%	0.18%
Long-term	After 10 years up to 40 years	0.95%	1.99%
Very long-term	Exceeding 40 years	0.66%	1.99%

HM Treasury provides discount rates for general provisions on a nominal rate basis. Expected future cash flows are therefore adjusted for the impact of inflation before discounting using nominal rates. The following inflation rates are set by HM Treasury, effective from 31 March 2022:

	Inflation rate	Prior year rate
Year 1	4.00%	1.20%
Year 2	2.60%	1.60%
Into perpetuity	2.00%	2.00%

Early retirement provisions and injury benefit provisions both use the HM Treasury's pension discount rate of minus 1.30% in real terms (prior year: minus 0.95%).

Clinical negligence costs

NHS Resolution operates a risk pooling scheme under which the trust pays an annual contribution to NHS Resolution, which, in return, settles all clinical negligence claims. Although NHS Resolution is administratively responsible for all clinical negligence cases, the legal liability remains with the Trust. The total value of clinical negligence provisions carried by NHS Resolution on behalf of the trust is disclosed at note 25.1 but is not recognised in the Trust’s accounts.

Non-clinical risk pooling

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

Note 1.18 Contingencies

Contingent assets (that is, assets arising from past events whose existence will only be confirmed by one or more future events not wholly within the entity's control) are not recognised as assets, but are disclosed in note 26 where an inflow of economic benefits is probable.

Contingent liabilities are not recognised, but are disclosed in note 26, unless the probability of a transfer of economic benefits is remote.

Contingent liabilities are defined as:

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

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

Note 1.19 Public dividend capital

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

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

A charge, reflecting the cost of capital utilised by the trust, is payable as public dividend capital dividend. The charge is calculated at the rate set by HM Treasury (currently 3.5%) on the average relevant net assets of the trust during the financial year. Relevant net assets are calculated as the value of all assets less the value of all liabilities, with certain additions and deductions as defined by the Department of Health and Social Care.

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

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

Note 1.20 Value added tax

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

Note 1.21 Climate change levy

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

Note 1.22 Third party assets

Assets belonging to third parties in which the Trust has no beneficial interest (such as money held on behalf of patients) are not recognised in the accounts. However, they are disclosed in a separate note to the accounts in accordance with the requirements of HM Treasury's FReM.

Note 1.23 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 through insurance cover had the Trust not been bearing their own risks (with insurance premiums then being included as normal revenue expenditure).

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

Note 1.24 Gifts

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

Note 1.25 Early adoption of standards, amendments and interpretations

No new accounting standards or revisions to existing standards have been early adopted in 2021/22.

Note 1.26 Standards, amendments and interpretations in issue but not yet effective or adopted

IFRS 16 Leases

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

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

On transition to IFRS 16 on 1 April 2022, the Trust will apply the standard retrospectively without restatement and with the cumulative effect of initially applying the standard recognised in the income and expenditure reserve at that date. For existing operating leases with a remaining lease term of more than 12 months and an underlying asset value of at least £5,000, a lease liability will be recognised equal to the value of remaining lease payments discounted on transition at the trust's incremental borrowing rate. The Trust's incremental borrowing rate will be defined by HM Treasury. For 2022, this rate is 0.95%. The related right of use asset will be measured equal to the lease liability adjusted for any prepaid or accrued lease payments. For existing peppercorn leases not classified as finance leases, a right of use asset will be measured at current value in existing use or fair value. The difference between the asset value and the calculated lease liability will be recognised in the income and expenditure reserve on transition. No adjustments will be made on 1 April 2022 for existing finance leases.

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

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

	£000
Estimated impact on 1 April 2022 statement of financial position	
Additional right of use assets recognised for existing operating leases	60,214
Additional lease obligations recognised for existing operating leases	-60,214
Changes to other statement of financial position line items	0
Net impact on net assets on 1 April 2022	**0**
Estimated in-year impact in 2022/23	
Additional depreciation on right of use assets	-5,786
Additional finance costs on lease liabilities	-797
Lease rentals no longer charged to operating expenditure	0
Other impact on income / expenditure	0
Estimated impact on deficit in 2022/23	**-6,583**
Estimated increase in capital additions for new leases commencing in 2022/23	**25,941**

From 1 April 2022, the principles of IFRS 16 will also be applied to the Trust's PFI liabilities where future payments are linked to a price index representing the rate of inflation. The PFI liability will be remeasured when a change in the index causes a change in future repayments and that change has taken effect in the cash flow. Under existing accounting practices, amounts relating to changes in the price index are expensed as incurred. This is expected to increase the PFI liability on the statement of financial position upon transition to IFRS 16. The effect of this has not yet been quantified.

Note 1.27 Critical judgements in applying accounting policies

The following are the judgements, apart from those involving estimations (see below) that management has made in the process of applying the trust accounting policies and that have the most significant effect on the amounts recognised in the financial statements. For 2021/22 the Trust has identified the following critical judgements that are required to be disclosed under IAS 1 paragraph 122. All other material judgements within this financial year relate to estimations and are disclosed in the relevant notes:

Assets relating to Land and Buildings are subject to a desktop valuation as at 31st March 2022, complete on an "modern equivalent asset" basis. An exiting use value alternative is used which assumes the assets would be replaced with a modern equivalent, i.e. not a building of identical design - but with the same service provision as the existing assets which reflects the challenges healthcare providers face when utilising NHS Estate. Under the Trust's alternative modern equivalent asset valuation, the modern alternative hospitals are of the same service potential but on a smaller physical footprint to serve the catchment area of population.

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

Note 1. Sources of estimation uncertainty

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

Material areas including estimates within the 2021/22 accounts are as follows:

Property, Plant and Equipment valuation including PFI infrastructure assets; estimation of the valuation of Property and Land is based upon professional valuer methodologies for applying modern equivalent asset concepts to the estimation of depreciated replacement cost. This methodology assumes a modern asset equivalent (MEA) approach to valuation of Trust's specialised assets, with replacement buildings being of the same service potential. Inherent within the MEA valuation approach, using the depreciated replacement cost, is the Build Cost Information Service Indices (BCIS) input. The carrying value of build assets valued under DRC approach was £271.6m (part of the £285.2m land and buildings disclosed in note 15). The valuer uses the latest BCIS information closest to the date of valuation in valuing the Trust's specialised assets. Significant changes in the BCIS indices used valuations would result in a significantly lower of higher carrying value of building assets held by the Trust. For example a 10% decrease in percentage change in the building assets would result in a decrease in asset values by £27m over the next financial year with an estimated decrease to PDC of £0.5m.

Note 2 Operating Segments

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

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

The Trusts income is predominantly from contracts for the provision of healthcare with Clinical Commissioning Groups and NHS England. This accounts for 91% of the Trust total income. Disclosure of all material transactions with related parties is included within note 34 to these financial statements. There are no other parties that account for more than 10% of total income.

Note 3 Operating income from patient care activities

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

Note 3.1 Income from patient care activities (by nature)	2021/22	2020/21
	£000	£000
Acute services		
Block contract / system envelope income	529,330	465,001
High cost drugs income from commissioners (excluding pass-through costs)	9,192	2,575
Other NHS clinical income	4,655	4,207
All services		
Private patient income	922	677
Elective recovery fund	15,602	0
Additional pension contribution central funding	13,854	12,824
Other clinical income	7,300	10,764
Total income from activities	**580,855**	**496,048**

The Elective Recovery Framework (ERF) was introduced in 2021/22 to help the NHS in the recovery programme for Elective care following the COVID-19 pandemic. The aim of the ERF fund was to give Systems access to additional financial support to allow delivery of significant reductions to the number of patients waiting for treatment in excess of 52 weeks.

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

Included within Other Clinical Income are Sexual Health contracts with Local Authorities, Overseas Patients, Injury Cost Recovery scheme and bowel screening service.

Note 3.2 Income from patient care activities (by source)

	2021/22	2020/21
Income from patient care activities received from:	**£000**	**£000**
NHS England	106,296	104,378
Clinical commissioning groups	462,901	382,002
Other NHS providers	3,436	3,442
NHS other	0	1
Local authorities	5,327	4,177
Non-NHS: private patients	922	677
Non-NHS: overseas patients (chargeable to patient)	400	189
Injury cost recovery scheme	707	326
Non NHS: other	866	856
Total income from activities	**580,855**	**496,048**
Of which:		
Related to continuing operations	580,855	496,048
Related to discontinued operations	0	0

The income movement in Clinical Commissioning Groups (CCG) income is partly a result of the increased funding given to the Trust to support the Covid-19 pandemic response but also funding to cover growth, inflationary pressures, Stroke reconfiguration, Independent Sector Provider use and additional top-up funds to cover the increased costs during the pandemic.

NHS injury cost recovery income is subject to a provision for impairment of receivables, previously the Trust has calculated this estimate using historical information for each main site. For 2021/22 the Trust was consistent with the prior year and has provided in full for all debt up to and including 2020/21 and debt relating to 2021/22 the Trust is using the DHSC given rate of 23.76% (2020/21 - 22.43%).

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

	2021/22	2020/21
	£000	£000
Income recognised this year	400	189
Cash payments received in-year	118	138
Amounts added to provision for impairment of receivables	281	217
Amounts written off in-year	337	11

Note 4 Other operating income

	2021/22			2020/21		
	Contract income	Non-contract income	Total	Contract income	Non-contract income	Total
	£000	£000	£000	£000	£000	£000
Research and development	1,734	0	**1,734**	1,347	0	**1,347**
Education and training	12,522	792	**13,314**	11,634	513	**12,147**
Non-patient care services to other bodies	16,410	0	**16,410**	14,189	0	**14,189**
Reimbursement and out of envelope top up funding	6,441	0	**6,441**	29,038	0	**29,038**
Receipt of capital grants and donations	0	377	**377**	0	1,392	**1,392**
Charitable and other contributions to expenditure	0	1,970	**1,970**	0	7,743	**7,743**
Rental revenue from operating leases	0	188	**188**	0	107	**107**
Other income	2,602	0	**2,602**	2,185	0	**2,185**
Total other operating income	**39,709**	**3,327**	**43,036**	**58,393**	**9,755**	**68,148**
Of which:						
Related to continuing operations			43,036			68,148
Related to discontinued operations			0			0

Reimbursement and out of envelope top up funding included within other operating income relates to swabbing, vaccination and rapid testing costs which are reimbursed through a separate regime to the base top up.

Within Charitable and other contributions to expenditure - In response to the COVID 19 pandemic, the Department of Health and Social Care centrally procured personal protective equipment and passed these to NHS providers free of charge. During 2021/22 the Trust received £1,970k of items purchased by DHSC (2020/21: £7,690k).

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

	2021/22	2020/21
	£000	£000
Revenue recognised in the reporting period that was included in within contract liabilities at the previous period end	0	0

Due to the change in finance regime for 2020-21 which continued throughout 2021-22; NHS Providers and Commissioners transact via block contract arrangements, the provider's entitlement to income does not vary based on the treatment of individual patients.

Note 5.2 Fees and charges

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

	2021/22	2020/21
	£000	£000
Income	1,346	669
Full cost	-2,248	-2,334
Surplus / (deficit)	**-902**	**-1,665**

This income relates to Car Parking £0.89m and Catering £0.46m. The Trust under national guidance gave free car parking to all staff across the hospital sites. The Trust was unable to avoid the majority of the costs as they are fixed in nature.

Note 6.1 Operating expenses

	2021/22	2020/21
	£000	£000
Purchase of healthcare from NHS and DHSC bodies	7,194	6,302
Purchase of healthcare from non-NHS and non-DHSC bodies	20,127	6,381
Staff and executive directors costs	374,642	342,645
Remuneration of non-executive directors	149	126
Supplies and services - clinical (excluding drugs costs)	46,171	45,234
Supplies and services - general	5,142	7,206
Drug costs (drugs inventory consumed and purchase of non-inventory drugs)	60,688	52,880
Inventories written down	0	673
Consultancy costs	3,135	3,855
Establishment	2,625	2,465
Premises	24,879	20,556
Transport (including patient travel)	2,599	1,994
Depreciation on property, plant and equipment	16,030	12,409
Amortisation on intangible assets	1,747	1,419
Net impairments	-16,051	4,699
Movement in credit loss allowance: contract receivables / contract assets	736	757
Increase/(decrease) in other provisions	0	0
Change in provisions discount rate(s)	22	184
Fees payable to the external auditor		
audit services- statutory audit	104	99
other auditor remuneration (external auditor only)	0	0
Internal audit costs	117	104
Clinical negligence	18,899	19,070
Legal fees	1,416	272
Insurance	1,836	539
Education and training	2,949	3,466
Rentals under operating leases	4,614	4,804
Redundancy	0	189
Charges to operating expenditure for on-SoFP IFRIC 12 schemes (e.g. PFI / LIFT)	5,631	5,417
Car parking & security	3,147	2,131
Hospitality	16	0
Losses, ex gratia & special payments	45	585
Other services, e.g. external payroll	300	350
Other	2,529	3,489
Total	**591,438**	**550,300**
Of which:		
Related to continuing operations	591,438	550,300
Related to discontinued operations	0	0

Included within 2021-22 legal fees and insurance are provisions relating for a specific legal case, these were reported in losses and special payments for the prior year.

The movement within Purchase of healthcare from non-NHS and non-DHSC bodies relates to the use of independent sector for elective activity, Community Diagnostic Centre (CDC) MRI And CT capacity and Post Covid Assessment Service (PCAS).

Included within supplies and services - clinical are £3.4m (2020-21 £5.4m) of consumables donated from DHSC group bodies for Covid response.

Net impairments within note 6.1 above include reversals for 2021/22, please see note 7.

The audit fees included within Note 6.1 above are reported as the gross position, the value excluding VAT for 2021/22 is £86.6k (2020/21 £82.1k).

Note 6.2 Other auditor remuneration

The Trust has no other auditors remuneration

Note 6.3 Limitation on auditor's liability

The limitation on auditor's liability for external audit work is £2 million (2020/21: £2 million).

Note 7 Impairment of assets

	2021/22	2020/21
	£000	£000
Net impairments charged to operating surplus / deficit resulting from:		
Changes in market price	-16,051	4,699
Total net impairments charged to operating surplus / deficit	**-16,051**	**4,699**
Impairments charged to the revaluation reserve	-12,345	2,778
Total net impairments	**-28,396**	**7,477**

The Trust commissioned its independent professional valuers to undertake a desktop valuation as at the 31st March 2022 to support its assessment of year end property valuations. The result of the valuation has been a net increase in property values leading to a net reversal of previous impairments of £16m charged to the Income and Expenditure account. In addition an assessment of the current value in existing use has been undertaken for IT devices (PCs, Laptops and IPads) based on the valuation model used by the Trust, in accordance with the Trust's policy 1.9. For 2021/22 the assessment totalled £0.2m (2020-21 £1.3m). These two impairment entries make up the change in market price figure in note 7.

The net impairments charged to the revaluation reserve is an in-year impairment against the business reserve of £0.2m less reversal of previous balance sheet impairment (£12.6m).

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

Note 8 Employee benefits

	2021/22 Total £000	2020/21 Total £000
Salaries and wages	275,015	255,636
Social security costs	27,959	26,419
Apprenticeship levy	1,376	1,277
Employer's contributions to NHS pensions *	45,592	42,246
Pension cost - other	35	76
Temporary staff (including agency)	24,783	19,490
Total gross staff costs	**374,760**	**345,144**
Recoveries in respect of seconded staff	0	0
Total staff costs	**374,760**	**345,144**
Of which		
Costs capitalised as part of assets	118	2,310

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

* The employer contribution rate for NHS pensions increased from 14.3% to 20.6% totalling £13.9m (£12.8m 2020/21 excluding administration charge) from 1st April 2020. For 2021-22, NHS providers continued to pay over contributions at the former rate with the additional amount being paid over by NHS England on provider's behalf. The full cost and related funding have been recognised in these accounts.

Note 8.1 Retirements due to ill-health

During 2021/22 there were 3 early retirements from the trust agreed on the grounds of ill-health (1 in the year ended 31 March 2021). The estimated additional pension liabilities of these ill-health retirements is £109k (£12k in 2020/21).

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

Note 9 Pension costs

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

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

a) Accounting valuation

A valuation of scheme liability is carried out annually by the scheme actuary (currently the Government Actuary's Department) as at the end of the reporting period. This utilises an actuarial assessment for the previous accounting period in conjunction with updated membership and financial data for the current reporting period, and is accepted as providing suitably robust figures for financial reporting purposes. The valuation of the scheme liability as at 31 March 2022, is based on valuation data as 31 March 2021, updated to 31 March 2022 with summary global member and accounting data. In undertaking this actuarial assessment, the methodology prescribed in IAS 19, relevant FReM interpretations, and the discount rate prescribed by HM Treasury have also been used.

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

b) Full actuarial (funding) valuation

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

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

The 2016 funding valuation also tested the cost of the Scheme relative to the employer cost cap that was set following the 2012 valuation. There was initially a pause to the cost control element of the 2016 valuations, due to the uncertainty around member benefits caused by the discrimination ruling relating to the McCloud case.

HMT published valuation directions dated 7 October 2021 (see Amending Directions 2021) that set out the technical detail of how the costs of remedy are included in the 2016 valuation process. Following these directions, the scheme actuary has completed the cost control element of the 2016 valuation for the NHS Pension Scheme, which concludes no changes to benefits or member contributions are required. The 2016 valuation reports can be found on the NHS Pensions website at https://www.nhsba.nhs.uk/nhs-pension-scheme-accounts-and-valuation-reports.

Included within the employee benefits note are employer contributions to NHS Pension scheme £45.6m (£42.2m 2020-21) and other pensions scheme which are NEST and 247 time NEST totalling £98k (£76k 2020-21).

The Trust participates in the National Employees Saving Trust (NEST) scheme as an alternative to those employees who are not eligible to join the NHS Pension Scheme. This can 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 phase employer contribution rate of 3% for 2021-22 and remains at 3% for 2022-23. Trust contributions under the NEST scheme for the 2021-22 financial year totalled £35k (£23k 2020-21).

Note 10 Operating leases

Note 10.1 Maidstone And Tunbridge Wells NHS Trust as a lessor

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

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

	2021/22	2020/21
	£000	£000
Operating lease revenue		
Minimum lease receipts	188	107
Total	**188**	**107**

	31 March 2022	31 March 2021
	£000	£000
Future minimum lease receipts due:		
- not later than one year;	188	188
- later than one year and not later than five years;	703	751
- later than five years.	729	891
Total	**1,620**	**1,830**

Note 10.2 Maidstone And Tunbridge Wells NHS Trust as a lessee

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

The top five material leases are given in detail below:

Apogee - Lease of photocopiers and printers under a managed service arrangement, £657k (£657k 2020-21). The contract is expected to complete in March 2024.

MGIF - lease of Springwood Road staff accommodation. The Trust entered into an operating lease arrangement on the 29th March 2019 with MGIF including an initial leaseback of the existing staff residences whilst planning permission is sought by the landlord to redevelop the site, including the provision of new staff accommodation. The overarching lease is structured in different tiers, with the initial period phasing into a 40 year primary term lease on the new accommodation, structured into two interlinked lease periods, with an ultimate option for the Trust to acquire the property for fair value at the end of the arrangement. The current rent is £558.3k per annum; the rent for the new accommodation will be £960k per annum, subject to RPI uplifts annually, with a cap and collar arrangement. It is anticipated that the new accommodation will reach practical completion in June 2022. The Trust manages the tenancies with staff and receives the sublease rentals.

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

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

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

	2021/22	2020/21
	£000	£000
Operating lease expense		
Minimum lease payments	5,204	5,325
Contingent rents	0	0
Less sublease payments received	-590	-521
Total	**4,614**	**4,804**

	31 March 2022	31 March 2021
	£000	£000
Future minimum lease payments due:		
- not later than one year;	6,217	5,630
- later than one year and not later than five years;	20,396	16,082
- later than five years.	46,638	47,577
Total	**73,251**	**69,289**
Future minimum sublease payments to be received	-46,892	-44,027

Note 11 Finance income

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

	2021/22	2020/21
	£000	£000
Interest on bank accounts	18	9
Total finance income	**18**	**9**

Note 12.1 Finance expenditure

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

	2021/22	2020/21
	£000	£000
Interest expense:		
Loans from the Department of Health and Social Care	238	281
Interest on late payment of commercial debt	4	5
Main finance costs on PFI and LIFT schemes obligations	9,540	9,816
Contingent finance costs on PFI and LIFT scheme obligations	4,751	4,591
Total interest expense	**14,533**	**14,693**
Unwinding of discount on provisions	-5	1
Total finance costs	**14,528**	**14,694**

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

	2021/22	2020/21
	£000	£000
Amounts included within interest payable arising from claims made under this legislation	4	5

Note 13 Other gains / (losses)

	2021/22	2020/21
	£000	£000
Gains on disposal of assets	42	16
Losses on disposal of assets	-79	0
Total gains / (losses) on disposal of assets	**-37**	**16**
Total other gains / (losses)	**-37**	**16**

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

Note 14.1 Intangible assets - 2021/22

	Software licences	Internally generated information technology	Intangible assets under construction	Total
	£000	£000	£000	£000
Valuation / gross cost at 1 April 2021 - brought forward	**2,257**	**10,567**	**7,209**	**20,033**
Additions	17	327	2,660	**3,004**
Reclassifications	108	6,519	-7,210	**-583**
Disposals / derecognition	-406	-3,384	0	**-3,790**
Valuation / gross cost at 31 March 2022	**1,976**	**14,029**	**2,659**	**18,664**
Amortisation at 1 April 2021 - brought forward	**888**	**8,487**	**0**	**9,375**
Provided during the year	273	1,474	0	**1,747**
Disposals / derecognition	-406	-3,384	0	**-3,790**
Amortisation at 31 March 2022	**755**	**6,577**	**0**	**7,332**
Net book value at 31 March 2022	**1,221**	**7,452**	**2,659**	**11,332**
Net book value at 1 April 2021	**1,369**	**2,080**	**7,209**	**10,658**

The main AUC projects are: 1) Digital Theatre £1.2m; 2) EPMA (part of EPR rollout) £1.1m; 3) Patient Tracking £0.4m and 3) Digital Maternity £0.3m.

Note 14.2 Intangible assets - 2020/21

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

Note 15.1 Property, plant and equipment - 2021/22

	Land	Buildings excluding dwellings	Assets under construction	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000
Valuation/gross cost at 1 April 2021 - brought forward	**12,454**	**240,809**	**9,132**	**91,252**	**610**	**20,130**	**2,797**	**377,184**
Additions	0	3,781	12,635	4,380	0	2,834	0	**23,630**
Impairments charged to operating expenses	0	-1,027	0	0	0	-205	0	**-1,232**
Impairments charged to the revaluation reserve	-157	-55	0	0	0	0	0	**-212**
Reversal of impairments credited to operating expenses	0	17,283	0	0	0	0	0	**17,283**
Reversal of impairments credited to the revaluation reserve	983	11,574	0	0	0	0	0	**12,557**
Revaluations	224	-1,481	0	0	0	0	0	**-1,257**
Reclassifications	0	917	-8,986	5,617	236	2,799	0	**583**
Disposals / derecognition	0	0	0	-12,108	-270	-6,959	-291	**-19,628**
Valuation/gross cost at 31 March 2022	**13,504**	**271,801**	**12,781**	**89,141**	**576**	**18,599**	**2,506**	**408,908**
Accumulated depreciation at 1 April 2021 - brought forward	**0**	**165**	**0**	**64,161**	**374**	**11,406**	**2,626**	**78,732**
Provided during the year	0	6,118	0	6,998	35	2,777	102	**16,030**
Revaluations	0	-6,099	0	0	0	0	0	**-6,099**
Reclassifications	0	0	0	0	0	0	0	**0**
Disposals / derecognition	0	0	0	-12,029	-270	-6,959	-291	**-19,549**
Accumulated depreciation at 31 March 2022	**0**	**184**	**0**	**59,130**	**139**	**7,224**	**2,437**	**69,114**
Net book value at 31 March 2022	**13,504**	**271,617**	**12,781**	**30,011**	**437**	**11,375**	**69**	**339,794**
Net book value at 1 April 2021	**12,454**	**240,644**	**9,132**	**27,091**	**236**	**8,724**	**171**	**298,452**

Note - the adjustments within the disposal/derecognition line relates to housekeeping exercise clearing zero Net Book Value assets that have been sold or scrapped. For further analysis on Assets Under Construction can be found in Note 15.4.

Note 15.2 Property, plant and equipment - 2020/21

	Land	Buildings excluding dwellings	Assets under construction	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000
Valuation / gross cost at 1 April 2020 - as previously stated	**12,414**	**245,957**	**8,797**	**88,926**	**652**	**22,148**	**2,797**	**381,691**
Additions	0	4,721	8,260	8,594	236	8,370	0	**30,181**
Impairments	0	-8,382	0	0	0	-1,262	0	**-9,644**
Reversals of impairments	35	2,132	0	0	0	0	0	**2,167**
Revaluations	5	-4,080	0	0	0	0	0	**-4,075**
Reclassifications	0	461	-7,925	2,078	0	426	0	**-4,960**
Disposals / derecognition	0	0	0	-8,346	-278	-9,552	0	**-18,176**
Valuation/gross cost at 31 March 2021	**12,454**	**240,809**	**9,132**	**91,252**	**610**	**20,130**	**2,797**	**377,184**
Accumulated depreciation at 1 April 2020 - as previously stated	**0**	**110**	**0**	**67,642**	**652**	**19,726**	**2,374**	**90,504**
Provided during the year	0	6,060	0	4,865	0	1,232	252	**12,409**
Revaluations	0	-6,005	0	0	0	0	0	**-6,005**
Disposals / derecognition	0	0	0	-8,346	-278	-9,552	0	**-18,176**
Accumulated depreciation at 31 March 2021	**0**	**165**	**0**	**64,161**	**374**	**11,406**	**2,626**	**78,732**
Net book value at 31 March 2021	**12,454**	**240,644**	**9,132**	**27,091**	**236**	**8,724**	**171**	**298,452**
Net book value at 1 April 2020	**12,414**	**245,847**	**8,797**	**21,284**	**0**	**2,422**	**423**	**291,187**

Note 15.3 Property, plant and equipment financing - 2021/22

	Land	Buildings excluding dwellings	Dwellings	Assets under construction	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Net book value at 31 March 2022									
Owned - purchased	13,504	98,234	0	12,781	27,815	437	11,309	69	**164,149**
On-SoFP PFI contracts and other service concession arrangements	0	173,305	0	0	0	0	0	0	**173,305**
Owned - donated/granted	0	78	0	0	2,196	0	66	0	**2,340**
NBV total at 31 March 2022	**13,504**	**271,617**	**0**	**12,781**	**30,011**	**437**	**11,375**	**69**	**339,794**

Note 15.4 Property, plant and equipment financing - 2020/21

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

Assets Under Construction (AUC) in year additions of £15.3m relates to Build £5.8m, Plant & Machinery £6.3m, IT £0.6m and Intangible £2.7m. These are assets at 31st March 2022 which are classed as "work in progress" and were not available for use at the end of 2021-22.

The main AUC projects are: 1) Maidstone Barn Theatre enabling works £2.5m; 2) Linac 3M £2.3m; 3) linac 2M £1.9m; 4) Pembury infrastructure works £1.2m; 5) Maidstone Oncology Outpatients Build £1.1m; 6) Barn Theatre equipment £1.1m; 7) Maidstone Office accommodation build £1m and 8) Spect CT £0.7m.

The Trust spent £23m on tangible assets and £3m on intangible assets from its capital resources in 2021-22. The main items were as follows: £1.4m on Paeds ED build at TWH; £6.9m Electronic Patient Record project; £2.5m on Linear Accelerator Machine; £1m on an MRI at Maidstone; £0.8m on interventional X-Ray machine; £3.3m of estates backlog, renewal and PFI Lifecycle; £0.5m on IT equipment for Endoscopy; £0.6m on upgrades to Servers

Note 16 Donations of property, plant and equipment

In the financial year 2021-22 the Trust recognised donated assets of £0.4m including Trust purchased and centrally procured loan equipment. The Trust acquired eleven assets from charitable funds and laptops and accessories from a Grant. The most significant purchases were two ultrasound machines for £0.1m and two vascular ultrasounds for £0.08m, Lung function Machine for £0.04m and three Bladder Scanners £0.02m. The remaining balance relates to eight transport ventilators which have been formally transferred from DHSC in 2021/22 totalling £0.09m.

Note 17 Revaluations of property, plant and equipment

The Trust's depreciation on tangible assets (including donated) in the year was £16m and amortisation for intangible assets £1.7m.

The Trust has carried out housekeeping exercise on its zero valued assets held in its asset register. Throughout 2021-22 the Trust reviewed these assets and de-recognised any zero valued assets (excluding Build and Land) that the Trust confirmed as having been disposed. Going forward the Trust will continue to review any zero valued assets held.

This is the Trust second year following its full valuation in accordance with the five year cyclical valuation period. In keeping with the Trust previous practice a desktop valuation was commissioned from independent professional valuers, Montagu Evans LLP. This was undertaken on the Trust's Land and Building assets as at 31st March 2022. The lead relationship partner from Montagu Evans LLP is qualified to BSc MRICS.

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

The 31st March 2022 valuation resulted in an overall increase in the carrying value of the Trust's Land and Property assets as at the 31st March of £33.6m, of which £1m is an in year charge to I&E impairments and £17.3m reversed previous I&E impairments; both of these are reflected in operating expenses. (£0.2m) relates to an in year impairment charge to the revaluation reserve and £12.6m reversed previous impairments taken to the revaluation reserve. The upward valuations are driven by an overall increase in the building costs (BCIS) indices reflecting the market. This included some component assets driven by specific BCIS elements there was an increase of £4.8m with no previous reversal to the revaluation reserve. The valuer considered the remaining useful economic lives of the assets taking into account backlog and capital work undertaken between valuations, and the age and condition of the properties.

The valuer has reported that at the valuation date property markets are functioning sufficiently to provide an adequate quantum of market evidence on which to base the opinions of value. The valuer has continued to exercise professional judgement in providing the valuation; the Trust has reviewed and challenged the valuation in detail and is satisfied that this remains the best information to the Trust.

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

Note 18 Inventories

	31 March 2022 £000	31 March 2021 £000
Drugs	4,074	3,209
Consumables	1,100	1,089
Consumables donated from DHSC group	104	1,581
Energy	224	108
Other	3,656	4,001
Total inventories	**9,158**	**9,988**
of which:		
Held at fair value less costs to sell	0	0

Inventories recognised in expenses for the year were £67,261k (2020/21: £56,932k). Write-down of inventories recognised as expenses for the year were £0k (2020/21: £673k).

These inventories were recognised as additions to inventory at deemed cost with the corresponding benefit recognised in income. The utilisation of these items is included in the expenses disclosed above.

Note 19.1 Receivables

	31 March 2022 £000	31 March 2021 £000
Current		
Contract receivables	19,649	7,239
Allowance for impaired contract receivables / assets	-1,589	-1,358
Prepayments (non-PFI)	6,308	5,206
PDC dividend receivable	0	1,136
VAT receivable	3,386	3,702
Other receivables	916	887
Total current receivables	**28,670**	**16,812**
Non-current		
Contract receivables	1,127	1,474
Allowance for impaired contract receivables / assets	-1,127	-924
PFI lifecycle prepayments	1,565	1,201
Other receivables	1,326	1,065
Total non-current receivables	**2,891**	**2,816**
Of which receivable from NHS and DHSC group bodies:		
Current	8,919	5,769
Non-current	1,326	1,065

The majority of trade is with Clinical Commissioning Groups (CCGs) as commissioners for NHS patient care services. As CCGs are funded by Government to buy NHS patient care services, no credit scoring of them is considered necessary. The calculation for the allowance of other impaired receivables has been amended to reflect the change in IFRS 9 accounting standards for provision of expected credit losses. Please see note 19.2 for further information.

The most significant elements within current contract receivables are 1) £5.7m recharge costs relating the Kent and Medway Medical School (KMMS) accommodation project; 2) £1.6m of swabbing cost recharge to NHSE; 3) £1.5 ERF income to K&M CCG and 4) £1m High Cost Drugs recharges

Note 19.2 Allowances for credit losses

	2021/22		2020/21	
	Contract receivables and contract assets	All other receivables	Contract receivables and contract assets	All other receivables
	£000	£000	£000	£000
Allowances as at 1 April - brought forward	**2,282**	**0**	**1,556**	**0**
New allowances arising	2,320	0	1,403	0
Reversals of allowances	-1,584	0	-646	0
Utilisation of allowances (write offs)	-302	0	-31	0
Allowances as at 31 Mar 2022	**2,716**	**0**	**2,282**	**0**

Following the implementation of IFRS 9 in 2018-19 the Trust is required to measure the loss allowance of lifetime expected credit losses at initial recognition of the debt being raised. This is assessed by looking at classes of debtor with common credit characteristics.

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

Under IFRS 9 the Trust attributed the trade debtors into six categories grouped by similar characteristics with assessment based on prior year debt write off levels. Due to Covid 19 and the heightened risk to the economy the Trust has taken a prudent view and for all trade debt categories these are now fully provided for over 60 days

Injury Cost recovery – The Trust is continuing with the same approach for 21/22 as it took in 20/21. The Trust has provided in full for all prior year debt, and for 2021/22 the Trust will is using the DHSC given rate of 23.76% (2021-22.43%).

Note 19.3 Exposure to credit risk

The Trust adheres to best practice in credit control activities which includes referral to an external debt collection agency and formal litigation procedures if required to trace debtors and seek to recover overdue debt. In addition the majority of the Trust's revenue comes from contracts with other public sector bodies which in turn are supported by underlying contractual agreements and specific payment terms. As a result, it is deemed that the Trust has a low exposure to credit risk.

Expected credit losses for contract and other receivables are reviewed on a regular basis taking account of historic, current and forecast information to determine a sufficient and appropriate level of allowance for impaired contract and other receivables.

Note 20.1 Cash and cash equivalents movements

Cash and cash equivalents comprise cash at bank, in hand and cash equivalents. Cash equivalents are readily convertible investments of known value which are subject to an insignificant risk of change in value.

	2021/22	2020/21
	£000	£000
At 1 April	**26,221**	**3,355**
Net change in year	-14,383	22,866
At 31 March	**11,838**	**26,221**
Broken down into:		
Cash at commercial banks and in hand	23	23
Cash with the Government Banking Service	11,815	26,198
Total cash and cash equivalents as in SoFP	**11,838**	**26,221**

Note 20.2 Third party assets held by the trust

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

	31 March 2022	31 March 2021
	£000	£000
Monies on deposit	1	0
Total third party assets	**1**	**0**

Note 21.1 Trade and other payables

	31 March 2022 £000	31 March 2021 £000
Current		
Trade payables	8,938	13,093
Capital payables	5,813	6,110
Accruals	26,671	26,648
Social security costs	161	5
Other taxes payable	177	0
PDC dividend payable	613	0
Other payables	3,361	3,078
Total current trade and other payables	**45,734**	**48,934**
Of which payables from NHS and DHSC group bodies:		
Current	5,251	11,291

Included within Accruals value above is an estimate for annual leave untaken of £4m (2020-21 £4.7m).

Note 21.2 Early retirements in NHS payables above

The Trust has no early retirements

Note 22 Other liabilities

	31 March 2022 £000	31 March 2021 £000
Current		
Deferred income: contract liabilities	3,647	2,454
Total other current liabilities	**3,647**	**2,454**

Note 23.1 Borrowings

	31 March 2022 £000	31 March 2021 £000
Current		
Loans from DHSC	983	985
Other loans	461	443
Obligations under finance leases	0	0
Obligations under PFI, LIFT or other service concession contracts	5,688	5,402
Total current borrowings	**7,132**	**6,830**
Non-current		
Loans from DHSC	4,458	5,432
Other loans	571	949
Obligations under PFI, LIFT or other service concession contracts	171,082	176,771
Total non-current borrowings	**176,111**	**183,152**

The Trust has two remaining capital investment loans totalling £5.4m with the Department of Health and Social Care. The £11m (current remaining balance £2.2m) loan received on the 15th March 2010 has a final repayment date of 15th March 2025, with a fixed interest rate of 3.91% and the loan of £6m (current remaining balance £3.2m) taken out on the 15th December 2010 has a final repayment date of 15th September 2035 at a fixed rate of 4.73%.

The Trust also has Salix loans total value of £1m which appears in "other loans" in both current and non current borrowings, this relates to improving the energy efficiency of the Trust. These loans are repayable over 5 years and is interest free. Salix Finance Ltd provides interest-free Government funding to the public sector to improve their energy efficiency, reduce carbon emissions and lower energy bills.

Under IFRS 9 the loan values also include their associated interest charges.

Note 23.2 Reconciliation of liabilities arising from financing activities - 2021/22

	Loans from DHSC	Other loans	PFI and LIFT schemes	Total
	£000	£000	£000	£000
Carrying value at 1 April 2021	**6,417**	**1,392**	**182,173**	**189,982**
Cash movements:				
Financing cash flows - payments and receipts of principal	-974	-361	-5,402	**-6,737**
Financing cash flows - payments of interest	-240	0	-9,541	**-9,781**
Non-cash movements:				
Application of effective interest rate	238	0	9,540	**9,778**
Other changes	0	1	0	**1**
Carrying value at 31 March 2022	**5,441**	**1,032**	**176,770**	**183,243**

Note 23.3 Reconciliation of liabilities arising from financing activities - 2020/21

	Loans from DHSC	Other loans	PFI and LIFT schemes	Total
	£000	£000	£000	£000
Carrying value at 1 April 2020	**34,174**	**1,743**	**187,522**	**223,439**
Cash movements:				
Financing cash flows - payments and receipts of principal	-27,696	-351	-5,349	**-33,396**
Financing cash flows - payments of interest	-342	0	-9,816	**-10,158**
Non-cash movements:				
Application of effective interest rate	281	0	9,816	**10,097**
Carrying value at 31 March 2021	**6,417**	**1,392**	**182,173**	**189,982**

Note 24 Other financial liabilities

The Trust has no other financial liabilities

Note 25 Provisions for liabilities and charges analysis

	Pensions: injury benefits	Legal claims	Lease dilapidations	2019/20 Clinicians' pension reimbursements	Other	Total
	£000	£000	£000	£000	£000	£000
At 1 April 2021	**495**	**1,105**	**2,254**	**1,092**	**80**	**5,026**
Change in the discount rate	22	0	0	0	0	**22**
Arising during the year	0	2,433	387	258	239	**3,317**
Utilised during the year	-25	-192	0	0	0	**-217**
Reclassified to liabilities held in disposal groups	0	0	0	0	0	**0**
Reversed unused	-19	0	0	0	0	**-19**
Unwinding of discount	-5	0	0	0	0	**-5**
At 31 March 2022	**468**	**3,346**	**2,641**	**1,350**	**319**	**8,124**
Expected timing of cash flows:						
- not later than one year;	25	3,346	1,989	24	319	**5,703**
- later than one year and not later than five years;	443	0	86	62	0	**591**
- later than five years.	0	0	566	1,264	0	**1,830**
Total	**468**	**3,346**	**2,641**	**1,350**	**319**	**8,124**

Pension Injury Benefit costs relates to two ill health injury benefits calculated by current payment made by NHS Pensions Agency adjusted for average life expectancy using tables published by the National Statistics Office. Legal Claims include estimates notified by NHS Resolution.

Legal claims are notified at year end to the Trust from NHS resolution and other solicitors that the Trust engages with.

Lease dilapidations relates to provisions of leased properties of £1.1m and equipment of £1.5m

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

Note 25.1 Clinical negligence liabilities

At 31 March 2022, £407,689k was included in provisions of NHS Resolution in respect of clinical negligence liabilities of Maidstone And Tunbridge Wells NHS Trust (31 March 2021: £266,300k).

Note 26 Contingent assets and liabilities

	31 March 2022	31 March 2021
	£000	£000
Value of contingent liabilities		
NHS Resolution legal claims	-30	-43
Gross value of contingent liabilities	**-30**	**-43**
Amounts recoverable against liabilities	0	0
Net value of contingent liabilities	**-30**	**-43**
Net value of contingent assets	**0**	**0**

Contingent liability for 2021/22 relates to legal claims notified by NHS Resolution of £30k

Note 27 Contractual capital commitments

	31 March 2022	31 March 2021
	£000	£000
Property, plant and equipment	2,355	350
Intangible assets	120	326
Total	**2,475**	**676**

Note 28 Other financial commitments

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

Note 29 On-SoFP PFI, LIFT or other service concession arrangements

The Trust signed a PFI project agreement on 26th March 2008 for the new Tunbridge Wells Hospital at Pembury. The main building was handed over by the contractor in phases in December 2010 and May 2011 and recognised in the Trust's accounts accordingly. By joint agreement with the Trust's PFI partner the final phase of car parking & landscaping were completed and handed over early in January 2012, although contractual phasing and unitary payments were kept in line with the project agreement completion date of September 2012. The arrangement covers the provision of buildings, hard facilities management services and lifecycle replacement (building & engineering asset renewals). Under the project agreement the Trust has agreed expectations for the provision of these services and has termination options on default. The land remains the Trust's asset throughout the concession. The concession is due to run for 30 years until 2042 when the building will revert to the Trust. The annual unitary payment was contracted at £16.9m at 2005/06 prices, and is subject to an annual uplift by Retail Price Index which for the 2021/22 year was 1.37%. The RPI uplift for 2022/23 is 8.18%.

Note 29.1 On-SoFP PFI, LIFT or other service concession arrangement obligations

The following obligations in respect of the PFI, LIFT or other service concession arrangements are recognised in the statement of financial position:

	31 March 2022	31 March 2021
	£000	£000
Gross PFI, LIFT or other service concession liabilities	**291,071**	**306,014**
Of which liabilities are due		
- not later than one year;	14,939	14,942
- later than one year and not later than five years;	58,559	59,344
- later than five years.	217,573	231,728
Finance charges allocated to future periods	-114,301	-123,841
Net PFI, LIFT or other service concession arrangement obligation	**176,770**	**182,173**
- not later than one year;	5,688	5,402
- later than one year and not later than five years;	24,728	24,229
- later than five years.	146,354	152,542

Note 29.2 Total on-SoFP PFI, LIFT and other service concession arrangement commitments

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

	31 March 2022	31 March 2021
	£000	£000
Total future payments committed in respect of the PFI, LIFT or other service concession arrangements	**769,146**	**744,896**
Of which payments are due:		
- not later than one year;	28,747	26,567
- later than one year and not later than five years;	124,181	113,114
- later than five years.	616,218	605,215

Note 29.3 Analysis of amounts payable to service concession operator

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

	2021/22	2020/21
	£000	£000
Unitary payment payable to service concession operator	**26,345**	**25,989**
Consisting of:		
- Interest charge	9,540	9,816
- Repayment of balance sheet obligation	5,402	5,349
- Service element and other charges to operating expenditure	5,428	5,257
- Capital lifecycle maintenance	823	315
- Revenue lifecycle maintenance	0	0
- Contingent rent	4,751	4,591
- Addition to lifecycle prepayment	401	661
Other amounts paid to operator due to a commitment under the service concession contract but not part of the unitary payment	203	160
Total amount paid to service concession operator	**26,548**	**26,149**

Note 30 Off-SoFP PFI, LIFT and other service concession arrangements

The Trust has no Off- SOFP schemes

Note 31 Financial instruments

Note 31.1 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 2022 are in receivables from customers, as disclosed in the trade and other receivables note.

Liquidity risk

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

Note 31.2 Carrying values of financial assets

Carrying values of financial assets as at 31 March 2022	Held at amortised cost	Held at fair value through I&E	Held at fair value through OCI	Total book value
	£000	£000	£000	£000
Trade and other receivables excluding non financial assets	18,953	0	0	**18,953**
Other investments / financial assets	0	0	0	**0**
Cash and cash equivalents	11,838	0	0	**11,838**
Total at 31 March 2022	**30,791**	**0**	**0**	**30,791**

Carrying values of financial assets as at 31 March 2021	Held at amortised cost	Held at fair value through I&E	Held at fair value through OCI	Total book value
	£000	£000	£000	£000
Trade and other receivables excluding non financial assets	8,224	0	0	**8,224**
Other investments / financial assets	0	0	0	**0**
Cash and cash equivalents	26,221	0	0	**26,221**
Total at 31 March 2021	**34,445**	**0**	**0**	**34,445**

Note 31.3 Carrying values of financial liabilities

Carrying values of financial liabilities as at 31 March 2022	Held at amortised cost	Held at fair value through I&E	Total book value
	£000	£000	£000
Loans from the Department of Health and Social Care	5,441	0	**5,441**
Obligations under finance leases	0	0	**0**
Obligations under PFI, LIFT and other service concession contracts	176,770	0	**176,770**
Other borrowings	1,032	0	**1,032**
Trade and other payables excluding non financial liabilities	40,878	0	**40,878**
Other financial liabilities	0	0	**0**
Provisions under contract	0	0	**0**
Total at 31 March 2022	**224,121**	**0**	**224,121**

Carrying values of financial liabilities as at 31 March 2021	Held at amortised cost	Held at fair value through I&E	Total book value
	£000	£000	£000
Loans from the Department of Health and Social Care	6,417	0	**6,417**
Obligations under finance leases	0	0	**0**
Obligations under PFI, LIFT and other service concession contracts	182,173	0	**182,173**
Other borrowings	1,392	0	**1,392**
Trade and other payables excluding non financial liabilities	44,120	0	**44,120**
Other financial liabilities	0	0	**0**
Provisions under contract	0	0	**0**
Total at 31 March 2021	**234,102**	**0**	**234,102**

Note 31.4 Maturity of financial liabilities

The following maturity profile of financial liabilities is based on the contractual undiscounted cash flows. This differs to the amounts recognised in the statement of financial position which are discounted to present value.

	31 March 2022	31 March 2021
	£000	£000
In one year or less	57,263	60,491
In more than one year but not more than five years	61,547	63,428
In more than five years	219,614	234,026
Total	**338,424**	**357,945**

Note 31.5 Fair values of financial assets and liabilities

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

Note 32 Losses and special payments

	2021/22		2020/21	
	Total number of cases	Total value of cases	Total number of cases	Total value of cases
	Number	£000	Number	£000
Losses				
Cash losses	19	13	15	18
Fruitless payments and constructive losses	0	0	0	0
Bad debts and claims abandoned	182	545	18	16
Stores losses and damage to property	0	0	0	0
Total losses	**201**	**558**	**33**	**34**
Special payments				
Compensation under court order or legally binding arbitration award	0	0	0	0
Extra-contractual payments	0	0	0	0
Ex-gratia payments	60	525	27	18
Special severance payments	0	0	0	0
Extra-statutory and extra-regulatory payments	0	0	0	0
Total special payments	**60**	**525**	**27**	**18**
Total losses and special payments	**261**	**1,083**	**60**	**52**
Compensation payments received		0		0

The Trust has no individual cases that exceed £300k.

In keeping with policy 1.24 this note includes losses and compensations paid and accrued but excludes provisions which are reported under Note 24.

Ex-gratia payments within 2021-22 include special payments relating to 1 case totalling £494k for overtime corrective payments (Flowers judgement), this was provided for within 2020/21 but paid in 2021-22.

Note 33 Gifts

There were no gifts made by the Trust in 2021/22.

Note 34 Related parties

During the year none of the Department of Health and Social Care Ministers, Trust Board members or members of the key management staff, or parties related to any of them, have undertaken any material transactions with Maidstone and Tunbridge Wells NHS Trust

The Department of Health and Social Care (DHSC) is regarded as a related party. During the year 2021/22 the Trust has received £12.7m Capital funding in the form of PDC. The Trust also has loans with DHSC, interest paid within the year £0.2m, principal repayment of £1m. The trust has also had a significant number of material transactions with other entities for which the Department is regarded as the parent department e.g. NHSE/I. Other public sector bodies are recognised as relevant who are not part of the DHSC group e.g. HMRC. The following entities with material transactions of more than £1m are listed below:

East Sussex CCG
Kent and Medway CCG
South East London CCG
West Sussex CCG
NHS England
Health Education England
Kent Community Foundation Trust
East Kent University Hospitals Foundation Trust
Medway NHS Foundation Trust
Dartford and Gravesham NHS Trust
HMRC
NHS Pension Authority
NHS Resolution
NHS Supply Chain
NHS Blood and Transplant
NHS Property Services
Kent County Council

The Trust has also received revenue and capital payments from the Charitable Funds that it controls, the trustees for which are also members of the Trust Board. The Trust has not consolidated the Charitable Funds on the grounds of materiality to the Trust (see policy note 1.3). The transactions between the Trust and the Charity (Maidstone and Tunbridge Wells NHS Charitable Fund - charity registration number 1055215) are however material to the charity and therefore are disclosed below. Please note that this disclosure is based on the draft unaudited position of the charity. The audited accounts of the charity will be available later this year.

	2021-22	2020-21
	£000s	£000s
Total charitable resources expended with the Trust	210	217
Closing creditor (monies owed to the Trust by the Charity)	43	407
Total income received by the Charity in the reporting period	202	540
Total Charitable Funds at end of the reporting period	1,082	1,083

Note 35 Prior period adjustments

The Trust has not made any prior period adjustments

Note 36 Events after the reporting date

The Trust has no events after the reporting date

Note 37 Better Payment Practice code

	2021/22	2021/22	2020/21	2020/21
Non-NHS Payables	**Number**	**£000**	**Number**	**£000**
Total non-NHS trade invoices paid in the year	116,545	263,629	92,876	218,998
Total non-NHS trade invoices paid within target	111,769	245,894	89,409	205,094
Percentage of non-NHS trade invoices paid within target	95.9%	93.3%	96.3%	93.7%
NHS Payables				
Total NHS trade invoices paid in the year	2,448	34,396	3,194	39,080
Total NHS trade invoices paid within target	2,061	33,284	2,099	33,006
Percentage of NHS trade invoices paid within target	84.2%	96.8%	65.7%	84.5%

The Better Payment Practice code requires the NHS body to aim to pay all valid invoices by the due date or within 30 days of receipt of valid invoice, whichever is later.

Note 38 External financing limit

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

	2021/22	2020/21
	£000	**£000**
Cash flow financing	20,306	-11,322
External financing requirement	**20,306**	**-11,322**
External financing limit (EFL)	20,306	-7,032
Under / (over) spend against EFL	**0**	**4,290**

Note 39 Capital Resource Limit

	2021/22	2020/21
	£000	**£000**
Gross capital expenditure	26,634	33,341
Less: Disposals	-79	0
Less: Donated and granted capital additions	-377	-1,392
Plus: Loss on disposal from capital grants in kind	0	0
Charge against Capital Resource Limit	**26,178**	**31,949**
Capital Resource Limit	26,627	32,361
Under / (over) spend against CRL	**449**	**412**

Note 40 Breakeven duty financial performance

	2021/22	2020/21
	£000	**£000**
Adjusted financial performance surplus / (deficit) (control total basis)	231	330
Remove impairments scoring to Departmental Expenditure Limit	0	0
Add back non-cash element of On-SoFP pension scheme charges	0	0
IFRIC 12 breakeven adjustment	0	0
Breakeven duty financial performance surplus / (deficit)	**231**	**330**

There is no adjustment for the PFI (IFRIC 12) accounting as the on-balance sheet impacts to I&E are currently lower than the equivalent off-balance sheet reporting

Note 41 Breakeven duty rolling assessment

	2008/09	2009/10	2010/11	2011/12	2012/13	2013/14	2014/15
	£000	£000	£000	£000	£000	£000	£000
Breakeven duty in-year financial performance		189	1,710	300	129	-12,374	157
Breakeven duty cumulative position	-3,260	-3,071	-1,361	-1,061	-932	-13,306	-13,149
Operating income		311,889	322,176	345,101	367,391	375,714	403,310
Cumulative breakeven position as a percentage of operating income		(1.0%)	(0.4%)	(0.3%)	(0.3%)	(3.5%)	(3.3%)

	2015/16	2016/17	2017/18	2018/19	2019/20	2020/21	2021/22
	£000	£000	£000	£000	£000	£000	£000
Breakeven duty in-year financial performance	-23,413	-10,918	-10,790	20,324	7,587	330	231
Breakeven duty cumulative position	-36,562	-47,480	-58,270	-37,946	-30,359	-30,029	-29,798
Operating income	400,930	430,502	440,269	473,169	513,056	564,196	623,891
Cumulative breakeven position as a percentage of operating income	(9.1%)	(11.0%)	(13.2%)	(8.0%)	(5.9%)	(5.3%)	(4.8%)

The Trust's last formal 3 year break-even cycle commenced in 2013/14 and was not met by the period in 2015/16. The Trust has achieved in year break even duty surpluses and met it NHSEI control totals in each of the last three financial years. The Trust is not in any formal recovery regime relating to recovering its historic accumulated deficit but is required to achieve the in year breakeven position agreed as part of the overall Kent & Medway Integrated Care System (ICS) control total. The Trust reported a surplus of £0.2m in 2021/22 which was slightly better than plan and its system control total requirement.

Thank you for your support

Miles Scott, Chief Executive

David Highton, Chair of the Trust Board

The Trust receives support and well wishes from patients, carers, stakeholders, volunteers, and fundraisers. This support is expressed in a varied number of ways, including compliments sent directly to the Trust; letters sent to the local media; comments posted on social media; participation in the Patient Experience Committee; attendance at Trust Board meetings and the Annual General Meeting and fundraising to buy much needed equipment, to name but a few. This support is highly valued by the Trust's staff and the Board - without this, the Trust's task would be far harder. Thank you all.

taking pride

MTW exceptional people, outstanding care

MTW
Exceptional people, outstanding care

NHS
Maidstone and Tunbridge Wells
NHS Trust

Maidstone and Tunbridge Wells NHS Trust

Maidstone Hospital
Hermitage Lane
Maidstone
Kent, ME16 9QQ

01622 729000

www.mtw.nhs.uk

mymtwhealthcare

@mtw_nhs_trust

Search for: 'Maidstone and Tunbridge Wells NHS Trust'

@MTWnhs

@MTWnhs

Search for: 'Maidstone and Tunbridge Wells NHS Trust'

Our PRIDE values