NHS
Kent Community Health
NHS Foundation Trust

Welcome to our seventh annual report

2017 to 2018

we care

Kent Community Health
NHS Foundation Trust

Annual report and accounts 2017 to 2018

Presented to Parliament pursuant to Schedule 7,
paragraph 25 (4) (a) of the National Health Service Act 2006

Kent Community Health
NHS Foundation Trust

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A snapshot of our year

We provided more than 70 services, with a budget of **£224 million.**

97.2% of people who used our services said they would recommend them to family and/or friends.

The time patients needed to be in a community hospital ward decreased to 19.84 days from 21.6 days.

97% of 63,912 people were satisfied with the care we provided.

1,978 health MOTs were completed.

99.84% of people waited less than four hours in our minor injury units.

Patient safety work resulted in a 41% reduction in falls with harm in our community hospitals.

We opened a new high-tech orthotics lab manufacturing custom-made orthotic insoles.

Our **5,000** plus staff had over 2.1 million patient contacts.

We introduced dementia champions who have extra training to support patients and colleagues.

91% of new mothers received their health visiting check at six to eight weeks.

One You lifestyle advisers saw **2,850** new clients.

560 people lost weight working with us, with an average weight loss of 4.2%.

We opened a wound centre in Sevenoaks.

We were named as one of 14 organisations in Europe to secure €8 million to take part in a project to create systemic changes in health and social care.

Contracts with an overall value of **£22.5million were won** by the trust; two of these were retained business.

Kent Community Health
NHS Foundation Trust

The performance report

The performance report

Overview of performance

Welcome to our seventh annual report.

During the past 12 months, our trust has continued to deliver high-quality care to the people we serve in Kent, East Sussex and parts of London. Our relentless drive for excellent quality ensures our services are safe, effective and provide high-quality care.

As always, our focus remains our patients, our people and our partners and this is best reflected in our organisational mission – to empower adults and children to live well, to be the best employer and work with our partners as one.

An annual report is an appropriate time to reflect on the past year; we have delivered a 41 per cent reduction in patient falls in our community hospitals. Our four wound medicine centres are making a real difference to people's lives, with a 16 per cent improvement in healing rates, which exceeded the five per cent target.

The Care Quality Commission assesses our services as 'Good', and we are continuing to drive improvement through our 'we care' review programme taking place across our services and also by listening to what our patients, staff and partners tell us.

It's fantastic that 97.2 per cent of people who used our services in 2017-18 said they would recommend them to family and friends and 97 per cent said they were satisfied with the care they received from us. But we want to achieve more, so in the year to come we will.

We want to deliver our vision of a community that supports each other to live well and we can only do that with the support of people, such as our patients and staff who give us such positive and constructive feedback on ways to get better.

Working closely with our partners on the delivery of local care in the Kent and Medway Sustainability Partnership was a priority in 2017-18 and will continue to be in 2018-19. A compelling case for change was published in spring 2017.

Multi-disciplinary teams of skilled professionals, from the health and social care sectors delivering care suitable for the 21st century, is integral to making sure patients recover faster and, in some cases, not need medical care because they are being supported to lead healthier lifestyles and improved outcomes.

Our One You lifestyle advisers are already contributing to the improving the health of the people we serve having seen nearly 3,000 new clients in 2017-18 and we provided more than 2,500 health MOTs.

In 2017-18, we continued to be successful in winning new business and retaining services we already provided, such as East Sussex Children's Integrated Therapy and Equipment Service. In total, we won 10 contracts worth £22.5million.

We celebrated our first year of delivering sexual health services in Medway too and started delivering dental services in eight London boroughs.

In further work with our partners, we developed 'A Different View', a recruitment website and campaign, supporting multiple health and social care providers in Kent and Medway – working together to recruit and retain staff.

We know there is always more we can do and it is one of our drivers for the future. For example, we need to make sure more people die in their preferred place of death; 84.5 per cent of our patients did, but we wanted to reach the 95 per cent target that had been set. End of life care is so very important.

Our governors continued to be a valuable part of the trust during the past 12 months, with increasing involvement with the public and our foundation trust members, of which we now have 12,481.

A Kent and Medway-wide governor network was developed, sharing best practice and discussing issues that affect councils of governors in the area.

The trust ended the period covered by this report within budget and made a small required surplus. We continued to have one of the lowest running costs of NHS community health providers in England and our use of resources rating is at 1, the highest possible score, as assessed by our regulator, NHS Improvement.

We made the progress we have because of the hard work and skills of our team members; it is the right point to thank them for all they have done and continue to do so.

We hope you enjoy reading our annual report.

Kind regards

David Griffiths

Chair: .....

Date 24 May 2018

Paul Bentley

Chief Executive Officer: .....

Date 24 May 2018

Overview:
Who we are and what we do

Kent Community Health NHS Foundation Trust was formed in April 2011. We are a large provider of NHS care in patients' homes and in the community in England. Our budget for 2017-18 was £224million. We employ in the region of 4,600 members of staff in a wide range of clinical and support roles. We serve three million people; 1.5million living in Kent and 1.5million people outside of Kent.

We have more than two million contacts with patients a year; many of these are in their own homes and in other locations, including GP surgeries, nursing homes, clinics, community hospitals, minor injury units and children's centres.

Our workforce includes doctors, community nurses, dieticians, health visitors, dentists, podiatrists, occupational therapists, physiotherapists, family therapists, clinical psychologists, speech and language therapists, radiographers, pharmacists, health trainers and many more.

The trust provides services for children and adults to support them to stay healthy, manage their long-term health conditions, help them avoid going into hospital and, when they have needed to be in hospital, help them to get home quickly.

Advice and support for children's emotional and physical health and wellbeing is available from a range of services, including health visitors, by attending one of the trust's parenting support groups in children's centres or from our school-based nurses.

Our health improvement services support people to make positive lifestyle choices. Help is available to increase exercise, eat healthily, quit smoking and assist with wider health and social care needs. Sexual health services encourage safe sex and provide contraception, family planning and treatment.

If people do become ill and need treatment, they can access a minor injury unit, emergency and specialist dental treatment or a range of other specialist services, including therapists, podiatry, orthopaedics and chronic pain.

These are provided in the community so people can get treatment close to home. Nursing and therapy teams provide care in people's homes and help in managing long-term conditions, so they don't have to unnecessarily go into hospital.

We have rapid response services 24-hours-a-day, seven-days-a-week where experienced nurses, following a request from a GP or other health professional, assess a patient's needs within two hours and put support in place to enable the patient to stay at home rather than go to hospital.

Step-up and step-down care is provided in in-patient units in community hospitals. This more complex care means people are less likely to need to go into an acute hospital. If people do need to, our staff support them to get back home by providing rehabilitation at home and in community hospitals. We also provide specialist care in the community, for example for seriously ill children or rehabilitation following a serious illness or injury and we provide care for disabled children and adults.

Our mission, vision and values

Our strategy

Our vision

A community that **supports each other** to **live well**.

Our mission

To **empower adults and children** to live well, to be the **best employer** and **work with our partners** as one.

Our values

Compassionate

Aspirational

Responsive

Excellent

The Kent and Medway Sustainability and Transformation Partnership

The Kent and Medway Sustainability and Transformation Partnership (STP) describes how local services will evolve and become sustainable during a five-year period. It is a partnership of health and social services in Kent and Medway and it looks to meet four key challenges:

Demand for care is rising. The population is growing and ageing, and there are growing numbers of people with multiple mental and physical long-term conditions. Too many people are admitted to hospital and/or stay too long in hospital, which increases pressure, results in sub-optimal care and poor use of resources.

Resources are limited. There will continue to be very limited growth in resources for the NHS for the foreseeable future, set against rising costs of care. Kent has an NHS budget of approximately £3billion; across Kent all NHS providers face significant financial challenges. Funding for council-provided services is reducing due to budget pressures.

Recruiting and retaining sufficient skilled staff continues to be very challenging and leads to extensive use of temporary staff. The combination of rising demand, limited resources and these workforce pressures is that services across the whole system are under severe pressure and struggling to meet their objectives – in primary, community, mental health, acute and social care.

Patients don't consistently experience the very best care. Services are often fragmented, there are unwarranted variations in the quality and performance and there are inequalities in the health and outcomes of the populations we serve.

In the past 12 months, the STP has:

- carried out an extensive consultation into the future of stroke services in Kent and Medway looking to potentially create three hyper acute stroke units
- examined where the STP is making progress one year after its creation
- moved forward with planning, preparation and delivery around local care.

You can find out more at www.kentandmedway.nhs.uk

Our strategic goals:

Our goals

- **Prevent** ill health
- Deliver high-quality care **at home** and **in the community**
- **Integrate** services
- Develop **sustainable** services

Our priorities for 2017-18

- **Engage** and **empower** patients and carers as **active partners** to support health, wellbeing and independent living.
- Nurture **leadership**, support **staff development** and foster flexibility and adaptability to **recruit and retain** the right workforce.
- Establish formal **partnerships** to enable joint working across **health and social care**.
- Research, **innovate** and continually improve to be **affordable** and deliver **safe care** with the **best outcomes**.

Supporting our strategic goals

The trust uses a selection of enabling strategies to support the patient care we provide. These include the workforce plan, organisational development plan, transformation framework, people strategy, estates strategy, financial plans, information and technology strategy, communications and engagement strategy, membership strategy and stakeholder engagement plan.

Our enabling strategies help secure:

- care which is safe, clinically effective and improves the patient experience

  (clinical strategy, governance and quality)
- patient and carer partnerships (communications and engagement)
- clinical leadership and culture development (workforce and organisational development)
- information knowledge management
- new, more innovative, cost effective pathways with our partners (transformation framework).

Overview: Going concern

The annual accounts describe the trust's end of year financial position and key financial performance information. The Audit and Risk Committee considered the basis of the trust's ability to continue as a going concern and recommended this to the Board on the basis that:

- the trust does not have any plans to apply to the Secretary of State for dissolution
- the trust has cash balances forecast to be not below £24.7 million at end of each month during 2018-19
- the trust is forecasting a liquidity rating of 1 throughout 2018-19, the highest rating possible
- the trust has agreed contracts for 2018-19 with all its commissioners
- the trust has plans that align with the local health and care economy, with a transformation agenda for greater integration of services
- the trust has not agreed a working capital facility in 2018-19 (nor 2017-18) as this was unused in 2015-16 and not forecast as required, after considering possible downside scenarios.

After making enquiries, the directors have reasonable expectation that the trust has adequate resources to continue in operational existence for the foreseeable future. For this reason, they continue to adopt the 'going concern' basis in preparing the accounts. The principle risks and uncertainties facing the trust are included in the annual governance statement.

Performance analysis

In this section, we describe some of the highlights of the year, the difference they are making to patients and our performance against our key performance indicators. The trust measures its performance against the following strategic goals:

Strategic goal one: Prevent ill health

We will empower families to give their children the best start in life, support adults to make healthy choices and focus on communities that need us most. We will take every opportunity to prevent ill health and improve how we detect and treat disease.

At the beginning of April, we started delivering a new school health service, designed to give greater access and support for children and young people. The Kent County Council-awarded contracts were for school-aged children and included increased opening hours, easier access with one number, uniforms to make the School Health Team more visible and increased drop-ins at schools.

We worked with the Encompass Vanguard to promote a smartphone app called Waitless, designed to reduce waiting times at accident and emergency departments in east Kent by using live waiting times at urgent call centres with up-to-the-minute travel information. The app had been used more than 160,000 times up to 31 March 2018.

We launched a campaign to make sure people are keeping their hands clean in our clinics and community hospitals. Advice around the importance of good hand hygiene to prevent infections, such as C-Difficile, flu and norovirus was given.

Our Dental Team recruited the highest number of people to a national survey, which investigated whether a specially trained dental nurse-led service would prevent tooth decay in children and improve dental health behaviour.

In the autumn, we celebrated the first anniversary of delivering sexual health services in Medway, having developed a website specifically for Clover Street.

Thousands of children across Kent in years 1, 2, 3 and 4 were immunised against flu in the run-up to Christmas by our Immunisations Team.

Bower Mount Medical Practice in Maidstone was the latest GP practice to put its best foot forward and encourage patients to join a Health Walk. The scheme encourages people to get out for a volunteer-led walk once a week to help improve their health and wellbeing. Funded by Maidstone Borough Council, it is provided by KCHFT.

During 1 April 2017 – 31 March 2018

- One You lifestyle advisers saw 2,850 new clients.
- 62 per cent of clients seen by One You lifestyle advisers were from the two most deprived quintiles or of no fixed abode and, of the goals completed, 85 per cent were achieved or partly achieved.
- 1,978 health MOTs were completed, giving a baseline assessment of their health and information on how to improve their results.
- In 2017-18, One You lifestyle advisers helped 102 clients register with a GP, an estimated saving of £204,000 to the NHS.
- More than 4,000 health walks took place with 310 volunteer walk leaders.
- We supported 560 people to lose weight via our weight loss programme with an average weight loss of 4.2 per cent; national guidance is three per cent.
- To date, 3,015 people quit smoking during the past year, which is 89 per cent of the 3,400 target set.
- A stop smoking home visits pilot in South Kent Coast and Thanet funded by the clinical commissioning groups, started in September 2017 and to date has had 155 quit dates set with 61 quits.

Strategic goal two: Deliver high-quality care at home and in the community

We will provide a wide range of safe, effective services. We will offer high-quality compassionate care to make sure we achieve the best outcomes and a positive experience for our patients, their families and carers.

We were one of 21 trusts in the UK and the only community health provider to take part in a 90-day programme looking at what more could be done to prevent falls in community hospitals. The NHS Improvement Falls Collaborative makes sure we have the information, skills and tools to reduce falls, resulting in injury.

In May, we opened another wound centre, this time in Sevenoaks. Staffed by advanced wound nurses supported by tissue viability specialist nurses, the clinic means patients with chronic, complex or surgical wounds have access to specialist care. The centre was helped by a generous £13,000 donation by Sevenoaks Hospital League of Friends.

We celebrated Volunteers' Week in June, saying thank you to our army of 500 people who voluntarily give their time to help our 70 plus services. Between them, they donated more than 35,000 hours in a year.

2017-18 was another challenging year nationally across the NHS and we felt that pressure in the areas where we deliver services, particularly during the severe winter weather in early 2018.

However, our staff rallied together and continued to provide excellent care for our patients despite increased demand and the often treacherous travel conditions.

Patient safety work resulted in a 41 per cent reduction in falls with harm in our community hospitals, which exceeded the target we had set of 10 per cent.

There was a 35 per cent reduction in grade three and four pressure ulcers in 2017-18, which achieved our target. There was a 44 per cent reduction in grade two pressure ulcers.

We introduced dementia champions who have extra training to be able to support patients and colleagues and our baywatch campaign – where we place patients with similar impairments in bays together for more effective monitoring and care.

The environment in which our patients with dementia are cared for was addressed during the summer and autumn to make it easier to get around. Simple things like painting doors and walls and changing signage have made an enormous difference.

In March, we opened a free breastfeeding room for mums to use when they're out in Ashford town centre. The NHS One You shop opened a dedicated room that boasts a few home comforts, such as a comfy chair, foot stall and radio. There are also baby changing facilities on site.

During 1 April 2017 – 31 March 2018

- 91 per cent of new mothers received their health visiting check at six to eight weeks.
- We achieved 99.41 per cent of our target for face-to-face contacts with patients with long-term conditions and 97.21 per cent of our target for intermediate care and rehabilitation patients.
- We exceeded our four per cent target for patients who did not attend appointments for these two services with a percentage of just 1.2 per cent.
- 97.1 per cent of patients seen by our specialist electives services and 97.12 per cent by our children's therapies services partially or fully met their agreed outcomes.
- 93.9 per cent of reception year children and 95.4 per cent of pupils in Year 6 were screened for height and weight against a trust target of 90 per cent.

Strategic goal three: Integrate services

We will work with our partners to connect the care patients receive from other NHS trusts, social care or voluntary or community organisations.

In the spring of 2017, leaders from the NHS in Kent and Medway, along with Kent County Council and Medway Council published a compelling 'case for change' which set out why services needed to change to meet the needs of local people.

Compiled by the Kent and Medway Sustainability and Transformation Partnership, of which we are part, the case for change showed that every day 1,000 people in Kent and Medway are stuck in hospital beds when they could get the health and social care they need out of hospital if the right services were available.

A series of workshops followed through the summer and autumn asking for people's thoughts on the proposals.

In August, we worked with South East Water for the 'don't dry out initiative', which focussed on older people and whether they drink enough fluid during the day. A celebratory tea party at Hawkhurst Community Hospital got things under way.

The campaign was rolled out to community hospitals, nursing and care homes. Specially designed tear-off pads and wipeable reusable posters, which help to keep track of the amount of water a person drinks throughout the day, were handed to carers and nursing staff, along with coasters and room thermometers.

In September, we held our annual general meeting (AGM) in Sevenoaks. We took the opportunity to hold a diabetes roadshow before the AGM, following the success of a similar event earlier that year.

A number of organisations took part, including Carer's First, Diabetes UK, Hypo Hounds, Healthwatch, Fixing Dad and the Diabetes Psychology Service.

They were joined by a number of our own services, such as the Clinical Nutrition and Dietetics Service, Tissue Viability Team and the Vulnerable Foot Team. Some of our governors were on hand to lend their support too.

In October, we pledged our support for Healthwatch's Help Cards, which allow patients to discreetly indicate they may need additional help at their appointment, such as filling in forms.

As winter approached, we teamed up with our partners from acute hospitals, such as East Kent Hospitals University NHS Foundation Trust to deliver messages around health in winter and the best ways to get help and places to visit.

We heavily promoted our minor injury units as an alternative to visiting A&E, as well as promoting the benefits of the flu jab to patients and our own staff.

We were delighted in November to be one of a number of organisations in the UK taking part in an exciting new European project called Transforming Integrated Care in the Community (TICC).

The programme secured €8million for the partnership, which involves 14 organisations from the UK, France, the Netherlands and Belgium. TICC will create systemic change in health and social care, providing services better suited to our ageing population by addressing holistic needs.

This model significantly reduces the back office, simplifies IT and coaches rather than manages, providing better outcomes for people, lower costs, fewer unplanned hospital admissions and consistency of care.

We continued development of Home First, designed to get patients home quicker so they can recover faster across Kent and launched our clothes bank appeal to help our patients recover faster.

In January, a consultation on stroke services was launched as part of the work of the Kent and Medway Sustainability and Transformation Partnership.

During 1 April 2017 – 31 March 2018

- We had 90.8 per cent of our beds occupied, within our target of between 87 and 92 per cent.
- The length of time patients needed to be in a community hospital ward decreased to 19.84 days, from 21.6 days.
- Our delayed transfers of care decreased from 11.8 per cent to 10.1 per cent against our commissioner target of 9.5 per cent.
- 99.84 per cent of people waited less than four hours in our minor injury units.
- Our long-term conditions teams and intermediate care services had 63,119 patient contacts, resulting in admission to hospital being avoided. This was 16.1 per cent of all patents seen, against the trust's target of 15 per cent.

Strategic goal four: Develop sustainable services

We will innovate to develop services that are affordable. We aim to be the best employer, making sure colleagues have the right skills to meet the needs of our communities today and in the future.

We have worked really hard to develop innovative services that are not only affordable to the taxpayer, but which deliver high-quality services for the people we care for too. Thanks to our efforts, we were awarded 10 contracts during 2017-18, with two of these being retained business. The overall contract value of these was almost £22.5million, with an annual contract value to KCHFT of almost £6.5million.

Our successes included: Postural stability classes in east Kent; East Sussex Children's Integrated Therapy and Equipment Service; intermediate oral surgery in Havering, Barking and Dagenham; the ESCAPE pain programme for older people with chronic joint pain in Tunbridge Wells, Herne Bay and Maidstone; Kent and Medway School and Community Immunisations Service.

We launched our five-year People Strategy in 2017-18, which set out our commitment to investing in our staff to provide the best possible care for our patients. It supports us to recruit and retain the best people and includes nurturing leadership skills at every level, fostering continuous improvement and creating and maintaining a culture where people are supported to perform at their best.

Our online store, where you can buy some things from the NHS you might normally pay for privately or not be able to receive elsewhere, went live in April 2017.

We worked with our health and social care partners in east Kent to launch A Different View; a recruitment campaign centred on driving interested job applicants to a single website that has vacancies from all partners. It focuses on the lifestyle you can enjoy by living on the coast on east Kent.

We opened a new high-tech orthotics lab manufacturing custom-made orthotic insoles at Discovery Park, Sandwich in the summer.

In September, we officially opened the Maidstone Lions Sensory Room at our clinic in Coxheath for patients using our services. It followed an appeal by our charity i care, which helps to provide services and items that cannot be funded by the NHS, to enhance patient care and boost patients' and staff morale.

Early in 2018, our Chair David Griffiths announced he was retiring from the position after seven years. David oversaw the inception of the trust in 2011, when KCHFT was formed from the merger of two previous trusts. He has played a key role in maintaining the quality of care KCHFT provides and its financial stability.

In March, we said goodbye to some of our governors and welcomed new people on to the Council of Governors.

During 1 April 2017 – 31 March 2018

- 97.4 per cent of people were treated within 18 weeks of referral to our consultant-led services and 95.98 per cent were treated within 18 weeks of referral to our AHP services.
- 100 per cent of people had access to genito-urinary medicine within 48 hours of contacting us.
- In 2017-18 KCHFT won 10 contracts with an overall value of nearly £22.5million.

Patient feedback

- **59,052** surveys, including the NHS Friends and Family Test question, were completed across the trust.
- In 2017-18, we received feedback from **63,912** people receiving our care with an overall satisfaction score of **97 per cent.**
- **97.2 per cent** of people who used our services in 2017-18 would recommend them to family and/or friends.
- **20.2 per cent** of patients visiting our minor injury units (MIUs) and **39 per cent** of patients discharged from our community hospitals gave us feedback, exceeding the trust's target of surveying **10 per cent** of our patients.

Safe care

- We are 100 per cent compliant with NICE guidance.
- There were four cases of Clostridium difficile infection reported – all were deemed unavoidable and due to appropriate antimicrobial prescribing.
- There were no incidences of MRSA attributed to the trust.
- There hasn't been any never events.
- There were seven falls resulting in fractures reported as serious incidents.
- There were 17 grade three and four attributable and avoidable pressure ulcers, which is a 35 per cent reduction from last year.

Our charity

The main focus for the first six months of 2017-18 was on the Gift of Play sensory room appeal, after it had been launched the year before.

We made several online appeals and attended meetings of local businesses and community groups, and we successfully raised the full amount needed for the room, mainly due to an extremely generous donation from Maidstone Lions Club.

The lions donated all the equipment needed for the room, up to a value of £20,000. The remainder of the funds raised (approximately £5000) was used to cover installation costs and for extra toys and equipment.

The room was officially opened in September 2017 and is called the Maidstone Lions Sensory Room. It is now extensively used by patients as an integral part of our therapy programme in Coxheath.

Many items and services have been purchased via successful bids to charitable funds that are designed to help patients with dementia (or with symptoms of dementia) in our community hospitals and in our district nursing teams.

Community hospitals bought a GERT dementia simulation suit for use in staff training situations to help people understand how someone with dementia may be feeling physically, mentally and emotionally. The suits are used to train hospital and community staff and volunteers.

Hospitals were able to purchase dementia-friendly crockery, thanks to i care. This is blue heavyweight crockery designed to help patients with dementia and/or visual impairment to identify their food more easily as it gives better contrast.

The crockery also features large raised rims so that it's harder for the food to slip off. We are continuing to promote the charity generally, both internally and externally.

In 2018-19, we are linking with some other NHS charities through the Big 7Tea – an integrated campaign to promote NHS charities during the anniversary 70th year.

This work is being led by a steering group headed by Imperial Health Charity and we have already made sure the sensory room campaign is showcased on its website and promoted though the NHS7tea campaign.

Sustainability report

Our buildings and travel

Our estates strategy is to optimise the size and location of our estate. This not only supports a shift away from unnecessary car travel to more sustainable and healthy transport alternatives, but makes sure the buildings we work in, and deliver services from, are energy efficient, less wasteful and closer to our patients.

The trust has carried out several energy efficiency schemes in 2017-18; including LED lighting replacement projects, installing building management systems, reducing the trust's overall carbon footprint and reducing costs overall.

In 2018-19, there will be further energy efficiency and sustainability projects, such as installing solar PV panels and the installation of electric vehicle car chargers to enable a change to a low carbon way of travel.

We started the journey to a low carbon way of working in 2017-18 by surrendering leases on several inefficient buildings and encouraging more collaborative working practices as well as better space efficiency by increasing open plan and hot desk working. In 2018-19, we will continue to develop sustainable procurement practice.

Sustainable procurement

We take our responsibility to procure goods and services in a sustainable way seriously. The trust recognises its wider impact in terms of the social value it can create by virtue of its actions and is committed to investing its resources in a way that maximises the positive social, economic and environmental impace for our communities and staff.

The trust's sustainability and social value strategy is ambitious, but achievable:

- A 20 per cent reduction in the amount of carbon produced by the trust by 2020, with the eventual aim of meeting an 80 per cent reduction as soon as practicably possible.
- Increased use of technology to reduce unnecessary journeys, such as dialling into meetings using conference call where possible.
- Improved staff health and wellbeing benefits and promotion of employment of people with learning disabilities.

Putting sustainability at the heart of the way we work, using innovation to drive change and present different ways of working will push the trust towards the sustainable delivery of 21st century healthcare.

The trust aims to reduce the social and environmental impacts from the purchase, use, and disposal of the products we procure.

The trust seeks to promote and maintain high standards of social, ethical and environmental conduct across its procurement activities and work with its suppliers to make sure they also adopt this approach.

Signed:  Date: 24/5/2018

Paul Bentley, Chief Executive Officer (on behalf of the Board)

The whole performance report is signed by the chief executive on behalf of the Board.

The accountability report

The directors' report

Board

Non-executive directors
Pippa Barber
Jennifer Tippin
Bridget Skelton
Peter Conway
Richard Field
Steve Howe CBE

David Griffiths
Chair

Council of Governors

Paul Bentley
Chief Executive

Gordon Flack
Director of Finance

Ali Strowman
Chief Nurse

Lesley Strong
Chief Operating Officer/Deputy Chief Executive

Dr Sarah Phillips
Medical Director

Natalie Davies
Corporate Services Director

Louise Norris
Director of Workforce, Organisational Development and Communications

Portfolios of executive voting board members include:

- the chief executive: Has overall executive accountability to the Board
- the deputy chief executive/chief operating officer: Leads on operations and workforce
- the director of workforce, organisational development and communications: Leads on workforce and organisational development, communications and engagement
- the director of finance: Leads on audit, finance, performance, information management and technology, and business development and service improvement
- the chief nurse: Leads on clinical strategy, quality, clinical governance and is the director of infection prevention and control and safeguarding assurance
- the medical director: Leads the clinical strategy, quality, medical revalidation, clinical audit and research and development.

The Leadership Team also consisted of two additional posts, accountable to the chief executive:

- corporate services director: Includes regulatory framework, members and governors, governance and risk
- associate director of strategy and delivery

The Board is responsible for setting the vision and strategy of the organisation and for its overall performance. This is informed by the views of the Council of Governors, following consultation with foundation trust members.

Membership of the Board is consistent with requirements of the foundation trust's constitution. The non-executive directors' skills and experience make sure there is sufficient scrutiny of executive decision-making. The Board meets in public every two months.

The Board delegates responsibility for the day-to-day implementation of strategy through appropriate management systems to executive officers of the trust. All board members have confirmed their support for, and adherence to, the code of conduct for NHS board members. All non-executive directors are considered to be independent.

Directors' roles and responsibilities

David Griffiths, Chair

David has had a career in professional services for more than 25 years; initially as a chartered accountant and then for the majority of that time as a management consultant. He was a partner in Accenture, the leading global management consultancy, for more than 12 years and was responsible during that time for leading a large number of assignments for FTSE100 and other large, complex organisations operating at board level. He is a fellow of the Institute of Chartered Accountants in England and Wales.

On leaving Accenture, he established a portfolio of interests in the charitable and public sectors. Before becoming chair of Kent Community Health NHS Foundation Trust, he held these posts:

- non-executive director of the Kent and Medway Strategic Health Authority
- chair of Swale Primary Care Trust
- chair of NHS West Kent
- interim chair of NHS Medway
- trustee, vice-chair and chair of the Royal London Society for the Blind
- governor of a leading independent school and chair of its finance committee
- chair of two smaller not-for-profit organisations

Jen Tippin, Non-executive Director

Jen was appointed the group people and productivity director for Lloyds Banking Group in July 2017 and is responsible for leading the people function and managing the group's cost base. In this role she attends the Group Executive Committee.

Before her current role, Jen was group organisation design and cost management director, group customer services director and managing director, retail business banking.

Graduating from the University of Oxford, Jen has enjoyed a career spanning multiple industries, including banking, engineering and the airline sector. Jen is a non-executive director on the Board of Lloyds Bank corporate markets.

Pippa Barber, Non-executive Director

Pippa has more than 30 years' experience in the NHS. She spent the past 14 years in various Board roles, most recently as the executive director of nursing and governance at Kent and Medway Social Care Partnership Trust and executive nurse at NHS Medway.

Before this, Pippa was director of clinical services at Canterbury and Coastal Primary Care Trust and the Kent and Medway Cardiac network director.

She is the independent nurse for a clinical commissioning group governing body in London, where she maintains an essential focus on clinical quality, safety and effectiveness.

Pippa, who has worked as a district nurse and lives in east Kent, is passionate about community services.

Bridget Skelton, Non-executive Director

Bridget has 25 years' experience as a senior executive and board member in organisations in the legal, financial, management consultancy, retail, public and voluntary sectors.

She brings particular knowledge to effect business transformation, enhance performance and manage cultural development and change. She is KCHFT's senior independent director (from 10 October 2017).

Bridget lives in Otterden, Kent.

Peter Conway, Non-executive Director

Peter has a professional background in banking and finance spanning 27 years, latterly as a finance director with Barclays Bank. He now has a portfolio of primarily public sector roles and these include:

- non-executive director and audit chair of the Rural Payments Agency
- independent member of the Audit Committee of DEFRA
- independent member of the Audit Committee of the Ministry of Justice.

Previous roles include non-executive director and audit chair of NHS West Kent, trustee director of Citizens' Advice Bureau in north and west Kent and independent member and audit committee roles with the Home Office, the Health and Safety Executive and the Child Maintenance and Enforcement Commission.

Richard Field, Non-executive Director

Richard has a professional background in the manufacturing sector with large multi-national organisations, including Unilever and Dalgety. His career has involved sales and marketing, general management and running manufacturing businesses and multi-site operations. Richard has also worked in the animal feeds business and had carried out consultancy work with a number of large animal feeds manufacturing organisations. He is:

- former chair of Age UK Canterbury
- former chair of the Canterbury Multi-Academy trust
- member and past president of the Canterbury Forest of Blean Rotary Club
- former non-executive director of Eastern and Coastal Kent Community Services
- former regional manager within a Unilever Agribusiness
- former regional general manager of Dalgety Agriculture
- former non-executive director of St Nicholas Court Farms.

Steve Howe CBE, Non-executive Director

Steve served for 39 years in Royal Army Medical Corps having joined as a soldier but later undergoing training at the Royal Military Academy Sandhurst. He went on to command medical regiments, field hospitals and medical groups, both in peacetime locations and operations. He has held strategic and operational medical planning appointments in the UK, US, Australia and Supreme Headquarters Allied Powers Europe (NATO). He is:

- former non-executive director of Eastern and Coastal Kent Community Services
- former brigade commander (chief executive) of the army's 11 deployable field hospitals
- former Ministry of Defence (MOD) director of medical operations with strategic oversight of the medical aspects of operations in Iraq and Afghanistan.
- a fellow of the Institute of Healthcare Managers.

David Robinson, Non-executive Director

David has senior board experience in executive and non-executive roles. Executive roles have been in public affairs and government relations, including reputation and media management, crisis communications and government communications in both the private and public sector, nationally and internationally. He is:

- KCHFT's senior independent director (to 30 September 2017)
- KCHFT's non-executive director contact for whistleblowing (to 30 September 2017)
- school governor at Fulston Manor Academy and chair of Finance Committee
- former director of public affairs, Texaco
- former executive director communications and marketing with the Qualifications and Curriculum Authority (QCA)
- former non-executive director for Eastern and Coastal Kent Community Services.

David retired from the Board on 30 September 2017

Paul Bentley, Chief Executive

Before joining KCHFT as chief executive, Paul had been director of workforce and communications at Maidstone and Tunbridge Wells NHS Trust since 2011. He has worked in the NHS since 1987 and as an NHS director since 1998, leading on strategy, organisational development and workforce and communications. During this time he was also interim chief executive in Surrey.

Paul studied for his graduate university education in the UK, before completing his post-graduate education in America.

He lives in south west London with his wife and has grown-up children.

Lesley Strong, Deputy Chief Executive/ Chief Operating Officer

Lesley trained as a general nurse in 1976 at Middlesex Hospital, London and then pursued a clinical career in the community as a health visitor and district nurse. She moved into a management role in the community sector in 1988.

Lesley is:

- former primary care trust director of nursing and operations, Mid Sussex 2001
- former director of children's services, West Sussex 2007
- former chief operating officer, East Sussex 2008
- former managing director, Greenwich Community Health Services 2011.

Gordon Flack, Director of Finance

Gordon is a fellow of the Chartered Association of Certified Accountants (FCCA) and has a professional background in NHS finance spanning 33 years. Following an early career with health authorities, his director experience is with acute and community trusts and has been at the trust since 2011.

His responsibilities include financial management and control, capital and audit, IM&T, business development and service improvement, as well as performance and business intelligence.

Gordon lives in Essex with his wife and two sons and is keen on gliding and sailing.

Louise Norris, Director of Workforce, Organisational Development and Communications

Louise joined Kent Community Health NHS Foundation Trust in July 2015. Louise has more than 30 years' experience, 20 of them as a director, in NHS human resources. She joined us from Central and North West London NHS Foundation Trust, where she was director of human resources.

She is a fellow of the Chartered Institute of Personnel and Development. She has an MBA and an MA in strategic human resources. She is a management side representative on the NHS Staff Council.

Louise lives with her husband in West Malling.

Natalie Davies, Corporate Services Director

Natalie has worked within the NHS, in both acute and community settings, for more than 20 years. Natalie has a strong background in corporate governance and worked with the Board for a number of years before becoming corporate services director in 2015.

Natalie has primary responsibility for a number of areas, including estates, trust secretary, legal and risk, information governance, compliance, resilience and soft facilities management.

In addition to spending time with her family, Natalie has a number of hobbies including acting with local groups.

Sarah Phillips, Medical Director (from 10 April 2017)

Sarah is a GP at Newton Place Surgery in Faversham, Kent.

Before joining the trust as medical director, Sarah was clinical chair of Canterbury and Coastal Clinical Commissioning Group and chair of East Kent Strategy Board. The Board, now known as the East Kent Programme Board, was set up by local health and care commissioners to spearhead the drive to determine how best to provide health and care services to the population of east Kent. Its work is part of the wider sustainability and transformation plan (STP) for Kent and Medway.

Sarah's work on the Board included reviewing issues around staff retention, use of technology, buildings and estates, and clinical pathways, such as maternity, paediatrics, end-of-life care and mental health.

Until April 2017, Sarah was also commissioner co-chair of Kent and Medway Sustainability and Transformation Partnership Clinical Board, which was set up to make sure NHS future plans meet the health and social care needs of the communities it serves.

Sarah lives in east Kent with her husband and two children. She is also a keen tennis player.

Ali Strowman, Chief Nurse

Ali qualified as a registered general nurse in 1994. She completed a number of post-graduate studies and qualified as a registered mental health nurse in 2004. Ali graduated from the NHS Leadership Academy Nye Bevan Executive Development Programme in 2014. She has worked in the NHS for more than 27 years holding a variety of senior nursing posts in a number of trusts in London, Devon, Kent, Surrey and Sussex.

Ali is passionate about ensuring patients receive the best care possible, delivered by staff with compassion and competence. She has a clinical background in acute, community and mental health nursing, as well as holding a national position with NHS England providing clinical leadership to the National Ebola Team.

Ali lives in West Sussex with her partner and their young son.

Dr Arokia Antonysamy, Acting Medical Director (from 1 to 9 April 2017)

Aroika was recognised as a Health Service Journal rising star in 2015 for her contribution to new service models. She trained as a psychiatrist in Lancashire and Manchester and she worked with NHS England to develop the mental health quality toolkit. She was awarded the Rethink Academic prize by Manchester Medical Society in 2008 for her research project in the mother and baby unit at Wythenshawe hospital, which looked at patients' satisfaction and unmet needs.

Board and committee attendance

Formal Board

		May 17	Jun 16	Jul 17	Sep 17	Nov 17	Jan 18	Mar 18
David Griffiths	Chair	✓	✓	✓	✓	✓	✓	✓
Paul Bentley	Chief Executive	✓	✓	✓	✓	✓	✓	✓
Pippa Barber	Non-executive Director	✓	✓	×	✓	✓	✓	✓
Peter Conway	Non-executive Director	✓	✓	✓	✓	✓	×	✓
Richard Field	Non-executive Director	✓	✓	✓	✓	✓	×	✓
Steve Howe	Non-executive Director	✓	✓	✓	✓	✓	✓	✓
David Robinson	Non-executive Director	✓	×	×	✓	N/A	N/A	N/A
Bridget Skelton	Non-executive Director	×	✓	×	✓	✓	×	✓
Jennifer Tippin	Non-executive Director	×	×	✓	✓	×	✓	×
Gordon Flack	Director of Finance	✓	✓	×	✓	✓	✓	✓
Louise Norris	Director of Workforce, Organisational Development and Communications	✓	✓	✓	✓	✓	✓	✓
Sarah Phillips	Medical Director (from 10 April 2017)	✓	✓	✓	✓	✓	✓	✓
Lesley Strong	Chief Operating Officer/ Deputy Chief Executive	✓	✓	✓	✓	✓	✓	✓
Ali Strowman	Chief Nurse	✓	✓	✓	✓	✓	×	✓

Audit and Risk Committee

		May 17	Sept 17	Nov 17	Feb 18
David Griffiths	Chair	N/A	N/A	N/A	N/A
Paul Bentley	Chief Executive	N/A	N/A	N/A	N/A
Peter Conway	Non-executive Director (Chair)	✓	✓	✓	✓
Richard Field	Non-executive Director	×	×	✓	✓
Bridget Skelton	Non-executive Director	✓	✓	✓	✓
Gordon Flack	Director of Finance	✓	✓	✓	✓

Finance, Business and Investment Committee

		Apr 17	May 17	Jun 17	Jul 17	Sep 17	Oct 17	Nov 17	Jan 18	Feb 18	Mar 18
David Griffiths	Chair	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Paul Bentley	Chief Executive	×	×	×	✓	×	×	✓	✓	×	×
Peter Conway	Non-executive Director	✓	N/A	✓	N/A	✓	N/A	✓	✓	✓	N/A
Richard Field	Non-executive Director (Chair)	✓	✓	✓	✓	✓	✓	✓	×	✓	✓
Steve Howe	Non-executive Director	N/A	N/A	✓	N/A	N/A	N/A	✓	N/A	N/A	✓
Bridget Skelton	Non-executive Director	✓	×	✓	✓	✓	✓	✓	✓	✓	✓
Jennifer Tippin	Non-executive Director	✓	✓	✓	✓	×	×	✓	×	✓	×
Gordon Flack	Director of Finance	✓	✓	✓	×	✓	✓	✓	✓	✓	✓
Lesley Strong	Chief Operating Officer/Deputy Chief Executive	✓	✓	✓	✓	✓	✓	✓	✓	×	✓

Charitable Fund Committee

		April 17	Oct 17	Jan 18
David Griffiths	Chair	N/A	N/A	N/A
Paul Bentley	Chief Executive	N/A	N/A	N/A
Jennifer Tippin	Non-executive Director (Chair)	✓	×	✓
Richard Field	Non-executive Director	✓	✓	×
Gordon Flack	Director of Finance	×	×	✓
Lesley Strong	Chief Operating Officer/Deputy Chief Executive	×	✓	✓

Quality Committee

		Apr 17	May 17	Jun 17	Jul 17	Sep 17	Oct 17	Nov 17	Dec 17	Feb 18	Mar 18
David Griffiths	Chair	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Paul Bentley	Chief Executive	✓	×	✓	×	✓	×	×	×	×	✓
Pippa Barber	Non-executive Director	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Richard Field	Non-executive Director	N/A	N/A	N/A	N/A	✓	N/A	N/A	N/A	N/A	✓
Steve Howe	Non-executive Director (Chair)	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
David Robinson	Non-executive Director (to 30 Sept 2017)	✓	✓	✓	✓	✓	N/A	N/A	N/A	N/A	N/A
Arokia Antonysamy	Acting Medical Director (to 9 April 2017)	✓	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Louise Norris	Director of Workforce, Organisational Development and Communications	✓	×	×	×	N/A	N/A	N/A	N/A	N/A	N/A
Sarah Phillips	Medical Director (from 10 April 2017)	N/A	✓	×	✓	✓	✓	✓	✓	✓	×
Lesley Strong	Chief Operating Officer/ Deputy Chief Executive	✓	×	✓	✓	✓	✓	✓	✓	✓	×
Ali Strowman	Chief Nurse	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓

Strategic Workforce Committee

		Nov 17	Jan 18	Mar 18
David Griffiths	Chair	N/A	N/A	N/A
Paul Bentley	Chief Executive	N/A	N/A	N/A
Bridget Skelton	Non-executive Director (Chair)	✓	✓	✓
Pippa Barber	Non-executive Director	✓	×	✓
Peter Conway	Non-executive Director	×	✓	×
Richard Field	Non-executive Director	×	×	✓
Steve Howe	Non-executive Director	✓	✓	×
Jennifer Tippin	Non-executive Director	×	×	✓
Louise Norris	Director of Workforce, Organisational Development and Communications	✓	✓	✓
Sarah Phillips	Medical Director (from 10 April 2017)	✓	✓	×
Lesley Strong	Chief Operating Officer/Deputy Chief Executive	✓	✓	×
Ali Strowman	Chief Nurse	✓	×	✓

Directors' report: Compliance statements

The directors' register of interests is available on the trust's website at www.kentcht.nhs.uk

The trust has in place a major incident plan that is fully compliant with the requirements of the NHS England Preparedness, Resilience and Response Framework 2015. The trust regularly participates in exercises and training with public sector partners.

The trust's internal auditor produces an annual internal audit plan, which reviews the economy, efficiency and effectiveness of resources. The work programme is agreed and monitored by the Audit and Risk Committee.

The Board and Council of Governors comply with the Fit and Proper Person's test.

The trust complies with the better payment practice code (BPPC), which requires NHS organisations to pay all creditors within 30 days of receiving goods or a valid invoice (whichever is later) unless other payment terms have been agreed.

The trust's compliance with the BPPC for 2017-18 is set out here:

Better payment practice code

	2017-18 Number	2017-18 £000s
Non-NHS payables		
Total non-NHS trade invoices paid in the period	36,895	54,718
Total non-NHS trade invoices paid within target	36,529	54,109
Percentage of non-NHS trade invoices paid within target	99.01%	98.89%
NHS payables		
Total NHS trade invoices paid in the period	1,810	13,780
Total NHS trade invoices paid within target	1,741	13,046
Percentage of NHS trade invoices paid within target	96.19%	94.67%
Total		
Total non-NHS and NHS trade invoices paid in the period	38,705	68,498
Total non-NHS and NHS trade invoices paid within target	38,270	67,155
Percentage of non-NHS and NHS trade invoices paid within target	98.88%	98.0%

The trust is also a signatory of the prompt payment code (PPC), which sets standards for payment practices and best practice and is administered by the Chartered Institute of Credit Management.

The trust has had regard to NHS Improvement's quality governance framework in arriving at its overall evaluation of the organisation's performance, internal control and board assurance framework and a summary of action plans to improve the governance of quality. The trust's Quality report is included as an Appendix to this annual report. The aim of the report is to improve public accountability for the quality of care.

So far as the Board is aware, there is no relevant audit information of which the trust's auditor is unaware. All members of the Board have taken the steps that they ought to have to make themselves aware of any relevant audit information and to establish that the trust's auditor is aware of that information.

The directors consider the annual report and accounts, taken as a whole, to be fair, balanced and understandable providing the information necessary for patients, regulators and stakeholders to assess the NHS foundation trust's performance, business model and strategy.

Council of Governors

Elected public governors as at 31 March 2018

Ashford
John Fletcher

Canterbury
Mary Straker

Dartford
Gary Frost
(until May 2017, vacancy until 31 March 2018)

Dover/Deal
Carol Coleman

Gravesham
Pete Sutton

Maidstone
David Price

Sevenoaks
Jo Naismith

Shepway
Jo Clifford

Swale
Amanda Green
(Until to Feb 2018, vacancy until 31 March 2018)

Thanet
Jane Hetherington

Tonbridge and Malling
Sue Stephens

Tunbridge Wells
Mike Mackenzie
(Until June 2017, vacancy until 31 March 2018)

Rest of England
Anthony Moore

Elected staff governors

Dr Mark Johnstone
(Until November 2017, vacancy until 31 March 2018)

Lisa Sheratt
(Until November 2017, vacancy until 31 March 2018))

Sonja Bigg

Claire Buckingham

Appointed governors

Universities
Dr Susan Plummer

Public Health
Andrew Scott-Clark

Governors are elected for a period of two or three years.

Elected public governors at 31 March 2018

Membership: Representation, and effectiveness

At the end of March 2018, the trust's membership stood at 12,481. This represents 0.72 per cent of the population of Kent and a slight decrease of 76 members from the previous year.

The trust's aim is to achieve and maintain one per cent of Kent's population as members of the trust, although there is no longer a requirement from NHS Improvement to increase membership by a minimum of one per cent each year.

In July 2017, the trust introduced a new database for managing members, which gives us improved methods of communication to increase member activity and engagement. Areas where we need to increase our numbers to achieve a more representative membership:

- males
- BME and Asian ethnicities
- under 22-year-olds.

Geographical areas we need to increase membership include:

- Dartford
- Gravesham
- Shepway
- Tonbridge and Malling
- Tunbridge Wells.

Members are asked to indicate how they would like to be involved, from responding to questionnaires and commenting on trust leaflets, to being invited to events or simply to receive information from the trust and our partners.

- 7,840 members receive our Community Health magazine by email or post.
- Almost 1,700 want to respond to surveys.
- Nearly 1,100 want to be invited to events or attend working groups.
- 450 want to comment on our leaflets.

In September 2017, we held our second themed event for members, which preceded our Annual General Meeting and Annual Members' Meeting.

As with the themed event we held in 2016-17, we focussed on the myths and facts about diabetes.

We invited KCHFT services that provide care for people living with diabetes to have stalls in our market place, including podiatry, dietetics and health visiting. We also invited partner organisations, such as Carers FIRST and Diabetes UK to participate. A guest speaker from TV programme Fixing Dad talked about his experience of being diagnosed with diabetes.

As well as being sent our quarterly Community Health magazine, members also received information from our partners on topics, such as the Kent and Medway Sustainability and Transformation Partnership (STP) and stroke consultation.

Members were encouraged to be involved by commenting on a review of our end of life strategy and feeding back on the content and design of the trust strategy. We had almost 100 responses to these pieces of work, which resulted in changes to the documents to incorporate the suggestions received.

Targeted invitations were sent to members in areas where Expert Patient Programme courses were about to start. Some members booked places.

Understanding the views of governors and members

The trust has continued to develop and deliver an effective governor induction and a continuing governor development programme, which enables all members of the council to keep up-to-date with service delivery and issues around the STP.

This also ensures they develop their role as governors, representing their constituents in holding the trust to account for its performance. Governors have two full-day development sessions each year, with four morning sessions held before council meetings devoted to any topic of their choice. Attendance is voluntary, but has been consistently high.

A Kent and Medway-wide governor network has been developed and continues to flourish. It means governors in all Kent and Medway foundation trusts learn from best practice and discuss matters of interest to all councils, including the transformation plans. To ensure the best possible and consistent support mechanism, support services staff from all trusts have a developed a productive regular virtual network, with quarterly meetings.

Governors are well supported to gather views from members and the wider public through attending public events, networking with partners and linking into the trust's patient and public engagement.

Engagement with local groups and organisations

The trust intends to expand on our successful events held for public members, with two themed events in 2018-19 talking about care and support for patients and their families with dementia.

KCHFT plans to approach other foundation trusts and voluntary and community organisations to work together on these. This is a great way of reaching the maximum number of members and the public. Follow-up articles and social media posts will be available for people unable to attend.

KCHFT's Engagement Team continues to attend a range of community events and networks, including events for carers, young people, older people, black and minority ethnic people.

We are a member of the Kent-wide physical disability network and Kent and Medway Cancer Collaborative. At these events, members of the team raise awareness of KCHFT's services and encourage people to-sign up as members.

Following on from work in 2016-17 with young people developing the model for the Kent School Health Service, a small focus group was held to help shape the look, feel and content of the school health microsite for our website. The name for the microsite was chosen by young people.

Community involvement continued to grow. Every community hospital had a patient experience group and our volunteers continued to provide a valued service. All volunteers were thanked during National Volunteers Week in June 2017.

In January 2018, an existing volunteer database was transferred to our membership database. This allows our two volunteer service managers to better engage with and record their volunteers' information, including training needs.

KCHFT continues to have an excellent relationship with Healthwatch Kent, meeting quarterly, working jointly on the Kent and Medway Youth Forum and having and representatives on our patient experience group. We also signed a pledge to support the Healthwatch help cards.

Remuneration report

This remuneration report presents information from 1 April 2017 to 31 March 2018.

Annual statement on remuneration

The chief executive's performance against the agreed objectives was discussed. These were met in full and consequently the committee agreed that the 10 per cent earn back should be awarded, the chief executive's salary having been reduced by 10 per cent.

There were no other substantial changes relating to senior managers' remuneration made during the year. No bonuses were paid during 2017-18.

The Council of Governors has not been asked to review the salaries for the chair and non-executive directors.

Senior managers' remuneration policy

Policy on remuneration for executive directors

The Remuneration Committee determines the salaries of the chief executive and the other executive directors by considering market rates. Existing trust very senior manager (VSM) contracts and notice periods of six months follow the VSM guidance from the Department of Health. Notice periods for all very senior managers hired after 1 March 2015 are three months. Notice periods should normally be worked to make sure the NHS receives benefit during the notice period. This could include carrying out special projects and short-term placements.

Pay component	How that component supports the trust's short and long-term strategy	How it operates	Maximum payable
Senior managers are entitled to a basic salary, which is determined by the Remuneration Committee. The rates paid to individual directors are determined by the Remuneration Committee, which takes into account: • qualifications required for the role • spans of responsibility and accountability • performance • market forces.	The trust believes its senior managers should be fairly remunerated for their work. Trust salaries should be competitive and enable the trust to attract and, in due course, retain high-calibre staff. However, salaries should not be overly high and should be positioned in the top quartile of salaries for similar organisations. The Remuneration Committee will reference its salaries to the NHS Providers' survey of executive salaries and independent advice as required.	Salaries are reviewed against external NHS benchmarking and set at the lower end of the upper quartile for similar organisations, taking into account other factors including performance and qualifications. In the case of any salary above £150,000 ministers' views are sought. An earn back scheme is applied to the medical directors salary. Annual salary is reduced by 10% each year. On the achievement of agreed objectives, the earn back is paid. A report is presented to the Remuneration Committee.	
The annual uplift		As described above.	1%
Chief executive earn back	The trust believes the chief executive should be properly remunerated for their work. Trust salaries should be competitive and enable the trust to attract high-calibre staff. However, salaries should not be overly high and should be positioned in the top quartile of salaries for similar organisations. The Remuneration Committee will reference its salaries to the NHS Providers' survey of executive salaries and independent advice as required. Where applicable, views of ministers are sought.	An earn back scheme is applied. Annual salary is reduced by 10% each year. On the achievement of agreed objectives, the earn back is paid.	£15K

Each contract for directors gives the trust the right to deduct from a director's salary, or any other sums owed, any money owed to the trust. If on termination of the appointment the director has taken in excess of their accrued holiday entitlement, the trust will be entitled to recover by way of deduction from any payments due.

No provisions for the recovery of sums paid or for withholding of sums to senior managers have been made in the period. The trust's policy on senior managers' remuneration and its general policy on employees' remuneration differ only, in so far as other staff are on the Agenda for Change or medical and dental pay scales, while directors' pay is determined outside of this framework.

Policy on remuneration for non-executive directors

The remuneration for non-executive directors (NEDs) is set by the Council of Governors. No golden hellos, compensation for loss of office or other remuneration from the trust was received by any of the above during 2017-18. Non-executive members do not receive pensionable remuneration.

The Council of Governors determines the pay for the chair and non-executive directors and, in so doing, takes into account comparative remuneration of other foundation trusts. They are on fixed term, renewable contracts. There is no performance-related pay and no compensation for early termination.

There are three levels of remuneration based on the level of commitment expected of the post holder: Trust chair; chair of Audit and Risk, Quality and Finance, Business and Investment and Strategic Workforce committees; other non-executive directors.

Pay component	Description	Application
Chair basic pay	A spot rate salary £46,500	Trust's chair
Non-executive basic pay	A spot rate salary £13,000	All NEDs
NED committee – chair responsibility	20% uplift	Audit and Risk, Quality and Finance, Business and Investment and Strategic Workforce committee chairs

Service contract obligations

There is one standard contract for all directors, excluding the medical director who is employed on a standard consultant contract. This puts the following obligations on the trust:

- Review performance annually.
- Give reasonable notice of any variation to salary.
- Determine redundancy pay by reference to part XI of the Employment Rights Act 1996. Any redundancy payment will be calculated in accordance with paragraphs 16.8 and 16.9 of the NHS terms and conditions of service handbook.
- Pay appropriate expenses incurred in the course of duties in accordance with the trust's travel and expenses policy.
- Annual leave follows standard NHS terms, likewise sickness.
- The notice period for all executive directors appointed post-April 2015 except the chief executive is three months; Chief Executive has to give six months' notice.
- No executive director is on a fixed-term contract.

Policy on loss of office

- Notice periods as above for resignation chief executive and all directors.
- Payments in lieu of notice are at the discretion of the trust.
- Senior managers' performance is relevant for loss of office when a material element of the business plan has not been delivered and then there can be dismissal without notice.

Setting senior managers remuneration policy

This has been a matter solely for the Remuneration Committee statement of consideration of employment. The pay and conditions of employees, including any other group entities, were not taken into account when setting the remuneration policy for senior managers except senior managers were subject to the same financial restrictions as other staff.

The trust did not consult with employees when preparing the senior managers' remuneration policy. The chief executive confirms the remuneration report covers senior managers who have authority or responsibility for directing or controlling the major activities of the trust. These managers influence decisions of the entity as a whole rather than the decisions of individual directorates or department. This definition includes all executives and the trust secretary.

Annual report on remuneration

Information not subject to audit

Remuneration Committee

The Remuneration Committee is a formal committee of the Board. The purpose of this committee is to advise the Board on all aspects of the remuneration and terms of conditions for the chief executive, executive directors and directors reporting to the chief executive ensuring that these properly support the objectives of the trust represent value for money and comply with statutory requirements.

The committee's members are the non-executive directors of the trust and the committee is chaired by the trust's chair. Between 1 April 2017 and 31 March 2018, there were five meetings of the Remuneration Committee.

Remuneration Committee	Meetings attended 2017-18
David Griffiths	5
Richard Field	5
Peter Conway	4
Steve Howe	5
David Robinson	2
Bridget Skelton	3
Jennifer Tippin	2
Pippa Barber	4

The chief executive and HR director also attend meetings by invitation; however they are not present where matters relating to them are under discussion.

This committee determines the remuneration and conditions of service of the chief executive and other directors and senior managers with Board responsibility who report directly to the chief executive, ensuring these properly support the objectives of the trust, represent value for money and comply with statutory requirements. The committee does not determine the remuneration of the non-executive chair and the non-executive directors, which is set by the Council of Governors.

Service contracts

Executive director service contracts are permanent with the following notice periods:

Senior manager	Date effective	Notice
Paul Bentley Chief Executive Officer	1 March 2016	6 months
Lesley Strong, Chief Operating Officer/Deputy Chief Executive Officer	1 March 2015	6 months
Ali Strowman Chief Nurse	10 October 2016	3 months
Arokia Antonysamy Acting Medical Director from 1 March to 9 April 2017	1 March 2017	3 months
Sarah Phillips Medical Director from 10 April 2017	10 April 2017	3 months
Gordon Flack Director of Finance	1 March 2015	6 months
Natalie Davies Corporate Services Director	1 June 2015	3 months
Louise Norris Director of Workforce, Organisational Development and Communications	7 July 2015	3 months

Non-executive director service contracts are fixed-term with the following unexpired terms as at 31 March 2018:

Senior manager	Date effective	End date	Unexpired term
David Griffiths, Chair	1 March 2017	24 May 2018	2 months
Richard Field, Vice Chair	1 April 2017	31 March 2020	2 years
Peter Conway, Non-executive Director	1 April 2015	31 March 2018	0 months
Steve Howe, Non-executive Director	1 April 2015	31 March 2018	0 months
David Robinson, Non-executive Director (to 30 September 2017)	1 October 2016	30 September 2017	–
Pippa Barber, Non-executive Director	1 December 2016	29 November 2019	1 year, 8 months
Bridget Skelton, Non-executive Director	7 April 2016	6 April 2019	1 year
Jennifer Tippin, Non-executive Director	1 March 2017	29 February 2020	1 years, 11 months

The service contract end date for David Griffiths was 29 February 2020, however he is retiring with effect from 24 May 2018.

Peter Conway and Steve Howe's service contracts expire on 31 March 2018. However their service contracts have been renewed with effect from 1 April 2018 and with an expiry date of 31 March 2021.

Expenses of senior managers and governors

The following expenses were paid to senior managers in the period:

Directors and senior managers	Expenses* (rounded to nearest 100) £00	
	2017-18	2016-17
Paul Bentley, Chief Executive Officer	20	25
Lesley Strong, Chief Operating Officer/Deputy Chief Executive	26	35
Claire Poole, Acting Director of Operations: Children and Young People (to 31 December 2016)	–	37
Nicola Lucey, Director of Nursing and Quality (left 31 August 2016)	–	7
Ali Strowman, Chief Nurse (from 10 October 2016)	19	9
Peter Maskell, Medical Director (left 5 February 2017)	–	27
Arokia Antonysamy, Acting Medical Director (to 9 April 2017)	1	1
Sarah Phillips, Medical Director (from 10 April 2017)	31	–
Gordon Flack, Director of Finance	10	19
Natalie Davies, Corporate Services Director	6	25
Nichola Gardner, Director of Strategy and Transformation (left 17 July 2016)	–	4
Louise Norris, Director of Workforce, Organisational Development and Communications	19	19
David Griffiths, Chair	20	33
Richard Field, Vice Chair	10	12
Peter Conway, Non-executive Director	8	5
Steve Howe, Non-executive Director	14	16
David Robinson, Non-executive Director (left 30 September 2017)	8	7
Pippa Barber, Non-executive Director (from 1 December 2016)	20	6
Bridget Skelton, Non-executive Director	10	7
Jennifer Tippin, Non-executive Director	3	5
Total	**225**	**299**

*Taxable benefits are included within the remuneration table on page 57.

There were a total of 16 executive and non-executive directors in post in the reporting period 2017-18 and all 16 of these received expenses paid by the trust. The aggregate sum of directors' expenses comes to £22,521.

The following expenses were paid to governors in the period:

Governors	Expenses (rounded to nearest 100) £00	
	2017-18	2016-17
Carol Coleman	7	10
David Price	1	2
Gary Frost	–	3
Jack Wise	–	2
Jo Clifford	2	–
John Fletcher	2	–
Kate Wortham	0	10
Mary Straker	0	–
Pete Sutton	2	0
Sue Stephens	3	–
Total	**17**	**27**

There are a total of 21 governor positions. There have been 19 individuals working as governors within the year, with five leaving and one starting in the period.

As at 31 March 2018, there are 14 governors in post, governors have been elected/appointed for the seven vacant positions and are due to start on 1 April 2018.

In the reporting period 2017-18, eight governors received expenses paid by the trust. The aggregate sum of governors' expenses totals £1,738.95.

Information subject to audit

Name and title	2017-18						2016-17					
	Salary and fees	Taxable benefits	Annual performance -related bonuses	Long-term performance -related bonuses	All pension -related benefits	Total	Salary and fees	Taxable benefits	Annual performance -related bonuses	Long-term performance -related bonuses	All pension -related benefits	Total
	(bands of £5,000) £000	(to the nearest £100) £	(bands of £5,000) £000	(bands of £5,000) £000	(bands of £2,500) £000	(bands of £5,000) £000	(bands of £5,000) £000	(to the nearest £100) £	(bands of £5,000) £000	(bands of £5,000) £000	(bands of £2,500) £000	(bands of £5,000) £000
Paul Bentley, Chief Executive Officer	150-155		15-20		0	165-170	150-155		15-20		0	165-170
Lesley Strong, Chief Operating Officer/ Deputy Chief Executive	130-135				17.5-20	145-150	125-130				0-2.5	130-135
Claire Poole, Acting Director of Operations, Children and Young People (from 1 Nov 2015 to 31 Dec 2016)							70-75	1,500			75-77.5	150-155
Nicola Lucey, Director of Nursing and Quality (left 31 Aug 2016)							45-50				10-12.5	60-65
Ruth Herron, Acting Director of Nursing (from 1 Sept 2016 to 9 Oct 2016)							5-10				5-7.5	15-20
Ali Strowman, Chief Nurse (from 10 Oct 2016)	120-125				172.5-175	290-295	50-55				77.5-80	125-130
Peter Maskell, Medical Director (left 5 Feb 2017)							135-140				0	135-140
Arokia Antonysamy, Acting Medical Director (from 1 Mar to 9 Apr 2017)	0-5				0	0-5	5-10				2.5-5	10-15
Sarah Phillips, Medical Director (from 10 Apr 2017)	145-150		5-10		0	150-155						
Gordon Flack, Director of Finance	135-140	2,200			97.5-100	235-240	125-130	6,700			137.5-140	270-275
Natalie Davies, Corporate Services Director	90-95				30-32.5	120-125	90-95				32.5-35	125-130
Nichola Gardener, Director of Strategy and Transformation (left 17 Jul 2016)							25-30				10-12.5	35-40
Louise Norris, Director of Workforce, Organisational Development and Communications	110-115				15-20	125-130	110-115				35-37.5	145-150

Information subject to audit

Name and title	2017-2018						2016-17					
	Salary and fees	Taxable benefits	Annual performance -related bonuses	Long-term performance -related bonuses	All pension -related benefits	Total	Salary and fees	Taxable benefits	Annual performance -related bonuses	Long-term performance -related bonuses	All pension -related benefits	Total
	(bands of £5,000) £000	(to the nearest £100) £000	(bands of £5,000) £000	(bands of £5,000) £000	(bands of £2,500) £000	(bands of £5,000) £000	(bands of £5,000) £000	(to the nearest £100) £000	(bands of £5,000) £000	(bands of £5,000) £000	(bands of £2,500) £000	(bands of £5,000) £000
David Griffiths, Chair	45-50	1,900				45-50	45-50	2,300				45-50
Richard Field, Vice chair	15-20	1,000				15-20	15-20	1,200				15-20
Peter Conway, Non-executive director	15-20	800				15-20	15-20	500				15-20
Steve Howe, Non-executive director	15-20	1,400				15-20	15-20	1,600				15-20
David Robinson, Non-executive director (left 30 Sept 2017)	5-10	800				5-10	10-15	700				10-15
Catherine Gaskell, Non-executive director (left 6 Apr 2016)							0-5					0-5
Pippa Barber, Non-executive director (from 1 Dec 2016)	10-15	2,000				15-20	0-5	600				0-5
Bridget Skelton, Non-executive director	10-15	800				10-15	10-15	700				10-15
Jennifer Tippin, Non-executive director	10-15	300				10-15	10-15	500				10-15

During the period 1 April 2017 to 31 March 2018 there was one change in personnel of the Executive Team; Dr Sarah Phillips joined the trust as medical director on 10 April 2017. Dr Arokia Antonysamy was acting medical director to cover this role before Sarah's start.

The annual performance-related bonuses awarded to the chief executive officer and medical director outlined in the table, have been granted in line with the chief executive earn back and earn back scheme applied to the medical director's salary. Annual salary is reduced by 10 per cent each year, and achieving agreed objectives the earn back is paid.

The trust remunerates Dr Sarah Phillips solely for her management role, as she does not have a patient-facing role with the trust.

No payments were made for loss of office or to past senior managers in the period.

Pension benefits

Name and title	Real increase in pension at pension age (bands of £2,500) £000	Real increase in pension lump sum at pension age (bands of £2,500) £000	Total accrued pension at pension age at 31.03.18 (bands of £5,000) £000	Lump sum at pension age related to accrued pension at 31.03.18 (bands of £5,000) £000	Cash equivalent transfer value at 01.04.17 £000	Cash equivalent transfer value at 31.03.18 £000	Real increase in cash equivalent transfer value £000	Employer's contribution to stakeholder pension £000
Paul Bentley, Chief Executive Officer	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Lesley Strong, Chief Operating Officer/Deputy Chief Executive	0-2.5	2.5-5	65-70	195-200	N/A	N/A	N/A	N/A
Ali Strowman, Chief Nurse (from 10 Oct 2016)	7.5-10	17.5-20	35-40	85-90	391	527	132	N/A
Arokia Antonysamy, Acting Medical Director (from 1 Mar 2017 to 9 Apr 2017)	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Sarah Phillips, Medical Director (from 10 Apr 2017)	0-2.5	0	10-15	25-30	171	177	4	N/A
Gordon Flack, Director of Finance	5-7.5	15-17.5	55-60	170-175	980	1,151	161	N/A
Natalie Davies, Corporate Services Director	0-2.5	0-2.5	25-30	60-65	309	356	43	N/A
Louise Norris, Director of Workforce, Organisational Development and Communications	0-2.5	2.5-5	40-45	130-135	816	901	76	N/A

Any data expressed as n/a in the above tables is not applicable. The chief executive officer is a deferred member of the NHS pension scheme.

No figures are reported for Arokia Antonysamy as the information had not been received from NHS pensions at the time of reporting.

As non-executive members do not receive pensionable remuneration, there are no entries in respect of pensions for non-executive members.

Cash equivalent transfer values

A cash equivalent transfer value (CETV) is the actuarially assessed capital value of the pension scheme benefits accumulated by a member at a particular point in time. The benefits valued are the member's accumulated benefits and any contingent spouse's pension payable from the scheme. CETVs are calculated within the guidelines and framework prescribed by the Institute and Faculty of Actuaries.

A CETV is a payment made by a pension scheme or arrangement to secure pension benefits in another pension scheme or arrangement when the member leaves a scheme and chooses to transfer the benefits accrued in their former scheme. The pension figures shown relate to the benefits that the individual has accrued as a consequence of their total membership of the pension scheme, not just their service in a senior capacity to which disclosure applies. The CETV figures and the other pension details include the value of any pension benefits in another scheme or arrangement, which the individual has transferred to the NHS pension scheme. They also include any additional pension benefit accrued to the member as a result of their buying additional years of pension service in the scheme at their own cost. CETV figures are only applicable up to the normal pension age (NPA). NPA is age 60 in the 1995 section, age 65 in the 2008 section, or state pension age (SPA) or age 65, whichever is the later in the 2015 Scheme.

Real Increase in CETV

This reflects the increase in CETV effectively funded by the employer. It does not include 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.

Inflation figure applied to calculate real increases to pensions, lump sums and CETVs over the period

The inflation applied to the accrued pension, lump sum and CETV is the percentage, if any, by which the consumer prices index (CPI) for September before the start of the tax year is higher than it was for the previous September.

For 2017-18, the difference in CPI between September 2015 and September 2016 was one per cent. For calculation purposes, the trust has used an inflation rate assumption of one per cent to calculate real increases to pensions, lump sums and CETVs over the period.

The trust considers this an appropriate inflation figure to be used in calculations as Greenbury pension guidance lists it as value of the consumer price index.

Fair pay multiple

Reporting bodies are required to disclose the relationship between the remuneration of the highest paid director in their organisation and the median remuneration of the organisation's workforce.

The banded remuneration of the highest paid director in Kent Community Health NHS Foundation Trust in the financial year 2017-18 was £165k-£170k (2016-17, £165k-170k).

This was 6.5 times (2016-17, 6.6 times) the median remuneration of the workforce, which was £26k (2016-17, £25k). The decrease in the fair pay multiple is due to the slight increase in median salary.

In 2017-18, no employee (2016-17, one employee) received remuneration in excess of the highest-paid director.

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

Signed: ..... Date: 24/5/2018

Paul Bentley, Chief Executive Officer (on behalf of the Board)

Staff report

This year we developed our People Strategy, a five-year plan, to create an organisation where staff feel empowered to act in line with our values and to recognise the contribution we make to health and wellbeing, as well as building our reputation as a top employer.

As part of this plan, we launched our new managers' induction programme; saw the introduction of standing desks in response to staff feedback to support their wellbeing and the development of our very own fitness programme.

During 1 April 2017 – 31 March 2018

- Overall, we exceeded our mandatory training target of 85 per cent, achieving 94.8 per cent.
- Sickness absence was above our 3.9 per cent target at 4.36 per cent.
- Unplanned turnover exceeded our eight per cent target at 15.5 per cent for the year. It is a key priority for us and we are working with NHS Improvement on its retention programme to consider additional solutions to address this.
- We did not reach our target of a less than five per cent vacancy rate, at 11.6 per cent, but we have a robust recruitment and retention plan; regularly monitored at senior level in the organisation. This will also be impacted by the changes we make as a result of the NHS Improvement programme.

Staff sickness absence

	2017-18	2016-17
Total working days lost	39,608	40,161
Total staff years	4,038	4,310
Average days lost	10	9

The above staff sickness data is provided centrally by NHS Digital using the statistics held within the ESR (electronic staff record) data warehouse. The data is based on the 2017 calendar year and represents a full year for comparison purposes.

The Department of Health and Social Care considers the resulting figures to be a reasonable proxy for financial year equivalents. To further aid consistency, the trust has also reconciled the centrally provided data to its own underlying local data.

The gender distribution of our workforce at 31 March 2018 is:

FTE	Female	Male	Total	% Female	% Male	% Total
Directors	5.00	2.00	7.00	71.43%	28.57%	100.00%
Employees	3368.13	442.73	3810.86	88.38%	11.62%	100.00%
Senior managers	34.47	10.80	45.27	76.14%	23.86%	100.00%
Grand total	3407.60	455.53	3863.13	88.21%	11.79%	100.00%

Staff costs

	Permanent £000	Other £000	2017-18 Total £000	2016-17 Total £000
Salaries and wages	117,238	3,778	**121,016**	125,187
Social security costs	9,958	235	**10,193**	10,380
Apprenticeship levy	582	–	**582**	–
Employer's contributions to NHS pensions	15,305	271	**15,576**	16,104
Pension cost – other	12	1	**13**	13
Other post employment benefits	–	–	**–**	–
Other employment benefits	–	–	**–**	–
Termination benefits	1,319	–	**1,319**	115
Temporary staff – agency/contract staff		4,246	**4,246**	7,947
Total gross staff costs	**144,414**	**8,531**	**152,945**	**159,746**
Recoveries in respect of seconded staff	(13)	–	**(13)**	(54)
Total staff costs	**144,401**	**8,531**	**152,932**	**159,692**
Of which Costs capitalised as part of assets	16	72	**88**	3

Average number of employees (WTE basis)

	Permanent number	Other number	2017-18 Total number	2016-17 Total number
Medical and dental	83	5	**88**	68
Ambulance staff	–	–	**–**	–
Administration and estates	1,304	48	**1,352**	1,379
Healthcare assistants and other support staff	774	57	**831**	889
Nursing, midwifery and health visiting staff	1,129	63	**1,192**	1,366
Nursing, midwifery and health visiting learners	20	–	**20**	27
Scientific, therapeutic and technical staff	679	20	**699**	747
Healthcare science staff	–	–	**–**	–
Social care staff	13	–	**13**	18
Other	–	–	**–**	–
Total average numbers	**4,002**	**193**	**4,195**	**4,494**
Of which: Number of employees (WTE) engaged on capital projects	1	1	**2**	–

Reporting of compensation schemes – exit packages 2017-18

	Number of compulsory redundancies number	Number of other departures agreed number	Total number of exit packages number
Exit package cost band (including any special payment element)			
<£10,000	18	19	**37**
£10,001-£25,000	23	2	**25**
£25,001-50,000	15	–	**15**
£50,001-£100,000	4	–	**4**
£100,001-£150,000	–	–	**–**
£150,001-£200,000	–	–	**–**
>£200,000	–	–	**–**
Total number of exit packages by type	**60**	**21**	**81**
Total resource cost (£)	£1,319,000	£116,000	**£1,435,000**

Reporting of compensation schemes – exit packages 2016-17

	Number of compulsory redundancies number	Number of other departures agreed number	Total number of exit packages number
Exit package cost band (including any special payment element)			
<£10,000	3	11	**14**
£10,001-£25,000	2	1	**3**
£25,001-50,000	2	–	**2**
£50,001-£100,000	–	–	**–**
£100,001-£150,000	–	–	**–**
£150,001-£200,000	–	–	**–**
>£200,000	–	–	**–**
Total number of exit packages by type	**7**	**12**	**19**
Total resource cost (£)	£115,000	£38,000	**£153,000**

	2017-18		2016-17	
	Payments agreed number	Total value of agreements number	Payments agreed number	Total value of agreements number
Exit packages: other (non-compulsory) departure payments				
Voluntary redundancies including early retirement contractual costs	–	–	–	–
Mutually agreed resignations (MARS) contractual costs	–	–	–	–
Early retirements in the efficiency of the service contractual costs	–	–	–	–
Contractual payments in lieu of notice	21	116	**12**	38
Exit payments following employment tribunals or court orders	–	–	–	–
Non-contractual payments requiring HMT approval				
Total	**21**	**116**	**12**	**38**
Of which: Non-contractual payments requiring HMT approval made to individuals where the payment value was more than 12 months' of their annual salary	–	–	–	–

Expenditure on consultancy

Consultancy expenditure was £429K for the year.

	Number of engagements
All off-payroll engagements, as of 31 March 2018, for more than £245 per day and that last for longer than six months	
Number of existing engagements as of 31 March 2018	0
Of which…	
Number that have existed for less than one year at time of reporting	0
Number that have existed for between one and two years at time of reporting	0
Number that have existed for between two and three years at time of reporting	0
Number that have existed for between three and four years at time of reporting	0
Number that have existed for four or more years at time of reporting	0

	Number of engagements
All new off-payroll engagements, or those that reached six months in duration, between 1 April 2017 and 31 March 2018, for more than £245 per day and that last for longer than six months	
Of which…	
Number of new engagements, or those that reached six months in duration, between 1 April 2017 and 31 March 2018	0
Number assessed as within the scope of IR35	0
Number assessed as not within the scope of IR35	0
Number engaged directly (via PSC contracted to trust) and are on the trust's payroll	0
Number of engagements reassessed for consistency/assurance purposes during the year	0
Number of engagements that saw a change to IR35 status following the consistency review	0

	Number of engagements
All off-payroll engagements of board members, and/or, senior officials with significant financial responsibility, between 1 April 2017 and 31 March 2018	
Number of off-payroll engagements of board members, and/or, senior officials with significant financial responsibility, during the financial year	0
Number of individuals that have been deemed 'board members and/or senior officials with significant financial responsibility' during the financial year. This figure must include both off-payroll and on-payroll engagements	16

Health and safety performance

The trust fully meets all its obligations under the Health and Safety at Work Act 1974 and various associated regulations.

The trust has a Health and Safety Committee, which reports to the Corporate Assurance and Risk Management Group. Fire safety, security, estates and moving and handling report into the Health and Safety Committee to provide assurance of compliance with safety legislation.

During 2017-18, the trust received one Health and Safety Executive (HSE) improvement notice (Control of Substances Hazardous to Health Regulations 2002 Regulation 11(1) – health surveillance. There were no prosecutions or fees for Interventions.

The trust reported 14 incidents, which fell under the requirements of the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 2013 (RIDDOR). All these reports were submitted to the HSE within the required legal timeframes.

The trust's approach to health and safety is documented in the health and safety policy and other associated policies/strategies available on the staff intranet.

Occupational health

PAM is our occupational health provider. The service is accessed via a referral by a manager. PAM also provides the staff counselling service. The trust's approach to occupational health is documented in its occupational health and associated, policies, available on its staff intranet.

Counter fraud

The trust's counter fraud specialists provide professional expertise to tackle fraud, corruption and bribery and operate in a national legal framework for tackling fraud, corruption and bribery. All work was completed in accordance with legal standards and in compliance with guidance provided by NHS Protect, which ceased to exist from November 2017. It was replaced by the NHS Counter Fraud Authority. The trust's approach to counter fraud is documented in its counter fraud, corruption and bribery policy.

Equality and diversity

As an inclusive employer, the trust is committed to ensuring equality of access to employment, career development and training and the application of human rights for all staff.

This approach is set out in the trust's equality and diversity policy, which give full and fair consideration to disabled applicants and continuing support to staff who become disabled.

In 2017-18, our Workforce Equality Group developed guidance for managers and staff on implementing reasonable adjustments and we are piloting training on unconscious bias.

Equality is written into the trust's values framework. It ensures all our staff receive training in the subject, it uses equality analysis and equality and diversity is embedded into trust policies.

Additionally, we use the Equality Delivery System 2 to record and evidence the work we do and publish equality objectives annually on our website. Staff networks promote and support staff from a BME background, LGBTQ, disabled and who have religious beliefs.

Freedom to speak up

The trust has had a freedom to speak up guardian (FTSU) in post for more than 12 months, who has a key role in fostering a culture of openness.

A campaign to promote the benefits of speaking up ran throughout the year and included a range of promotional materials, such as postcards, badges, film and posters. It included ways to get in touch, such as the dedicated email and phone line for colleagues to report their concerns, and how the FTSU guardian can help.

Between 1 April 2017 and 31 March 2018, the FTSU guardian logged and was involved in 28 cases. Themes of the cases were discussed with the chief executive and a six monthly report is presented to the Audit and Risk Committee.

The guardian also made sure senior managers were aware freedom to speak up and its importance by presenting to Management Committee, at the Council of Governors and in team meetings.

In August, the trust started to develop a freedom to speak up ambassadors' programme and there are now 16 ambassadors across the trust. Their role includes encouraging colleagues to speak up, by providing informal advice, sign-posting and promoting positive examples of changes that have occurred as a result of speaking up.

The trust was visited by the National Guardian, Dr Henrietta Hughes in December who was impressed with our campaign and commitment to freedom to speak up.

Communication with staff

Our Communications and Marketing Team has a successful track record of delivering improved communications for staff.

The trust has good communication and engagement channels and mechanisms for gaining feedback and involving patients and staff in shaping our services. We value our staff – our most important asset.

We recognise the challenges that they face and we want them to feel listened to and involved and create a culture of openness, trust and accountability. Research has shown that a more engaged workforce results in better patient care.

Our now double award-winning social intranet, flo can be accessed by all our staff. It ensures that colleagues working in different departments can talk to each other and can make cross-service referrals, as well as give colleagues working in different geographical areas the opportunity to share best practice via workspaces.

The site receives around 115,000 page views every month, with the most visited area, our 'how to' guides, with an average of 12,000 monthly visits. We have more than 40 new blog posts every month with the reach and engagement continuing to grow. Discussions in forums are also increasing.

We produce a digital weekly round-up of what is happening in the organisation, flo mail, which is shared with all trust colleagues and our governors. We also produced a monthly Team Brief for managers to use in meetings to cascade key messages, plus add their own service specific news.

Our #yesyoucan roadshow, led by the Executive Team, which aims to seek ideas to deliver more power and authority to frontline staff continues, with future campaigns planned to encourage staff to embrace devolved power, where appropriate.

Communications support played an integral role in launching the We care review programme and making sure staff understood what it was and how they could get involved.

Our quarterly magazine Community Health – featuring case studies of good outcomes – has an opportunity to see for each edition of up to 117,000 according to industry data. It is available to staff, as well as the public.

Many of our staff also engage on our established social media profiles on Facebook, Twitter and YouTube. We have 5,470 followers on Facebook and 3,554 Twitter followers. Our videos on YouTube and Vimeo have been viewed more than 100,000 times.

The Executive Team holds regular staff engagement events and the trust also has a Staff Partnership Forum, which meets monthly. More information can be found in the trust's communication and engagement strategy published at www.kentcht.nhs.uk.

NHS Staff Survey summary of performance

Of the 4,801 questionnaires sent out, 2,953 staff surveys were returned. The response rate for the trust was 62 per cent in 2017, which is above average when compared to other community trusts.

	Key finding			
	Trust score 2017	**Trust score 2016**	**National 2017 average for community trusts**	**Trust improvement/ deterioration**
KF21. Percentage of staff believing that the organisation provides equal opportunities for career progression or promotion	92%	92%	88%	No change
KF27. Percentage of staff/colleagues reporting most recent experience of harassment, bullying or abuse.	57%	55%	53%	No change
KF30. Fairness and effectiveness of procedures for reporting errors, near misses and incidents	3.87	3.85	3.81	No change
KF29. Percentage of staff reporting errors, near misses or incidents witnessed in the last month	95%	94%	93%	No change
KF16. Percentage of staff working extra hours	68%	67%	71%	No change

	Key finding			
	Trust score 2017	**Trust score 2016**	**National 2017 average for community trusts**	**Trust improvement/ deterioration**
KF31. Staff confidence and security in reporting unsafe clinical practice	3.72	3.74	3.80	No change
KF23. Percentage of staff experiencing physical violence from staff in past 12 months.	1%	1%	1%	No change
KF3. Percentage of staff agreeing their role makes a difference to patients/service users	89%	90%	90%	No change
KF13. Quality of non-mandatory training, learning or development	4.03	4.04	4.08	No change
KF1. Staff recommendation of the organisation as a place to work or receive treatment	3.70	3.72	3.76	No change

In 2017-18, the Board agreed all directorates should focus on key findings bottom ranking scores and where there had been a decline from the 2016 scores.

In addition, it agreed the focus should be around engagement and a cultural shift to ensure the trust's values were translated into management and leadership actions.

Key finding	2016	2017	Ranking	Change
Staff recommendation of the organisation as a place to work or receive treatment	3.72	3.70	Average (2016 average)	No change
Staff motivation at work	3.93	3.92	Average (2016 average)	No change
Percentage of staff able to contribute towards improvements at work	69%	70%	Average (2016 average)	No change

While no areas decreased, disappointingly none of the actions taken had a positive impact on the scores. Each locality and directorate has been asked to analyse specific findings and develop an action plan to address key areas of concern where they are below the national average.

Our plan includes presenting key findings and monitoring developed action plans to key groups, such as the Strategic Workforce Committee and Management Committee.

At a corporate level, the focus will be on improving staff engagement and involvement to increase the overall engagement score. Quarterly, we will measure whether actions are having an impact via the staff family and friends test, with added questions measuring engagement.

Management Committee will look at actions that can be taken corporately and at a local level to improve communication and staff involvement in decision-making. An example is a campaign planned for 2018-19 to re-energise team meetings and improve communication flow to the front line.

A refer a friend proposal is being considered too, together with what actions need to be taken to have a positive impact on:

- staff recommending the organisation as a place to work or receive treatment
- the percentage of staff agreeing their role makes a difference to patients
- staff confidence and security in reporting unsafe clinical practice.

Overall, the survey findings for 2017 are positive given service changes that were implemented during 2017-18. There was a real improvement in relation to staff's perception of their managers. Our engagement score stayed the same.

It is important we continue to strive to improve all scores; that there is ownership of actions and these are followed through so staff understand what they have to say does matter and that as a trust we listen and we act on feedback.

NHS Foundation Trust Code of Governance

Kent Community Health NHS Foundation Trust has applied the principles of the NHS Foundation Trust Code of Governance on a comply or explain basis. The NHS Foundation Trust Code of Governance, most recently revised in July 2014, is based on the principles of the UK Corporate Governance Code, issued in 2012.

This table of disclosures is required so the trust complies with the requirements of the code of governance.

Disclosure relating to	NHS Improvement Code of Governance reference	Kent Community Health NHS Foundation Trust disclosure
Board and Council of Governors	A.1.1	The trust's Board meets 12 times per year and also attends five strategy and development days. The trust's Board meets formally in public every two months. There are approved standing orders, standing financial instructions and a scheme of delegation in place. The annual governance statement describes the role of each of the Board's committees. The trust's constitution sets out how disagreements between the council and the Board would be resolved; the chair, as chair of both bodies, would initially seek to resolve the disagreement, if this is not successful, a joint committee of governors and directors would be established. If this committee's recommendations were unable to resolve the dispute, the Board would make a final decision. A referral to NHS Improvement or other external body might also be considered. There has been no requirement to activate this process during 2017-18.
Board, Nomination Committee(s), Audit and Risk Committee, Remuneration and Terms of Service Committee	A.1.2.	This annual report describes the roles and responsibilities of the Board on pages 31. The number of Board and committee meetings and a record of attendance are found on pages 39.
Council of Governors	A.5.3	Page 44 of this annual report identifies the members of the Council of Governors, the lead governor and their respective constituencies. The council has formally met four times. It is due to continue formal quarterly meetings.

Board	B.1.1	The directors of the trust all meet the required independence criteria set out by NHS Improvement. The directors are identified on page 29 of this annual report. All material pecuniary and non-pecuniary interests are declared and reported as per the trust's policy and regularly reported to the Board. They are also included in this annual report at page 43.
Board	B.1.4	The biographies of Board members are included in this report on pages 31 to 38. The Board has completed a self-assessment and considers that the skills and experience of the members gives an appropriate balance in order to effectively conduct its business. This is reviewed continually through the Nominations Committee.
Nominations Committee(s)	B.2.10	The Nominations Committee is a committee of the council, which is designed to consider the appointment or removal, succession planning and process for appraisal for non-executive directors. The committee does this by reviewing the overall balance and skills of all the non-executive directors and makes recommendations to the council for consideration. The Nominations Committee sat three times in the past year.
Chair/Council of Governors	B.3.1.	The job specification for the trust's chair defines the role and capabilities required and the expected time commitment. The chair's other significant responsibilities are outlined in his biography on page 31 of this annual report. The Nominations Committee will oversee future appointments, as required.
Council of Governors	B.5.6	Mechanisms for canvassing members continue to develop. Election of governors – there is a process for electing new governors, which is conducted by an external election company (Election Reform Services). In the past 12 months, there were two public elections. The council now consists of 13 publicly elected governors and four staff elected governors. The rest of the council consists of two appointed governors. All have been to one formal meeting of the council during the past 12 months.
Board	B.6.1	The trust commissioned Deloitte to do an external governance review focussing on the well-led domain. The report was positive and identified actions have been completed or scheduled for completion. The Board is assessed for effectiveness and individual effectiveness assessments of Board members are conducted as part of the appraisal process. The Board collectively assesses its effectiveness after every formal meeting.
Board	B6.2	The Audit and Risk Committee takes responsibility for oversight of the governance process. It achieves this through internal audit, external audit, deep dives and the assessment of the risk profile of the organisation.
Board	C.1.1	The statement of the directors' responsibilities for the annual report and accounts is on page 43.
Board	C.2.1	This is covered in the annual governance statement included in this annual report.

Audit Committee/ Control Environment	C.2.2	This is covered in the annual governance statement included in this annual report. The independent auditor's report is on page 95.
Audit Committee/ Council of Governors	C.3.5	This information is included in the trust's annual governance statement, included in this report.
Audit Committee	C.3.9	This information is included in the trust's annual governance statement, included in this report.
Board/ Remuneration Committee	D.1.3	None of the trust's executive directors are released to serve on external appointments, such as non-executive directorships elsewhere.
Board	E.1.5	The members of the Board and, in particular the non-executive directors, will attend meetings of the Council of Governors, as and when required, to develop an understanding of the views of the council and the trust's members about the organisation. The Board will take account of surveys and consultations canvassing the opinion of the membership.
Board/ Membership	E.1.6	There will soon be a trust membership strategy. The methodology for NHS monitoring of effective member engagement and how representative it is of the community the trust serves is included in the communications and engagement strategy. The council has established a Membership Committee to discharge this responsibility.
Membership	E.1.4	The trust's corporate services director oversees compliance with this requirement. The governors of the trust can be contacted by: email: kcht.governors@nhs.net phone 01622 211972 Post: Governor Support Office Kent Community Health NHS Foundation Trust The Oast Unit D Hermitage Court Hermitage Lane Barming Maidstone Kent ME16 9NT

NHS Improvement's Single Oversight Framework

Single Oversight Framework

NHS Improvement's Single Oversight Framework provides the framework for overseeing providers and identifying potential support needs. The framework looks at five themes:

- quality of care
- finance and use of resources
- operational performance
- strategic change
- leadership and improvement capability (well-led).

Based on information from these themes, providers are segmented from one to four, where four reflects providers receiving the most support, and one reflects providers with maximum autonomy. A foundation trust will only be in segments three or four where it has been found to be in breach or suspected breach of its licence.

The Single Oversight Framework applied from quarter 3 of 2016-17. Before this, Monitor's Risk Assessment Framework (RAF) was in place. Information for the previous year and first two quarters of 2016-17 relating to the RAF has not been presented as the basis of accountability was different. This is in line with NHS Improvement's guidance for annual reports.

Segmentation

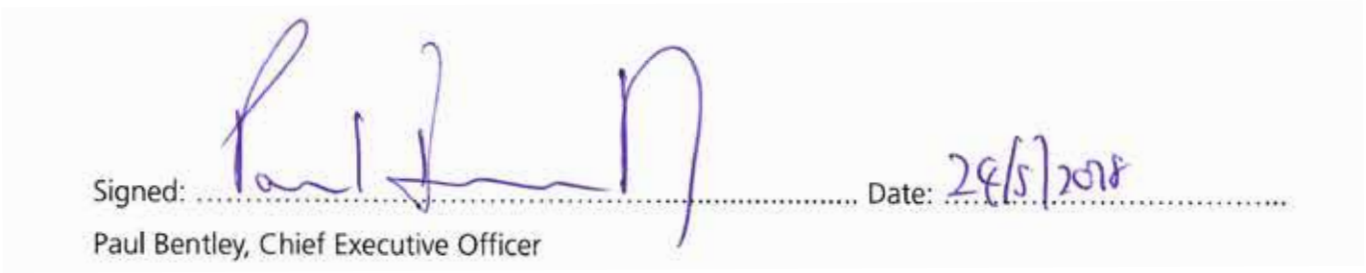
The latest segmentation information available, as at 31 March 2018, places KCHFT in segment one, which is the top scoring segment.

Current segmentation information, including descriptions of each segment classification, for NHS trusts and foundation trusts is published on the NHS Improvement website.

Finance and use of resources

The finance and use of resources theme is based on the scoring of five measures from one to four, where one reflects the strongest performance. The scores are then weighted to give an overall score. The results for KCHFT for 2017-18 and Q3 and Q4 2016-17 in relation to the finance and use of resources metrics are presented here:

			2017-18 scores				2016-17 scores	
Financial criteria	**Weight %**	**Metric**	**Q4**	**Q3**	**Q2**	**Q1**	**Q4**	**Q3**
Financial sustainability	0.2	Capital service capacity	1	1	1	1	1	1
	0.2	Liquidity (days)	1	1	1	1	1	1
Financial efficiency	0.2	I&E margin	1	1	1	1	1	1
Financial controls	0.2	Distance from financial plan	1	1	1	1	1	1
	0.2	Agency spend	1	1	1	1	1	1
		Overall scoring	**1**	**1**	**1**	**1**	**1**	**1**



Statement of accounting officer's responsibilities

Statement of the chief executive's responsibilities as the accounting officer of Kent Community Health NHS Foundation Trust

The NHS Act 2006 states the chief executive is the accounting officer of the NHS foundation trust. The relevant responsibilities of the accounting officer, including their responsibility for the propriety and regularity of public finances for which they are answerable, and for the keeping of proper accounts, are set out in the NHS Foundation Trust accounting officer memorandum, issued by NHS Improvement.

NHS Improvement, in exercise of the powers conferred on Monitor by the NHS Act 2006, has given accounts directions, which require Kent Community Health NHS foundation Trust to prepare for each financial year a statement of accounts in the form and on the basis required by those directions.

The accounts are prepared on an accruals basis and must give a true and fair view of the state of affairs of Kent Community Health NHS Foundation Trust and of its income and expenditure, total recognised gains and losses and cash flows for the financial year.

In preparing the accounts, the accounting officer is required to comply with the requirements of the Department of Health and Social Care Group accounting manual and, in particular, to:

- observe the accounts direction issued by NHS Improvement, including the relevant accounting and disclosure requirements, and apply suitable accounting policies on a consistent basis
- make judgements and estimates on a reasonable basis
- state whether applicable accounting standards as set out in the NHS Foundation Trust annual reporting manual (and the Department of Health and Social Care Group accounting manual) have been followed, and disclose and explain any material departures in the financial statements
- ensure that the use of public funds complies with the relevant legislation, delegated authorities and guidance
- prepare the financial statements on a going concern basis.

The accounting officer is responsible for keeping proper accounting records which disclose with reasonable accuracy at any time the financial position of the NHS foundation trust and to enable him/her to ensure that the accounts comply with requirements outlined in the above mentioned act.

The accounting officer is also responsible for safeguarding the assets of the NHS foundation trust and for taking reasonable steps for the prevention and detection of fraud and other irregularities.

To the best of my knowledge and belief, I have properly discharged the responsibilities set out in the NHS Foundation Trust accounting officer memorandum.

Signed: ..... Date: 24/04/2018

Paul Bentley, Chief Executive Officer

NHS
Kent Community Health
NHS Foundation Trust

Annual governance statement

Annual governance statement – 1 April 2017 to 31 March 2018 Kent Community Health NHS Foundation Trust

1. Scope of responsibility

As accounting officer, I have responsibility for maintaining a sound system of internal control that supports the achievement of the NHS foundation trust's policies, aims and objectives, while 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 the NHS foundation 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 foundation trust accounting officer memorandum.

2. 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 a continuing process designed to identify and prioritise the risks to the achievement of the policies, aims and objectives of Kent Community Health NHS Foundation 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 Kent Community Health NHS Foundation Trust for the year ended 31 March 2018 and up to the date of approval of the annual report and accounts.

3. Capacity to handle risk

In March 2015, the trust was authorised as a foundation trust and continues to assess itself to meet all of the requirements of Monitor's Code of Governance.

The governance framework of Kent Community Health NHS Foundation Trust has a Board, which comprises executive and non-executive directors. The Board's function is to:

- ensure all stakeholders have a good understanding of Kent Community Health NHS Foundation Trust's purpose
- set the values for the trust and its strategic direction
- hold management to account for the success and safety of the trust
- shape the organisational culture that supports its vision and values and encourages openness, honesty and integrity.

Through its strategic vision, values and goals, the Board is committed to delivering a strong, financially viable and sustainable organisation with quality of service at the heart of its business.

Leadership and co-ordination of risk management activities is provided by the corporate services director and their team with support from all members of the Executive Team. Operational responsibility rests with all staff aligned to their individual roles. Risk management training is part of staff induction and training updates for existing staff are also provided.

Risk identification, prioritisation, mitigation or elimination occurs through assessment and grading using a nationally-recognised matrix of impact and likelihood. Incident reporting is a factor in the continuing assessment of risk and results in the instigation of changes in practice. Complaints and other feedback from users and stakeholders are also used and reported to the Board. Risk management is incorporated in objective setting and appraisals.

To give Board members grounding and greater understanding and clarity, there has been development in engaging each member with We care reviews, to help understand patient journeys and pathways with case interrogation of individual case studies.

The Board is invited to senior managers' conferences, team leaders' conferences and executive and heads of service events, where they meet senior management and discuss new service models, service improvements and innovations.

4. The risk and control framework

As accounting officer, I have overall responsibility for risk management. Specific responsibilities are delegated to senior managers throughout the organisation.

The Board oversees risks, establishes a risk appetite for high level risks on a risk-by-risk basis and encourages proactive identification and mitigation of risks.

The risk management strategy and policy was presented to the Board in March 2018. The strategy explicitly describes the trust's approach to tolerating risks. The trust is continuing to implement and embed the principles contained within this document.

The top risks identified through the risk management process that have a significant impact on the ability of the trust to deliver its strategic goals are documented in the Board assurance framework. During 2017-18, there was a significant amount of work to manage, rationalise and ensure consistency of risks identified through the risk management process.

Key strategic risks have been identified through strategic assessment and business planning processes. These are:

- patient care may suffer if we are unable to recruit and retain a quality workforce, increasing reliance on agencies and resulting in an inability to capitalise on clinical leadership
- development of the Sustainability and Transformation Plan (STP) is complex and wide ranging across many different organisations. Due to organisational structures, accountabilities and sphere of control, the trust may be unable to ensure successful implementation of the whole system solutions needed to deliver the trust's strategy for the right care in the most effective setting.

These risks continue to be managed through the risk management and assurance processes in 2018-19.

Where appropriate, the trust will discuss risks which threaten achieving its objectives with commissioners, partners in healthcare and social services, local authorities, voluntary bodies and through involvement of public (particularly members) and patients' representatives in the trust's business.

4.1 Care Quality Commission

Kent Community Health NHS Foundation Trust maintains its good rating from the most recent Care Quality Commission (CQC) inspection in 2014 and is fully compliant with the CQC registration requirements and has specific statutory duties which are established in law.

Arrangements for discharge of these statutory duties are in place, have been checked and are legally compliant. Mechanisms include the committee structure and terms of reference and assurance sources, including internal and external audit.

In October 2017, a joint inspection by the CQC and Her Majesty's Inspectorate of Prisons (HMIP) reviewed our Dental Services at Harmondsworth Immigration Removal Centre. No issues of concern were identified.

4.2 Committee structure

Throughout 2017-18, the Board and its committees were quorate on all occasions.

4.3 Quality Committee

This is a non-executive committee of the Board with delegated decision-making powers. The chief nurse, medical director and chief operating officer attend these meetings. Other individuals with specialist knowledge attend for specific items with consent of the chair. In particular, and where appropriate, the committee invites clinical representatives to attend its meetings to provide assurance on key governance and risk issues and quality Improvement

The purpose of the committee is to:

- provide assurance to the Board there is an effective system of risk management and internal control across clinical activities of the organisation that supports its objectives and the trust's ability to provide excellent quality care by excellent people.

Specific responsibilities of the Quality Committee include:

- providing assurance that the risks associated with the trust's provision of excellent care are identified managed and mitigated appropriately. In doing so, the Quality Committee may consider any quality issue it deems appropriate to ensure that this can be achieved.

Providing assurance to the Board by:

- ensuring the strategic priorities for quality assurance are focused on those which best support delivery of the trust's quality priorities in relation to patient experience, safety of patients and service users and effective outcomes for patients and service users
- reviewing compliance with regulatory standards and statutory requirements, for example Duty of Candour, the CQC, NHS Resolution and the NHS Performance Framework
- reviewing quality risks, which have been assigned to the Quality Committee and satisfying itself as to the adequacy of assurances on the operation of key controls and action plans to address weaknesses in controls and assurances
- reviewing the annual quality report ahead of its submission to the Board for approval
- overseeing deep dive reviews of identified risks to quality identified by the Board or the committee, particularly serious incidents and how well any recommended actions have been implemented
- reviewing how lessons are disseminated, learned and embedded in the trust.
- overseeing the ratification of clinical policies and any other formal clinical document where mandatory compliance is required.

The committee may also initiate such reviews based on its own tracking and analysis of quality trends flagged up through the regular performance reporting to the Board.

4.4 Audit and Risk Committee

This committee is a non-executive committee of the Board with delegated decision-making powers to provide assurance and hold the Executive Team to account for the corporate governance and internal control.

The director of finance, corporate services director, head of internal audit, head of external audit and the local counter fraud specialist attend meetings. Other individuals with specialist knowledge attend for specific items with consent of the chair.

The purpose of the Audit and Risk Committee is to:

- seek assurance that the financial reporting, risk management and internal control principles are applied
- maintain an appropriate relationship with the trust's internal and external auditors
- offer advice and assurance to the trust's Board about the reliability and robustness of the systems of internal control.

As it deems necessary, the Board may request the Audit and Risk Committee to review specific issues where it requires additional assurance about effectiveness of systems of internal control or areas where risk management reports highlight concerns.

It is incumbent on the Audit and Risk Committee to work closely with other committees of the trust's Board to make sure all issues relating to finance, risk management and internal control are considered in a holistic and integrated way.

4.5 Finance, Business and Investment Committee

Committee membership is appointed from among the executive and non-executive directors of the trust and includes the chief executive, director of finance and deputy chief executive/chief operating officer.

Executive directors and senior service leads attend by invitation when the committee discusses issues relating to their area of responsibility.

The overall objectives of the committee are to:

- scrutinise current financial performance and future financial plans (annual plan and budget and long-term financial model)
- monitor performance against cost improvement plans
- scrutinise development and implementation of service line reporting and service line management
- monitor decisions to bid for business opportunities and approve those up to £15million contract turnover in line with trust's strategy and reviewing and referring and recommending larger and novel bids to the Board for approval
- review and approve capital investment decisions between £1million and £3million within capital budget and the overall capital programme development, refer, with recommendation larger cases to the Board for approval
- review and approve revenue business cases between £1million and £3million annual value and refer, with recommendation, larger cases to the Board for approval
- approve treasury management policy and scrutinise implementation
- promote good financial practice throughout the trust.

All procedural matters in respect of conduct of meetings follow the trust's standing orders.

4.6 Remuneration and Terms of Service Committee

Committee members are non-executive directors of the trust. The committee is chaired by the trust's chair. The chief executive and director of workforce, organisational development and communications will also normally attend meetings, except where matters relating to them are under discussion.

It is responsible for setting the remuneration and conditions of service for the chief executive and other directors with Board responsibility who report directly to the chief executive and other directors; ensuring these properly support the objectives of the trust, represent value for money and comply with statutory requirements.

The committee does not determine the remuneration of the non-executive chair and the non-executive directors, which is set by the Council of Governors.

When required, the committee will oversee the appointment of executive directors in accordance with standing orders. During these sittings, the committee will be known as the Executive Appointments Committee and the minutes should reflect this position.

4.7 Charitable Funds Committee

Members of the Charitable Fund Committee include two non-executive directors (one as chair), director of finance and deputy chief executive/chief operating officer, Staff Side representative and a patient representative.

The Charitable Fund Committee will act on behalf of the corporate trustee, in accordance with the Kent Community Health NHS Foundation Trust's standing orders to oversee the charity's operation and to ensure that the administration of charitable funds is distinct from the trust's exchequer funds.

The committee is authorised by the Board to obtain reasonable external, legal or other independent professional advice, and to secure the attendance of outsiders with relevant experience or expertise, if it considers this to be necessary.

4.8 Strategic Workforce Committee

This is an assurance committee that has delegated authority from the Board to provide assurance and hold the Executive Team to account for strategic workforce issues. Its purpose is also to keep abreast of the strategic context in which the trust is operating, the consequences and implications on the workforce.

The committee is delegated by the Board to carry out the following duties and any others appropriate to fulfilling purpose to provide assurance on the following:

- Oversee development and implementation of the trust's People Strategy, ensuring that the trust has robust plans in place to support continuing development of the workforce.
- Review the trust's plans to identify and develop leadership capacity and capability in the trust, including talent management.
- Ensure there is an effective workforce plan in place, so the trust has sufficient staff, with the necessary skills and competencies to meet the needs of patients and services users.
- Ensure the trust continually reviews its workforce models, to reflect new roles and new ways of working to support delivery of the trust's contractual obligations.

- Receive and provide assurance the trust has an appropriate pay and reward system linked to delivery of the organisation's strategic objectives, outcomes and desired behaviours.
- Ensure the training and education provided and commissioned by the trust is fully aligned to the trust's strategy.
- Ensure there are mechanisms to support the mental and physical health and wellbeing of the trust's staff.
- Receive information on strategic themes relating to employment issues, ensuring they are understood and actioned;
- Ensure the trust is compliant with relevant legislation and regulations relating to workforce matters.
- Ensure the trust has appropriate workforce policies in place.

Members of the Strategic Workforce Committee include two non-executive directors (one as chair), director of workforce, organisational development and communications; deputy chief executive/chief operating officer; chief nurse and medical director. The deputy director of finance also attends.

4.9 Council of Governors

The Council of Governors represent the interests of our members and the wider public. The governors' role is to enable local people, patients, staff and our partners to have a say about the development of community services. They are a direct link between the trust and the people it serves.

Governors have an important role to play in making the trust publicly accountable for the services it provides. Each category of governor – public, staff and appointed governors bring valuable perspectives and contributions to the trust's activities and future planning.

During 2017-18, governors attended two multi-agency events led by the trust to highlight services available for people with diabetes. The full Council of Governors met quarterly and an annual members' meeting was held in September 2017, alongside the trust's annual general meeting.

4.10 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.

4.11 Sustainability

The trust has carried out risk assessments and carbon reduction delivery plans are in place in accordance with emergency preparedness and civil contingency requirements, based on UKCIP 2009 weather projects, to ensure the organisation complies with obligations under the Climate Change Act and the Adaptation Reporting requirements.

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

The Board takes responsibility for oversight and risk management assurance throughout the trust and receives the Board assurance framework at its formal meetings.

The trust's strategic goals form the basis of the Board assurance framework. The strategic goals are linked to key risks, internal controls and assurance sources.

Mitigating controls and assurances are recorded and monitored to deliver reasonable assurance for prevention of risks, deterrent to risks arising and management of current risks.

Control mechanisms in place are designed to minimise or eliminate the risk of failure to deliver business objectives, including robust corporate and performance management frameworks, service level agreements and contract monitoring, policies and procedures.

The Board delegated detailed oversight of the Board assurance framework to the Audit and Risk Committee. It assesses the effectiveness of risk management by managing and monitoring implementation of the Risk Management Strategy; considering findings from internal and external audit reviews; calling executive directors to account for their risk portfolios and monitoring the Board assurance framework at each of its meetings.

The Audit and Risk Committee is supported by the corporate services director who produces regular reports on risk for review.

The end of year review of the Board assurance framework by the head of internal audit has resulted in an opinion of reasonable assurance that it is effective.

Clinical risk and patient safety are overseen by the Quality Committee, the chief nurse, the medical director and the operational directors. The Board receives monthly quality reports encompassing quality and patient safety aspects.

The Quality Committee has focused on assurance that the trust is embedding lessons learned from incidents. It has also sought assurance on the progress of action plans that were developed in relation to the trust's NHS Improvement quality governance assurance framework score and the Care Quality Commission's inspection of the trust. This assurance is reported to the Board.

Specialised risk management activities, for example information governance; emergency planning and business continuity and health and safety, fire and security, are carried out by the Corporate Assurance and Risk Management Group, which reports to the Executive Team and is accountable to the Audit and Risk Committee.

The committee received regular reports from the local counter fraud specialists, which identified specific fraud risks and investigated whether there was evidence of those being exploited. No significant risks, classes of transactions or account balances were identified.

It focused some attention on the relationship between claims and the associated costs and incidents reported.

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

These include policies, committee structure and Board assessment of compliance with and progress against, equality and diversity best practice.

5. Information governance (IG)

The trust takes all reported incidents seriously. Each, regardless of severity is analysed and, where appropriate, categorised as a serious incident needing further investigation. From 1 April 2017 to 31 March 2018, there was one serious incident categorised at level 2. This was reported to the information commissioner's office (ICO) in June 2017.

The incident, an unauthorised disclosure, was a result of patient information being left in an alleyway. The outcome of the ICO investigation was that no further action was necessary. Recommendations from the ICO were put into place, including a review of policies and procedures for handling data.

There was also a reminder to staff about the need to complete a risk assessment for transporting confidential information and to make sure that all induction and leavers' checklists are completed. All staff were subject to a campaign around awareness of data protection risks and the policies and procedures the trust has in place to prevent incidents from happening.

6. Annual quality report

The directors are required under the Health Act 2009 and the National Health Service (Quality Accounts) Regulations 2010 (as amended) to prepare Quality Accounts for each financial year.

NHS Improvement (in exercise of the powers conferred on Monitor) has issued guidance to NHS foundation trust boards on the form and content of annual quality reports, which incorporate the above legal requirements in the NHS Foundation Trust annual reporting manual.

Each year, the trust consults with our staff, the public and other stakeholders to align the priorities for the quality report to the risks, business objectives and national priorities.

During the year, as data is collected, the trust reports quarterly to the Quality Committee and clinical commissioning groups (CCG) on progress with all metrics.

The draft quality report is presented to the trust's Quality Committee, Council of Governors and Board. In addition, it is presented to all clinical commissioning groups, the Overview and Scrutiny Committee, Healthwatch and other stakeholders for comments.

.7. Review of effectiveness

As accounting 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 in the NHS foundation trust who have responsibility for development and maintenance of the internal control framework.

I have drawn on the content of the quality report attached to 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 Board, Audit and Risk Committee and Quality Committee and a plan to address weaknesses and ensure continuous improvement of the system is in place.

The internal audit report for 2017-18 confirmed 17 audits, of which two received substantial assurance; they were:

- the information governance toolkit assessment (IGTA)
- nurse revalidation

Only one report received limited initial assurance, which was site visits. The MiComputer Aided Design Database received limited assurance for the original report. However it was subsequently rated as reasonable in the follow-up.

There is a clear, dynamic process for monitoring progress against audit recommendations with oversight by the Audit and Risk Committee. Recommendations from any reports providing limited assurance are prioritised.

Director statements from executive directors and senior managers in the organisation who have responsibility for development and maintenance of the system of internal control provide me with assurance.

The Board assurance framework provides me with evidence that the effectiveness of controls, which manage risks to the organisation in achieving its principal objectives have been reviewed and addressed.

I have been advised on the implications of the result of my review of the effectiveness of the system of internal control by the Board, supported by the Audit and Risk and Quality Committee's regular reports to the Board.

Processes are in place to maintain and review the effectiveness of the system of internal control by:

- the Board providing overall leadership for management of risk against achieving organisational objectives
- the Board receiving the Board assurance framework at its meetings
- the Audit and Risk Committee and the Corporate Assurance and Risk Management Group providing assurance on the effective operation of the risk management system
- each level of management being responsible for risks in their areas, regularly reviewing them and the controls in place to mitigate them
- the internal assurance process used to monitor compliance with the Care Quality Commission essential standards.

For the year 2017-18, the following significant issue has been identified:

Significant issue description:	Remedial action taken and plans for mitigation:
In common with other trusts in the country, workforce issues have impacted on the trust's operations. The trust has had a higher turnover and a greater level of vacancies than target and the limited numbers of nurses and other healthcare professionals available nationally has impacted on the trust's ability to achieve its goals.	Trust focus on being a better employer, improving staff retention, satisfaction, reducing vacancies, turnover and developing new roles to support the new models of care

Conclusion

With the exception of the internal control issues that I have outlined in this statement, which have been or are being addressed, my review confirms that Kent Community Health NHS Foundation Trust has a sound system of internal control. This supports the achievement of its goals, vision, values, policies, aims and objectives.

Signed: ..... Date: 29 May 2018

Paul Bentley, Chief Executive Officer

Independent auditor's report to the Council of Governors of Kent Community Health NHS Foundation Trust

Report on the Audit of the Financial Statements

Opinion

Our opinion on the financial statements is unmodified

We have audited the financial statements of Kent Community Health NHS Foundation Trust (the 'Trust') for the year ended 31 March 2018 which comprise the Statement of Comprehensive Income, the Statement of Financial Position, the Statement of Changes in Equity, the Statement of Cash Flows and notes to the financial statements, including a summary of significant accounting policies. The financial reporting framework that has been applied in their preparation is applicable law and the NHS foundation trust annual reporting manual 2017/18.

In our opinion the financial statements:

- give a true and fair view of the financial position of the Trust as at 31 March 2018 and of its expenditure and income for the year then ended; and
- have been properly prepared in accordance with International Financial Reporting Standards (IFRSs) as adopted by the European Union, as interpreted and adapted by the NHS foundation trust annual reporting manual 2017/2018; and
- have been prepared in accordance with the requirements of the National Health Service Act 2006.

Basis for opinion

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

Who we are reporting to

This report is made solely to the Council of Governors of the Trust, as a body, in accordance with Schedule 10 of the National Health Service Act 2006. Our audit work has been undertaken so that we might state to the Trust's Council of Governors 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 Council of Governors, as a body, for our audit work, for this report, or for the opinions we have formed.

Conclusions relating to going concern

We have nothing to report in respect of the following matters in relation to which the ISAs (UK) require us to report to you where:

- the Accounting Officer's use of the going concern basis of accounting in the preparation of the financial statements is not appropriate; or

- the Accounting Officer has not disclosed in the financial statements any identified material uncertainties that may cast significant doubt about the Trust's ability to continue to adopt the going concern basis of accounting for a period of at least twelve months from the date when the financial statements are authorised for issue.

Overview of our audit approach

- Overall materiality: £3,222,000, which represents 2% of the Trust's gross operating costs (consisting of operating expenses and finance expenses);
- Key audit matters were identified as:
    - Obtaining assurance that the revenue from patient care activities was not materially misstated

Key audit matters

Key audit matters are those matters that, in our professional judgment, were of most significance in our audit of the financial statements of the current year and include the most significant assessed risks of material misstatement (whether or not due to fraud) that we identified. These matters included those that had the greatest effect on: the overall audit strategy; the allocation of resources in the audit; and directing the efforts of the engagement team. These matters were addressed in the context of our audit of the financial statements as a whole, and in forming our opinion thereon, and we do not provide a separate opinion on these matters.

Key Audit Matter	How the matter was addressed in the audit
Risk 1 Obtaining assurance that the revenue from patient healthcare activities was not materially misstated Over 95% of the Trust's income is from patient healthcare activities, including income from NHS commissioners. The Trust invoices its commissioners throughout the year for services provided, and at the year-end estimates and accrues for activity not yet invoiced. Some invoices may involve further negotiation of contractual adjustments with commissioners after the deadline for the production of the financial statements, although the risk is reduced where significant amounts of patient care income are received through block contracts, as for the Trust. We identified the risk that income from patient healthcare activities had not occurred, or had not been accurately stated, as a significant risk, and as the most significant assessed risk of material misstatement.	Our audit work included, but was not restricted to: • evaluating the Trust's accounting policy for recognition of healthcare income for appropriateness and consistency with the prior year; • gaining an understanding of the Trust's system for accounting for health care income and evaluating the design of the associated controls; • using an analysis provided by the Department of Health to identify any significant differences in income balances with contracting NHS bodies, and confirming the validity of these differences; and • agreeing, on a sample basis, amounts recognised in income in the financial statements to signed contracts and invoices. The Trust's accounting policy on income recognition, including income from patient healthcare activities, is disclosed at note 1.4 in the financial statements. An analysis of income from patient healthcare activities is disclosed at Note 3. **Key observations** We obtained sufficient, appropriate audit evidence to conclude that: - the basis of the valuation was appropriate and the assumptions and processes used by management in determining the estimate were reasonable; and - the valuation of property disclosed in the financial statements is reasonable.

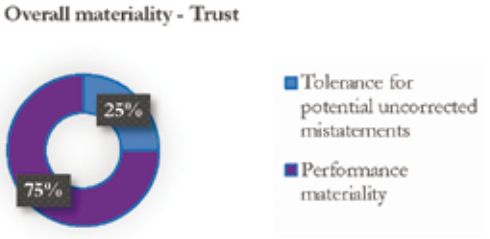
Our application of materiality

We define materiality as the magnitude of misstatement in the financial statements that makes it probable that the economic decisions of a reasonably knowledgeable person would be changed or influenced. We use materiality in determining the nature, timing and extent of our audit work and in evaluating the results of that work.

Materiality was determined as follows:

Materiality Measure	Trust
Financial statements as a whole	£3,222,000 which is 2% of the Trust's gross operating costs. This benchmark is considered the most appropriate because we consider users of the financial statements to be most interested in how it has expended its revenue and other funding. Materiality for the current year is at the same percentage level of gross operating costs as we determined for the year ended 31 March 2017 as we did not identify any significant changes in the Trust or the environment in which it operates.
Performance materiality used to drive the extent of our testing	75% of financial statement materiality.
Specific materiality	We did not identify any areas where we considered it appropriate to use a specific, lower, level of materiality.
Communication of misstatements to the Audit and Risk Committee	£223,000 and misstatements below that threshold that, in our view, warrant reporting on qualitative grounds.

The graph below illustrates how performance materiality interacts with our overall materiality and the tolerance for potential uncorrected misstatements.



An overview of the scope of our audit

Our audit approach was based on a thorough understanding of the Trust's business and was risk based. In particular our audit included:

- planning procedures to evaluate of the Trust's internal control environment including its IT systems and the controls over key financial systems;
- an interim visit to perform early testing, including analytical procedures and substantive testing of transactions
- a final visit to carry out the audit of the Trust's financial statements.
- a focus on the significant risks identified, including the risk that revenue from patient healthcare activities had been materially misstated.

Other information

The Accounting Officer is responsible for the other information. The other information comprises the information included in the Annual Report set out on pages 5 to 94 and 157 to 209 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 of the Trust obtained in the course of our work including that gained through work in relation to the Trust's arrangements for securing value for money through economy, efficiency and effectiveness in the use of its resources 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.

In this context, we also have nothing to report in regard to our responsibility to specifically address the following items in the other information and to report as uncorrected material misstatements of the other information where we conclude that those items meet the following conditions:

- Fair, balanced and understandable set out on page 43 in accordance with provision C.1.1 of the NHS Foundation Trust Code of Governance – the statement given by the directors that they consider the Annual Report and financial statements taken as a whole is fair, balanced and understandable and provides the information necessary for patients, regulators and other stakeholders to assess the Trust's performance, business model and strategy, is materially inconsistent with our knowledge of the Trust obtained in the audit.

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 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 meet the disclosure requirements set out in the NHS foundation trust annual reporting manual 2017/18. 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.

Our opinion on other matters required by the Code of Audit Practice is unmodified

In our opinion:

- the parts of the Remuneration Report and the Staff Report to be audited have been properly prepared in accordance with IFRSs as adopted by the European Union, as interpreted and adapted by the NHS foundation trust annual reporting manual 2017/18 and the requirements of the National Health Service Act 2006; and
- based on the work undertaken in the course of the audit of the financial statements and our knowledge of the Trust gained through our work in relation to the Trust's arrangements for securing economy, efficiency and effectiveness in its use of resources, the other information published together with the financial statements in the Annual Report for the financial year for which the financial statements are prepared is consistent with the financial statements.

Matters on which we are required to report by exception

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

- we have reported a matter in the public interest under Schedule 10 (3) of the National Health Service Act 2006 in the course of, or at the conclusion of the audit; or
- we have referred a matter to the regulator under Schedule 10 (6) of the National Health Service Act 2006 because we had reason to believe that the Trust, or a director or officer of the Trust, was about to make, or had made, a decision which involved or would involve the incurring of expenditure that was unlawful, or was about to take, or had taken a course of action which, if followed to its conclusion, would be unlawful and likely to cause a loss or deficiency.

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

Responsibilities of the Accounting Officer and Those Charged with Governance for the financial statements

As explained more fully in the Statement of Accounting Officer's responsibilities set out on page 83 the Chief Executive, as Accounting Officer, is responsible for the preparation of the financial statements in the form and on the basis set out in the Accounts Directions included in the NHS foundation trust annual reporting manual 2017/18, for being satisfied that they give a true and fair view, and for such internal control as the Accounting Officer determines 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 Accounting Officer is 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 the Trust lacks funding for its continued existence or when policy decisions have been made that affect the services provided by the Trust.

The Audit and Risk Committee are Those Charged with Governance.

Auditor's responsibilities for the audit of the financial statements

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

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

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

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

Under the Code of Audit Practice we are required to report to you if, in our opinion we have not been able to satisfy ourselves that the Trust has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources for the year ended 31 March 2018.

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

Responsibilities of the Accounting Officer

The Accounting 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 paragraph 1 of Schedule 10 of the National Health Service Act 2006to be satisfied that the Trust has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources and to report where we have not been able to satisfy ourselves that it has done so. We are not required to consider, nor have we considered, whether all aspects of the Trust's arrangements for securing economy, efficiency and effectiveness in its use of resources are operating effectively.

We have undertaken our review in accordance with the Code of Audit Practice, having regard to the guidance on the specified criterion issued by the Comptroller and Auditor General in November 2017, as to whether in all significant respects, the Trust had proper arrangements to ensure it took properly informed decisions and deployed resources to achieve planned and sustainable outcomes for taxpayers and local people. The Comptroller and Auditor General determined this criterion as that necessary for us to consider under the Code of Audit Practice in satisfying ourselves whether the Trust put in place proper arrangements for securing economy, efficiency and effectiveness in its use of resources for the year ended 31 March 2018, and to report by exception where we are not satisfied.

We planned our work in accordance with the Code of Audit Practice. Based on our risk assessment, we undertook such work as we considered necessary to be satisfied that the Trust has put in place proper arrangements for securing economy, efficiency and effectiveness in its use of resources.

Report on other legal and regulatory requirements - Certificate

We certify that we have completed the audit of the financial statements of Kent Community Health NHS Foundation Trust in accordance with the requirements of Chapter 5 of Part 2 of the National Health Service Act 2006 and the Code of Audit Practice.

Sarah L Ironmonger

Sarah Ironmonger
Associate Director
for and on behalf of Grant Thornton UK LLP

30 Finsbury Square, London, EC2A 1AG

25 May 2018

Kent Community Health
NHS Foundation Trust

Annual accounts

Foreword to the accounts

Kent Community Health NHS Foundation Trust

These accounts, for the year ended 31 March 2018, have been prepared by Kent Community Health NHS Foundation Trust in accordance with paragraphs 24 & 25 of Schedule 7 within the National Health Service Act 2006.

Signed: ..... Date: 24/04/2018

Statement of comprehensive income for the year ended 31 March 2018

	Note	2017/18 £000	2016/17 £000
Operating income from patient care activities	3	212,768	218,204
Other operating income	4	8,663	9,480
Operating expenses	5, 7	(214,797)	(223,108)
Operating surplus/(deficit) from continuing operations		**6,634**	**4,576**
Finance income	10	63	59
Finance expenses	11	-	(5)
PDC dividends payable		(116)	-
Net finance costs		**(53)**	**54**
Other gains / (losses)	12	(65)	-
Surplus / (deficit) for the year from continuing operations		**6,516**	**4,630**
Surplus / (deficit) on discontinued operations and the gain / (loss) on disposal of discontinued operations		**-**	**-**
Surplus / (deficit) for the year		**6,516**	**4,630**
Other comprehensive income			
Will not be reclassified to income and expenditure:			
Impairments	6	(151)	-
Revaluations	15	79	-
Total comprehensive income / (expense) for the period		**6,444**	**4,630**

The notes on pages 111 to 153 form part of this account.

Statement of financial position as at 31 March 2018

	Note	31 March 2018 £000	31 March 2017 £000
Non-current assets			
Intangible assets	13	483	238
Property, plant and equipment	14	14,933	16,717
Trade and other receivables	19	77	68
Total non-current assets		**15,493**	**17,023**
Current assets			
Inventories	18	-	-
Trade and other receivables	19	19,753	18,345
Cash and cash equivalents	20	27,633	19,167
Total current assets		**47,386**	**37,512**
Current liabilities			
Trade and other payables	21	(26,096)	(23,247)
Provisions	25	(1,460)	(3,584)
Other liabilities	22	(1,760)	(585)
Total current liabilities		**(29,316)**	**(27,416)**
Total assets less current liabilities		**33,563**	**27,119**
Total non-current liabilities		**-**	**-**
Total assets employed		**33,563**	**27,119**
Financed by			
Public dividend capital		2,613	2,613
Revaluation reserve		694	766
Income and expenditure reserve		30,256	23,740
Total taxpayers' equity		**33,563**	**27,119**

The notes on pages 111 to 153 form part of this account.

The financial statements on pages 106 to 110 were approved by the Board on 24 May 2018 and on its behalf by:

Signed.....

Name: Paul Bentley, Chief Executive Officer

Statement of changes in equity for the year ended 31 March 2018

	Public dividend capital £000	Revaluation reserve £000	Income and expenditure reserve £000	Total £000
Taxpayers' equity at 1 April 2017 - brought forward	**2,613**	**766**	**23,740**	**27,119**
Surplus/(deficit) for the year	-	-	6,516	**6,516**
Impairments	-	(151)	-	**(151)**
Revaluations	-	79	-	**79**
Taxpayers' equity at 31 March 2018	**2,613**	**694**	**30,256**	**33,563**

Statement of Changes in Equity for the year ended 31 March 2017

	Public dividend capital £000	Revaluation reserve £000	Income and expenditure reserve £000	Total £000
Taxpayers' equity at 1 April 2016 - brought forward	**2,613**	**766**	**19,110**	**22,489**
Surplus/(deficit) for the year	-	-	4,630	**4,630**
Taxpayers' equity at 31 March 2017	**2,613**	**766**	**23,740**	**27,119**

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 used by the trust, is payable to the Department of Health and Social Care 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 for the year ended 31 March 2018

	Note	2017/18 £000	2016/17 £000
Cash flows from operating activities			
Operating surplus / (deficit)		6,634	4,576
Non-cash income and expense:			
Depreciation and amortisation	5	5,020	2,591
Net impairments	6	22	-
(Increase) / decrease in receivables and other assets		(1,375)	(3,780)
Increase / (decrease) in payables and other liabilties		3,901	(6,694)
Increase / (decrease) in provisions		(2,124)	2,562
Net cash generated from / (used in) operating activities		**12,078**	**(745)**
Cash flows from investing activities			
Interest received		53	59
Purchase of intangible assets		(480)	(89)
Purchase of property, plant, equipment and investment property		(3,108)	(3,110)
Sales of property, plant, equipment and investment property		71	3
Net cash generated from / (used in) investing activities		**(3,464)**	**(3,137)**
Cash flows from financing activities			
Other interest paid		-	(5)
PDC dividend (paid) / refunded		(148)	27
Net cash generated from / (used in) financing activities		**(148)**	**22**
Increase / (decrease) in cash and cash equivalents		**8,466**	**(3,860)**
Cash and cash equivalents at 1 April		**19,167**	**23,027**
Cash and cash equivalents at 31 March	20	**27,633**	**19,167**

Notes to the accounts

Note 1 Accounting policies and other information

Note 1.1 Basis of preparation

NHS Improvement, in exercising the statutory functions conferred on Monitor, has directed 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 2017-18 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, which is judged to be most appropriate to the particular circumstances of the trust for the purpose of giving a true and fair view has been selected. The particular policies adopted are described below. These have been applied consistently in dealing with items considered material in relation to accounts.

Note 1.1.1 Accounting convention

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

Note 1.1.2 Going concern

After making enquiries, the directors have a reasonable expectation that the trust has adequate resources to continue in operational existence for the foreseeable future. For this reason, they continue to adopt the going concern basis in preparing the accounts.

Note 1.2 Critical accounting estimates and judgements

In the application of the trust's accounting policies, management is required to make judgements, estimates and assumptions about the carrying amounts of assets and liabilities that are not readily apparent from other sources. The estimates and associated assumptions are based on historical experience and other factors considered to be relevant. Actual results may differ from estimates and the estimates and underlying assumptions are continually reviewed. Revisions to accounting estimates are recognised in the period in which the estimate is revised, if the revision affects only that period or in the period of the revision and future periods if the revision affects both current and future periods.

The following are the bases for the estimations that management has used in the process of applying the trust accounting policies and that have the most significant effect on the amounts recognised in the financial statements:

Redundancy provision

A provision has been recognised in respect of redundancy as a result of service changes and other events, based on estimated probabilities as noted below. Note 25.1 provides further analysis of the provisions accounted.

Legal claims and other provisions

The trust has received expert opinion from external advisers as to the expected value and probability of such costs being settled.

Valuation of land and buildings (owned)

This is based on the professional judgement of the trust's Independent valuer with extensive knowledge of the physical estate and market factors.

The trust has not made any other assumptions concerning the future or applied any estimations that have a significant risk of causing a material adjustment to the carrying amounts of assets and liabilities within the next financial year.

Note 1.3 Interests in other entities

NHS Charitable Fund

The trust is the corporate trustee of Kent Community Health Charitable Fund. The trust has assessed its relationship to the charitable fund and determined it to be a subsidiary because the trust is exposed to, or has rights to, variable returns and other benefits for itself, patients and staff from its involvement with the charitable fund and has the ability to affect those returns and other benefits through its power over the fund. However, the transactions are immaterial in the context of the group and transactions have not been consolidated. Details of the transactions with the charity are included in the related parties' notes.

Note 1.4 Income

Income in respect of services provided is recognised when, and to the extent that, performance occurs and is measured at the fair value of the consideration receivable. The main source of income for the trust is contracts with commissioners in respect of health care services.

Where income is received for a specific activity which is to be delivered in a subsequent financial year, that income is deferred.

Income from the sale of non-current assets is recognised only when all material conditions of sale have been met, and is measured as the sums due under the sale contract.

Revenue grants and other contributions to expenditure

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. The trust did not receive any government grants in 2017-18.

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, the corresponding notional expense is also recognised at the point of recognition for the benefit.

Note 1.5 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. Payments for overtime and enhancements are paid one month in arrears and the accounts presented incorporate an accrual for the cost of overtime and enhancements worked in March 2018 but to be paid in April 2018.

Pension costs

Past and present employees are covered by the provisions of the NHS pension scheme. The scheme is an unfunded, defined benefit scheme that covers NHS employers, general practices and other bodies, allowed under the direction of secretary of state, in England and Wales. 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 schemes are accounted for as though they are defined contribution schemes.

Employer's pension cost 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.

National Employment Savings Trust (NEST)

The Pensions Act 2008 (the Act) introduced a new requirement for employers to automatically enrol any eligible job holders working for them into a workplace pension scheme that meets certain requirements and provides a minimum employer contribution. Where an employee is eligible to join the NHS pension scheme, then they will be automatically enrolled into this scheme. However, where an employee is not eligible to join the NHS pension scheme, an alternative scheme must be made available by the trust. The trust's alternative scheme is NEST. NEST is a defined contribution pension scheme that was created as part of the government's workplace pensions reforms under the Pensions Act 2008. Employers' pension cost contributions are charged to operating expenses as and when they become due.

Note 1.6 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 1.7 Property, plant and equipment

Note 1.7.1 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 reliably measured
- 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 inter-dependent, had broadly simultaneous purchase dates, are anticipated to have similar disposal dates and are under single managerial control
- items forming part of the initial equipping and setting-up cost of a new building, ward or unit, irrespective of their individual or collective cost.

Where a large asset, for example a building, includes a number of components with significantly different asset lives, such as plant and equipment, these components are treated as separate assets and depreciated over their own useful economic lives.

Note 1.7.2 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.

Subsequent measurement is as follows:

- Assets held for their service potential and are in use (for example, operational assets used to deliver either front line services or back office functions) are measured at their current value in existing use. For in use non-specialised property assets, current value in existing use should be interpreted as market value for existing use. In the Royal Institution of Chartered Surveyors; (RIC's Red Book Appraisal and Valuation Standards) this is defined as existing use value (EUV).
- Specialised assets are held at current value in existing use 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.
- Assets held for their service potential but are surplus are valued at current value in existing use, if there are restrictions on the trust or the asset, which will prevent access to the market at the reporting date. If the trust can access the market, then the surplus asset is valued at fair value using IFRS 13.

- Assets which are not held for their service potential are valued in accordance with IFRS 5 or IAS 40 depending on whether the asset is actively held for sale.
- Assets which are not being used to deliver services and there is no plan to bring it back into use, with no restrictions on sale, and do not meet the IFRS 5 and IAS 40 criteria, these assets are considered surplus and are valued at fair value using IFRS 13.

IFRS 13 fair value is adopted in full; however, IAS 16 and IAS 38 have been adapted and interpreted for the public sector context which limits the circumstances in which a valuation is prepared under IFRS 13.

Revaluations are performed with sufficient regularity to ensure that carrying amounts are not materially different from those that would be determined at the end of the reporting period.

Current values are determined as follows:

- Land and non-specialised buildings - market value for existing use (EUV).
- Specialised buildings - depreciated replacement cost on the basis of a modern equivalent asset.
- Leasehold improvements - in respect of buildings for which the trust is a lessee under an operating lease will be depreciated over the lease duration (or other period deemed appropriate) and carried at depreciated historic cost, as this is not considered to be materially different from current value. Thus, improvements are not revalued and no indexation is applied as the adjustments, which would arise are not considered material. HM Treasury has adopted a standard approach to depreciated replacement cost valuations based on modern equivalent assets and, where it would meet the location requirements of the service being provided, an alternative site can be valued. Properties in the course of construction for service or administration purposes are carried at cost, less any impairment loss. Cost includes professional fees but not borrowing costs, which are recognised as expenses immediately, as allowed by IAS 23. Assets are revalued and depreciation commences on assets when they are brought into use, other than grouped information technology (IT) assets. Depreciation starts on grouped IT assets on receipt by the trust and not when the separable parts are brought into use, as this is more practicable by alleviating the requirement to fixtures and equipment are carried at depreciated historic cost as this is not considered to be materially different from current value.

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.

Depreciation

Items of property, plant and equipment are depreciated over their remaining useful economic lives in a manner consistent with the consumption of economic or service delivery benefits. The estimated useful life of an asset is the period over which the trust expects to obtain economic benefits or service potential from the asset. This is specific to the trust and may be shorter than the physical life of the asset itself. Estimated useful lives and residual values are reviewed each year end, with the effect of any changes recognised on a prospective basis. 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' ceases to be depreciated upon the reclassification.

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 income.
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.

Note 1.7.3 Derecognition

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

- the asset is available for immediate sale in its present condition subject only to terms, which are usual and customary for such sales
- the sale must be highly probable, for example
  - management is 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
  - the actions needed to complete the plan indicate it is unlikely that the plan will be dropped or significant changes made to it.

Following reclassification, the assets are measured at the lower of their existing carrying amount and their fair value less costs to sell. Depreciation ceases to be charged. Assets are de-recognised when all material sale contract conditions have been met.

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

Note 1.7.4 Useful economic lives of property, plant and equipment

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

	Minimum life years	Maximum life years
Buildings, excluding dwellings*	1	35
Plant and machinery	1	12
Transport equipment	2	4
Information technology	1	10
Furniture and fittings	1	4

*Category consists of both trust-owned properties and leasehold improvements and the minimum life stated recognises the short-term nature of some of the leases in place.

Note 1.8 Intangible assets

Note 1.8.1 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, where the cost of the asset can be measured reliably and where the cost is at least £5,000.

Internally generated intangible assets

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

Expenditure on research is not capitalised.

Expenditure on development is capitalised only where all of the following can be demonstrated:

- 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, for example the presence of a market for it or its output, or where it is to be used for internal use, the usefulness of the asset;
- adequate financial, technical and other resources are available to the trust to complete the development and sell or use the asset
- the trust can measure reliably the expenses attributable to the asset during development.

Software

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

Note 1.8.2 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 under IFRS 13, if it does not meet the requirements of IAS 40 of IFRS 5.

Amortisation

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

Note 1.8.3 Useful economic lives of intangible assets

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

Intangible assets – purchased	Minimum life years	Maximum life years
Software	1	5

Note 1.9 Inventories

The trust holds no material inventories. Community hospitals hold consumables to cover approximately one week's consumption. Consumable expenditure is charged directly to revenue.

Note 1.10 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 three 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.

Note 1.11 Financial instruments and financial liabilities

Financial assets

Financial assets are recognised when the trust becomes party to the financial instrument contract or, in the case of trade receivables, when the goods or services have been delivered. Financial assets are de-recognised when the rights to receive cash flows from the assets have expired or the trust has transferred substantially all of the risks and rewards of ownership.

Financial assets are initially recognised at fair value.

Financial assets are classified into the following categories: Financial assets at fair value through profit and loss; held to maturity investments; available for sale financial assets, and loans and receivables. The classification depends on the nature and purpose of the financial assets and is determined at the time of initial recognition.

The trust does not hold any financial assets with different risk characteristics to their host contract (and so requiring a fair value adjustment), held to maturity investments, or available for sale financial assets.

The trust's financial assets consist of accrued and invoiced receivables and cash. The trust has not issued any loans.

Financial liabilities

Financial liabilities are recognised on the statement of financial position when the trust becomes party to the contractual provisions of the financial instrument or, in the case of trade payables, when the goods or services have been received. Financial liabilities are de-recognised when the liability has been discharged, that is, the liability has been paid or has expired.

The trust does not have any loans, financial guarantee contract liabilities, liabilities which require a fair value adjustment, or other financial liabilities. The trust's financial liabilities consist of payables and provisions.

Note 1.12 Leases

Leases are classified as finance leases when substantially all the risks and rewards of ownership are transferred to the lessee. The trust does not have any finance leases.

All other leases are regarded as operating leases and the rentals are charged to operating expenses on a straight-line basis over the term of the lease. Operating lease incentives received are added to the lease rentals and charged to operating expenses over the life of the lease.

Note 1.13 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 the discount rates published and mandated by HM Treasury.

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 25.2, but is not recognised in the trust's accounts.

Non-clinical risk pooling

The trust participates in the property expenses scheme and the liabilities to third parties scheme. Both are risk pooling schemes under which the trust pays an annual contribution to NHS Resolution and in return receives assistance with the costs of claims arising. The annual membership contributions, and any excesses payable in respect of particular claims are charged to operating expenses when the liability arises.

Note 1.14 Contingencies

A contingent asset is a possible asset that arises from past events and whose existence will be confirmed by the occurrence or non-occurrence of one or more uncertain future events not wholly within the control of the trust. A contingent asset is disclosed where an inflow of economic benefits is probable.

A contingent liability is a possible obligation that arises from past events and whose existence will be confirmed only by the occurrence or non-occurrence of one or more uncertain future events not wholly within the control of the trust, or a present obligation that is not recognised because it is not probable that a payment will be required to settle the obligation or the amount of the obligation cannot be measured sufficiently reliably. A contingent liability is disclosed unless the possibility of a payment is remote.

Note 1.15 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.

At any time, the secretary of state can issue new PDC to, and require repayments of PDC from, the trust. PDC is recorded at the value received.

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 per cent) on the average relevant net assets of the trust during the financial year. Relevant net assets are calculated as the value of all assets less the value of all liabilities, except for

(i) donated assets (including lottery funded assets),

(ii) average daily cash balances held with the Government Banking Services (GBS) and National Loans Fund (NLF) deposits, excluding cash balances held in GBS accounts that relate to a short-term working capital facility, and

(iii) any PDC dividend balance receivable or payable.

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

Note 1.16 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 1.17 Corporation tax

The trust has determined that it is has no corporation tax liability on the basis it has no activities subject to corporation tax as all activities are core or related to core healthcare as defined under Section 14(1) of HSCA.

Note 1.18 Foreign exchange

The trust's functional currency and presentational currency is sterling. Transactions denominated in a foreign currency are translated into sterling at the exchange rate ruling on the dates of the transactions. At the end of the reporting period, monetary items denominated in foreign currencies are re-translated at the spot exchange rate on 31 March. Resulting exchange gains and losses for either of these are recognised in the trust's surplus/deficit in the period in which they arise.

Note 1.19 Third party assets

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

Note 1.20 Losses and special payments

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

However 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 1.21 Early adoption of standards, amendments and interpretations

No new accounting standards or revisions to existing standards have been early adopted in 2017-18.

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

The following list of issued accounting standards and amendments have not yet been adopted by the HM Treasury FReM and are therefore not applicable in 2017/18. The trust does not expect the subsequent application of IFRS 9 and IFRS 15 to have a material impact on 2018-19 accounts:

- IFRS 9 financial instruments: Application required for accounting periods beginning on or after 1 January 2018, but not yet adopted by the FReM: early adoption is not therefore permitted.
- IFRS 14 regulatory deferral accounts: Not yet EU endorsed. Applies to first time adopters of IFRS after 1 January 2016 and therefore not applicable to DHSC group bodies.
- IFRS 15 revenue for contracts with customers: Application required for accounting periods beginning on or after 1 January 2018, but not yet adopted by the FReM: early adoption is not therefore permitted.
- IFRS 16 leases: Application required for accounting periods beginning on or after 1 January 2019, but not yet adopted by the FReM: early adoption is not therefore permitted.
- IFRS 17 insurance contracts: Application required for accounting periods beginning on or after 1 January 2021, but not yet adopted by the FReM: early adoption is not therefore permitted.
- IFRIC 22 foreign currency transactions and advance consideration: Application required for accounting periods beginning on or after 1 January 2018.
- IFRIC 23 uncertainty over income tax treatments: Application required for accounting periods beginning on or after 1 January 2019.

Note 2 Operating segments

The trust does not produce any segmental analysis for any individual elements of the trust's operations. Indicative Service Line Reporting for income and expenditure is produced as management information. Assets and liabilities are not segmented.

The majority of funding was provided by Clinical Commissioning Groups, Local Authorities and NHS England. Revenue for patient care and other operating activities from these bodies was as follows:

	2017/18 £000s	% of total revenue
Clinical Commissioning Groups	131,416	59.35%
Local Authorities	46,567	21.03%
NHS England	26,675	12.05%

	2016/17 £000s	% of total revenue
Clinical Commissioning Groups	147,757	64.90%
Local Authorities	45,340	19.91%
NHS England	17,955	7.89%

Note 3 Operating income from patient care activities

Note 3.1 Income from patient care activities (by nature)

	2017/18	2016/17
	£000	£000
Community services		
Community services income from CCGs and NHS England	153,492	161,645
Income from other sources (e.g. local authorities)	59,200	56,473
All services		
Private patient income	76	86
Total income from activities	**212,768**	**218,204**

Note 3.2 Income from patient care activities (by source)

Income from patient care activities received from:	2017/18	2016/17
	£000	£000
NHS England	22,298	14,715
Clinical commissioning groups	131,194	146,930
Other NHS providers	9,086	8,119
Local authorities	46,567	45,340
Non-NHS: private patients	76	86
NHS injury scheme	405	371
Non NHS: other	3,142	2,643
Total income from activities	**212,768**	**218,204**
Of which:		
Related to continuing operations	212,768	218,204
Related to discontinued operations	-	-

Note 4 Other operating income

	2017/18	2016/17
	£000	£000
Education and training	1,742	2,292
Charitable and other contributions to expenditure	100	118
Non-patient care services to other bodies	516	1,489
Sustainability and transformation fund income	4,329	3,212
Other income	1,976	2,369
Total other operating income	**8,663**	**9,480**
Of which:		
Related to continuing operations	8,663	9,480
Related to discontinued operations	-	-

Note 4.1 Income from activities arising from commissioner requested services

Under the terms of its provider licence, the trust is required to analyse the level of income from activities that has arisen from commissioner requested and non-commissioner requested services. Commissioner-requested services are defined in the provider licence and are services that commissioners believe would need to be protected in the event of provider failure. This information is provided in the table below:

	2017/18	2016/17
	£000	£000
Income from services designated as commissioner requested services	-	-
Income from services not designated as commissioner requested services	221,431	227,684
Total	**221,431**	**227,684**

In line with guidance from NHS Improvement all foundation trusts' mandatory services were designated as commissioner requested services when licensing began. However, commissioners were required to review this designation by 1 April 2016 and, as a result, none of the trust's services provided since 1 April 2016 have been designated as commissioner requested.

Note 4.2 Profits and losses on disposal of property, plant and equipment

No land and buildings assets disposed during the year resulted in a profit or loss.

Note 5 Operating expenses

	2017/18	2016/17
	£000	£000
Staff and executive directors costs	151,525	159,574
Remuneration of non-executive directors	150	155
Supplies and services - clinical (excluding drugs costs)	20,778	20,064
Supplies and services - general	1,103	1,500
Drug costs (drugs inventory consumed and purchase of non-inventory	5,395	4,595
Consultancy costs	429	440
Establishment	6,823	6,026
Premises	9,349	8,581
Transport (including patient travel)	5,012	5,475
Depreciation on property, plant and equipment	4,915	2,561
Amortisation on intangible assets	105	30
Net impairments	22	-
Increase/(decrease) in provision for impairment of receivables	(63)	117
Audit fees payable to the external auditor		
audit services- statutory audit	58	59
Internal audit costs	111	121
Clinical negligence	348	249
Legal fees	366	223
Insurance	177	167
Education and training	924	725
Rentals under operating leases	7,546	9,060
Redundancy	(1,132)	2,942
Hospitality	29	6
Other services, eg external payroll	345	436
Other	482	2
Total	**214,797**	**223,108**
Of which:		
Related to continuing operations	214,797	223,108
Related to discontinued operations	-	-

Note 5.1 Limitation on auditor's liability

The auditor's liability for external audit work carried out for the financial year 2017-18 is limited to £2,000,000.

Note 6 Impairment of assets

	2017/18	2016/17
	£000	£000
Net impairments charged to operating surplus / deficit resulting from:		
Changes in market price	22	-
Total net impairments charged to operating surplus / deficit	**22**	**-**
Impairments charged to the revaluation reserve	151	-
Total net impairments	**173**	**-**

Note 7 Employee benefits

	2017/18 Total £000	2016/17 Total £000
Salaries and wages	121,016	125,187
Social security costs	10,193	10,380
Apprenticeship levy	582	-
Employer's contributions to NHS pensions	15,576	16,104
Pension cost - other	13	13
Termination benefits	1,319	115
Temporary staff (including agency)	4,246	7,947
Total gross staff costs	**152,945**	**159,746**
Recoveries in respect of seconded staff	(13)	(54)
Total staff costs	**152,932**	**159,692**
Of which		
Costs capitalised as part of assets	88	3

Note 7.1 Retirements due to ill-health

During 2017-18 there were eight early retirements from the trust, agreed on the grounds of ill-health (four in the year ended 31 March 2017). The estimated additional pension liabilities of these ill-health retirements is £493k (£270k in 2016-17).

The cost of these ill-health retirements will be borne by the NHS Business Services Authority – pensions' division.

Note 7.2 Directors' remuneration

The aggregate amounts payable to directors were:

	2017/18 £000	2016/17 £000
Salary	938	893
Taxable benefits	11	15
Performance related bonuses	24	15
Employer's pension contributions	93	99
Total	**1,066**	**1,022**

Note 8 Pension costs

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

So 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 (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 reporting period, and is accepted as providing suitably robust figures for financial reporting purposes. The valuation of the scheme liability as at 31 March 2018, is based on valuation data as 31 March 2017, updated to 31 March 2018 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 last published actuarial valuation done for the NHS pension scheme was completed for the year ending 31 March 2012. The scheme regulations allow for the level of contribution rates to be changed by the secretary of state for health, with the consent of HM Treasury, and consideration of the advice of the scheme actuary and employee and employer representatives as deemed appropriate.

The next actuarial valuation is to be carried out as at 31 March 2016 and is being prepared. The direction assumptions are published by HM Treasury, which are used to complete the valuation calculations, from which the final valuation report can be signed off by the scheme actuary. This will set the employer contribution rate payable from April 2019 and will consider the cost of the scheme relative to the employer cost cap. There are provisions in the Public Service Pension Act 2013 to adjust member benefits or contribution rates if the cost of the Scheme changes by more than two per cent of pay. Subject to this employer cost cap assessment, any required revisions to member benefits or contribution rates will be determined by the Secretary of State for Health after consultation with the relevant stakeholders.

Other schemes

The trust participates in the National Employees Savings Trust (NEST) scheme as an alternative for employees who are not eligible to join the NHS pension scheme. NEST is a defined contribution scheme with a phased employer contribution rate, currently 1%. The employer contribution will increase to two per cent from 6 April 2018.

Note 9 Operating leases

Note 9.1 Kent Community Health NHS Foundation Trust as a lessee

This note discloses costs and commitments incurred in operating lease arrangements where Kent Community Health NHS Foundation Trust is the lessee.

	2017/18	2016/17
	£000	£000
Operating lease expense		
Minimum lease payments	7,546	9,060
Contingent rents	-	-
Less sublease payments received	-	-
Total	**7,546**	**9,060**

	31 March 2018	31 March 2017
	£000	£000
Future minimum lease payments due:		
- not later than one year;	2,632	2,739
- later than one year and not later than five years;	6,510	6,786
- later than five years.	5,664	4,401
Total	**14,806**	**13,926**
Future minimum sublease payments to be received	-	-

Note 10 Finance income

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

	2017/18	2016/17
	£000	£000
Interest on bank accounts	63	59
Total	**63**	**59**

Note 11.1 Finance expenditure

Finance expenditure represents interest paid on the late payment of commercial debt.

	2017/18	2016/17
	£000	£000
Interest expense:		
Interest on late payment of commercial debt	-	5
Total interest expense	**-**	**5**

Note 11.2 The late payment of commercial debts (interest) Act 1998/ Public Contract Regulations 2015

	2017/18	2016/17
	£000	£000
Amounts included within interest payable arising from claims made under this legislation	-	5
Compensation paid to cover debt recovery costs under this legislation	-	-

Note 12 Other gains/losses

	2017/18	2016/17
	£000	£000
Gains on disposal of assets	-	-
Losses on disposal of assets	(65)	-
Total gains / (losses) on disposal of assets	**(65)**	**-**

A loss of £65k was recorded in 2017/18 on the disposal of dental machinery and equipment.

Note 13 Intangible assets 2017-18

	Software licences £000	Intangible assets under construction £000	Total £000
Valuation / gross cost at 1 April 2017 - brought forward	**284**	**28**	**312**
Additions	350	-	**350**
Reclassifications	28	(28)	**-**
Gross cost at 31 March 2018	**662**	**-**	**662**
Amortisation at 1 April 2017 - brought forward	**74**	**-**	**74**
Provided during the year	105	-	**105**
Amortisation at 31 March 2018	**179**	**-**	**179**
Net book value at 31 March 2018	**483**	**-**	**483**
Net book value at 1 April 2017	**210**	**28**	**238**

Note 13.1 Intangible assets 2016-17

	Software licences £000	Intangible assets under construction £000	Total £000
Valuation / gross cost at 1 April 2016	**93**	**-**	**93**
Additions	191	28	**219**
Valuation / gross cost at 31 March 2017	**284**	**28**	**312**
Amortisation at 1 April 2016	**44**	**-**	**44**
Provided during the year	**30**	**-**	**30**
Amortisation at 31 March 2017	**74**	**-**	**74**
Net book value at 31 March 2017	**210**	**28**	**238**
Net book value at 1 April 2016	**49**	**-**	**49**

Note 14.1 Property, plant and equipment – 2017-18

	Land £000	Buildings excluding dwellings £000	Assets under construction £000	Plant & machinery £000	Transport equipment £000	Information technology £000	Furniture & fittings £000	Total £000
Valuation/gross cost at 1 April 2017 - brought forward	**1,472**	**7,914**	**924**	**2,024**	**294**	**12,419**	**858**	**25,905**
Transfers by absorption	-	-	-	-	-	-	-	**-**
Additions	-	974	738	130	-	1,454	65	**3,361**
Impairments	-	(173)	-	-	-	-	-	**(173)**
Revaluations	-	(443)	-	-	-	-	-	**(443)**
Reclassifications	-	350	(865)	349	-	166	-	**-**
Disposals / derecognition	-	(423)	-	(205)	-	(799)	(38)	**(1,465)**
Valuation/gross cost at 31 March 2018	**1,472**	**8,199**	**797**	**2,298**	**294**	**13,240**	**885**	**27,185**
Accumulated depreciation at 1 April 2017 - brought forward	**-**	**2,117**	**-**	**895**	**294**	**5,292**	**590**	**9,188**
Provided during the year	**-**	**815**	**-**	**244**	**-**	**3,718**	**138**	**4,915**
Revaluations	-	(522)	-	-	-	-	-	**(522)**
Disposals / derecognition	-	(423)	-	(69)	-	(799)	(38)	**(1,329)**
Accumulated depreciation at 31 March 2018	**-**	**1,987**	**-**	**1,070**	**294**	**8,211**	**690**	**12,252**
Net book value at 31 March 2018	**1,472**	**6,212**	**797**	**1,228**	**-**	**5,029**	**195**	**14,933**
Net book value at 1 April 2017	**1,472**	**5,797**	**924**	**1,129**	**-**	**7,127**	**268**	**16,717**

Note 14.2 Property, plant and equipment – 2016-17

	Land £000	Buildings excluding dwellings £000	Assets under construction £000	Plant & machinery £000	Transport equipment £000	Information technology £000	Furniture & fittings £000	Total £000
Valuation/gross cost at 1 April 2016	**1,472**	**7,715**	**183**	**1,965**	**486**	**10,167**	**758**	**22,746**
Additions	-	583	904	81	-	2,175	145	**3,888**
Reclassifications	-	11	(163)	47	-	86	19	**-**
Disposals / derecognition	-	(395)	-	(69)	(192)	(9)	(64)	**(729)**
Valuation/gross cost at 31 March 2017	**1,472**	**7,914**	**924**	**2,024**	**294**	**12,419**	**858**	**25,905**
Accumulated depreciation at 1 April 2016	**-**	**1,859**	**-**	**720**	**457**	**3,801**	**516**	**7,353**
Provided during the year	**-**	**653**	**-**	**241**	**29**	**1,500**	**138**	**2,561**
Disposals/ derecognition	-	(395)	-	(66)	(192)	(9)	(64)	**(726)**
Accumulated depreciation at 31 March 2017	**-**	**2,117**	**-**	**895**	**294**	**5,292**	**590**	**9,188**
Net book value at 31 March 2017	**1,472**	**5,797**	**924**	**1,129**	**-**	**7,127**	**268**	**16,717**
Net book value at 1 April 2016	**1,472**	**5,856**	**183**	**1,245**	**29**	**6,366**	**242**	**15,393**

Note 14.3 Property, plant and equipment – 2017-18

	Land £000	Buildings excluding dwellings £000	Assets under construction £000	Plant & machinery £000	Transport equipment £000	Information technology £000	Furniture & fittings £000	Total £000
Net book value at 31 March 2018								
Owned	1,472	6,212	797	1,228	-	5,029	195	**14,933**
NBV total at 31 March 2018	**1,472**	**6,212**	**797**	**1,228**	**-**	**5,029**	**195**	**14,933**

Note 14.4 Property, plant and equipment financing – 2016-17

	Land £000	Buildings excluding dwellings £000	Assets under construction £000	Plant & machinery £000	Transport equipment £000	Information technology £000	Furniture & fittings £000	Total £000
Net book value at 31 March 2017								
Owned	1,472	5,797	924	1,129	-	7,127	268	**16,717**
NBV total at 31 March 2017	**1,472**	**5,797**	**924**	**1,129**	**-**	**7,127**	**268**	**16,717**

Note 15 Revaluations of property, plant and equipment

An interim revaluation exercise was carried out of the trusts owned buildings and land as at 31 March 2018. This followed the last full revaluation exercise carried out as at 28 February 2015 and so the interim revaluation authorised is in line with the trust's five-year revaluation cycle, with the next full revaluation exercise planned for March 2020.

The interim revaluation exercise as at 31 March 2018 was completed by David Boshier MRICS of Boshier and Company chartered surveyors, an independent valuer. The valuation was prepared in accordance with the requirements of the RICS Valuation Global Standards.

The trust's freehold estate comprises purpose-built accommodation used to deliver NHS services. The principal method of valuation of individual assets is by depreciated replacement cost (DRC). Where buildings have been valued using the DRC method of valuation, the assumption is replacement costs will reflect those of a modern equivalent asset (MEA). Due to the specialised nature of the operational assets valued using the depreciated replacement cost method of valuation, the value is not based on the sale of similar assets in the market. The value of operational assets held for their service potential do not reflect the market value for an alternative use which may be higher or lower than the reported value.

There were no material changes made to accounting estimates related to the valuation and none of these are idle assets.

Note 16 Investments – 2017-18

The trust has no investments (including investments in property). Nil for March 2017.

Note 17 Disclosure of interests in other entities

The trust has no interests in other entities other than those disclosed in note 1.3

Note 18 Inventories

The trust holds no material inventories.

Note 19.1 Trade receivables and other receivables

	31 March 2018 £000	31 March 2017 £000
Current		
Trade receivables	12,652	14,105
Accrued income	4,943	2,080
Provision for impaired receivables	(298)	(389)
Prepayments (non-PFI)	1,469	1,481
Interest receivable	10	-
PDC dividend receivable	32	-
VAT receivable	129	612
Other receivables	816	456
Total current trade and other receivables	**19,753**	**18,345**
Non-current		
Prepayments (non-PFI)	77	68
Total non-current trade and other receivables	**77**	**68**
Of which receivables from NHS and DHSC group bodies:		
Current	12,992	10,626
Non-current	-	-

Note 19.2 Provision for impairment of receivables

	2017/18 £000	2016/17 £000
At 1 April	**389**	**356**
Increase in provision	81	188
Amounts utilised	(28)	(84)
Unused amounts reversed	(144)	(71)
At 31 March	**298**	**389**

The trust adheres to best practice in credit control activities, which includes referral of debt to an external debt collection agency and formal litigation procedures if required to trace debtors and seek to recover overdue debt. Debts are reviewed on a regular basis and a detailed assessment made to determine those debts deemed irrecoverable or at risk of non-payment. This forms the basis for the provision for impairment of receivables in the accounts.

Note 19.3 Credit quality of financial assets

	31 March 2018		31 March 2017	
	Trade and other receivables	Investments & Other financial assets	Trade and other receivables	Investments & Other financial assets
Ageing of impaired financial assets	**£000**	**£000**	**£000**	**£000**
0 - 30 days	-	-	89	-
30-60 Days	-	-	-	-
60-90 days	6	-	19	-
90- 180 days	18	-	16	-
Over 180 days	274	-	265	-
Total	**298**	**-**	**389**	**-**
Ageing of non-impaired financial assets past their due date				
0 - 30 days	283	-	183	-
30-60 Days	218	-	388	-
60-90 days	49	-	98	-
90- 180 days	474	-	155	-
Over 180 days	124	-	85	-
Total	**1,148**	**-**	**909**	**-**

Non-impaired receivables not past their due date are primarily those receivables supported by underlying contractual agreements and therefore full payment is expected on a timely basis.

Note 20 Cash and cash equivalents movements

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

	2017/18	2016/17
	£000	£000
At 1 April	**19,167**	**23,027**
Net change in year	8,466	(3,860)
At 31 March	**27,633**	**19,167**
Broken down into:		
Cash at commercial banks and in hand	41	49
Cash with the Government Banking Service	27,592	2,118
Deposits with the National Loan Fund	-	17,000
Total cash and cash equivalents as in SoFP	**27,633**	**19,167**
Total cash and cash equivalents as in SoCF	**27,633**	**19,167**

Note 20.1 Third party assets held by the trust

The trust held no cash and cash equivalents which relate to monies held by the foundation trust on behalf of patients or other parties. Nil for 2016-17.

Note 21.1 Trade and other payables

	31 March 2018 £000	31 March 2017 £000
Current		
Trade payables	2,856	5,321
Capital payables	1,704	1,581
Accruals	16,666	11,518
Social security costs	1,768	1,767
Other taxes payable	1,018	985
PDC dividend payable	-	-
Other payables	2,084	2,075
Total current trade and other payables	**26,096**	**23,247**
Total non-current trade and other payables	**-**	**-**
Of which payables to NHS and DHSC group bodies:		
Current	11,077	8,367
Non-current	-	-

Note 21.2 Early retirements in NHS payables above

There are no early retirement payables, Nil for 2016-17.

Note 22 Other liabilities

	31 March 2018 £000	31 March 2017 £000
Current		
Deferred income	1,760	585
Total other current liabilities	**1,760**	**585**

Note 23 Borrowings

The trust has no borrowings. Nil for 2016-17.

Note 24 Finance leases

Note 24.1 Kent Community Health NHS Foundation Trust as a lessor

The trust has no finance lease arrangements. Nil for 2016-17.

Note 24.2 Kent Community Health NHS Foundation Trust as a lessee

The trust has no finance lease obligations. Nil for 2016-17.

Note 25.1 Provisions for liabilities and charges analysis

	Legal claims	Redundancy	Other	Total
	£000	£000	£000	£000
At 1 April 2017	**245**	**3,339**	**-**	**3,584**
Arising during the year	127	1,146	430	**1,703**
Utilised during the year	(99)	(1,319)	-	**(1,418)**
Reversed unused	(132)	(2,277)	-	**(2,409)**
At 31 March 2018	**141**	**889**	**430**	**1,460**
Expected timing of cash flows:				
- not later than one year;	141	889	430	**1,460**
Total	**141**	**889**	**430**	**1,460**

The redundancy provision is a recognition of the expected redundancy costs associated with service changes. These are recognised following the development of detailed formal plans for service changes with uncertainties typically about which staff will be successful with re-deployment etc. The legal provision includes continuing employment tribunals and the provision for liabilities to third parties scheme (LTPS) claims administered and informed by the NHS Resolution (see also Accounting Policy Notes 1.2 and 1.13). The provision classified as other, relates to an continuing HMRC review with regards to the VAT recoverability on historic invoices and the potential for repayment of the VAT previously claimed.

Note 25.2 Clinical negligence liabilities

At 31 March 2018, £2,534k was included in provisions of NHS Resolution in respect of clinical negligence liabilities of Kent Community Health NHS Foundation Trust (31 March 2017: £2,803k).

Note 26 Contingent assets and liabilities

	31 March 2018 £000	31 March 2017 £000
Value of contingent liabilities		
NHS Resolution legal claims	(15)	(13)
Gross value of contingent liabilities	**(15)**	**(13)**
Amounts recoverable against liabilities	-	-
Net value of contingent liabilities	**(15)**	**(13)**
Net value of contingent assets	-	-

Note 27 Contractual capital commitments

	31 March 2018 £000	31 March 2017 £000
Property, plant and equipment	607	1,136
Intangible assets	-	-
Total	**607**	**1,136**

Note 28 Other financial commitments

The trust is committed to making payments under non-cancellable contracts, which are not leases, PFI contracts or other service concession arrangement, analysed by the period during which the payment is made:

	31 March 2018 £000	31 March 2017 £000
not later than 1 year	210	652
after 1 year and not later than 5 years	1,057	1,003
paid thereafter	705	969
Total	**1,972**	**2,624**

Note 29 Defined benefit pension schemes

The trust has no defined benefit pension schemes.

Note 30 Financial instruments

Note 30.1 Financial risk management

Financial reporting standard IFRS 7 requires disclosure of the role that financial instruments have had during the period in creating or changing the risks a body faces in carrying out its activities. Due to the continuing service provider relationship that Kent Community Health NHS Foundation Trust (KCHFT) has with NHS and local authority commissioners and the way those commissioners are financed, the 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. KCHFT, as an NHS foundation 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 organisation in undertaking its activities.

The organisation's treasury management operations are carried out by the finance department, within parameters defined formally within the organisation's standing financial instructions and policies agreed by the board of directors. Treasury activity is subject to review by the organisation's internal auditors.

Currency risk

The trust is a wholly UK-based organisation with the great majority of transactions, assets and liabilities being in the UK and sterling based. The trust has no overseas operations. The organisation, therefore, has low exposure to currency rate fluctuations.

Interest rate risk

The trust has no borrowings and so is not exposed to any interest rate risk.

Credit risk

As the majority of the trust's revenue comes from contracts with other public sector bodies, the organisation has low exposure to credit risk. The maximum exposure as at 31 March 2018 is in receivables from customers, as disclosed in the trade and other receivables note. However the trust utilises external tracing and debt collection agencies, and court procedures, to pursue overdue debt.

Liquidity risk

The trust's operating costs are incurred under contracts with commissioning organisations, which are financed from resources voted annually by Parliament. The organisation funds its capital expenditure through internally generated cash. The organisation is not, therefore, exposed to significant liquidity risks.

Note 30.2 Carrying values of financial assets

	Loans and receivables	Assets at fair value through the I&E	Held to maturity	Available-for-sale	Total book value
	£000	£000	£000	£000	£000
Assets as per SoFP as at 31 March 2018					
Trade and other receivables excluding non financial assets	18,123	-	-	-	**18,123**
Cash and cash equivalents at bank and in hand	27,633	-	-	-	**27,633**
Total at 31 March 2018	**45,756**	**-**	**-**	**-**	**45,756**

	Loans and receivables	Assets at fair value through the I&E	Held to maturity	Available-for-sale	Total book value
	£000	£000	£000	£000	£000
Assets as per SoFP as at 31 March 2017					
Trade and other receivables excluding non financial assets	16,252	-	-	-	**16,252**
Cash and cash equivalents at bank and in hand	19,167	-	-	-	**19,167**
Total at 31 March 2017	**35,419**	**-**	**-**	**-**	**35,419**

Note 30.3 Carrying values of financial liabilities

	Other financial liabilities £000	Liabilities at fair value through the I&E £000	Total book value £000
Liabilities as per SoFP as at 31 March 2018			
Trade and other payables excluding non financial liabilities	23,310	-	**23,310**
Total at 31 March 2018	**23,310**	**-**	**23,310**

	Other financial liabilities £000	Liabilities at fair value through the I&E £000	Total book value £000
Liabilities as per SoFP as at 31 March 2017			
Trade and other payables excluding non financial liabilities	20,495	-	**20,495**
Total at 31 March 2017	**20,495**	**-**	**20,495**

Note 30.4 Fair values of financial assets and liabilities

There is no material difference between the carrying value and fair value of the Financial Assets and Financial Liabilities shown above.

Note 30.5 Maturity of financial liabilities

	31 March 2018 £000	31 March 2017 £000
In one year or less	23,310	20,495
Total	**23,310**	**20,495**

Note 31 Losses and special payments

	2017/18 Total number of cases Number	2017/18 Total value of cases £000	2016/17 Total number of cases Number	2016/17 Total value of cases £000
Losses				
Cash losses*	3	-	-	-
Bad debts and claims abandoned	163	28	158	84
Total losses	**166**	**28**	**158**	**84**
Special payments				
Ex-gratia payments*	4	-	11	52
Total special payments	**4**	**-**	**11**	**52**
Total losses and special payments	**170**	**28**	**169**	**136**

*values of cash losses and special payments total less than £200.

Note 32 Related parties

All bodies within the scope of the whole government accounts (WGA) are treated as related parties of an NHS foundation trust, including the Department of Health and Social Care as the trust's parent organisation. Income and expenditure for the reporting period and year-end receivable and payable balances with these organisation types is summarised below:

As at 31 March 2018 the trust has a receivable of £2k with Kent Community Health Charitable Fund where the corporate trustee is the trust's Board. The accounts of the charity are available separately and are not included in these accounts as per note 1.3.

	Receivables		Payables	
	31 March 2018	31 March 2017	31 March 2018	31 March 2017
	£000	£000	£000	£000
Department of Health and Social Care	-	-	-	-
Public Health England	5	-		-
NHS England & Clinical Commissioning Groups	8,095	8,338	1,447	201
NHS Trusts	3,941	1,118	1,381	1,454
NHS Foundation Trusts	690	1,123	951	1,847
Health Education England	17	47	39	212
Other DHSC Bodies	212	-	8,027	4,865
NHS Shared Business Services	-	-	37	41
Local Authorities	2,890	4,761	725	647
Other Government Departments*	606	17,673	4,894	4,826
Total	**16,456**	**33,060**	**17,501**	**14,093**

*2016-17 includes short-term deposit with the HM Treasury national loans fund.

	Income		Expenditure	
	31 March 2018	31 March 2017	31 March 2018	31 March 2017
	£000	£000	£000	£000
Department of Health and Social Care	-	-	2	-
Public Health England	5	5	1	-
NHS England & Clinical Commissioning Groups	158,091	165,712	-	119
NHS Trusts	6,214	5,050	3,708	3,726
NHS Foundation Trusts	3,469	3,743	3,867	3,810
Health Education England	2,041	1,810	14	6
Other DHSC Bodies	286	1,353	11,613	11,365
NHS Shared Business Services	-	-	345	436
Local Authorities	46,567	45,340	81	90
Other Government Departments*	-	-	26,364	26,484
Total	**216,673**	**223,013**	**45,995**	**46,036**

Note 33 events after the end of the reporting period

There are no events after the end of the reporting period.

NHS

Kent Community Health

NHS Foundation Trust

Quality Report

2017 to 2018

we care

Kent Community Health
NHS Foundation Trust

Contents page

Part one

1.1 Statement on quality from the chief executive

Welcome to our Quality Report for Kent Community Health NHS Foundation Trust for 2017-18.

A year on from refreshing our values, we re-visited our mission, vision and goals to ensure they complemented the Five Year Forward View and the emerging Kent and Medway Sustainability and Transformation Plan.

Every year, we have more than three million chances to change a life – that's the number of contacts the trust has with patients, clients and service users. We need to make sure that we make a difference each and every time we interact with a patient or service user.

As part of this, we have developed a new internal assurance visit programme, aligned to the one used by the Care Quality Commission and our own values, to make sure the care we provide is always up to the standard those we serve deserve.

We know our patients value what our nurses, doctors, therapists, domestics, porters and support staff do because they tell us so. Our patient satisfaction rate remained high at 97 per cent following feedback from 63,912 patient surveys.

Our Board and Executive Team continue to be visible on our wards and in our clinics, spending time shadowing staff and making sure that our We Care inspection programme is identifying areas of excellent clinical practice and any issues.

In terms of our clinical effectiveness and in recognition of the rising number of patients we care for who have dementia or a form of cognitive impairment, our staff now receive mandatory dementia awareness training.

We introduced dementia champions who have extra training to be able to support patients and colleagues and our baywatch campaign – where we place patients with similar impairments in bays together for more effective monitoring and care.

The environment in which our patients with dementia are cared for was addressed during the summer and autumn to make it easier to get around. Simple things like painting doors and walls and changing signage have made an enormous difference.

We set ourselves a target of recruiting 200 people to take part in National Institute of Health Research portfolio studies and exceeded this target, with 545 participants.

The trust took part in the NHS Improvement Falls Collaborative, where our aim was to improve falls prevention across our in-patient sites and make sure there was always a multi-disciplinary approach to preventing falls, this and other related work resulted in a 41 per cent reduction in falls with harm in our community hospitals, which exceeded the target we had set of 10 per cent.

We did undertake some strong work on reducing pressure ulcers, so we were pleased that there was a 35 per cent reduction in grade three and four pressure ulcers in 2017-18, which exceeded our target. Equally, the 44 per cent reduction in grade two pressure ulcers went beyond what we initially thought was achievable, which is good news for patients and demonstrates the continuing hard work of our teams to get it right.

The Executive Team gave its backing to a staff and managers' pledge to reduce pressure ulcer harm. We are committed to being open and honest

There are some areas where we want to improve further, such as increasing the number of people who die in their preferred place. We also want to reduce catheter-associated urinary tract infections in our community hospitals and launched a campaign at the beginning of 2018-19 to help us do this.

We don't always get everything right, but I promise your feedback helps shape the way we learn and continue to improve.

You can read more information about our trust in our annual report, which can be downloaded from our website, www.kentcht.nhs.uk

Signed: ..... Date: 24 May 2018

Paul Bentley, Chief Executive

Part two

Priorities for improvement and statements of assurance from the Board

2.1 Priorities for improvement

About our trust:

We provide wide-ranging NHS care for people in the community, in a range of settings including people's own homes; nursing homes; health clinics; community hospitals; minor injury units and in mobile units.

Kent Community Health NHS Foundation Trust (KCHFT) is a large NHS community health provider, serving a population of about 1.4 million across Kent and 600,000 in East Sussex and London. We employ about 4,600 staff, including doctors, community nurses, physiotherapists, dietitians and many other healthcare professionals. We became a foundation trust on 1 March 2015.

We refreshed our vision, mission, values and goals during 2017 following extensive engagement with our patients, public and colleagues.

Mission:

Our mission is to empower adults and children to live well, to be the best employer and work with our partners as one.

Vision:

Our vision is a community that supports each other to live well.

Values we care

We have four values:

1. Compassionate: We put patients and our service users at the heart of everything we do. We're positive, kind and polite. We understand diversity. We're respectful, patient and tolerant.
2. Aspirational: We feel empowered and we empower our patients. We strive to improve. Our focus is on research and generating ideas and innovations. We're open, transparent and we think creatively.
3. Responsive: We listen. We act. We communicate clearly. We do what we say we will. We take account of other's opinions.
4. Excellent: We strive to deliver the best care we can. We grow a culture of excellence in our teams. We challenge complacency.

Our goals are to:

1. prevent ill health
2. deliver high-quality care at home and in the community
3. integrate services
4. develop sustainable services.

Our quality strategy 2017 to 2020

Our organisational strategy recognises the importance of providing high-quality services and is central to our vision, mission and values. This is enshrined in our quality strategy.

It places quality at the heart of everything we do. We strive to deliver services we are proud of and that make a positive difference to the communities we serve.

Improving quality is the role of every single employee. We understand the importance of working with patients and carers, where possible, to drive continuous quality improvements to our services.

We aim to embed quality at all levels and to deliver demonstrable improvements in patient care by:

- enhancing patient experience
- improving population health by improving patient outcomes, clinical effectiveness and national benchmarks; improving safety and reducing harm
- improving staff experience at work
- reducing cost and increasing value for money to increase efficiency.

This is known as the quadruple aim.

Quality is central to all we aspire to achieve:

1. Patient experience – be nice to me.
2. Patient safety – do me no harm.
3. Clinical effectiveness – make me better, help me live with my condition and help me die in a way I choose.

Our objectives for quality are:

1. visible leadership
2. all employees to take ownership
3. improved patient experience and increased patient and public engagement and involvement
4. clinically and cost effective evidence-based services
5. improved patient safety
6. organisational learning to enhance quality
7. engagement with external partners.

Delivering quality:

New structures

Patient Experience Group (PEG)
Patient Safety and Clinical Risk Group (PSCRG)
Clinical Effectiveness Group (CEG)
→ Quality Committee

New roles

Heads of quality, governance and professional standards director/deputy community services director/chiefoperating officer
→ Community services

Task and finish groups

Quality action teams → PEG/PSCRG/CEG → Quality Committee

We have a comprehensive action plan to achieve our quality strategy.

Summary against 2017-18 priorities

Our trust priorities for last year were:

- research, innovate and continually improve to be affordable and deliver safe care with the best outcomes
- engage and empower patients and carers as active partners to support health, wellbeing and independent living
- nurture leadership, support staff development and foster flexibility and adaptability to recruit and retain the right workforce.

Our quality priorities for 2017-18 were developed in consultation with our partners, service users and their families. They are shown here:

Patient experience

- All services to survey at least **10%** of their caseload.
- Ensure a minimum of **95%** of our patients die in their preferred place.
- Increase the number of surveys from patients, carers and families at end of life to 40 surveys per quarter.

Patient safety

- **10%** reduction in falls with harm in our community hospitals.
- **20%** reduction in category three and four avoidable pressure ulcers acquired in our care.
- **10%** reduction in category two avoidable pressure ulcers acquired in our care.
- No more than **12** catheter-associated urinary tract infections acquired in our care.

Clinical effectiveness

- To improve wound healing times by **5%** in our wound medicine centres.
- Community hospital environments to work towards becoming dementia friendly, as required by the Hospital Charter 2020, including tier 2 training for staff in these areas.
- At least **200** patients enrolled in National Institute for Health Research portfolio studies.

Quality achievements 2017-18

We have highlighted below our key achievements during the past year.

Section three of this report explains in more detail what we have achieved against our quality priorities, and the areas we need to improve upon.

Patient experience

- **63,912** patient experience surveys completed across the trust with an average satisfaction rate of **97%**.

Patient safety

- **41%** reduction in falls with harm within our community hospitals, exceeding our target.
- **35%** reduction in grades three and four pressure ulcers, exceeding our target.
- **44%** reduction in grade two pressure ulcers, exceeding our target.

Clinical effectiveness

- Improved wound healing times in our wound management clinics by **16%**, exceeding our target.
- Achieved a recruitment figure of **545** participants to National Institute for Health Research portfolio studies, well exceeding the target of **200**.
- Improved the environment and facilities in our community hospitals so they are more dementia friendly.
- Trained **89%** of identified staff in tier 2 dementia training.

Our priorities for 2018-19

Through a robust consultation process, four quality priority areas were selected as the trust's quality priorities for 2018-19.

To align with our quality strategy objectives and to increase workforce engagement, how we measure and monitor the quality priorities will be based on quality improvement science and methodologies. Each of these priorities will be developed into a quality improvement (QI) project.

A summary of next year's quality priorities and what we intend to achieve is shown here:

Our patients' safety

We will learn from incidents and complaints, improving the safety of our patients. We will introduce an improved methodology of patient centred investigation.

We will:

- involve families in all relevant RCA investigations for serious incidents
- survey patients and families on their involvement in investigations
- share serious incidents and complaints' stories at our quality improvement network

We need more staff trained in root cause analysis investigation training. There is a national agenda for shared learning and improving and we want to improve our processes.

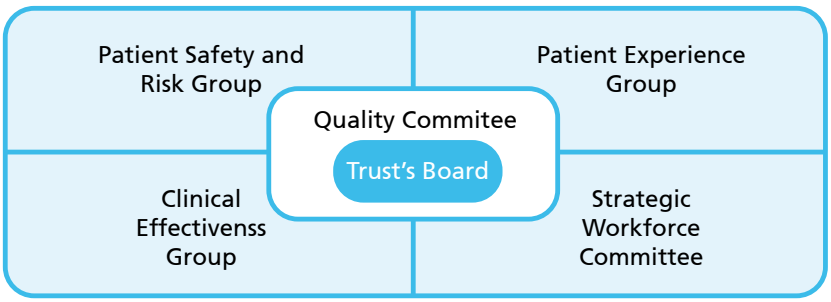
Our patients' experience

We will ensure our patients are co-leaders in their care, by working together with our patients and local population to improve our responsiveness.

We will

- develop and publish an involvement and experience strategy
- ensure all relevant patients have a personalised plan of care developed by competent staff:

We want to be responsive to the needs of our population. We have started personalised care planning across the trust, but have further work to do to embed. This is a CQUIN for us for 2018–19.



Our clinical effectiveness

We will adopt a quality improvement (QI) methodology to support quality assurance; educate and train our workforce to increase awareness.

We will:

- develop and deliver our quality improvement training plan
- Start 20 quality improvement projects

This is a local driver, to move from quality assurance to quality improvement. It is part of our Quality Strategy and organisational objectives.

Our staff

We will improve recruitment and retention of our workforce.

We will

- participate in the NHSI Retention Improvement Collaborative.
- aim to reduce our staff turnover by 2% in 2018–19

We, like other trusts in Kent, are experiencing issues with recruitment and retention so this is an area we want to improve.

2.2 Statements of assurance from the Board

During 2017-18 KCHFT provided and/or sub-contracted 51 relevant health services.

KCHFT has reviewed all data available on the quality of care in all of these relevant health services.

The income generated by the relevant health services reviewed in 2017-18 represents 100 per cent of the total income generated from the provision of relevant health services by KCHFT for 2017-18.

During 2017-18, five national clinical audits and no national confidential enquiries covered relevant health services that KCHFT provides.

During that period KCHFT participated in 100 per cent national clinical audits and 100 per cent national confidential enquiries of the national clinical audits and national confidential enquiries, which it was eligible to participate in.

The national clinical audits and national confidential enquiries that KCHFT was eligible to participate in during 2017-18 are as follows:

- national audit of intermediate care (NAIC)
- national chronic obstructive pulmonary disease (COPD) audit programme
- national diabetes audit – adults
- Sentinel stroke national audit programme (SSNAP)
- UK Parkinson's audit (incorporating occupational therapy, speech and language therapy, physiotherapy, elderly care and neurology)
- Learning disability mortality review programme (LeDeR).

The national clinical audits and national confidential enquiries KCHFT participated in during 2017-18 were:

- national audit of intermediate care (NAIC)
- national chronic obstructive pulmonary disease (COPD) audit programme
- national diabetes audit – adults
- Sentinel stroke national audit programme (SSNAP)
- UK Parkinson's audit (speech and language therapy)
- learning disability mortality review programme (LeDeR).

The national clinical audits and national confidential enquiries that KCHFT participated in, and for which data collection was completed during 2017-18 are listed below alongside the number of cases submitted to each audit or enquiry as a percentage of the number of registered cases required by the terms of that audit or enquiry.

- National audit of intermediate care (NAIC) (57 per cent).
- National chronic obstructive pulmonary disease (COPD) Audit programme (96 per cent).
- National diabetes audit – adults (national diabetes footcare audit).
- Sentinel stroke national audit programme (SSNAP). No set case number required.
- UK Parkinson's audit (speech and language therapy). No set case number required.
- Learning disability mortality review programme (LeDeR). No set case number required.

The report of one national clinical audit was reviewed by the provider in 2017-18 and KCHFT intends to take no action to improve the quality of healthcare provided because the data input into NACR provides assurance we meet the criteria for a comprehensive cardiac rehabilitation service.

The reports of 46 local clinical audits were reviewed by the provider in 2017-18 and KCHFT intends to take the these actions to improve the quality of healthcare provided:

- Improve response time to referrals for nocturnal enuresis.
- Increase the number of people over 50 with HIV who have an annual medication review, sexual health screening, three-year cardio vascular, three-year fracture risk assessment.
- Improve communication with GPs and patients about the annual flu vaccine
- Use a new discharge document template to record information given verbally to the patient upon discharge, which is given to the patient/carer and GP upon discharge to enhance self-care.
- Communication needs to be better identified, recorded, flagged, shared and met
- Standardised partner notification practice and documentation across all areas in Kent for sexually transmitted diseases with improved liaison pathways. Develop pathways to enable clinicians to verify that sexual partners have been screened and treated.
- Falls prevention champion to be identified in each community hospital and an improved programme of staff training on falls awareness and prevention practices introduced.
- Increase awareness of falls for people with a learning disability and their carers with access to appropriate intervention for people with learning disability who fall.
- Screening for smoking and alcohol drinking status for all patients admitted to the inpatient units with advice, medication and support offered to help reduce risky behaviours.
- Improve information to reduce the number of women needing emergency contraception.
- Increase robustness of safeguarding process to make sure appropriate escalation and prevent re-occurrence.
- Standardise and use a multi-disciplinary approach to personalised care planning.
- Have a drive to increase wound healing with better assessment and increased referrals to specialised tissue viability nurses or wound medicine centre for wounds not healing within four weeks.
- Increase HIV testing for people at increased risk of infection.

The number of patients receiving relevant health services provided or sub-contracted by KCHFT in April 2017 to March 2018 who were recruited to participate in research approved by a research ethics committee was 523.

A proportion of KCHFT income in 2017-18 was conditional on achieving quality improvement and innovation goals agreed between KCHFT and any person or body it entered into a contract, agreement or arrangement to provide relevant health services, through the commissioning for quality and Innovation (CQUIN) payment framework.

Further details of the agreed goals for 2017-18 and for the following 12-month period are available electronically at www.england.nhs.uk/nhs-standard-contract/cquin/cquin-17-19 for the majority of the CQUINs, further details on agreed goals outside of nationally mandated schemes with NHS England and Kent County Council are available on request.

KCHFT is required to register with the Care Quality Commission and its current registration status is registered with no conditions. The Care Quality Commission has not taken enforcement action against KCHFT during 2017-18.

KCHFT has not participated in any special reviews or investigations by the CQC during the reporting period.

KCHFT submitted 78,773 records during 2017-18 to the Secondary Uses Service for inclusion in the hospital episode statistics, which are included in the latest published data.

The percentage of records in the published data, which included the patient's valid NHS number was:

- 100 per cent for admitted patient care
- 99.5 per cent for accident and emergency care.

which included the patient's valid General Medical Practice Code was:

- 99.2 per cent for admitted patient care
- 99.02 per cent for accident and emergency care.

KCHFT's Information Governance Assessment Report overall score for 1 April 2017 to 31 March 2018 was 89 per cent and was graded satisfactory (green).

KCHFT was not subject to the payment by results clinical coding audit during 2017-18 by the Audit Commission.

KCHFT has taken the following actions to improve this percentage, and so the quality of its services:

- by regularly analysing performance and
- reviewing admission and attendance criteria.

During 2017-18 43 of KCHFT patients died. This comprised the following number of deaths, which occurred in each quarter of that reporting period: Data not reported in the first quarter; two in the second quarter; 20 in the third quarter; 21 in the fourth quarter.

By 2018, 35 case record reviews and no investigations had been carried out in relation to 35 of the deaths included in the previous item.

In 0 cases a death was subjected to both a case record review and an investigation. The number of deaths in each quarter for which a case record review or an investigation was carried out was: 0 in the first quarter; two in the second quarter; 17 in the third quarter; 16 in the fourth quarter.

No patient deaths during the reporting period are judged to be more likely than not to have been due to problems in the care provided to the patient. No patient deaths relating to this were reported during any quarter 2017-18.

These numbers have been estimated using a locally adapted version of Prism II methodology, incorporating structured judgement for mortality review.

Here are the learning points that have been found from the case record reviews conducted in relation to the deaths identified in the previous item:

- End of life discussions were not always recorded in patient notes.
- Notes should have included expected death 'nurse may verify'. Staff need to know what to do if: a) not documented that nurse can verify b) nobody on duty is able to verify.
- Medical and nursing staff to be advised of need to make contact with coroner to have initial phone discussion before proceeding with completion of death certificate and funeral arrangements.
- The end of life drugs chart was not used; staff on the ward were not aware of this document, however this did not impact on the level of care provided.
- In some cases, medical entries were not on the documenting system CIS, so the patient record is fragmented with no obvious place to record discussion with patient and relatives, or that the bereavement leaflet was given to relatives.
- In one case, notes were unclear in terms of chronology, the date of admission was not obvious, but found eventually. The nursing admission checklist has no place to put the date.
- A patient stayed too long in hospital while an appropriate care home was sourced.
- Use of term failed discharge was used on numerous occasions, following discharge from an acute hospital. A more appropriate term is re-admitted.
- The doctor's name was not recorded against one of the medical entries in the patient's notes.

Areas of good practice were:

- the patient assessed comprehensively with a care plan in place
- responsive to a patient's needs, admitted directly by their family, end of life care administered and staff took turns to sit with patient until she died. There was evidence of a very caring and holistic approach
- a clear GP clerking form
- staff gave good end of life care, there was considerable team work across departments and external organisations to get end of life medication on New Year's Day
- good record keeping throughout, clear evidence of communication and support of the family
- CIS records clearly document any issues and how these were dealt with
- comprehensive range of referrals made in a short space of time and clear liaison with dietitian/Home Enteral Nutrition Team for advice
- investigations appropriately cancelled, evidence of medication review and end of life medication prescribed
- good evidence of regular communication with family.

The actions KCHFT took in 2017-18, and proposes to take following the reporting period in consequence of what KCHFT has learned during the reporting period, (see previous item):

The medical director has discussed documentation issues with ward matrons to influence part of a wider piece of work to standardise documentation in community hospitals. The electronic patient records system is being reviewed. A task and finish group is planned as a quality action team that will report into the Quality Committee. Consultant geriatricians have been involved with mortality reviews and shared learning with staff. They will take steps to make sure that the one occurrence of a patient staying too long in hospital while a care home was sourced is avoided whenever possible, as well as ensuring that the appropriate terminology is used in mortality reviews.

The mortality review policy and process are making changes to create a central review team made up of doctors and quality leads who will rotate on a monthly basis, along with administration support. This is different to the current system of allocating each death to a hospital multi-disciplinary team to review. This change in process was the result of the planned review six months after implementing the policy. This should allow for a more efficient way of reviewing deaths. All learning will continue to be reviewed by the Mortality Surveillance Group monthly, which will collate learning and monitor how this is fed back to teams through matrons' meetings and other methods. The medical director will work with the Legal Team to contact the coroner's office to clarify how the teams can receive feedback following a referral to the coroner.

An assessment of the impact of the actions described in the previous item, which were taken by KCHFT during 2017-18:

The mortality review policy has been in place for six months and has already helped to support a culture of reflective learning. In one case, a GP referred a patient to us for mortality review and a consultant geriatrician met the family to discuss the death, helping to foster good communication and partnership working. While none of the deaths so far reviewed have been judged more likely than not to be due to problems in care, there has been rich learning from individual patient journeys and some emerging themes, such as documentation issues with clear actions attached. The Quality Action Team will need to work as a task and finish group to understand, make recommendations and oversee implementation of changes to address documentation issues. This work is just starting so we are not yet able to demonstrate the impact.

No case record reviews and no investigations completed after 2017-18, which related to deaths that took place before the start of the reporting period.

None of the patient deaths before the reporting period are judged to be more likely than not due to problems in the care provided to the patient. This number has been estimated using a locally adapted version of Prism II methodology, incorporating structured judgement for mortality review.

No patient deaths during 2017-18 are judged to be more likely than not due to problems in care provided to the patient.

2.3 Reporting against core indicators

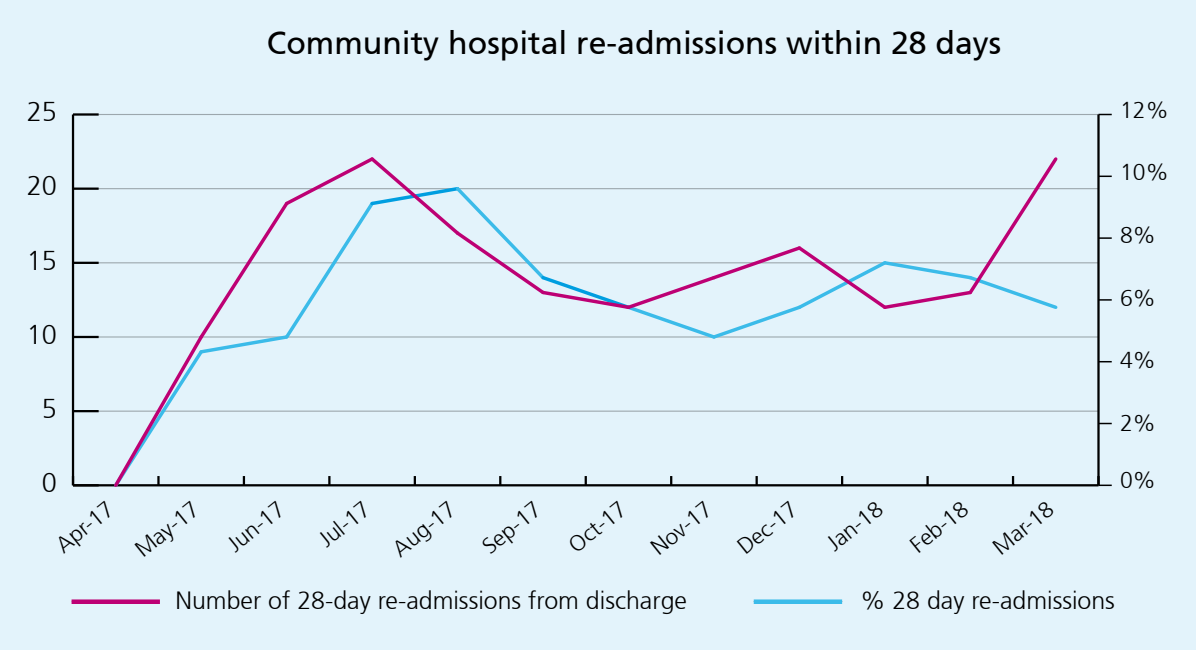
Indicator 19: hospital re-admissions

The percentage of patients aged:

(i) 0 to 14 and
(ii) 15 and over
re-admitted to a hospital within 28 days of being discharged from a hospital is shown here:

KCHFT	Apr 2017	May 2017	Jun 2017	Jul 2017	Aug 2017	Sep 2017	Oct 2017	Nov 2017	Dec 2017	Jan 2018	Feb 2018	Mar 2018
Number of 28-day readmissions from discharge	0	9	10	19	20	14	12	10	12	15	14	12
% 28-day readmissions	5.11 %	5.08 %	9.13 %	10.3 %	8.09 %	6.42 %	5.62 %	6.45 %	7.61 %	5.71 %	6.38 %	10.4 %

	2017-18
Number of 28-day re-admissions from discharge	168
% 28-day readmissions	7.21%



KCHFT considers that this data is as described because it is:

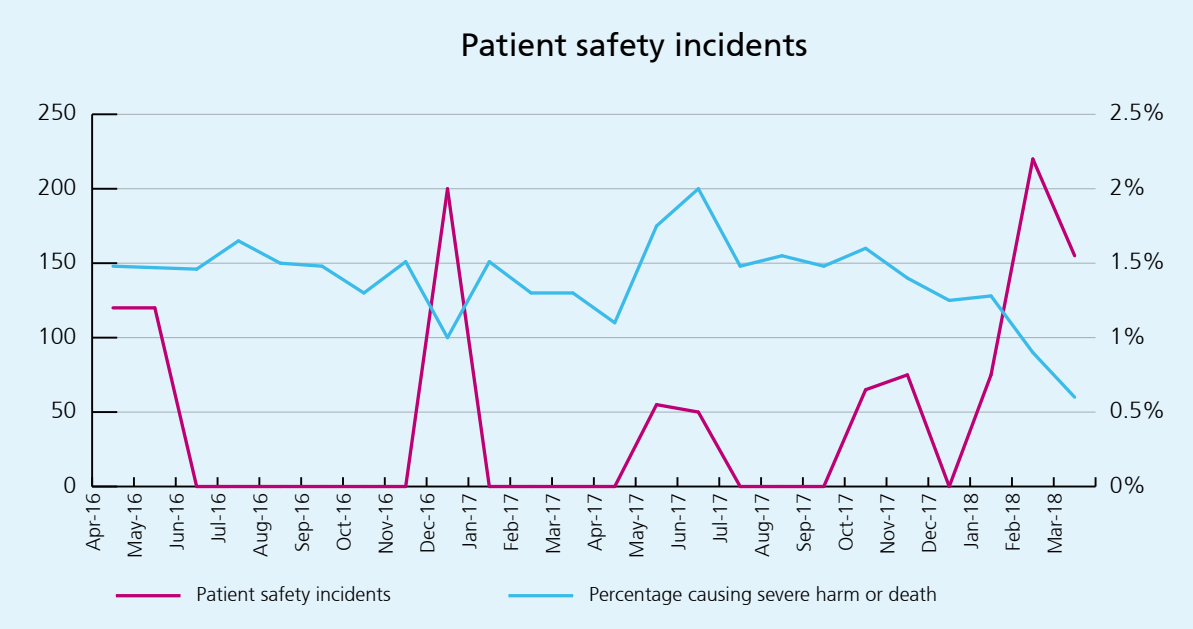
- regularly extracted and checked
- shared with services for validation
- collected at point of delivery in the majority of cases.

KCHFT has taken the following actions to improve the percentage of patients re-admitted within 28 days and the quality of its services by regularly analysing performance and reviewing admission criteria.

Indicator 25: Patient safety incidents

The number and, where available, rate of patient safety incidents reported in the trust during the reporting period and the number and percentage of patient safety incidents that resulted in severe harm or death are shown here:

	2016-17	2017-18
Avoidable patient safety incidents	1,675	1,668
Avoidable patient safety incidents (causing severe harm or death)	4	8
Percentage causing severe harm or death	0.24%	0.48%



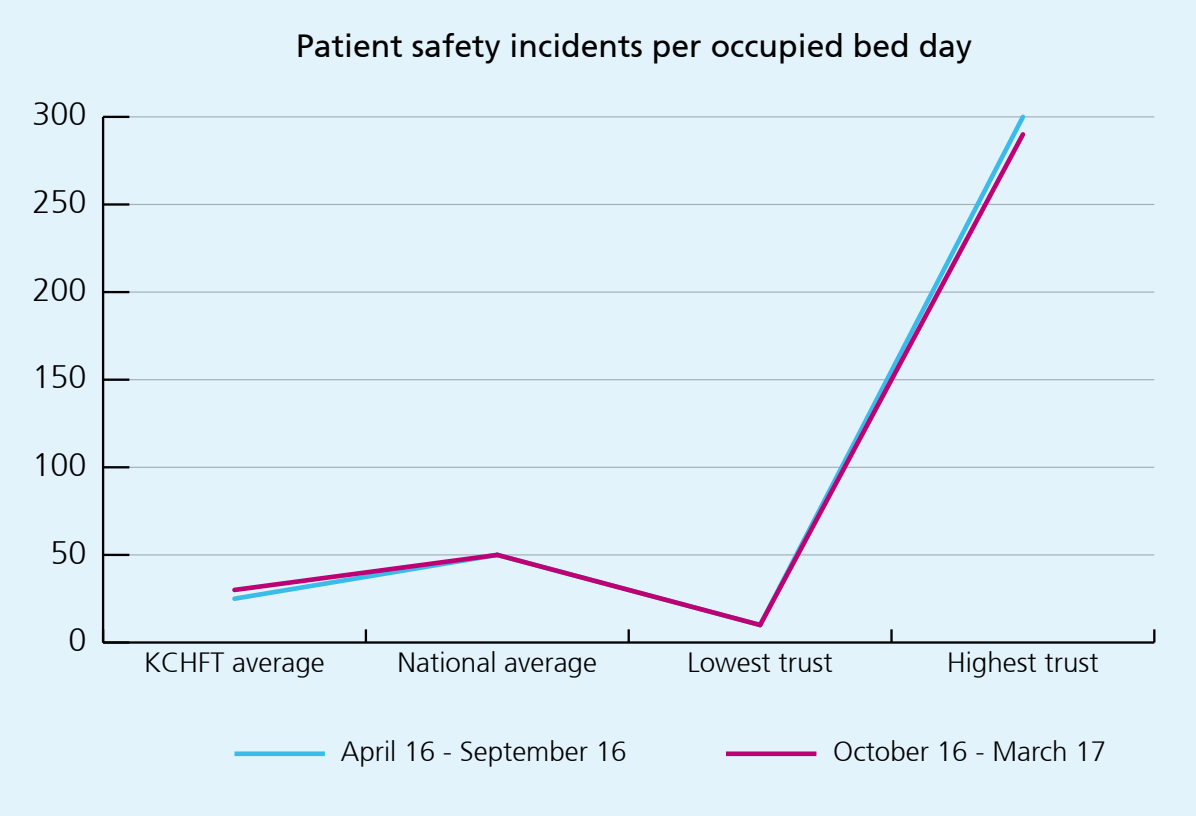
KCHFT considers this data is as described for the following reasons: It is captured on the Datix system by the member of staff who discovered the incident, ensuring the data is first-hand information.

Incidents are subject to a comprehensive review process at multiple levels across the organisation validating the accuracy of the data.

To improve this number and the quality of services, we have:

- developed a comprehensive risk and incident training package, which has been delivered to services identified as low reporters
- enhanced the reports produced to include improvements. This has facilitated a positive patient safety culture where staff are able to see the benefits of reporting incidents.

The graph and table here shows the number of patient safety incidents per occupied bed day (OBD) and how KCHFT compares to the national average.

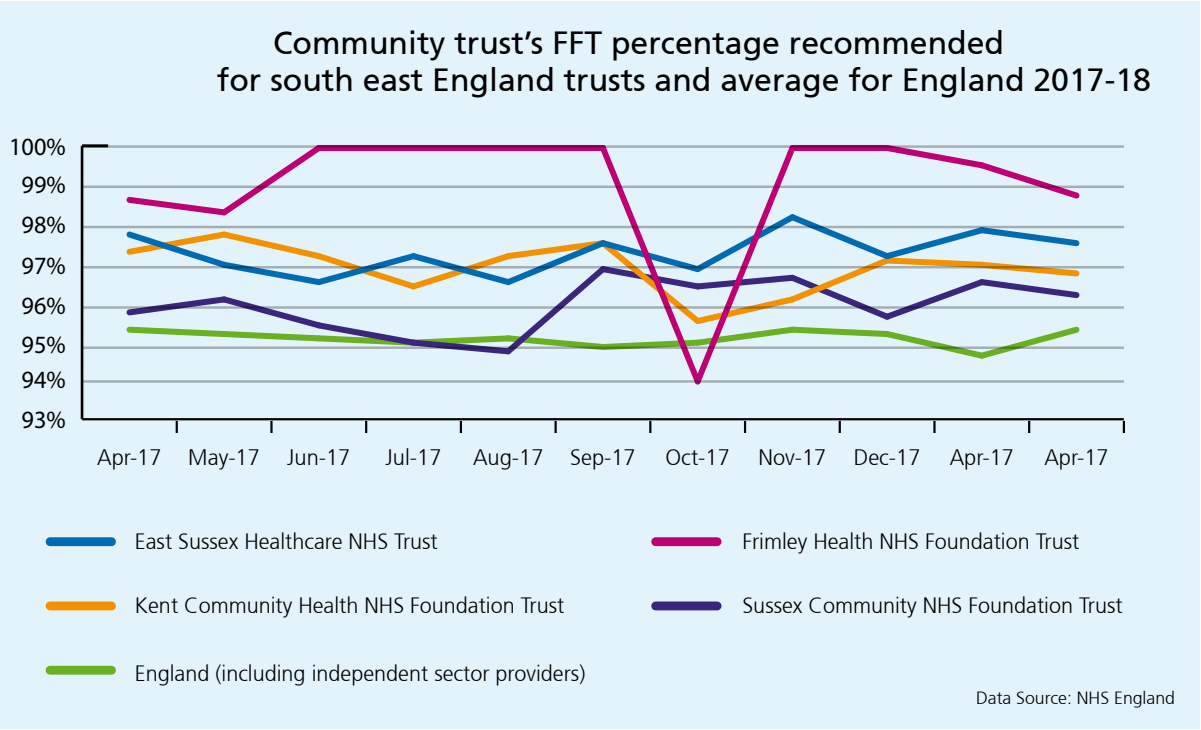


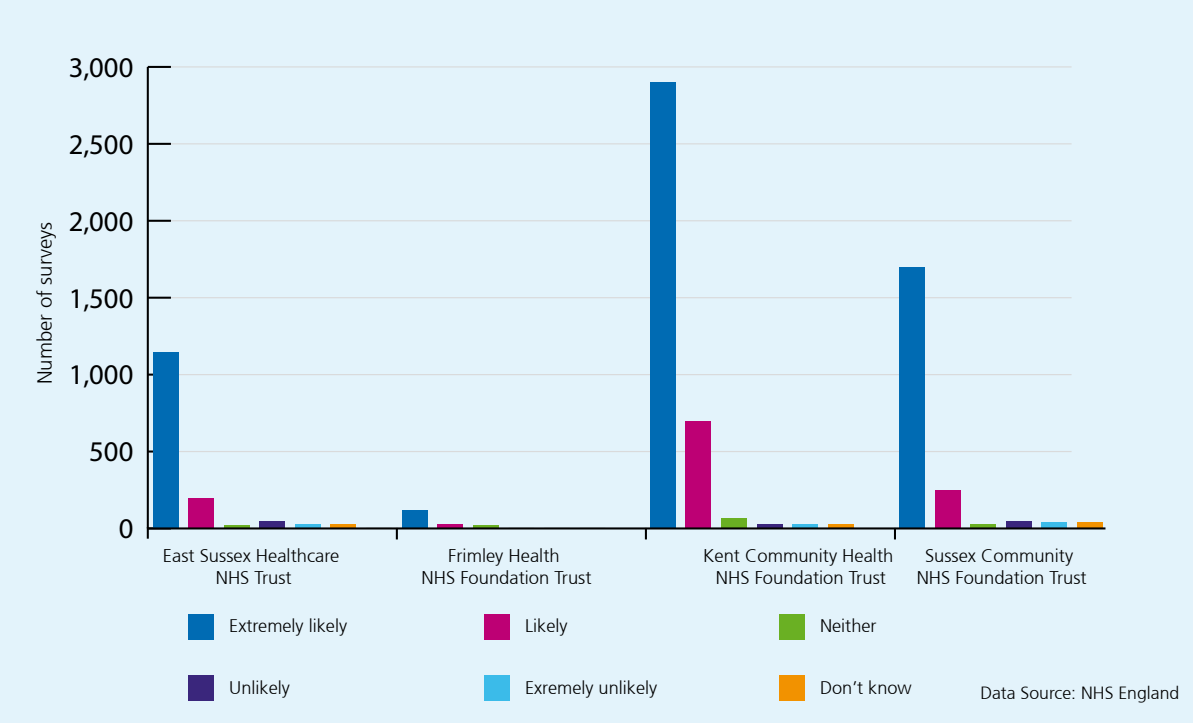
	April 2016-September 2016	October 2016 - March 2017
KCHFT average	25	33
National average	48	46
Lowest trust	12	13
Highest trust	304	295

National data is not yet available for the period 2017-18.

21 Friends and family test (FFT)

The graphs below show how KCHFT is performing against the patient friends and family test in comparison to other community health trusts and nationally.





Part three

Overview of quality of care

This section gives an overview of the quality of care offered by KCHFT based on performance against the 2017-18 indicators we agreed and published in our 2016-17 Quality Report. It explains in more detail what we have achieved during the past year and those areas we need to improve upon.

Where possible, we have presented the data by clinical commissioning group (CCG) area.

Regulation: Care Quality Commission

The Care Quality Commission (CQC) is the independent regulator of health and social care in England.

Rating

KCHFT was rated 'good' overall by the CQC following inspection in June 2014. All areas rated 'requires improvement' were addressed within an improvement plan. The CQC has confirmed it is satisfied with the improvements made. Our rating will not change until the CQC inspects the trust again.

	Safe	Effective	Caring	Responsive	Well led	Overall
Children and Young People	Good	Good	Good	Good	Good	Good
Adult Community Services	Good	Requires improvement	Good	Good	Good	Good
Inpatient Community	Good	Good	Good	Good	Good	Good
End of Life	Requires improvement	Requires improvement	Good	Requires improvement	Requires improvement	Requires improvement
Overall rating	Good	Requires improvement	Good	Good	Good	Good

Our inspection reports can be viewed here: www.cqc.org.uk/provider/RYY

Inspections 2017-18

In October 2017, a joint inspection by the CQC and Her Majesty's Inspectorate of Prisons (HMIP) reviewed our Dental Services at Harmondsworth Immigration Removal Centre. No issues of concern were identified.

We care visit programme

This year we reviewed and refreshed our internal assurance visit programme, designing new visit tools aligned with the CQC's key lines of enquiry and our own trust's CARE values.

This new model enables us to rate teams against our CARE values, using the CQC's rating methodology. It gives us a clear picture of where we are doing well and where we need to improve.

We had an ambitious aim to implement the programme during February 2018 and make sure all our services receive at least one visit and a rating by September 2018. We are progressing well with this target with about half of services rated by the end of April 2018.

The programme involves all levels and disciplines of staff in the trust, together with our governors, patient representatives and CCG colleagues. Those participating in a visit receive guidance, tools and training beforehand and are provided with a pre-visit data pack summarising the data we hold about the team or service. This includes complaints, incidents, risks and patient feedback.

During the visit, participants talk to staff, visit clinical areas and attend home visits with clinicians; giving a full picture of the standard of care being provided.

A meeting at the end of the visit enables all participants to share observations from the visit and contribute to a report and agree ratings.

After each visit, the hosting team is given feedback, a summary report, and a certificate displaying its ratings. The team is asked to produce an improvement plan and a re-visit is planned, depending on the rating.

Trust-wide areas for improvement are also identified and themes arising from the visits shared.

Compassionate

We put patients and our service users at the heart of everything we do. We're positive, kind and polite. We understand diversity. We're respectful, patient and tolerant.

Aspirational

We feel empowered and we empower our patients. We strive to improve. Our focus is on research and generating ideas and innovations. We're open, transparent and we think creatively.

Responsive

We listen. We act. We communicate clearly. We do what we say we will. We take account of the opinions of others.

Excellent

We strive to deliver the best care we can. We grow a culture of excellence in our teams. We challenge complacency.

Patient experience

End of life care

Goals for 2017-18

Goal	% 2016-17	% 2017-18	2017-18 target	Outcome
Ensure a minimum of 95% of our patients die in their preferred place	86.2%	84.5%	95%	Not achieved

Our goal was to increase the number of patients who die in their preferred place of death.

Why this is important

This is a national indicator and is also considered an indicator for the provision of quality care.

Our vision is to be the leading provider and co-ordinator for end of life care, delivering excellent care – enabling those receiving end of life care to live as comfortably as possible through their last weeks and days of life and to be able to be supported to die in their place of choice.

What we did

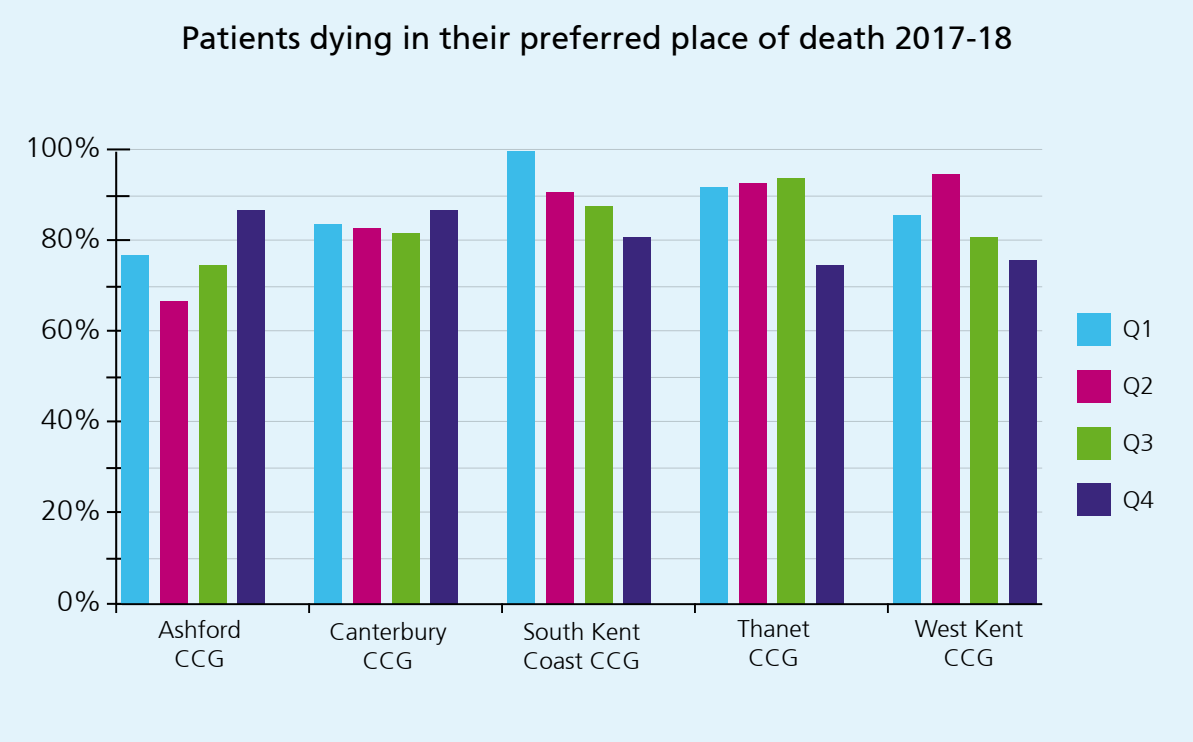
We aimed to improve data collection and the numbers of deaths recorded. We provided teams with a guide on how to enter this data and made clear that this is a priority for us.

What this means for you as a patient

An informed conversation will allow patients to decide where they would like to spend their last days.

What we achieved

Staff have made every effort to make sure that patients die in their preferred place of death. This this has not always been possible due to the patient's health or need for specialist care. Progress has been made in terms of accurate recording and this remains a priority for staff. Data from other sources, including patient experience is monitored closely to ensure high-quality end of life care is being delivered.



Patients dying in their preferred place of death 2017-18

	Q1	Q2	Q3	Q4	17/18
Ashford CCG	76.9%	66.7%	75.0%	87.0%	77.1%
Canterbury CCG	83.7%	82.5%	81.5%	86.5%	83.3%
South Kent Coast CCG	100.0%	90.6%	87.5%	81.0%	87.8%
Thanet CCG	92.0%	92.3%	93.3%	75.0%	89.2%
West Kent CCG	86.2%	95.3%	81.4%	75.0%	84.4%
Trust-wide	87.8%	85.5%	83.8%	80.9%	84.4%

Goal	Number 2016-17	Number 2017-18	2017-18 target	Outcome
Increase number of surveys from patients at the end of life, their carers and families to 40 surveys per quarter	Not measured	47 across the year	40 per quarter	Not achieved

Our aim was to increase the number of surveys completed by staff for patients at the end of life, their carers and families by promoting the survey and its importance.

Why this is important

We want to learn how we can improve end of life care and if our patients and their relatives are given the opportunity to share their experiences, this can help us do this.

What we did

We increased the skills of teams so they were confident to have a discussion with patients and their relatives about end of life care. We gave our end of life care champions additional training to enable them to support their teams.

We adapted the survey with staff and have promoted it to all teams. The feedback from surveys is reviewed at team meetings and a thematic analysis of the feedback is reported to the End of Life Steering Group.

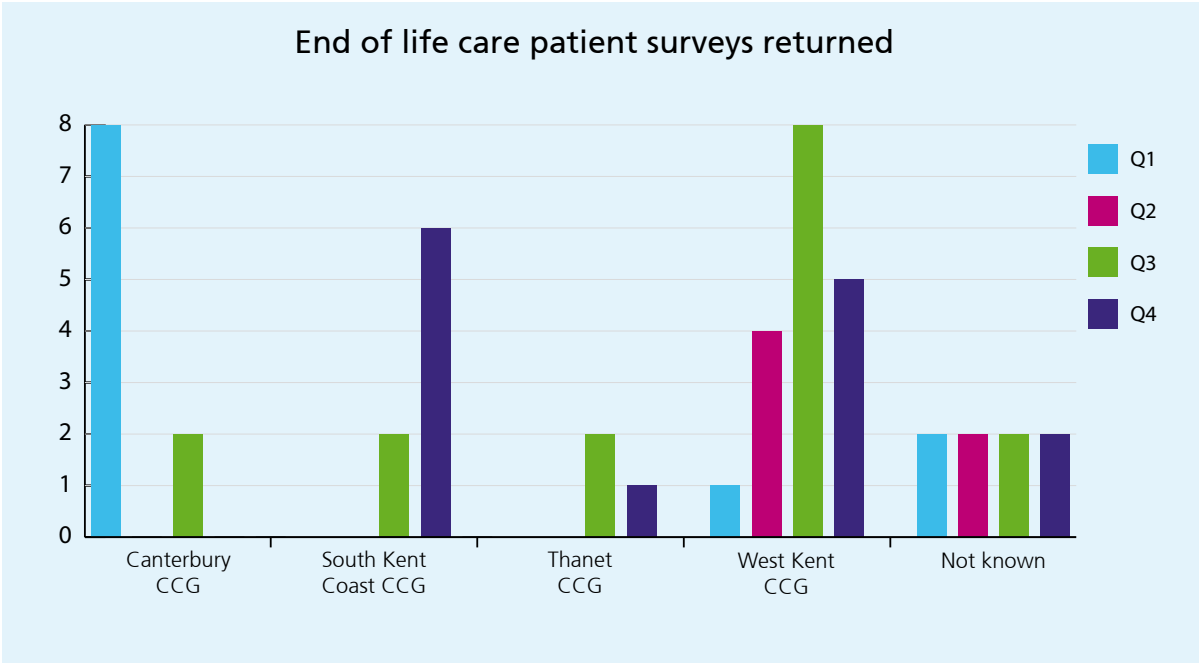
What this means for you as a patient

We want patients to feel that by sharing their experience they can improve care for other patients.

What we achieved

We increased the number of surveys being returned but did not achieve the target. We received 47 surveys across the year.

Different methods of collecting the experience of patients or their relatives at end of life are being explored to complement the traditional survey approach.



End of life care patient surveys returned

	Q1	Q2	Q3	Q4
Ashford and Canterbury CCG	0	0	0	0
Canterbury CCG	8	0	2	0
South Kent Coast CCG	0	0	2	6
Thanet CCG	0	0	2	1
West Kent CCG	1	4	8	5
Not known	2	2	2	2
Total	**11**	**6**	**18**	**14**

Patient experience

Patient feedback

Goal	Number 2016-7	Number 2017-8	2017-18 target	Outcome
Services to survey at least 10% of their caseload	Not measured	9% across the trust	10% per service	Not achieved

We wanted to increase the number of patient experience surveys completed, aiming for each service to survey a minimum of 10 per cent of their caseload.

Why this is important

KCHFT is committed to seeking feedback from patients, carers and families about the quality of the care they receive and to using this to improve our service. Increasing our survey returns across the organisation will enable us to make sure we are receiving feedback from a wide range of patients, carers and families.

What we did

We worked with individual services to find various ways to support feedback from particular service users.

Surveys are available in a variety of formats and are accessible in paper form and online. They are also available on wall-mounted handheld devices in our minor injury units and clinics. Staff working in the community now have surveys available on their handheld devices.

Additionally, we can now email service users with a survey.

While surveys are an effective method of obtaining feedback for most services, there are other methods which are more suitable for particular service users.

For example, feedback is obtained via our locally-held patient experience groups. Our website also promotes the completion of online feedback via other websites, such as NHS Choices and Care Opinion.

We have developed our public website making it easier for people to give us feedback in a variety of ways most suitable to them.

What this means for you as a patient

KCHFT is committed to listening to our patients, carers and families and is keen to involve them as partners to improve our service. Patients now have a greater number of ways of providing us with feedback.

What we achieved

During 2017-18 KCHFT received 63,912 surveys with an overall satisfaction rate of 97 per cent.

KCHFT surveyed nine per cent of caseload across the trust during quarters three and four. This varied depending on the individual service and the nature of service user. The highest number of surveys per caseload was achieved by community hospitals, which surveyed up to 59 per cent of their caseload.

Patient safety
Falls

Goals for 2017-18

Goal	Number 2016-7	Number 2017-8	% reduction	Outcome
10% reduction in falls with harm in our community hospitals	17	10	41%	Achieved

Our target was to reduce falls that result in harm in our community hospitals by 10 per cent.

Why this is important

Falls represent the most frequent and serious type of accident in people aged 65 and over and can cause serious injury and increased care costs. Research has shown that falls can be reduced by introducing assessments and interventions.

What we did

KCHFT took part in the NHS Improvement falls collaborative. Our aim was to improve falls prevention across all our inpatient sites, ensuring a multi-professional approach to falls prevention. We implemented quality improvement initiatives, which included:

- completion of a multi-factorial falls risk assessment on patients aged 65 or older or who are aged between 54 to 64 and are judged to be at a higher risk of falling because of an underlying condition; we followed NICE guidance CG161
- ensuring the call bell is within reach of each patient
- ensuring the appropriate mobility aid is within reach
- taking and reviewing lying and standing blood pressure on admission
- carrying out a medication review
- completing a bedside vision check
- developing a falls prevention personalised care plan with the patient and their family.

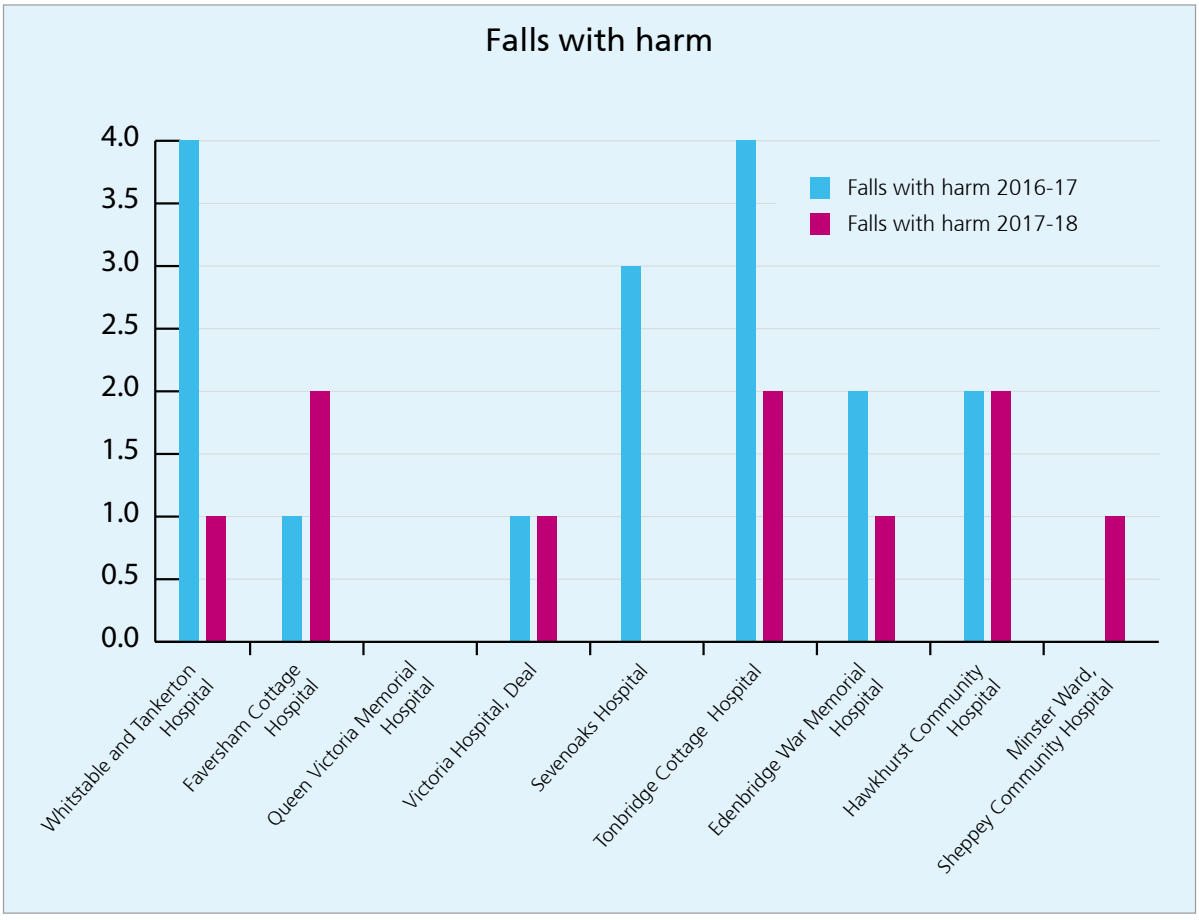
These improvement initiatives make up the trust-wide falls prevention improvement action plan. Progress against this plan is regularly reviewed by our Falls Prevention and Improvement Group.

What this means for patients

When our patients enter our inpatient sites across the organisation, assessments and interventions introduced through our quality improvement initiatives have reduced the risk of a fall resulting in harm.

What we achieved

In 2016-17, there were 17 avoidable falls with harm in community hospitals compared with 10 avoidable falls with harm in community hospitals during 2017-18, resulting in an overall reduction for the year of 41 per cent. The graph and table below details the locations of these falls for the past two years.



CCG	Location	Falls with harm 2016-17	Falls with harm 2017-18
Ashford and Canterbury CCG	Whitstable and Tankerton Hospital	4	1
	Faversham Cottage Hospital	1	2
	Queen Victoria Memorial Hospital, Herne Bay	0	0
South Kent Coast	Victoria Hospital, Deal	1	1
West Kent CCG	Sevenoaks Hospital	3	0
	Tonbridge Cottage Hospital	4	2
	Edenbridge and District War Memorial Hospital	2	1
	Hawkhurst Community Hospital	2	2
North Kent	Minster Ward, Sheppey Community Hospital	0	1
Total		**17**	**10**

The table here shows the number of falls with moderate to severe harm per occupied bed day (OBD). The national average is 0.19, placing KCHFT just below the average number at 0.18.

	Apr -17	May -17	Jun -17	Jul -17	Aug -17	Sep -17	Oct -17	Nov -17	Dec -17	Jan -18	Feb -18	Mar -18	YTD total
KCHFT occupied bed day	4,255	4,513	4,516	4,734	4,589	4,404	4,731	4,731	4,586	4,990	4,301	4,894	55,244
Avoidable patient falls with harm	0	3	1	0	1	0	0	2	0	1	1	1	10
Avoidable patient falls per 1,000 occupied bed days	0	0.66	0.22	0	0.22	0	0	0.42	0	0.20	0.23	0.20	0.18

Patient safety

Pressure ulcers

Goals for 2017-18

		Number 2016-7	Number 2017-8	% reduction	Outcome
1.	20% reduction in category 3 and 4 avoidable pressure ulcers acquired in our care	26	17	35%	Achieved
2.	10% reduction in category 2 avoidable pressure ulcers acquired in our care	32	18	44%	Achieved

We had two targets; to reduce category three and four avoidable pressure ulcers by 20 per cent, and to reduce category two avoidable pressure ulcers by 10 per cent.

What is a pressure ulcer?

Pressure ulcers, previously known as bed sores and an injury that affects areas of the skin and underlying tissue, are caused when placed under pressure over time. Their presentation can vary in severity from discoloured skin to open wounds.

Pressure ulcers develop when a large amount of pressure is applied to an area of skin over a short period of time. Or, they can happen when less force is applied but over a longer period of time. This could be from a number of causes, such as sitting or lying in one position without moving for too long, to friction caused by clothing, shoes and straps etc.

The extra pressure disrupts the flow of blood through the skin. Without a blood supply, the affected area of skin becomes starved of oxygen and nutrients. It begins to break down, leading to the formation of an ulcer.

Why this is important

This is a national initiative driven by NHS England to improve the quality and safety of patients receiving care. Each year, we set a reduction trajectory with the aim of reaching zero tolerance.

What we did

The primary focus for the organisation has been a continued proactive approach with an emphasis on prevention strategies and patient empowerment to effectively reduce the risk of patient harms acquired in our care.

This year, we introduced a new validated risk assessment screening tool PURPOSE T to support early identification of at-risk patients, enabling clinicians to plan and implement prevention strategies to lower the risk of harm. This tool was rolled out via a planned educational programme to all nurses and therapists at KCHFT.

To make sure our systems and processes to reduce pressure ulcer harm were robust, auditors carried out a detailed review of our training programmes; policies, procedures and pathways; incident reporting and monitoring processes.

The trust achieved reasonable assurance that our pressure ulcer prevention strategies were robust. Equally, an internal audit of clinical practice, in accordance with our pressure ulcer policy, offered significant assurance to the trust.

KCHFT regularly benchmarks performance against 17 other community trust providers in England, which identifies we are consistently below the national benchmark.

A staff and managers' pledge was launched, supported by the Executive Team, to demonstrate our commitment to reducing pressure ulcer harm.

Before the summer, there was a focused campaign to raise awareness of the effect of heat and moisture on the skin which could exacerbate pressure damage.

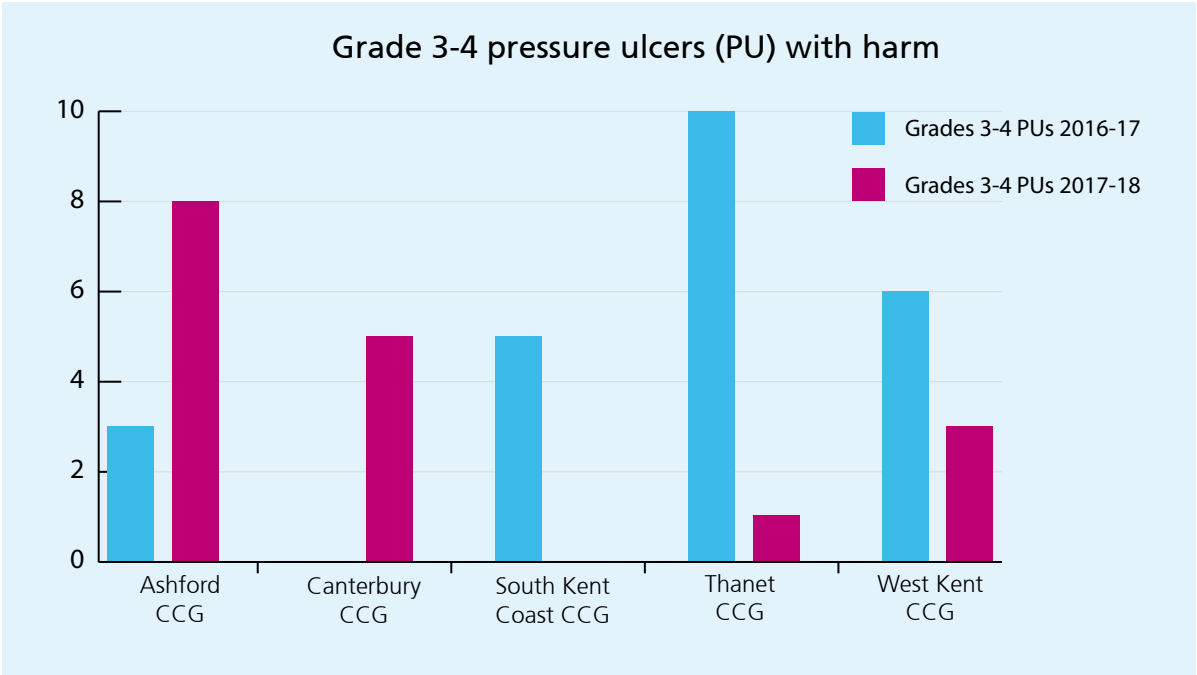
Our patients were given leaflets and coasters with clear prevention messages, including keep cool; keep hydrated and keep moving, resulting in no reported serious harms to our patients for four consecutive months.

What this means for patients

Patients under our care are at reduced risk of experiencing a pressure ulcer following our increased emphasis on prevention strategies.

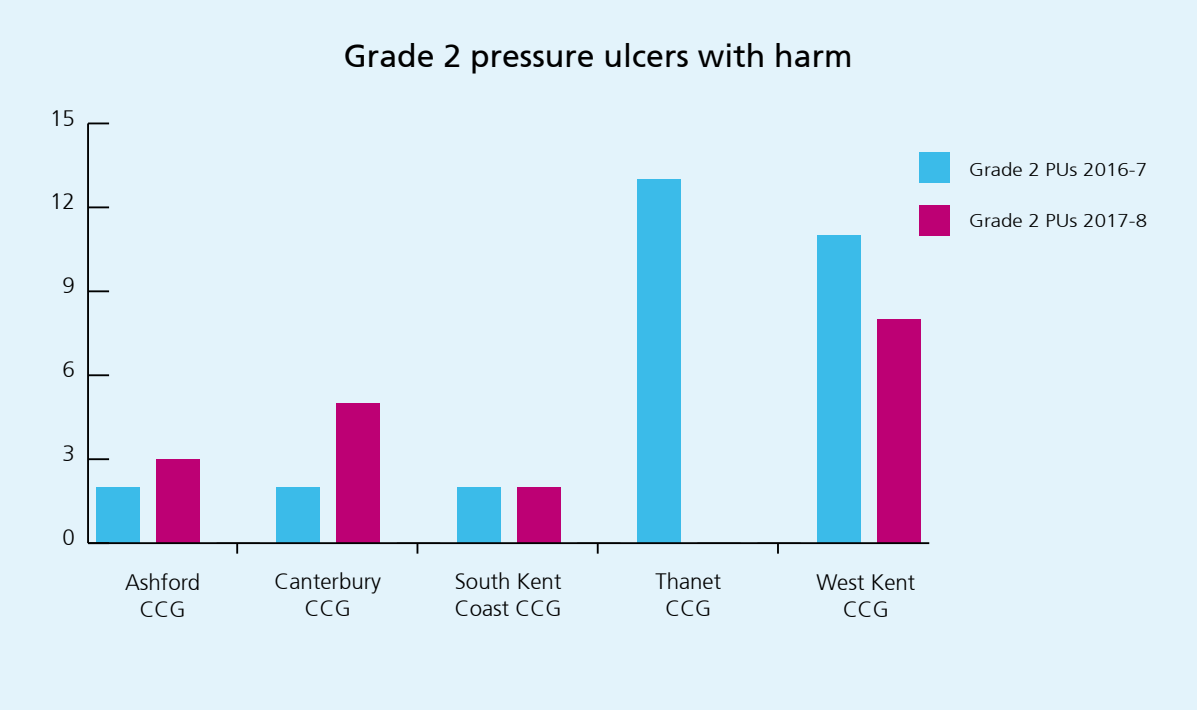
What we achieved

For the year 2017-18, we achieved a reduction of 35 per cent grade three and four attributable pressure ulcers, and a reduction of 44 per cent grade two attributable pressure ulcers. This exceeded our targets. A breakdown of the figures and comparison to last year can be seen in the tables here:



CCG	Grades 3-4 PUs 2016-17	Grades 3-4 PUs 2017-18
Ashford CCG	3	8
Canterbury CCG	0	5
South Kent Coast	5	0
Swale CCG	2	N/A*
Thanet CCG	10	1
West Kent CCG	6	3
Total	**26***	**17**

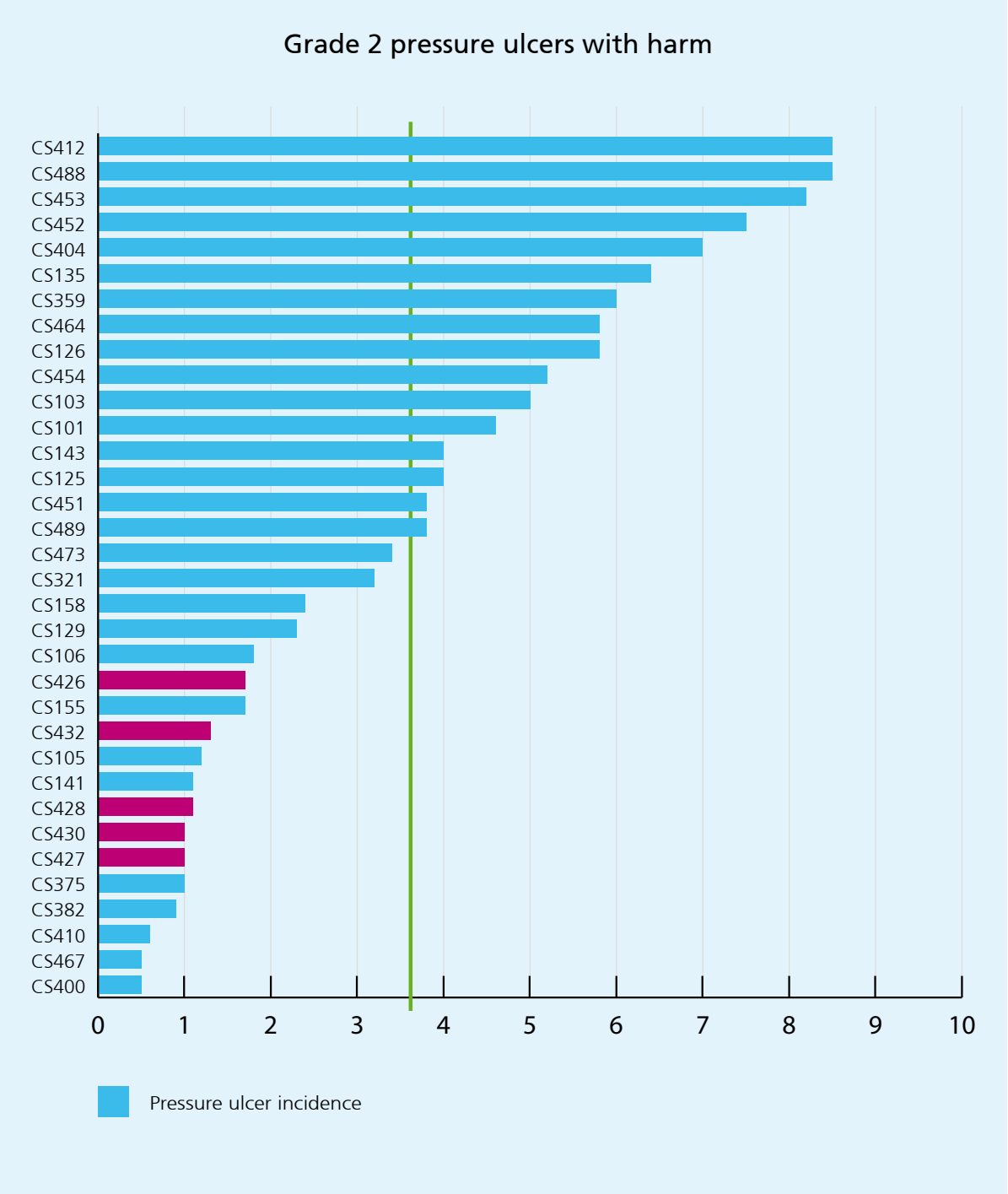
* The trust no longer provides services in Swale CCG's area, so this field is not applicable for 2017-18.



CCG	Grade 2 PUs 2016-17	Grade 2 PUs 2017-18
Ashford CCG	2	3
Canterbury CCG	2	5
South Kent Coast	2	2
Swale CCG	2	N/A*
Thanet CCG	13	0
West Kent CCG	11	8
Total	**32***	**18**

* The trust no longer provides services in Swale CCG's area, so this field is not applicable for 2017-18.

KCHFT is a member of a community trust benchmarking group. The following graph shows the average number of pressure ulcers (all grades) for community nursing is 3.56 (mean) and 3.30 (median) for 2016-17.


Grade 2 pressure ulcers with harm
CS412
CS488
CS453
CS452
CS404
CS135
CS359
CS464
CS126
CS454
CS103
CS101
CS143
CS125
CS451
CS489
CS473
CS321
CS158
CS129
CS106
CS426
CS155
CS432
CS105
CS141
CS428
CS430
CS427
CS375
CS382
CS410
CS467
CS400
0
1
2
3
4
5
6
7
8
9
10
Pressure ulcer incidence

Patient safety

Catheter-associated urinary tract infections (CAUTIs)

Goal	Rate per 100,000 occupied bed days (OBDs) 2016-7	Rate per 100,000 occupied bed days (OBDs) 2017-8	Comparison to target	Outcome
A 15% reduction of catheter-associated urinary tract infection acquired in our care	21.6	32.5	33% increase	Not achieved

The aim was to reduce CAUTIs in patients within the inpatient wards by 15 per cent compared to 2016-17 – using a rate comparison that allows for changes in bed occupancy, providing more accurate data and true trends (due to the closure of beds in 2016-17).

Why this is important

Catheter associated urinary tract infections are the highest single cause of healthcare-associated infections. Reducing these means more of our patients remain healthy, despite having a long-term invasive device. It is also acknowledged that CAUTIs are the highest single cause of healthcare-associated gram negative blood stream infections – a specific cause of sepsis. If we reduce the number of simple infections, we will reduce the number of people who develop sepsis.

What we did

Throughout the year, the number of CAUTIs increased, requiring a multi-modal approach to tackling the increase. The trust has implemented a full CAUTI/UTI reduction campaign, which dovetailed with a national programme to reduce infections. It was jointly launched with the Nutrition and Dietetics Team during National Hydration Week.

- The HOUDINI protocol has been implemented, providing staff with clear guidance on how and when to assess a patient's needs for a urinary catheter, and encouraging them to be removed.
- Staff testing algorithms were revised.
- To dip or not to dip guidance was provided for staff to encourage them to act on patients' clinical symptoms of potential infection, instead of traditional urine dipstick results – a type of indicative test that has historically been used to suggest infection; however, known to not be accurate for patients with urinary catheters.
- The trust's catheter passport was revised and re-launched, providing further guidance for patients and staff on self-care and hygiene, as well as a central record for catheter changes and clinical interventions.

- There is collaborative working with colleagues in acute trusts and commissioning services to focus locally on training and education requirements for staff.

The campaign was not launched until the end of the year – owing to increasing CAUTIs at that time – and to complement national guidance and programmes, ensuring our guidance reflected the changing national guidance.

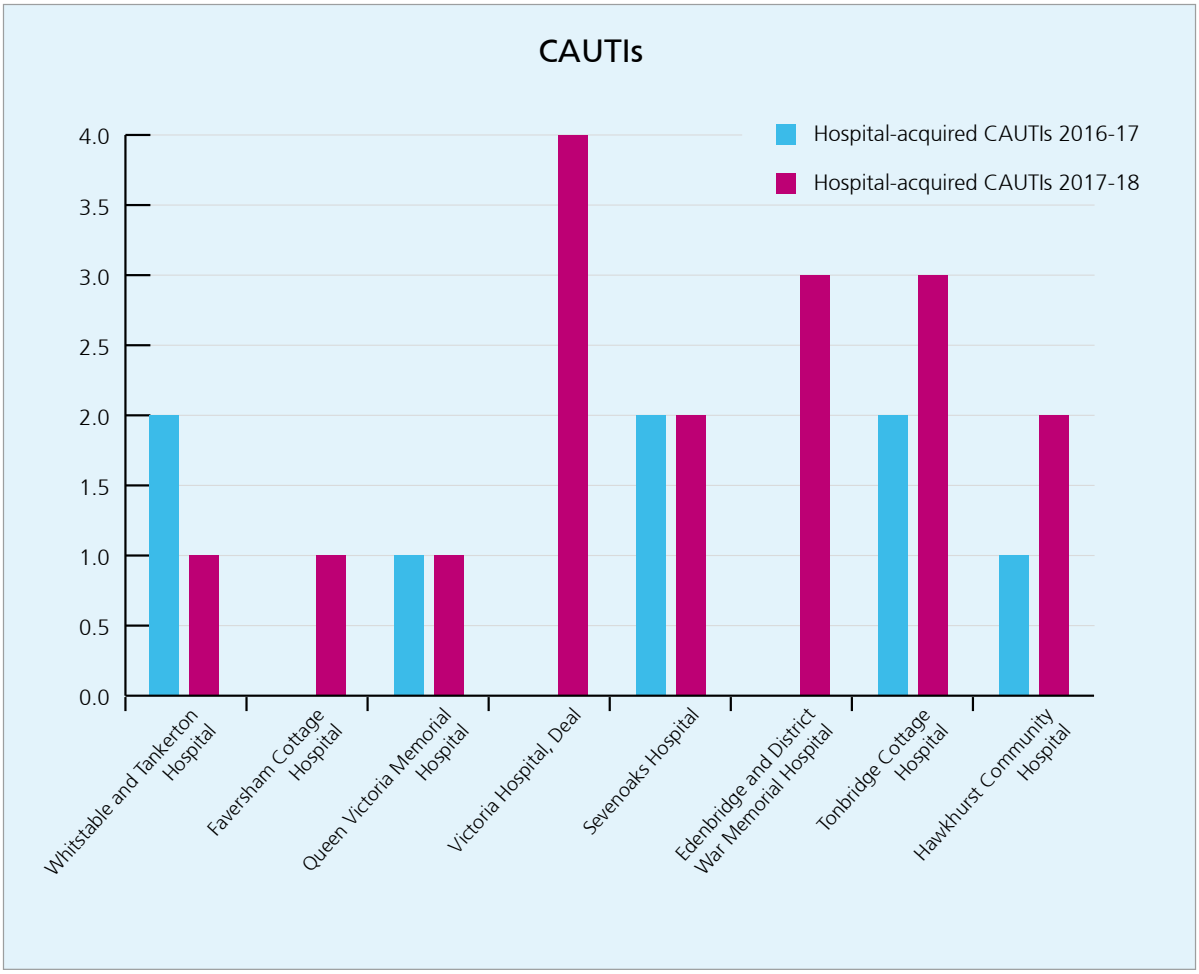
What this means for you as a patient

Staff are focussing on ensuring both they and patients have the information required to reduce the risk of catheter-associated infections

What we achieved

This target was not achieved this year, with 17 reported CAUTIs at the end of the year.,

* This figure was reported as 14 in our 2016-17 report as it included Gravesham Community Hospital, Livingstone Hospital in Dartford, and Sheppey Community Hospital, for which we are no longer the provider. These numbers have been removed for comparison purposes.



CCG	Location	Hospital – acquired CAUTIs 2016-17	Hospital – acquired CAUTIs 2017-18
Ashford and Canterbury CCG	Whitstable and Tankerton Hospital	2	1
	Faversham Cottage Hospital	0	1
	Queen Victoria Memorial Hospital, Herne Bay	1	1
South Kent Coast	Victoria Hospital, Deal	0	4
West Kent CCG	Sevenoaks Hospital	2	2
	Tonbridge Cottage Hospital	0	3
	Edenbridge and District War Memorial Hospital	2	3
	Hawkhurst Community Hospital	1	2
Total		**8***	**17**

Clinical effectiveness

Wound management

Goals for 2017-18

Goal	Number 2016-7	Number 2017-8	2017-8 target	Outcome
To improve wound healing times by 5% in our wound medicine centres	Not measured	16%	5%	Achieved

The trust now has four operational wound management clinics (WMCs) in Sevenoaks Hospital, Victoria Hospital, Deal, Queen Victoria Memorial Hospital, Herne Bay and Vicarage Road Clinic in Ashford.

They are staffed by community nurses, educated to advanced wound care level and overseen by a tissue viability nurse.

We wanted to improve wound healing times in these clinics.

Why this is important

To improve patients' experience and reduce time and costs.

What we did

To maintain quality and assurance, the WMCs have been supported by our Tissue Viability Nurse Specialist with regular visits to manage complex patients, supervise practice and provide guidance. The WMCs are also supported by our central referral unit through telehealth.

A number of nurses in the WMCs studied for the University of Kent-accredited level 6 wound management module run by the trust to improve their knowledge and skills.

What this means for you as a patient

Patients are in discomfort for less time and require clinical intervention over a shorter period of time.

What we achieved

Excellent feedback has been received from patients and there has been a **16 per cent** improvement in healing rates, 11 per cent higher than the five per cent target.

Clinical effectiveness

Dementia

Goals for 2017-18

Goal	Training 2016-7	Training 2017-8	Target	Outcome
Community hospital environments to work towards becoming dementia friendly as required by the Hospital Charter 2020, including tier 2 training for staff in these areas	75%	89%	85%	Achieved

Our goal was to complete further work towards achieving dementia-friendly environments in our community hospitals and to ensure that staff have received tier two dementia training.

Why this is important

We want to ensure patients' dementia and cognitive impairment needs are met during their stay in our community hospitals. This will aid their rehabilitation to enable them to return to their home environment.

What we did

We introduced dementia champions across four community hospitals. The dementia champions are dedicated to ensuring patients with cognitive impairments and diagnosed dementia have their needs recognised and included in care planning. They also support in decision making and daily routines such as bathroom visits, dressing etc.

The baywatch campaign is also being implemented across the hospitals. This will replace the one-to-one support requirement as patients with similar impairments will be in bays of four. One staff member per shift will be designated to that bay. They will have a specific colour lanyard so other staff can identify them. These staff will work closely with the therapeutic worker to ensure continued stimulation for patients within their bays.

Therapeutic workers in each of the hospitals work with patients with dementia and cognitive impairments.

Dementia-friendly crockery is being rolled out across the community hospitals.

Patient activity groups are being re-evaluated to make sure they are less intimidating and more home-like.

Continued environmental improvements have been implemented to support patients' movement around the units, such as clearer signage with pictorial images, as well as colour and text friendly visuals.

What this means for you as a patient

`This will reassure patients and their families that staff and the environments in our community hospitals are able to support them during their stay.

The environment improvements will make sure patients feel safe and relaxed during their rehabilitation before being discharged to their home environment.

What we achieved

In total, 89 per cent of staff received tier two dementia training and hospital environments have been improved.

Clinical effectiveness

Research

Goals for 2017-18

Goal	Number 2016-7	Number 2017-8	2017-8 target	Comparison to target	Outcome
At least 200 patients enrolled in NIHR portfolio studies	407	545	200	172%	Achieved

We wanted to increase the number of patients involved in National Institute of Health Research (NIHR) studies to at least 200.

Alongside this overarching target, we wanted to:

- increase the number of good clinical practice (GCP) trained staff to equip more clinical teams to be research-ready to open studies
- increase the number of non-medical principal investigators
- open and recruit to our first commercial study.

Why this is important

We want to offer patients and services the opportunity to contribute to national research studies.

What we did

We met clinical teams to discuss the importance of NIHR research studies and the opportunities for patients when we open these. This led to more staff wanting to complete their GCP training and an increased understanding of what opening an NIHR study involves. This has seen non-medical staff appreciate their role in opening and leading on studies relevant to their service.

We continued to submit expressions of interest for commercial studies, gaining increased experience of developing our response to enable us to stand out against more experienced trusts. We attended a network event, which helped us to identify what commercial companies seek when selecting new organisations. We are now able to promote the great work of our clinical teams to recruit to industry research.

What this means for you as a patient

This gives patients more opportunities to take part in national studies. This could lead to access to a new intervention or the opportunity to contribute personal voice/experience to a topic under investigation.

It also places the trust in a stronger position to open studies quickly and be more attractive to commercial companies with research-ready staff.

The trust is in a stronger position to open studies in an increased number of services.

The trust now has a positive history of recruiting to commercial research, putting it in a strong and attractive position to take on further commercial research.

What we achieved

We recruited well at the beginning of the year and quickly achieved our target of 200 quickly, so we ambitiously increased our target to 300. We also exceeded this target this year, with a final recruitment figure of 545.

The number of GCP-trained staff has increased year-on-year. In the past year an extra 20 staff have been added to the pool of research-ready staff.

There are now more non-medical principal investigators in the trust than medical, which reflects the demographics of the workforce.

In the past year, we have opened our first commercial study over two sites. We recruited to target, ahead of time and were recognised as the top recruiting trust in the country.

This section shows our performance against the relevant indicators and performance thresholds set out in the oversight documents issued by NHS Improvement. For our trust, this is only one indicator:

The maximum time of 18 weeks from point of referral to treatment (RTT) in aggregate – patients on an incomplete pathway:

	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18
RTT incomplete pathways	99.46%	98.74%	99.52%	99.35%	98.92%	98.74%	98.42%	97.40%	93.64%	94.06%	92.40%	88.68%

Annex 1

Statements from commissioners, local Healthwatch organisations and overview and scrutiny committees

BURGESS, Jane (KENT COMMUNITY HEALTH NHS FOUNDATION TRUST)

From: ELLIS, Victoria (KENT COMMUNITY HEALTH NHS FOUNDATION TRUST)
Sent: 25 April 2018 15:23
To: HOSC@KENT.GOV.UK; healthscrutiny@eastsussex.gov.uk; enquiries@healthwatcheastsussex.co.uk; info@healthwatchkent.co.uk; REYNOLDS, Maria (NHS THANET CCG); BISSET, Dawn (NHS SOUTH KENT COAST CCG); PARKIN, Jooles (NHS CANTERBURY AND COASTAL CCG); CREATON, Tracey (NHS WEST KENT CCG); BOXALL, Marie (NHS SWALE CCG); LOCOCK, Gail (NHS SWALE CCG); KNIGHT, Sharon (NHS SWALE CCG); EKE, Nnenna (NHS BRENT CCG); VAUX, Sarah (NHS MEDWAY CCG); HOLLIS, Dawn (NHS ENGLAND); qualityaccount (KENT COMMUNITY HEALTH NHS FOUNDATION TRUST); Qualityinbox (NHS ASHFORD CCG); WILKINS, Paula (NHS WEST KENT CCG); COLLINS, Becky (NHS WEST KENT CCG)
Cc: GODDEN, Annie (NHS ENGLAND); PATEL, Rita (NHS ENGLAND); Andrew Scott Clark; Anna.Czepil@eastsussex.gov.uk; Quality (NHS THANET CCG); Quality (NHS SOUTH KENT COAST CCG)
Subject: KCHFT Quality Report

Importance: High

Dear Colleagues,

Please find attached the Draft copy of Kent Community Health NHS Foundation Trust's Quality Account 2017/18 for your review. I am sending this via email for speed as there is a limited time to review the content. If you would like a hard copy then please respond to this email and I will arrange that.

This draft reflects data available up to the end of the eleven month period; this will be updated with year-end data before publication on the 31st of May 2017.

The final layout, photographs and patient/carer stories will be added by the Communication's team prior to the final publication.

I invite all stakeholder's to review and comment. For West Kent Colleagues this is a 'Must Do' as commissioner of the largest population area.

Please respond by the 18th May 2017 if possible, to kcht.qualityaccount@nhs.net

Thank you in advance for your feedback,

Kind regards,

Vicky

Vicky Ellis
Assistant Director Clinical Governance
Kent Community Health NHS Foundation Trust
The Oast, Unit D, Hermitage Court
Maidstone, Kent. ME16 9NT.

v.ellis1@nhs.net
Tel: 01622 211919

Kent County Council
kent.gov.uk

Vicky Ellis
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Kent Community Health NHS Foundation Trust
The Oast, Unit D, Hermitage Court
Maidstone
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ME16 9NT

Members Suite
Kent County Council
Sessions House
County Hall
Maidstone
Kent
ME14 1XQ

Direct Dial: 03000 412775
Email: HOSC@kent.gov.uk
Date: 26 April 2018

Dear Vicky

Draft Kent Community Health NHS Foundation Trust Quality Account 2017/18

Thank you for offering Kent County Council's Health Overview & Scrutiny Committee (HOSC) the opportunity to comment on the Kent Community Health NHS Foundation Trust's Quality Account for 2017/18.

As the Committee did not formally scrutinise any services directly provided by the Trust in 2017/18, the Committee will not be making any comments on the Trust's Quality Account this year.

As part of its ongoing overview function, the Committee would appreciate receiving a copy of the finalised Quality Account for this year and hope to be able to become more fully engaged in next year's process.

Kind regards

Sue Chandler
Chair, Health Overview and Scrutiny Committee
Kent County Council

kent.gov.uk

NHS Dartford, Gravesham and Swanley CCG and NHS Swale CCG Statement

The Trust's draft Quality Account document was sent to the Clinical Commissioning Groups (CCGs) for consultation and comment. The CCGs have a responsibility to review the Quality Account of the Trust each year, using the Department of Health's Quality Account checklist tool to ascertain whether all of the required elements are included within the document.

The Trust's Quality Account flows consistently and is in a format that is clear and easily understood. The detail included is well structured and concise and follows a consistent format throughout. The report identifies areas of further improvement but does not state clearly why and how the organisation is planning to report back on progress to their patients and the public.

The CCGs confirm that all required data has been included within this document in relation to the NHS Services provided or sub contracted and is an accurate reflection of achievement with the exception of how the Trust's investigations and learnings from deaths have informed their quality improvement plans and how the provider is implementing the priority clinical standards for seven day hospital services. It is noted that KCHFT has worked hard to achieve many of the areas within the identified priorities during 2017/18 and the pressure ulcer and falls priorities have achieved the full expected outcome. The Quality Account could have been enhanced further by expanding on how the Trust anticipates continued focus and will strive to achieve these areas previously identified as priorities.

The Trust has identified four overarching priorities for 2017/18, which include projects within the themes of Patient Safety, Patient Experience and Clinical Effectiveness and aim to deliver demonstrable improvements in patient care through their 'quadruple aim' as aligned with the quality strategy objectives. It has outlined clearly the rationale but does not reference the current status and how each priority will be monitored and measured. The CCGs would welcome the opportunity to work with the Trust to ensure targets remain on track throughout the year and reported against at CCG level in the 2018/19 Quality Account, where appropriate but acknowledges that not all priority areas will be applicable to the services we commission.

The CCGs are in agreement with the areas selected by the Trust and recognise that the priorities identified are person and carer centred, appropriate and striving to be effective in improving quality, safety and patient care.

In conclusion, the report is well structured and highlights that the quality of patient care remains a clear focus for the Trust and at the forefront of its service provision.

The CCGs thanks the Trust for the opportunity to comment on this document and looks forward to further strengthening the relationships with the Trust through continued collaborative working in the future.

Zoe Hicks-John
Deputy Chief Nurse

Annex 2

Statement of directors' responsibilities for the quality report

The directors are required under the Health Act 2009 and the National Health Service (Quality Accounts) Regulations to prepare quality accounts for each financial year.

NHS Improvement has issued guidance to NHS foundation trust boards on the form and content of annual quality reports, which incorporates the above legal requirements and on the arrangements that NHS foundation trust boards should put in place to support the data quality for the preparation of the quality report.

In preparing the Quality Report, directors are required to take steps to satisfy themselves that:

- the content of the Quality Report meets the requirements set out in the NHS foundation trust annual reporting manual 2017-18 and supporting guidance
- the content of the Quality Report is not inconsistent with internal and external sources of information including:
  - Board minutes and papers for the period April 2017 to March 2018
  - papers relating to quality reported to the board over the period April 2016 to March 2018
  - feedback from commissioners: North Kent CCG (undated)
  - feedback from governors dated May 2018
  - feedback from local Healthwatch organisations not received
  - feedback from Overview and Scrutiny Committee dated 26 April 2018
  - the trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, dated May 2018
  - the 2017 National Staff Survey
  - the Head of Internal Audit's annual opinion of the trust's control environment dated 19 April 2018
  - CQC inspection report dated September 2014
- the Quality Report presents a balanced picture of the NHS foundation trust's performance over the period covered
- the performance information reported in the Quality Report is reliable and accurate
- there are proper internal controls over the collection and reporting of the measures of performance included in the Quality Report, and these controls are subject to review to confirm that they are working effectively in practice
- the data underpinning the measures of performance reported in the Quality Report is robust and reliable, conforms to specified data quality standards and prescribed definitions, is subject to appropriate scrutiny and review and
- the Quality Report has been prepared in accordance with NHS Improvement's annual reporting manual and supporting guidance (which incorporates the Quality Accounts regulations) as well as the standards to support data quality for the preparation of the Quality Report.

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

By order of the Board

24 May 2018 Date.....Chair

24 May 2018 Date.....Chief Executive

Abbreviations

CAUTI	Catheter-associated urinary tract infection
CCG	Clinical commissioning group
CEG	Clinical Effectiveness Group
CIS	Community Information System
COPD	Chronic obstructive pulmonary disease
CQC	Care Quality Commission
CQUIN	Commissioning for quality improvement and innovation
GCP	Good clinical practice
HOUDINI	Haematuria, obstruction, urology, decubitus sacral ulcer, input/output, nursing, immobility
KCC	Kent County Council
KCHFT	Kent Community Health NHS Foundation Trust
LeDeR	Learning disability mortality review programme
NAIC	National audit of intermediate care
NICE	National Institute of Health and Clinical Excellence
NIHR	National Institute for Health Research
OBD	Occupied bed day
PEG	Patient Experience Group
PSCRG	Patient Safety and Clinical Risk Group
PURPOSE T	Pressure ulcer risk assessment tool
QI	Quality improvement
RCA	Root cause analysis
SI	Serious incident
SSNAP	Sentinel stroke national audit programme
UTI	Urinary tract infection
WMC	Wound management centre

Independent Practitioner's Limited Assurance Report to the Council of Governors of Kent Community Health NHS Foundation Trust on the Quality Report

We have been engaged by the Council of Governors of Kent Community Health NHS Foundation Trust to perform an independent limited assurance engagement in respect of Kent Community Health NHS Foundation Trust's Quality Report for the year ended 31 March 2018 (the "Quality Report") and certain performance indicators contained therein against the criteria set out in the 'NHS foundation trust annual reporting manual 2017/18' and additional supporting guidance in the 'Detailed requirements for quality reports 2017/18' (the 'Criteria').

Scope and subject matter

The indicators for the year ended 31 March 2018 subject to the limited assurance engagement consist of the national priority indicators as mandated by NHS Improvement:

- Percentage of incomplete pathways within 18 weeks for patients on incomplete pathways at the end of the reporting period
- 20% reduction in category 3 and 4 avoidable pressure ulcers acquired in the Trust's care.

We refer to these national priority indicators collectively as the 'Indicators'.

Respective responsibilities of the directors and Practitioner

The directors are responsible for the content and the preparation of the Quality Report in accordance with the criteria set out in the 'NHS foundation trust annual reporting manual 2017/18' and supporting guidance issued by NHS Improvement.

Our responsibility is to form a conclusion, based on limited assurance procedures, on whether anything has come to our attention that causes us to believe that:

- the Quality Report is not prepared in all material respects in line with the Criteria set out in the 'NHS foundation trust annual reporting manual 2017/18' and supporting guidance;
- the Quality Report is not consistent in all material respects with the sources specified in NHS Improvement's 'Detailed requirements for external assurance for quality reports 2017/18'; and
- the indicators in the Quality Report identified as having been the subject of limited assurance in the Quality Report are not reasonably stated in all material respects in accordance with the 'NHS foundation trust annual reporting manual 2017/18' and supporting guidance and the six dimensions of data quality set out in the "Detailed requirements for external assurance for quality reports 2017/18'.

We read the Quality Report and consider whether it addresses the content requirements of the 'NHS foundation trust annual reporting manual 2017/18' and supporting guidance, and consider the implications for our report if we become aware of any material omissions.

We read the other information contained in the Quality Report and consider whether it is materially inconsistent with:

- Board minutes for the period 1 April 2017 to 24 May 2018;

- papers relating to quality reported to the Board over the period 1 April 2017 to 24 May 2018;
- feedback from commissioners: North Kent CCG (undated)
- feedback from governors (not received)
- feedback from local Healthwatch organisations (no feedback received)
- feedback from the Overview and Scrutiny Committee dated 26 April 2018;
- the Trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, dated May 2018;
- the 2017 National Staff survey; and
- the Head of Internal Audit's annual opinion over the Trust's control environment dated 19 April 2018

We consider the implications for our report if we become aware of any apparent misstatements or material inconsistencies with those documents (collectively, the "documents"). Our responsibilities do not extend to any other information.

The firm applies International Standard on Quality Control 1 (Revised) and accordingly maintains a comprehensive system of quality control including documented policies and procedures regarding compliance with ethical requirements, professional standards and applicable legal and regulatory requirements.

We are in compliance with the applicable independence and competency requirements of the Institute of Chartered Accountants in England and Wales (ICAEW) Code of Ethics. Our team comprised assurance practitioners and relevant subject matter experts.

This report, including the conclusion, has been prepared solely for the Council of Governors of Kent Community Health NHS Foundation Trust as a body, to assist the Council of Governors in reporting Kent Community Health NHS Foundation Trust's quality agenda, performance and activities. We permit the disclosure of this report within the Annual Report for the year ended 31 March 2018, to enable the Council of Governors to demonstrate they have discharged their governance responsibilities by commissioning an independent assurance report in connection with the indicators. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the Council of Governors as a body, and Kent Community Health NHS Foundation Trust for our work or this report, except where terms are expressly agreed and with our prior consent in writing.

Assurance work performed

We conducted this limited assurance engagement in accordance with International Standard on Assurance Engagements 3000 (Revised) 'Assurance Engagements other than Audits or Reviews of Historical Financial Information' issued by the International Auditing and Assurance Standards Board ('ISAE 3000'). Our limited assurance procedures included:

- evaluating the design and implementation of the key processes and controls for managing and reporting the indicators
- making enquiries of management
- limited testing, on a selective basis, of the data used to calculate the indicators tested against supporting documentation

- comparing the content requirements of the 'NHS foundation trust annual reporting manual 2017/18' and supporting guidance to the categories reported in the Quality Report; and
- reading the documents.

A limited assurance engagement is smaller in scope than a reasonable assurance engagement. The nature, timing and extent of procedures for gathering sufficient appropriate evidence are deliberately limited relative to a reasonable assurance engagement.

Limitations
Non-financial performance information is subject to more inherent limitations than financial information, given the characteristics of the subject matter and the methods used for determining such information.

The absence of a significant body of established practice on which to draw allows for the selection of different, but acceptable, measurement techniques that can result in materially different measurements and can affect comparability. The precision of different measurement techniques may also vary. Furthermore, the nature and methods used to determine such information, as well as the measurement criteria and the precision of these criteria, may change over time. It is important to read the Quality Report in the context of the criteria set out in the 'NHS foundation trust annual reporting manual 2017/18' and supporting guidance.

The scope of our limited assurance work has not included governance over quality or non-mandated indicators, which have been determined locally by Kent Community Health NHS Foundation Trust.

Our audit work on the financial statements of Kent Community Health NHS Foundation Trust is carried out in accordance with our statutory obligations. This engagement will not be treated as having any effect on our separate duties and responsibilities as Kent Community Health NHS Foundation Trust's external auditors. Our audit reports on the financial statements are made solely to Kent Community Health NHS Foundation Trust's members, as a body, in accordance with paragraph 24(5) of Schedule 7 of the National Health Service Act 2006. Our audit work is undertaken so that we might state to Kent Community Health NHS Foundation Trust's members those matters we are required to state to them in an auditor's report and for no other purpose. Our audits of Kent Community Health NHS Foundation Trust's financial statements are not planned or conducted to address or reflect matters in which anyone other than such members as a body may be interested for such purpose. In these circumstances, to the fullest extent permitted by law, we do not accept or assume any responsibility to anyone other than Kent Community Health NHS Foundation Trust and Kent Community Health NHS Foundation Trust's members as a body, for our audit work, for our audit reports, or for the opinions we have formed in respect of those audits.

Conclusion
Based on the results of our procedures, as described in this report, nothing has come to our attention that causes us to believe that, for the year ended 31 March 2018:

- the Quality Report is not prepared in all material respects in line with the Criteria set out in the 'NHS foundation trust annual reporting manual 2017/18' and supporting guidance;
- the Quality Report is not consistent in all material respects with the sources specified in NHS Improvement's 'Detailed requirements for external assurance for quality reports 2017/18'; and
- the indicators in the Quality Report identified as having been subject to limited assurance have not been reasonably stated in all material respects in accordance with the 'NHS foundation trust annual reporting manual 2017/18' and supporting guidance.

Grant Thornton UK LLP

Grant Thornton UK LLP
Chartered Accountants

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25 May 2018