NHS
Kent Community Health
NHS Foundation Trust

# Welcome to our eighth annual report

## 2018 to 2019

we care

www.kentcht.nhs.uk

Kent Community Health
NHS Foundation Trust

# Annual report and accounts 2018 to 2019

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

# Contents

# A snapshot of our year

We provided more than 60 services with a budget of £222million and a workforce of around...

...4,800.

We had more than two million patient contacts.

66,085 patients/relatives/ carers completed surveys with an overall satisfaction rate of 97 per cent.

99.69% of people waited less than four hours to be seen in our minor injury units.

We achieved 99.6 per cent of our target face-to-face contacts with patients with long-term conditions.

**Delayed transfers of care decreased** from 10.1 per cent to 9.6 per cent.

We remained in a strong financial position, with a maximum score of 1 against our resources.

2,154 health MOTs were completed.

7.4%

...of our patients cared for by our community nurses or in our community hospitals received end of life care.

94 per cent of reception year children and 93.7 per cent of Year 6 pupils were screened for height and weight against a trust target of 90 per cent.

100%...

...of people had access to genito-urinary medicine (GUM) within 48 hours of contacting us.

90.7 per cent of patients seen by specialist and elective services partially or fully met their agreed outcomes.

We had more than 500 volunteers supporting services across the trust.

ONE YOU

lifestyle advisors saw 2,212 new clients.

# The performance report

# Overview of performance

## Welcome to our eighth annual report

We are very proud of our 4,800-strong workforce, who continue to deliver high-quality care to the people we serve in Kent, Medway, East Sussex and parts of London.

During the past 12 months, our focus has remained our patients, our people and our partners as we continue with our mission to empower adults and children to live well, to be the best employer and work with our partners as one.

In the period covered by this report, we had two million patient contacts.

We have so very much to be proud of in the past year.

The NHS Long Term Plan was published in January, setting out the vision for health and social care during over the next 10 years. What is certain is that community care plays a pivotal role in delivering the aims and ambitions of the plan.

In the past year, we have launched our Nursing Academy to provide home grown talent that we can develop and retain at KCHFT.

We also embarked on our Transforming Integrated Care in the Community programme, which looks at delivering nursing holistically, using the principles of Buurtzorg. Working with Kent County Council, the four-year project will be using principles that have been shown to have strong clinical outcomes, strong patient satisfaction and increased recruitment and retention of care staff in Holland.

Our partnership work with acute partners means that we supported patients to go home as soon as possible from hospital in our Hospital@home scheme and in east Kent too, we played a pivotal role in supporting discharge services.

One of our proudest achievements is the safe care we deliver for the patients we serve, examples are that category two pressure ulcers (less serious but still unpleasant for a patient) fell by 11 per cent from 18 to 16 and category three and four (the most serious) dropped by 50 per cent, from 18 to 9. The number of patient falls also reduced by 63 per cent cent (from 41 to 15) and so did serious incidents by 15 per cent.

Avoidable patient safety incidents decreased, but we still want to do more to reduce this even further – good patient outcomes and patient safety is at the heart of what we do It is because of this that we have set our new quality priorities for the year ahead, which are ambitious to ensure we continue to improve the care we provide the people we serve.

By the end of the year, our feedback surveys told us that we have an overall patient satisfaction score of 97 per cent; our friends and family test score was 96.9 per cent overall (55,405 friends and famiy test responses) – while we are not satisfied and want the score to be even higher, albeit we compare very well with other providers of care in the NHS and outside.

While our priority is the delivery of great care for all the people we serve, managing the money well means we can provide great care and invest in what our patients need We also remain in a strong, stable financial position, with a maximum score of one against resources.

Thank you for your support of the trust last year, we really appreciate it.

Kind regards

**John Goulston,** Chair
**Paul Bentley,** Chief Executive Officer


**John Goulston**

Chair:

Date: 23 May 2019

**Paul Bentley**

Chief Executive Officer:

Date: 23 May 2019

# 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 2018/19 was £222million. We employ in the region of 4,800 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.


£222million
budget for 2018/19

4800

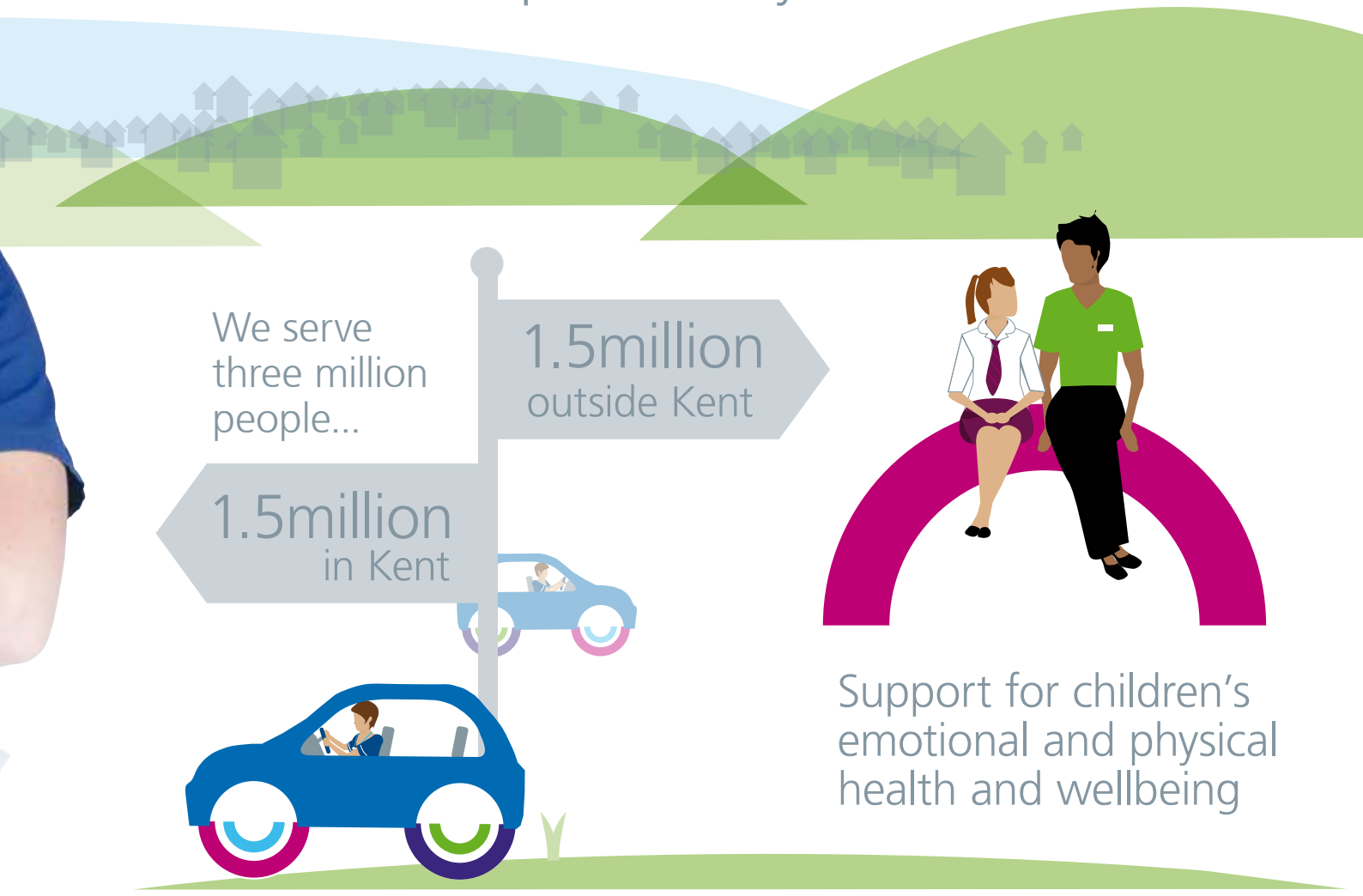
...members of staff in a wide range of clinical and support roles

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.

Helping people to get home quickly from hospital.

More than
# two million contacts
with patients a year






Support for children's emotional and physical health and wellbeing

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.


One You lifestyle advisors saw 2,212 new clients.

## Support groups for parents and their children continue to flourish

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 home treatment 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.

7.4% of our patients cared for by our community nurses or in our community hospitals received end of life care.

We have home treatment services 24-hours-a-day, seven-days-a-week

Our volunteers continue to increase and support our services

Patients' needs are assessed within two hours and support put in place so the patient can remain at home

# Our mission, vision and values

## 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

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.

# Our strategic priorities for 2018/19

## Workforce

Recruit and retain the right workforce to implement new, sustainable service models focussed on integrating services and preventing ill health.

## Local care

Establish and develop formal partnerships to enable joint working across health and social care.

## IT

Invest in technology to enable new ways of working.

## Quality improvement

Innovate and continually improve quality to deliver safe, affordable care with the best outcomes for the people we serve.

# Kent and Medway

## Sustainability and Transformation Partnership

Kent and Medway Sustainability and Transformation Partnership (STP) includes all NHS organisations, Kent County Council and Medway Council. As a partnership we are working together 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 across Kent and Medway.

### During 2018/19 the sustainability and transformation partnership:

- secured additional funding for suicide prevention across Kent and Medway and supported the development of a new app to help prevent suicide
- supported the successful bid for a new medical school in Kent and Medway
- consulted on establishing hyper acute stroke units and made a decision on the location of three units to serve patients across all parts of Kent and Medway
- developed plans for a single Kent and Medway Care Record; connecting the IT systems of health and care providers so clinicians can offer more joined up care for patients
- further developed potential options for reconfiguring hospital services in east Kent and engaged with local people on the proposals
- established a pathology service review to improve quality and efficiency.

**You can find out more and sign up for regular updates on the work of the STP at www.kentandmedway.nhs.uk**

**Transforming health and social care** in Kent and Medway

Quality of life, quality of care

# Overview: Going concern

## The annual accounts describe the trust's end of year financial position and key financial performance information.

The Finance Business and Investment Committee considered the basis of the trust's ability to continue as a going concern and this has been recommended 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 £26.7million at end of each month during 2019/20
- the trust is forecasting a liquidity rating of 1 throughout 2019/20, the highest rating possible
- the trust has agreed three year contracts starting 2019/20 with all its main NHS 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 agreed it does not need a working capital facility in 2019/20 and has not had one since 2015/16, which was unused, 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:

## 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.**

We teamed up with P&O Ferries to offer health checks, smokefree sessions and weight-loss groups as part of the company's drive to improve the health and wellbeing of employees.

We also carried our health checks at libraries in Swale, as well as pubs and at other businesses as part of our outreach programme.

A text service for young people aged 11 to 19 started. Following the success of ChathHealth in our East Sussex service, Kent School Health Service adopted the scheme, which offers confidential text messages for young people to contact a school nurse with any health concerns of questions.

We started our contract to deliver immunisations to all children from birth to 19-years-old in Kent and Medway.

The organisation signed up to the Time to Change programme as part of a pledge to encourage openness about mental health in its workforce. Consequently, more than 120 people signed up as Time to Change champions to support colleagues.

We launched a project, called Apple Tree, designed to make sure reasonable adjustments are made when a person with learning disabilities needs an appointment at a sexual health clinic.

A partnership designed to improve the confidence of teenage girls in care in Thanet proved such a success, it could roll out across Kent and expand to include teenage boys. Our Looked After Children's Service teamed up with Virtual School Kent and the beauty department at Canterbury College to improve self-esteem and opportunities available to girls aged 12 to 17.


Our Looked After Children's Service teamed up with Virtual School Kent and the beauty department at Canterbury College

We introduced infant feeding co-ordinators to support parents who are struggling in the early days of breastfeeding. They co-ordinate our volunteer peer supporters and our breastfeeding champions. We also opened a free breastfeeding room for mums to use in Ashford town centre at our NHS One You shop.

## From 1 April 2018 to 31 March 2019:

- One You lifestyle advisors saw 2,212 new clients.
- 64 per cent of clients seen by One You lifestyle advisors were from the two most deprived quintiles or of no fixed abode.
- 2,154 health MOTs were completed, giving a baseline assessment of people's health and information on how to improve their results.
- There were more than 41,000 attendances at our health walks, with 280 volunteer walk leaders.
- We supported 330 people to lose weight via our weight loss programme.
- To date, 2,655 people quit smoking during the past year, 78.1 per cent of the 3,400 target set.

## 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.**

In July 2018, we celebrated 70 years of the NHS with our colleagues from across the country. Our NHS 70 campaign featured 70 members of staff talking about why they do what they do and revealing the people who make up the NHS.


Consultant Geriatrician Dr Shelagh O'Riordan was named as south east person-centred care champion in the NHS70 Parliamentary Awards after a nomination from MP for Faversham and Mid-Kent Helen Whatley.

We launched free patient wifi in all our community hospitals and set visiting hours were scrapped at the hospitals to support patients with dementia.

A two-year project dedicated to improving the health of people from migrant communities started after an award from the Government. KCHFT and Kent County Council received £853,106 from the Ministry of Housing, Communities and Local Government to improve access to healthcare.

We set up a new frailty team to support elderly patients in Canterbury and Ashford, who are at risk of admission, or readmission, to hospital.

Our Health Visiting Service took over responsibility for supporting Kent mums to breastfeed. The teams make sure there has continued to be professional, peer and specialist support for women who want to breastfeed their babies and who need extra help.


Our Health Visiting Service was given its second seal of approval from UNICEF on its way to be baby friendly-accredited.

Excellent clinical practice and a little bit of magic were used to raise awareness of catheter associated urinary tract infections through the HOUDINI assessment, which identifies whether a catheter is still needed.

During the summer, we were awarded the REVAMP quality mark to show we are at the forefront of excellent volunteer management in Kent.

One of our wound centres celebrated its fourth birthday. Herne Bay wound medicine centre was praised by patients who called it 'a magnificent service'.

**From 1 April 2018 to 31 March 2019:**

- 88.5 per cent of new mothers received their health visiting check at six to eight weeks.
- We achieved 99.6 per cent of our target for face-to-face contacts with patients with long-term conditions and 89.9 per cent of our target for intermediate care and patients under rehabilitation.
- We exceeded our four per cent target for patients who did not attend appointments for the two services named above, with a percentage of 3.6 per cent.
- 90.7 per cent of patients seen by our specialist and elective services 97.7 per cent of our children's therapies services partially or fully met their outcomes.
- 94 per cent of reception year children and 93.7 per cent of pupils in Year 6 were screened for height and weight, against a trust target of 90 per cent.

Patients at Victoria Hospital, Deal benefitted from a new £250,000 x-ray machine thanks to support from the league of friends.

## 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.**

Working with Maidstone and Tunbridge Wells NHS Trust, we developed Hospital@home to offer intensive medical and nursing support for a short time when people are discharged from hospital. Hospital@home is aimed at patients who need further nursing or medical care following admission to hospital for a surgical procedure or medical condition.

We re-designed services in east Kent to make sure the pressures of winter were manageable. Working with East Kent Hospitals University NHS Foundation Trust, our teams worked hard to reduce delayed transfers of care.

We opened eight temporary beds in the winter of 2018 at Sheppey Community Hospital after receiving a request for support from our commissioners.

We held two events in Maidstone and Canterbury focussing on dementia. The sessions – Let's Discuss Dementia – attracted around 200 people, who heard about work being done to support people affected by dementia. They brought together organisations from around Kent.

Residents in Edenbridge became one step closer to getting a new health and wellbeing centre – putting multiple health and social care services in one place – after land next to the Eden Centre was identified as the best site fir the purpose-built centre. KCHFT is working with partners West Kent Clinical Commissioning Group and Edenbridge Medical Practice on the project.

### From 1 April 2018 to 31 March 2019:

- We had 88.4 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 increased slightly to 20.9 days, from 19.8 days.
- Our delayed transfers of care decreased from 10.1 per cent to 9.6 per cent against a national target of 9.5 per cent.
- 99.69 per cent of people waited fewer than four hours in our minor injury units to be seen.
- Our long-term conditions teams and intermediate care services had 74,188 patient contacts, resulting in admission to hospital being avoided. This was 17.4 per cent of all patients seen, against the trust's target of 15 per cent.

## 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.

In summer 2018, we launched our own Nursing Academy, which opened to students in February 2019. The academy offers a four-year degree level course for people wanting to become a registered nurse and a shorter two-year course to become an associate nurse.

We also recruited for a team in Edenbridge, west Kent to trial a programme of nursing guided by the principles of Buurtzorg, in the Transforming Integrated Care in the Community project. The Eden team is now up and running, with a similar team being planned for Charing in east Kent.

## Our Children's Integrated Therapy and Equipment Services in East Sussex celebrated after being awarded a new three-year contract. Between 600 and 1,000 children with complex needs are using the service at any one time.

We started our quality improvement programme, looking at continual ways of delivering the highest quality services to our patients and service users.

And we reinforced our work to make sure patients are fully involved in co-designing services. Our workforce was encouraged to look for new and innovative ways of doing things through our #yesyoucan project.

In November, we welcomed John Goulston as KCHFT's new chair and said thank you to Richard Field who had acted as vice chair since David Griffiths' retirement in May.

We took on the 70-day end PJ paralysis challenge, together with other NHS trusts around the country. For 70 days, our hospitals recorded how many patients each of our eight hospitals managed to get up, dressed and moving using a specially-created national app.

A great gay bake off, awareness training and LGBTea party were among the ways our workforce marked LGBT History Month in February 2019



### From 1 April 2018 to 31 March 2019:

- 92.87 per cent of people were waiting less than 18 weeks of referral to our consultant-led services and 91.82 per cent were treated within 18 weeks of referral to our allied health professional services by 31 March 2019.
- 93.56 per cent of children waited less than six weeks of referral for audiology tests by 31 March 2019.
- 100 per cent of people had access to genito-urinary medicine within 48 hours of contacting us.

# Patient feedback

- **66,085** patient experience surveys completed across the trust with an average satisfaction rate of 97 per cent.
- **93 per cent** of the workforce completed training on personalised care plans.
- **60 per cent** of the people we care for at the end of their lives had a personalised plan of care by the end of quarter four.


# Safe care

- **100 per cent** of all relevant serious incident investigations involved patients, families and carers from the beginning of the investigation.

- We shared learning from serious incidents and complaint stories across services at the Quality Improvement Network.

# Our charity

2018/19 was the year of the partnership for our charity, i care. During 2018, we joined forces with the national NHS Charities network, headed by Imperial Health Charity, to launch and promote all NHS charities during the 70th birthday celebration for the NHS and beyond.

This included taking part in The Big 7Tea, a national campaign to raise money for NHS charities. i care prominently featured on the front page of the NHS Charities website during the launch and ITV Meridian covered the charity in its broadcast covering the campaign (filmed at the sensory room in Coxheath).

We also linked up with the other NHS Trusts in the Kent and Medway area to form a networking group looking at sharing best practice and supporting each other's fundraising and charity promotion. The group meets quarterly at venues across Kent and regularly keeps in contact via email.

We are now registered as an official charity on Facebook and, as such, can receive donations via the Facebook donate now button; this also allows people to directly fundraise for us for a special occasion.

Charity expenditure very much focused on ensuring our community hospitals and services are as dementia-friendly as possible, building on work already done the previous year with dementia awareness training, GERT training suits and new improved blue crockery.

All our community hospitals are undergoing or have completed refurbishments to make them more dementia-friendly, under the guidance of our dementia leads.

This includes brightly coloured handrails, furniture and doors to prevent falls; replacing flooring with a matt covering so that it doesn't appear slippery; improved clear signage and making doors and exits that are only for staff use white or pale grey so patients don't wander through by accident.

In addition, the charity paid for other items, such as the Faversham bus stop, a replica bus stop inside the hospital that patients with dementia symptoms and/or anxiety can use to help calm them and dementia-related activities, such as tea dances and film screenings.

# Sustainability report

The trust has carried out risk assessments and has a sustainable development management plan in place, which takes account of UK Climate Projections 2018 (UKCP18).

The trust makes sure its obligations under the Climate Change Act and the Adaptation Reporting requirements are complied with. Examples for this year include:

## Paper

Introduction of recycled paper in 2018/19 equated to a saving of 204,580 kWh, 16.96 tonne of carbon dioxide (CO2) and has already saved 636 trees.

KCHFT's policy of supporting paper lite practices equates to a saving of 148455 kWh, 12.3 tonnes of CO2 and 461 trees when 2017/18 figures are compared with 2018/19.

## Energy

Using LED lights at three sites saved 24839 kWh in 2018/19, while replacing 111 photocopiers with energy saving functions saved 11,766 kWh during the year.

Four electric car charging points were installed, with more planned for 2019/20. The introduction of solar panels produced 7599 kW in 2018/19, equivalent to more than 2.1 tonnes of CO2.

## Forward plan

The trust is refining and developing its sustainable development management plan. Implementing the plan during the next year will be overseen by the director of strategy and the newly appointed energy manager, together with colleagues from procurement and responsible officers across the trust.

# Review 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 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 progress of action plans that were developed in relation to the trust's we care visits to all services.

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.

We work with the support of our internal and external auditors to strengthen and embed our assurance framework. The work of external audit supports Kent Community Health NHS Foundation Trust consideration and evaluation of controls, governance and risk.

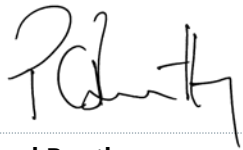
The work of external audit is developed and monitored by the Audit and Risk Committee through regular update reports. Financial governance arrangements are supported by internal and external audit to ensure economic, efficient and effective use of resources with no significant issues reported for the period 2018/19.

Following a review of effectiveness, external audit was reappointed in 2018 for the period of 3 years with the previous tender conducted in 2016.

The committee received regular reports from 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 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.



**Paul Bentley**

Chief Executive Officer

Date: 23 May 2019

# The accountability report

# The directors' report

## Board

**Non-executive Directors**

**Council of Governors**

**Chair**
John Goulston

**Chief Executive**
Paul Bentley

**Chief Operating Officer**
Lesley Strong

**Director of Strategy**
Gerard Sammon
On secondment

**Medical Director**
Dr Sarah Philips

**Director of Workforce, Organisational Development and Communications**
Louise Norris

**Executive Director of Finance**
Gordon Flack

**Corporate Services Director**
Natalie Davies

**Chief Nurse**
Dr Mercia Spare
On secondment

Portfolios of executive 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, organisational development and communications:** Leads on workforce, 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 director of strategy:** Leads on development of strategy for the trust, with the role having a particular focus on changes made by national policy and local policy, internally and as part of whole system partnership working. The director plays a key role in developing and maintaining relationships with stakeholders.
- **corporate services director:** Includes regulatory framework, members and governors, governance and risk and estates.

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 ensure 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 to the chief executive. 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

## John Goulston,
Chair

Father-of-three John has a wealth of experience working as a chief executive of acute and community health providers. He has been an executive director of NHS London, the strategic health authority for London, plus director of finance at two London teaching hospitals during his career.

During his time at Croydon Health Services NHS Trust, he led transformation of the trust's services, overseeing quality improvements and steering it out of financial special measures. He was instrumental in empowering frontline staff to make the changes they wanted to improve care standards.

John, who lives in Beckenham, helped establish One Croydon Alliance, a 10-year agreement to integrate services across health and social care. Aimed at increasing partnership working between Croydon's NHS, GPs, the local council and the voluntary sector, the alliance seeks to give people greater control of their health and choice of services.

Much of his early career was in Kent, working in Maidstone during the 1980s. John's daughter is a doctor and his wife is a community physiotherapist.

## David Griffiths,
Chair (retired)

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

## 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 know how to effect business transformation, enhance performance and manage cultural development and change. Bridget lives in rural Kent.

## Jennifer Tippin,
### Non-executive Director

Jen was appointed group director, people and productivity for Lloyds Banking Group in July 2017. She is responsible for leading the people function, managing sourcing and supply chain management, property and divestment and development, in addition to managing the group's cost base. Jen is a member of the Group Executive Committee.

Before her current position, she was group organisation design and cost management director, group customer services director and managing director for business banking.

Graduating from Oxford University, Jen has enjoyed a career spanning multiple industries, including banking, engineering and the airline sector. Jen is also a non-executive director on the boards 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 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 Kent and Medway Cardiac Network director.

Now, 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.

## 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 PLC.

He has been a non-executive director with the NHS since 2006. He has held a portfolio of public sector roles including:

- non-executive director and audit chair, Rural Payments Agency
- non-executive director and audit chair, NHS West Kent
- independent member of the Audit Committees of the Home Office, Ministry of Justice, DEFRA, Health and Safety Executive and Child Maintenance and Enforcement Commission
- trustee director, Citizens Advice North and West Kent.

## 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 is now carrying out consultancy work with a large animal feeds manufacturing organisation. He is chair of Age UK Canterbury, chair of Canterbury Academy, member and past president of Canterbury Forest of Blean Rotary Club and former non-executive director of Eastern and Coastal Kent Community Services.

## Steve Howe CBE,
### Non-executive Director

Steve served in Royal Army Medical Corps for 39 years, having joined as a soldier. He later trained at the Royal Military Academy, Sandhurst.

Steve went on to command medical regiments, field hospitals and medical groups on operations in the Balkans and Middle East.

He 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 of the army's 11 deployable field hospitals
- former Ministry of Defence (MOD) director of medical operations, responsible for contingency planning and strategic oversight of operations in Iraq and Afghanistan.
- co-chair of the MOD/Department for Health Committee for Military-NHS Operational Co-operation and chair of a NATO Committee for Medical Standardisation.
- a fellow of the Institute of Healthcare Managers.

## Martin Cook,
### Non-executive Director

Martin Cook, from Whitstable, has had a long and successful career in the public and private sector, beginning in the Civil Service before moving into professional services with Capgemini and EY (formerly Ernst and Young).

Martin has a strong background in strategy, but his experience also includes running a large IT services business and managing major change programmes in both the public and private sectors.

Martin is a lay member of the Council of the University of Kent and a trustee of Turner Contemporary in Margate, among other things.

## Professor Francis Drobniewski,
### Non-executive Director

Francis divides his time between clinical practice, education and research. He is professor of global health and tuberculosis (TB) at Imperial College, London, a consultant medical microbiologist and was a tuberculosis physician.

He has worked in Europe, USA and Africa, and was director of the public health UK National TB Laboratory for 19 years. Francis is clinical TB adviser for the National Institute of Clinical Excellence (NICE) and an adviser to the World Health Organisation.

Having spent 20 years as a consultant, he has worked alongside public health, community services and believes in keeping people out of hospital, wherever possible.

## Nigel Turner,
### Non-executive Director

Nigel has been a group human resources director and has a proven track record in leading contemporary transformational people-change in some of the most challenging UK organisational scenarios.

His career has included leading the people agenda of the £400million digital transformation of Argos before its sale to Sainsbury's.

He also took the lead role for people in the government-funded modernisation of the Royal Mail, providing strategic support to the HR director at Northern Rock following the financial crisis and led the people strategy at Spire Healthcare.

Nigel lives in Harrietsham, near Maidstone.

## Paul Bentley,
### Chief Executive

Before joining KCHFT as chief executive, Paul was 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 did his graduate university education in the UK, before completing his post graduate education in the US.

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
- director of children's services, West Sussex 2007
- chief operating officer, East Sussex 2008
- managing director, Greenwich Community Health Services 2011.

## Gordon Flack,
### Director of Finance

Gordon is a fellow of the Chartered Association of Certified Accountants and has a professional background in NHS finance spanning 34 years.

Following an early career with health authorities, his director experience is with acute and community trusts and he 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 has more than 30 years' experience in NHS Human Resources and joins us from Central and North West London NHS Foundation Trust.

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 in the NHS in acute and community settings for more than 20 years.

As corporate services director, she has a strong background in corporate governance, risk management and compliance.

Natalie has primary responsibility for areas, including estates, facilities, legal, risk and compliance.

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

## Dr Sarah Phillips,
### Medical Director

Sarah is a GP at Newton Place Surgery in Faversham. Before joining the trust as medical director, she 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 to spearhead the drive to determine how best to provide health and care services to east Kent. Its work is part of the wider Sustainability and Transformation Plan (STP) for Kent and Medway.

Sarah's work included reviewing issues around staff retention, the use of technology, 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, set up to ensure NHS future plans meet the health and social care needs of the communities it serves.

Sarah lives in Canterbury with her two children. She is a keen tennis player.

## Dr Mercia Spare,
### Chief Nurse (Interim) (from 2018)

Mercia joined KCHFT on secondment from NHS Improvement in 2018. She has more than 30 years' experience working in the NHS at a local, regional and national level, as well as holding roles in central Government and NHS regulation.

Mercia has primary responsibility for Caldecott, the annual flu campaign, safeguarding, CQC compliance and is the executive Time to Change champion.

## Ali Carruth,
### Chief Nurse (to maternity leave)

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 children.

## **Gerard Sammon,**
## Director of Strategy (from 2018)

Before joining KCHFT on secondment, Gerard has experience of working for more than 20 years in the NHS in a number of board and managerial roles including being an interim chief executive.

In previous posts, he led system-wide changes and programmes of work with other health and care organisation that spanned north Kent and south East London and pioneered the introduction of group models into the NHS.

He previously studied at Kings College London, Ashridge Business School and was a member of the NHS Top Leaders' Programme. He is keen on coaching youth basketball and is married with three children.

# Board and committee attendance

| | Formal Board | | Audit and Risk Committee | | Quality Committee | | Finance Business and Investment Committee | | Strategic Workforce Committee | | Charitable Funds Committee | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **Non-executive Directors** | **A** | **B** | **A** | **B** | **A** | **B** | **A** | **B** | **A** | **B** | **A** | **B** |
| Pippa Barber | 6 | 6 | | | 10 | 10 | | 2 | | 1 | | 2 |
| Peter Conway | 6 | 4 | 4 | 4 | | 2 | | 6 | | 4 | | |
| Martin Cook | 3 | 3 | | | | 1 | 5 | 5 | | | 1 | 1 |
| Francis Drobniewski | 3 | 3 | | | 5 | 3 | | | | 2 | | |
| Richard Field | 6 | 6 | 4 | 4 | | 5 | 10 | 10 | | 3 | 4 | 3 |
| John Goulston | 3 | 3 | | 1 | | | | 3 | | 2 | | 1 |
| Steve Howe | 6 | 6 | | | 10 | 9 | | 2 | | 2 | | |
| Bridget Skelton | 6 | 6 | 4 | 4 | | 1 | 10 | 9 | 6 | 6 | | |
| Jennifer Tippin | 6 | 3 | | | | | 10 | 4 | | 2 | 4 | 4 |
| Nigel Turner | 3 | 2 | | 1 | 1 | 3 | | 1 | 3 | 2 | | |
| David Griffiths | 1 | 1 | | | | | | | | | | |

| **Executive Directors** | **A** | **B** | **A** | **B** | **A** | **B** | **A** | **B** | **A** | **B** | **A** | **B** |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Paul Bentley | 6 | 6 | | 2 | | 3 | | 3 | | | | |
| Ali Carruth | 3 | 3 | | | 7 | 5 | | | 3 | 1 | | |
| Natalie Davies | 6 | 6 | | 3 | | | | | | | | |
| Gordon Flack | 6 | 5 | | 4 | | | 10 | | | | 4 | 1 |
| Louise Norris | 6 | 6 | | | | | | | 6 | 6 | | |
| Gerard Sammon | 3 | 3 | | | | | | | | 2 | | |
| Sarah Phillips | 6 | 6 | | | 10 | 6 | 1 | 1 | 6 | 3 | | |
| Lesley Strong | 6 | 6 | | | 10 | 10 | 10 | 9 | 6 | 6 | 4 | 1 |
| Dr Mercia Spare | 3 | 3 | | | 3 | 3 | | | 3 | 3 | | |

**A** total number of meetings the director was eligible to attend as a member of the committee.
**B** total number of meetings the director did attend.

# Directors' report: Compliance statements

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

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

The trust has a major incident plan in place 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 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 2018/19 is set out here:

## Better payment practice code 2018/19

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 2018/19 is set out here:

| Non-NHS payables | 2018/19 Number | 2018/19 £000s |
|---|---|---|
| Total non-NHS trade invoices paid in the period | 34,488 | 64,008 |
| Total non-NHS trade invoices paid within target | 34,074 | 63,292 |
| Percentage of non-NHS trade invoices paid within target | 98.80% | 98.88% |

| NHS payables | 2018/19 Number | 2018/19 £000s |
|---|---|---|
| Total NHS trade invoices paid in the period | 1,901 | 13,177 |
| Total NHS trade invoices paid within target | 1,785 | 12,270 |
| Percentage of NHS trade invoices paid within target | 93.90% | 93.11% |

**Total**

| | | |
|---|---|---|
| Total non-NHS and NHS trade invoices paid in the period | 36,389 | 77,185 |
| Total non-NHS and NHS trade invoices paid within target | 35,859 | 75,562 |
| Percentage of non-NHS and NHS trade invoices paid within target | 98.54% | 97.90% |

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 in trust's performance, business model and strategy.

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.

# Council of Governors as at 31 March 2019

## Public governors

**Ashford**
John Fletcher

**Canterbury**
Mary Straker

**Dartford**
Avtar Sandhu

**Dover/Deal**
Carol Coleman

**Gravesham**
Pete Sutton

**Maidstone**
David Price

**Sevenoaks**
John Harris

**Shepway**
Jo Clifford

**Swale**
Miles Lemon

**Jane Hetherington**
Thanet

**Tonbridge and Malling**
Ruth Davies

**Tunbridge Wells**
Tony Quigley

**Rest of England**
John Woolgrove

## Staff governors

**Sonja Bigg**
Health and Wellbeing

**Jan Allen**
Corporate Services

**Maria-Loukia Bratsou**
Children and Families

**Claire Buckingham**
Health and Wellbeing

**Amy Heskett**
Adult Services

## Appointed governors

Dr Susan Plummer
**Universities**

Andrew Scott-Clark
**Public Health**

Nigel Stratton
**Age UK**

Matthew Wright
**Head Teachers' Association**

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

## Membership: Representation and effectiveness

The trust agreed a membership strategy for 2018 to 2021 which set out four objectives, linked to our communication and engagement goals, to make sure our members are fully informed and involved.

The action plan set against these objectives is monitored by the governors' Communications and Engagement Committee.

The four objectives are:

1. to provide members with accurate information about our services and how to improve on their health and wellbeing
2. to increase opportunities for membership to feedback on our services and ensure these are fed into service design and improvement
3. to increase membership levels by two per cent year-on-year (with a stretch target of five per cent) and ensure our membership reflects the population that we serve
4. to ensure members know who their local governor is, what they do/their role and why and how to contact them.

## Understanding the views of governors and members

There is a process for electing new governors, which is conducted by an external election company (Electoral Reform Services).

In the past 12 months, seven public governors were elected. The council now consists of 13 publicly elected governors, five staff governors and four appointed governors. All governors have been to at least one formal meeting of the council during the past 12 months.

The trust has continued to 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 Sustainability and Transformation Plan.

This also ensures they develop their role as governors, representing their constituents and holding the trust to account for its performance.

Governors have at least two full-day development sessions each year, with four morning sessions held before council meetings devoted to a range of topics including service presentations, quality accounts and learning from other councils. Attendance is voluntary, but has been consistently high.

A Kent and Medway-wide governor network lead by Kent Community Health NHS Foundation Trust 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 developed a productive virtual network.

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 the public, patients, local groups and organisations

The trust held two successful events in Maidstone and Canterbury in 2018/19 talking about care and support for people with dementia and their families.

The events involved a number of voluntary organisations and the Canterbury event was held in partnership with East Kent Hospitals University NHS Foundation Trust.

KCHFT's Engagement Team worked with Kent County Council (KCC) colleagues to engage deaf people and this resulted in the One You service developing a new pathway for deaf people to access support to quit smoking, lose weight or exercise more.

The trust also worked with Action on Hearing Loss to provide equipment for patients with hearing loss in our community hospitals and other services such as falls prevention and deaf awareness training for staff.

After working with migrant communities in Kent for some time, we were successful in securing funds, in partnership with KCC, from the Department of Communities for a two-year programme of work with migrant families, involving health visitors, school health and health trainers. This programme started in summer 2018 and will help migrant families to appropriately access health care and reduce the health inequalities they experience.

The trust continued to engage with people with learning disabilities in partnership with East Kent Mencap to develop Easy Read patient information, holding regular focus groups and involving people in our Patient Engagement Network (PEN).

PEN members are patients/service users, carers and public members who provide an invaluable contribution as patient/public representatives on the trust's patient experience and advisory groups.

This includes patients and carer involvement in some of the trust's quality improvement initiatives, patient and carer representatives on interview panels recruiting staff to the organisation and a new virtual advisory group for young people using sexual health services.

We continued to increase the number of volunteers who support our clinical and administrative staff and enhance patient experience. From cardio rehabilitation and health walks to dining companions and meet and greet volunteers, we now have more than 600 volunteers.

KCHFT continues to have an excellent relationship with Healthwatch Kent and is planning to work closely with the organisation in the next year to look at the quality of care at home and end of life care.

In March 2019, we started work with a group of patient representatives to produce a toolkit and training on co-design. This approach is about ensuring patients, carers and staff work together to improve services as equal partners.

We continued to increase the number of volunteers who support our clinical and administrative staff and enhance patient experience.

# Remuneration report

This remuneration report presents information from 1 April 2018 to 31 March 2019.

## Annual statement on remuneration

The chief executive's and medical director's performance against the agreed objectives was discussed. These were met in full and, consequently, the committee agreed there would be no claw back of salary.

There were no other substantial changes relating to senior managers' remuneration during the year.

The Council of Governors has not been asked to review salaries for the chair and the 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 is three months. Notice periods should normally be worked to ensure 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. Rates paid to individual directors are determined by the Remuneration Committee, which takes into account:<br>• qualifications required for the role<br>• spans of responsibility and accountability<br>• performance<br>• market forces | The trust believes that 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.<br>However, salaries should not be overly high and should be positioned in the top quartile of salaries for similar organisations.<br>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.<br>In the case of any salary above £150,000, views of ministers are sought.<br>A claw back scheme is in place for the medical director's salary. Should objectives not be achieved, the salary is reduced by 10%.<br>A report is presented to the Remuneration Committee. | |
| The annual uplift | | As described above. | 3% |

| Pay component | How that component supports the trust's short and long-term strategy | How it operates | Maximum payable |
|---|---|---|---|
| Chief executive earn back | The trust believes that the chief executive should be properly remunerated for their work. Trust salaries should be competitive and enable the trust to attract high-calibre staff.<br><br>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.<br><br>Where applicable views of ministers are sought. | A claw back scheme is in place.<br><br>Should objectives not be achieved, the salary is reduced by 10%. | £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 is 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 2018/19. 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 committees, Strategic Workforce Committee and 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 |

## Service contracts obligations

There is one standard contract for all directors. The medical director's contract includes a clause regarding claw back. This standard contract 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.
- To 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; the 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 the decisions of the entity as a whole, rather than the decisions of individual directorates or department.

# Annual report on remuneration

Information not subject to audit

## Remuneration Committee

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

The committee's members are non-executive directors of the trust and the committee is chaired by the trust's chair. Between 1 April 2018 and 31 March 2019, there were six meetings of the Remuneration Committee.

| Remuneration Committee | Meetings attended 2018/19 |
|---|---|
| David Griffiths | 2 |
| John Goulston | 3 |
| Richard Field | 6 |
| Peter Conway | 6 |
| Steve Howe | 6 |
| Bridget Skelton | 5 |
| Jennifer Tippin | 3 |
| Pippa Barber | 6 |
| Martin Cook | 3 |
| Francis Drobniewski | 3 |
| Nigel Turner | 3 |

The chief executive and director of workforce, organisational development and communications 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, other directors and senior managers with Board responsibility who report directly 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 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 Carruth,** Chief Nurse | 10 October 2016 | 3 months |
| **Mercia Spare,** Interim Chief Nurse | 26 November 2018 | n/a |
| **Sarah Phillips,** Medical Director | 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 |
| **Gerard Sammon,** Director of Strategy | 15 October 2016 | n/a |

Mercia Spare and Gerard Sammon do not have notice periods as they are seconded staff. The secondment end date for Mercia Spare is 25 January 2020, and the secondment end date for Gerard Sammon is 14 October 2019.

Non-executive director service contracts are fixed-term with the following unexpired terms as at the 31 March 2019:

| Non-executive directors | Date effective | End date | Unexpired term |
|---|---|---|---|
| **David Griffiths,** Chair | 1 March 2017 | 24 May 2018 | – |
| **John Goulston,** Chair | 1 November 2018 | 31 October 2021 | 2 years, 7 months |
| **Richard Field,** Vice Chair | 1 April 2017 | 30 April 2019 | 1 month |
| **Pippa Barber,** Non-executive Director | 1 December 2016 | 30 November 2019 | 8 months |
| **Peter Conway,** Non-executive Director | 1 April 2018 | 31 March 2021 | 2 years |
| **Martin Cook,** Non-executive Director | 1 October 2018 | 31 January 2022 | 2 years, 10 months |
| **Francis Drobniewski,** Non-executive Director | 1 October 2018 | 31 January 2022 | 2 years, 10 months |
| **Steve Howe,** Non-executive Director | 1 April 2018 | 30 April 2019 | 1 month |
| **Bridget Skelton,** Non-executive Director | 7 April 2016 | 6 April 2022 | 3 years |
| **Jennifer Tippin,** Non-executive Director | 1 March 2017 | 29 February 2020 | 11 months |
| **Nigel Turner,** Non-executive Director | 1 October 2018 | 30 September 2021 | 2 years, 6 months |

David Griffiths retired on 24 May 2018; from this date Richard Field was interim chair until newly appointed Chair John Goulston joined on 1 November 2018.

Three new non-executive directors joined on 1 October 2018 – Martin Cook, Francis Drobniewski and Nigel Turner.

Martin Cook and Francis Drobniewski joined as associate non-executive directors, meaning they did not have voting rights. They were subsequently granted voting rights from 1 February 2019. On this date Richard Field and Steve Howe became non-voting non-executive directors.

Richard Field and Steve Howe left the trust at the end of April 2019. Bridget Skelton's next term in office started on 7 April 2019.

## 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 | |
|---|---|---|
| | 2018/19 | 2017/18 |
| **Paul Bentley,** Chief Executive Officer | 16 | 20 |
| **Lesley Strong,** Chief Operating Officer/Deputy Chief Executive | 28 | 26 |
| **Ali Carruth,** Chief Nurse | 16 | 19 |
| **Mercia Spare,** Interim Chief Nurse (from 26 November 2018) | 80 | – |
| **Arokia Antonysamy,** Acting Medical Director (to 9 April 2017) | – | 1 |
| **Sarah Phillips,** Medical Director (from 10 April 2017) | 19 | 31 |
| **Gordon Flack,** Director of Finance | 13 | 10 |
| **Natalie Davies,** Director of Corporate Services | 14 | 6 |
| **Louise Norris,** Director of Workforce, Organisational Development and Communications | 19 | 19 |
| **Gerard Sammon,** Director of Strategy (from 15 October 2018) | 11 | – |
| **David Griffiths,** Chair (to 24 May 2018) | 3 | 20 |
| **John Goulston,** Chair (from 1 November 2018) | 14 | – |
| **Richard Field,** Vice Chair (Interim Chair from 25 May to 31 October 2018) | 22 | 10 |
| **Pippa Barber,** Non-executive Director | 22 | 20 |
| **Peter Conway,** Non-executive Director | 8 | 8 |
| **Martin Cook,** Non-executive Director (from 1 October 2018) | 4 | – |
| **Francis Drobniewski,** Non-executive Director (from 1 October 2018) | – | – |
| **Steve Howe,** Non-executive Director | 13 | 14 |
| **David Robinson,** Non-executive Director (left 30 September 2017) | – | 8 |
| **Bridget Skelton,** Non-executive Director | 10 | 10 |
| **Jennifer Tippin,** Non-executive Director | – | 3 |
| **Nigel Turner,** Non-executive Director (from 1 October 2018) | – | – |
| **Total** | **312** | **225** |

* Taxable benefits are included within the remuneration tables on pages 49 to 50.

There were a total of 20 executive and non-executive directors in post in the reporting period 2018/19 and 17 of these received expenses paid by the trust. The aggregate sum of directors' expenses comes to £31,181.86.

The following expenses were paid to governors in the period:

| Governors | Expenses (rounded to nearest 100) £00 | |
|---|---|---|
| | 2018/19 | 2017/18 |
| Jo Clifford | 3 | 2 |
| Carol Coleman | 14 | 7 |
| John Fletcher | 3 | 2 |
| John Harris | 1 | - |
| Miles Lemon | 0 | - |
| Anthony Moore | 2 | - |
| David Price | 1 | 1 |
| Anthony Quigley | 1 | - |
| Mary Straker | 1 | 0 |
| Nigel Stratton | 1 | - |
| Sue Stephens | - | 3 |
| Pete Sutton | 4 | 2 |
| Kate Wortham | - | |
| **Total** | **31** | **17** |

There are a total of 22 governor positions. There have been 24 individuals working as governors within the year, with two leaving and 11 starting in the period, seven of which filled vacant posts.

As at 31 March 2019, there were 22 governors in post, with no vacant positions. In the reporting period 2018/19, 10 governors received expenses paid by the trust. The aggregate sum of governors' expenses totals £3,089.19.

## Information subject to audit

| Name and title | 2018/19 | | | | | | 2017/18 | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | Salary and fees | Taxable benefits | Annual performance -related earn back* | Long-term performance -related bonuses | All pension -related benefits | Total | Salary and fees | Taxable benefits | Annual performance -related earn back* | 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 | 175-180 | | 5-10 | | 0 | **185-190** | 150-155 | | 15-20 | | 0 | **165-170** |
| **Lesley Strong,** Chief Operating Officer/ Deputy Chief Executive | 130-135 | | | | 0 | **130-135** | 130-135 | | | | 17.5-20 | **145-150** |
| **Ali Carruth,** Chief Nurse | 95-100 | | | | 35-37.5 | **130-135** | 120-125 | | | | 172.5-175 | **290-295** |
| **Mercia Spare,** Interim Chief Nurse (from 26 Nov 2018) | 35-40 | | | | 20-22.5 | **55-60** | | | | | | |
| **Arokia Antonysamy**, Acting Medical Director (from 1 Mar to 9 Apr 2017) | | | | | | | 0-5 | | | | 0 | **0-5** |
| **Sarah Phillips**, Medical Director (from 10 Apr 2017) | 170-175 | | 5-10 | | 57.5-60 | **235-240** | 145-150 | | 5-10 | | 0 | **150-155** |
| **Gordon Flack**, Director of Finance | 145-150 | | | | 0 | **145-150** | 135-140 | 2,200 | | | 97.5-100 | **235-240** |
| **Natalie Davies**, Director of Corporate Services | 95-100 | | | | 30-32.5 | **125-130** | 90-95 | | | | 30-32.5 | **120-125** |
| **Louise Norris**, Director of Workforce, Organisational Development and Communications | 115-120 | | | | 20-22.5 | **135-140** | 110-115 | | | | 15-20 | **125-130** |
| **Gerard Sammon**, Director of Strategy (from 15 October 2018) | 60-65 | | | | 5-10 | **65-70** | | | | | | |

*The annual performance-related earn back awarded to the chief executive officer and the medical director outlined in the table above, have been granted in line with the chief executive earn back and earn back scheme applied to the medical director's salary.

| Name and title | 2018/19 | | | | | | 2017/18 | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | 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 |
| **David Griffiths,** Chair | 5-10 | 0 | | | | **5-10** | 45-50 | 1,900 | | | | **45-50** |
| **John Goulston,** Chair (from 1 November 2018) | 15-20 | 1,400 | | | | **20-25** | | | | | | |
| **Richard Field,** Vice chair (Interim Chair from 25 May to 31 October 2018) | 25-30 | 2,000 | | | | **30-35** | 15-20 | 1,000 | | | | **15-20** |
| **Pippa Barber,** Non-executive director (from 1 Dec 2016) | 10-15 | 2,100 | | | | **15-20** | 10-15 | 2,000 | | | | **15-20** |
| **Peter Conway,** Non-executive director | 15-20 | 800 | | | | **15-20** | 15-20 | 800 | | | | **15-20** |
| **Martin Cook,** Non-executive director (from 1 October 2018) | 5-10 | 300 | | | | **5-10** | | | | | | |
| **Francis Drobniewski,** Non-executive director (from 1 October 2018) | 5-10 | 0 | | | | **5-10** | | | | | | |
| **Steve Howe,** Non-executive director | 15-20 | 1,300 | | | | **15-20** | 15-20 | 1,400 | | | | **15-20** |
| **David Robinson,** Non-executive director (left 30 Sept 2017) | | | | | | | 5-10 | 800 | | | | **5-10** |
| **Bridget Skelton,** Non-executive director | 15-20 | 1,000 | | | | **15-20** | 10-15 | 800 | | | | **10-15** |
| **Jennifer Tippin,** Non-executive director | 10-15 | 0 | | | | **10-15** | 10-15 | 300 | | | | **10-15** |
| **Nigel Turner,** Non-executive director | 5-10 | 0 | | | | **5-10** | | | | | | |

From 1 April 2018 to 31 March 2019, there were a couple of changes in personnel to the Executive Team. Mercia Spare joined the trust on secondment from NHS Improvement on 26 November 2018 as interim chief nurse to cover Ali Carruth's maternity leave. Gerard Sammon also joined the trust on secondment from Dartford and Gravesham NHS Trust on 15 October 2018 as director of strategy.

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

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 31.03.19 (bands of £5,000) £000 | Lump sum at pension age related to accrued pension at 31.03.19 (bands of £5,000) £000 | Cash equivalent transfer value at 01.04.18 £000 | Cash equivalent transfer value at 31.03.19 £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 | 0 | 65-70 | 195-200 | n/a | n/a | n/a | n/a |
| **Ali Carruth,** Chief Nurse | 2.5-5 | 0-2.5 | 35-40 | 90-95 | 527 | 654 | 94 | n/a |
| **Mercia Spare,** Interim Chief Nurse (from 26 Nov 2018) | 0-2.5 | 0-2.5 | 25-30 | 80-85 | 500 | 635 | 36 | n/a |
| **Sarah Phillips**, Medical Director (from 10 Apr 2017) | 2.5-5 | 0-2.5 | 15-20 | 30-35 | 198 | 285 | 55 | n/a |
| **Gordon Flack**, Director of Finance | 0 | 0 | 55-60 | 170-175 | 1,151 | 1,293 | 95 | n/a |
| **Natalie Davies**, Director of Corporate Services | 0-2.5 | 0-2.5 | 25-30 | 60-65 | 356 | 449 | 69 | n/a |
| **Louise Norris**, Director of Workforce, Organisational Development and Communications | 0-2.5 | 0-2.5 | 45-50 | 135-140 | 901 | 1,053 | 109 | n/a |
| **Gerard Sammon**, Director of Strategy (from 15 Oc 2018) | 0-2.5 | 0 | 35-40 | 90-95 | 549 | 663 | 35 | 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. Lesley Strong and Gordon Flack opted out of the NHS Pension Scheme in October 2018.

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 purchasing 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 during 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 the September before the start of the tax year is higher than it was for the previous September.

For 2018/19, the difference in CPI between September 2016 and September 2017 was three per cent. Therefore, for calculation purposes the trust has used an inflation rate assumption of three per cent to calculate real increases to pensions, lump sums and CETVs during the period. The trust considers this an appropriate inflation figure to be used in calculations as the 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 2018/19 was £185k to £190k (2017/18, £165k to £170k). This was seven times (2017/18, 6.5 times) the median remuneration of the workforce, which was £27k (2017/18, £26k). The increase in the fair pay multiple is due to the slight increase in median salary and the increase in the highest paid director's salary.

In 2018/19, no employee (2017/18, no employee) received remuneration in excess of the highest-paid director. Remuneration ranged from £11k to £187k (2017/18 £7k-£170k).

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.....

**Paul Bentley, Chief Executive Officer**

Date: 23 May 2019

# Staff report

Following publication of our people strategy last year, we worked throughout this financial year to develop robust action plans to deliver the strategy and embed the principles in everyday working life for our workforce.

As part of this plan, we held our Big Listen event with the main aim of reducing turnover by two per cent by July 2019. We received more than 1,300 replies. They contained four main themes, which were a focus for work during the year. The four themes were:

- develop a new electronic patient record system
- colleagues need to feel valued and able to make a difference
- targets should be balanced with patient care
- managing change more effectively.

We launched our Nursing Academy offering a new route into nursing in the community. It gives students the chance to earn while they learn and be the workforce of the future for the organisation.

## Key achievements in 2018/19

- We achieved a reduction in vacancy rate from 10.18 per cent in April 2018 to 8.23 per cent in March 2019.
- We achieved a reduction in turnover from 18.47 per cent in April 2018 to 17.87 per cent in March 2019.
- We exceeded our appraisal completion rate target of 85 per cent, achieving 99 per cent.
- We exceeded our statutory and mandatory training target of 85 per cent, achieving 95 per cent.

## Staff costs

| | Permanent £000 | Other £000 | 2018/19 Total £000 | 2017/18 Total £000 |
|---|---|---|---|---|
| Salaries and wages | 118,463 | 5,153 | **123,616** | 121,016 |
| Social security costs | 10,179 | 376 | **10,555** | 10,193 |
| Apprenticeship levy | 595 | – | **595** | 582 |
| Employer's contributions to NHS pensions | 15,450 | 351 | **15,801** | 15,576 |
| Pension cost – other | 25 | 1 | **26** | 13 |
| Termination benefits | 309 | – | **309** | 1,319 |
| Temporary staff | – | 5,361 | **5,361** | 4,246 |
| **Total gross staff costs** | **145,021** | **11,242** | **156,263** | **152,945** |
| Recoveries in respect of seconded staff | (20) | – | **(20)** | (13) |
| **Total staff costs** | **145,001** | **11,242** | **156,243** | **152,932** |
| Of which<br>Costs capitalised as part of assets | 36 | 42 | **78** | 88 |

## Staff numbers

| | Permanent number | Other number | 2018/19 Total number | 2017/18 Total number |
|---|---|---|---|---|
| Medical and dental | 80 | 7 | **87** | 88 |
| Administration and estates | 1,312 | 62 | **1,375** | 1,352 |
| Healthcare assistants and other support staff | 754 | 61 | **815** | 831 |
| Nursing, midwifery and health visiting staff | 1,070 | 76 | **1,145** | 1,192 |
| Nursing, midwifery and health visiting learners | 11 | – | **11** | 20 |
| Scientific, therapeutic and technical staff | 664 | 24 | **688** | 699 |
| Social care staff | – | – | – | 13 |
| **Total average numbers** | **3,891** | **231** | **4,121** | **4,195** |
| Of which<br>Number of employees (WTE) engaged on capital projects | 1 | 1 | **2** | 2 |

## Gender distribution

The gender distribution of our workforce as at 31 March 2019 is:

| Role FTE | Female | Male | Total |
|---|---|---|---|
| Directors | 4.00 | 2.00 | 6.00 |
| Senior managers | 20.26 | 7.60 | 27.86 |
| Employees | 3388.30 | 467.11 | 3855.41 |
| Grand total | 3412.56 | 476.71 | 3889.27 |

| Role % | % Female | % Male | % Total |
|---|---|---|---|
| Directors | 66.7% | 33.3% | 100.00% |
| Senior managers | 72.7% | 27.3% | 100.00% |
| Employees | 87.9% | 12.1% | 100.00% |
| Grand total | 87.7% | 12.3% | 100.00% |

## Staff sickness absence

| | 2018/19 | 2017/18 |
|---|---|---|
| Total working days lost | 40,042 | 39,608 |
| Total staff years | 3,861 | 4,038 |
| Average days lost | 10 | 10 |

Staff sickness data is provided centrally by NHS Digital (using reconciled data from within the NHS electronic staff record and the Cabinet Office reported by central Government to permit aggregation across the NHS).

The figures reported are for calendar years 2018 (January to December 2018) and 2017 (January to December 2017). The Department of Health and Social Care (DHSC) considers the figures for the calendar year to be a reasonable proxy for the financial year.

# Staff policies and actions

## 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.

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

Our Workforce Equality Group developed guidance for managers and the workforce on implementing reasonable adjustments and the trust piloted training on unconscious bias, which we plan to roll out further in the coming year.

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

Additionally, we use Equality Diversity System 2 to record and evidence work we do and publish equality objectives annually on our website. Active staff networks promote and support colleagues from a Black Asian Minority Ethnic (BAME) background, Lesbian, Gay, Bisexual Transgender, Queer, + (LGBTQ+) and Disability and Careers Network (DCN) with more than 100 members across all networks.

We are working closely with Kent Supported Employment Agency to recruit people with learning disabilities, actively recruiting six new staff. This was supported by the training of staff in learning disability awareness.

## Freedom to speak up

The trust has had a freedom to speak up guardian (FTSU) in post all year, 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. 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 2018 and 31 March 2019, the FTSU guardian logged and was involved in 42 cases. Themes were discussed with the chief executive officer and a six-monthly report is presented to the Board. The Board has a freedom to speak up champion – Jen Tippin.

In August 2017, the trust started to develop a freedom to speak up ambassadors' programme and there are now 15 ambassadors. Their role includes encouraging colleagues to speak up, by providing informal advice, sign-posting and promoting positive examples of changes that happened as a result of speaking up.

Equality and diversity is embedded into trust policies.

## Communication with staff

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

In 2018/19, the team developed a new communications, engagement and patient experience strategy, working with colleagues, which complements the trust's mission, vision, strategic goals and objectives. The strategy is due for approval in the spring and runs until 2022. It will replace the current strategy.

The trust has good communication and engagement channels supported by mechanisms for gaining feedback to ensure that patients and colleagues are involved in shaping our services.

We value our staff – our most important asset. We recognise the challenges faced every day and ensuring our staff feel listened to and involved helps maintain a culture of openness, trust and accountability. Research has shown that a more engaged workforce results in better patient care.

Our award-winning social intranet, flo, can be accessed by all our staff. It ensures that colleagues working in different departments can effectively communicate with each other and 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 130,000 visits each month, with the most visited area, being our 'how to' guides, and the staff health and wellbeing section –You – seeing about four per cent of the traffic on the site. We have more than 40 new blog posts every month.



We produce a digital weekly round-up of what is happening in the organisation. Flomail has a consistent open rate of above 50 per cent among colleagues. We also produce a monthly Team Brief for managers to use in meetings to cascade key messages, plus add their own service specific news, and a monthly stakeholder news bulletin.

The #yesyoucan roadshow, led by the Executive Team aimed to seek ideas to deliver more power and authority to frontline staff continues. Future campaigns are planned to encourage staff to embrace devolved power as part of the trust's quality improvement drive.

Our quarterly magazine, Community Health, which features positive case studies reaches up to 100,000 readers. It is available to staff, as well as the public in a variety of formats.

Many of our staff also engage on our established social media profiles on Facebook, Twitter and YouTube. We have 7,301 followers on Facebook and 4,106 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.

## Consultation with staff

The trust takes a consultative approach to engagement with its workforce. Our active staff partnership forum is well attended by both Staff Side and management representatives. Change proposals are taken to this forum and added to the intranet for discussion, as well as full staff consultation on any changes that will impact staff. Views from all parties are gathered and given due consideration before any final decisions are made.

## Involving staff in the trust's performance

The trust has a robust performance reporting structure from the Board with a clear line of accountability and monitoring. The integrated performance report is supported by division level performance reports, which are produced monthly and reviewed and discussed at performance reviews with the Executive Team.

These division reports include service-level dashboards illustrating performance data for individual teams to allow services to have a clear understanding of their performance.

Service leads are encouraged to share the reports with their teams to give an understanding of the role in performance and share accountability.

In addition, the trust has a business intelligence tool enabling team leaders and managers to access performance data on a routine basis and share this information with teams, or investigate areas of adverse performance and celebrate success.

## Occupational health

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

## Health and safety performance

The trust fully meets its obligations under the Health and Safety at Work etc. Act 1974 and 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.

The trust reported 14 incidents, which fell under the requirements of the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 2013 (RIDDOR). All but one of these reports was submitted to the Health and Safety Executive 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 its intranet.

## Counter fraud and corruption

The trust's counter fraud specialists provide professional expertise and operate within a national legal framework for tackling fraud, corruption and bribery. All work was completed in accordance with legal standards and in compliance with guidance from NHS Counter Fraud Authority. The trust's approach to counter fraud and corruption is documented in its counter fraud, corruption and bribery policy, available on the intranet.

# Staff survey

## Staff engagement

A key part of our people strategy has been our culture change programme. The trust is developing a culture of trust and ownership, where people feel engaged and empowered to make decisions and act upon them.

Work is under way through a number of initiatives, including the Transforming Integrated Care in the Community programme, guided by the principles of Buurtzorg, with two pilot sites operational and further pilot sites identified.

The Strategic Workforce Committee has introduced a focus on employees' mental health. We introduced our Time to Change programme, training champions across the trust to reduce the stigma around mental health and increase awareness. This programme has been well received and we now have more than 80 champions across KCHFT.

## NHS staff survey

The NHS staff survey is carried out every year. From 2018 onwards, the results from questions are grouped to give scores in 10 indicators. The scores are based on a score out of 10 for certain questions, with the indicator score being the average of those.

The response rate to the 2018 survey among trust staff was 59.7 per cent. Scores for each indicator together with that of the survey benchmarking group (other community trusts) for the past three years are presented below.

Morale is a new theme for 2018/19 so there is no historical comparison data. The comparison figure for benchmarking is the average score of our comparator organisations (with best and worst scores shown in brackets).

| | 2018/19 | | 2017/18 | | 2016/17 | |
|---|---|---|---|---|---|---|
| | KCHFT | Benchmarking Group – other community Trusts* | KCHFT | Benchmarking Group – other community Trusts* | KCHFT | Benchmarking Group – other community Trusts* |
| Equality, diversity and inclusion | 9.5 | 9.3 (best 9.6/worst 8.8) | 9.4 | 9.3 (best 9.6/worst 8.9) | 9.4 | 9.4 (best 9.6/worst 9.0) |
| Health and wellbeing | 6.2 | 5.9 (best 6.5/worst 5.2) | 6.2 | 6.0 (best 6.5/worst 5.7) | 6.4 | 6.1 (best 6.6/worst 5.6) |
| Immediate managers | 7.4 | 7.0 (best 7.6/worst 6.7) | 7.2 | 7.0 (best 7.4/worst 6.8) | 6.9 | 6.9 (best 7.2/worst 6.5) |
| Morale | 6.2 | 6.1 (best 6.6/worst 5.7) | – | – | – | – |
| Quality of appraisals | 5.8 | 5.6 (best 6.0/worst 5.0) | 5.6 | 5.4 (best 5.9/worst 4.6) | 5.6 | 5.6 (best 5.9/worst 4.7) |
| Quality of care | 7.3 | 7.3 (best 8.0/worst 7.1) | 7.3 | 7.3 (best 7.9/worst 7.0) | 7.4 | 7.5 (best 7.9/worst 6.9) |
| Safe environment – bullying and harassment | 8.6 | 8.4 (best 8.8/worst 7.1) | 8.5 | 8.4 (best 8.7/worst 8.0) | 8.5 | 8.4 (best 8.7/worst 8.0) |
| Safe environment – violence | 9.8 | 9.7 (best 9.9/worst 9.6) | 9.7 | 9.7 (best 9.9/worst 9.5) | 9.7 | 9.7 (best 9.9/worst 9.5) |
| Safety culture | 7.0 | 7.0 (best 7.3/worst 6.2) | 6.9 | 6.9 (best 7.2/worst 6.4) | 6.9 | 6.8 (best 7.1/worst 6.5) |
| Staff engagement | 7.0 | 7.1 (best 7.5/worst 6.5) | 6.9 | 6.9 (best 7.4/worst 6.7) | 6.9 | 6.9 (best 7.4/worst 6.7) |

*best and worse scores in brackets

**Key data highlights:**

- KCHFT 2018/19 results were improved from 2017/2018 results in seven of the themes.
- KCHFT is performing the same or better than other community trusts in nine of the 10 themes.
- There weren't any themes, which received a lower score than 2017/18. KCHFT maintained or improved across all themes.
- Although there was a drop in response rate from 2017/18, where 62 per cent of staff responded, KCHFT had a higher than average response rate compared to other community Trusts, 53 per cent, and nationally, 46 per cent.

## Future priorities and targets

Our approach will be to develop action plans, both corporate and directorate level, to address any areas of:

- local decline
- minimal progression from last year
- where we do not compare well to other community trusts
- where we believe we can push ourselves to achieve the best within our benchmarking group.

Our main overall corporate focus will continue to be staff engagement during the coming months, continuing the work already underway and further developing this.

Action plans will also be developed corporately to positively affect change on:

- staff putting themselves under pressure to come to work
- ensuring staff training, learning and development is identified and actioned
- staff experiencing musculoskeletal problems as a result of work activities
- reducing the numbers of errors, near misses, or incidents that could have hurt staff, patients/service users.

The Strategic Workforce Committee will monitor progress and report to the Board. Quarterly, we will measure whether actions are having an impact via the staff friends and family test.

Overall, the staff survey findings for 2018 were very positive. It is important we continue to strive to improve all scores; that there is ownership of actions and these are followed through, so colleagues understand what they have to say does matter.

Staff need to be confident that as a trust we listen and act on feedback. A you said, we did campaign will share the 2018 staff survey results with the workforce.

The response rate to the 2018 survey among trust staff was 59.7 per cent

# Trade union facility time disclosures

Table 1

## Relevant union officials

| Number of employees who were relevant union officials during the relevant period | FTE employee numbers |
|---|---|
| 33 | 30.61 |

Table 2

## Percentage of time spent on facility time

| Percentage of time | Number of employees |
|---|---|
| 0% | 8 |
| 1% - 50 % | 25 |
| 51% - 99% | 0 |
| 100% | 0 |



Table 3

## Percentage of pay bill spent on facility time

| | Figures |
|---|---|
| Total cost of facility time | £37,134 |
| Total pay bill | £149,998k |
| Percentage of the total pay bill spent on facility time | 0.025% |

Table 4

## Paid trade union activities

| Time spent on paid trade union activities as a percentage of total paid facility time hours |
|---|
| 92% |

# Expenditure on consultancy

Expenditure on consultancy this year was £649k. This is an increase from last year (2017/18 = £429k spent on consultancy).

## Off-payroll arrangements

| All off-payroll engagements, as of 31 March 2019, for more than £245 per day that last for longer than six months | Number of engagements |
|---|---|
| Number of existing engagements as of 31 March 2019 | 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 |

| All new off-payroll engagements, or those that have reached six months in duration, between 1 April 2018 and 31 March 2019, for more than £245 per day and that last for longer than six months | Number of engagements |
|---|---|
| Number of new engagements, or those that reached six months in duration, between 1 April 2018 and 31 March 2019 | 0 |
| Of which… | |
| 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 |

| All off-payroll engagements of board members, and/or, senior officials with significant financial responsibility, between 1 April 2018 and 31 March 2019 | Number of engagements |
|---|---|
| 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 arrangements | 20 |

# Exit packages

## Reporting of compensation schemes – exit packages 2018/19

| | 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 | 1 | 13 | **14** |
| £10,001-£25,000 | 9 | 1 | **10** |
| £25,001-50,000 | 3 | – | **3** |
| £50,001-£100,000 | 1 | – | **1** |
| £100,001-£150,000 | – | – | **–** |
| £150,001-£200,000 | – | – | **–** |
| >£200,000 | – | – | **–** |
| **Total number of exit packages by type** | **14** | **14** | **28** |
| **Total resource cost (£)** | £309,000 | £83,000 | **£392,000** |

## 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** |

## Exit packages: other (non-compulsory) departure payments

| | 2018/19 | | 2017/18 | |
|---|---|---|---|---|
| | 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 | 14 | 83 | 21 | 116 |
| Exit payments following employment tribunals or court orders | – | – | – | – |
| Non-contractual payments requiring HMT approval | | | | |
| **Total** | **14** | **83** | **21** | **116** |
| Of which:<br>Non-contractual payments requiring HMT approval made to individuals where the payment value was more than 12 months' of their annual salary | – | – | – | – |

# Disclosures set out in the NHS foundation trust code of governance

## 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 four 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 2018/19. |
| 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 to 36. The number of Board and committee meetings and a record of attendance are found on page 37. |
| Council of Governors | A.5.3 | Page 39 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 pages 34 to 35 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 36. 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. |

| Disclosure relating to | NHS Improvement Code of Governance reference | Kent Community Health NHS Foundation Trust disclosure |
|---|---|---|
| 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 nine times in the past year. In addition, Nominations Committee members participated in interview panels and stakeholder events to recruit a new chair and two non-executive directors. |
| 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 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, seven public governors were elected. The council now consists of 13 publicly elected governors, five staff elected governors and four appointed governors. All governors have been to at least one formal meeting of the council during the past 12 months. |
| Board | B.6.1 | The trust commissioned EYP to do a Board effectiveness review as part of a Board development programme. 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 38. |
| 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 77. |
| 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. |

| Disclosure relating to | NHS Improvement Code of Governance reference | Kent Community Health NHS Foundation Trust disclosure |
|---|---|---|
| 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 is 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 Communications and Engagement 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:<br>email: kcht.governors@nhs.net phone 01622 211972<br>Post:<br>Governor Support Office<br>Kent Community Health NHS Foundation Trust<br>The Oast<br>Unit D Hermitage Court<br>Hermitage Lane<br>Barming<br>Maidstone<br>Kent ME16 9NT |

# 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 that 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 the use of public funds complies with the relevant legislation, delegated authorities and guidance
- confirm the annual report and accounts, taken as a whole, is fair, balanced and understandable and provides the information necessary for patients, regulators and stakeholders to assess the NHS foundation trust's performance, business model and strategy
- 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 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 hence 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.....

**Paul Bentley, Chief Executive Officer**

Date: 23 May 2019


# Annual governance statement

# Annual Governance Statement

## 1 April 2018 to 31 March 2019
## Kent Community Health NHS Foundation Trust
## (Organisational Code – RYY)

## 1. Scope of responsibility

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

In the delivery of my responsibilities and objectives, I am accountable to the Board and my performance is reviewed regularly and formally by the chair on behalf of the Board.

During 2018/19, the organisation routinely reported on financial, operational, and strategic matters.

## 2. The purpose of the system of internal control

The system of internal control is based on a continuing programme designed to recognise, identify and prioritise the trusts risks against the achievement of aims and objectives.

The aim of the internal control system is to alleviate the likelihood of risks occurring and to manage them effectively and efficiently.

The system of internal control has been in place in Kent Community Health NHS Foundation Trust for the year end 31 March 2019 and up to the date of approval of the annual reports 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 the NHS code of governance.

The governance framework of Kent Community Health NHS Foundation Trust is overseen by the trust's 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, including risk management
- 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 was development

in engaging each member with We care reviews, to help understand patient journeys and pathways with 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. Risk management controls 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 2019. The strategy explicitly describes the trust's approach to managing and tolerating risks. The trust is continuing to implement and embed the principles contained within this document.

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 2018/19, there was a significant amount of work done to manage, rationalise and ensure consistency of the risks identified through the risk management process.

Key strategic risks are identified dynamically through the year by strategic assessment and the business planning process. At 31 March 2019, these were:

- implementing a clinical system including double running with the existing system and at the same time as the Kent care record is being implemented may negatively impact on production of timely information and service delivery
- changes in system architecture may provide uncertainty in the future delivery of integrated services
- inability to meet cost improvement plan targets, detailed in 2019/20 plans, as growing reliance on economy level transformation for savings.

Risk management is a core component of the job descriptions of senior managers within the trust. A range of risk management training is provided to staff and there are procedures in place, which describe roles and responsibilities for identification, management and control of risk, along with the risk management process of escalation and de-escalation to be followed. All relevant risk policies and procedures are available to staff via the intranet.

The trust learns from good practice through mechanisms, including clinical supervision and performance management, continuing professional development, clinical and process audit and application of evidence-based practice. At the heart of the trust's risk management strategy and policy is the desire to learn from events and situations to continuously improve quality of care.

Leadership and co-ordination of risk management activities is provided by the corporate services director and the Risk Management 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 management is incorporated in objective setting and appraisals.

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.

The trust operates a We care review programme, which encompasses NHS Improvement's well-led framework. The visits encourage shared learning, provide assurance and stimulate quality improvements. The visits focus on assessing our values in action, as well as assessing compliance with the Care Quality Commission fundamental standards – safe, effective, caring, responsive and well-led.

The programme involves all levels and disciplines of staff in the trust, with our governors, executive and non-executive directors, patient representatives and partners from external agencies, such as clinical commissioning groups and Kent County Council.

Those taking part in a visit receive guidance tools and training before a visit and are provided with a pre-

visit data pack summarising the data the trust holds about the team or service, which includes complaints, incidents, risks and patient feedback.

During the visit, participants talk to staff, visit clinical areas and attend home visits with clinicians, giving an understanding of the standard of care being provided, as well as the leadership, culture and performance of the service.

A collaboration meeting at the end enables all participants to share their observations and contribute to the visit report and agree ratings of assurance.

After each visit, the service is provided with feedback, a summary report and a certificate displaying its ratings. It is asked to produce an action plan for areas requiring improvement and a re-visit is planned, based on the rating.

Information from the We care reviews is used as a self-assessment by the trust, with trust-wide areas for improvement and themes arising from visits identified, shared and acted upon, where necessary.

Non-executive directors also routinely carry out deep dives into services to seek assurance that systems of performance and quality control are robust, working and reliable.

Non-executive directors provide independent assurance – they are not involved with direct delivery of care. This brings a fresh perspective and constructive challenge, as well as ensuring non-executive directors and the Board truly understand what is happening at the frontline.

# 5. 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.

# 6. The governance framework of the organisation

## 6.1 Council of Governors

The Council of Governors represents 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.

The full Council of Governors met quarterly and an annual members' meeting was held in September 2018, alongside the trust's annual general meeting.

## 6.2 Board

The Board has overall responsibility for the activity, integrity and strategy of the trust and is held accountable, through its chair, by our Council of Governors, which is made up of members of the public elected by you to represent your views.

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

The Board is also invited to leaders' conferences, where they meet leaders and discuss new service models, service improvements and innovations.

The role of the Board has the following key functions:

- Set strategic direction, define Trust objectives and agree trust operating plans.
- Monitor performance and ensure corrective action is taken, where required.
- Ensure financial stewardship.
- Ensure high standards of corporate and clinical governance.
- Appoint, appraise and remunerate directors.
- Ensure dialogue with external stakeholders.

The Board is made up of non-executive directors who use the skill and experience gained from the private, public and voluntary sectors to help run the trust, but who do not have day-to-day managerial responsibilities

and executive directors, who are paid employees, with clear areas of work responsibility within the trust.

## 6.3 Committees of the Board

The trust is supported by sub-committees. Membership includes non-executive directors, directors and senior managers. A formal update report for each sub-committee is reported to the Board, regularly outlining the activity against individual committees' terms of reference.

The sub-committees are:

### 6.3.1 Audit and Risk Committee

This committee provides assurance and holds 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 the consent of the chair.

The audit committee provides the board with assurance on key aspects including:

- effective systems of internal control and risk management
- effective internal audits and service reviews
- reviews the findings of external audits and other significant assurance functions
- reviews and reporting on the annual report and financial statements.

It is incumbent upon 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.

### 6.3.2 Charitable Funds Committee

The Charitable Funds 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 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

The Charitable Funds Committee oversees all aspects relating to charitable funds in KCHFT. The committee's main functions include:

- supporting and monitoring fundraising on behalf of the Trusts charities
- developing and approving charitable finds guidelines and polices
- consider and manage charitable funds, applications and investments.

### 6.3.3 Finance Business and Investment Committee

The Finance Business and Investment committee maintains robust financial management by monitoring financial performance and making recommendations to the Executive Team and the Board. Executive directors and senior service leads attend by invitation when the committee discusses issues relating to their area of responsibility. The Committee's main functions include:

- receiving and approving financial strategy and policy documents
- monitoring the financial management of income and expenditure
- approving and monitor the financial management of the balance
- approving and assessing the commercial management issues
- scrutinising current financial performance and future financial plans
- monitoring performance against cost improvement plans
- scrutinising development and implementation of service line reporting and service line management
- monitoring decisions to bid for business opportunities and approve those up to £15m contract turnover in line with Trust Strategy and reviewing and then referring and recommending larger and novel bids to the Board for approval;
- reviewing and approving capital investment decisions between £1million to £3million within capital budget and the overall capital programme development, refer with recommendation, larger cases to the Board

for approval

- reviewing and approve revenue business cases between £1million to £3million annual value and refer with recommendation, larger cases to the Board for approval
- approving treasury management policy and scrutinise implementation.

### 6.3.4 Quality Committee

The Quality Committee is an assurance committee of the Board.

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. The committee invites clinical representatives to attend to provide assurance on key governance and risk issues and quality improvement.

The Quality Committee provides leadership and assurance that clinical governance systems and processes are in place and effective in providing safe, high-quality care. The committee's main functions include:

- ensuring that 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
- reviewing compliance with regulatory standards and statutory requirements, for example those of the Duty of Candour, the CQC, NHS Resolution and the NHS Performance Framework
- overseeing We care visits associated action plans and risks
- reviewing quality risks, which have been assigned to the Quality Committee and provide assurance that key controls and action plans are adequate to address gaps in controls
- 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 from ward to Board
- overseeing the ratification of clinical policies and any other formal clinical document where mandatory compliance is required.

The trust's approach to quality is informed by listening to patient experience and understanding safety alongside delivering and maintaining services.

This approach has been formally identified through the trust's values and strategic objectives with executive leadership and board ownership.

### 6.3.5 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 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 reflect this position.

### 6.3.6 Strategic Workforce Committee

This committee provides the Board with assurance regarding strategic workforce issues. Its purpose is also to keep abreast of the strategic context in which the trust is operating in, the consequences and implications on the workforce.

The strategic workforce committee provides advice and assurance to the Board on all matters relating to workforce planning, strategy and pay and rewards. It is also responsible for organisation development, including health and wellbeing and equality and diversity.

The committee's main functions include:

- oversee development and implementation of

the trust's people strategy, ensuring the trust has robust plans 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, so the trust has sufficient staff, with the necessary skills and competencies to meet the needs of patients and service 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 action
- 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 and deputy director of workforce are also members.

## 6.4 Management Committee

The membership of the Management Committee is made up of the executive directors and the assistant directors reporting directly to the executive directors. It is chaired by the chief executive.

The Management Committee supports the Board, chief executive and executive to ensure Kent Community Health NHS Foundation Trust operates efficiently and effectively in development of strategy and in the execution and implementation of strategy into operational reality.

It contributes to the development of the trust's strategy. It is a key component of the communication network for information. It peer reviews quality, operating and financial performance, and strategic, corporate and operational risk. It also discusses, agrees and quality assures plans for the delivery of strategy before, during and after implementation.

The committee is responsible for the effective implementation of strategy and for the operational performance of the trust with regard to performance, quality, financial and contractual.

# 7. 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 deductions from salary, employer's contributions and payments into the scheme are in accordance with the scheme's rules, and that member pension scheme records are accurately updated, in accordance with the timescales in the regulations.

# 8. Sustainability

The foundation trust has carried out risk assessments and carbon reduction delivery plans are in place in accordance with emergency preparedness and civil contingency requirements, as based on UKCIP 2009 weather projects, to ensure this organisation's obligations under the Climate Change Act and the adaptation reporting requirements are complied with.

# 9. Workforce

The trust ensures short, medium and long-term

workforce strategies and staffing systems are in place, which assures the Board staffing processes are safe, sustainable and effective.

Assurance is provided through the trust's Strategic Workforce Committee, people strategy, related KPIs and action plans. Workforce risks are also managed throughout the trust committee structures. Staff receive annual appraisals to support in development and managing managing the trust's values and objectives.

## 10. 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. 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. This committee 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 Audit has resulted in an opinion of reasonable assurance that the Board Assurance Framework is effective.

Clinical risk and patient safety are overseen by the Quality Committee, the director of nursing and quality, the medical director and the operational director. The Board receives monthly quality reports encompassing the quality and patient safety aspects for the trust.

The Quality Committee focused on assurance that the trust is embedding lessons learned from incidents. It 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, 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 Audit and Risk Committee received regular reports from the local counter fraud specialist, 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. The committee focused some attention on the relationship between claims and the associated costs, and incidents reported.

Control measures are in place to ensure all the organisation's obligations under equality, diversity and human rights legislation are complied with. These include policies, the committee structure and Board assessment of compliance with, and progress against, equality and diversity best practice.

The trust has published an up-to-date register of interests for decision-making staff in the past 12 months.

## 11. Information governance (IG)

The trust takes all information governance incidents very seriously, and regardless of severity, they are

analysed and, where appropriate, categorised as a serious incident requiring further investigation. From 1 April 2018 to 31 March 2019, there weren't any serious incidents reported to the Information Commissioner's Office.

## 12. 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 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 monthly 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, overview and scrutiny committees, Healthwatch, and other stakeholders for comments.

Policies and protocols are updated when new guidance, such as NICE is issued; audits and incidents will confirm when a review is warranted, for example following a serious incident.

A monthly review of all quality related information, including waiting list data and soft intelligence is carried out by the Executive Team. Queries are followed up by the Nursing and Quality Team, which conducts quality reviews – We care reviews – proactively and reactively.

## 13. 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 within the NHS foundation trust who have responsibility for the 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, the Audit and Risk Committee and Quality Committee and a plan to address weaknesses and ensure continuous improvement of the system is in place.

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.

From 2018/19, one limited assurance report was received. This was in relation to locally held personnel files. An action plan is in place to address this and the implementation plan is overseen by the Strategic Workforce Committee.

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 the risks to the organisation 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 Committees' 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 the achievement of organisational objectives;
- the Board's receipt of 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 the 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's essential standards.

In 2018/19, no significant issues were identified.

## 14. Conclusion

My review confirms that Kent Community Health NHS Foundation Trust has a sound system of internal control. The Head of Internal Audit has assessed Kent Community Health NHS Foundation Trust of having Reasonable Assurance overall. This supports the achievement of its goals, vision, values, policies, aims and objectives.

Signed.....

**Paul Bentley, Chief Executive Officer**

Date: .....

23 May 2019

# 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 five 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 two, three, four, where it has been found to be in breach of its licence.

## Segmentation

The latest segmentation information available as at 31 March 2019 places KCHFT in segment two.

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.

Given that finance and use of resources is only one of the five themes feeding into the Single Oversight Framework, the segmentation of the trust disclosed above might not be the same as the overall finance score presented below.

The results for KCHFT for 2018/19 and 2017/18 in relation to the finance and use of resources metrics are:

| | | | 2018/19 scores | | | | 2017/18 scores | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| Financial criteria | Weight % | Metric | Q4 | Q3 | Q2 | Q1 | Q4 | Q3 | Q2 | Q1 |
| Financial sustainability | 0.2 | Capital service capacity | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 |
| | 0.2 | Liquidity (days) | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 |
| Financial efficiency | 0.2 | I&E margin | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 |
| Financial controls | 0.2 | Distance from financial plan | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 |
| | 0.2 | Agency spend | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 |
| | | **Overall scoring** | **1** | **1** | **1** | **1** | **1** | **1** | **1** | **1** |

Signed .....

**Paul Bentley, Chief Executive Officer**

Date: 23 May 2019

# 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 NHS Foundation Trust (the 'Trust') for the year ended 31 March 2019 which comprise the Statement of Comprehensive Income, the Statement of Financial Position, the Statement of Changes in Equity, the Statement of Cash Flows and notes to the financial statements, including a summary of significant accounting policies. The financial reporting framework that has been applied in their preparation is applicable law and International Financial Reporting Standards (IFRSs) as adopted by the European Union, and as interpreted and adapted by the Accounts Directions issued under the National Service Act 2006, the NHS foundation trust annual reporting manual 2018/19 and the Department of Health and Social Care group accounting manual 2018/19.

In our opinion the financial statements:

- give a true and fair view of the financial position of the Trust as at 31 March 2019 and of its expenditure and income for the year then ended;
- have been properly prepared in accordance with International Financial Reporting Standards (IFRSs) as adopted by the European Union, as interpreted and adapted by the Department of Health and Social Care group accounting manual 2018-19; 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.

### 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

### Financial statements audit

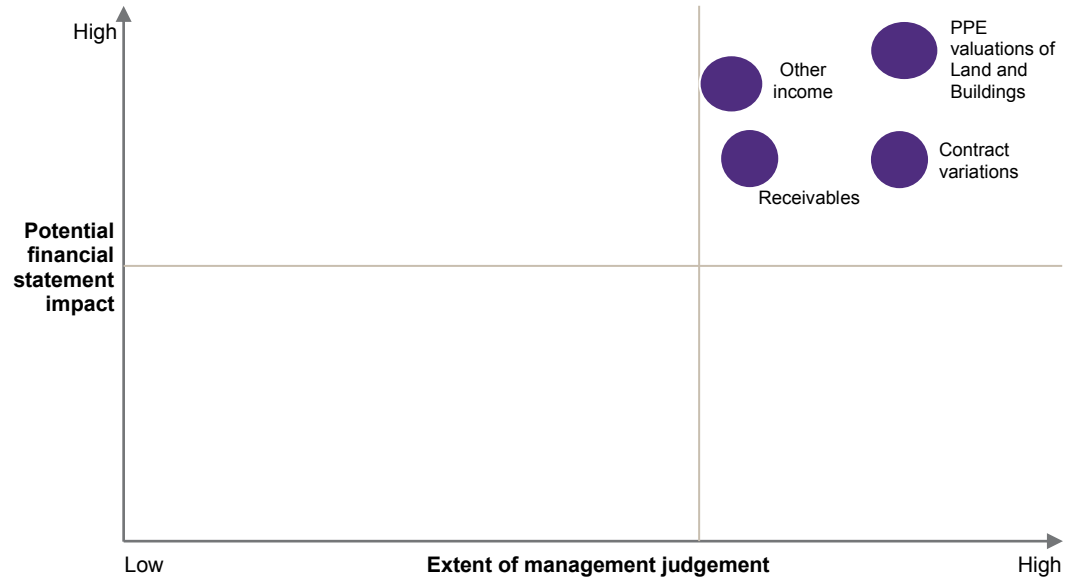
- Overall materiality: £4,295,940 which represents 2% of the Trust's gross operating costs (consisting of operating expenses and finance expenses);
- Key audit matters were identified as:
  - Valuation of land and buildings,
  - Occurrence and accuracy of non-block contract patient care income and other operating income and existence of associated receivable balances.
- We have exposed to testing the Trust's material income and expenditure streams and assets and liabilities covering 99% of the Trust's income, 100% of the Trust's expenditure, 94% of the Trust's assets and 93% of the Trust's liabilities.

### Conclusion on the Trust's arrangements for securing economy, efficiency and effectiveness in its use of resources

- We identified no significant risks in respect of the Trust's arrangements for securing economy, efficiency and effectiveness in its use of resources (see Report on other legal and regulatory requirements section).

## Key audit matters

The graph below depicts the audit risks identified and their relative significance based on the extent of the financial statement impact and the extent of management judgement.




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 – Valuation of land and buildings**<br>The Trust revalues its land and buildings on a five yearly cycle to ensure that the carrying value is not materially different from the current value at the financial statements date. This valuation represents a significant estimate by management in the financial statements.<br>Management have engaged the services of a valuer to estimate the current value as at 31 March 2019.<br>The valuation of land and buildings is a key accounting estimate which is sensitive to changes in assumptions and market conditions.<br>We therefore identified valuation of land and buildings, particularly revaluations and impairments, as a significant risk, which was one of the most significant assessed risks of material misstatement. | Our audit work included, but was not restricted to:<br>• Evaluating management's processes and assumptions for the calculation of the estimate, the instructions issued to valuation experts and the scope of their work;<br>• Evaluating the competence, capabilities and objectivity of the valuation expert;<br>• Discussions with the valuer about the basis on which the valuations were carried out and challenge of the key assumptions;<br>• Challenging the information used by the valuer to assess completeness and consistency with our understanding;<br>• Testing revaluations made during the year to ensure they were recorded accurately in the Trust's asset register;<br>• Evaluating the assumptions made by management for those assets not revalued during the year and how management has satisfied themselves that carrying value is not materially different to current value in existing use.<br>The Trust's accounting policy on valuation of property, plant and equipment is shown in note 1.7 to the financial statements and related disclosures are included in note 15.1.<br>**Key observations**<br>We obtained sufficient, appropriate audit evidence to conclude that:<br>• The basis of the valuation was appropriate, and the assumptions and processes used by management in determining the estimate were reasonable; and<br>• The valuation of land and buildings disclosed in the financial statements is reasonable. |
| **Risk 2 – Occurrence and accuracy of non-block contract patient care income and other operating income and existence of associated receivable balances**<br>The Trust's significant income streams are operating income from patient care activities and other operating income.<br>The Trust recognises income from patient care activities during the year based on the completion of these activities. This includes the block contract, which is agreed in advance at a fixed price, and non-block contract income.<br>Patient care activities provided that are additional to those incorporated in the block contracts with NHS commissioners, are subject to verification and agreement of the completed activity by commissioners. As such, there is a risk that income is recognised in the financial statements for these additional services that is not subsequently agreed to by the commissioners.<br>Due to the nature of block contracts and education and training income we have not identified a significant risk of material misstatement in relation to block contracts and education and training income.<br>We therefore identified occurrence and accuracy of all income and other operating income and existence of associated receivable balances as a significant risk, | Our audit work included, but was not restricted to:<br>• Evaluating the Trust's accounting policies for recognition of income for appropriateness and compliance with the Department of Health and Social Care (DHSC) group accounting manual 2018-19;<br>• Obtaining an understanding of the Trust's system for accounting for income and evaluating the design of the associated controls;<br>In respect of patient care income:<br>• obtaining an exception report from the DHSC that details differences in reported income and expenditure and receivables and payables between NHS bodies, agreeing the figures in the exception report to the Trust's financial records; and obtaining supporting information for all differences over £300,000, to corroborate the amount recorded in the financial statements by the Trust;<br>• Agreeing, on a sample basis, amounts for under and over-performance of contracted patient care activities with the main NHS Commissioners to invoices or alternative evidence;<br>• Agreeing, on a sample basis, non-contract receivables at year end to invoices and subsequent cash receipts or, for cases in our |

| Key Audit Matter | How the matter was addressed in the audit |
|---|---|
| which was one of the most significant assessed risks of material misstatement. | sample where cash was yet to be receipted, to alternative evidence.<br><br>In respect of other operating revenue:<br><br>• agreeing, on a sample basis, income and year end receivables from other operating revenue to invoices and cash payment or other supporting evidence;<br>• for the Provider Sustainability Funding, agreeing income recognised in Q1 – Q3 to NHS Improvement notifications;<br>• for Quarter 4, agreeing to supporting evidence that confirms the Trust met NHS Improvement requirements for recognising Q4 income.<br><br>The Trust's accounting policy on income recognition is shown in note 1.4 to the financial statements and related disclosures are included in notes 3 and 4.<br><br>**Key observations**<br><br>We obtained sufficient, appropriate audit evidence to conclude that the income recognised in the Trust's financial statements had occurred and was therefore correct to be recognised by the Trust and the amounts recognised were accurate. In addition, we obtained sufficient, appropriate audit evidence to conclude that the associated receivables balances within the financial statements existed and where therefore due to be received by the Trust. |

## Our application of materiality

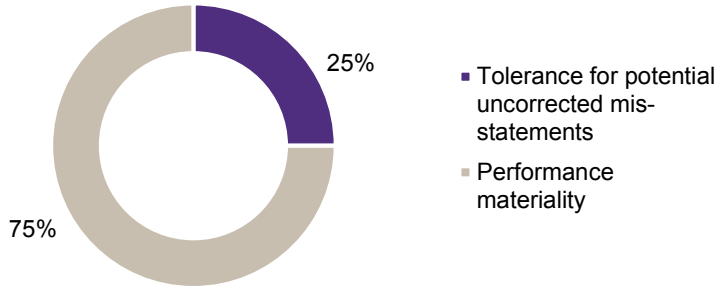
We define materiality as the magnitude of misstatement in the financial statements that makes it probable that the economic decisions of a reasonably knowledgeable person would be changed or influenced. We use materiality in determining the nature, timing and extent of our audit work and in evaluating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

Materiality was determined as follows:

| Materiality Measure | Trust |
|---|---|
| Financial statements as a whole | £4,295,940 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 the Trust has expended its revenue and other funding.<br><br>Materiality for the current year is at the same percentage level of gross operating costs as we determined for the year ended 31 March 2018 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 |
| Communication of misstatements to the Audit and Risk Committee | £214,797 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.

**Overall materiality – Trust**




## An overview of the scope of our audit

Our audit approach was based on a thorough understanding of the Trust's business, was risk based and included an evaluation of the Trust's internal controls environment including relevant IT systems and controls over key financial systems.

The scope of our audit included:

- obtaining supporting evidence, on a sample basis, for all of the Trust's material income streams covering 99% of the Trust's revenues;
- obtaining supporting evidence, on a sample basis, for 100% of the Trust's operating costs;
- obtaining supporting evidence, on a sample basis, for property plant and equipment and the Trust's other material assets and liabilities.
- There were no changes in the scope of the current year audit from the scope of the prior year

## Other information

The Accounting Officer is responsible for the other information. The other information comprises the information included in the Annual Report[1], other than the financial statements and our auditor's report thereon. Our opinion on the financial statements does not cover the other information and, except to the extent otherwise explicitly stated in our report, we do not express any form of assurance conclusion thereon.

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

We have nothing to report in this regard.

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 in accordance with provision C.1.1 of the NHS Foundation Trust Code of Governance 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 2018/19 or is misleading or inconsistent with the information of which we are aware from our audit. We are not required to consider whether the Annual Governance Statement addresses all risks and controls or that risks are satisfactorily addressed by internal controls.

We have nothing to report in this regard.

**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 2018/19 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 issue a report 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 refer a matter to the regulator under Schedule 10 (6) of the National Health Service Act 2006 because we have reason to believe that the Trust, or a director or officer of the Trust, is about to make, or has made, a decision which involves or would involve the incurring of expenditure that was unlawful, or is about to take, or has begun to take a course of action which, if followed to its conclusion, would be unlawful and likely to cause a loss or deficiency.

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 the Chief Executive's responsibilities as the accounting officer, 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 2018/19, 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 Accounting Officer has been informed by the relevant national body of the intention to dissolve the Trust without the transfer of the Trust's services to another public sector entity.

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

### Auditor's responsibilities for the audit of the financial statements

Our objectives are to obtain reasonable assurance about whether the financial statements as a whole are free from material misstatement, whether due to fraud or error, and to issue an auditor's report that includes our opinion. Reasonable assurance is a high level of assurance but is not a guarantee that an audit conducted in accordance with ISAs (UK) will always detect a material misstatement when it exists.

Misstatements can arise from fraud or error and are considered material if, individually or in the aggregate, they could reasonably be expected to influence the economic decisions of users taken on the basis of these financial statements.

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

## 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 2019. We have determined that there are no significant risks in the context of our conclusion on the adequacy of the Trust's arrangements for securing economy, efficiency and effectiveness in its use of resources.

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 2006 to 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 2019, 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.

### Use of our report

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.

***Sarah L Ironmonger***

**Sarah Ironmonger, Key Audit Partner**
for and on behalf of Grant Thornton UK LLP, Local Auditor

**110 Bishopsgate**

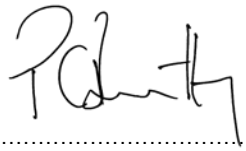
24 May 2019


# Annual accounts

# Foreword to the accounts

## Kent Community Health NHS Foundation Trust

These accounts, for the year ended 31 March 2019, 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 23 May 2019

**Name** Paul Bentley
**Job title** Chief Executive Officer

# Statement of comprehensive income for the year ended 31 March 2019

| | Note | 2018/19 £000 | 2017/18 £000 |
|---|---|---|---|
| Operating income from patient care activities | 3 | 209,770 | 212,768 |
| Other operating income | 4 | 13,483 | 8,663 |
| Operating expenses | 6, 8 | (214,514) | (214,797) |
| **Operating surplus/(deficit) from continuing operations** | | **8,739** | **6,634** |
| Finance income | 11 | 200 | 63 |
| Finance expenses | 12 | (1) | - |
| PDC dividends payable | | (34) | (116) |
| **Net finance costs** | | **165** | **(53)** |
| Other gains / (losses) | 13 | (2) | (65) |
| **Surplus / (deficit) for the year from continuing operations** | | **8,902** | **6,516** |
| Surplus / (deficit) on discontinued operations and the gain / (loss) on disposal of discontinued operations | | - | - |
| **Surplus / (deficit) for the year** | | **8,902** | **6,516** |
| **Other comprehensive income** | | | |
| **Will not be reclassified to income and expenditure:** | | | |
| Impairments | 7 | - | (151) |
| Revaluations | 16 | - | 79 |
| **Total comprehensive income / (expense) for the period** | | **8,902** | **6,444** |

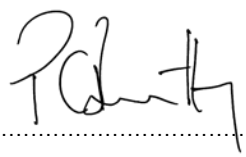
The notes on pages 90 to 123 form part of this account

# Statement of financial position as at 31 March 2019

| | Note | 31 March 2019 £000 | 31 March 2018 £000 |
|---|---|---|---|
| **Non-current assets** | | | |
| Intangible assets | 14 | 548 | 483 |
| Property, plant and equipment | 15 | 15,252 | 14,933 |
| Receivables | 20 | 330 | 77 |
| **Total non-current assets** | | **16,130** | **15,493** |
| **Current assets** | | | |
| Inventories | 19 | - | - |
| Receivables | 20 | 25,835 | 19,753 |
| Cash and cash equivalents | 21 | 27,377 | 27,633 |
| **Total current assets** | | **53,212** | **47,386** |
| **Current liabilities** | | | |
| Trade and other payables | 22 | (23,267) | (26,096) |
| Provisions | 26 | (1,053) | (1,460) |
| Other liabilities | 23 | (1,553) | (1,760) |
| **Total current liabilities** | | **(25,873)** | **(29,316)** |
| **Total assets less current liabilities** | | **43,469** | **33,563** |
| **Non-current liabilities** | | | |
| Provisions | 26 | (728) | - |
| **Total non-current liabilities** | | **(728)** | **-** |
| **Total assets employed** | | **42,741** | **33,563** |
| | | | |
| **Financed by** | | | |
| Public dividend capital | | 2,889 | 2,613 |
| Revaluation reserve | | 694 | 694 |
| Income and expenditure reserve | | 39,158 | 30,256 |
| **Total taxpayers' equity** | | **42,741** | **33,563** |

The notes on pages 90 to 123 form part of these accounts.

The financial statements on pages 85 to 89 were approved by the Board on 23 May 2019 and signed on its behalf by:

Signed  Date 23 May 2019

**Name** Paul Bentley
**Job title** Chief Executive Officer

# Statement of changes in equity for the year ended 31 March 2019

| | Public dividend capital | Revaluation reserve | Income and expenditure reserve | Total |
|---|---|---|---|---|
| | £000 | £000 | £000 | £000 |
| **Taxpayers' equity at 1 April 2018 - brought forward** | **2,613** | **694** | **30,256** | **33,563** |
| Surplus/(deficit) for the year | - | - | 8,902 | 8,902 |
| Public dividend capital received | 276 | - | - | 276 |
| **Taxpayers' equity at 31 March 2019** | **2,889** | **694** | **39,158** | **42,741** |

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

| | Public dividend capital | Revaluation reserve | Income and expenditure reserve | Total |
|---|---|---|---|---|
| | £000 | £000 | £000 | £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** |

# 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 (DHSC). 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. The trust received additional PDC of £276k during 2018/19 following successful application to the DHSC for centrally-allocated capital funding programmes (wifi and pharmacy infrastructure).

## 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 2019

| | Note | 2018/19 £000 | 2017/18 £000 |
|---|---|---|---|
| **Cash flows from operating activities** | | | |
| Operating surplus / (deficit) | | 8,739 | 6,634 |
| **Non-cash income and expense:** | | | |
| Depreciation and amortisation | 6 | 3,263 | 5,020 |
| Net impairments | 7 | - | 22 |
| (Increase) / decrease in receivables and other assets | | (6,267) | (1,375) |
| Increase / (decrease) in payables and other liabilties | | (2,131) | 3,901 |
| Increase / (decrease) in provisions | | 321 | (2,124) |
| **Net cash generated from / (used in) operating activities** | | **3,925** | **12,078** |
| **Cash flows from investing activities** | | | |
| Interest received | | 198 | 53 |
| Purchase of intangible assets | | (211) | (480) |
| Purchase of property, plant, equipment and investment property | | (4,346) | (3,108) |
| Sales of property, plant, equipment and investment property | | 3 | 71 |
| **Net cash generated from / (used in) investing activities** | | **(4,356)** | **(3,464)** |
| **Cash flows from financing activities** | | | |
| Public dividend capital received | | 276 | - |
| Other interest | | (1) | - |
| PDC dividend (paid) / refunded | | (100) | (148) |
| **Net cash generated from / (used in) financing activities** | | **175** | **(148)** |
| **Increase / (decrease) in cash and cash equivalents** | | **(256)** | **8,466** |
| **Cash and cash equivalents at 1 April - brought forward** | | **27,633** | **19,167** |
| **Cash and cash equivalents at 31 March** | 21 | **27,377** | **27,633** |

The notes on pages 90 to 123 form part of this account

# 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 that the financial statements of the trust shall meet the accounting requirements of the Department of Health and Social Care Group Accounting Manual (GAM), which shall be agreed with HM Treasury. Consequently, the following financial statements have been prepared in accordance with the GAM 2018/19 issued by the Department of Health and Social Care. The accounting policies contained in the GAM follow international financial reporting standards to the extent that they are meaningful and appropriate to the NHS, as determined by HM Treasury, which is advised by the Financial Reporting Advisory Board. Where the GAM permits, a choice of accounting policy, the accounting policy that is judged to be most appropriate to the particular circumstances of the trust for the purpose of giving a true and fair view has been selected. The particular policies adopted are described below. These have been applied consistently in dealing with items considered material in relation to the accounts.

### 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 that are considered to be relevant. Actual results may differ from those estimates and the estimates and underlying assumptions are continually reviewed. Revisions to accounting estimates are recognised in the period in which the estimate is revised if the revision affects only that period or in the period of the revision and future periods if the revision affects both current and future periods.

The following are the bases for the estimations that management have 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 26.1 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 1.4.1 Revenue from contracts with customers

Where income is derived from contracts with customers, it is accounted for under IFRS 15. The GAM expands the definition of a contract to include legislation and regulations which enables an entity to receive cash or another financial asset that is not classified as a tax by the Office of National Statistics (ONS). As directed by the GAM, the transition to IFRS 15 in 2018/19 has been completed in accordance with paragraph C3 (b) of the Standard: applying the Standard retrospectively but recognising the cumulative effects at the date of initial application (1 April 2018).

In the adoption of IFRS 15, a number of practical expedients offered in the Standard have been employed. These are as follows:

- As per paragraph 121 of the standard, the trust will not disclose information regarding performance obligations part of a contract that has an original expected duration of one year or less;
- The trust is to similarly not disclose information where revenue is recognised in line with the practical expedient offered in paragraph B16 of the standard where the right to consideration corresponds directly with the value of the performance completed to date;
- The GAM has mandated the exercise of the practical expedient offered in C7(a) of the standard that requires the trust to reflect the aggregate effect of all contracts modified before the date of initial application.

The trust has carried out a comprehensive review of its revenue streams applying the IFRS 15 five step model framework in determining the effect of implementation of IFRS 15. This review confirmed that the implementation of IFRS 15 on 1 April 2018 resulted in no net impact on opening reserves. In turn, the implementation of IFRS 15 has had no impact on operating income recognised by the trust during 2018/19 compared to that amount that would have been recognised under IAS 18.

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

Satisfaction of performance obligations will result in immediate payment (in cases of verbal or implied contracts) or creation of a contract receivable with payment from the customer expected in line with the credit terms outlined in the relevant written contract.

### Revenue from NHS contracts

The main source of income for the trust is contracts with commissioners for health care services. A performance obligation relating to delivery of a spell of health care is generally satisfied over time as healthcare is received and consumed simultaneously by the customer as the trust performs it. The customer in such a contract is the commissioner, but the customer benefits as services are provided to their patient. Even where a contract could be broken down into separate performance obligations, healthcare generally aligns with paragraph 22(b) of the Standard entailing a delivery of a series of goods or services that are substantially the same and have a similar pattern of transfer. At the year end, the trust accrues income relating to activity delivered in that year.

If in the event a contract or invoice is challenged, revenue is recognised to the extent that collection of the consideration is probable.

The trust receives income from commissioners under Commissioning for Quality and Innovation (CQUIN) schemes. The CQUIN payments are not considered distinct performance obligations in their own right; instead they form part of the transaction price for performance obligations under the contract.


Kent Community Health NHS Foundation Trust
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## Note 1.4.2 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 2018/19.

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 1.4.3 Other income

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.

## 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 2019, but to be paid in April 2019.

### Pension costs

#### NHS pension scheme

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 scheme is accounted for as though it is a defined contribution scheme.

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 measured reliably
- the item has cost of at least £5,000, or
- collectively, a number of items have a cost of at least £5,000 and individually have cost of more than £250, where the assets are functionally interdependent, had broadly simultaneous purchase dates, are anticipated to have similar disposal dates and are under single managerial control
- 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, for example, plant and equipment, then 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.
- Specialised assets are held at current value in existing use which is interpreted as the present value of the asset's remaining service potential, which is assumed to be at least equal to the cost of replacing that service potential.
- 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 of property, plant and equipment are performed with sufficient regularity to ensure that carrying values are not materially different from those

that would be determined at the end of the reporting period. Current values in existing use are determined as follows:

- Land and non-specialised buildings - market value for existing use (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.

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

## 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 De-recognition

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

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

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

## Note 1.7.4

### Useful lives of property, plant and equipment

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

| | Min life Years | Max life Years |
|---|---|---|
| Buildings, excluding dwellings* | 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, eg an operating system, is capitalised as part of the relevant item of property, plant and equipment. Software, which is not integral to the operation of hardware, for example 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.

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

### Amortisation

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

## Note 1.8.3 Useful economic life of intangible assets

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

| | Min life Years | Max life Years |
|---|---|---|
| Software licences | 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 assets and financial liabilities

## Note 1.11.1 Recognition

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

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

## Note 1.11.2 Classification and measurement

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

The trust's financial assets and financial liabilities are classified as subsequently measured at amortised cost.

### Financial assets and financial liabilities at amortised cost

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

The trust's financial assets consist of cash and cash equivalents; and contract and other receivables. The trust has not issued any loans and does not currently hold any financial assets with different characteristics to their host contract i.e. derivatives.

The trust's financial liabilities consist of trade and other payables. The trust does not have any loans, financial guarantee liabilities or other financial liabilities.

### Impairment of financial assets

For financial assets measured at amortised cost for example contract and other receivables, the trust recognises an allowance for expected credit losses.

The trust adopts the simplified approach to impairment for contract and other receivables, measuring expected losses as at an amount equal to lifetime expected losses.

The expected credit loss for contract and other receivables is determined by separately categorising contract and other receivables into specific classes of debt for example by type of debt and common credit characteristics. This classification exercise is completed on review of historical credit loss experience for each type of debt and modified to reflect current and forecast economic conditions. In devising such a provision matrix and in line with the GAM, the trust has excluded the recognition of expected credit losses in relation to other DHSC bodies as it is deemed that the DHSC will provide a guarantee of last resort against the debts of DHSC bodies.

Expected losses are charged to operating expenditure within the statement of comprehensive income and reduce the net carrying value of the financial asset in the statement of financial position.

## Note 1.11.3 Derecognition

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

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

## Note 1.12 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 currently 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 26.2 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.

Contingent liabilities are not recognised, but are disclosed in note 27, unless the probability of a transfer of economic benefits is remote.

Contingent liabilities are defined as:

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

for which it is not probable that a transfer of economic benefits will arise or for which the amount of the obligation cannot be measured with sufficient reliability.

## Note 1.15 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 thus 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 2018/19.

## 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 2018/19:

- 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 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 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:

| | 2018/19 £000s | % of total revenue |
|---|---|---|
| Clinical commissioning groups | 129,304 | 57.92% |
| Local authorities | 44,681 | 20.01% |
| NHS England | 28,196 | 12.63% |

| | 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% |

## Note 3 Operating income from patient care activities

All income from patient care activities relates to contract income recognised in line with accounting policy 1.4.1

### Note 3.1 Income from patient care activities (by nature)

| | 2018/19 £000 | 2017/18 £000 |
|---|---|---|
| **Community services** | | |
| Community services income from CCGs and NHS England | 150,813 | 153,492 |
| Income from other sources (eg local authorities) | 56,056 | 59,200 |
| **All services** | | |
| Private patient income | 34 | 76 |
| Agenda for Change pay award central funding | 2,867 | - |
| **Total income from activities** | **209,770** | **212,768** |

## Note 3.2 Income from patient care activities (by source)

### Income from patient care activities received from:

| | 2018/19 £000 | 2017/18 £000 |
|---|---|---|
| NHS England | 21,816 | 22,298 |
| Clinical commissioning groups | 128,997 | 131,194 |
| Department of Health and Social Care | 2,867 | - |
| Other NHS providers | 8,340 | 9,086 |
| Local authorities | 44,681 | 46,567 |
| Non-NHS: Private patients | 34 | 76 |
| Injury cost recovery scheme | 344 | 405 |
| Non NHS: Other | 2,691 | 3,142 |
| **Total income from activities** | **209,770** | **212,768** |
| **Of which:** | | |
| Related to continuing operations | 209,770 | 212,768 |
| Related to discontinued operations | - | - |

## Note 4 Other operating income

| | 2018/19 £000 | 2017/18 £000 |
|---|---|---|
| **Other operating income from contracts with customers:** | | |
| Education and training (excluding notional apprenticeship levy income) | 1,689 | 1,742 |
| Non-patient care services to other bodies | 2,854 | 516 |
| Provider sustainability / sustainability and transformation fund income (PSF / STF) | 6,350 | 4,329 |
| Other contract income | 2,544 | 1,976 |
| **Other non-contract operating income** | | |
| Charitable and other contributions to expenditure | 46 | 100 |
| **Total other operating income** | **13,483** | **8,663** |
| **Of which:** | | |
| Related to continuing operations | 13,483 | 8,663 |
| Related to discontinued operations | - | - |

## Note 5.1 Additional information on revenue from contracts with customers recognised in the period

| | 2018/19 £000 |
|---|---|
| Revenue recognised in the reporting period that was included in within contract liabilities at the previous period end | 1,756 |

## Note 5.2 Transaction price allocated to remaining performance obligations

The trust has exercised the practical expedients permitted by IFRS 15 paragraph 121 in preparing this disclosure. Revenue from (i) contracts with an expected duration of one year or less and (ii) contracts where the trust recognises revenue directly corresponding to work done to date is not disclosed.

## Note 5.3 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 license 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:

| | 2018/19<br>£000 | 2017/18<br>£000 |
|---|---|---|
| Income from services designated as commissioner requested services | - | - |
| Income from services not designated as commissioner-requested services | 223,253 | 221,431 |
| **Total** | **223,253** | **221,431** |

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 6 Operating expenses

| | 2018/19 £000 | 2017/18 £000 |
|---|---|---|
| Staff and executive directors costs | 155,856 | 151,525 |
| Remuneration of non-executive directors | 158 | 150 |
| Supplies and services - clinical (excluding drugs costs) | 17,599 | 20,778 |
| Supplies and services - general | 1,060 | 1,103 |
| Drug costs (drugs inventory consumed and purchase of non-inventory drugs) | 5,623 | 5,395 |
| Consultancy costs | 649 | 429 |
| Establishment | 7,689 | 6,823 |
| Premises | 7,349 | 9,349 |
| Transport (including patient travel) | 5,048 | 5,012 |
| Depreciation on property, plant and equipment | 3,117 | 4,915 |
| Amortisation on intangible assets | 146 | 105 |
| Net impairments | - | 22 |
| Movement in credit loss allowance: contract receivables / contract assets | 47 | |
| Movement in credit loss allowance: all other receivables and investments | 7 | (63) |
| Audit fees payable to the external auditor | | |
| audit services- statutory audit | 62 | 58 |
| Internal audit costs | 114 | 111 |
| Clinical negligence | 453 | 348 |
| Legal fees | 628 | 366 |
| Insurance | 165 | 177 |
| Education and training | 1,114 | 924 |
| Rentals under operating leases | 7,183 | 7,546 |
| Redundancy | (148) | (1,132) |
| Hospitality | 38 | 29 |
| Losses, ex gratia and special payments | 6 | - |
| Other services, eg external payroll | 320 | 345 |
| Other | 231 | 482 |
| **Total** | **214,514** | **214,797** |
| **Of which:** | | |
| Related to continuing operations | 214,514 | 214,797 |
| Related to discontinued operations | - | - |

## Note 6.1 Limitation on auditor's liability

The auditor's liability for external audit work carried out for the financial year 2018/19 is limited to £2,000,000.

## Note 7 Impairment of assets

| | 2018/19 £000 | 2017/18 £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 8 Employee benefits

| | 2018/19 Total £000 | 2017/18 Total £000 |
|---|---|---|
| Salaries and wages | 123,616 | 121,016 |
| Social security costs | 10,555 | 10,193 |
| Apprenticeship levy | 595 | 582 |
| Employer's contributions to NHS pensions | 15,801 | 15,576 |
| Pension cost - other | 26 | 13 |
| Termination benefits | 309 | 1,319 |
| Temporary staff (including agency) | 5,361 | 4,246 |
| **Total gross staff costs** | **156,263** | **152,945** |
| Recoveries in respect of seconded staff | (20) | (13) |
| **Total staff costs** | **156,243** | **152,932** |
| **Of which** | | |
| Costs capitalised as part of assets | 78 | 88 |

## Note 8.1 Retirements due to ill-health

During 2018/19 there were four early retirements from the trust agreed on the grounds of ill-health (eight in the year ended 31 March 2018). The estimated additional pension liabilities of these ill-health retirements is £302k (£493k in 2017/18).

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

## Note 8.2 Directors' remuneration

**The aggregate amounts payable to directors were:**

| | 2018/19 £000 | 2017/18 £000 |
|---|---|---|
| Salary | 1,091 | 938 |
| Taxable benefits | 9 | 11 |
| Performance related bonuses | 16 | 24 |
| Employer's pension contributions | 84 | 93 |
| **Total** | **1,200** | **1,066** |

## Note 9 pension costs

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

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

### a) Accounting valuation

A valuation of scheme liability is carried out annually by the scheme actuary (currently the Government Actuary's Department) as at the end of the reporting period. This uses an actuarial assessment for the previous accounting period in conjunction with updated membership and financial data for the current reporting period, and is accepted as providing suitably robust figures for financial reporting purposes. The valuation of the scheme liability as at 31 March 2019, is based on valuation data as 31 March 2018, updated to 31 March 2019 with summary global member and accounting data. In undertaking this actuarial assessment, the methodology prescribed in IAS 19, relevant FReM interpretations, and the discount rate prescribed by HM Treasury have also been used.

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

## b) Full actuarial (funding) valuation

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

The latest actuarial valuation carried out for the NHS pension scheme was completed as at 31 March 2016. The results of this valuation set the employer contribution rate payable from April 2019. The Department of Health and Social Care have recently laid Scheme Regulations confirming that the employer contribution rate will increase to 20.6 per cent of pensionable pay from this date.

The 2016 funding valuation was also expected to test the cost of the scheme relative to the employer cost cap set following the 2012 valuation. Following a judgment from the Court of Appeal in December 2018, the Government announced a pause to that part of the valuation process pending conclusion of the continuing legal process.

## Other schemes

The trust participates in the national employees savings trust (NEST) scheme as an alternative for those employees who are not eligible to join the NHS pension scheme. NEST is a defined contribution scheme with a phased employer contribution rate, currently two per cent. The employer contribution will increase to three per cent from 6 April 2019.

# Note 10 Operating leases

## Note 10.1 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.

| | 2018/19 £000 | 2017/18 £000 |
|---|---|---|
| Operating lease expense | | |
| Minimum lease payments | 7,183 | 7,546 |
| **Total** | **7,183** | **7,546** |

| | 31 March 2019 £000 | 31 March 2018 £000 |
|---|---|---|
| **Future minimum lease payments due:** | | |
| - not later than one year; | 2,439 | 2,632 |
| - later than one year and not later than five years; | 6,081 | 6,510 |
| - later than five years. | 4,821 | 5,664 |
| **Total** | **13,341** | **14,806** |

# Note 11 Finance income

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

| | 2018/19 £000 | 2017/18 £000 |
|---|---|---|
| Interest on bank accounts | 200 | 63 |
| **Total finance income** | **200** | **63** |

# Note 12.1 Finance expenditure

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

| | 2018/19 £000 | 2017/18 £000 |
|---|---|---|
| **Interest expense:** | | |
| Interest on late payment of commercial debt | 1 | - |
| **Total interest expense** | **1** | **-** |

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

| | 2018/19 £000 | 2017/18 £000 |
|---|---|---|
| Amounts included within interest payable arising from claims under this legislation | 1 | - |

## Note 13 Other gains / (losses)

| | 2018/19 £000 | 2017/18 £000 |
|---|---|---|
| Gains on disposal of assets | 3 | - |
| Losses on disposal of assets | (5) | (65) |
| **Total gains / (losses) on disposal of assets** | **(2)** | **(65)** |

## Note 14.1 Intangible assets - 2018/19

| | Software licences £000 | Intangible assets under construction £000 | Total £000 |
|---|---|---|---|
| **Valuation / gross cost at 1 April 2018 - brought forward** | **662** | **-** | **662** |
| Additions | 211 | - | 211 |
| Disposals / derecognition | (32) | - | (32) |
| **Valuation / gross cost at 31 March 2019** | **841** | **-** | **841** |
| | | | |
| **Amortisation at 1 April 2018 - brought forward** | **179** | **-** | **179** |
| Provided during the year | 146 | - | 146 |
| Disposals / derecognition | (32) | - | (32) |
| **Amortisation at 31 March 2019** | **293** | **-** | **293** |
| | | | |
| **Net book value at 31 March 2019** | **548** | **-** | **548** |
| **Net book value at 1 April 2018** | **483** | **-** | **483** |

## Note 14.2 Intangible assets - 2017/18

| | Software licences | Intangible assets under construction | Total |
|---|---|---|---|
| | £000 | £000 | £000 |
| **Valuation / gross cost at 1 April 2017** | **284** | **28** | **312** |
| Additions | 350 | - | **350** |
| Reclassifications | 28 | (28) | - |
| **Valuation / gross cost at 31 March 2018** | **662** | **-** | **662** |
| | | | |
| **Amortisation at 1 April 2017** | **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 15.1 Property, plant and equipment - 2018/19

| | Land | Buildings excluding dwellings | Assets under construction | Plant and machinery | Transport equipment | Information technology | Furniture & fittings | Total |
|---|---|---|---|---|---|---|---|---|
| | £000 | £000 | £000 | £000 | £000 | £000 | £000 | £000 |
| **Valuation/gross cost at 1 April 2018 - brought forward** | **1,472** | **8,199** | **797** | **2,298** | **294** | **13,240** | **885** | **27,185** |
| Additions | - | 589 | 801 | 222 | 4 | 1,803 | 22 | 3,441 |
| Impairments | - | - | - | - | - | - | - | - |
| Revaluations | - | - | - | - | - | - | - | - |
| Reclassifications | - | 267 | (726) | 267 | 6 | 159 | 27 | - |
| Disposals / derecognition | - | - | - | (17) | (97) | (629) | - | (743) |
| **Valuation/gross cost at 31 March 2019** | **1,472** | **9,055** | **872** | **2,770** | **207** | **14,573** | **934** | **29,883** |
| **Accumulated depreciation at 1 April 2018 - brought forward** | **-** | **1,987** | **-** | **1,070** | **294** | **8,211** | **690** | **12,252** |
| Provided during the year | - | 726 | - | 259 | 1 | 2,037 | 94 | 3,117 |
| Revaluations | - | - | - | - | - | - | - | - |
| Disposals / derecognition | - | - | - | (12) | (97) | (629) | - | (738) |
| **Accumulated depreciation at 31 March 2019** | **-** | **2,713** | **-** | **1,317** | **198** | **9,619** | **784** | **14,631** |
| **Net book value at 31 March 2019** | **1,472** | **6,342** | **872** | | | **4,954** | **150** | **15,252** |
| **Net book value at 1 April 2018** | **1,472** | **6,212** | **797** | **1,228** | **-** | **5,029** | **195** | **14,933** |

## Note 15.2 Property, plant and equipment - 2017/18

| | Land | Buildings excluding dwellings | Assets under construction | Plant and machinery | Transport equipment | Information technology | Furniture & fittings | Total |
|---|---|---|---|---|---|---|---|---|
| | £000 | £000 | £000 | £000 | £000 | £000 | £000 | £000 |
| **Valuation / gross cost at 1 April 2017** | **1,472** | **7,914** | **924** | **2,024** | **294** | **12,419** | **858** | **25,905** |
| 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** | **-** | **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 15.3 Property, plant and equipment financing - 2018/19

| | Land | Buildings excluding dwellings | Assets under construction | Plant and machinery | Transport equipment | Information technology | Furniture & fittings | Total |
|---|---|---|---|---|---|---|---|---|
| | £000 | £000 | £000 | £000 | £000 | £000 | £000 | £000 |
| **Net book value at 31 March 2019** | | | | | | | | |
| Owned | 1,472 | 6,342 | 872 | 1,453 | 9 | 4,954 | 150 | 15,252 |
| **NBV total at 31 March 2019** | **1,472** | **6,342** | **872** | **1,453** | **9** | **4,954** | **150** | **15,252** |

## Note 15.4 Property, plant and equipment financing - 2017/18

| | Land | Buildings excluding dwellings | Assets under construction | Plant and machinery | Transport equipment | Information technology | Furniture & fittings | Total |
|---|---|---|---|---|---|---|---|---|
| | £000 | £000 | £000 | £000 | £000 | £000 | £000 | £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 16 Revaluations of property, plant and equipment

A revaluation exercise was carried out of the trust's owned buildings and land in March 2019, to consider whether movement in the value of these assets for the 12-month period to 31 March 2019 had been material. This exercise was carried out by Stephen Boshier MRICS of Boshier & Company Chartered Surveyors, an independent valuer.

The above followed the interim revaluation exercise carried out as at 31 March 2018 and the last full revaluation exercise carried out as at 28 February 2015. In accordance with the trust's five-year revaluation cycle, the next full revaluation exercise is planned for March 2020.

The trust's freehold estate comprises purpose built accommodation used to deliver NHS services.

Having researched the movement in market value of healthcare property and land during the past 12 months in Kent and south east England, the valuer is of the opinion that there has been no material change in the trust's freehold operational assets during the 12-month period to 31 March 2019.

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

## Note 17 Investments 2018/19

The trust has no investments (including investments in property). Nil for March 2018.

## Note 18 Disclosure of interests in other entities

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

## Note 19 Inventories

The trust holds no material inventories.

## Note 20.1 Trade receivables and other receivables

| | 31 March 2019 £000 | 31 March 2018 £000 |
|---|---|---|
| **Current** | | |
| Contract receivables* | 23,403 | - |
| Trade receivables* | - | 12,652 |
| Accrued income* | - | 4,943 |
| Allowance for impaired contract receivables / assets* | (59) | - |
| Allowance for other impaired receivables | (223) | (298) |
| Prepayments (non-PFI) | 1,538 | 1,469 |
| Interest receivable | 12 | 10 |
| PDC dividend receivable | 98 | 32 |
| VAT receivable | 582 | 129 |
| Other receivables | 484 | 816 |
| **Total current trade and other receivables** | **25,835** | **19,753** |
| | | |
| **Non-current** | | |
| Prepayments (non-PFI) | 330 | 77 |
| **Total non-current trade and other receivables** | **330** | **77** |
| | | |
| **Of which receivables from NHS and DHSC group bodies:** | | |
| Current | 14,814 | 12,992 |
| Non-current | - | - |

*Following the application of IFRS 15 from 1 April 2018, the trust's entitlements to consideration for work performed under contracts with customers are shown as contract receivables. This replaces the previous analysis into trade receivables and accrued income. IFRS 15 is applied without restatement therefore the comparative analysis of receivables has not been restated under IFRS 15.

## Note 20.2 Allowances for credit losses - 2018/19

| | Contract receivables and contract assets £000 | All other receivables £000 |
|---|---|---|
| **Allowances as at 1 Apr 2018 - brought forward** | | **298** |
| Impact of implementing IFRS 9 (and IFRS 15) on 1 April 2018 | 61 | (61) |
| New allowances arising | 51 | 41 |
| Reversals of allowances | (4) | (34) |
| Utilisation of allowances (write-offs) | (49) | (21) |
| **Allowances as at 31 Mar 2019** | **59** | **223** |

## Note 20.3 Allowances for credit losses - 2017/18

IFRS 9 and IFRS 15 are adopted without restatement therefore this analysis is prepared in line with the requirements of IFRS 7 before IFRS 9 adoption. As a result, it differs in format to the current period disclosure.

| | All Receivables £000 |
|---|---|
| **Allowances as at 1 Apr 2017** | **389** |
| Increase in provision | 81 |
| Amounts utilised | (28) |
| Unused amounts reversed | (144) |
| **Allowances as at 31 Mar 2018** | **298** |

## Note 20.4 Exposure to credit risk

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

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

## Note 21 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.

| | 2018/19 £000 | 2017/18 £000 |
|---|---|---|
| **At 1 April** | **27,633** | **19,167** |
| Net change in year | (256) | 8,466 |
| **At 31 March** | **27,377** | **27,633** |
| **Broken down into:** | | |
| Cash at commercial banks and in hand | 40 | 41 |
| Cash with the Government Banking Service | 2,337 | 27,592 |
| Deposits with the National Loan Fund | 25,000 | - |
| **Total cash and cash equivalents as in SoFP** | **27,377** | **27,633** |
| **Total cash and cash equivalents as in SoCF** | **27,377** | **27,633** |

## Note 21.1 Third party assets held by the trust

The trust held no cash and cash equivalents which relate to monies held by the trust on behalf of patients or other parties. Nil for 2017/18.

## Note 22.1 Trade and other payables

| | 31 March 2019 £000 | 31 March 2018 £000 |
|---|---|---|
| **Current** | | |
| Trade payables | 3,610 | 2,856 |
| Capital payables | 799 | 1,704 |
| Accruals | 13,432 | 16,666 |
| Social security costs | 1,960 | 1,768 |
| Other taxes payable | 1,182 | 1,018 |
| Other payables | 2,284 | 2,084 |
| **Total current trade and other payables** | **23,267** | **26,096** |
| **Total non-current trade and other payables** | **-** | **-** |
| **Of which payables from NHS and DHSC group bodies:** | | |
| **Current** | **7,157** | **11,077** |
| **Non-current** | **-** | **-** |

## Note 22.2 Early retirements in NHS payables above

There are no early retirement payables. Nil for 2017/18.

## Note 23 Other liabilities

| | 31 March 2019 £000 | 31 March 2018 £000 |
|---|---|---|
| **Current** | | |
| Deferred income: Contract liabilities | 1,553 | 1,760 |
| **Total other current liabilities** | **1,553** | **1,760** |

## Note 24 Borrowings

The trust has no borrowings. Nil for 2017/18.

## Note 25 Finance leases

## Note 25.1 Kent Community Health NHS Foundation Trust as a lessor

The trust has no finance lease arrangements. Nil for 2017/18.

## Note 25.2 Kent Community Health NHS Foundation Trust as a lessee

The trust has no finance lease obligations. Nil for 2017/18.

## Note 26.1 Provisions for liabilities and charges analysis

| | Legal claims £000 | Redundancy £000 | Other £000 | Total £000 |
|---|---|---|---|---|
| **At 1 April 2018** | **141** | **889** | **430** | **1,460** |
| Arising during the year | 499 | 551 | 824 | **1,874** |
| Utilised during the year | (49) | (309) | - | **(358)** |
| Reversed unused | (56) | (709) | (430) | **(1,195)** |
| **At 31 March 2019** | **535** | **422** | **824** | **1,781** |
| **Expected timing of cash flows:** | | | | |
| - not later than one year | 535 | 422 | 96 | **1,053** |
| - later than one year and not later than five years | - | - | 274 | **274** |
| - later than five years | - | - | 454 | **454** |
| **Total** | **535** | **422** | **824** | **1,781** |

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, a property rental claim 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 a provision for dilapidations liabilities for the trust's commercially leased properties. The dilapidations provision represents the estimated re-instatement costs required when the trust is due to vacate the properties and has been advised by an external surveyor (BNP Paribas Real Estate).

## Note 26.2 Clinical negligence liabilities

At 31 March 2019, £2,836k was included in provisions of NHS Resolution in respect of clinical negligence liabilities of Kent Community Health NHS Foundation Trust (31 March 2018: £2,534k).

## Note 27 Contingent assets and liabilities

| | 31 March 2019 £000 | 31 March 2018 £000 |
|---|---|---|
| **Value of contingent liabilities** | | |
| NHS Resolution legal claims | (31) | (15) |
| **Gross value of contingent liabilities** | **(31)** | **(15)** |
| **Amounts recoverable against liabilities** | **-** | **-** |
| **Net value of contingent liabilities** | **(31)** | **(15)** |
| **Net value of contingent assets** | **-** | **-** |

NHS Resolution legal claims - contingent liability relates to Liabilities to Third Party Scheme (LTPS) claims as administered and advised by NHS Resolution.

## Note 28 Contractual capital commitments

| | 31 March 2019 £000 | 31 March 2018 £000 |
|---|---|---|
| Property, plant and equipment | 329 | 607 |
| Intangible assets | - | - |
| **Total** | **329** | **607** |

## Note 29 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 2019 £000 | 31 March 2018 £000 |
|---|---|---|
| not later than 1 year | 904 | 210 |
| after 1 year and not later than 5 years | 1,487 | 1,057 |
| paid thereafter | 440 | 705 |
| **Total** | **2,831** | **1,972** |

## Note 30 Defined benefit pension schemes

The trust has no defined benefit schemes.

# Note 31 Financial instruments

# Note 31.1 Financial risk management

Financial reporting standard IFRS 7 requires disclosure of the role that financial instruments have had during the period in creating or changing the risks a body faces in undertaking its activities. 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 2019 is in receivables from customers, as disclosed in the trade and other receivables note. However, the trust uses 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 31.2 Carrying values of financial assets

IFRS 9 Financial instruments is applied restrospectively from 1 April 2018 without restatement of comparatives. As such, comparative disclosures have been prepared under IAS 39 and the measurement categories differ to those in the current year analysis.

| | Held at amortised cost | Held at fair value through I&E | Held at fair value through OCI | Total book value |
|---|---|---|---|---|
| **Carrying values of financial assets as at 31 March 2019 under IFRS 9** | **£000** | **£000** | **£000** | **£000** |
| Trade and other receivables excluding non financial assets | 23,617 | - | - | 23,617 |
| Cash and cash equivalents at bank and in hand | 27,377 | - | - | 27,377 |
| **Total at 31 March 2019** | **50,994** | **-** | **-** | **50,994** |

| | Loans and receivables | Assets at fair value through the I&E | Held to maturity | Available-for-sale | Total book value |
|---|---|---|---|---|---|
| **Carrying values of financial assets as at 31 March 2018 under IAS 39** | **£000** | **£000** | **£000** | **£000** | **£000** |
| 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** |

## Note 31.3 Carrying value of financial liabilities

IFRS 9 financial instruments is applied restrospectively from 1 April 2018 without restatement of comparatives. As such, comparative disclosures have been prepared under IAS 39 and the measurement categories differ to those in the current year analysis.

| | Held at amortised cost | Held at fair value through the I&E | Total book value |
|---|---|---|---|
| | **£000** | **£000** | **£000** |
| **Carrying values of financial liabilities as at 31 March 2019 under IFRS 9** | | | |
| Trade and other payables excluding non financial liabilities | 20,125 | - | 20,125 |
| **Total at 31 March 2019** | **20,125** | **-** | **20,125** |

| | Other financial liabilities | Held at fair value through the I&E | Total book value |
|---|---|---|---|
| | £000 | £000 | £000 |
| **Carrying values of financial liabilities as at 31 March 2018 under IAS 39** | | | |
| Trade and other payables excluding non financial liabilities | 23,310 | - | 23,310 |
| **Total at 31 March 2018** | **23,310** | **-** | **23,310** |

## Note 31.4 Fair values of financial assets and liabilities

There is no material difference between the carrying value and fair value of the financial assets and liabilities shown above.

## Note 31.5 Maturity of financial liabilities

| | 31 March 2019 | 31 March 2018 |
|---|---|---|
| | £000 | £000 |
| In one year or less | 20,125 | 23,310 |
| In more than one year but not more than two years | - | - |
| In more than two years but not more than five years | - | - |
| In more than five years | - | - |
| **Total** | **20,125** | **23,310** |

## Note 32 Losses and special payments

| | 2018/19 | | 2017/18 | |
|---|---|---|---|---|
| | Total number of cases | Total value of cases | Total number of cases | Total value of cases |
| | Number | £000 | Number | £000 |
| **Losses** | | | | |
| Cash losses | - | - | 3 | - |
| Fruitless payments | 1 | 4 | - | - |
| Bad debts and claims abandoned | 197 | 70 | 163 | 28 |
| **Total losses** | **198** | **74** | **166** | **28** |
| **Special payments** | | | | |
| Ex-gratia payments | 9 | 12 | 4 | - |
| **Total special payments** | **9** | **12** | **4** | **-** |
| **Total losses and special payments** | **207** | **86** | **170** | **28** |

## Note 33 Initial application of IFRS 9

IFRS 9 financial instruments as interpreted and adapted by the GAM has been applied by the trust from 1 April 2018. The standard is applied retrospectively with the cumulative effect of initial application recognised as an adjustment to reserves on 1 April 2018. The implementation of IFRS 9 has had no net impact on the trust's opening reserves.

IFRS 9 replaces IAS 39 and introduces a revised approach to classification and measurement of financial assets and financial liabilities, a new forward-looking expected loss impairment model and a revised approach to hedge accounting.

## Note 33.1 Initial application of IFRS 15

IFRS 15 Revenue from Contracts with Customers as interpreted and adapted by the GAM has been applied by the trust from 1 April 2018. The standard is applied retrospectively with the cumulative effect of initial application recognised as an adjustment to the income and expenditure reserve on 1 April 2018.

IFRS 15 introduces a new model for the recognition of revenue from contracts with customers replacing the previous standards IAS 11, IAS 18 and related Interpretations. The core principle of IFRS 15 is that an entity recognises revenue when it satisfies performance obligations through the transfer of promised goods or services to customers at an amount that reflects the consideration to which the entity expects to be entitled to in exchange for those goods or services.

As directed by the GAM, the trust has applied the practical expedient offered in C7A of the standard removing the need to retrospectively restate any contract modifications that occurred before the date of implementation (1 April 2018).

The implementation of IFRS 15 has had no net impact on opening reserves or on the recognition of operating income by the trust during 2018/19.

## Note 34 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. A list of the main entities (those with transactions or balances of more than £1million) within the scope of the Whole Government Accounts (WGA) with which the trust has transacted with during the reporting period or has receivables or payables balances reported as at period end, are as follows:

Department of Health and Social Care

Health Education England

NHS Ashford CCG

NHS Canterbury and Coastal CCG

NHS Dartford, Gravesham and Swanley CCG

NHS Eastbourne, Hailsham and Seaford CCG

NHS Hastings and Rother CCG

NHS High Weald Lewes Havens CCG

NHS Medway CCG

NHS South Kent Coast CCG

NHS Swale CCG

NHS Thanet CCG

NHS West Kent CCG

NHS England

NHS Property Services

East Kent Hospitals University NHS Foundation Trust

Medway NHS Foundation Trust

Dartford and Gravesham NHS Trust

Maidstone and Tunbridge Wells NHS Trust

East Sussex County Council

Kent County Council

Medway Council

HM Revenue & Customs

NHS Pension Scheme

HM Treasury National Loans Fund

As at 31 March 2019 the trust has a receivable of £2k with Kent Community Health Charitable Fund whose 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.

## Note 35 Events after the reporting date

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

NHS
Kent Community Health
NHS Foundation Trust

# Quality Report

## 2018 to 2019

we care

# Contents page

# Part one: Introduction

## Statement on quality from the chief executive

### Welcome to our quality report for Kent Community Health NHS Foundation Trust for 2018/19.

High-quality care is at the heart of all we aspire to do, so I am pleased to report that we made significant progress against all our quality priorities and delivered excellent care to our patients and service users. We know we need to make sure we make a difference each and every time we interact with a patient or service user.

For example, patients had care plans developed by competent staff, a specific task as part of our patient experience quality priority. Our target was 85 per cent, we achieved 93 per cent, which is good news because patients benefit from being involved in decisions about their care and this should be part of their care experience.

It's reassuring that 96.9 per cent of people who completed the Friends and Family Test said they would recommend us and that patients felt our staff treated them with kindness and respect, as it should be. In total, 66,085 patient experience surveys were filled in across the trust. This is great news because patient and service user feedback is crucial for us to deliver a strong service and learn where we can do better.

Where there are incidents, it is important that patients, families and carers are involved from the beginning of any investigation and, while we work to ensure there aren't any incidents, I am pleased to say that happened in 100 per cent of cases in 2018/19 that patients, families and carers were involved.

We are fully committed to a quality improvement approach and already there are more than 60 projects taking place as part of this – the ultimate aim is to provide the best on every occasion for our patients, seeking new and innovative ways of working and involve patients in co-design, wherever possible. We have a five-year plan in place to ensure staff across the trust are trained in effectively using a quality improvement approach to all our engagements with the people we serve.

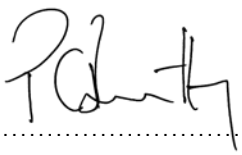
Supporting our staff is crucial and is why staff experience was one of our quality priorities in 2018/19. We held the BIG Listen for all our staff as one of a number of ways to feedback about what it's like to work for KCHFT and as part of our programme to retain our people. To support recruitment, we launched our Nursing Academy, which we hope to open up to allied health professionals and other staff groups in the near future.

Our Board and Executive Team continue to be visible in our services shadowing staff and making sure our We care inspection programme is identifying areas of excellent clinical practice and any issues. Our staff are our most important asset. Without them, we could not deliver the excellent services that we do. In 2018/19, we signed up to the Time to Change programme promoting positive mental health. As part of this we encouraged people to sign up as Time to Change champions and we now have more than 120.

We value the opportunity of taking part in national clinical audits and research projects. In 2018/19, we participated in 15 national clinical audits and multiple research projects.

The number of pressure ulcers acquired in our care and avoidable fell again last year, with category 2 pressure ulcers at 16, down from 18 (11 per cent) and category 3 and above pressure ulcers at 9, down from 18 (50 per cent drop).

We don't always get everything right, but your feedback really does help shape the way we learn and continue to improve.



**Paul Bentley**, Chief Executive Officer

Date 23 May 2019

# Part two: Our quality priorities

## Priorities for improvement and statements of assurance from the board

## 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 one of the largest NHS community health providers in England. We serve three million people; 1.5million living in Kent and 1.5million people outside of Kent . We employ around 4,800 staff, including doctors, community nurses, physiotherapists, dietitians and many other healthcare professionals. We became a foundation trust on 1 March 2015.

### Mission

Our mission is to empower adults and children to live well, 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 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.

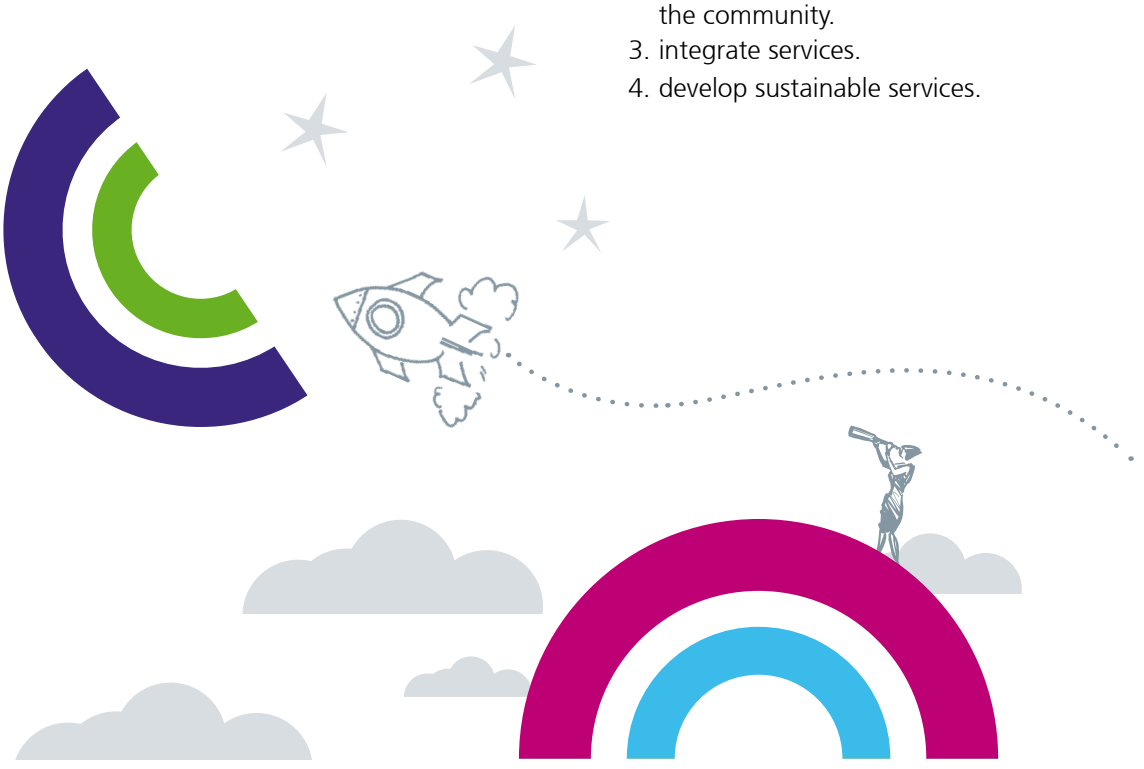
2. Aspirational – we feel empowered and we empower our patients. We strive to improve. Our focus is on research and generating ideas and innovations. We're open, transparent and we think creatively.

3. Responsive – we listen. We act. We communicate clearly. We do what we say we will. We take account of the opinions of others.

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:

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 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 and we wish to partner with patients and carers, where possible, to bring about 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:

- Patient experience – be nice to me.
- Patient safety – do me no harm.
- 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:

- visible corporate leadership
- all employees to take ownership
- improved patient experience and increased patient and public engagement and involvement
- clinically and cost effective evidence-based services
- improved patient safety
- organisational learning to enhance quality
- Engagement with external partners.

## Delivering quality:

### New structures

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

→ Reporting to... Quality Committee

### New roles

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

### Task and finish groups

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

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

# Summary against 2018/19 priorities

## Our trust priorities for 2018/19 were:

- We will learn from incidents and complaints, thereby improving the safety of our patients. We will introduce an improved methodology of patient-centred investigation.
- 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 adopt quality improvement (QI) methodology to support quality assurance; educate and train our workforce to increase awareness.
- We will improve recruitment and retention of our workforce.

Our quality priorities for 2018/19 were developed in consultation with our partners, service users and their families. They are shown here:

### Patient experience

- Develop and publish an involvement and experience strategy.
- Ensure all relevant patients have a personalised plan of care developed by competent staff.

### Patient safety

- Involve families in all relevant investigations for serious incidents.
- Survey patients and families on their involvement in investigations.
- Share serious incidents and complaints' stories at our quality improvement network.

### Clinical effectiveness

- Develop and deliver our quality improvement training plan.
- Start 20 quality improvement projects.

### Staff experience

- Participate in the NHSI Retention Improvement Collaborative.
- Aim to reduce our staff turnover by two per cent in 2018/19.

# Quality achievements 2018/19

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 those areas we need to improve upon.

## Patient experience

- Draft patient involvement and experience strategy published (part of the Communications, Engagement and Patient Experience Survey).
- 66,085 patient experience surveys completed across the trust with an average satisfaction rate of 97%.
- 93% of staff completed training on personalised care plans.
- 60% of the people we care for at the end of their lives had a personalised plan of care by the end of quarter four.

## Patient safety

- 100% of all relevant serious incident investigations involved patients, families and carers from the beginning of the investigation.
- We shared learning from serious incidents and complaint stories across services at the Quality Improvement Network.

## Clinical effectiveness

- 66 colleagues completed quality, service improvement and redesign (QSIR) practitioner training and 56 individuals completed quality improvement fundamentals training.
- 68 quality improvement projects started.

## Staff experience

- More than 120 people signed up to become Time to Change mental health champions.
- The Nursing Academy was launched, recruiting 22 nursing apprentices and 23 nursing associate apprentices.

# Our strategic priorities for 2019/20

Through a robust consultation process four strategic priorities were selected for 2019/20. These are:

- **improve quality:** Innovate, improve and learn so everyone gets the best health and wellbeing outcomes.
- **support our people:** Engage, develop and value our people so they deliver high-quality care throughout long, rewarding careers.
- **joined-up care:** Progress partnerships so people feel supported by one multi-skilled team.
- **develop our digital ways of working:** Invest in technology and training to give more time to care, better access to services and the power of information to all.

The strategic priorities have been mapped to our quality priorities to make sure we have a clear thread from the organisational strategy to operational service delivery.

This aims to streamline the number of differing requirements placed on our staff, while delivering key improvements we all agree are required for our people and our patients.

## Our quality priorities for 2019/20 are:

- **improving the safety of the people we care for:** Implement an early warning system and escalation process that prevents harm and promotes agreed outcomes and wellbeing.
- **improving clinical effectiveness:** Use research and QI methodologies to provide an evidence-based approach to improve our care and services.
- **improve the experience of the people we care for:** Develop and deliver services and pathways in collaboration with people and carers at all stages of their journey.
- **improving the experience of our people:** Enable and empower our people to maintain personal and team wellbeing.

A summary of the 2019/20 quality priorities and what we intend to achieve is shown opposite.

| Quality priorities | **Improving the safety of the people we care for:** Implement an early warning system and escalation process that prevents harm and promotes agreed outcomes and wellbeing. | **Improving clinical effectiveness:** Use research and QI methodologies to provide an evidence-based approach to improve our care and services. | **Improve the experience of the people we care for:** Develop and deliver services and pathways in collaboration with people and carers at all stages of their journey. | **Improving the experience of our people:** Enable and empower our people to maintain personal and team wellbeing. |
|---|---|---|---|---|
| **Personalised plans of care (including end of life plans)** | 15% increase of all relevant patients to have a personalised plan of care. | Participate in the Sweeney programme collaborative to improve the experience of patients at the end of life and their families. | 90% of relevant patients report their personal goals were accounted for. | 90% of relevant staff state: The personalised plans of care developed, meets the needs of the people they care for. |
| **Human factors** | 20% increase in the number of investigators supported to recognise human factors as a contributing factor | Continue our quality improvement journey with a total of 100 people completing the QSIR practitioner course and 300 people completing the QI fundamentals course. | 15 patient and service users to complete the QI fundamentals training. | Work with our staff to increase the accessibility and usability of our policies, procedures and guidelines using a QI approach. |
| **Improving outcomes** | Implement and embed NEWS2 across our community hospitals | 10 projects with associated reports and poster abstracts will be done as part of the research champions' programme to develop the research capabilities of our clinical staff. | Where able, 75% of patients report they were confident, empowered and supported to undertake their usual activities. | A 35% positive response for "Does your organisation take positive action on health and wellbeing?" in the NHS staff survey. |

Our quality priorities follow an established governance structure, which monitors and measures performance and progress.

Each individual quality priority has a responsible lead who monitors and reports progress each quarter to the Quality Committee, a sub-committee of the Board with delegated decision-making powers.

The Quality Committee is responsible for providing information and assurance to the Board that the trust is safely managing the quality of patient care, the effectiveness of quality interventions and the safety of patients.

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 the priorities will be developed into a quality improvement (QI) project.

# Statements of assurance from the Board

During 2018/19 KCHFT provided and/or sub-contracted 53 relevant health services.

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

The income generated by the relevant health services reviewed in 2018/19 represents 100 per cent of the total income generated from the provision of relevant health services by KCHFT for 2018/19.

During 2018/19, 15 national clinical audits and one national confidential enquiry 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, in which it was eligible to participate.

National clinical audits and national confidential enquiries KCHFT was eligible to participate in during 2018/19 are:

- National Diabetes Footcare Audit
- Sentinel Stroke National Audit Programme (SSNAP)
- National Audit of Cardiac Rehabilitation
- National Audit of Care at the End of Life
- Ventilation study (National Confidential Enquiries into Patient Outcome and Death (NCEPOD)
- BASHH (British Association for Sexual Health and HIV) 2018 HIV partner notification
- Management of non-specific urethritis (NSU).

National clinical audits and national confidential enquiries KCHFT participated in during 2018/19 were:

- National Diabetes Footcare Audit
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- BASHH (British Association for Sexual Health and HIV) 2018 HIV partner notification
- Management of non-specific urethritis (NSU).

The national clinical audits and national confidential enquiries KCHFT participated in, and for which data collection was completed during 2018/19, 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 the audit or enquiry.

- National Diabetes Footcare Audit – no set case number required.
- Sentinel Stroke National Audit Programme (SSNAP) – no set case number required.
- National Audit of Cardiac Rehabilitation - no set case number required.
- National Audit of Care at the End of Life – 100 per cent.
- Ventilation study (National Confidential Enquiries into Patient Outcome and Death (NCEPOD) – 100 per cent.
- BASHH (British Association for Sexual Health and HIV) 2018 HIV partner notification – no set case number required.
- Management of non-specific urethritis (NSU) – no set case number required.

The reports of 11 national clinical audits were reviewed by the provider in 2018/19 and KCHFT intends to take the following actions to improve the quality of healthcare provided:

- Explore the use of digital programme delivery options for people unable to attend traditional cardiac rehab.
- Scope the provision of group interventions, where applicable, when developing new pathways.
- Identify remediable factors in the care of patients before their 25th birthday who are receiving, or have received, long-term ventilation.

The reports of 56 local clinical audits were reviewed by the provider in 2018/19 and KCHFT intends to take the following actions to improve the quality of healthcare provided:

- Communication needs to be better identified, recorded, flagged, shared and met.
- Review local safeguarding process to make sure of appropriate escalation and to prevent re-occurrence.

- Standardise approach to personalised care planning, including regular audit to assure quality of documentation and patient outcomes.
- 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.
- DNACPR (Do not attempt cardio-pulmonary resuscitation) forms to be discussed and reviewed to ensure legibility.
- Ensure clear protocols are in place for processing, storing and managing caseloads.
- Improve awareness of the need to include all risks and benefits of all dental treatment options – including the option of no treatment – in the patient record.
- All Family Nurse Partnership clients to be given the opportunity to be seen alone and to document whether this has been accepted or declined. (This service is no longer provided).
- For applicable services to implement reason, observation, comment, assessment/analysis, intervention plan (ROCAIP) training to increase practitioners' awareness.

The number of patients receiving relevant health services provided or subcontracted by KCHFT during 2018/19 who were recruited to participate in research approved by a research ethics committee was 388.

A proportion of KCHFT income in 2018/19 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 with to provide relevant health services, through the Commissioning for Quality and Innovation payment framework.

Further details of the agreed goals for 2018/19 and for the following 12-month period are available electronically at https://www.england.nhs.uk/nhs-standard-contract/cquin/cquin-17-19/ for the majority of the CQUINs. Further detail on agreed goals outside of nationally mandated schemes with NHS England are available on request.

The monetary total for income in 2018/19 conditional upon achieving quality improvement and innovation goals was £3,433,200. The monetary total for income in 2017/18 was £3,141,670.

KCHFT is required to register with the Care Quality Commission and its current registration status is registered without conditions.

The Care Quality Commission took enforcement action against KCHFT during 2018/19. This was a requirement notice, issued in February 2019, for Dental Services, HMP Maidstone relating to regulation 17 – good governance.

KCHFT responded to the requirement notice with a report and action plan, which has been acknowledged by the CQC.

KCHFT did not take part in any special reviews or investigations by the CQC during the reporting period.

KCHFT submitted 82,471 records during 2018/19 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
- 99.3 per cent for accident and emergency care

which included the patient's valid general medical practice code was:

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

KCHFT's data security and protection assessment (DSPA) reported an overall score of standards met and all mandatory assertions were responded to and evidence provided.

The assessment was published on the 14 March 2019 for 2018/19. The annual audit of the DSPA was provided by TIAA in March 2019 and the trust was awarded substantial assurance. The assessment would be categorised as green, although the RAG status is no longer used within the assessment.

KCHFT was not subject to the payment by results clinical coding audit during 2018/19 by the Audit Commission.

KCHFT continues to improve the data quality of its services by:

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

During 2018/19, 51 KCHFT patients died. This comprised the following number of deaths, which happened in each quarter of the reporting period: 12 in the first quarter; 14 in the second quarter; 13 in the third quarter and 12 in the fourth quarter. This figure relates to inpatient deaths in our community hospitals only.

By 31 March 2019, 43 case record reviews and zero investigations were carried out in relation to 43 of the deaths included in the previous item.

In no cases, was a death 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: 12 in the first quarter; 14 in the second quarter; 13 in the third quarter and four 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 in 2018/19.

These numbers have been estimated using a multi-disciplinary mortality review process adapted for community use from the RCP structured judgement review form.

Areas of good practice identified during mortality reviews include good communication with families and relatives, anticipatory medicines being put in place early and relevant assessments being completed promptly and thoroughly.

There are some excellent examples of person-centred, holistic care, including consideration of spiritual needs and eating for pleasure at end of life. Areas for learning include:

- improving consistency of documentation, particularly with regard to care plans
- recognition of end of life should be earlier in some cases, where there is a lack of advance care planning
- improved understanding of the role of lasting power of attorney and what to do if the patient has no known next of kin.

More generally, learning and themes earlier in the year were limited due to the design of the mortality review form used by KCHFT, which was originally based on the PRISM2 methodology. Themes are now aligned to the five Priorities of Care for the Dying Patient to increase staff awareness.

Following workshops with quality leads and doctors, a new mortality review form was created in line with the RCP structured judgement review, adapted for use in a community trust. Following the Gosport Inquiry, a question was added on misuse/mismanagement of controlled drugs; a new centralised multi-disciplinary meeting format allows for rotation of reviewers for objectivity. A sample of deaths of patients receiving community based treatment is submitted for review at monthly mortality review meetings. These samples are determined within each speciality or service to ensure an overview of areas of need regarding learning and improvement and include all unexpected deaths and those cases where complaints or concerns have been raised. There is a continuing piece of work around trust-wide care planning which is being taken through the Clinical Effectiveness Group.

A bereavement pack is being developed to provide consistent information for families, which is now in place across the community hospitals. Training is planned for community hospital staff to clarify lasting power of attorney and the Legal Team has circulated guidance to all community hospitals around patients who die with no known next of kin. This guidance will also be added into the care after death policy.

Richer learning and a more detailed patient background story is being captured on the new mortality review forms, while the new question added on misuse/ mismanagement of controlled drugs provides additional assurance in light of the Gosport Inquiry.

The multi-disciplinary review group format allows for different clinical staff to take part each time, which has contributed to a raised profile of mortality reviews across the trust and staff involved have consistently fed back  the sessions were interesting and beneficial.

Ward staff are now used to receiving regular feedback aligned to the five priorities of care for the dying patient and themes are shared more widely at the End of Life Quality Improvement Group, which provides a route for taking forward areas for operational improvement.

Five case record reviews and zero investigations were completed after 1 April 2018, which related to deaths that took place before the start of the reporting period.

This figure is an estimate as before June 2018, reviews were being carried out by non-centralised teams at each hospital and records of exact review dates are largely unavailable.

From June 2018 onwards, scheduled multi-disciplinary review sessions are held twice a month and records are maintained centrally.

None of the patient deaths before the reporting period are judged to be more likely than not to have been due to problems in the care provided to the patient.

This number has been estimated using a multi-disciplinary mortality review process adapted for community use from the RCP structured judgement review form.

No patient deaths during 2018/19 are judged to be more likely than not to have been due to problems in the care provided to the patient.

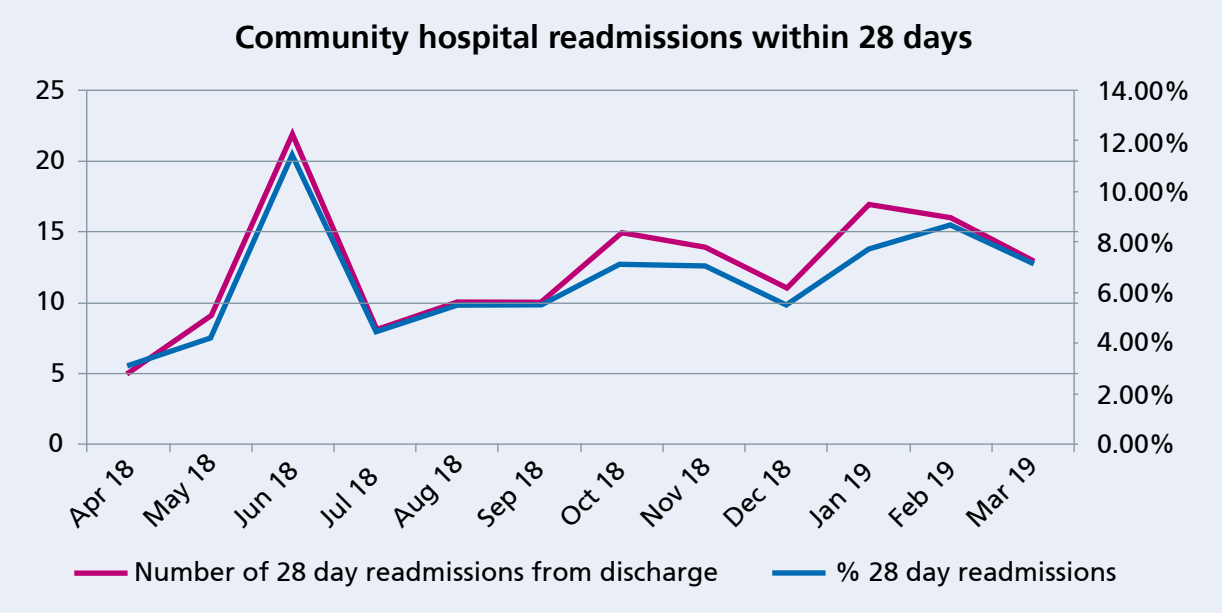
# Reporting against core indicators

## Indicator 19: Hospital re-admissions

KCHFT is not commissioned to deliver inpatient paediatric care. Therefore, only the percentage of patients aged 15 and over re-admitted to a hospital within 28 days of being discharged from a hospital is shown here:

| | Apr 2018 | May 2018 | Jun 2018 | Jul 2018 | Aug 2018 | Sep 2018 | Oct 2018 | Nov 2018 | Dec 2018 | Jan 2019 | Feb 2019 | Mar 2019 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Number of 28-day readmissions from discharge | 5 | 9 | 22 | 8 | 10 | 10 | 15 | 14 | 11 | 17 | 16 | 13 |
| % 28 day readmissions | 3.14 % | 4.19 % | 11.46 % | 4.44 % | 5.52 % | 5.52 % | 7.18 % | 7.07 % | 5.50 % | 7.73 % | 8.70 % | 7.18 % |

| | 2017/18 | 2018/19 |
|---|---|---|
| Number of 28-day readmissions from discharge | 168 | 150 |
| % 28-day readmissions | 7.21% | 6.52% |



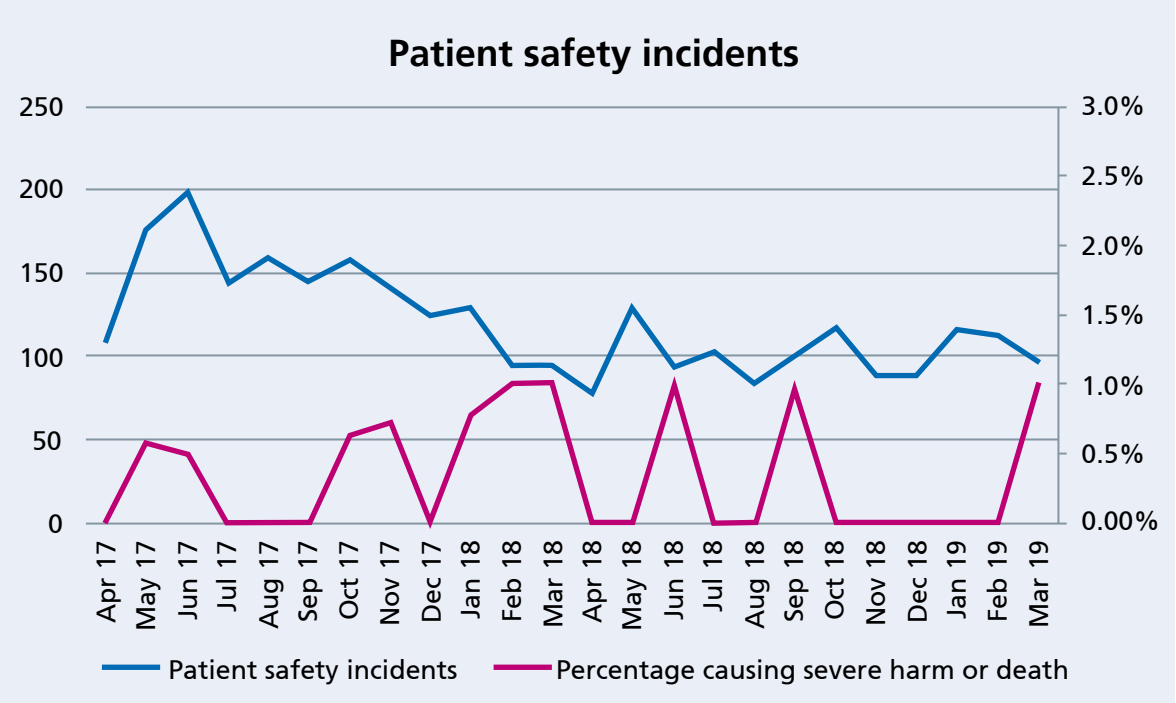

KCHFT considers this data is as described for the following reasons:

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

## Indicator 25: Patient safety incidents

The number and, where available, rate of patient safety incidents reported in the trust during 2018/19 and the number and percentage of patient safety incidents that resulted in severe harm or death are shown here:

| | 2017/18 | 2018/19 |
|---|---|---|
| Avoidable patient safety incidents | 1,674 | 1,209 |
| Avoidable patient safety incidents (causing severe harm or death) | 7 | 3 |
| Percentage causing severe harm or death | 0.42% | 0.25% |




KCHFT considers this data is as described for the following reasons:

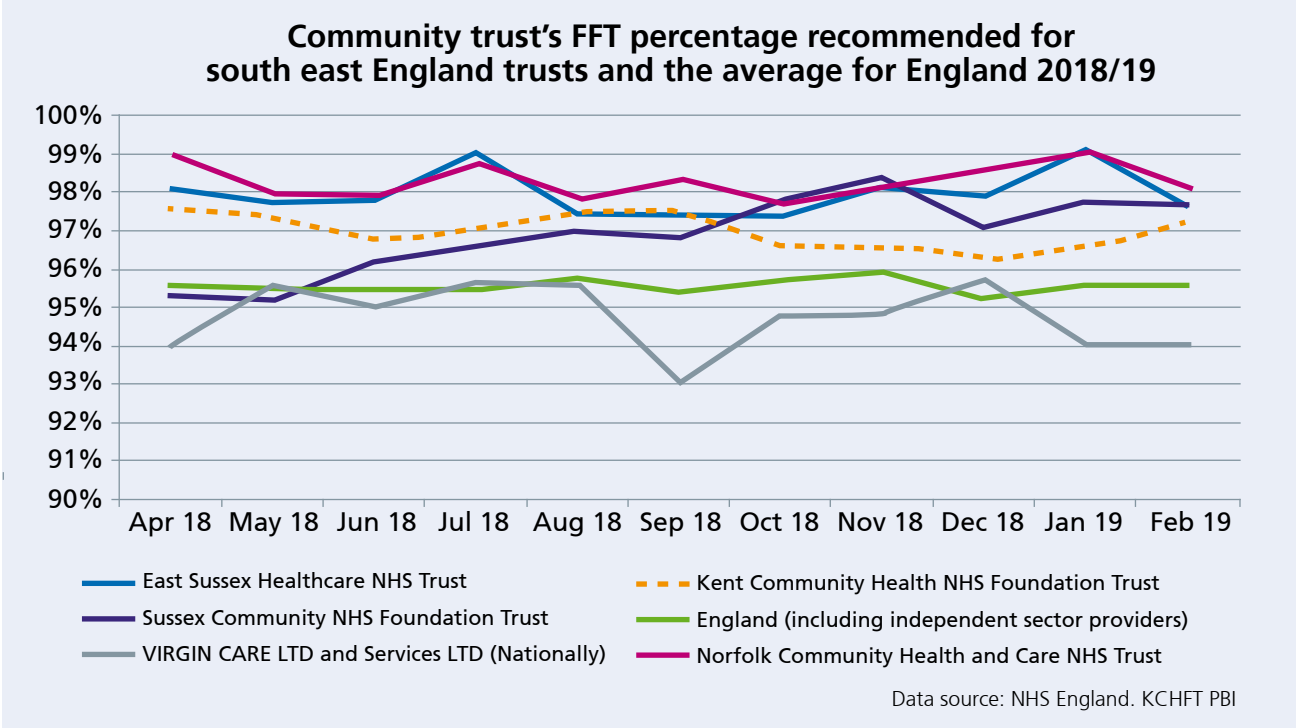
- It is captured on the Datix system by the employee who discovered the incident, ensuring data is first-hand information.
- Incidents are subject to a comprehensive review process at multiple levels across the organisation validating the accuracy of the data.

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

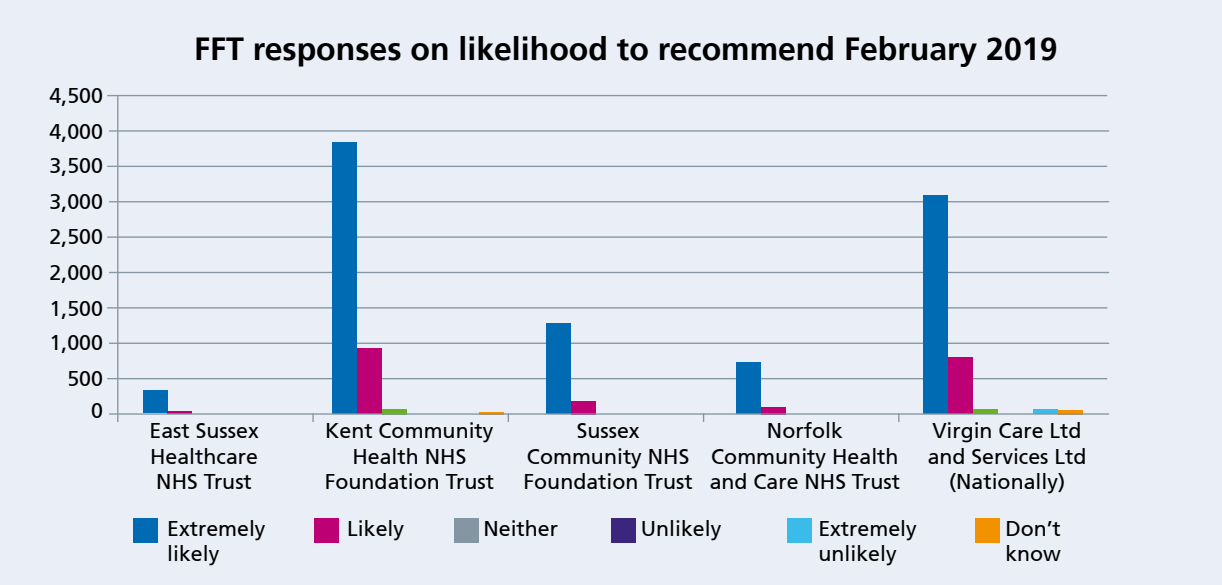
- developed a comprehensive risk and incident training package, which has been delivered to services identified as low reporters
- enhanced reports to include improvements. This has encouraged a positive patient safety culture where staff can see the benefits of reporting incidents.
- shared learning from incidents at the trust's Quality Improvement Network, creating a positive safety learning culture.

## 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.

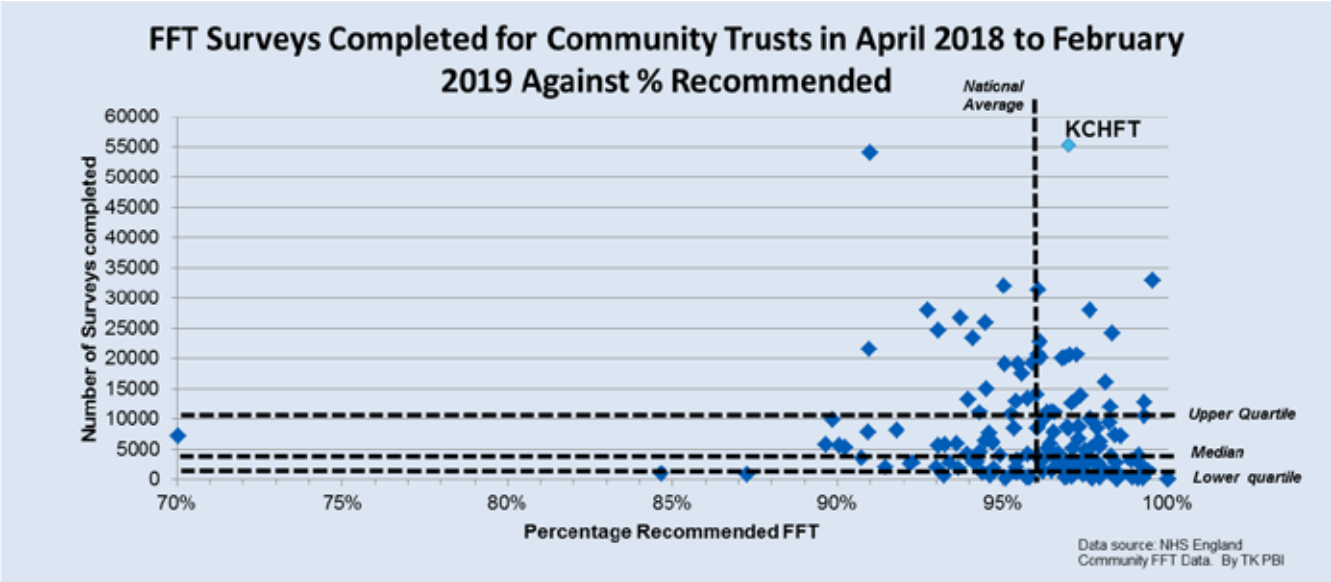



Data source: NHS England. KCHFT PBI



At 11 April 2019, in the latest national datasets published run up to February 2019, KCHFT had completed 55,405 FFT responses from April 2018 to February 2019. This is the highest of all service providers which feature on the national community health datasets.

As the graph shows, KCHFT's percentage (95.33 per cent) recommend for the FFT is above the national average (96.9 per cent) for April to February and at the top of the upper quartile for surveys completed.




## RTT indicator

This section shows our performance against 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 2018 | May 2018 | Jun 2018 | Jul 2018 | Aug 2018 | Sep 2018 | Oct 2018 | Nov 2018 | Dec 2018 | Jan 2019 | Feb 2019 | Mar 2019 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| RTT incomplete pathways | 89.7 % | 90.6 % | 90 % | 89.9 % | 89.8 % | 91.2 % | 94 % | 96.4 % | 96 % | 97.3 % | 97.2 % | 96.7 % |

# Part three: Overview of quality of care

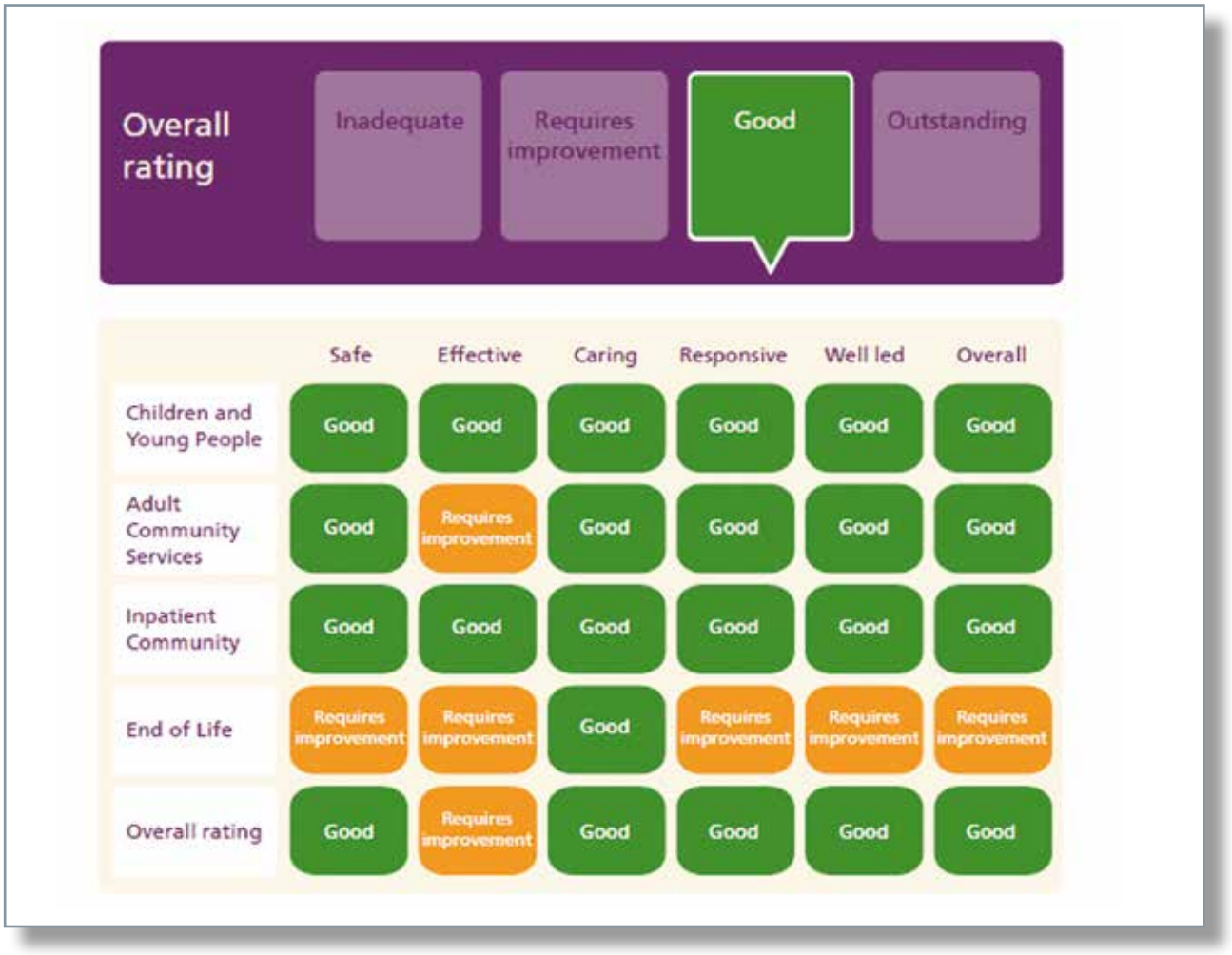
This section gives an overview of the quality of care offered by KCHFT based on performance against the 2018/19 indicators we agreed and published in our 2017/18 quality Report. It explains in more detail what we have achieved during the past year and those areas we need to improve upon.

## Regulation: Care Quality Commission

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

## Rating

For 2018/19, KCHFT maintained its 'good' rating from the inspection in June 2014. All areas rated requires improvement were addressed within an improvement plan and the CQC was satisfied with improvements made at the time.




| | 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: **http://www.cqc.org.uk/provider/RYY**

## Inspections 2018/19

In February 2019, the CQC issued a requirement notice following an inspection of our Dental Services at HMP Maidstone.

The requirement notice was in relation to regulation 17, good governance which KCHFT responded to with a report and action plan, acknowledged by the CQC.

## We care visit programme

The We care reviews are a supportive learning programme to encourage shared learning, to provide assurance and stimulate quality improvements.

The visits focus on assessing our values in action, as well as compliance with the Care Quality Commission fundamental standards and key lines of enquiry (KLOE).

Since the programme started in February 2018, 58 services were reviewed. The services were prioritised through a risk stratification approach, based on data provided from the CQC dashboard and the likelihood of being inspected by the CQC.

Of the 58 services reviewed, 19 per cent (11) rated as outstanding, 76 per cent (44) have been rated overall as good, and five per cent (three) of services as requires improvement.

The services, which were rated as requires improvement, were supported to develop and implement an improvement plan. A further We care review was conducted in October 2018 on these services to monitor their progress. All services evidenced improvements and recognised further improvements required to enable an overall good rating.

The programme involves all levels and disciplines of staff within the trust, together with our governors, patient representatives and CCG colleagues.

Those participating in a visit receive guidance, tools and training before the visit 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 collaboration meeting at the end of the visit enables participants to share observations from the visit and contribute to the visit report and agree ratings. After each visit, the service is provided with feedback, a summary report, and a certificate displaying their ratings. They are asked to produce an action plan for areas requiring improvement and a re-visit is planned based on their 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.

## Freedom to speak up guardian

KCHFT has a freedom to speak up (FTSU) guardian who is responsible for supporting colleagues in raising concerns in the trust. The FTSU guardian provides confidential advice to colleagues, agency workers employed by KCHFT or volunteers, about concerns they have and/or the way their concern is handled.

FTSU guardians don't get involved in investigations or complaints, but help the process. They have a key role in making sure colleagues do not experience discrimination or are victimised because they raise a concern in good faith, particularly those who may be more likely to be discriminated against due to race, disability or sexual orientation.

They will:

- ensure colleagues' concerns are treated confidentially unless otherwise agreed
- ensure colleagues receive timely support to progress their concern
- escalate to the Board indications if anyone is being subjected to detriment for raising their concern
- remind the organisation of the need to give colleagues timely feedback on how their concern is being dealt with
- ensure colleagues have access to personal support since raising their concern may be stressful.

In August 2017, KCHFT started to develop a freedom to speak up ambassadors' programme and there are now 15 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.

A campaign to promote the benefits of speaking up ran throughout the year and included a range of promotional materials. 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. All new staff receive FTSU guidance at induction.

Between 1 April 2018 and 31 March 2019, the FTSU guardian logged and was involved in 42 cases. Themes of the cases were discussed with the chief executive officer. A six-monthly report is presented to the Board.

# Patient experience

| Goal | Outcome |
|---|---|
| To develop and publish a patient involvement and experience strategy | Achieved |

## Why this is important

To deliver high-quality care at home and in the community we need to build on our culture of listening to and involving patients and carers through sustained engagement, use of patient feedback and the development of co-production to ensure a range of voices are heard and help to shape the development of high-quality services deliver.

## What we did

We worked with our public members and patient representatives to develop and publish a combined communication, engagement and patient experience strategy. The strategy incorporates an action plan which will be driven by the Patient Experience Group.

## What this means for you as a patient

There will be more opportunities for you to provide feedback to work as equal partners with KCHFT to be involved in service design and redesign.

## What we achieved

Strategy and action plan developed and published.

| Goal | 2017/18 | 2018/19 | 2018/19 target | Outcome |
|---|---|---|---|---|
| All relevant patients will have a personalised plan of care | 19% | 32% | 65% | Not achieved |
| Patients will have care plans developed by competent staff | Not measured | 93.3% | 85% | Achieved |

## Why this is important

A growing body of literature shows that patients benefit from being involved in making decisions about their care and in how that care is delivered to meet their needs and wishes. The impacts include:

- improved knowledge of their condition and treatment options
- increased confidence to self-manage aspects of their own care
- increasing the likelihood of keeping to a chosen course of treatment and participating in monitoring and prevention programmes
- improved satisfaction with their care and chosen treatment
- more accurate risk perceptions
- reduced length of hospital stay and readmission rates.

## What we did

We established a working group with representation from clinical services to support the implementation of personalised care plans (PCPs).

We changed the functionality of tablets so personalised care plans could be completed with the patient. This included adjusting the expectation from patients having one care plan, to having a single profession/service care plan.

We produced a video for new staff who want guidance on writing a PCP, as well as developing a personalised care planning elearning course.

Where the PCP is completed, we make sure the patient is given a paper copy for them to keep, with updated copies being provided, as necessary.

## What this means for you as a patient

PCPs aim to ensure you are an equal partner in your health care and will reflect your needs, wishes, goals and choices. They will also help you manage your condition and tell you what support you will receive. If you are unable to make decisions, your care plan will be written in your best interests in consultation with your family and carers, where possible.

## What we achieved

While the outcome has not been achieved, people who receive support from KCHFT do receive care which is personalised to them.

Progress has been made in terms of increasing accessibility and usability of personalised care plans; as well as increasing the number of staff who have received training.

We will be continuing our work on personalised care plans in 2019/20. For patients receiving end of life care, 60.4 per cent had a personalised care plan in place by the end of quater four.

# Patient safety

| Goal | 2017/18 | 2018/19 | 2018/19 target | Outcome |
|---|---|---|---|---|
| 100% of all relevant serious incidents investigations carried out in 2018/19 will involve patients, families and carers from the beginning of the investigation | Not measured | 100% | 100% | Achieved |

## Why this is important

KCHFT promotes a culture that encourages candour, openness and honesty at all levels of the organisation. We are committed to ensure all incidents, complaints and claims involving patients are dealt with openly and honestly. This is an integral part of our safety culture, which supports organisational and personal learning.

Occasionally, things may go wrong and a small number of these incidents may cause harm to patients. When things do go wrong, we have a duty to inform our patients what has happened. We are committed to talking to patients/carers/families at a very early stage to understand what has happened and learn to prevent them happening again to improve patient safety.

We are committed to involving people as equal partners in investigations, providing reasonable support, truthful information and what to expect from the investigation and an apology. This also meets our statutory requirements under regulation 20: Statutory duty of candour.

## What we did

We ensured staff understand what is required of them by raising awareness, providing training and guidance, which is available on our intranet. All new starters receive duty of candour training at induction.

We improved communication with people by making early contact and ensuring any questions are answered in an open, honest and transparent way. We also improved our method of recording our communication with people.

We worked with our patient representatives to develop a duty of candour leaflet to inform people what to expect, provide guidance on the process of the investigation and a single point of contact.

We did an audit of duty of candour compliance and staff awareness and made recommendations for improvements.

## What this means for you as a patient

Our staff have a better understanding of the importance of involving people in patient safety investigations and have the knowledge, skills and resources to ensure this is effective and meaningful and that investigations are person-centred.

Staff will have a variety of resources easily available to support people in process and implementation.

People will be aware of the duty of candour process and where to obtain support, if needed, by way of a single point of contact.

Investigations involve people from the beginning of the investigation and people are able to provide feedback to help improve duty of candour implementation in the trust.

Accurate recording and monitoring of duty of candour will indicate timely and effective support for people and demonstrate the trust is open and transparent when incidents occur.

Review and evaluation of duty of candour processes, staff knowledge and skills and the patient/family feedback ensures staff are competent in carrying out high-quality duty of candour intervention.

## What we achieved

Where relevant we involved 100 per cent of all people from the beginning of an investigation by supporting our staff through guidance and training.

## Why this is important

It is important to understand how patients and families feel about their experience of being involved in the RCA process.

| Goal | Outcome |
|---|---|
| All relevant patients and their families will be surveyed on the RCA process and the experience of their involvement. | Partially achieved |

## What we did

We took the key requirements of regulation 20: Duty of candour and developed a draft survey to enable patients and families to provide feedback on the quality of their interactions with us. This was reviewed by the trust's Patient Experience Group. Amendments were suggested and the draft was revised in response.

The Patient Experience Group wanted the survey to be accompanied by a leaflet describing what people can expect of the investigation process before being given the survey. A leaflet was co-produced and is waiting to be printed.

## What this means for you as a patient

If you are involved in an investigation you will be given a leaflet that explains and helps you understand what you can expect of the process and you may be asked to give feedback on your experience.

## What we achieved

None of the people involved in incidents reported during 2018/19 have yet been asked to complete a survey on the RCA process; however, a leaflet and survey were co-produced with the trust's Patient Experience Group for use in 2019/20.

| Goal | 2018/19 target | Outcome |
|---|---|---|
| To ensure learning from serious incidents (SI) and complaints investigations are shared with all relevant managers and teams. | Each meeting will include a patient story from a complaint and a serious incident investigation | Achieved |

## Why this is important

- To prevent recurrence of similar incidents.
- To enable other teams to learn from investigations completed across the organisation.
- To ensure patient stories are heard at all levels of the organisation
- To share best practice in relation to duty of candour, being open and transparent and learning when things go wrong.

## What we did

Teams which had been involved in serious incidents and complaints presented their learning at the next available Quality Improvement Network meeting. They presented the story of the incident, the outcome for the patient and what they had done to support staff and patients, carers and families.

They talked about the lessons they had identified and the changes they made to prevent recurrence. Patients were asked to film their story for the Board. These were also shared at the meetings and discussed by staff.

## What this means for you as a patient

When something goes wrong with care, this is fully investigated and changes made to practice. The patient story will be heard across the organisation and learning and changes will be implemented across all services.

## What we achieved

Every meeting of the Quality Improvement Network heard and discussed a patient story.

# Clinical effectiveness

| Goal | 2018/19 target | Outcome |
|---|---|---|
| Develop and deliver our quality improvement training plan | 50 colleagues completed quality, service improvement and redesign (QSIR) practitioner training by end of March 2019. | Achieved |
| | 300 individuals completed 1 day QI fundamentals training by November 2019 | On track to achieve in November 2019 |

## Why this is important

The Kings Fund report Making the case for quality improvement, co-authored with the Health Foundation in October 2017, highlights QI benefits are greater if quality improvement techniques are applied consistently….across organisations and that 'even relatively small-scale quality improvement initiatives can lead to significant benefits for patients and staff'.

Building on this evidence, KCHFT introduced two levels of QI training:

- Quality, service improvement and redesign (QSIR) practitioner training details a comprehensive quality improvement methodology. Training colleagues ensures a consistent approach to QI projects across the trust and facilitates building capacity and capability, providing tools and techniques to enable colleagues to make change happen.
- Quality improvement fundamentals is a one-day course for colleagues, volunteers, patients and others using our services. It's an interactive and fun opportunity to learn the key elements and tools of quality improvement.

## What we did

A five-year quality improvement training plan was developed, which commenced with six colleagues becoming QSIR teaching faculty associates, enabling QSIR courses to be delivered internally.

By the end of March 2019, two QSIR practitioner and two QI fundamentals courses were delivered.

## What this means for you as a patient

Our commitment to our quality improvement journey will result in improvements to services and patient care across the trust.

## What we achieved

By the end of March 2019, two QSIR practitioner cohorts were delivered, with 66 colleagues completing the five-day course, with five more QSIR practitioner courses scheduled for 2019/20.

Two QI fundamentals courses took place with 56 individuals completing, including a patient representative. There are seven more QI fundamentals courses scheduled for 2019/20.

## Comments from colleagues include:

"Thank you for a fun, friendly course. I have learned a great deal and it has helped me to make a plan for changes I am intending to make."

"I will definitely use in practice what I leared today."

| Goal | 2018/19 target | Outcome |
|---|---|---|
| 20 quality improvement projects completed or active by end of March 2019 | 20 quality improvement projects completed or active in one year that focus on four areas:<br>• Increasing joy at work.<br>• Improving patient outcomes.<br>• Reducing duplication and inefficiencies.<br>• Improving patient experience and delivery of safe care. | Achieved |

## Why this is important

QI projects are a primary driver of improvements in and across services and organisations. The more volume and variety of successfully completed projects, the greater amount of demonstrable improvement has taken place using consistent methods.

## What we did

We made completion of a QI project a commitment for QSIR practitioner training – ensuring that, as a minimum, the number of projects would closely align with the number of QSIR practitioners in the organisation. And, where appropriate, for the projects to be aligned to one or more of the key focus areas.

## What this means for you as a patient

Ensuring continuing improvement work is done with patient care and outcomes at the centre.

## What we achieved

At the end of March 2019 there were 68 active QI projects:

- 31 aligned to joy at work
- 11 aligned to improving patient outcomes
- 5 aligned to reducing duplication and inefficiency
- 11 aligned to improving patient experience and delivery of safe care.
- 10 related to other themes.

# Staff experience

| Goal | 2017/18 | 2018/19 | 2018/19 target | Outcome |
|---|---|---|---|---|
| Participate in the NHS Retention Improvement collaborative. Our aim in 2018/19 will be to reduce staff turnover by 2% | 18.47% | 17.87% | 16.47% | Not achieved |

## Why this is important

High staff turnover can result in an impact on staff morale which, in turn, may affect the quality of patient care. In addition, it can cause higher costs due to the need to use agency staff.

## What we did

The Strategic Workforce Committee was established at the beginning of 2018/19 to provide advice and assurance to the Board on all matters relating to workforce planning, strategy and pay and rewards. It is also responsible for organisation development, including health and wellbeing and equality and diversity.

In June 2018, we did the Big Listen. This was an internal engagement campaign to gain qualitative feedback from colleagues to improve staff retention.

The initiative featured a confidential and anonymous 24-hour online survey, along with two lunchtime focus groups. As a result of the feedback, we developed an action plan to address the issues raised. Some of the actions are identified below:

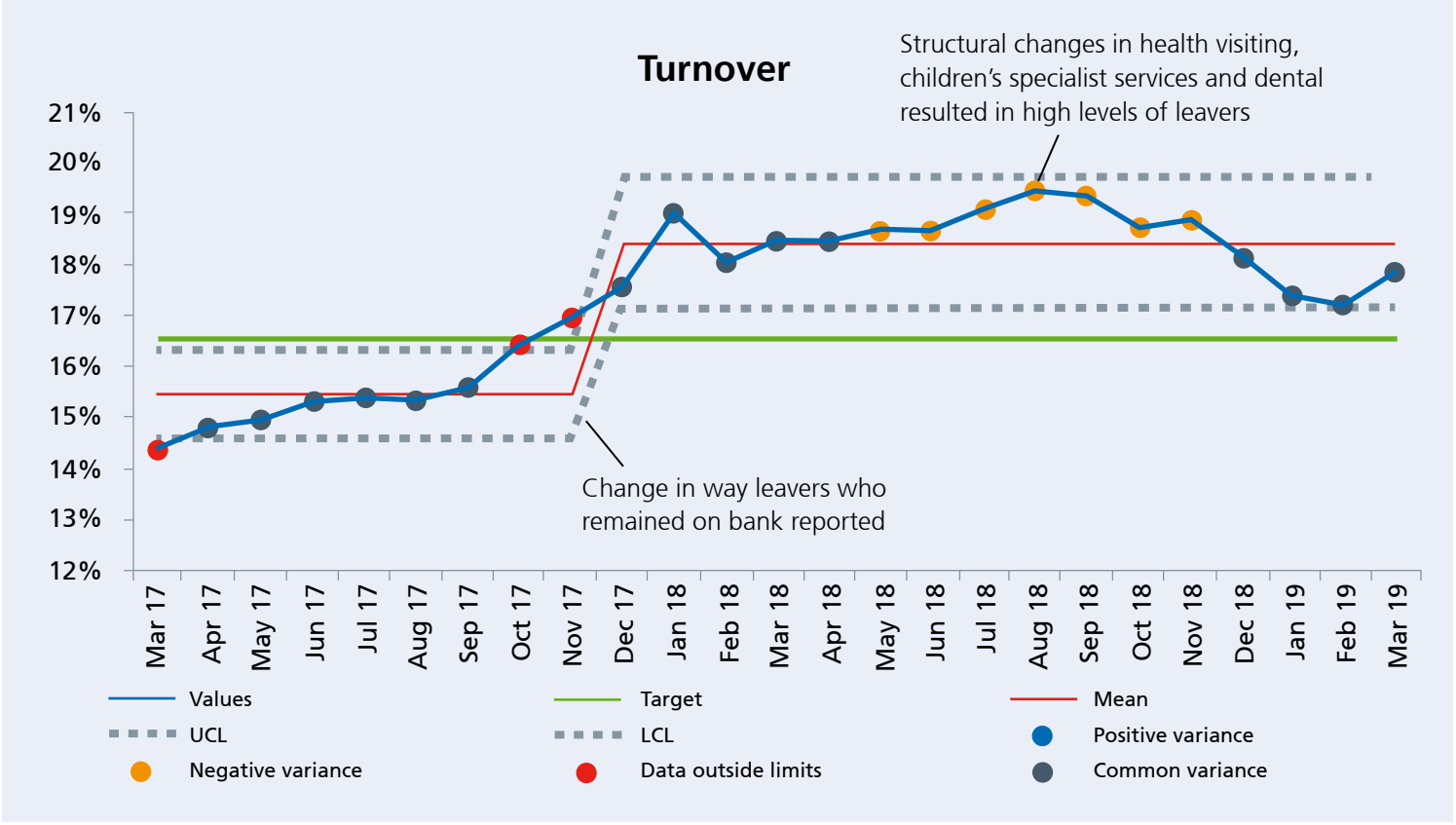
- We introduced a talent management programme to identify people with outstanding levels of achievement in their appraisal, who wish to progress.
- The health and wellbeing of our workforce is really important, so we introduced health check machines and 120-plus people signed up to become Time to Change mental health champions.
- We launched the Nursing Academy to ensure our future staffing pipeline. We recruited 22 nursing apprentices and 23 nursing associate apprentices. Once their apprenticeship is complete, they will join us as permanent members of the team.
- We held a cut the red tape campaign where staff were asked to identify aspects of their work, which could be changed to release more time to get involved in quality improvements that positively impact on patient care and experience.
- We are introducing self-managed teams, which will have the authority to make decisions about caseload, recruitment, office, supplies, roles, budgets, coaching and more – all in line with an agreed framework.

## What this means for you as a patient

Reducing workforce instability and staff turnover rates will have a positive effect on the quality of care you receive, through reducing delays in delivering patient care and workflow inefficiencies whilst improving patient safety, patient experience and staff morale.

## What we achieved

We made significant progress; however turnover is experiencing common cause variation and is failing to meet the target. We have seen a downward trend in turnover in recent months as the outputs of the Big Listen are implemented.



# Abbreviations

| | |
|---|---|
| BASHH | British Association for Sexual Health and HIV |
| CARE values | Compassionate, aspirational, responsive, excellent |
| CCG | Clinical commissioning group |
| CQC | Care Quality Commission |
| CQUINs | Commissioning for Quality and Innovation |
| DNACPR | Do not attempt cardio-pulmonary resuscitation |
| DSPA | Data security and protection assessment |
| FFT | Friends and family test |
| HIV | Human Immunodeficiency Virus |
| HMP | Her majesty's prison |
| KCHFT | Kent Community Health NHS Foundation Trust |
| KLOE | Key lines of enquiry |
| NCEPOD | National confidential enquiries into patient outcome and death |
| NHS | National Health Service |
| NHSI | NHS Improvement |
| NSU | Management of non-specific urethritis |
| PCP | Personalised care plans |
| QI | Quality improvement |
| QSIR | Quality, service improvement and redesign |
| RAG status | Red, amber, green |
| RCA | Root cause analysis |
| RCP | Royal College of Physicians |
| ROCAIP | Reason, observation, comment, assessment/analysis, intervention, plan |
| RTT | Referral to treatment |
| SI | Serious incident |
| SMART | Specific, measurable, attainable, realistic, timely |
| SSNAP | Sentinel Stroke National Audit Programme |

# Annex 1

## Statements from commissioners, local Healthwatch organisations and overview and scrutiny committees

*Sent on behalf of Cllr Colin Belsey, Chair of East Sussex HOSC*

Dear Vicky Ellis

Thank you for providing the East Sussex Health Overview and Scrutiny Committee (HOSC) with the opportunity to comment on your Trust's draft Quality Report 2018/19.

On this occasion the Committee has not provided a statement as we do not have any specific evidence to submit to you. However, we look forward to an ongoing involvement in the development of future Trust Quality Reports.

Please contact Harvey Winder, Democratic Services Officer, on 01273 481796 should you have any queries.

Councillor Colin Belsey

Chair
Health Overview and Scrutiny Committee

Kent County Council
kent.gov.uk

*Sent via email*
kcht.qualityaccount@nhs.net
Vicky Ellis
Assistant Director, Clinical Governance
Kent Community Health NHS Foundation Trust
The Oast, Unit D, Hermitage Court
Maidstone
Kent
ME16 9NT

**Members Suite**
Kent County Council
Sessions House
County Hall
Maidstone
Kent
ME14 1XQ

Direct Dial: 03000 416512
Email: HOSC@kent.gov.uk
Date: 3rd May 2019

Dear Vicky,

**Draft Kent Community Health NHS Foundation Trust Quality Account 2018/19**

Thank you for offering Kent County Council's Health Overview and Scrutiny Committee the opportunity to comment on the Kent Community Health NHS Foundation Trust's Quality Account for 2018/19. HOSC has received a number of similar requests from Trusts providing services in Kent, and we may well receive more.

Given the number of Trusts which will be looking to KCC's HOSC for a response, and the window of 30 days allowed for responses, the Committee does not intend to submit a statement for inclusion in any Quality Account this year.

Please be assured that the decision not to comment should not be taken as any reflection on the quality of the services delivered by your organisation and as part of its ongoing overview function, the Committee would appreciate receiving a copy of your Quality Account for this year once finalised.

Kind regards

Sue Chandler
**Chair, Health Overview and Scrutiny Committee**
**Kent County Council**

kent.gov.uk

We welcome the Quality Account for Kent Community Hospitals NHS Trust. The CCGs have a responsibility to review the Quality Accounts of the Trust each year, using the Department of Health's Quality Accounts checklist tool to ascertain whether all of the required elements are included within the document and the CCG confirms that the Quality Account has been developed in line with the national requirements with all of the required areas included.

The quality account is set out according to the department of health guidance and clearly sets out what the 2018/19 priorities were and explains in concise detail where these have been met or not met. It is noted where a priority has not yet been met, as with the action to have all patients with a personalised plan of care, or the reduction of staff turnover by 2%, there has been significant improvement in these areas with further work planned in the coming year. The benchmarking against other community health providers in the report showed that the organisation is performing well against the national average.

We support the coming year's priorities and there is clear detail on how you plan to work towards achievements of these goals with clear and measurable targets set.

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 service provision. The CCG 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.

Paula Wilkins
Chief Nurse for Medway, North and West Kent Clinical Commissioning Groups

Ashford and Canterbury and Coastal CCGs
Ground Floor
Canterbury Council Offices
Military Rd
Canterbury
CT1 1YW

Paul Bentley
Kent Community Health NHS Foundation Trust
The Oast
Hermitage Court
Maidstone
ME16 9NT

22nd May 2019

**East Kent CCGs KCHFT Quality Account Comments 18/19**

Dear Paul,

East Kent CCG's (Ashford, Canterbury, SKC and Thanet CCG) welcome the 2018/19 Quality Account submitted by KCHFT. We have reviewed the information provided by KCHFT and our view is that the report is materially accurate. It is presented in the format required by the Department of Health's toolkit and the information it contains accurately represents the Trust's Quality profile.

East Kent CCGs are pleased to note the overall reduction in harm for patients receiving care in East Kent. The work being implemented to ensure that service users and patients are involved in planning their care alongside KCHFT is applauded and we look forward to this being further embedded in practice.

East Kent CCGs welcome KCHFT's approach to Quality Improvement and the opportunities this affords for Quality Improvement across the system. We look forward to the opportunity to work collaboratively together to identify Quality Improvements for service users in East Kent CCGs.

East Kent CCG's support KCHFT's priorities for the year ahead: personalised plans of care, including end of life, to improve the overall experience for patients and their families; recognition of human factors that contribute towards error (and roll out of their QSIR practitioner and fundamentals courses to support staff delivery of this priority) and implementation and embedment of NEWS2 across the Trust's community hospitals.

East Kent CCGs acknowledge the work that has been undertaken by KCHFT to support the delivery of local care and look forward to continuing to work closely with KCHFT colleagues, during 2018/19, to assure the quality of local services and ensure the culture of continuous improvement.

Yours sincerely

Sarah Vaux
Chief Nurse – East Kent CCG

The four clinical commissioning groups (CCGs) in east Kent are working together to improve healthcare across their communities
NHS Ashford CCG - NHS Canterbury and Coastal CCG - NHS South Kent Coast CCG - NHS Thanet CCG

# 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 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.

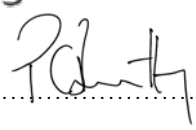
In preparing the quality report, directors are required to take steps to satisfy themselves that:

- the content of the quality report meets the requirements set out in the NHS foundation trust annual reporting manual 2018/19 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 2018 to March 2019
    - papers relating to quality reported to the board over the period April 2018 to March 2019
    - feedback from commissioners: Dartford, Gravesham and Swanley; East Kent; Medway; Swale and West Kent clinical commissioning groups dated 20 May 2019 and 21 May 2019
    - feedback from governors dated May 2019
    - feedback from local Healthwatch organisations (not received)
    - feedback from Overview and Scrutiny Committee dated 26 April 2019
    - the trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, dated May 2019
    - the 2018 National Staff Survey
    - the head of internal audit's annual opinion of the trust's control environment dated 19 April 2019
    - CQC inspection report dated September 2014
- the quality report presents a balanced picture of the NHS foundation trust's performance during 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 above requirements in preparing the quality report.

By order of the Board.

..... **John Goulston**, Chair Date 23 May 2019



..... **Paul Bentley**, Chief Executive Officer Date 23 May 2019

# 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 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 2019 (the "Quality Report") and certain performance indicators contained therein against the criteria set out in the 'NHS foundation trust annual reporting manual 2018/19' and additional supporting guidance in the 'Detailed requirements for quality reports 2018/19' (the 'Criteria').

**Scope and subject matter**

The indicators for the year ended 31 March 2019 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: selected from the subset of mandated indicators as this was the only indicator mandated for Community Trusts which was applicable to the Trust.
- 100% of all relevant RCA for serious incidents undertaken in 2018-19 will involve patients, families and carers from the beginning of the investigation: selected from the subset of quality indicators following discussion with the client and taking into account the Trust's 2018/19 quality priorities.

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 2018/19' 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 2018/19' 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 2018/19'; 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 2018/19' and supporting guidance and the six dimensions of data quality set out in the ''Detailed requirements for external assurance for quality reports 2018/19'.

We read the Quality Report and consider whether it addresses the content requirements of the 'NHS foundation trust annual reporting manual 2018/19' 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 2018 to May 2019;
- papers relating to quality reported to the Board over the period 1 April 2018 to May 2019;
- feedback from commissioners dated 20 May 2019;
- feedback from local Healthwatch organisations dated May 2019;

- feedback from the Overview and Scrutiny Committee dated 26 April and 3 May 2019;
- the Trust's complaints report published under regulation 18 of the Local Authority, Social Services and National Health Service Complaints (England) Regulations 2009, dated 20 May 2019;
- the national staff survey dated 2017;
- the local staff survey dated 2018;
- the Head of Internal Audit's annual opinion over the Trust's control environment dated May 2019; and,
- the Care Quality Commission's inspection report dated 2 September 2014.

We consider the implications for our report if we become aware of any apparent misstatements or material inconsistencies with these 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 2019, 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 2018/19' and supporting guidance to the categories reported in the Quality Report; and
- reading the documents.

A limited assurance engagement is narrower 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 2018/19' 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 and is subject to separate terms and conditions. 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 2019:

- 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 2018/19' 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 2018/19'; and
- the indicators in the 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 2018/19' and supporting guidance.

***Grant Thornton UK LLP***

Grant Thornton UK LLP

Chartered Accountants

110 Bishopsgate, London, EC2N 4AY

24 May 2019