Kent Community Health NHS
NHS Foundation Trust

Annual Report And Accounts

1 March 2015 to 31 March 2015

Kent Community Health NHS Foundation Trust
Annual Report and Accounts 1 March 2015 to 31 March 2015
Presented to Parliament pursuant to Schedule 7, paragraph 25 (4) (a) of the National Health Service Act 2006

Contents

Strategic Report: Introduction

Welcome to our fourth annual report.

Over the last four years our Trust has been through a process of major change and progress. We merged two predecessor organisations, aligned ourselves to Clinical Commissioning Group boundaries, innovated in a number of areas and increased provision of services in and outside of Kent. Our relentless focus on quality continued ensuring that all our services are safe and provide the best quality care for our patients.

In June 2014 we were inspected by the Care Quality Commission and given a rating of GOOD. On 1 March 2015 we were authorised as a Foundation Trust.

Our highlights, our performance against key indicators and our accounts between 1 April 2014 and 28 February 2015 are included in a separate annual report. This report covers our performance and accounts for the period from 1 – 31 March when we were operating as a Foundation Trust.

During the past year there has been significant change for our staff who have responded positively to the challenges and opportunities this brings. They have remained dedicated to providing high quality services for their patients delivered with care and compassion. Staff were more likely than their colleagues nationally to recommend their Trust's services to their friends and family and their Trust as a place to work.

Working closely with our partners in health and social care and the voluntary sector is vital to delivering our vision. This collaborative working has been strengthened through sub-contracting and formal working arrangements such as integrated discharge teams.

Community involvement has continued to grow. At the end of March 2015 we had almost 11,000 public members, a Council of Governors in place and involvement from patients on many of our committees and working groups. Every community hospital had a patient engagement group and our volunteers continued to provide a valued service.

The Trust ended the period covered by the report within budget and made a small required surplus which was invested in capital projects. We had the second lowest costs of any NHS community health provider in England and our financial risk rating remains at the best possible score, a Level 4.

It is the responsibility of the Board of Directors to prepare the annual report and accounts and we consider them, taken as a whole, to be fair, balanced and understandable and provide the information necessary for patients, regulators and other stakeholders to assess the Trust's performance, business model and strategy.

Kind regards,

David Griffiths
Chairman

Date 28/05/2015

Marion Dinwoodie
Chief Executive

Date 28/05/2015

Section one: Who we are and what we do

Kent Community Health NHS Foundation Trust was formed in April 2011. We are one of the largest providers of NHS care in patients' homes and in the community in England. Our budget for 2014/15 was £239million. We employ in the region of 5,500 members of staff in a wide range of clinical and support roles. We serve two million people; 1.4million living in Kent and 600,000 people in areas outside of Kent, where we provide services.

We have 3million contacts with patients a year, many of these are in their own homes and in other locations, including GP surgeries, nursing homes, health clinics, community hospitals, minor injury units and children's centres.

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

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

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

Our health and wellbeing 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 needs. Sexual health services encourage safe sex and provide contraception, family planning and treatment.

If people do become ill and need treatment, there are seven minor injury units across Kent. We also provide emergency and specialist dental treatment.

A range of other specialist services, including therapists, podiatry, wheelchairs, orthopaedics and chronic pain are provided in the community so that 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 go into hospital unnecessarily.

We have a rapid response service 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 a package of care in place to enable the patient to stay at home rather than go to hospital.

Step-up and step-down care is provided in the county's 12 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 provide care for disabled children and adults.

The Annual Accounts describe the Trust's end of year financial position and key financial performance information. 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. The principle risks and uncertainties facing the Trust are included in the Annual Governance Statement on page 29. For more

information about the Trust's full range of services please visit our website www.kentcht.nhs.uk or contact us using the information on the back of this report.

Our mission, vision and values

Our mission is to provide high-quality, value for money community-based services to prevent people from becoming unwell, to avoid people going into hospital or to leave earlier and to provide support closer to home.

Kent Community Health NHS Foundation Trust's vision is to be the provider of delivering excellent care and improving the health of our communities. We will achieve this through these five core values:

- caring with compassion
- listening, responding and empowering
- leading through partnerships
- learning, sharing and innovating
- striving for excellence.

Our strategic goals

1. Preventing people from becoming unwell and dying prematurely by improving the health of the population through universal targeted services.
2. Enhancing the quality of life for people with long-term conditions by providing integrated services to enable them to manage their condition and maintain their health.
3. Helping people recover from periods of ill health or following injury through the provision of responsive community services.
4. Ensuring that people have a positive experience of care and improved health outcomes by delivering excellent healthcare.
5. Ensuring people receive safe care through best practice

Strategies that support our work

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

Our enabling strategies help secure:

- Care which is safe, clinically effective and improves the patient experience (Clinical Strategy, Governance and Quality)
- Patient and Carer Partnerships (Communication and Engagement)
- Clinical leadership and culture development (Workforce and Organisational Development)
- Information knowledge management
- The Trust will push the boundaries of community health care to develop new, more innovative, cost effective pathways with our partners (Transformation Framework).

Section two: performance against our strategic goals

Strategic Goal 1: To prevent people from becoming unwell and dying prematurely by improving the health of the population through universal targeted services.

During 1 March 2015 – 31 March 2015

- We helped 280 people to stop smoking, this is 36.3% of our overall target of 771 for the month, however 88.2% of smoking quits were verified through Carbon Monoxide readings, exceeding the national benchmark of 70.4%
- We built on the 3273 positive results for the first 11 months of the year (84.6% of the target) for Chlamydia screening, with an additional 149 positive results in the month.
- 4153 people were invited for a Health Check, 3595 checks were carried out which is an uptake rate of 86.6%.
- We achieved our target of 60% for increased uptake of child perinatal mental health assessment at 78%.
- We met our target of health visitor recruitment by April 2015; we now have 343.5 whole time equivalents, exceeding our target of 342.2 WTE.

Strategic Goal 2: To enhance the quality of life for people with long-term conditions by providing integrated services to enable them to manage their condition and maintain their health.

During 1 March 2015 – 31 March 2015

- We achieved 89.75% of our targeted total number of face to face contacts with patients with long-term conditions and achieved our target for intermediate care and rehabilitation patients by 91.1%.
- We exceeded our 4% target for patients who “Did Not Attend” appointments with a percentage of just 1.2%.
- We have increased the number of patients being managed using Teletechnology which enables people to remain at home and have their vital signs monitored by staff remotely. We now have 609 patients using Teletechnology. This was 131.5% of our 463 target.

Strategic Goal 3: To help people recover from periods of ill health or following injury through the provision of responsive community services.

During 1 March 2015 – 31 March 2015

- We exceeded our less than 18.5% target for people being readmitted to an acute hospital following care in one of our step down beds with just 9.5% needing to be readmitted.
- 99.98% of people waited less than 4 hours in our Minor injury Units.
- 100% of people were treated within 18 weeks of referral to our consultant led services.
- 100% of people had access to Genito Urinary Medicine within 48 hours of contacting us
- We exceeded our target for patients supported to remain out of hospital, 1,267 patients avoided a hospital admission, 87% above our target
- We had 89.6% of our beds occupied, within our target of between 87-92%
- The length of time patients needed to be in a community hospital ward increased to 27.6 days, at the end of the March from 23.2 days at the start.
- Our delayed transfers of care increased from 4.2% to 15% against our target of 3.5% for this month.

Strategic Goal 4: To ensure that people have a positive experience of care and improved health outcomes by delivering excellent healthcare.

During 1 March 2015 – 31 March 2015

- The Trust's overall patient satisfaction score was 96.7% based on 5,074 surveys.
- There were 61 complaints. The top three themes were treatment, staff attitude and access to appointments. This equates to 1 complaint per 5,000 patient contacts.
- There were 5 complaints about staff attitude. Or 1 complaint per 35,000 patient contacts.
- We asked 24.4% of patients in minor injury units and inpatient wards if they would recommend the service to friends and family, exceeding our target of surveying 15% of patients. Our Friends and Family Test Score was 96.8%, exceeding our target of 95%.
- 100% of patients died in their preferred place, better than our target of 90%.
- 92.6% per cent of patients achieved their desired outcomes following planned care and therapy services, our target was at least 80%.

Strategic Goal 5: To ensure people receive safe care through best practice.

During 1 March 2015 – 31 March 2015

- There was 1 incidences of C.Diff, compared to 0 in the same period last year.
- There was 0 incidence of MRSA attributed to the Trust
- There have been 0 "never events"
- There were 0 falls resulting in fractures in March
- Our safety thermometer which measures the level of harm free care in the Trust is better than our 95% target at 98.59%
- We were 100% compliant with NICE guidance
- There were 2 grade 3 and 4 attributable and avoidable pressure ulcers, 3 less than the same period the previous year. Our target was less than 3 for the month

Our staff

During 1 March 2015 – 31 March 2015

- Overall we exceeded our mandatory training target of 85%, achieving 92.1%.
- Sickness absence was lower than our 4% target at 3.68%
- Unplanned turnover exceeded our 8% target at 16% for the month
- We did not quite reach our target of a less than 5% vacancy rate, at 5.1%, however, the Trust continues with a rigorous recruitment campaign.

The gender distribution of our workforce is:

	Female	Male	Total	% Female	% Male	% Total
Directors	4	3	7	57.14%	42.86%	100.00%
Senior Managers	23	8	31	74.19%	25.81%	100.00%
Employees	5050	542	5592	90.31%	9.69%	100.00%
Total	5077	553	5630	90.18%	9.82%	100.00%

Sustainability report

The Trust continues to drive improvements in its environmental performance towards the targets set by the Department of Health for reducing its carbon footprint due to energy use, procurement and waste disposal. The Trust is committed to achieving a more sustainable future, recognising the need to minimise its impact on the environment in order to deliver the highest quality healthcare to the communities we serve, now and into the future. By conserving the natural environment and its resources, the Trust aims to meet national targets to reduce our carbon footprint, increase focus on using renewable energies, invest in more sustainable technologies and reduce waste.
Strong climate and energy policies that promote investment in energy efficiency, renewable energy and other low-carbon solutions are essential for the transition to a sustainable economy. This report has been prepared in line with guidance issued by the NHS Sustainable Development Unit.

Carbon and energy management

The Trust's carbon management plan continues to be developed, which will help The Trust to achieve its 2016 NHS carbon reduction target. As part of our Building Management System (BMS), £10k has been invested in energy efficiency measures, specifically lighting improvements at the Trust HQ and two other large administrative hubs in east Kent. During this financial year, the programme has been rolled out into smaller administration areas and will continue to focus on these into the next year. As a direct result of this investment, electricity consumption is down by approximately 110,816 kWh, a 42 per cent drop against the previous year's figures on these sites and continues at a similar rate year on year.

Waste

The Trust has seen an increase in non-clinical waste recycled, resulting in a reduction in waste sent to landfill, which in turn reduces CO^2 emissions. Waste recycling schemes include cardboard baling and mixed waste segregation, which are currently deployed in non-clinical areas are part of a plan to extend these to the whole organisation during 2015/16.
Working with waste management providers, the Trust has reduced the number of waste vehicle movements, giving an indirect CO^2 emissions reduction. Waste segregation schemes include reclassification of clinical waste allowing more appropriate methods of disposal with lower carbon intensity. The Trust is currently implementing a programme to replace hand towel dispensers with hand dryers, which will reduce general waste across the county.

Sustainable procurement

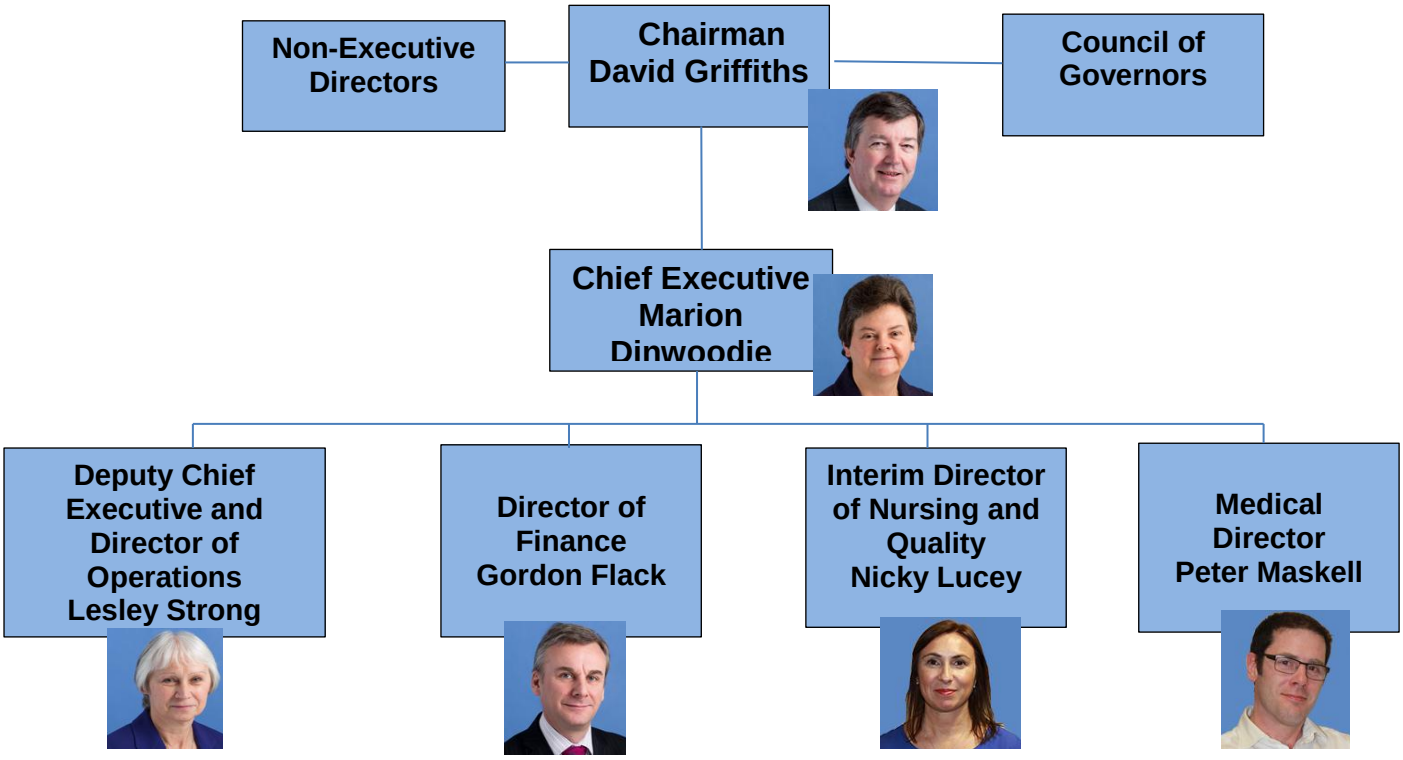
The Trust aims to reduce the social and environmental impacts from the purchase, use, and disposal of the products we procure. The Trust seeks to promote and maintain high standards of social, ethical and environmental conduct across its procurement activities and work with its suppliers to make sure they also adopt this approach.

Priorities for 2015/16:

- Maximise return on investment through continuous commissioning of the building management system and other energy saving initiatives
- Develop and Environmental Management System (EMS) that helps to mitigate the implications of activities, minimising the impact on climate change
- Increase staff awareness of the Trust's responsibilities to reduce its carbon emissions and how they can support the EMS
- Minimise waste through reducing reliability on plastic based packaging and replacing it with cardboard based alternatives

Directors' Report Section four: Management arrangements

The Foundation Trust's Board



Portfolios of executive voting board members include:

- The Chief Executive: Has overall executive accountability to the board
- The Deputy Chief Executive/Director of Operations: Leads on operations and information technology
- The Director of Finance: Leads on audit, finance, performance, information management, and commercial services.
- The Director of Nursing and Quality: 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.

In March 2015, the Leadership Team consisted of four additional posts, accountable to the chief executive:

- Trust Secretary: Includes regulatory framework, members and governors, governance and risk
- Director of Workforce, Organisational Development and Communications
- Director of Operations, Children and Young People: Includes universal targeted and specialist children's services, dental services and estates.
- Strategy and Transformation Director: Includes Trust Strategy, business planning and transformation

The Board of Directors is responsible for setting the vision and strategy of the organisation and for the overall performance of the organisation. This is informed by the views of the Council of Governors, following consultation with Foundation Trust members. The membership of the Board is consistent

with the requirements of the Foundation Trust's constitution and the non-executive directors' skills and experience ensures that there is sufficient scrutiny of executive decision making. The Board meets in public every two months. The Board delegates responsibility for the day-to-day implementation of strategy through appropriate management systems to executive officers of the Trust.

All board members have confirmed their support for, and adherence to, the code of conduct for NHS board members. All non-executive directors are considered to be independent. The Board considers that the Annual Report and Accounts taken as a whole are fair, balanced and understandable; and provide the information necessary for patients, regulators and other stakeholders to assess the Trust's performance, business model and strategy.

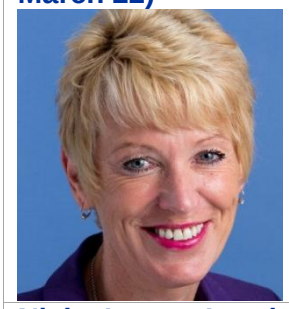
Directors' roles and responsibilities

David Griffiths, Chairman 	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 than12 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 chairman of Kent Community Health NHS Foundation Trust, he held these posts: • non-executive director of Kent and Medway Strategic Health Authority • chairman of Swale Primary Care Trust • chairman of NHS West Kent • interim chairman 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
Jennifer Tippin, Non-executive Director 	Jennifer has extensive experience as a senior executive in a wide range of industries. She is currently the managing director of small business banking for Lloyds Banking Group and a member of the Retail Executive Committee. She has a breadth of skills including leading major transformational change, improving customer service and delivering strong commercial results. Together with her husband and three young children, Jennifer lives in Hildenborough, Kent. • chairman of Kent Community Health NHS Foundation Trust's Charitable Funds Committee • Member of the Finance, Business and Investment Committee

Catherine Gaskell, Non-executive Director 	Catherine Gaskell has worked in healthcare for 30 years. She has held Chief Executive and Deputy Chief Executive positions and has been Director of Nursing in community and mental health trusts. She has carried out investigations and provided training in the acute sector and has worked for the past five years advising trusts on patient safety, patient experience, clinical governance and improving clinical practice. Catherine lives in Bromley, Kent. She is: • member of Kent Community Health NHS Foundation Trust's Quality Committee and Patient Experience Committee • non-executive lead for complaints • managing Director of The Results Company, a consultancy specialising in healthcare and estates management. • healthcare trainer working with Understanding Modern Government. • trustee of TalkEasy Trust (mental health promotion and anti-bullying awareness for teenagers)
Bridget Skelton, Non-executive Director 	Bridget Skelton 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 expertise to effect business transformation, enhance performance and manage cultural development and change. Bridget lives in Otterden, Kent. She is: • member of Kent Community Health NHS Foundation Trust's Finance, Business and Investment Committee plus Audit and Risk Committee • Managing Director of Bridget Skelton Ltd a consulting business specialising in Executive and Board Development • trustee of Demelza Hospice Care for Children • Trading Director and Member of Finance and Fundraising Committee at Demelza Hospice Care for Children • former Director and Managing Partner of PA Consulting Group • former Practice Group Head Partner of the Global Business Transformation Group
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 now has a portfolio of primarily public sector roles and these include: • chairman of Kent Community Health NHS Foundation Trust's Audit and Risk Committee • non-executive director and audit chair of the Rural Payments Agency • independent member of the Audit Committee of the Ministry of Justice • trustee director of Tonbridge Citizens' Advice Bureau Previous roles include Non-Executive Director and Audit Chair of NHS West Kent and Independent Member/Audit Committee roles with the Home Office, DEFRA, the Health and Safety Executive and the Child Maintenance and Enforcement Commission. Peter and his family have lived in Kent for 22 years.

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. He has also worked in the animal feeds business and is now carrying out consultancy work with a large animal feeds manufacturing organisation. He is: • member of Kent Community Health NHS Foundation Trust's Audit and Risk Committee and Charitable Funds Committee • chair of Kent Community Health NHS Foundation Trust's Finance, Business and Investment Committee • chairman of Age UK Canterbury • trustee of Age UK Sheppey • director of the Canterbury Academy • member and past president of the Canterbury Forest of Blean Rotary Club • former non-executive director of Eastern and Coastal Kent Community Services NHS Trust • former regional manager within a Unilever Agribusiness • former regional general manager of Dalgety Agriculture • former non-executive director of St Nicholas Court Farms Ltd
Steve Howe CBE, Non-executive Director 	Steve served for 39 years in The Royal Army Medical Corps in command and staff appointments. He is: • chair of Kent Community Health NHS Foundation Trust's Quality Committee • former non-executive director of Eastern and Coastal Kent Community Services NHS Trust • former brigade commander (chief executive) 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 • a fellow of the Institute of Healthcare Management
David Robinson, Non-executive Director 	David has senior board experience in executive and non-executive roles. Executive roles have been in public affairs and government relations, including reputation and media management, crisis communications and government communications in both the private and public sector, nationally and internationally. He is: • member of Kent Community Health NHS Foundation Trust's Quality Committee • Kent Community Health NHS Foundation Trust's Senior Independent Director • Kent Community Health NHS Trust's nominated NED contact for whistleblowing • Chair of Governors at Fulston Manor Academy and member of the multi-academy strategic board • former director of public affairs, Texaco • former executive director communications and marketing with the Qualifications and Curriculum Authority (QCA) • former non-executive director of Eastern and Coastal Kent Community Services NHS Trust

Marion Dinwoodie, Chief Executive 	Marion has many years' experience working in the NHS, starting in hospital pharmacy and then moving into general management. In 1985 she managed children's, maternity and community services as unit general manager in Harrow. She set up NHS trusts in North West Thames Regional Health Authority and primary care groups in Tyneside. She moved to Kent to take on the role of chief executive of Ashford Primary Care Trust when it was first established. Kent Community Health NHS Foundation Trust is the sixth chief executive role Marion has held in Kent and Medway. She has held the following roles: • panel member, Independent Commission on Whole Person Care • member of Department of Health steering groups, for example Year of Care Tariff for Long-term Conditions and Dental Practitioners' Contract Review • member of the governing body of Health Education Kent, Surrey and Sussex and Chair of the Kent Partnership Council • led transformation roles in Kent, e.g. Choose and Book, commissioning a patient-led NHS • led commissioning roles in Kent, e.g. Chair, Kent Joint Commissioning Board for Mental Health; Chair, Kent Cancer Network; Chair, Kent and Medway Collaborative Commissioning Board and Chair, South East Coast Commissioning Rules Panel • member, South East Coast Enhancing Quality Committee. • was professional secretary and editor of the Guild of Hospital Pharmacists
Lesley Strong, Deputy Chief Executive/Director of Operations 	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 also responsible for Information Technology. Lesley is: • former primary care trust director of nursing and operations, Mid Sussex 2001 • former director of children's services, West Sussex 2007 • former chief operating officer, East Sussex 2008 • former managing director, Greenwich Community Health Services 2011
Peter Maskell, Medical Director 	Peter qualified from The Royal Free Hospital School of Medicine in 1995. He trained in general and elderly medicine at St Thomas' Hospital/Brighton and Sussex University Hospital. Peter became a consultant in general and geriatric medicine with an interest in stroke medicine at Maidstone and Tunbridge Wells NHS Trust in 2005. He undertakes sessions as a stroke physician at Maidstone and Tunbridge Wells NHS Trust. His responsibilities at Kent Community Health NHS Trust include clinical strategy, quality, Caldicott Guardian, medical revalidation, clinical audit and research and development.

Karen Proctor, Director of Nursing and Quality (until March 22) 	Karen Proctor has worked in the NHS for 30 years, clinically and managerially, in a variety of primary and secondary care organisations up and down the country. A large part of Karen's career has been managing children's maternity services and has always managed to maintain some clinical practice to date in both areas. Her last role was a combined one as Deputy Chief Operating Officer/Director of Nursing. Karen is a registered nurse by background, has a thorough understanding of clinical practice and brings to KCHT broad nursing and operational experience.
Nicky Lucey, Interim Director of Nursing and Quality 	During her career Nicky has held a number of senior roles, most recently director of clinical standards at Portsmouth Hospitals NHS Trust. Her wealth of experience includes having successfully led many initiatives, such as workforce redesign involving education and career development, as well as patient care improvements. Nicky, who trained at Uxbridge, Middlesex, also has an MBA from Solent University. She has a professional background in cardiothoracic and critical care. Nicky's responsibilities include nursing leadership and providing advice to the board, quality standards and performance, clinical governance, improving patient experience and patient safety, safeguarding children and adults. She is also director of infection prevention and control.
Gordon Flack, Director of Finance 	Gordon has a professional background in NHS finance spanning 30 years. His experience is principally within the acute sector and for a number of community trusts. His responsibilities include capital, performance and commercial services, as well as audit and financial control. Gordon is a qualified accountant, a fellow of the Chartered Association of Certified Accountants and has been a Finance Director in several NHS Trusts since 2003.

Board and Committee Attendance

Formal Board		Mar-15
David Griffiths	Chairman	✓
Marion Dinwoodie	Chief Executive	✓
Peter Conway	Non Executive Director	✓
Richard Field	Non Executive Director	✓
Jennifer Tippin	Non Executive Director	✓
David Robinson	Non Executive Director	✓
Cathe Gaskell	Non Executive Director	✓
Steve Howe	Non Executive Director	✓
Bridget Skelton	Non Executive Director	✓
Gordon Flack	Finance Director	✓
Peter Maskell	Medical Director	X
Karen Proctor	Director of Nursing and Quality	✓
Lesley Strong	Deputy Chief Executive Officer and Director of Operations	✓

There was no Audit and Risk Committee, Remuneration and Terms of Service Committee, or Charitable Funds Committee meeting in March 2015.

Finance Business and Investment Committee

		Mar-15
Marion Dinwoodie	Chief Executive	✓
Richard Field	Non Executive Director (Chair)	✓
Bridget Skelton	Non Executive Director	✓
Jennifer Tippin	Non Executive Director	x
Gordon Flack	Director of Finance	
Lesley Strong	Deputy Chief Executive Officer and Director of Operations	

Quality Committee

		Mar-15
Steve Howe	Non Executive Director (Chair)	✓
David Robinson	Non Executive Director	✓
Cathe Gaskell	Non Executive Director	X
Peter Maskell	Medical Director	X
Nicky Lucey	Interim Director of Nursing and Quality	✓
Mark Shepperd	Director of Children and Young People	X
Lesley Strong	Deputy Chief Executive Officer and Director of Operations	✓

Council of Governors

Governors are elected for a period of either 2 or 3 years. Details of eligibility for election and numbers of members required in a constituency can be found in the Trust's constitution on the Trust's website.

Elected Public Governors as at 31 March 2015

				
Ashford: David Nutley	**Canterbury** Kate Wortham	**Dover** Roisin Murray	**Gravesham** Peggy Lawlor	**Sevenoaks** Jo Naismith
				**Vacant** **Rest of England** **Dartford** **Maidstone** **Tunbridge Wells**
Shepway Marion Keates	**Swale and Lead Governor** Ken Rogers	**Thanet** Stuart Alexander	**Tonbridge and Malling** Jack Wise	

Elected Staff Governors

				**Vacant** **Adult Services 2nd governor**
Adult Services Sonja Bigg	**Children's Services** Dr Mark Johnstone	**Corporate Services** Kathy Walters	**Health and Wellbeing Services** Claire Buckingham	

Appointed Governors

				**Vacant** **Education Kent County Council Social Services**
Police Adrian Futers	**Public health** Andrew Scott-Clark	**Universities** Dr Susan Plummer	**Voluntary organisations** Jane Roberts	

Membership: Representation, Engagement and Effectiveness

At the end of March 2015, The Trust's total public membership stood at 10,972. This represents 0.8% of the population of Kent. The Trust's aim is to achieve 1% of Kent's population as members of the Trust and then to increase membership by 1% year on year.

We increased our overall membership by approximately 50 during March 2015. Monitor's requirement is to increase membership by a minimum of 1% each year.

Areas where we need to increase our numbers are:

- Males
- Asian ethnicities (all BME, but Asian the most. Other categories are black, mixed and other).
- 30 to 59-year-olds and over 90-year-olds
- Working class (social grades D and E)
- Urban prosperity (ACORN classification)

Geographical areas we need to increase membership include:

- Dartford
- Tunbridge Wells
- Gravesham
- Shepway

Members are involved in a variety of ways, from responding to questionnaires and commenting on Trust leaflets to being invited to events or to sit on panels or working groups which are relevant to their interests. More than 8,000 public members receive the Trust's Community Health magazine, 1,700 members want to respond to surveys, more than 1,000 want to be invited to events, 400 want to comment on our leaflets and nearly 200 want to be part of a panel or working group.

Compliance Statements

The Director's register of interests is available on request.

The Trust has in place a Major Incident Plan that is fully compliant with the requirements of the NHS Commissioning Board Emergency Preparedness Framework (2013) and associated guidance. The Trust regularly participates in exercises and training with public sector partners.

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

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 in order to make themselves aware of any relevant audit information and to establish that the Trust's auditor is aware of that information.

As required by the NHS Act 2006 (as amended), the Board has satisfied itself that the income from the provision of goods and services for the purpose of the delivery of health services in England is greater than that from the provisions of goods and services for any other purpose. The Trust's income is shown in the Annual Accounts, which can be found on pages 27-85. The Board considers that there is no material impact upon the provision of goods and services for the provision of healthcare in England from the income it has received from other sources.

Accounting policies for pensions and other retirement benefits are set out in note 8 to the accounts. The details of senior employees' remuneration can be found on page 91 of the remuneration report.

Compliance with the Monitor 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.

The following table of disclosures are those that are required of the Trust in order to comply with the requirements of the Code of Governance.

Disclosure relating to	Monitor Code of Governance Reference	Kent Community Health NHS Foundation Trust Disclosure
Board and Council of Governors	A.1.1	The Trust Board meets 12 times per year and holds at least 5 Strategy and Development days. The Trust Board meets formally in public every 2 months. There are currently 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 Committees. The Trust's constitution sets out how disagreements between the Council and the Board would be resolved; the Chairman, 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 of Directors would make a final decision. A referral to Monitor or other external body might also be considered. There has been no requirement to activate this process during March 2015.
Board, Nomination Committee(s), Audit Committee, Remuneration Committee	A.1.2	This Annual Report describes the roles and responsibilities of the Board of Directors on pages 9-12. The number of Board and Committee meetings and a record of attendance is found at page 15.
Council of Governors	A.5.3	Page 13 of this Annual Report identifies the members of the Council of Governors, the Lead Governor and their respective constituencies. As the Foundation Trust Licence was only awarded on 1 March 2015, the Council is yet to formally meet. It will formally convene on 21 May 2015, and quarterly thereafter.
Board	B.1.1	The Non-Executive Directors of the Trust all meet the required independence criteria set out by Monitor. The Directors are identified on pages 9-12 of this Annual Report. All material pecuniary and non-pecuniary interests are declared and reported as per Trust policy and reported to the Board regularly. They are also included in this Annual Report at page 84.
Board	B.1.4	The biographies of the Board members are included in this report on pages 9-12. 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.
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 has not sat in the period since the Foundation Trust licence was awarded.
Chair/Council of Governors	B.3.1	The job specification for the Trust Chair defines the role and capabilities required and the expected time commitment. The Chairman's other significant responsibilities are outlined in his biography on page 10 of this annual report. The Nominations Committee will oversee future appointments as required.
Council of Governors	B.5.6	The mechanisms for Governors engaging members are still being developed. Due to the timescales involved, the opportunity to canvass on the forward plan has been limited. As the Council is yet to formally convene, it has not yet required the attendance of Directors of the Trust for the purpose of obtaining information about the Foundation Trust's performance of its functions or the directors' performance of their duties, as per the NHS Act 2006.
Board	B.6.1	The Board has been assessed as part of the Foundation Trust readiness assessment for effectiveness. Individual effectiveness assessments of Board members are conducted as part of the appraisal process and the Board

		collectively assesses its effectiveness after every formal meeting.
Board	B.6.2	The Board and the governance processes have been reviewed in detail during 2014 in readiness for Foundation Trust status. This has involved reviews by Monitor, the Care Quality Commission and KPMG. In these assessments the Trust was approved to move forward in the pipeline. The Board recognises that further external evaluations should be facilitated every three years.
Board	C.1.1	This is covered by the Directors' Report section on pages 9-15.
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.
Audit Committee/ Council of Governors	C.3.5	The Council of Governors shall formally consider the recommendation of the Audit and Risk Committee pertaining to the appointment of the External Auditor at its meeting on 21 May 2015.
Audit Committee	C.3.9	This information is included in the Trust's Annual Governance Statement, included in this report.
Board/ Remuneration Committee	D.1.3	None of the Trust's Executive Directors are currently released to serve on external appointments such as non-executive directorships elsewhere.
Board	E.1.5	The members of the Board of Directors, and in particular the Non-Executive Directors, will attend the meetings of the Council of Governors as and when required in order to develop an understanding of the views of the Council and the Trust's members. The Board will also take account of surveys and consultations canvassing the opinion of the membership.
Board/Membership	E.1.6	The Board has approved the Trust's membership strategy. The ongoing methodology for the monitoring of effective member engagement and how representative of the community the Trust serves is, is included in the Trust's Communications and Engagement Strategy.
Membership	E.1.4	The Trust Secretary, oversees compliance with this requirement. The Governors of the Trust can be contacted by: Email kcht.governors@nhs.net Telephone 01622 211 908 By post at: Governor Support Office Kent Community Health NHS Foundation Trust The Oast Unit D Hermitage Court Hermitage Lane Maidstone Kent ME16 9NT

The Trust meets its obligations under the Health and Safety at Work Act. The Trust has a Health and Safety Committee that reports to the Corporate Assurance and Risk Management Group.

The Trust reported no Serious Incidents to the Health and Safety Executive in March 2015.

Regulatory Ratings Report

As the Kent Community Health NHS Foundation Trust was authorised on 1 March 2015, it has not been assigned Continuity of Service or Governance ratings by Monitor. As and when the ratings are assigned they will be found on Monitor's website www.monitor.gov.uk. These ratings will form a part of future annual reports. The Trust's anticipated rating is four.

Quality Report

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. The Quality Report has also been subject to an assurance report from the Trust's external auditors, a copy of which is included in the appendix to the Annual Report on pages 87-89. The Trust Board has had regard to the Monitor Quality Governance Assurance Framework in its overall evaluation of the Trust's performance. The Board has oversight of the quality of care through the Trust's governance structure, which is described in the Annual Governance Statement, which is included on pages 29-38 of the report. In particular, the Quality Committee has responsibility for the monitoring of any action plans related to the Trust's quality performance.

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 of its staff. This approach is set out in the Trust's Equality and Diversity Policy which gives full and fair consideration to disabled applicants and ongoing support to staff who become disabled. Equality is written into the Trust's values framework; it ensures all of our staff receive training in the subject, it uses equality analysis and equality and diversity is embedded into Trust policies. Additionally the Trust uses the Equality Delivery System to record and evidence the work it does and publishes its equality objectives annually on its public website. Staff networks promote and support staff who are Lesbian, Gay, Bisexual, Transgender, Questioning, disabled and have religious beliefs.

Communication with staff

The Trust has concentrated on building on solid foundations for good communication and engagement and has put in place communication channels and mechanisms for getting feedback and involving patients and staff in shaping our services.
We value our staff - our most important asset. We recognise the challenges that they face and we want them to feel listened to and involved and create a culture of openness, trust and accountability. Research has shown that a more engaged workforce results in better patient care.
Actions are taken to provide employees systematically with information on matters of concern to them as employees and to encourage their involvement in improving Trust performance including financial and economic factors. The Trust has a staff intranet which has news and picture stories, video messages, films, blogs and organisational updates uploaded to its home page on a daily basis. The 'You' section promotes staff health and wellbeing.
There is a section dedicated to consultations which provides an opportunity for all staff to give feedback on policy changes, redesign and restructures, in addition to consultation meetings with staff who are directly affected.
All of this information is publicised and summarised in a weekly bulletin emailed to all staff which is also printed out for staff who do not have easy access to a computer. A monthly briefing is produced to help managers cascade and discuss key messages from the Board with staff in team meetings. The Trust's quarterly Community Health magazine is sent to all staff bases. The Executive Team holds regular staff engagement sessions which serve as an open forum for all staff to attend and the Chief Executive chairs a monthly sounding board with staff. The Trust also has a Staff Partnership Forum which meets monthly. More information can be found in the Trust's Communications and Engagement Strategy published on its website.

Staff Survey summary of performance

The results of the 2014 annual staff survey showed that more Trust staff felt that care of patients was a top priority for the Trust, their role was more likely to make a difference to patients, team working was effective, there was more support from line managers and better communication from senior management.

Staff felt that the Trust listens and makes changes as a result of patient feedback. The Trust also scored highly for equal opportunities for career progression and for incident reporting being fair and effective, compared to other community health trusts. The percentage of staff experiencing harassment and bullying from patients and working extra hours was lower than average, pressure to attend work when unwell dropped and job satisfaction increased.

The Trust's results are gradually improving although in some cases are still around the average for community trusts. More staff would recommend the Trust to friends and family as a place to work or for treatment than the previous year. Areas for improvement include how satisfied staff are with the patient care they feel able to deliver, which has remained level. The full report is available here.

The key findings for the Trust from the NHS staff survey are set out below:

	2013		**2014**		**Trust improvement/ deterioration**
Response rate	**Trust**	**National Average**	**Trust**	**National Average**	
2762	58%	53%	55%	48%	3% deterioration

	2013		2014		Trust improvement/ deterioration
Top 5 ranking scores	**Trust**	**National Average**	**Trust**	**National Average**	
Fairness and effectiveness of incident reporting procedures	3.61%	3.53%	3.70%	3.58%	0.09% improvement
Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months	24%	27%	22%	24%	2% improvement (n.b. a lower score is an improved position)
Percentage of staff working extra hours	67%	71%	66%	71%	1% improvement (n.b. a lower score is an improved position)
Percentage of staff agreeing that feedback from patients/service users is used to make informed decisions in their directorate/ department	n/a new questio n	n/a new question	58%	52%	n/a New question
Percentage of staff believing the trust provides equal opportunities for career progression or promotion	94%	91%	92%	91%	2% deterioration

	2013		2014		Trust improvement/ deterioration
Bottom 5 ranking scores	**Trust**	**National Average**	**Trust**	**National Average**	
Percentage of staff receiving health and safety training in last 12 months	65%	76%	61%	76%	4% deterioration
Percentage of staff having equality and diversity training in last 12 months	59%	66%	51%	68%	8% deterioration
Percentage of staff able to contribute towards improvements at work	69%	69%	68%	70%	1% deterioration
Percentage of staff appraised in last 12 months	83%	87%	85%	90%	2% improvement
Percentage of staff feeling satisfied with the quality of work and patient care they are able to deliver	73%	75%	73%	75%	No change

Future Priorities and Targets

The results from both the national NHS staff survey and the Staff Friends and Family test provide a rich source of data for the organisation that builds a picture of staff experience and engagement over the last year. It also offers the organisation the opportunity to monitor the changes that have happened since the last survey in staff groups as well as Directorates.

There are clear areas that require improvement and it has been agreed that all Directorates will take the following three key findings as a priority for next year:

- Percentage of staff feeling satisfied with the quality of work and patient care they are able to deliver (a higher score is better)
- Percentage of staff appraised in the last 12 months
- Percentage of staff able to contribute towards improvements at work

As the Trust aspires to reach the upper quartile in these key findings it is important that services do not benchmark themselves against the overall KCHFT result but that they aspire to at least the average for community trusts and preferably to the upper quartile. The action plan to address these three Key Findings is currently in development

Director of Finance Report for the period Ended 31 March 2015

Accounting Requirements

The accounts for the period reported have been prepared in accordance with the 2014/15 Foundation Trust Annual Reporting Manual (FT ARM) issued by Monitor. The accounting policies contained in that manual follow International Financial Reporting Standards (IFRS) and HM Treasury's Financial Reporting Manual (FReM) to the extent that they are meaningful and appropriate to NHS Foundation Trusts.

Surplus for the period and Comprehensive income

The Trust reports £52k comprehensive income for the period, made up of a retained surplus of £64k for the Foundation Trust and deficit of £12k for the Charitable Funds where there was expenditure of £12k but no income in the period.

Statement of Financial Position

The Trust ends the period with a strong financial position. Total net assets have increased by £0.1m over the period. The Trust has no borrowings. The Trust owns land and buildings of £7.7m and these have been independently valued at the period end at fair values in accordance with the Notes to the Accounts note 1.5.

Pension Liabilities

The trust's accounting policy on pension costs is disclosed in note 8 to the accounts and note 26.1 includes outstanding pension contributions at the period end. The pension entitlements of senior managers are disclosed in the remuneration report.

2015/16 and Beyond

The Trust's vision is to be the provider of choice by delivering excellent care and improving the health of our communities.

Our mission is to provide community based services to prevent people becoming unwell, avoid going into hospital, support people who have had to go into hospital to leave early, and support care closer to home.

To deliver this vision the Trust embarked on a journey to become a Foundation Trust which it achieved 1st March 2015. The Foundation Trust application process was rigorous and required the Trust to have plans to be sustainable and provide quality services.

This is the fourth year of the Trust building a track record of success by meeting its financial duties.

The challenges ahead are about how collectively healthcare and social care providers work more closely together and deliver integrated services. This means KCHFT working in partnership and bringing its expertise in community services to benefit more patients.

Financial disclosure information

Disclosure of audit information

So far as the Directors are aware, there is no relevant audit information of which the auditors are unaware and have made individual positive declarations to this effect.

The Directors have taken all steps that they ought to have taken as Directors in order to make themselves aware of any relevant audit information and to establish that the auditors are aware of that information.

Cost of work performed by the auditor

The Trust has not purchased work from its external auditors for non-audit services in period ended 31 March 2015.

Better Payment Practice Code

The Better Payment Practice Code requires the Trust to pay all undisputed invoices by the due date or within 30 days of receipt of goods or a valid invoice, whichever is later, unless other payment terms have been agreed with the supplier.

The Trust's compliance with the Code is set out in the Notes to the Accounts in note 38.
Non NHS percentage of Trade invoices paid within target was 99.11% by value.
NHS percentage of Trade invoices paid within target was 90.54% by value.

Prompt Payment Code

The Prompt Payment Code is a payment initiative developed by Government with the Institute of Credit Management. The Trust was formally signed-up to the Code in August 2012.

Fraud
The Trust has a bribery and anti-fraud policy and a Local Counter Fraud service that provides proactive activity to counter fraud and corruption and investigates suspect incidents and makes referrals to the Police.

Exit packages and severance payments

The exit packages agreed are shown on the Notes to the Accounts in note 7.3. There was 1 package at a cost of £58k. This was a redundancy cost paid in accordance with the provisions of the NHS Scheme.

Off-payroll engagements

The Treasury requires public sector bodies to report arrangements whereby individuals are paid through their own companies (and so are responsible for their own tax and NI arrangements). The Trust has no such arrangements.

Cost allocation and charges for information

The Trust complies with HM Treasury's guidance on setting charges for information.

Annual Accounts for the Period Ended 31 March 2015 including Annual Governance Statement

Statement of the Chief Executive's Responsibilities as the Accountable 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 Monitor.

Under the NHS Act 2006, Monitor has directed Kent Community Health NHS Foundation Trust to prepare for each financial year a statement of accounts in the form and on the basis set out in the Accounts Direction. 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 *NHS Foundation Trust Annual Reporting Manual* and in particular to:

- observe the Accounts Direction issued by Monitor, 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* have been followed, and disclose and explain any material departures in the financial statement;
- ensure that the use of public funds complies with the relevant legislation, delegated authorities and guidance; and
- prepare the financial statements on a going concern basis.

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

Signed:.....Chief Executive

Date:28.5.15

Monitor's NHS Foundation Trust Accounting Officer Memorandum.

Annual Governance Statement – 1 March 2015 -31 March 2015

Scope of responsibility

As Accounting Officer, I have responsibility for maintaining a sound system of internal control that supports the achievement of the NHS Foundation Trust's policies, aims and objectives, whilst safeguarding the public funds and departmental assets for which I am personally responsible, in accordance with the responsibilities assigned to me. I am also responsible for ensuring that 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.

The purpose of the system of internal control

The system of internal control is designed to manage risk to a reasonable level rather than to eliminate all risk of failure to achieve policies, aims and objectives; it can therefore only provide reasonable and not absolute assurance of effectiveness. The system of internal control is based on an ongoing process designed to identify and prioritise the risks to the achievement of the policies, aims and objectives of Kent Community Health NHS Foundation Trust, to evaluate the likelihood of those risks being realised and the impact should they be realised, and to manage them efficiently, effectively and economically. The system of internal control has been in place in Kent Community Health NHS Foundation Trust for the period 1 March to 31 March 2015 and up to the date of approval of the annual report and accounts.

Capacity to handle risk

As Accountable Officer, I am aware that effective corporate governance is a fundamental cornerstone for the success of the Trust. The Board has formally signed up to the Code of Conduct and Code of Accountability for NHS Boards. The Trust has also considered the balance of clinical and non-clinical reporting at the Board together with strategic versus operational matters considered by the Board. It has taken steps to maintain a balance in the quality and frequency of clinical quality and patient experience information being reported to the Board.

As Accountable 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.

Leadership and co-ordination of risk management activities are provided by the Trust Secretary and her 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 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 ongoing 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.

The Audit and Risk Committee has ratified a revision of the Risk Management Strategy that explicitly describes the Trust's approach to tolerating risks. The Trust is continuing to implement and embed the principles contained within the Strategy.

The top risks identified through the risk management process that have a significant impact on the ability of the Trust to deliver its strategic goals are documented on the Board Assurance Framework. During March 2015 there has been a significant amount of work undertaken to manage, rationalise and ensure consistency of the risks identified through the risk management process.

At the end of March 2015, the Board approved key strategic risks which have been identified through strategic assessment and business planning processes. These are:

- Risk that care is not delivered to the same high standard across the organisation [due to workforce factors]
- Risk of losing market share
- Risk that the Trust will be unable to continue to meet Cost Improvement Programme targets as detailed in 2015/16, 2016/17 and 2017/18 plans
- Risk that the Trust does not fully achieve its clinical strategy to shift care from acute to community
- Risk that the Trust will not embed lessons learned from previous Serious Incidents and incidents across the Trust
- Risk that the benefits of the Community Information System (CIS) will not be realised within the required timescales and budget

These risks will continue to be managed through the risk management and assurance processes throughout 2015/16. Where appropriate, the Trust will discuss risks which threaten the achievement of its objectives with commissioners, our partners in healthcare and social services, the local authority, voluntary bodies and through involvement of public (particularly members) and patients' representatives in Trust business.

Kent Community Health NHS Foundation Trust has a Board of Directors (the Board), which comprises both Executive and Non-Executive Directors. The Board's function is to:

- Ensure all Stakeholders have an understanding of Kent Community Health NHS Foundation Trust's purpose
- Set the values for the Trust and its strategic direction
- Hold management to account for the success and safety of the Trust
- Shape the organisational culture that supports its vision and values and encourages openness, honesty and integrity

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

The risk and control framework

As an NHS Body, Kent Community Health NHS Foundation Trust has specific statutory duties which are established in law. The 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 detailed below, assurance sources detailed further in this statement, internal and external audit together with external reviews by bodies such as the Care Quality Commission.

To discharge its duties effectively, and in particular to ensure compliance with Foundation Trust Condition 4, the Board has a number of formally constituted Board committees with delegated responsibilities as set out within the Foundation Trust's Scheme of Reservation and Delegation. The established Board committees, alongside their respective delegated responsibilities are detailed below.

The Trust's committee structure is based on a
rationale that the Committees' purpose is to receive assurance and hold the executive team to account. The key features of the committee structure include:

- All are chaired by a Non-Executive Director of the Board
- All committees work closely with others to ensure that all governance issues relating to quality, finance, risk management and internal control are considered in a holistic and integrated way
- Streamlined and effective administration of the Board Committees with structured reports, forward planning, schemes of delegation and escalation processes
- A centralised business intelligence function to manage the annual work programme and data flows

All committees report regularly the findings, issues and assurances discussed at each of their meetings to the Board.

The Board

Throughout March 2015 the Board and its committees that have met did so whilst quorate and standing members have attended in compliance with each committee's terms of reference.

The Board has conducted a skills audit and is actively participating in a structured programme of development. All Board members have a personal development plan and have had an appraisal. Board effectiveness has been assessed through external governance reviews. The Board has reviewed the findings of the assessments and taken action to address identified gaps including:

- Devised and implemented a Board development programme to ensure Board members are up to date with strategic developments both nationally and locally and have the opportunities to thoroughly review Trust strategy
- Developed the Quality Strategy to engage teams from board to floor in setting quality goals, in mirroring the organisational goals into their own annual work-plans. The Board has also received regular reports relating to patient experience.

Council of Governors

As an NHS Foundation Trust, the Trust has a Council of Governors with thirteen publicly elected governors, five elected staff governors and seven appointed governors representing a range of local partner organisations. There are currently nine vacancies on the council across both elected and appointed constituencies. The Council of Governors meets at least quarterly and holds an annual members' meeting. The Trust consults with the Council on a range of issues, including its strategy and risks to achieving objectives.

The Audit and Risk Committee

The Committee is comprised from amongst the Non-Executive Directors of the Trust.

The Director of Finance, Trust Secretary, 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 prior consent of the Chairman.

The purpose of the Audit and Risk Committee is to:

- Seek assurance that the financial reporting, risk management and internal control principles are applied;

- Maintain an appropriate relationship with the Trust's internal and external auditors; and
- Offer advice and assurance to the Board about the reliability and robustness of the systems of internal control.
- Recommend the appointment of the external auditor to the Council of Governors.

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

The Trust has an internal audit function, which provides independent and objective appraisal and assurance in compliance with Public Sector Internal Audit Standards. The function provides an opinion to the Chief Executive, the Board of Directors and the Audit and Risk Committee on the degree to which risk management, control and governance support the achievement of the organisations agreed objectives. Internal audit plans are based on a risk assessment of all activities in the Trust (clinical, financial and other) using the Trust's objectives and risk assessment processes recorded in the Board Assurance Framework as a primary source. The Trust's internal audit service is provided by TIAA Limited, a specialist independent provider of internal assurance services.

The Quality Committee

The Committee is comprised from amongst the Non-Executive Directors of the Trust. The Director of Nursing and Quality, the Medical Director and Directors with Operational portfolios attend meetings. Other individuals with specialist knowledge attend for specific items with the prior consent of the Quality Committee Chairman. In particular and where appropriate, the Committee invites clinical teams to attend its meetings to provide assurance on key governance and risk issues.

The Quality Committee:

- Assures the Board that all clinical services comply with the required quality standards to ensure the delivery of safe, high quality, patient-centred care
- Provides assurance to the Board regarding whether:
  - efficient and effective systems of clinical internal control including risk management are in place
  - data quality for reporting is appropriate
  - clinical performance management processes are effective
  - improvement targets are based on achievable action plans
  - improvement initiatives are addressing shortcomings in the quality of services, should they be identified
- Performance manages and reviews quality improvement targets as set out in the Integrated Business Plan, workforce plans and any other relevant plans
- Contributes to the active review and on-going development of the Clinical Strategy to ensure it is effective and being implemented
- Provides oversight to the Quality account production on an annual basis and in-year monitoring against the Quality goals described within it
- Reviews serious incidents and ensures that action plans are appropriate and that any lessons learned are shared across the Trust

Finance, Business and Investment Committee

The Committee membership is appointed from amongst the executive and Non-Executive Directors of the Trust and includes the Chief Executive, the Director of Finance and the Deputy Chief Executive/Director of Operations.

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

The overall objectives of the Committee are to:

- Scrutinise current financial performance and future financial plans (Annual Plan and Budget and Long Term Financial Model)
- Monitor performance against the Cost Improvement Programme
- Scrutinise the development and implementation of service line reporting and service line management;
- Monitor decisions to bid for business opportunities;
- Review capital investment decisions over £1m and the overall capital programme development;
- Approve treasury management policy and scrutinise implementation;
- Promote good financial practice throughout the Trust.

The Trust's Standing Financial Instructions extend the delegated limit of the FBI Committee to £3m. All procedural matters in respect of conduct of meetings follow the Trust's Standing Orders.

Remuneration and Terms of Service Committee

The Committee's members are the Non-Executive Directors of the Trust and the Committee is chaired by the Trust Chairman. The Chief Executive will also normally attend meetings, except where matters relating to them are under discussion.

This Committee determines the remuneration and conditions of service of the Chief Executive and other Directors 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 Chairman and the Non-Executive Directors, which is set by the Council of Governors.

When required, the Committee oversees the appointment of the Chief Executive and Executive Directors in accordance with the Trust's Standing Orders. During these sittings the committee will be known as the Executive Appointments Committee and the minutes will reflect this position.

As a Foundation Trust, the Trust has an elected Council of Governors. A Nominations Committee has been formed comprised of members of the Council of Governors and the Trust Chairman. This Committee will lead the process for all Board appointments and make recommendations to the Board.

Charitable Funds Committee

Members of the Charitable Funds Committee include two Non-Executive Directors (one as Chairman), Director of Finance and Deputy Chief Executive/Director of Operations Adults, Staff Side Representative and Patient Representative.

The Charitable Funds Committee acts on behalf of the Corporate Trustee, in accordance with the Trust's Standing Orders to oversee the charity's operation and to ensure that the administration of charitable funds is distinct from the Trust's exchequer funds.

Strategic Risk Management

The Board takes responsibility for oversight and risk management assurance throughout the Trust and receives the Board Assurance Framework at its 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. The 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 the 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 Trust Secretary who produces regular reports on risk for review.

The end of year review of the Board Assurance Framework by the Head of Internal Audit has established that the organisation has a framework that is fit for purpose and that the Trust Board has been effectively engaged with it. The Head of Internal Audit has given an opinion of 'substantial assurance' regarding the Assurance Framework for 2014/15.

Clinical risk, patient safety and patient experience are overseen by the Quality Committee, the Director of Nursing and Quality, the Medical Director and the Operational Directors. The Board receives monthly quality reports encompassing the quality and patient safety aspects for the Trust. The Quality Committee has focused on assurance that the Trust is embedding the lessons learned from incidents across the Trust. It has also sought assurance on the progress of the action plans that were developed in relation to the Trust's Monitor 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 undertaken 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 is established to receive regular reports from the Local Counter Fraud Specialist which identify specific fraud risks and investigate whether there was evidence of those being exploited.

The Foundation Trust is fully compliant with the registration requirements of the Care Quality Commission.

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

Scheme are in accordance with the Scheme rules, and that member Pension Scheme records are accurately updated in accordance with the timescales detailed in the Regulations.

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

The Foundation Trust has undertaken 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 that this organisation's obligations under the Climate Change Act and the Adaptation Reporting requirements are complied with.

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

One of the aims of the system of internal control and governance is to ensure that the Trust uses its resources at optimal efficiency. The financial and non-financial performance of the Trust is reported to the Board at each of its meetings through the integrated performance report. Indicators track performance against national, contractual and internally set requirements.

The Audit and Risk Committee agrees the Trust's internal audit plan, which reviews the economy, efficiency and effectiveness of resources. The committee routinely reviews the internal audit reports, the management response and progress against associated action plans.

The Trust's Cost Improvement Programme is tracked via a detailed performance report which includes reference to key clinical quality indicators. The programme board reports to the Finance Business and Investment Committee and the Board regularly reviews performance.

There have been 20 reported IG incidents in March 2015. Of these incidents, there was one 'serious' incident which was categorised as sufficiently serious to be reported to the Information Commissioner's Office, described below. A root cause analysis is undertaken for all serious incidents and the recommendations and lessons learned are shared across the Trust.

Summary of Serious Incidents requiring investigation involving personal data as reported to the Information Commissioner's Office in March 2015					
Date of incident	**Nature of incident**	**Nature of data involved**	**Number of data subjects potentially affected**	**Notification steps**	**Further action on information risk**
March 2015	Disclosed in error	Employment information	1526	Will be completed following the final outcome of the Root Cause Analysis	Ongoing root cause analysis report

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.

Monitor has issued guidance to NHS foundation trust boards on the form and content of annual Quality Reports which incorporate the above legal requirements in the NHS Foundation Trust Annual Reporting Manual.

The steps which have been put in place to assure the Board that the Quality Report presents a balanced view and that there are appropriate controls in place are as follows:

- The production of a balanced Quality Report is the responsibility of the Director of Nursing and Quality, supported by the Assistant Director of Clinical Governance and Quality.
- The Trust's framework for quality reporting across clinical services is agreed by the Board and overseen by the Quality Committee for assurance purposes.
- The Quality Committee has been consulted on the design and content of the Quality Report.
- The Quality Report draws on a number of performance indicators as reported to the Board monthly through the Integrated Performance Report. These include patient safety and service user feedback metrics.
- The Trust's Council of Governors has selected a quality performance indicator for audit, to supplement the mandated indicators.
- The specific metrics underpinning the Quality Report are drawn from the Trust's data recording and monitoring systems. The Audit and Risk Committee oversees the governance of data quality on behalf of the Board.

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 that 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.

The Head of Internal Audit has provided an opinion of reasonable assurance that there was generally a sound system of internal control, which was designed to meet the organisation's objectives, and that controls were generally being applied consistently.

A total of twelve internal audit reports were issued. Five gave substantial assurance and a further five gave reasonable assurance. The Trust has been issued with limited assurance reports for the Active Directory Migration Review and the Mobile Telephony Management Review. A further seven audits were at the planning or field work stage. There is a clear, dynamic process for monitoring progress against audit recommendations with oversight by the Audit and Risk Committee. Recommendations from reports providing limited assurance are prioritised.

Director statements from executive directors and senior managers within the organisation who have responsibility for the 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 that 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 the 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 Essential Standards.

Significant Issues

Our Annual Governance Statement for 2013/14 highlighted six significant issues as summarised below:

- A prevention of future deaths report issued by the Coroner
- An HSE investigation related to bed rails used at Sheppey Community Hospital,
- The prevalence of pressure ulcers,
- The impact of staff vacancies and turn-over,
- Indications of low staff morale,
- Failure to achieve expected targets in relation to statutory and mandatory training.

Clear action plans have been developed and implemented as a result of these issues. Pressure ulcers remain an issue in some localities but there has been a marked improvement in reporting and in the prevention of grade three and four ulcers.

The Board receives regular reports on the status of statutory and mandatory training compliance.

At March 2015 the following significant issues were identified:

Significant Issue Description:	Remedial Action Taken and Plans for Mitigation:
In November 2013 the HSE conducted an investigation following an incident at Sheppey Community Hospital whereby a patient fell from his bed due to a problem with the bed rails. Fortunately the patient did not suffer any significant injuries and returned to the ward that same evening and was discharged as was planned prior to the incident. The HSE is prosecuting the Trust in relation to the case. The Trust has entered a plea of not guilty.	On 30 September 2014 the Trust received notification of HSE's criminal prosecution. In response the Trust declared an SI Investigation, to investigate the substantive elements of the Prosecution's case, in order to decide on what plea to enter at the Plea Before Venue Hearing. At the Hearing the Trust entered a not guilty plea and elected trial in the Crown Court. At present, the Trust has presented the HSE with their initial findings of the SI, and the HSE are now reviewing their decision to continue with the Prosecution case. Subsequently the Trust was found Not Guilty in May 2015.

A number of services across the Trust are suffering from high vacancies and turnover. This in turn exposes the Trust to the risk that safety and quality of care may be compromised.	The Trust has been working to reduce vacancy levels in the affected services and localities. Human Resources provide specific support to managers struggling to recruit. Targeted recruitment campaigns are run in areas where normal procedures are not filling vacancies. The Trust also has a programme to support nurses who wish to return to practice and a programme of overseas recruitment. All staff complete an exit questionnaire when they leave the Trust in order to develop understanding of the motivation of leavers. The Trust has a workforce in which a significant proportion of staff are approaching retirement age, and is exposed to a higher risk that changes to service provision may lead to staff leaving as a result.
The Trust is not achieving the expected targets in relation to the completion of statutory and mandatory training. In particular there are gaps in safeguarding training.	Significant action has been taken to address these areas and although progress is noted, this has not been sufficient. Action being taken includes: • On-going review of mandatory training requirements: • Expanded methods to deliver training including e-learning, out of hours training and targeted training delivered at convenient locations. • Increases in number of trainers available • Data cleansing and data quality assessments.
South Kent Coast CCG raised a contract query notice in reference to staffing levels and the competence of staff	The Trust has reviewed actions taken to date and a revised action plan to address the CCG's concerns has been developed.

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

Accountable Officer:

Marion Dinwoodie, Chief Executive, Kent Community Health NHS Foundation Trust

Signed:.....

Date:....28.5.15.....

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

Our opinion on the financial statements is unmodified

In our opinion the financial statements:

- give a true and fair view of the state of the financial position of the Group and Kent Community Health NHS Foundation Trust as at 31 March 2015 and of the Group and Trust's income and expenditure for the period then ended; and
- have been properly prepared in accordance with the NHS Foundation Trust Annual Reporting Manual and the directions under paragraph 25(2) of Schedule 7 of the National Health Service Act 2006.

Who we are reporting to

This report is made solely to the Council of Governors of Kent Community Health NHS Foundation Trust, as a body, in accordance with paragraph 24(5) of Schedule 7 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.

What we have audited

We have audited the financial statements of Kent Community Health NHS Foundation Trust ('the Trust') for the period ended 31 March 2015 which comprise the Group and Trust statement of comprehensive income, the Group and Trust statement of financial position, the Group and Trust statement of cash flows, the Group and Trust statements of changes in taxpayers' equity and the related notes.

The Group financial statements include the financial transactions of Kent Community Health NHS Foundation Trust and Kent Community Health Charitable Fund for the period ended 31 March 2015.

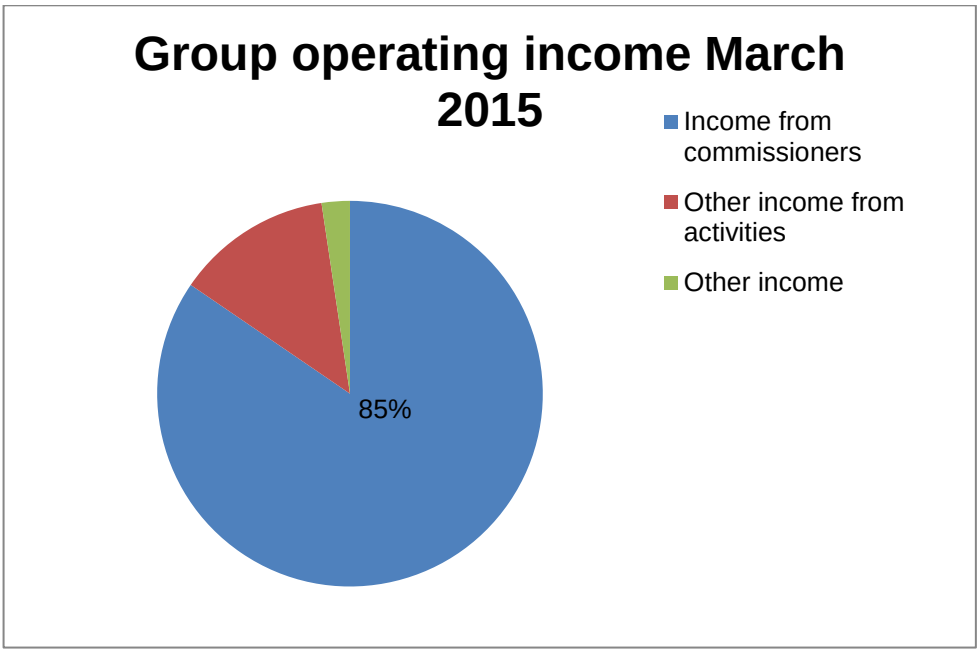
The financial reporting framework that has been applied in their preparation is the NHS Foundation Trust Annual Reporting Manual issued by Monitor, the Independent Regulator of NHS Foundation Trusts.

Our assessment of risk

In arriving at our opinions set out in this report, we highlight the following risks that are, in our judgement, likely to be most important to users' understanding of our audit.

Valuation of contract income from commissioning bodies and associated receivables

The risk: The Group receives a large proportion of its income from commissioners of healthcare services. It invoices its commissioners throughout the period for services provided, and at the period-end estimates and accrues for activity not yet invoiced. Invoices for the period are not finalised and agreed until after the period-end and after the deadline for the production of the financial statements. There is therefore a risk that the income from commissioners (and associated receivables) recognised in the financial statements may be misstated. We identified the accounting for the contract arrangements with commissioning bodies (in particular the consistency of the income with contract terms) as one of the risks that had the greatest impact on our audit strategy.



Our response: Our audit work included, but was not restricted to, assessing the Group's accounting policy for revenue recognition, understanding management's processes to recognise this income in accordance with the stated accounting policy, performing walk-throughs of management's key controls over income recognition (for example controls over contract billing, pricing and agreement of contract variations) to assess whether they were designed effectively and substantively testing the income and associated receivables.

Our substantive testing included:

- testing a sample of income receipts to confirm they are in line with contractually agreed amounts;
- review and testing of significant contracts to ensure the income received under these contracts was accounted for correctly; and
- review and testing of a sample of contractual adjustments to ensure they were accounted for appropriately.

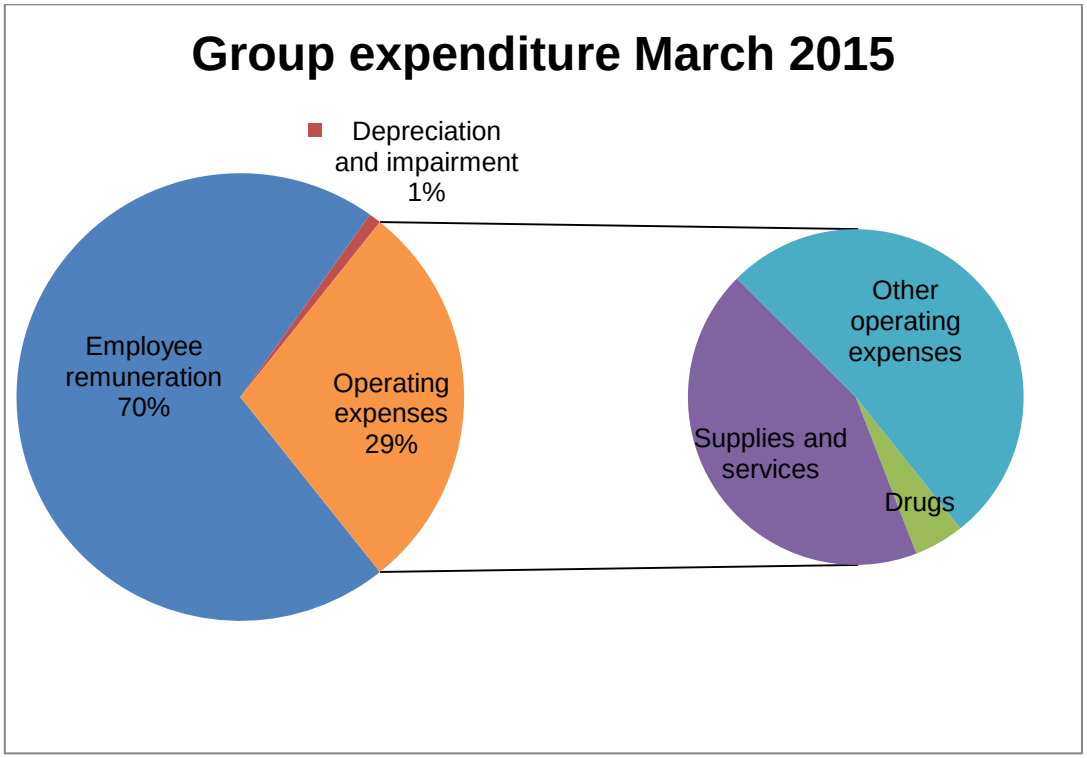
The Group's accounting policy on revenue recognition is shown in note 1.2 to the financial statements and its analysis of its total operating income is included in notes 3.1 and 3.2.

Our findings:

We did not identify any material errors in the valuation of income from commissioners from our testing, but we noted some non-trivial misstatements which we have reported to Those Charged with Governance at the Group (the Trust Audit and Risk Committee) in our Audit Findings Report**.** Management agreed to amend the financial statements to correct a number of these non-trivial misstatements and management provided us with a written response to confirm why they had decided not to amend the financial statements for the other non-trivial misstatements. We have confirmed with the Audit and Risk Committee that they agree with management that, because of the immaterial impact, no adjustment need be made.

Completeness of employee remuneration and operating expenses and associated payables

The risk: The majority of the Group's expenditure relates to employee remuneration and operating expenses. Together they account for 99% of the Group's gross expenditure. The Group pays the majority of this expenditure through its payroll and accounts payable systems and at the period-end estimates and accrues for un-invoiced expenses. Invoices for the final weeks of the period are not received and processed until after the period-end and in many cases after the deadline for the production of the financial statements. There is therefore a risk that the expenses (and associated payables) recognised in the financial statements may be misstated. We identified the completeness of employee remuneration and operating expenses (in particular the understatement of accruals) as risks that had the greatest impact on our audit strategy.



Our response: Our audit work included, but was not restricted to, understanding management's processes to recognise payroll and accounts payable expenditure and period-end accruals for unprocessed invoices and expenditure incurred and not yet invoiced, walking through management's key controls over recognition of expenditure (for example authorisation of expenditure subsystem interfaces, processing of adjustments and authorisation of payments) to assess whether they were designed effectively and substantively testing expenditure and associated payables.

Our substantive testing included:

- testing the completeness of payroll records through trend analysis of costs to identify any unusual cost variations;
- sample testing of payroll transactions to supporting records;
- testing the reconciliation of employee remuneration expenditure in the financial statements to the general ledger and payroll subsystems;
- sample testing of expenditure, including agency staff, to source documents;
- testing the completeness of expenditure and period end payables through sample testing of post period-end payments.

The Group's accounting policy for recognition of expenditure is shown in notes 1.3 and 1.4, its analysis of employee remuneration costs is included in note 7 and its analysis of operating costs is included in note 5.1 to the financial statements.
Our findings:

We did not identify any material errors in the completeness of employee remuneration or operating expenses from our testing, but we noted some non-trivial misstatements in respect of this expenditure which we have reported to the Audit and Risk Committee in our Audit Findings Report. Management agreed to amend the financial statements to correct these non-trivial misstatements.

Our application of materiality and an overview of the scope of our audit materiality

We define materiality as the magnitude of misstatement in the financial statements that makes it probable that the judgement of a reasonably knowledgeable person would be changed or influenced.
We determined materiality for the audit of the Group financial statements as a whole to be £419,000, which is 2% of the Group's gross operating costs (which was based on draft accounts and did not require updating on receipt of the final accounts). This benchmark is considered the most appropriate because users of the financial statements are particularly interested in how healthcare funding has been spent. We use a different level of materiality, performance materiality, to drive the extent of our testing and this was set at 75% of financial statement materiality for the audit of the Group financial statements. We also determine a lower level of materiality for certain areas such as cash.

We determined the threshold at which we will communicate misstatements to the Trust's Audit and Risk Committee to be £21,000**.** In addition we communicate misstatements below that threshold that, in our view, warrant reporting on qualitative grounds.

Overview of the scope of our audit
We conducted our audit in accordance with International Standards on Auditing (ISAs) (UK and Ireland) having regard to the Financial Reporting Council's Practice Note 10 'Audit of Financial Statements of Public Bodies in the UK (Revised)'. Our responsibilities under the Code and the ISAs (UK and Ireland) are further described in the 'Responsibilities for the financial statements and the audit' section of our report. We believe that the audit evidence we have obtained from our audit is sufficient and appropriate to provide a basis for our opinion.

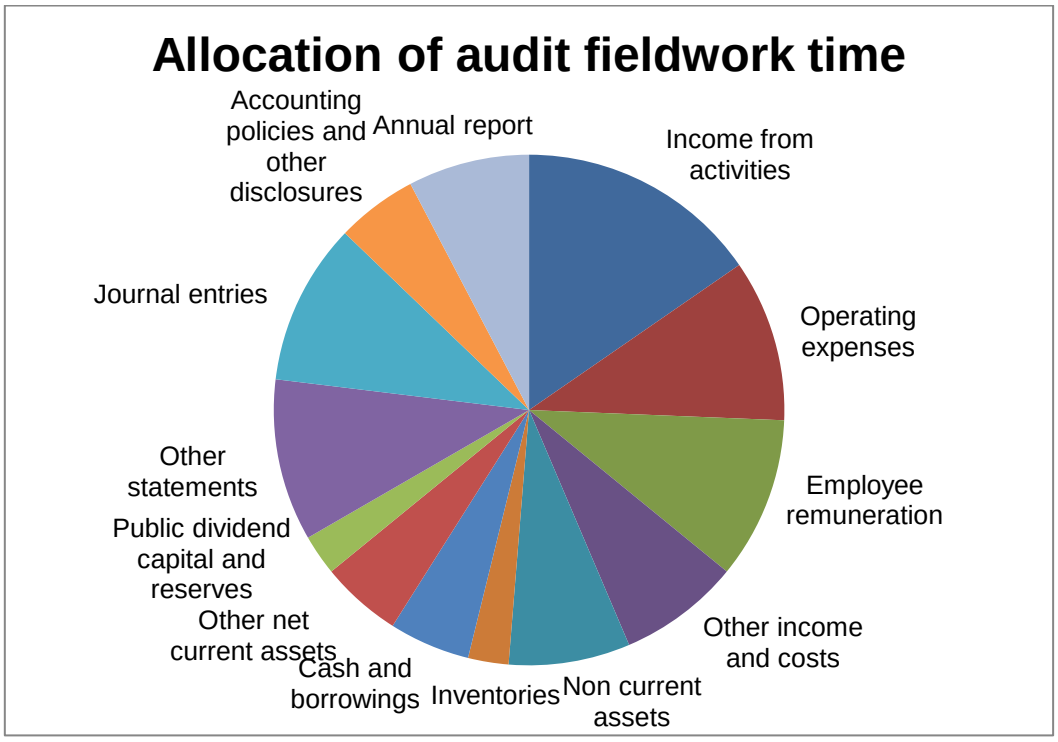
We are independent of the Group in accordance with the Auditing Practices Board's Ethical Standards for Auditors, and we have fulfilled our other ethical responsibilities in accordance with those Ethical Standards.

Our audit approach was based on a thorough understanding of the Group's business and is risk based. Payroll services are outsourced to NHS Shared Business Services, and the Electronic Staff Record is provided by McKesson UK. Accordingly, our audit work was focused on obtaining an understanding of, and evaluating, relevant internal controls at the Group and its third party service providers.

In order to gain appropriate audit coverage of the risks described above and of the Trust's charity, as an individually significant reporting component, we performed audit procedures on the significant consolidated charity balances as part of our audit on the Group financial statements.

We undertook substantive testing on significant transactions, balances and disclosures in the Group financial statements, the extent of which was based on various factors such as our overall assessment

of the Group's control environment, the design effectiveness of controls over significant financial systems and the management of risks.



Other reporting required by regulations

Our opinion on other matters prescribed by the Audit Code for NHS Foundation Trusts is unmodified

In our opinion:

- the part of the Directors' Remuneration Report subject to audit has been properly prepared in accordance with the NHS Foundation Trust Annual Reporting Manual 2014-15 issued by Monitor; and
- the information given in the strategic report and directors' report for the financial period for which the financial statements are prepared is consistent with the Group financial statements.

Matters on which we are required to report by exception
We are required by Monitor's Audit Code for NHS Foundation Trusts to satisfy ourselves that the Trust's Quality Report from 1 April 2014 to 31 March 2015 has been prepared in line with the requirements set out in Monitor's published guidance and is consistent with other sources of evidence.

Our testing of the mandated indicator 'Percentage of incomplete pathways within 18 weeks for patients on incomplete pathways at the end of the reporting period" identified that the Trust had not retained an audit trail for the published data for this indicator for the period 1 April 2014 to 28 February 2015. Our limited assurance report to the Board of Directors and Council of Governors of Kent Community Health NHS Foundation Trust on the Quality Report, is therefore qualified as we were unable to provide assurance that the indicators in the Quality Report, subject to limited assurance, had been reasonably stated in all material respects in accordance with the NHS Foundation Trust Annual Reporting Manual.

As a result of the above matter, we have been unable to satisfy ourselves that Kent Community Health NHS Foundation Trust's Quality Report has been prepared in line with the requirements set out in Monitor's published guidance and is consistent with other sources of evidence.

We have nothing to report in respect of the following:

Under the Code we are required to report to you if, in our opinion:

- the Annual Governance Statement does not meet the disclosure requirements set out in the NHS Foundation Trust Annual Reporting Manual or is misleading or inconsistent with the information of which we are aware from our audit; or
- 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.

Under the ISAs (UK and Ireland), we are also required to report to you if, in our opinion, information in the annual report is:

- materially inconsistent with the information in the audited financial statements; or
- apparently materially incorrect based on, or materially inconsistent with, our knowledge of the Group acquired in the course of performing our audit; or
- otherwise misleading.

In particular, we are required to report to you if:

- we have identified any inconsistencies between our knowledge acquired during the audit and the directors' statement that they consider the annual report is fair, balanced and understandable; or
- the annual report does not appropriately disclose those matters that were communicated to the Audit and Risk Committee which we consider should have been disclosed.

Responsibilities for the financial statements and the audit

What an audit of financial statements involves:
An audit involves obtaining evidence about the amounts and disclosures in the financial statements sufficient to give reasonable assurance that the financial statements are free from material misstatement, whether caused by fraud or error. This includes an assessment of: whether the

accounting policies are appropriate to the Group's circumstances and have been consistently applied and adequately disclosed; the reasonableness of significant accounting estimates made by the directors; and the overall presentation of the financial statements. In addition, we read all the financial and non-financial information in the annual report to identify material inconsistencies with the audited financial statements and to identify any information that is apparently materially inconsistent with the knowledge acquired by us in the course of performing the audit. If we become aware of any apparent material misstatements or inconsistencies we consider the implications for our report.

What the Chief Executive is responsible for as accounting officer:
As explained more fully in the Chief Executive's Responsibilities Statement, 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 Direction issued by Monitor and for being satisfied that they give a true and fair view.

What are we responsible for:
Our responsibility is to audit and express an opinion on the financial statements in accordance with applicable law, the Audit Code for NHS Foundation Trusts issued by Monitor, and ISAs (UK and Ireland). Those standards require us to comply with the Auditing Practices Board's Ethical Standards for Auditors.

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 Audit Code for NHS Foundation Trusts issued by Monitor.

As set out above, we have been unable to satisfy ourselves that the Trust's Quality Report has been prepared in line with the requirements set out in the NHS Foundation Trust Annual Reporting Manual and is consistent with other sources of evidence.

Darren Wells
Director
for and on behalf of Grant Thornton UK LLP

Fleming Way
Manor Royal
Crawley RH10 9GT

28 May 2015

Foreword to the accounts

Kent Community Health NHS Foundation Trust

These accounts, for the period ended 31 March 2015, 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 .....

Name: **Gordon Flack**
Job title: **Director of Finance**
Date: **28 May 2015**

Consolidated Statement of Comprehensive Income for period ended 31 March 2015

	Note	March 2015 Group £000	March 2015 Trust £000
Operating income from patient care activities	3	19,910	19,910
Other operating income	4	482	482
Total operating income from continuing operations		**20,392**	**20,392**
Operating expenses	5, 7	(20,344)	(20,332)
Operating surplus/(deficit) from continuing operations		**48**	**60**
Finance income	10	4	4
Finance expenses	11	-	-
PDC dividends payable		-	-
Net finance costs		**4**	**4**
Surplus/(deficit) for the period from continuing operations		**52**	**64**
Surplus/(deficit) on discontinued operations and the gain/(loss) on disposal of discontinued operations	14	**-**	**-**
Surplus/(deficit) for the period		**52**	**64**
Other comprehensive income		-	-
Total comprehensive income/(expense) for the period		**52**	**64**

Surplus / (deficit) for the period attributable to:	
non-controlling interests; and	-
the Foundation Trust	52
Total comprehensive income / (expense) for the period attributable to:	
non-controlling interests; and	-
the Foundation Trust*	52

***This includes a £12k loss in charitable funds**
For the period of March 2015, the Charitable Funds incurred expenditure of £12k and received no income

Consolidated Statement of Financial Position
as at 31 March 2015

	Note	31 March 2015 Group £000	1 March 2015 Group £000	31 March 2015 Trust £000	1 March 2015 Trust £000
Non-current assets					
Intangible assets	15	71	51	71	73
Property, plant and equipment	16	14,379	13,856	14,379	13,834
Total non-current assets		**14,450**	**13,907**	**14,450**	**13,907**
Current assets					
Inventories	21	-	-	-	-
Trade and other receivables	22	10,590	11,611	10,602	11,621
Cash and cash equivalents	25	19,447	18,959	18,799	18,297
Total current assets		**30,037**	**30,570**	**29,401**	**29,918**
Current liabilities					
Trade and other payables	26	(23,602)	(23,868)	(23,598)	(23,860)
Provisions	31	(984)	(823)	(984)	(823)
Other financial liabilities	29	(289)	(226)	(289)	(226)
Total current liabilities		**(24,875)**	**(24,917)**	**(24,871)**	**(24,909)**
Total assets less current liabilities		**19,612**	**19,560**	**18,980**	**18,916**
Total non-current liabilities		**-**	**-**	**-**	**-**
Total assets employed		**19,612**	**19,560**	**18,980**	**18,916**
Financed by					
Public dividend capital		2,613	2,613	2,613	2,613
Revaluation reserve		766	766	766	766
Income and expenditure reserve		15,601	15,537	15,601	15,537
Non-controlling interest		-	-	-	-
Charitable fund reserves	19	632	644	-	-
Total taxpayers' and others' equity		**19,612**	**19,560**	**18,980**	**18,916**

The notes on pages 52 to 85 form part of these accounts.

Name MARION DINWOODIE

Position CHIEF EXECUTIVE

Date 28.5.15

Consolidated Statement of Cash Flows for the period ended 31 March 2015

	Note	March 2015 Group £000	March 2015 Trust £000
Cash flows from operating activities			
Operating surplus/(deficit)		48	60
Non-cash income and expense:			
Depreciation and amortisation	5.1	181	181
(Increase)/decrease in receivables and other assets		1,021	1019
(Increase)/decrease in inventories		-	-
Increase/(decrease) in payables and other liabilities		(755)	(753)
Increase/(decrease) in provisions		161	161
NHS charitable funds - net movements in working capital, non-cash transactions and non-operating cash flows		(2)	-
Other movements in operating cash flows		-	-
Net cash generated from/(used in) operating activities		**654**	**668**
Cash flows from investing activities			
Interest received		4	4
Purchase of property, plant, equipment and investment property		(170)	(170)
Net cash generated from/(used in) investing activities		**(166)**	**(166)**
Cash flows from financing activities		-	-
Net cash generated from/(used in) financing activities		**-**	**-**
Increase/(decrease) in cash and cash equivalents		**488**	**502**
Cash and cash equivalents at 1 March 2015		**18,959**	**18,297**
Cash and cash equivalents at 31 March 2015	25.1	**19,447**	**18,799**

Statement of Changes in Equity for the period ended 31 March 2015

Group	Public dividend capital	Revaluation reserve	Income and expenditure reserve	NHS charitable funds reserves	Non-controlling interest	Total
	£000	£000	£000	£000	£000	£000
At 1 March 2015	**2,613**	**766**	**15,537**	**644**	**-**	**19,560**
Surplus/(deficit) for the period	-	-	64	(12)	-	**52**
Taxpayers' and others' equity at 31 March 2015	**2,613**	**766**	**15,601**	**632**	**-**	**19,612**

Trust	Public dividend capital	Revaluation reserve	Income and expenditure reserve	Total
	£000	£000	£000	£000
At 1 March 2015	**2,613**	**766**	**15,537**	**18,916**
Surplus/(deficit) for the period	-	-	64	**64**
Taxpayers' and others' equity at 31 March 2015	**2,613**	**766**	**15,601**	**18,980**

Information on reserves

NHS charitable funds reserves

This balance represents the ring-fenced funds held by the NHS charitable funds consolidated within these accounts. These reserves are classified as restricted or unrestricted.

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 trust. Additional PDC may also be issued to NHS foundation trusts by the Department of Health. A charge, reflecting the cost of capital utilised by the NHS foundation trust, is payable to the Department of Health as the public dividend capital dividend.

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 NHS foundation trust.

Notes to the Accounts

Note 1 Accounting policies and other information

Basis of preparation

Monitor has directed that the financial statements of NHS foundation trusts shall meet the accounting requirements of the Foundation Trust Annual Reporting Manual (FT ARM) which shall be agreed with HM Treasury. Consequently, the following financial statements have been prepared in accordance with the FT ARM 2014/15 issued by Monitor. The accounting policies contained in that manual follow IFRS and HM Treasury's Financial Reporting Manual (FReM) to the extent that they are meaningful and appropriate to NHS foundation trusts. The accounting policies have been applied consistently in dealing with items considered material in relation to the accounts.

Kent Community Health NHS Foundation Trust received authorisation as an Foundation Trust on 1 March 2015. All associated assets and liabilities of the former Kent Community Health NHS Trust as at 1 March 2015 were transferred to Kent Community Health NHS Foundation Trust.

Accounting convention

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

Going concern

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 1.1 Consolidation

NHS Charitable Fund

The NHS foundation trust is the corporate trustee to Kent Community Health Charitable Fund. The foundation trust has assessed its relationship to the charitable fund and determined it to be a subsidiary because the foundation 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. For this period the charitable fund is material to the foundation trust, however in a full year this is not the case.

The charitable fund's statutory accounts are prepared to 31 March in accordance with the UK Charities Statement of Recommended Practice (SORP) which is based on UK Generally Accepted Accounting Principles (UK GAAP). On consolidation, necessary adjustments are made to the charity's assets, liabilities and transactions to:

- recognise and measure them in accordance with the foundation trust's accounting policies; and
- eliminate intra-group transactions, balances, gains and losses.

Unless otherwise presented, there is no material difference between the amounts reported for the Trust and the Group.

Note 1.2 Income

Revenue in respect of services provided is recognised when, and to the extent that, performance occurs, and is measured at the fair value of the consideration receivable. The main source of revenue for the trust is from commissioners for healthcare services.

Where income is received for a specific activity that is to be delivered in the following year, that income is deferred where agreed with the counter-party.

The Trust receives income under the NHS Injury Cost Recovery Scheme, designed to reclaim the cost of treating injured individuals to whom personal injury compensation has subsequently been paid e.g. by an insurer. The Trust recognises the income when it receives notification from the Department of Work and Pension's Compensation Recovery Unit that the individual has lodged a compensation claim. The income is measured at the agreed tariff for the treatments provided to the injured individual, less a provision for unsuccessful compensation claims and doubtful debts.

The Trust sells some goods in the course of its business, although this is immaterial in value.

Note 1.3 Expenditure on employee benefits

Short-term employee benefits

Salaries, wages and employment-related payments are recognised in the period in which the service is received from employees. The cost of leave earned but not taken by employees at the end of the period is recognised in the financial statements. Overtime and enhancements are paid one month in arrears. In April 2015 one month of overtime and enhancements will be paid relating to shifts worked in March. This has been accrued for.

Retirement benefit costs

Past and present employees are covered by the provisions of the NHS Pensions Scheme. The scheme is an unfunded, defined benefit scheme that covers NHS employers, General Practices and other bodies, allowed under the direction of the Secretary of State, in England and Wales. The scheme is not designed to be run in a way that would enable NHS bodies to identify their share of the underlying scheme assets and liabilities. Therefore, the scheme is accounted for as if it were a defined contribution scheme: the cost to the NHS body of participating in the scheme is taken as equal to the contributions payable to the scheme for the accounting period. Employers pension cost contributions are charged to operating expenses as and when they become due.

For early retirements other than those due to ill health the additional pension liabilities are not funded by the scheme. The full amount of the liability for the additional costs is charged to expenditure at the time the Trust commits itself to the retirement, regardless of the method of payment.

Note 1.4 Expenditure on other goods and services

Other operating expenses are recognised when, and to the extent that, the goods or services have been received. They are measured at the fair value of the consideration payable.

Note 1.5 Property, plant and equipment

Recognition

Property, plant and equipment is capitalised if:

● it is held for use in delivering services or for administrative purposes;

● it is probable that future economic benefits will flow to, or service potential will be supplied to the Trust;

● it is expected to be used for more than one financial year;

● the cost of the item can be measured reliably; and

● 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 a cost of more than £250, where the assets are functionally interdependent, they had broadly simultaneous purchase dates, are anticipated to have simultaneous disposal dates and are under single managerial control; or

● Items form part of the initial equipping and setting-up cost of a new building, ward or unit, irrespective of their individual or collective cost.

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

Valuation

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

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

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

● Land and non-specialised buildings – market value for existing use

● Specialised buildings – depreciated replacement cost

● Leasehold improvements in respect of buildings for which the trust is a lessee under an operating lease will be written off over the lease duration and carried at depreciated historic cost, as this is not considered to be materially different from fair value. Thus improvements are not revalued, and no indexation is applied as the adjustments which would arise are not considered material.

HM Treasury has adopted a standard approach to depreciated replacement cost valuations based on modern equivalent assets and, where it would meet the location requirements of the service being provided, an alternative site can be valued.

Properties in the course of construction for service or administration purposes are carried at cost, less any impairment loss. Cost includes professional fees but not borrowing costs, which are recognised as expenses immediately, as allowed by IAS 23 for assets held at fair value. Assets are revalued and depreciation commences on assets other than grouped information technology (IT) assets when they are brought into use. Depreciation commences 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.

Fixtures and equipment are carried at depreciated historic cost as this is not considered to be materially different from fair value.

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

Subsequent expenditure

Where subsequent expenditure enhances an asset beyond its original specification, the directly attributable cost is capitalised. Where subsequent expenditure restores the asset to its original specification, the expenditure is capitalised and any existing carrying value of the item replaced is written-out and charged to operating expenses.

Useful economic life of tangible assets	Min life in years	Max life in 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

Note 1.6 Intangible assets

Recognition

Intangible assets are non-monetary assets without physical substance, which are capable of sale separately from the rest of the trust's business or which arise from contractual or other legal rights. They are recognised only when it is probable that future economic benefits will flow to, or service potential be provided to, the trust; where the cost of the asset can be measured reliably, and where the cost is at least £5000.

Intangible assets acquired separately are initially recognised at fair value. Software that is integral to the operating of hardware, for example an operating system, is capitalised as part of the relevant item of property, plant and equipment. Software that is not integral to the operation of hardware, for example application software, is capitalised as an intangible asset. Expenditure on research is not capitalised: it is recognised as an operating expense in the period in which it is incurred. Internally-generated assets are recognised if, and only if, all of the following have been demonstrated:

- the technical feasibility of completing the intangible asset so that it will be available for use
- the intention to complete the intangible asset and use it
- the ability to sell or use the intangible asset
- how the intangible asset will generate probable future economic benefits or service potential
- the availability of adequate technical, financial and other resources to complete the intangible asset and sell or use it
- the ability to measure reliably the expenditure attributable to the intangible asset during its development

Measurement

The amount initially recognised for internally-generated intangible assets is the sum of the expenditure incurred from the date when the criteria above are initially met. Where no internally-generated intangible asset can be recognised, the expenditure is recognised in the period in which it is incurred.

Following initial recognition, intangible assets are carried at fair value by reference to an active market, or, where no active market exists, at amortised replacement cost (modern equivalent assets basis), indexed for relevant price increases, as a proxy for fair value. Internally-developed software is held at historic cost to reflect the opposing effects of increases in development costs and technological advances.

Useful economic life of intangible assets

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

	Min life Years	Max life Years
Intangible assets - purchased		
Software	1	5

Note 1.7 Depreciation, amortisation and impairments

Freehold land, assets under construction, and assets held for sale are not depreciated.

Otherwise, depreciation and amortisation are charged to write off the costs or valuation of property, plant and equipment and intangible non-current assets, less any residual value, over their estimated useful lives, in a manner that reflects the consumption of economic benefits or service potential of the assets. 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. Assets held under finance leases are depreciated over their estimated useful lives

At each reporting period end, the Trust checks whether there is any indication that any of its tangible or intangible non-current assets have suffered an impairment loss. If there is indication of an impairment loss, the recoverable amount of the asset is estimated to determine whether there has been a loss and, if so, its amount. Intangible assets not yet available for use are tested for impairment annually.

A revaluation decrease that does not result from a loss of economic value or service potential is recognised as an impairment charged to the revaluation reserve to the extent that there is a balance on the reserve for the asset and, thereafter, to expenditure. Impairment losses that arise from a clear consumption of economic benefit should be taken to expenditure. Where an impairment loss subsequently reverses, the carrying amount of the asset is increased to the revised estimate of the recoverable amount but capped at the amount that would have been determined had there been no initial impairment loss. The reversal of the impairment loss is credited to expenditure to the extent of the decrease previously charged there and thereafter to the revaluation reserve.

Note 1.8 Revenue government and other grants

Government grants are grants from Government bodies other than income from commissioners or NHS 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 2014-15.

Note 1.9 Inventories

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

Note 1.10 Financial instruments and financial liabilities

Financial assets

Financial assets are recognised when the Trust becomes party to the financial instrument contract or, in the case of trade receivables, when the goods or services have been delivered. Financial assets are no longer when the contractual rights have expired or the asset has been transferred.

Financial assets are initially recognised at fair value.

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

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

The Trust's financial assets consist of accrued and invoiced receivables, and cash.

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.

Where the time value of money is material, contingencies are disclosed at their present value.

Financial liabilities

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

The Trust does not have any loans, financial guarantee contract liabilities, liabilities which require a fair value adjustment, or other financial liabilities.

Financial Liabilities consist of payables and provisions.

Note 1.11 Leases

Leases

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

Note 1.12 Provisions

The NHS foundation 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

The NHS Litigation Authority (NHSLA) operates a risk pooling scheme under which the trust pays an annual contribution to the NHSLA which in return settles all clinical negligence claims. The contribution is charged to expenditure. Although the NHSLA is administratively responsible for all clinical negligence cases the legal liability remains with the Trust. The total value of clinical negligence provisions carried by the NHSLA on behalf of the trust is disclosed at note 31.2.

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 the NHS Litigation Authority and, in return, receives assistance with the costs of claims arising. The annual membership contributions, and any excesses payable in respect of particular claims are charged to operating expenses as and when they become due.

Note 1.13 Contingencies

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

Note 1.14 Public dividend capital

Public dividend capital represents taxpayers' equity in the NHS trust. At any time the Secretary of State can issue new PDC to, and require repayments of PDC from, the trust. PDC is recorded at the value received. As PDC is issued under legislation rather than under contract, it is not treated as an equity financial instrument.

An annual charge, reflecting the cost of capital utilised by the trust, is payable to the Department of Health as public dividend capital dividend. The charge is calculated at the real rate set by HM Treasury (currently 3.5%) on the average carrying amount of all assets less liabilities cash balances with the Government Banking Service. The average carrying amount of assets is calculated as a simple average of opening and closing relevant net assets. The Trust is not currently required to pay PDC dividend as the average carrying amount is negative.

Note 1.15 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 1.16 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 1.17 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 1.18 Third party assets

Assets belonging to third parties (money held on behalf of patients) are not recognised in the accounts since the NHS foundation 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 1.19 Losses and special payments

Losses and special payments are items that Parliament would not have contemplated when it agreed funds for the health service or passed legislation. By their nature they are items that ideally should not arise. They are therefore subject to special control procedures compared with the generality of payments. They are divided into different categories, which govern the way that individual cases are handled.

Losses and special payments are charged to the relevant functional headings in expenditure on an accruals basis, including losses which would have been made good through insurance cover had NHS trusts not been bearing their own risks (with insurance premiums then being included as normal revenue expenditure).

Note 1.20 Early adoption of standards, amendments and interpretations

No new accounting standards or revisions to existing standards have been early adopted in 2014/15.

Note 1.21 Standards, amendments and interpretations in issue but not yet effective or adopted

The Treasury FReM does not require the following Standards and Interpretations to be applied in 2014-15. The application of the Standards as revised would not have a material impact on the accounts for 2014-15, were they applied in that year:

IFRS 9 Financial Instruments - subject to consultation - subject to consultation
IFRS 13 Fair Value Measurement - subject to consultation
IFRS 15 Revenue from Contracts with Customers

Note 1.22 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 critical judgements, apart from those involving estimations (see below) that management has made in the process of applying the Trust's accounting policies and that have the most significant effect on the amounts recognised in the financial statements.

Redundancy and Legal Claims provision

A provision has been recognised in respect of redundancy and legal costs as a result of service changes and other events, based on estimated probabilities as noted below. Note 32.1 details the accounting policy for provisions.

Key sources of estimation uncertainty

The following are the key assumptions concerning the future, and other key sources of estimation uncertainty at the end of the reporting period, that have a significant risk of causing a material adjustment to the carrying amounts of assets and liabilities within the next financial year:

Redundancy provision

Probabilities were estimated of the likelihood of redundancy and other payments arising from service changes. As a result, a redundancy provision of £648k has been recognised at the end of the reporting period. This is disclosed in note 31.1.

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.

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.

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:

	March 2015 £000s	% of total revenue
Clinical Commissioning Groups	14,186	70%
Local Authorities	2,369	12%
NHS England	3,052	15%

Note 3 Operating income from patient care activities

Note 3.1 Income from patient care activities (by nature)

	March 2015 £000
Community services	
Community services income from CCGs and NHS England	17,238
Community services income from other commissioners	2,668
All services	
Private patient income	4
Other clinical income	-
Total income from activities	**19,910**

Note 3.2 Income from patient care activities (by source)

Income from patient care activities received from:	March 2015 £000
CCGs and NHS England	17,238
Local authorities	2,369
Other NHS foundation trusts	111
NHS trusts	156
Non-NHS: private patients	4
NHS injury scheme (was RTA)	13
Non NHS: other	19
Total income from activities	**19,910**
Of which:	
Related to continuing operations	19,910
Related to discontinued operations	-

Note 3.3 Overseas visitors (relating to patients charged directly by the NHS foundation trust)

	March 2015 £000
Income recognised this period	-
Cash payments received in period	-
Amounts added to provision for impairment of receivables	-
Amounts written off in period	-

Note 4 Other operating income

	March 2015 £000
Research and development	-
Education and training	262
Charitable and other contributions to expenditure	42
Non-patient care services to other bodies	6
Other income	172
Total other operating income	**482**
Of which:	
Related to continuing operations	482
Related to discontinued operations	-

Note 4.1 Income from activities arising from commissioner requested services

Under the terms of its Provider License, 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:

	March 2015 £000
Income from services designated (or grandfathered) as commissioner requested services	17,149
Income from services not designated as commissioner requested services	3,243
Total	**20,392**

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

There was no disposal of property, plant and equipment in this period.

Note 5.1 Operating expenses

	March 2015 £000
Services from NHS foundation trusts	27
Services from NHS trusts	273
Employee expenses - executive directors	69
Employee expenses - non-executive directors	6
Employee expenses - staff	14,279
Supplies and services - clinical	2,363
Supplies and services - general	157
Establishment	464
Transport	452
Premises	279
Increase/(decrease) in provision for impairment of receivables	(10)
Drug costs	281
Rentals under operating leases	972
Depreciation on property, plant and equipment	179
Amortisation on intangible assets	2
Audit fees payable to the external auditor	
audit services- statutory audit	42
audit services- regulatory reporting (external auditor only)	-
other auditor remuneration (external auditor only)	-
Clinical negligence	18
Legal fees	134
Consultancy costs	47
Training, courses and conferences	189
Redundancy	54
Hospitality	4
Insurance	18
Other services, e.g. external payroll	33
Other -Charitable expenditure	12
Total	**20,344**
Of which:	
Related to continuing operations	20,344

Note 5.2 Other auditor remuneration

There was no other remuneration to the auditor in the reporting period.

Note 5.3 Limitation on auditor's liability

In accordance with the terms of engagement with our external auditors, Grant Thornton UK LLP, its members, partners and staff (whether contract, negligence or otherwise) in respect of services provided in connection with or arising out of the audit shall in no circumstances exceed £2 million in the aggregate in respect of all such services.

Note 6 Impairment of assets

No assets were impaired in the reporting period.

Note 7 Employee benefits

	Permanent £000	Other £000	March 2015 Total £000
Salaries and wages	10,942	43	**10,985**
Social security costs	702	-	**702**
Employer's contributions to NHS pensions	1,385	-	**1,385**
Termination benefits	58	-	**58**
Agency/contract staff	-	1,348	**1,348**
NHS charitable funds staff	-	-	**-**
Total gross staff costs	**13,087**	**1,391**	**14,478**
Recoveries in respect of seconded staff	-	-	**-**
Total staff costs	**13,087**	**1,391**	**14,478**
Included within:			
Costs capitalised as part of assets	72	-	**72**

Note 7.1 Average number of employees (WTE basis)

	Permanent Number	Other Number	March 2015 Total Number
Medical and dental	63	2	**65**
Administration and estates	1,362	4	**1,366**
Healthcare assistants and other support staff	847	-	**847**
Nursing, midwifery and health visiting staff	1,477	1	**1,478**
Nursing, midwifery and health visiting learners	61	-	**61**
Scientific, therapeutic and technical staff	758	1	**758**
Social care staff	21	-	**21**
Agency and contract staff	-	231	**231**
Bank staff	-	61	**61**
Total average numbers	**4,587**	**300**	**4,887**
Of which:			
Number of employees (WTE) engaged on capital projects	34	-	**34**

Note 7.2 Retirements due to ill-health

During March 2015 there were no early retirements from the trust agreed on the grounds of ill-health.

Note 7.3 Reporting of compensation schemes - exit packages
March 2015

	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	-	-	**-**
£10,001 - £25,000	-	-	**-**
£25,001 - 50,000	-	-	**-**
£50,001 - £100,000	1	-	**1**
£100,001 - £150,000	-	-	**-**
£150,001 - £200,000	-	-	**-**
>£200,000	-	-	**-**
Total number of exit packages by type	**1**	**-**	**1**
Total resource cost (£)	£58,000	£0	**£58,000**

Note 7.4 Directors' remuneration
The aggregate amounts payable to directors were:

	March 2015 £000
Salary	66
Taxable benefits	1
Performance related bonuses	0
Employer's pension contributions	10
Total	**77**

Further details of directors' remuneration can be found in the remuneration report.

Note 8 Pension costs

Past and present employees are covered by the provisions of the NHS Pensions Scheme. Details of the benefits payable under these provisions can be found on the NHS Pensions website at www.nhsbsa.nhs.uk/pensions. The scheme is an unfunded, defined benefit scheme that covers NHS employers, GP practices and other bodies, allowed under the direction of the Secretary of State, in England and Wales. The scheme is not designed to be run in a way that would enable NHS bodies to identify their share of the underlying scheme assets and liabilities. Therefore, the scheme is accounted for as if it were a defined contribution scheme: the cost to the NHS Body of participating in the scheme is taken as equal to the contributions payable to the 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 the scheme liability is carried out annually by the scheme actuary as at the end of the reporting period. This utilises an actuarial assessment for the previous accounting period in conjunction with updated membership and financial data for the current reporting period, and are accepted as providing suitably robust figures for financial reporting purposes. The valuation of the scheme liability as at 31st March 2015, is based on valuation data as 31 March 2014, updated to 31 March 2015 with summary global member and accounting data. In undertaking this actuarial assessment, the methodology prescribed in IAS 19, relevant FReM interpretations, and the discount rate prescribed by HM Treasury have also been used.
The latest assessment of the liabilities of the scheme is contained in the scheme actuary report, which forms part of the annual NHS Pension Scheme (England and Wales) Pension Accounts, published annually. These accounts can be viewed on the NHS Pensions website. 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 scheme (taking into account its recent demographic experience), and to recommend the contribution rates.

The last published actuarial valuation undertaken for the NHS Pension Scheme was completed for the year ending 31 March 2012.

The Scheme Regulations were changed to allow contribution rates to be set by the Secretary of State for Health, with the consent of HM Treasury, and consideration of the advice of the Scheme Actuary and appropriate employee and employer representatives as deemed appropriate.

The next formal valuation to be used for funding purposes will be carried out at as at March 2012 and will be used to inform the contribution rates to be used from 1 April 2015.

c) Scheme provisions

The NHS Pension Scheme provided defined benefits, which are summarised below. This list is an illustrative guide only, and is not intended to detail all the benefits provided by the Scheme or the specific conditions that must be met before these benefits can be obtained:
The Scheme is a “final salary” scheme. Annual pensions are normally based on 1/80th for the 1995 section and of the best of the last three years pensionable pay for each year of service, and 1/60th for the 2008 section of reckonable pay per year of membership. Members who are practitioners as

defined by the Scheme Regulations have their annual pensions based upon total pensionable earnings over the relevant pensionable service.

With effect from 1 April 2008 members can choose to give up some of their annual pension for an additional tax free lump sum, up to a maximum amount permitted under HMRC rules. This new provision is known as “pension commutation”.

Annual increases are applied to pension payments at rates defined by the Pensions (Increase) Act 1971, and are based on changes in retail prices in the twelve months ending 30 September in the previous calendar year. From 2011-12 the Consumer Price Index (CPI) has been used and replaced the Retails Prices Index (RPI).

Early payment of a pension, with enhancement, is available to members of the scheme who are permanently incapable of fulfilling their duties effectively through illness or infirmity. A death gratuity of twice final year’s pensionable pay for death in service, and five times their annual pension for death after retirement is payable.

For early retirements other than those due to ill health the additional pension liabilities are not funded by the scheme. The full amount of the liability for the additional costs is charged to the employer.
Members can purchase additional service in the NHS Scheme and contribute to money purchase AVC’s run by the Scheme’s approved providers or by other Free Standing Additional Voluntary Contributions (FSAVC) providers.

Estimated contribution due to the Scheme from 01/04/15-31/03/16 (2015-16)
Under the 1995, 2008 and 2015 NHS Pension Scheme Regulations, an employing authority/GP Practice must provide a statement of estimated total contributions due in respect of each scheme year, not later than one month before the beginning of the scheme year;

The Trust's estimated annual contributions for 2015-16 are £17,151k

Note 9 Operating leases

Note 9.1 Kent Community Health NHS Foundation Trust as a lessee

	March 2015 £000
Operating lease expense	
Minimum lease payments	972
Total	**972**

	31 March 2015 £000	1 March 2015 £000
Future minimum lease payments due:		
- not later than one year;	3,091	3,104
- later than one year and not later than five years;	6,842	6,899
- later than five years.	5,561	5,672
Total	**15,494**	**15,675**
Future minimum sublease payments to be received	-	-

Note 10 Finance income

	March 2015 £000
Interest on bank accounts	4
Total	**4**

Note 11.1 Finance expenditure
The trust has no finance costs to report for this period.

Note 11.2 The late payment of commercial debts (interest) Act 1998
There was no late payments interest in the reporting period.

Note 12 Foundation trust income statement and statement of comprehensive income

The Trust has presented a separate Group and Trust Income Statement and Statement of Comprehensive Income.

Note 13 Corporation tax
The Trust has no corporation tax liability.

Note 14 Discontinued operations
The Trust has no discontinued operations.

Note 15.1 Intangible assets - March 2015

	Software licences £000	Intangible assets under construction £000	NHS charitable fund assets £000	Total £000
Valuation/gross cost at 1 March 2015	**71**	**22**	**-**	**93**
Gross cost at 31 March 2015	**71**	**22**	**-**	**93**
Amortisation at 1 March 2015	**20**	**-**	**-**	**20**
Provided during the period	2	-	-	**2**
Amortisation at 31 March 2015	**22**	**-**	**-**	**22**
Net book value at 31 March 2015	**49**	**22**	**-**	**71**
Net book value at 1 March 2015	**51**	**22**	**-**	**73**

Note 15.2 Intangible assets financing March 2015

	Software licences £000	Intangible assets under construction £000	NHS charitable fund assets £000	Total £000
Net book value at 31 March 2015				
Purchased	49	22	-	**71**
Finance leased	-	-	-	**-**
Donated and government grant funded	-	-	-	**-**
NBV total at 31 March 2015	**49**	**22**	**-**	**71**

Note 16.1 Property, plant and equipment - March 2015

Group	Land	Buildings excluding dwellings	Assets under construction	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	NHS charitable fund assets	Total
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Valuation/gross cost at 1 March 2015	**1,472**	**7,268**	**272**	**1,196**	**566**	**7,449**	**601**	**-**	**18,824**
Additions	-	12	42	278	-	364	28	-	**724**
Valuation/gross cost at 31 March 2015	**1,472**	**7,280**	**314**	**1,474**	**566**	**7,813**	**629**	**-**	**19,548**
Depreciation at 1 March 2015	**-**	**1,027**	**-**	**474**	**419**	**2,655**	**415**	**-**	**4,990**
Provided during the period	-	75	-	16	5	77	6	-	**179**
Accumulated depreciation at 31 March 2015	**-**	**1,102**	**-**	**490**	**424**	**2,732**	**421**	**-**	**5,169**
Net book value at 31 March 2015	**1,472**	**6,178**	**314**	**984**	**142**	**5,081**	**208**	**-**	**14,379**
Net book value at 1 March 2015	**1,472**	**6,241**	**272**	**722**	**147**	**4,794**	**186**	**-**	**13,834**

Note 16.2 Property, plant and equipment financing - March 2015

Group	Land	Buildings excluding dwellings	Assets under construction	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	NHS charitable fund assets	Total
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Net book value at 31 March 2015									
Owned	1,472	6,178	314	984	142	5,081	208	-	**14,379**
NBV total at 31 March 2015	**1,472**	**6,178**	**314**	**984**	**142**	**5,081**	**208**	**-**	**14,379**

Note 17 Revaluations of property, plant and equipment

A full revaluation exercise was undertaken of the trust's owned buildings and land as at 28th February 2015 by Stephen Boshier MRICS of Boshier & Company Chartered Surveyors an independent valuer.

The BCIS All-in Tender Price Index forecasts an increase of +8.4% for the year to 31st March 2015. On the basis of the forecast the valuer is of the opinion that there has been no material change in value of either the Building Value or External Works Value of the Trust's fixed assets over the one month period to 31st March 2015.

The valuer is of the opinion that the movement in land value for the trust's portfolio for the one month period to 31st March 2015 has not been significant or material. For the purpose of financial reporting as at 31st March 2015, the Land Value of the trust's portfolio remains unchanged over the previous one month period.

The valuation was made in accordance with the Royal Institution of Chartered Surveyors Valuation - Professional Standards (January 2014) Incorporating the International Valuation Standards insofar as these terms are consistent with the requirements of HM Treasury and no departures from this have been noted.

The properties valued were all non-specialised operational assets. Non-specialised operational assets are valued to Existing Use Value and do not reflect the Market Value for an alternative use which may be higher or lower than the reported value.

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

Note 18 Investments

The trust has no investments.

Note 19 Analysis of charitable fund reserves

	31 March 2015 £000	1 March 2015 £000
Unrestricted funds:		
Unrestricted income funds	281	281
Restricted funds:		
Restricted income funds	351	363
	632	**644**

Unrestricted income funds are accumulated income funds that are expendable at the discretion of the trustees in furtherance of the charity's objects. Unrestricted funds may be earmarked or designated for specific future purposes which reduces the amount that is readily available to the charity.

Restricted funds may be accumulated income funds which are expendable at the trustee's discretion only in furtherance of the specified conditions of the donor and the objects of the charity. They may also be capital funds (e.g. endowments) where the assets are required to be invested, or retained for use rather than expended.

Note 20 Disclosure of interests in other entities
The trust has no interests in other entities.

Note 21 Inventories
The trust has no material inventories.

Note 22.1 Trade receivables and other receivables

	31 March 2015 £000	1 March 2015 £000
Current		
Trade receivables due from NHS bodies	5,721	4,897
Provision for impaired receivables	(457)	(467)
Prepayments (non-PFI)	1,535	1,738
Accrued income	519	2,408
PDC dividend receivable	240	120
VAT receivable	555	235
Other receivables	2,477	2,680
Trade and other receivables held by NHS charitable funds	-	-
Total current trade and other receivables	**10,590**	**11,611**
Total non-current trade and other receivables	**-**	**-**

Note 22.2 Provision for impairment of receivables

	March 2015 £000
At 1 March 2015	**467**
Increase in provision	(10)
Amounts utilised	-
Unused amounts reversed	-
At 31 March 2015	**457**

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

Note 22.3 Analysis of impaired receivables

Group	31 March 2015	
	Trade receivables	Other receivables
Ageing of impaired receivables	**£000**	**£000**
0 - 30 days	-	-
30-60 Days	-	1
60-90 days	-	25
90- 180 days	-	49
Over 180 days	-	382
Total	**-**	**457**
Ageing of non-impaired receivables past their due date		
0 - 30 days	-	515
30-60 Days	-	117
60-90 days	-	525
90- 180 days	-	33
Over 180 days	-	22
Total	**-**	**1,212**

Receivables neither past due and therefore not due are primarily those receivables supported by underlying contractual agreements and therefore full payment is expected on a timely basis.

Note 23 Other assets

The trust has no other assets.

Note 24 Liabilities in disposal groups

	31 March 2015 £000	1 March 2015 £000
Categorised as:		
Provisions	-	-
Trade and other payables	-	-
Other	-	-
Total	**-**	**-**

Note 25.1 Cash and cash equivalents movements

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

	March 2015 Group £000	March 2015 Trust £000
At 1 March 2015	**18,959**	**18,297**
Net change in period	488	502
At 31 March 2015	**19,447**	**18,799**
Broken down into:		
Cash at commercial banks and in hand	36	36
Cash with the Government Banking Service	19,411	18,763
Total cash and cash equivalents as in SoFP	**19,447**	**18,799**
Total cash and cash equivalents as in SoCF	**19,447**	**18,799**

Note 25.2 Third party assets held by the NHS foundation trust

Kent Community Health NHS Foundation Trust held cash and cash equivalents which relate to monies held by the foundation trust on behalf of patients. This has been excluded from the cash and cash equivalents figure reported in the accounts.

	31 March 2015 £000	1 March 2015 £000
Bank balances	-	-
Monies on deposit	2	2
Total third party assets	**2**	**2**

Note 26.1 Trade and other payables

	31 March 2015 £000	1 March 2015 £000
Current		
NHS trade payables	938	100
Other trade payables	2,471	2,341
Capital payables	661	114
Social security costs	1,550	1,537
Other taxes payable	1,240	1,214
Other payables	2,623	2,248
Accruals	14,114	16,309
PDC dividend payable	-	-
Trade and other payables held by NHS charitable funds	5	5
Total current trade and other payables	**23,602**	**23,868**
Total non-current trade and other payables	**-**	**-**
Included above:		
outstanding Pension Contributions at the period end	2,264	2,246

Note 26.2 Early retirements in NHS payables above
There are no early retirement payables.

Note 27 Other liabilities

	31 March 2015 £000	1 March 2015 £000
Current		
Other deferred income	289	226
Total other current liabilities	**289**	**226**
Total other non-current liabilities	**-**	**-**

Note 28 Borrowings
The trust has no borrowings.

Note 29 Other financial liabilities

Other financial liabilities are disclosed as deferred income in note 27 above

Note 30 Finance leases

Note 30.1 Kent Community Health NHS Foundation Trust as a lessor
The trust has no finance lease obligations.

Note 30.2 Kent Community Health NHS Foundation Trust as a lessee
The trust has no finance lease obligations.

Note 31.1 Provisions for liabilities and charges analysis

Group	Other legal claims £000	Redundancy £000	NHS charitable fund provisions £000	Total £000
At 1 March 2015	**171**	**652**	**-**	**823**
Arising during the period	200	92	-	**292**
Utilised during the period	(9)	(58)	-	**(67)**
Reversed unused	(26)	(38)	-	**(64)**
At 31 March 2015	**336**	**648**	**-**	**984**
Expected timing of cash flows:				
- not later than one year;	336	648	-	**984**
Total	**336**	**648**	**-**	**984**

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 change with uncertainties typically about which staff will be unsuccessful although it is certain the number of posts will be reduced at particular grades whilst this might be increased in other grades which may or may not be suitable alternatives. The legal provision relates to on-going Employment Tribunals, the provision for LTPS claims administered and informed by the NHSLA and a Health and Safety Executive legal case. See Accounting Policy Notes 1.12 and 1.22.

Note 31.2 Clinical negligence liabilities

At 31 March 2015, £733k was included in provisions of the NHSLA in respect of clinical negligence liabilities of Kent Community Health NHS Foundation Trust.

Note 32 Contingent assets and liabilities

	31 March 2015 £000	1 March 2015 £000
Value of contingent liabilities		
NHS Litigation Authority legal claims	(27)	(32)
Gross value of contingent liabilities	**(27)**	**(32)**
Amounts recoverable against liabilities	-	-
Net value of contingent liabilities	**(27)**	**(32)**
Net value of contingent assets	**-**	**-**

Note 33 Contractual capital commitments

	31 March 2015 £000	1 March 2015 £000
Property, plant and equipment	194	610
Total	**194**	**610**

Note 34 Defined benefit pension schemes
The trust has no defined benefit scheme.

Note 35 Financial instruments

Note 35.1 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, KCHFT 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
KCHFT is a wholly UK based organisation with the great majority of transactions, assets and liabilities being in the UK and sterling based. KCHFT has no overseas operations. The organisation therefore has low exposure to currency rate fluctuations.

Interest rate risk
KCHFT has no borrowings and so is not exposed to any interest rate risk.
Credit risk
As the majority of KCHFT's revenue comes from contracts with other public sector bodies, the organisation has low exposure to credit risk. The maximum exposures as at 31 March 2015 are in receivables from customers, as disclosed in the trade and other receivables note.

Liquidity risk
KCHFT'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 35.2 Financial assets

	Loans and receivables £000	Assets at fair value through the I&E £000	Held to maturity £000	Available for-sale £000	Total £000
Assets as per SoFP as at 31 March 2015					
Embedded derivatives	-	-	-	-	**-**
Trade and other receivables excluding non financial assets	9,057	-	-	-	**9,057**
Other investments	-	-	-	-	**-**
Other financial assets	-	-	-	-	**-**
Cash and cash equivalents at bank and in hand	18,799	-	-	-	**18,799**
Financial assets held in NHS charitable funds (Group only)	648	-	-	-	**648**
Total at 31 March 2015	**28,504**	**-**	**-**	**-**	**28,504**
Total at 1 March 2015	**28,832**	**-**	**-**	**-**	**28,832**

Note 35.3 Financial liabilities

	Other financial liabilities £000	Liabilities at fair value through the I&E £000	Total £000
Liabilities as per SoFP as at 31 March 2015			
Trade and other payables excluding non financial liabilities	23,597	-	**23,597**
Financial liabilities held in NHS charitable funds	5	-	**5**
Total at 31 March 2015	**23,602**	**-**	**23,602**
Total at 1 March 2015	**23,868**	**-**	**-**

Note 35.4 Maturity of financial liabilities

	31 March 2015 £000	1 March 2015 £000
In one year or less	23,602	23,868
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	**23,602**	**23,868**

Note 36 Losses and special payments

There were no losses or special payments in this period.

Note 37 Related Parties

"All bodies within the scope of the Whole Government Accounts (WGA) are treated as related parties of an NHS Foundation Trust. Income and expenditure for the reporting period and year-end Receivable and Payable balances with these organisation types is summarised below:

As at 31st March 2015 the Trust has a Receivable of £11k with Kent Community Health Charitable Funds whose Corporate Trustee is the Trust's Board of Directors. The Charity has been treated as a subsidiary for this reporting period in the preparation of Group Accounts and a result the receivable balance has been removed on consolidation.

	Receivables		Payables	
	31 March 2015 £000	**1 March 2015 £000**	**31 March 2015 £000**	**1 March 2015 £000**
Department of Health	241	122	-	
NHS England & Clinical Commissioning Groups	4,455	4,977	1,607	1,859
NHS Trusts	675	693	914	835
NHS Foundation Trusts	857	995	1,067	683
Other DH Bodies	-	-	3,322	3,664
Local Authorities	1,709	2,109	519	707
Other Government Departments	621	293	5,054	4,996
Total	**8,558**	**9,189**	**12,483**	**12,744**

	Income March 15 £000	**Expenditure March 15 £000**
NHS England & Clinical Commissioning Groups	17,256	-
Health Education England	226	-
NHS Trusts	214	614
NHS Foundation Trusts	139	483
Special Health Authorities	-	33
Other DH Bodies	-	737
Local Authorities	2,368	194
Other Government Departments	-	2,087
Total	**20,203**	**4,148**

Note 38 Better Payment Practice Code

Better Payment Practice Code	March 2015 Number	March 2015 £000s
Non-NHS Payables		
Total Non-NHS Trade Invoices Paid in the Period	**3,124**	**7,395**
Total Non-NHS Trade Invoices Paid Within Target	**3,058**	**7,329**
Percentage of NHS Trade Invoices Paid Within Target	**97.89%**	**99.11%**
NHS Payables		
Total NHS Trade Invoices Paid in the Period	**155**	**803**
Total NHS Trade Invoices Paid Within Target	**149**	**727**
Percentage of NHS Trade Invoices Paid Within Target	**96.13%**	**90.54%**

The Better Payment Practice Code requires the NHS body to aim to pay all valid invoices by the due date or within 30 days of receipt of a valid invoice, whichever is later.

Note 39 Events after the end of the reporting period

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

Remuneration Report

This remuneration report presents information from the 1st March 2015 to 31st March 2015 as the Trust became a Foundation Trust on 1st March 2015. A separate remuneration report is included in the Annual Report for Kent Community NHS Trust for the period 1st April 2014 to 28th February 2015.

Annual Statement on Remuneration

The Committee did not meet during the period and made no changes to senior manager's remuneration. The Trust continues to operate in an environment of austerity and senior managers pay remains restrained. The Committee however must counter balance restraint with the need to recruit, retain and motivate high calibre staff and be consistent with the principles of other pay reforms – Agenda for Change and Consultant Contract.

Senior Managers' Remuneration Policy

The policy on remuneration of Very Senior Managers (VSMs) for 2014-15 was based on guidance from the Department of Health. As such the Trust has not consulted with employees on this scheme. The national pay freeze continued to be implemented this year and no pay increments were paid to these senior managers. Agenda for Change Senior Managers received increments in line with their specific pay banding.

The Chief Executive assesses the performance of these VSMs against business and personal objectives and at the year-end provides the Remuneration Committee with a report on performance. The guidance on VSM's bonus payments was not implemented due to austerity.

The Very Senior Managers (VSM) reward package which comprise:

Pay Component	VSM standard	Application
Basic Pay	a spot rate salary for the post, determined by the role and an organisational weighting factor, and uplifted annually	Applicable to executives on VSM but no annual uplift applied due to austerity.
Additional payments	A Recruitment and Retention Premium (RRP) is an addition to the pay of an individual post (or specific group of posts) where market pressures would otherwise prevent the employer from being able to recruit and retain staff for the post(s) concerned at the normal basic salary for the post(s). Payments in respect of recruitment and retention should not normally exceed 30% of basic pay.	Not Applied.
	Additional payment for additional responsibilities. A total cumulative limit of 10% of basic salary applies to payments for additional responsibilities	Applied to Deputy Chief Executive Officer and Director of Operations - Adults for Deputy CEO responsibilities. Applied to Director of Finance for Commercial & Performance responsibilities.

Pay Component	VSM standard	Application
Annual performance bonus scheme comprising an annual uplift and a non-consolidated bonus described below	Pay awards for the financial year will be based upon placing the individual into one of four categories: Category Award A Outstanding annual uplift, consolidated into salary; plus a % non-consolidated bonus B Exceeds expectations annual uplift, consolidated into salary; plus a % non-consolidated bonus C Satisfactory annual uplift, consolidated into salary D Not satisfactory No increase The award payable to individual staff will be determined by the performance category into which they are placed. However, it is an essential criterion of the performance bonus scheme that the organisation achieves its financial control target	Not applied due to austerity measures not due to performance issues.
The annual uplift	The annual uplift will be applied to the basic pay being paid to the post holder (which would include any long-term RRP payment), provided that: 1) the organisation achieves its financial control target; and 2) the individual concerned is judged as performing at Category A, B or C. Those in Categories A, B and C will receive this annual uplift to their basic pay, which will be pensionable within the limits of the NHS Pension Scheme as they apply to each individual (provisions vary depending on date of joining the Scheme).	Not applied due to austerity measures not due to performance issues.
Non-consolidated performance bonus	Those in Categories A and B will receive, in addition to the annual uplift, a non-consolidated bonus payment,	Not applied due to austerity measures not due to performance issues.

Pay Component	VSM standard	Application
payments – Category A and B performers in organisations that achieve their financial control target	provided the essential criterion is met –i.e. that the organisation achieves its financial control target. Bonus payments will be non-pensionable, non-consolidated one-off payments paid in the following year. The value of the A & B non-consolidated bonus payments has been determined annually. Not more than 25%	

The Medical Director is on a consultant contract not VSM but is paid a management allowance for his Director role and this has been capped at total remuneration of £160k. This was determined by benchmarking by the Deputy Director of Human Resources and set at a comparable level for Medical Directors. Pay uplifts in his consultant contract will be offset with a reduction in the management allowance each year.

For Non-Executive Directors pay has been approved by the Council of Governors following a benchmarking review of other Foundation Trusts by the Trust Secretary and review by the Nominations Committee.

This was designed to ensure that the salary of the Non-Executive Directors (NEDs) be in keeping with other comparable Trusts and a consistent rate increase for the chairman and NEDs.

Pay Component	Description	Application
Chairman Basic Pay	a spot rate salary £46,500	Chairman
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 committee chairs

Service contract obligations
There are no provisions contained in senior managers' service contracts which could give rise to, or impact on, remuneration payments or payments for loss of office but which is not disclosed elsewhere in the remuneration report.

Policy on payment for loss of office
Existing Trust VSM contracts and notice periods of 6 months follow the Very Senior Managers guidance from the Department of Health. Notice periods for all very senior managers hired after 1st March 2015 are 3 months. Notice periods should normally be worked to ensure the NHS receives benefit during the notice period. This could include undertaking special projects, short term placements.

The Trust policy follows guidance previously issued by the former Strategic Health Authority the principle being that these are rare occurrences and alternative options should be fully explored, including secondments, retraining, use of capability and disciplinary procedures and third party mediation/intervention.

If having exhausted all other possibilities it becomes necessary to make a severance payment, a Business Case would be produced and vetted by the auditors before being agreed by the Remuneration Committee.

No awards have been made in the period to very senior managers.

The Chief Executive confirms that 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. This definition includes all executives and the Trust Secretary.

Annual Report on Remuneration

Information Not Subject to Audit

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

The Committee's members are the non-executive directors of the Trust and the Committee is chaired by the Trust Chairman:

Chairman:	David Griffiths
Member:	Peter Conway
Member:	Richard Field
Member:	Steve Howe
Member:	David Robinson
Member:	Bridget Skelton
Member:	Catherine Gaskell
Member:	Jennifer Tippin

The Chief Executive also normally attends meetings, except where matters relating to her 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 Chairman and the Non-Executive Directors, which is set by the Council of Governors.

The Committee has not met nor taken external advice in the period and therefore attendance by each member is not relevant.

Director service contracts are permanent with the following notice periods:

Senior Manager	Contract	Notice
Marion Dinwoodie, Chief Executive Officer	VSM	6 months
Lesley Strong, Deputy Chief Executive and Director of Operations, Adults	VSM	6 months
Gordon Flack, Director of Finance	VSM	6 months
Karen Proctor, Director of Nursing and Quality to 22nd March	VSM	6 months
Nicola Lucey, Interim Director of Nursing and Quality from 1st March	Agenda for Change on secondment	1 month
Mark Shepperd, Director of Operations Children and Young People	VSM	6 months
Peter Maskell, Medical Director	Consultant Contract	3 months
Natalie Davies, Trust Secretary	Agenda for Change	3 months
Nichola Gardner, Director of Strategy and Transformation	Agenda for Change	3 months

The following expenses were paid to Directors and Senior Managers in the period:

Directors & Senior Managers	Expenses (Rounded to nearest 100) £00
Lesley Strong, Deputy Chief Executive and Director of Operations, Adults	2
Gordon Flack, Director of Finance	2
Natalie Davies, Trust Secretary	2
Nichola Gardner, Director of Strategy and Transformation	1
Richard Field, Vice Chairman	3
Steve Howe, Non-Executive Director	4
Total	**14**

There were a total of 17 executive and non-executive directors in post in the reporting period and six of these received expenses paid by the Trust.

The following expenses were paid to Governors in the period:

Governors	Expenses (Rounded to nearest 100) £00
Peggy Lawlor	0
Catherine Wortham	0
Marion Keates	0
Stuart Alexander	0
Total	**0**

There were a total of 17 governors in office in the reporting period and four of these received expenses paid by the Trust.

Off – Payroll Arrangements

There is a requirement to disclose any off-payroll engagements where the Trust pays more than £220 per day over a period of more than six months. The Trust has no such engagements.

Information Subject to Audit

Salaries and allowances

Name & Title	2014-2015 Month 12					
	Salary & Fees	Taxable Benefits	Annual Performance-related Bonuses	Long term Performance-related Bonuses	All pension related benefits	Total
	(bands of £5000) £000	(Rounded to the nearest £100) £00	(bands of £5000) £000	(bands of £5000) £000	(bands of £2500) £000	(bands of £5000) £000
David Griffiths, Chairman	0 - 5					0 - 5
Marion Dinwoodie, Chief Executive	10 - 15	1			0	10 - 15
Lesley Strong, Deputy Chief Executive, Director of Operations, Adults	5 - 10				0	5 - 10
Mark Shepperd, Director of Operations, Childrens and Young People	5 - 10				0	5 - 10
Karen Proctor, Director of Nursing & Quality (to 22nd March)	5 - 10				0	5 - 10
Nicola Lucey, Interim Director of Nursing & Quality (from 1st March)	5 - 10				n/a	5 - 10
Gordon Flack, Director of Finance	5 - 10	6			0	10 - 15
Peter Maskell, Medical Director	10 - 15				12.5 - 15	25 - 30
Natalie Davies, Trust Secretary	5 - 10				0 - 2.5	5 - 10
Nichola Gardner, Director of Strategy and Transformation	5 - 10				0 - 2.5	5 - 10
Richard Field, Vice Chairman	0 - 5	2				0 - 5
Peter Conway, Non-Executive Director	0 - 5					0 - 5
Steve Howe, Non-Executive Director	0 - 5	3				0 - 5
David Robinson, Non-Executive Director	0 - 5					0 - 5
Catherine Gaskell, Non-Executive Director	0 - 5					0 - 5
Bridget Skelton, Non-Executive Director	0 - 5					0 - 5
Jennifer Tippin, Non-Executive Director	0 - 5					0 - 5

During the period 1st March 2015 to 31st March 2015 there was one new appointment; Nicola Lucey as Interim Director for Nursing & Quality. She started in post on 1st March 2015 and worked in this role alongside Karen Proctor, until Karen left on 22nd March 2015.

Pension Benefits

Name and Title	Real increase in pension at age 60 (bands of £2,500) £000	Real increase in pension lump sum at age 60 (bands of £2,500) £000	Total accrued pension at age 60 at 31.03.15 (bands of £5,000) £000	Lump sum at age 60 to accrued pension at 31.03.15 (bands of £5,000) £000	Cash Equivalent Transfer Value at 31.03.15 £000	Cash Equivalent Transfer Value at 01.03.15 £000	Real increase/ (decrease) in Cash Equivalent Transfer Value £000	Employer's Contribution to stakeholder pension £000
Marion Dinwoodie, Chief Executive	0	0	70 - 75	215 - 220	n/a	n/a	n/a	n/a
Lesley Strong, Deputy Chief Executive, Director of Operations, Adults	0 - 2.5	0 - 2.5	50 - 55	160 - 165	1,254	1,250	1	n/a
Mark Shepperd, Director of Operations, Children & Young People	0 - 2.5	0 - 2.5	40 - 45	125 - 130	783	781	0	n/a
Karen Proctor, Director of Nursing & Quality (to 22 March 15)	0 - 2.5	0 - 2.5	40 - 45	120 - 125	799	796	1	n/a
Nicola Lucey, Interim Director of Nursing & Quality (from 1st March)	n/a	n/a	40 - 45	120 - 125	649	n/a	n/a	n/a
Gordon Flack, Director of Finance	0 - 2.5	0 - 2.5	40 - 45	130 - 135	824	821	0	n/a
Peter Maskell, Medical Director	0 - 2.5	0 - 2.5	25 - 30	85 - 90	452	441	10	n/a
Natalie Davies, Trust Secretary	0 - 2.5	0 - 2.5	15 - 20	50 - 55	239	238	1	n/a
Nichola Gardner, Director of Strategy and Transformation	0 - 2.5	0 - 2.5	15 - 20	45 - 50	237	236	1	n/a

Any data expressed as n/a in the above tables is not applicable.

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 accrued by a member at a particular point in time. The benefits valued are the member's accrued benefits and any contingent spouse's pension payable from the scheme. 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. CETVs are calculated within the guidelines and framework prescribed by the Institute and Faculty of Actuaries. CETV figures are only applicable up to the age of 60.

Real Increase in CETV

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

Inflation Figure Applied to Calculate Real Increases to Pensions, Lump Sums and CETVs over the Period

The trust has used an inflation rate assumption of 0.225% to calculate real increases to pensions, lump sums and CETVs over the period. The Trust considers this an appropriate inflation figure to be used in calculations as at 31st March 2015 as it represents one twelfth of the 2.7% increase given to preserved and current pensioners over the financial year.

Highest Paid Director and Pay Multiples

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 figures below relate to full time annual salaries.

The banded annualised remuneration of the highest paid director in Kent Community Health NHS Foundation Trust in the financial period March 2015 was £135k-140k and was paid to the Chief Executive. This was 5 times the median annualised remuneration of the workforce, which was £25k.

In March 2015, 2 employees received remuneration in excess of the highest-paid director. Annualised remuneration for these two individuals was £138k and £198k. Total remuneration includes salary, non-consolidated performance-related pay, benefits-in-kind, but not severance payments. It does not include employer pension contributions and the cash equivalent transfer value of pensions.

Signed by:

Marion Dinwoodie, Chief Executive
(On behalf of the Board)

Appendix One
Kent Community Health NHS Foundation Trust
Quality Report

Kent Community Health NHS
NHS Foundation Trust

Quality Report

2014 - 2015

Excellent care, healthy communities

CONTENTS

SECTION 1

1.1 What is a Quality Report?

Quality Reports are annual reports that all providers of NHS services in England have a statutory duty to produce to the public about the quality of services they deliver and their plans for improvement. Some of the information in a Quality Report is mandatory but most is decided by patients and staff. This Quality report contains information about the quality of our services, the improvements we have made during 2014/15 and sets out our key priorities for next year.
This Report covers the full year 1 April 2014 to 31 March 2015, and covers both Kent Community NHS Trust (for the period 1 April 2014 to 28 February 2015) and Kent Community Health NHS Foundation Trust (for the period 1 March 2015 to 31 March 2015)

We have three important quality improvement areas that are the core of all our work:

- Patient safety
- Clinical effectiveness (how well the care provided works)
- Patient experience (how patients experience the care they receive)

We set five strategic Quality goals in last year's Quality Account (as the Quality Report was then called), with priorities within each goal, and these are reported on in section 3 of this report. These key areas are underpinned by enabling strategies to transform services to meet the needs of our population.

Clinical Commissioning Groups
Clinical Commissioning Groups (CCGs) commission most of the hospital and community NHS services in the local areas for which they are responsible. Commissioning involves deciding what services are needed, and ensuring that they are provided.

In our locality clinical commissioning groups are

- Ashford CCG
- Canterbury CCG
- Dartford , Gravesham and Swanley CCG
- South Kent Coast CCG
- Swale CCG
- Thanet CCG
- West Kent CCG

Information is provided in this report with details pertaining to individual Clinical Commissioning Groups, to demonstrate the differences in commissioning in different areas. For example, there are no community hospitals in Thanet CCG.

1.2

Statement on quality from the Chief Executive of the NHS Foundation Trust

Welcome to this year's Quality Report for Kent Community Health NHS Foundation Trust. I am delighted to share the progress and achievements we have made in 2014-2015 with our patients, staff and stakeholders and inform you of the quality of care and services we provide, together with the priorities we will deliver in 2015-2016.
Our patients and the quality of care they receive, is at the heart of everything we do. It is thanks to the commitment and dedication of our staff that we can continually improve the quality of our services. We have collaborated with the Clinical Commissioning Groups, our health and social care partners, NHS England, education authorities and the voluntary sector to shape health and social care in Kent and beyond. We have actively engaged with our partners, stakeholders and service users to assist us to co-design and develop our Quality goals and priorities and we know we need to increase this involvement in the development of our services.
We know the importance we place on safe care and effective treatment and it was encouraging to have this firmly endorsed by the Care Quality Commission which rated the Trust as GOOD following a thorough inspection in June 2014.
This rating and further rigorous assessments to demonstrate that we are consistently high-performing, well run, financially sound and have robust plans for the future resulted in Monitor approving us as a Foundation Trust on 1 March 2015.
Our staff and Board are very proud that we became the first NHS Trust is the county to be rated GOOD by the CQC and one of the first community trusts in the country to become a foundation trust. This is especially important to us as the process had a much stronger focus on quality following the Mid Staffordshire inquiry so that only the best performing organisations would pass.
Our Council of Governors, made up of local people, staff and representatives from partner organisations, has a leading voice in the future of community services and we have already signed up 11,000 public members, who along with our staff, have a greater say in the running of our Trust.
We are a learning organisation, striving to learn lessons when care does not meet expectations, implementing changes to improve standards. We share lessons through quality forums, mock CQC visits, root cause analysis of incidents and in our weekly communications with staff. We are committed to being "open and honest" and adhere to our duty of candour responsibilities.

We report our patient experience and complaints in public reports to the Board and on our website, our Quality Committee's in-depth focus every month scrutinises safety and quality, every directorate has a quality group and quality is on every team meeting agenda.
In 2014-2015 we have grown and developed taking on new business, gaining extra dental services, and services for children and young people to serve a wider geographical location and a greater population.
We are proud to report a culture of Compassionate Care (the six Cs). We are committed to providing care with intelligent kindness and "no decision about me, without me" communication.

We are dedicated to building a highly competent workforce through education, that can demonstrate courage to innovate and challenge, to improve patient care. We are ready to meet the challenges and opportunities for 2015/2016 and those set in the NHS Five Year Forward Plan.
Although we are in austere times, we remain focused on quality but also to maintain our financial responsibility for the present and the future.
There is more information about our Trust in our annual report which can be downloaded from our website www.kentcht.nhs.uk

Declaration

The Chief Executive should be the accountable officer for the Trust and that responsibility includes accountability for clinical governance and hence the quality and safety of care delivered by the Trust. The information in this Quality Report is provided from our data management and our quality improvement systems and to the best of my knowledge is accurate and provides a true reflection of our organisation.

Marion Dinwoodie
Chief Executive

2.1 Priorities for Improvement

KCHFT chose 6 priority areas for improvement which have been identified against our overall performance for 2014/15. These also reflect feedback received from key stakeholders, are underpinned by the strategic objectives and link to our quality aspirations and quality goals. All link to the three elements of quality – Patient Safety, Clinical Effectiveness and Patient Experience

			Page	2014/15	2013/14
1	Improving staff morale, recruitment and retention (workforce)	Implement the recruitment and retention strategy and workforce plan: • Reduce sickness absence to below 4% • Appraisal rates to be above 85%	 72 72	 X not achieved X not achieved	 X not achieved X not achieved
2	Learning from mistakes to improve safety (serious incidents)	Communicate honestly and openly with patients and their families when things go wrong. Implement the Duty of Candour Develop a new culture strategy called 'Embedding a Positive Culture'. Learn from lessons	61 61 72 61	√ achieved √ achieved √ achieved √ achieved	√ achieved Not applicable Not applicable √ achieved
3	Implementation of the Mental Capacity Act. (MCA)	Ensure that 85% of staff are compliant with safeguarding/MCA (Mental Capacity Act) and Deprivation of Liberty Safeguards (DoLS) Reduce the number of cases of avoidable harm	19 19	√ achieved √ achieved	√ achieved X not achieved
4	Reduction in medication errors	Reduce dosing errors and omitted does	17	√ achieved	√ achieved
5	Wound medicine - improve pathways, healing rates and reduction in pressure ulcers	Expand tissue viability team Ensure all staff are trained and competent in wound care Increase and ensure compliance with the first choice dressing list Continue the campaign on nutrition and hydration to aid healing Reduction in attributable pressure ulcers	31 30 31 42, 55 25, 30	√ achieved X not achieved √ achieved Partially achieved Partially achieved	Not applicable Not applicable Not applicable Achieved Partially achieved
6	Continue to develop integrated care pathways and ways of working	Implement the End of Life Care Strategy and Dementia Strategy Improved utilisation of community beds: • Improve discharge skill and competencies to support timely discharge and transfers • Increase health and wellbeing support in communities • Increase intravenous support in the community to allow care closer to home	40, 44 76 42 57 43	√ achieved √ achieved √ achieved √ achieved	Not applicable Not applicable Not applicable Not applicable

Our priorities for the coming year are;
Patient Experience: Aligned to our Strategic Goal 4

- End of Life care
- Patient feedback: listening and engaging with the public - increasing feedback
- Optimising health promotion and independence - health visitor metric; pathways such as the older person's volunteer programme with partners
- Right care in the right place at the right time – long-term conditions, continence services

Patient Safety: Aligned to our strategic Goal 5

- Reduction in Harm: measured through reductions in avoidable pressure ulcers; falls with harm; healthcare associated infection
- Medicines optimisation
- Vulnerable patients/clients: improve pathways for vulnerable patients - looked after children; dementia care; older person's health and wellbeing

Clinical Effectiveness: Aligned to our strategic Goals 1-3

- Increase research activity; innovation and evidence-based care
- Compliance with NICE guidance
- Open and transparent culture

These are all underpinned by enabling work streams that support quality care:

- Education and training
- Estates strategy
- Organisational culture
- Financial stability
- Partnership working
- Innovation and transformation

Goal 1: Prevent people from becoming unwell and dying prematurely by improving the health of the population through universal targeted services.

Goal 2: Enhance the quality of life for people with long-term conditions by providing integrated services to enable them to manage their condition and maintain their health.

Goal 3: Help people recover from periods of ill health or following injury through the provision of responsive community services.

Goal 4: Make sure people have a positive experience of care and improved health outcomes by delivering excellent health care.

Goal 5: Make sure people receive quality and safe care.

2.2 Statements of Assurance from the Board

1. During 2014-2015 Kent Community Health NHS Foundation Trust provided and/or sub-contracted sixty three relevant health services.

1.1 Kent Community Health NHS Foundation Trust has reviewed all the data available to it on the quality of care in sixty three of these relevant services.

1.2 The income generated by the relevant health services reviewed in 2014-2015 represents 93% of the total income generated from the provision of relevant health services by Kent Community Health NHS Foundation Trust for 2014-2015.

2. During 2014/15 three national clinical audits and three national confidential enquiries covered relevant health services that Kent Community Health NHS Foundation Trust provides.

2.1 During that period Kent Community Health NHS Foundation Trust participated in 100% national clinical audits and 100% national confidential enquiries of the national clinical audits and national confidential enquiries which it was eligible to participate in.

2.2 The list of the national clinical audits and national confidential enquiries that Kent Community Health NHS Foundation Trust was eligible to participate in during 2014/15 are as follows:

National Clinical Audit Title
Sentinel Stroke National Audit Programme
National Audit of Intermediate Care

National Confidential Enquiry Title
Lower Limb Amputation – organisational survey
Mortality Review –organisational survey
Sepsis – organisational survey

2.3 The national clinical audits and national confidential enquiries that Kent Community Health NHS Foundation Trust participated in during 2014/15 are as follows:

National Clinical Audit Title
Sentinel Stroke National Audit Programme
National Audit of Intermediate Care

National Confidential Enquiry Title
Lower Limb Amputation – organisational survey
Mortality Review –organisational survey
Sepsis – organisational survey

2.4. The national clinical audits and national confidential enquiries that Kent Community Health NHS Foundation Trust participated in, and for which data collected was completed during 2014/15 are listed below alongside the number of cases submitted to each audit or enquiry as a percentage of the number of registered cases required by the terms of that audit or enquiry.

National Clinical Audit Title	Percentage Submission
Sentinel Stroke National Audit Programme	N/A – there is no set case number requirement. We have submitted 110 cases which represents 27% of our total cases.

National Audit of Intermediate Care	N/A – there is no set case number requirement

National Confidential Enquiry Title	Percentage Submission
Lower Limb Amputation – organisational survey	N/A – Organisational survey completed not eligible for clinical audit element.
Mortality Review – organisational survey	N/A – Organisational survey completed not eligible for clinical audit element.
Sepsis – organisational survey	N/A – Organisational survey completed not eligible for clinical audit element.

2.5 - 2.8 The reports of 2 national clinical audits were reviewed by the provider in 2014/15 and Kent Community Health NHS Foundation Trust intends to take the following actions to improve the quality of healthcare provided:

- Joint BASHH BHIVA National Clinical Audit of HIV Partner Notification – as a result of this audit a proforma for partner notification has been developed and is currently being trialled. This acts as a prompt for clinicians.
- National Audit of Intermediate Care – Dementia training increased. In a separate but linked piece of work a dementia knowledge survey was conducted to test staff knowledge.

The reports of 99 local clinical audits were reviewed by the provider in 2014/15 and Kent Community Health NHS Foundation Trust intends to take the following actions to improve the quality of healthcare provided:

- Introduce a tick box for Being Open on Datix and to promote Duty of Candour training to heads of service.
- Liaise with the acute trust to agree that patients will only be transferred out of hours in an emergency.
- Implement Situation Background Action Recommendation (SBAR) communication model for handover across all services.
- Staff within Dartford Gravesham and Swanley community nursing to complete nutritional workshop on care planning and referral process.
- Arrange Mental Capacity Act training for agency staff with special emphasis for those on longer term contracts.
- Implement food diaries within the community setting to ensure monitoring of nutritional status in high risk patients.
- Amend infection control audit tool to concentrate on clinical aspects of patient care. This will include urinary catheter care and adherence to MRSA policy.
- Revise Safeguarding Supervision Policy to promote improved information sharing to aid and inform professionals' decisions on the outcome of service users' needs.
- Ashford Community Nursing team to re-introduce use of 'Consideration for Telehealth' form for all long-term condition patients.
- In response to Child Sexual Abuse (CSA) Care Pathway audit, multi-agency training to be introduced to raise awareness of the need to consider health aspects during assessment of cases referred for CSA care pathway and also to provide education regarding medical examinations.
- Ready, Steady, Go team to review current procedure and introduce an agreed process to ensure consistency when enquiring and recording signposting of families to suitable services.

- Establish an audit trail of transfer of care that the Do Not Attempt Cardio-Pulmonary Resuscitation (DNACPR) form has been reviewed by the senior clinician involved.
- Following a review of health assessments for looked after children, nurses to ensure that all elements of the health assessment are discussed and evidenced on the British Association for Adoption and Foster (BAAF) form and where an element is not applicable to explicitly document this. BAAF Medical and Social Report forms provide an integrated system for collecting information about children, birth parents and prospective adoptive parents or foster carers. They are used in community paediatrics for Looked After Children/Adoption services.
- Include patients and staff in education about antimicrobial resistance.
- Ensure staff in all services have appropriate information to support patient choice and understanding of pain management.

3.0 The number of patients receiving relevant health services provided or subcontracted by Kent Community Health NHS Foundation Trust that were recruited during that period to participate in research approved by a research ethics committee is 1895.

4.0 - 4.1 A proportion of Kent Community Health NHS Foundation Trust's income in 2014/15 was conditional on achieving quality improvement and innovation (CQUIN) goals agreed with commissioners, through the Commissioning for Quality and Innovation payment framework. Further details of the agreed goals for 2014-2015 are available electronically at www.kentcht.nhs.uk

Financial Statements

2013-2014	CQUIN		
	Plan	Actual	
CCG/Commissioner	**Annual Value**	**Achieved Q1-4**	**Variance**
Ashford	329,201	286,207	42,994
Canterbury	599,851	557,142	42,709
DGS	466,142	397,712	68,430
Medway	33,481		33,481
South Kent Coast	639,663	601,027	38,636
Swale	316,240	282,845	33,395
Thanet	488,351	458,855	29,496
West Kent	805,907	702,106	103,801
Trustwide	**3,678,836**	**3,285,895**	**392,941**

2014-2015*	CQUIN			LIS		
	Plan	Actual		Plan	Actual	
CCG/Commissioner	**Annual Value**	**Achieved Q1-4**	**Variance**	**Annual Value**	**Achieved Q1-4**	**Variance**
Ashford	£259,000	£226,571	-£32,429	£123,609	£52,962	£70,647
Canterbury	£633,000	£568,249	-£64,751	£311,523	£125,394	£186,129
DGS	£506,041	£90,455	-£415,586	£309,255	£85,769	£223,486
South Kent Coast	£600,000	£524,375	-£75,625	£257,609	£130,273	£127,336
Swale	£332,478	£77,717	-£254,761	£257,421	£58,939	£198,482
Thanet	£430,000	£390,583	-£39,417	£167,669	£89,932	£77,737
West Kent	£867,298	£834,232	-£33,066	£638,722	£317,020	£321,702
East Sussex	£110,997	£109,147	-£1,850	£0	£0	£0
NHSE	£672,000	£0	-£672,000	£0	£0	£0
Trustwide	**£4,410,814**	**£2,821,328**	**-£917,486**	**£2,065,808**	**£860,289**	**1,205,519**

CQUIN – Commissioning for quality improvement payment
LIS – local incentive scheme
*figures correct at time of publication

Synopsis		
CQUIN Q1 - 3 Actual	£1,964,407	
CQUIN Q4 Estimate	£856,921	Total CQUIN-LIS Impact
LIS Q1 - 3 Actual	£683,118	£288,033
CQUIN Q4 Estimate	£177,172	**favourable**

5.0 - 5.1 Kent Community Health NHS Foundation Trust is required to register with the Care Quality Commission and its current registration status is registered without conditions. The Care Quality Commission has not taken enforcement action against KCHFT during April 2014 to March 2015.

7.0 - 7.1 Kent Community Health Foundation NHS Trust participated in a special review by the Care Quality Commission relating to the following areas during April 2014-March 2015: “Review of health services for Children Looked After and Safeguarding in Kent (Communities served by West Kent, Swale, and Dartford, Gravesham & Swanley Clinical Commissioning Groups)”. The review included the Clinical Commissioning Groups (CCGs), Kent County Council, KCHFT and the acute Trusts in north Kent.

Recommendations were made for all agencies to implement, these related to: appropriate arrangements for information sharing and care planning; better understanding of and access to the Common Assessment Framework; quality assurance systems relating to domestic violence enquiries and procedures; systems for safeguarding notifications; completion of assessments; record keeping arrangements; completion of health action plans; arrangements for designated leads for children looked after; provision of health histories to care leavers; accountabilities of healthcare professionals; promotion of privacy and confidentiality; assessment of emotional and mental wellbeing of children looked after; policy regarding non-attendance at medical appointments; training for staff; quality assurance of outcomes and access to safeguarding supervision for staff.

All actions are in progress and many have been completed. The CCG is co-ordinating all agencies’ responses and progress against the action plan.

The CQC undertook a full inspection of KCHFT in June 2014. Following this the CQC rated the Trust as good. Areas the Trust must improve were identified around end of life care, including the need to improve completion of do not attempt resuscitation orders; provision of equipment to end of life patients and auditing of end of life care plans. The Trust implemented an improvement plan to address these issues and this is now complete.

8/8.1

Kent Community Health NHS Trust submitted 2434 records during April-14 to March-15 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 99.76% for admitted patient care
- which included the patient's valid General Medical Practice Code was 99.72% for admitted patient care.

Kent Community Health NHS Trust submitted 115200 records during April-14 to March-15 to the Secondary Uses service for inclusion in the A+E dataset 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 98.85% for admitted patient care
- which included the patient's valid General Medical Practice Code was 97.64% for admitted patient care.

9.0 Kent Community Health NHS Foundation Trust Information Governance Assessment Report overall score for 1 April 2014 to 31 March 2015 was 83% and was graded green (Satisfactory).

10.0 Kent Community Health NHS Foundation Trust was not subject to the Payment by Results clinical coding audit during 2014-2015 by the Audit Commission.

11.0 Kent Community Health NHS Foundation Trust will be taking the following actions to improve data quality

- Moving all applicable services to our new Community Information System (CIS) which is directly linked to the NHS Spine.
- Working with the systems teams to ensure gaps in data quality are investigated and actions put in place to improve.
- Regularly running data quality reports and sharing with services and systems teams.
- Working towards the Community Information Dataset (CIDS) which standardises data collection.
- We have a data quality improvement plan in place with CCGs, so we will be monitoring these plans and making improvements where necessary.

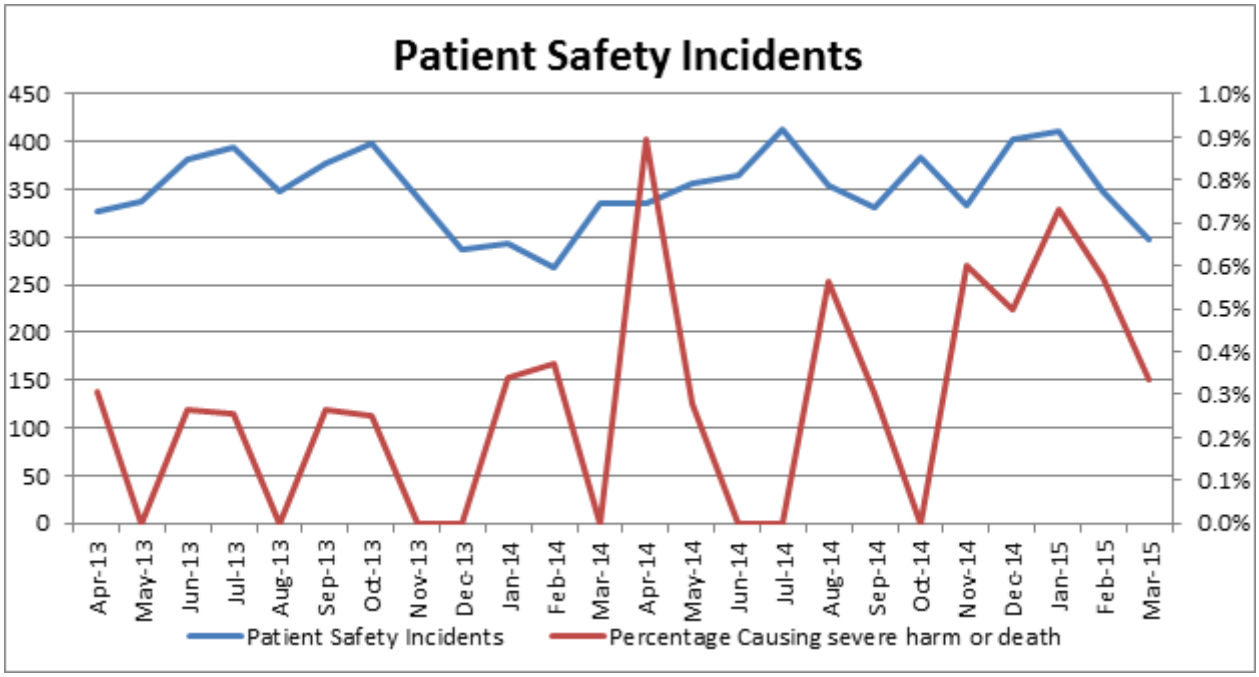
2.3 Reporting against core indicators

Since 2012/13 NHS foundation trusts have been required to report performance against a core set of indicators using data made available to the Trust by the Health and Social Care Information Centre (HSCIC). The numbering scheme used below corresponds with the numbering of the indicators in the Regulation 4 Schedule within the Quality Accounts Regulations.

Mandatory Statement 19

During 2014/15, 240 of 3,079 patients discharged from our community hospitals (all aged 15 or over) were re admitted to our community hospitals within 28 days (7.79%). This is a reduction from the 2013/14 figures of 265 of 3189 patients readmitted (8.31%)

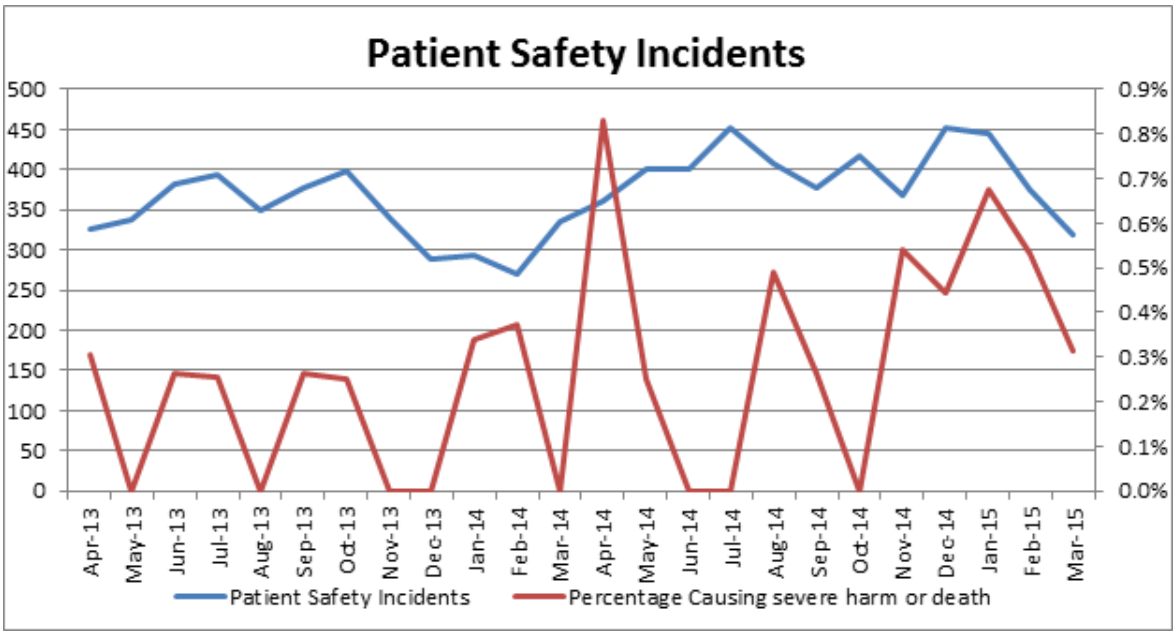
	2013/14	2014/15
Number of 28 day Readmissions from Discharge	265	228
% 28 day Readmissions	8.31%	7.96%



Kent Community Health NHS Foundation Trust considers that this data shows a slight decrease due to improved admission criteria.
Kent Community Health NHS Foundation Trust intends to improve this percentage, and the quality of its services, through the implementation of its Community Information System (CIS), monitoring the data regularly and having the services validate the findings, reporting at various levels within the organisation and spot checks to confirm accuracy and to correct any errors, tightening admission criteria to ensure appropriate admissions

Mandatory Statement 25; Patient Safety Incidents

	2013/14	2014/15
Attributable Patient Safety Incidents	4092	4773
Attributable Patient Safety Incidents (causing Severe Harm or Death)	7	17
Percentage causing Severe Harm or Death	0.2%	0.36%



During 2013/14, Kent Community Health NHS Foundation Trust had 4092 patient safety incidents, of which 7 (0.2%) resulted in a serious harm or death. In 2014/15, Kent Community Health NHS Foundation Trust had 4773 patient safety incidents, of which 17 (0.36%) resulted in a serious harm or death. This is an increase by 16.6% of all incidents and an increase by 170% of incidents that resulted in serious harm or death. Kent Community Health NHS Foundation Trust considers that this can be attributed to improved changes in reporting from integrated care units.

For the first 6 months of the year, KCHFT had 7 incidents causing severe harm or death, which equates to 0.3% of all patient safety incidents. The compares favourably with other Community Trusts over the same period, with the average being 1% of incidents resulting in severe harm or death. During this period, KCHFT were the second best performer, with the best performing Community Trust having no severe harm or death. The worst performing Community Trust had around 4% of incidents causing severe harm or death

Kent Community Health NHS Foundation Trust intends to take the following actions to improve this position, and the quality of its services, by continuing to monitor at service level through the Early Warning Trigger Tool, monitoring through the Board Report with relevant corrective actions taken and reviewing the reporting processes in integrated units.

3.1 Performance 2014/15

The following section of the report provides more detail on the achievements of the individual goals. There are a variety of subject areas underneath each goal which support delivery and attainment. Each subject area will provide an update on progress made during 2014/15 and will highlight the priority areas for continual improvement for 2015/16.

Patient Safety; Reduce the number of medication errors and increase optimisation of medicines
Goal 1: Measurable year on year improvement in every area of patient safety in community services.
Delivering Safe Medicine Management

GOALS ACHIEVED

Goals for 2014/15

The Trust recognises that the use of medicine by our service users is key to self management and wellbeing, so we developed ways, through the Medicines Optimisation Strategy, to optimise best medicines practise including medicines safety, effective medication choices and patient outcomes, and the patient experience of medicines.

- To develop and implement the Medicines Optimisation Strategy

Metric Targets

- Reduction in medication errors causing harm by 15% on 2013/14 baseline

How did we perform in 2014/15?

KCHFT provides safe management of medicines through the structured approach of Medicines Optimisation. Medicines Optimisation ensures that the right patients get the right medicines at the right time. By focussing on the patients and their experiences, the goal is to help patients to;

- Improve their outcomes
- Take their medicines correctly
- Avoid taking medicines unnecessarily
- Reduce wastage of medicines.
- Improve medicines safety

Medicines Optimisation is a patient-focussed approach to obtain the best from investment and use of medicines. It requires a holistic approach, an enhanced level of patient-centred professionalism and partnership between clinical professionals and patients. KCHFT has in place a Medicines Optimisation Five Year Strategy with an associated action plan.

KCHFT's Medicines Optimisation Strategy links with the KCHFT Medicines Optimisation Business Plan and objectives of all pharmacy staff. All documents are regularly reviewed by the Chief Pharmacist and governance is provided by the Medicines Management Governance Group.

All medicines systems and process are supported by policy and associated standard operating procedures which are available to staff via staff zone or the pharmacy team. All activities are supported by updated educational packages.

The recruitment of additional pharmacists has permitted twice weekly clinical visits to community hospitals and therefore more frequent pharmacy input into medicines reconciliation and work to introduce improved medicines practices in the community for both adults and children.

Patients and carers are involved individually on wards and domiciliary settings and are supported by aids and leaflets. Governance of medicines MMMGG (the Medicines Management Governance Group) membership, development of FCDL formulary and patient info line. This coming year will see the launch of the patient medicines information line.

Significant progress has been made with a new style Medicines Quality of Care Improvement System. The system using all available information concerning medicines, audit results, incident reports, information queries, patient and staff feedback to use of medicines and patient outcomes. Work will continue during 2015-16 to develop the system and make more effective use of information available to improve patient care.

Medicines Optimisation Assessment showed KCHFT as the second highest scoring Trust with respect to Medicines Optimisation Standards.

A repeat of the annual omitted dose audit has shown a further reduction in the number of omitted doses in community hospitals following the implementation of action identified the previous year. Omitted dose rates are, on average less than acute trusts nationally.

A decrease in the level of harm is noted:

The overall percentage of risk errors		
	2013	2014
significant risk	0.25%	0.11%
moderate risk	0.24%	0.12%
low risk	0.92%	0.92%

The frequency of peer checking is generally improving across community hospitals and is now embedded in practice at all community hospital sites. There is a positive correlation between frequency of peer checking and low omitted dose rates. An action plan is in place to improve further the frequency of omitted doses. A reduction in omitted doses means patients are receiving the medicines at the correct time which improves patient outcomes.

Patient Safety; Improve implementation of the Mental Capacity Act (MCA)
Goal 1: Measurable year on year improvement in every area of patient safety in community services.
Safeguarding: Decrease the number of safeguarding cases implicating KCHFT in safeguarding concerns

GOALS ACHIEVED

The Trust recognises its responsibility to prevent abuse of adults and children who are at risk. Safeguarding is a fundamental part of patient safety and healthcare professionals have a key role in identification of safeguarding concerns and responding appropriately to them.

Goals for 2014/15

- Ensuring that 85% of staff are compliant with safeguarding/MCA (Mental Capacity Act) and Deprivation of Liberty Safeguards (DoLS)
- Reducing the number of cases of avoidable harm remains a priority for KCHFT in 2015/16
- Supporting MCA link nurses to consolidate their role within Community Hospitals
- Achieve and maintain corporate compliance for all safeguarding training and ensure robust action plans are in place and delivered against by each service that continues to show non-compliance. 85% of community hospital band 6 and 7 practitioners to have their competency assessed for DoLS
- Review our MCA training to embed MCA into Consent and Safeguarding Children training.

How did we perform in 2014/15?

We have exceeded our target of 85% compliance in MCA and DoLs training with 90 % of staff having accessed the MCA training relevant to their role. Our commitment to ensure that we have a workforce that is appropriately trained and aware of its safeguarding and Mental Capacity Act (MCA) responsibilities has remained a priority within the Trust. We have created and provided innovative formats to deliver this training including DVD, face-to-face, e-learning, group discussion, supervision, and refresher tests, From January 2015, we have included MCA level 1 training in our corporate induction programme, which all new staff complete before they start in post which will significantly boost MCA training compliance across all clinical services.

The safeguarding team review incident reporting and are routinely involved in serious incident investigations. We feel there is improved engagement of operational services in what constitutes avoidable harm, how to reduce the incidence and early involvement of SG services practice concerns and decision-making. The safeguarding team collaborate with partner organisations in serious case reviews and investigations to continually evolve safeguarding proactively across all services and third party providers.

We achieved our target to reduce the number of cases of avoidable harm from nine in 2013-2014 to five in 2014-2015. We have exceeded our goal with 100% of senior Community Hospital staff having their MCA competencies assessed and signed off by our specialist safeguarding practitioners. We are now working with our clinical leads to agree how we may assess MCA competencies in Community Nursing teams across the Trust.

Patient Safety; Learning from mistakes to improve safety
Goal 1: Measurable year on year improvement in every area of patient safety in community services.
Safe Care Deliverables

GOALS ACHIEVED

Goals for 2014/15

- We will strive to reduce the severity of harm caused by patient safety incidents by encouraging our staff to report and learn from all incidents.
- We aim to improve incident reporting across the organisation by 10%

How did we perform in 2014/15?

We have encouraged staff to report and learn from all incidents by making it easier to identify learning from incidents on the incident form, promoted incident reporting twice yearly by the use of a screensaver on all Trust desktops and delivered training to services where the rate of incident reporting is low.

Incident reporting has increased by 15% in 2014-2015, exceeding our goal.

Patient Safety;
Goal 1: Measurable year on year improvement in every area of patient safety in community services.
Infection Prevention and Control Reduction in Health Care Associate Infections

GOALS PARTIALLY ACHIEVED

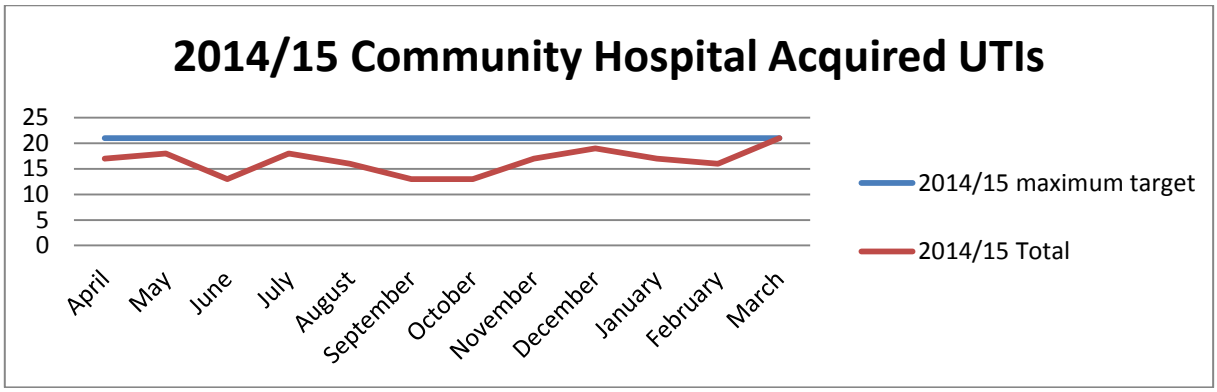
The Quality Goal 2014/15:

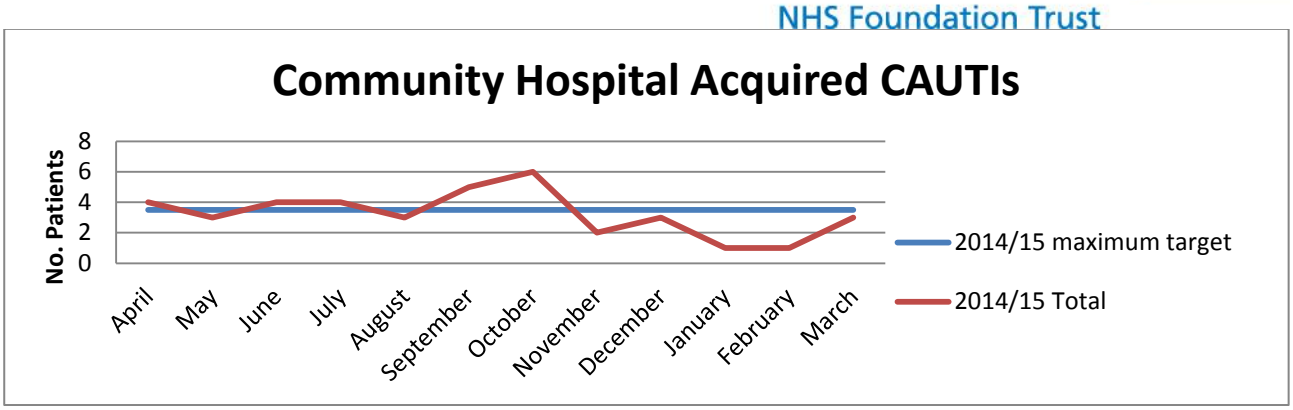
- Reduce Clostridium Difficle to no more than 7 cases
- Catheter Acquired Urinary Tract Infection (CAUTI) and Urinary Tract Infection (UTI) to reduce by a further 10%
- Ensure 100% compliance with Methicillin-resistant Staphylococcus aureus (MRSA) screening
- Increase the percentage scores on the Patient Lead assessment of the Care Environment (PLACE) audit to at least the national average
- Ensure full compliance with hand hygiene and improve compliance with infection prevention training
- Increase the percentage uptake of staff flu vaccinations

How did we perform in 2014/15?

Clostridium difficile
We did not achieve our target of *Clostridium difficile* infection reduction, breaching by one case; of the eight cases only one was deemed avoidable. We will now focus on identification of patients at risk and continue cross boundary working with the medicines management teams and the Kent-wide HCAI reduction group to assist in reduction.

UTIs and CAUTIs
We have exceeded our goal of a 10% reduction in CAUTIs in community hospitals, with 39 reported; a 15% reduction. We have exceeded our goal to reduce UTIs in community hospitals by 10% with 198 reported, a 29% reduction. A new catheter care bundle has been rolled out within the community hospitals and is now being introduced in the community nursing teams.





Reduction in overall HCAIs means ultimately decreased hospital stays for patients and decreased requirements for antimicrobials.

MRSA screening

We did not achieve our goal of 100% MRSA screening compliance, but screening has averaged 98.5% through the year; subsequently all patients were tested and found to be negative; no patients came to harm. Multiple factors were identified as influencers on our target, but mainly around staff failure to recognise need for screening, often owing to high use of agency or new staff. Increased training and support has been placed in the hospitals and the MRSA policy is currently under review, owing to publication of new guidance. There were no MRSA bacteraemias attributed to KCHFT.

PLACE scores

PLACE scores are reported in four sections; compared to national scores, KCHFT was above average for food but below for privacy and dignity, condition, appearance and maintenance and cleanliness. There has been a significant improvement in compliance to infection control and hand hygiene training, full compliance has been achieved for hand hygiene and just 1% below target for overall training. These are the highest compliance rates in over 2 years.

Whilst scores have improved in three areas, the Trust remains below the average scores for equivalent community trusts in three areas and due to changes in methodology, comparisons on privacy and dignity cannot be compared to the previous year. Whilst PLACE scores have improved, we have not achieved national average scores. The Trust's Estates team is working closely with clinical teams and NHS Property Services to produce action plans to improve compliance. However, as the Estate is not owned by KCHFT, it is envisaged these changes will take a prolonged time to complete.

	Cleanliness	Food	Privacy and Dignity	Condition, appearance and Maintenance
National Average	97.25%	88.79%	87.73%	91.97%
Community Provider national average	96.9%	90.5%	84.3%	90.3%
KCHFT average	92.67% (↑3.73%)	90.75% (↑4.7%)	73.82% (↓7.96%)	82.92% (↑5.03%)

Staff Flu vaccinations

We have achieved our target to increase the uptake of flu vaccinations achieving 46.8% among frontline health care staff but further improvements need to be made to achieve the national target of 75%. We are in line with other trusts in the South NHS England region. Vaccination of health care staff prevents transmission of flu to vulnerable people e.g. the elderly and those with chronic conditions such as COPD.

Part of the KCHFT staff flu campaign

CCG Positions

DGS CCG

Gravesham and Livingstone hospitals	Annual %		Annual total
Compliance to MRSA screening requirements	98.2	Catheter Associated Urinary Tract Infections	8
Hand Hygiene Audit Score	97.3	Urinary Tract Infections NOT associated with a catheter	23

Swale CCG

Sittingbourne and Sheppey hospitals	Annual %		Annual total
Compliance to MRSA screening requirements	100	Catheter Associated Urinary Tract Infections	11
Hand Hygiene Audit Score	98.7	Urinary Tract Infections NOT associated with a catheter	40

Ashford and Canterbury CCG – Faversham and QVMH Hernebay and Whit and Tank

Faversham, Queen Victoria Memorial and Whitstable and Tankerton hospitals	Annual %		Annual total
Compliance to MRSA screening requirements	99.8	Catheter Associated Urinary Tract Infections	9
Hand Hygiene Audit Score	99.9	Urinary Tract Infections NOT associated with a catheter	32

South Kent Coast CCG

Deal Hospital	Annual %		Annual total
Compliance to MRSA screening requirements	100	Catheter Associated Urinary Tract Infections	2

Hand Hygiene Audit Score	100	Urinary Tract Infections NOT associated with a catheter	15

West Kent CCG

Hawkhurst, Sevenoaks, Tonbridge, Edenbridge hospitals	Annual %		Annual total
Compliance to MRSA screening requirements	96.9	Catheter Associated Urinary Tract Infections	11
Hand Hygiene Audit Score	98.3	Urinary Tract Infections NOT associated with a catheter	77

Patient Safety;
Goal 1: Measurable year on year improvement in every area of patient safety in community services.
Harm Free Care

GOALS ACHIEVED

Delivering harm free care is important to KCHFT. The NHS Safety Thermometer allows us as a Trust and teams individually to measure harm and the proportion of patients that are 'harm free'.

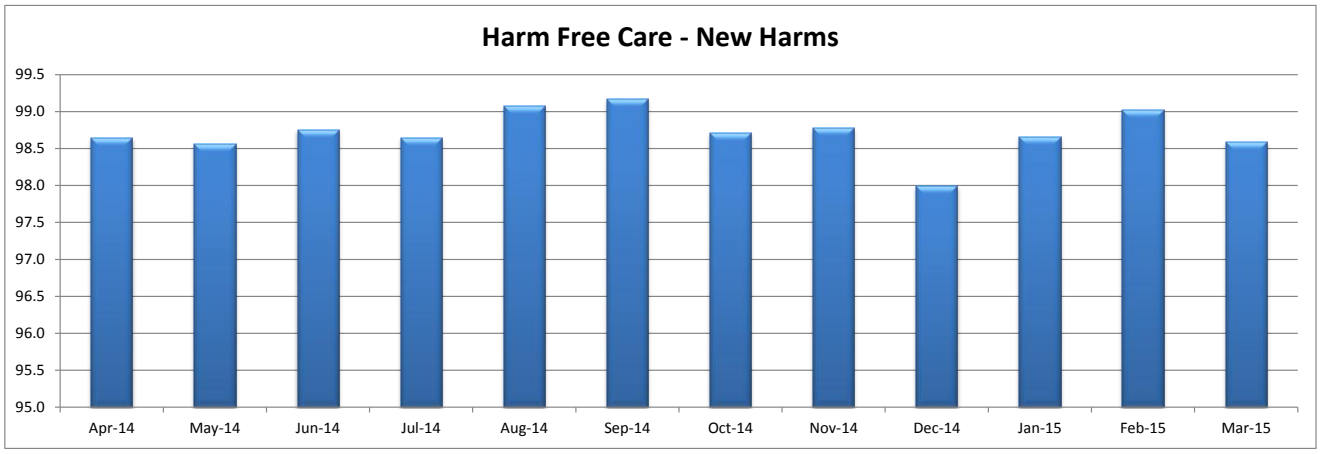
The Quality Goal 2014/15:

- To be an early implementer of the new national medication safety thermometer tool
- To maintain and improve 95% and above Harm Free Care for new harms
- To reduce the number of new harm pressure ulcers by 20%
- To reduce the number of old pressure ulcers by 5% by working in partnership across the whole system

How did we perform 2014/15?

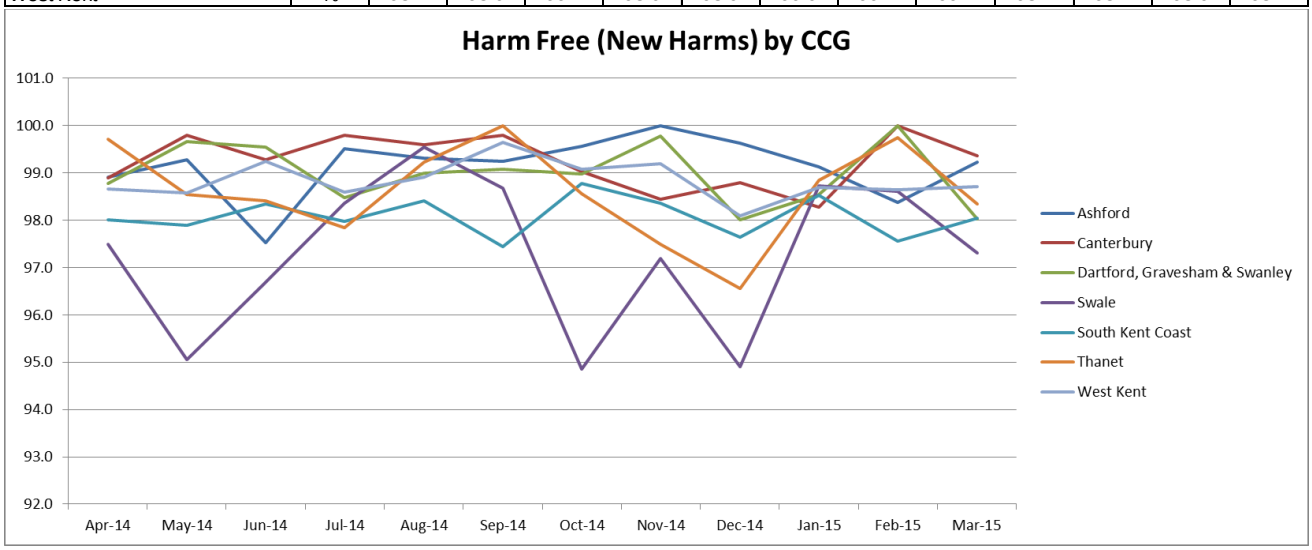
Kent Community Health NHS Foundation Trust (KCHFT) has signed up to participate in the Next Generation of Safety Thermometers by participating in the Medication Safety Thermometer. This project is currently in a pilot phase within KCHFT with one Intermediate Care team, three District Nursing teams and four hospitals now participating. The medication safety thermometer measures both 'Error Free' Care, monitoring omitted doses and 'Harm Free' Care, monitoring the administration of high risk medications, and the potential and actual harms caused by these medications. We anticipate that metrics will begin to be available during 2015/16.

KCHFT consistently achieves above 95% Harm Free Care for new harms (results displayed in the table below) with a Year End total of 98.7% Harm Free Care, achieving our goal and exceeding National Benchmarking targets consistently each month.



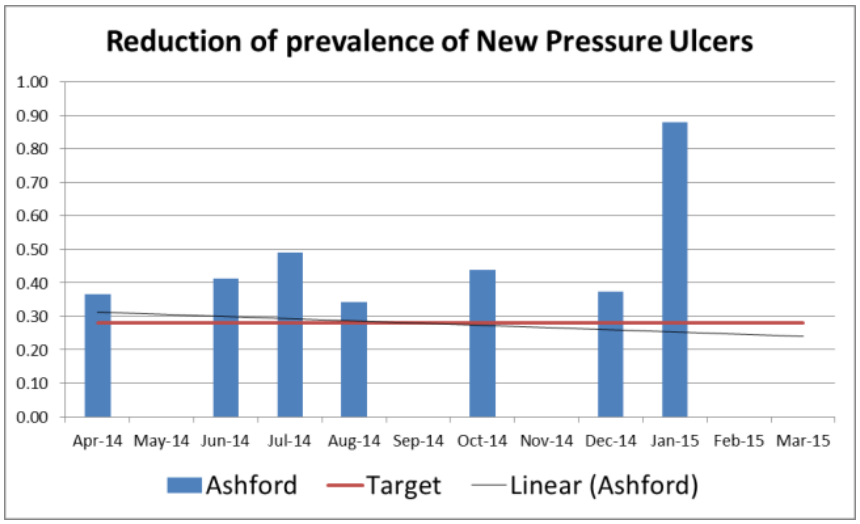
Details are provided at CCG level in the table below:

Harm Free (New Harms) by CCG		Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15
Ashford	%	**98.9**	**99.3**	**97.5**	**99.5**	**99.3**	**99.2**	**99.6**	**100.0**	**99.6**	**99.1**	**98.4**	**99.2**
Canterbury	%	**98.9**	**99.8**	**99.3**	**99.8**	**99.6**	**99.8**	**99.0**	**98.4**	**98.8**	**98.3**	**100.0**	**99.4**
Dartford, Gravesham & Swanley	%	**98.8**	**99.7**	**99.6**	**98.5**	**99.0**	**99.1**	**99.0**	**99.8**	**98.0**	**98.5**	**100.0**	**98.0**
Swale	%	**97.5**	**95.0**	**96.7**	**98.4**	**99.5**	**98.7**	**94.9**	**97.2**	**94.9**	**98.7**	**98.6**	**97.3**
South Kent Coast	%	**98.0**	**97.9**	**98.3**	**98.0**	**98.4**	**97.4**	**98.8**	**98.4**	**97.6**	**98.5**	**97.6**	**98.0**
Thanet	%	**99.7**	**98.5**	**98.4**	**97.8**	**99.2**	**100.0**	**98.6**	**97.5**	**96.6**	**98.8**	**99.7**	**98.3**
West Kent	%	**98.7**	**98.6**	**99.2**	**98.6**	**98.9**	**99.6**	**99.1**	**99.2**	**98.1**	**98.7**	**98.6**	**98.7**



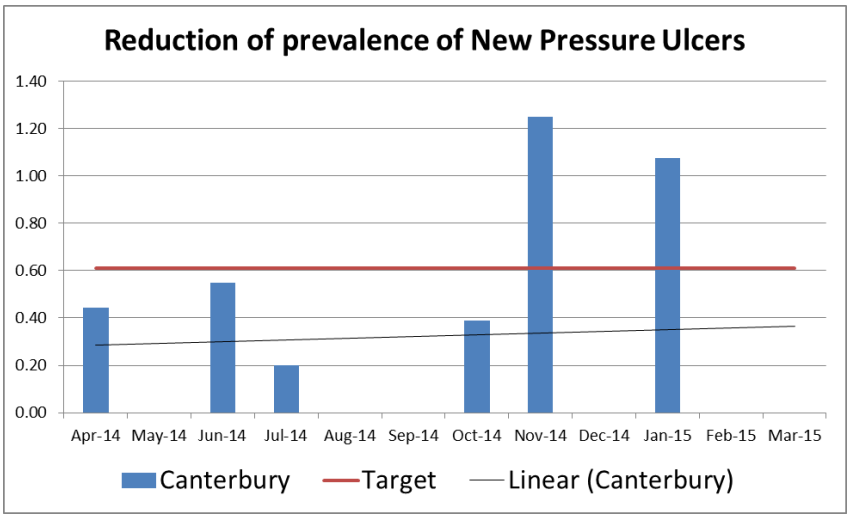
Ashford CCG

Ashford CCG locality has consistently achieved above 95% for Harm Free Care for new harms, with a year end figure of 99.1%. Ashford has achieved its target for the reduction in prevalence of new pressure ulcers in 5 out of 12 months in 2014-15, with monthly results showing an overall downward trend. Ashford has achieved its target for the reduction in prevalence of old pressure ulcers for 6 out of 12 months in 2014-15, with monthly results showing an overall downward trend.



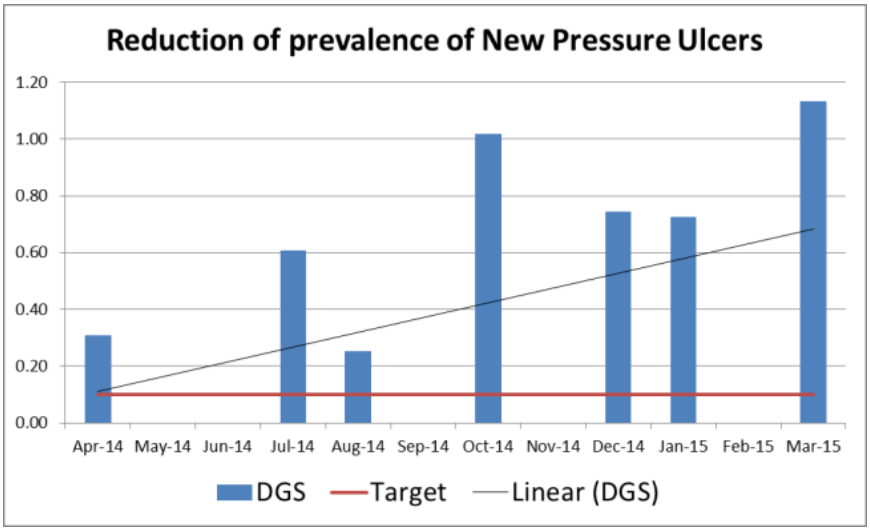
Canterbury CCG

Canterbury CCG locality has consistently achieved above 95% for Harm Free Care for new harms, with a yearend figure of 99.3%. Canterbury has achieved its target for the reduction in prevalence of new pressure ulcers for 10 out of 12 months in 2014-15, with monthly results showing an overall upward trend towards the end of the reporting year. Canterbury has achieved its target for the reduction in prevalence of old pressure ulcers for 10 out of 12 months in 2014-15, with monthly results showing an overall downward trend.



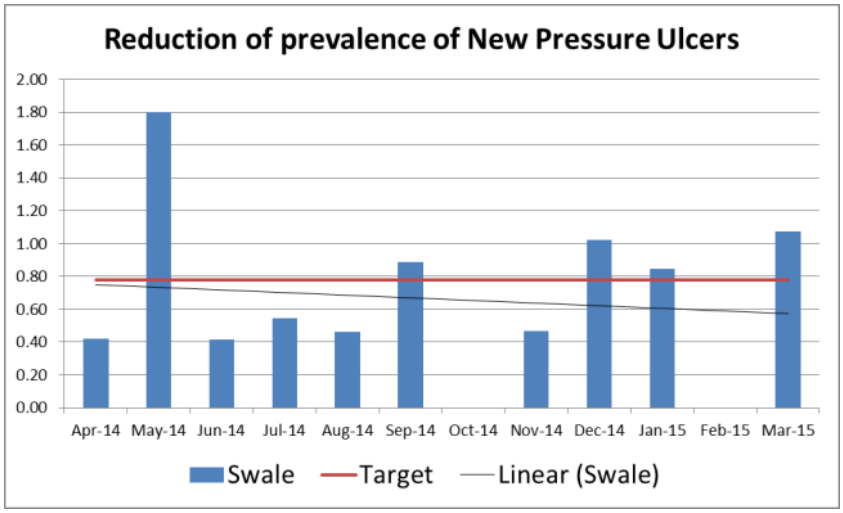
DGS CCG

DGS CCG locality has consistently achieved above 95% for Harm Free Care for new harms, with a yearend figure of 99.0%. DGS has achieved its target for the reduction in prevalence of new pressure ulcers for 5 out of 12 months in 2014-15, with monthly results showing an overall upward trend towards the end of the reporting year.



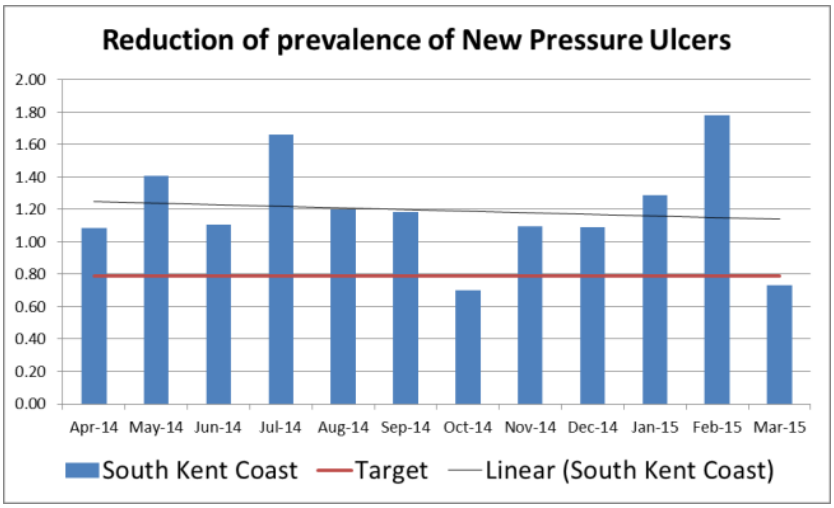
Swale CCG

Swale CCG locality has consistently achieved above 95% for Harm Free Care for new harms, only dropping just below target (to 94.9%) twice in the reporting year, with a year end figure of 97.4% Swale has achieved target for the reduction in prevalence of new pressure ulcers for 7 out of 12 months in 2014-15, with monthly results showing an overall downward trend.



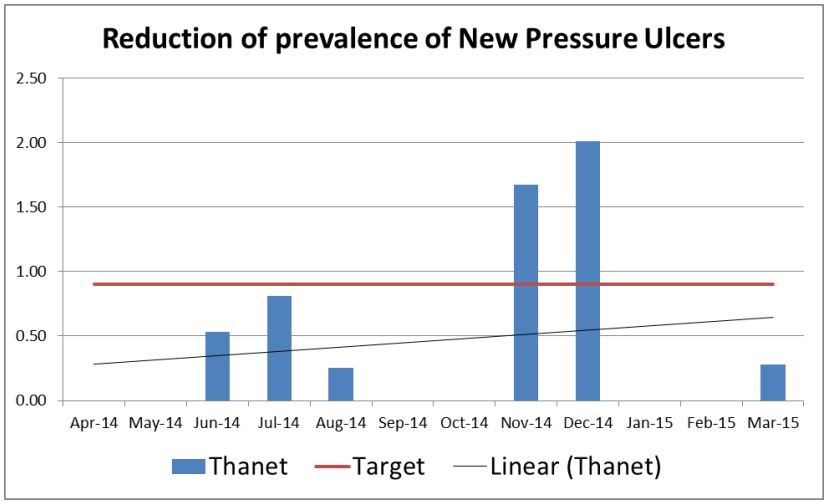
South Kent Coast CCG

South Kent Coast CCG locality has consistently achieved above 95% for Harm Free Care for new harms, with a YTD figure of 98.1%. South Kent Coast has achieved its target for the reduction in prevalence of new pressure ulcers for 2 out of 12 months in 2014-15, with monthly results showing an overall downward trend. South Kent Coast has achieved its target for the reduction in prevalence of old pressure ulcers for 11 out of 12 months in 2014-15, with monthly results showing an overall downward trend.



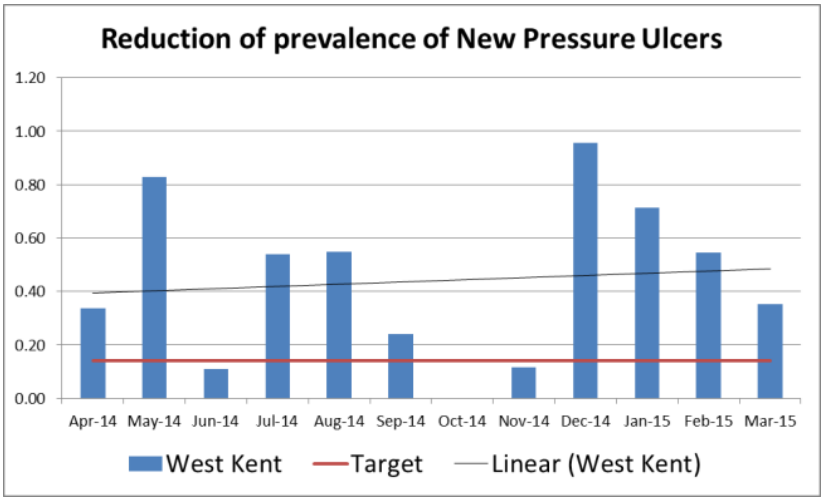
Thanet CCG

Thanet CCG locality has consistently achieved above 95% for Harm Free Care for new harms, with a year end figure of 98.6%. Thanet has achieved its target for the reduction in prevalence of new pressure ulcers for 9 out of 12 months in 2014-15, with monthly results showing an overall upward trend towards the end of the reporting year. Thanet has achieved its target for the reduction in prevalence of old pressure ulcers for 11 out of 12 months in 2014-15, with monthly results showing an overall downward trend.



West Kent CCG

West Kent CCG locality has consistently achieved above 95% for Harm Free Care for new harms, with a yearend figure of 98.8%. West Kent has achieved its target for the reduction in prevalence of new pressure ulcers for 3 out of 12 months in 2014-15, with monthly results showing an overall downward trend. West Kent has achieved its target for the reduction in prevalence of old pressure ulcers for 4 out of 12 months in 2014-15, with monthly results showing an overall.



KCHFT was asked to present at a national summit in October 2014 on the Next Generation of Safety Thermometers on the subject of engaging with staff. We were given recognition for being one of the largest trusts participating in the safety thermometer (classic) with the highest number of patients surveyed each month. Through this we have been able to share our learning of engaging with staff in the implementation of the safety thermometer and in the on-going monthly collection of safety thermometer information, which has had a major contribution to KCHFT obtaining a consistently high rate of harm free care over the past three years.

Patient Safety; Wound Medicine-improve pathways, healing rates and reduction in pressure ulcers
Goal 1: Measurable year on year improvement in every area of patient safety in community services.
Pressure Ulcer Prevention and Management Zero attributable and avoidable pressure ulcers

GOALS PARTIALLY ACHIEVED

The development of pressure damage has a profoundly negative effect on all aspects of a person's life and is very distressing for patients, carers and their families. The reduction of pressure ulcer incidents has been a key priority for the Trust and a key goal for staff.

Goals for 2014/15

- To identify further learning from teams who have achieved zero avoidable grade 3 and 4 pressure ulcers.
- Reduction in unavoidable pressure ulcers "all interventions in place" and "non concordant" by 20%
- 20% reduction in avoidable grade 2 pressure ulcers
- 50% reduction grade 3 & 4 pressure ulcers aiming for zero
- Increase and ensure compliance with the first choice dressing list
- Expand tissue viability team

How did we perform in 2014/15?

We have exceeded our target for Kent-wide trajectories for reduction in grade 2 pressure ulcers, but have not met other trajectory targets. However Thanet CCG has met all trajectories.

	2013/14	March 2015 position	% difference
Pressure ulcer Unavoidable as all interventions in place or patient had capacity non concordant	1078	1122	+4%
Avoidable - Category 2	126	48	-62%
Avoidable - Categories 3 & 4	66	47	-29%

The shift in avoidable/attributable pressure ulcers (PU) from Category 3 and 4 to Category 2 is positive indication of the education and identification and management of PUs. Focus on prevention will continue throughout 2015-2016.

Documents have been produced for the prevention of pressure ulcers

- An easy access patient guide to the prevention and management of pressure ulcers
- Leaflets for formal and informal carers on prevention of pressure damage
- A patient skin care leaflet
- A top tips handbook for the prevention and management of pressure ulcers has been distributed to all staff in contact with patients at risk of pressure damage

Educational resources have been developed and implemented

- The prevention and management of pressure ulcer clinical pathway
- eLearning for Waterlow (risk assessment tool)
- implementation of the Quality Nurse Indicators completed
- monthly "stop the pressure" campaign launched
- New NICE guidance is reflected in our prevention and management of pressure ulcer policy

- An update pressure ulcer audit started in February 2015 to underpin practice and evaluate interventions and compliance with treatments and care pathways for all attributable and avoidable harm reported over the last 12 months

Clinical Leadership is improved

- A strengthened Tissue Viability Team is in place led by a Clinical Improvement Manager
- Tissue Viability Nurses (TVN) are supporting Band 7 clinicians within KCHFT to achieve level 4 competency sign off in pressure ulcer care
- TVNs will lead on audit in their localities
- The wound medicine project and integrated care pathways for wound care is being fully implemented
- A specific wound medicine module in conjunction with the University of Kent.
- The PURE (Pressure Ulcer Reduction and Eradication Group) group has commissioned the Communications Team to repeat and re-energise the awareness raising around pressure ulcer prevention, management and reporting to capture new staff and encompass turnover.
- TVNs now have direct access to pressure ulcer related Datix reports so they can monitor and follow up compliance with Trust processes/policy in each locality, identifying themes and trends for locality-based action plans.

KCHFT non- medical prescribers have shown a consistently high level of compliance with the First Choice Dressing List of dressings for chronic wounds. Each individuals prescribing is monitored every three months as prescribing data is released nationally. Any abnormal patterns of prescribing or prescribing off the list are challenged with the prescriber. The majority of list prescribing is due to advice from either a tissue viability nurse or vascular surgeon for individual patient clinical reasons

CCG localities

West Kent and DGS have an increase in reported pressure ulcers, due to a larger volume of patients and increased reporting. Assurances have been gained that attributable/not attributable status is appropriately determined, through peer review.

Avoidable - Categories 3 and 4	2013/14	March 2015	% difference
Ashford CCG	2	4	+100%
Canterbury CCG	4	4	No change
Dartford/Gravesham/Swanley CCG	15	13	-13%
South Kent Coast (Dover/Deal) CCG	17	10	-41%
South Kent Coast (Shepway) CCG	8	4	-50%
Swale CCG	10	5	-50%
Thanet CCG	6	2	-66%
West Kent CCG	4	5	+25%

Pressure ulcer unavoidable as all interventions in place or patient had capacity non concordant	2013/14	March 2015	% difference
Ashford CCG	77	80	+4%
Canterbury CCG	144	121	-16%
Dartford/Gravesham/Swanley CCG	33	99	+200%
South Kent Coast (Dover/Deal) CCG	242	210	-13%
South Kent Coast (Shepway) CCG	141	131	-7%
Swale CCG	99	83	-16%
Thanet CCG	238	199	-16%
West Kent CCG	103	199	+93%

Avoidable - Category 2	2013/14	March 2015	% difference
Ashford CCG	11	4	-64%
Canterbury CCG	28	6	-78%
Dartford/Gravesham/Swanley CCG	8	6	-25%
South Kent Coast (Dover/Deal) CCG	22	9	-59%
South Kent Coast (Shepway) CCG	10	6	-40%
Swale CCG	20	4	-80%
Thanet CCG	16	2	-88%
West Kent CCG	8	11	+40%

Patient Safety;
Goal 1: Measurable year on year improvement in every area of patient safety in community services.
Venous Thrombo-embolism (VTE)

GOALS PARTIALLY ACHIEVED

All patients admitted into Community Hospitals should have a venous thrombo-embolism risk assessment completed within 24 hours to see if they are at risk of developing a blood clot as preventative treatment using daily injections helps to dramatically reduce the risk. We had no preventable VTE events or deaths in 2013/2014 and on average the Trust is achieving 97% compliance. Work continues to ensure processes are robust to ensure all patients are assessed within 24 hours to achieve 100%.

Goals for 2014/15

- 100% of assessments to be completed within 24 hours
- Revision of the VTE assessment tool to improve evidence of decision making
- Patient information leaflet to be given to all patients at the time of assessment
- All patients at risk of VTE are to have a care plan in place
- A rapid cycle audit will take place to ensure all recommendations are embedded

How did we perform in 2014/15?

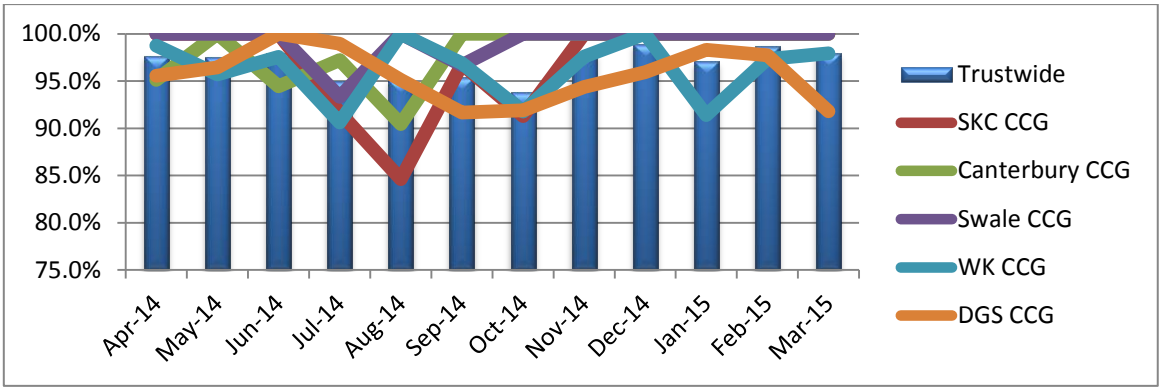
Kent Community Health Foundation Trust (KCHFT) has failed to achieve the goal of 100% VTE assessments within 24 hours, achieving 95% at year end, although it was achieved in ten of the twelve months. However an amalgamated audit was carried out in our community Hospitals in October to December 2014 and 100% of the patients were assessed on admission for increased risk of VTE.

	Apr -14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15
Trustwide	**97.7%**	**97.5%**	**97.9%**	**95.0%**	**95.1%**	**95.4%**	**93.8%**	**98.0%**	**98.9%**	**97.1%**	**98.7%**	**97.9%**

Unwell patients in our hospitals will have been transferred to the acute Trust before an assessment can be carried out, but systems within our hospitals have not enabled the full completion of these assessments within 24 hours of admission. Lack of assessment continuity is a risk in some locations with reliance on agency staff but this will be improved in 2015 with our own bank staff provision. Community Information System implementation will provide assurance of improved assessments.

Data collection has improved using an electronic tool, providing a more streamlined process. Progress is monitored monthly basis and results are analysed and exceptions (where a patient was not assessed within 24 hours) are reported on to the Nursing and Quality Directorate. The results of the analysis are shared in the monthly board report and with Service Directors. The patient information leaflet has recently been finalised and will be distributed for patient use. This was the final action of the previous audit. The VTE audit will be in the 2015-2016 programme.

CCG Data



Canterbury
Since Sept 2014 the three hospitals in the Canterbury CCG area (Faversham Cottage Hospital, Whitstable & Tankerton Hospital and Queen Victoria Memorial Hospital) have achieved 100% of VTE Risk Assessments being carried out within 24 hours of patient admission.

DGS
Of the two hospitals in the DGS CCG area, Gravesham community hospital has regularly achieved above 95% of VTE Risk Assessments being carried out within 24 hours of patient admission and has achieved 100% eight times in 12 months. Livingstone community hospital has achieved 100% only once and has dropped below 90% on three occasions.

SWALE
Of the two hospitals in Swale CCG area, both Sittingbourne Memorial hospital and Sheppey Community Hospital have achieved 100% in 11 out of 12 months, with one occurrence at Sheppey where they dropped below 90%. Overall for Swale CCG, 100% has been achieved 10 times in of 12 months.

SKC
Deal Hospital in the SKC CCG area has achieved 100% since November 2014, with results prior to this time being above 90% on all but one occasion.

West Kent
Of the four hospitals in West Kent CCG, Hawkhurst has achieved 100% 8 times in 12 months, Tonbridge 9 times, Sevenoaks 8 times and Edenbridge only 4 times. Overall, West Kent Hospitals have achieved 100% only twice, however the overall total has never dropped below 90%

Patient Safety; Learning from mistakes to improve safety
Goal 1: Measurable year on year improvement in every area of patient safety in community services.
Attributable Falls Prevention and Reduction by 10% and 10% reduction in attributable falls resulting in falls with harm

GOALS ACHIEVED

Goals for 2014/15

- Reduce the number of attributable falls by a further 10%
- Reduce the number of attributable falls with harm by a further 10%.
- Review comfort rounds and the use of the quality risk indicators tool in relation to falls.
- Undertake observational audits in all Community Hospitals to determine any key triggers for falls.
- Increase medications reviews to help support a reduction in falls.
- Focus awareness on medication starting in fall awareness week in June
- Focus support on people with dementia
- Review the environment in all wards, such as signage

How did we perform in 2014/15?

From April 2014 to Jan 2015, 805 falls were reported showing a similar rising trend and an overall increase in the numbers of falls compared to the previous two years, believed due to the increased staff awareness and reporting of falls incidents.

In 2014-2015 699 of the 805 reported falls occurred under the care of KCHFT services resulting in the following harms;
An aggregate of inpatient falls data analysed by occupied bed days shows an average of 8.07 falls per 1000 Occupied Bed Days (OBD). This figure falls just below the 2010 National benchmark of 8.6 falls per 1,000 OBD for community hospitals (NRLS benchmarking data 2010).

The falls prevention and improvement group (FP&IG) had a detailed action plan for 2014/15 focusing on the key areas and recommendations using data from the falls report completed April – December 2013 and issues highlighted during a number of observational visits to community hospitals.

Falls observational visits:

Between July and October 2014 the FI&PG members undertook a number of falls observational visits to all 12 community hospitals. The focus of these visits was to establish;

- If staff are aware and have had training on falls prevention.
- If staff are aware of the increased risk of falls in those with cognitive impairment such as dementia.
- Review comfort rounding and nutrition and hydration status of patients.
- If patients at risk of falls are being risk assessed and appropriate equipment and observations put in place.
- Observe the environment for risk of falls.

Action as a result of this audit meant;

- Introducing standardised equipment for prevention of falls within the hospital setting
- Ensuring the award winning “wrist band scheme” pioneered at the Livingstone Hospital was rolled out across all hospital sites.
- “Measles” charts introduced showing the floor plan of each hospital site in order to identify high risk areas.
- Updating and standardisation falls documentation and introducing robust training and checking for the use of bed rails.
- Added more detail to the online incident reporting system to enhance collection of more granular falls data to inform changes in practice.
- Started a trial of a home assessment tool to reduce falls risk in the home. “The Canadian Safer Home Tool” will be rolled out in Intermediate Care in West and East Kent, and evaluated.
- Started a trial of “safehip” – protective equipment for patients at risk of hip fractures.
- Increased awareness of medication risk with staff and public. A campaign to raise awareness in staff and patients/public took place in June 2014 focusing on medications and falls risk. Posters were placed in all sites and this was adapted as the screen saver on all Trust computers. Detailed advice was made available to staff indicating which particular medications may put patients at risk. All community hospitals are now having medications reviews by our community pharmacy team.

Working in partnership to reduce falls;

- Worked with all CCGs in Kent as well as partner organisations to co-design agreed falls pathways of care (still in progress).
- Adapted the KCHFT on line training and falls documentation, with the care home and voluntary sector to help support an integrated approach to falls prevention.
- Worked with KCC to develop on-line falls training for their staff as well as delivering face to face training
- Have submitted an application to start a falls registry, which will include the whole health economy, to capture data about patients who may be at risk of falls.

Patient Safety;
Goal 1: Measurable year on year improvement in every area of patient safety in community services.
Patient Safety Walkabouts (PSW)

GOALS ACHIEVED

Goals for 2014/15

- A revised quality and safety visit programme
- Increased visibility of the Executive and Board through executive road shows
- Improved communication with all teams, by improving communication channels and methods
- Continue to address issues raised by staff at the walkabout in a timely manner

How did we perform in 2014/15?

Visibility of the Executive and Board has increased through road shows, clinics and their attendance at team meetings.

The new Quality and Safety Walkabout (QSW) programme was launched in September 2014. The visit team comprises a board member, two members of the Nursing and Quality directorate and a governor. All members of the team being visited are invited to meeting arranged as part of the visit and asked to complete a survey sent to them before the visit.

A summary report is sent to the team leader after the visit and an action plan requested within two weeks. The Patient Safety Facilitators support teams with implementation of action plans.
Two or three visits have taken place each month. Seventeen visits in total have taken place between September 2014 and March 2015.

Assurance that teams are providing high quality and safe services and that any areas for improvement are identified and addressed, reported to the Board and areas of good practice and areas for improvement have been identified.

Staff engagement with the visit process is challenging in some areas due to staffing levels, restructures and other priorities.

Areas identified as needing improvement are taken forward with teams' individual action plans, supported by the Patient Safety Facilitators.

Promotion activity is taking place with the Communications team to improve staff awareness about the QSWs and what the purpose and benefits are of having a visit

Examples of learning

Victoria hospital Deal, 27 November 2014

Area for improvement	Must/could	Action taken	Date completed
Introduction of the falls wristband scheme, i.e. red, yellow, green to indicate help required when mobilising.	Must	This was actioned at the Matrons' meeting and subsequently introduced Trust wide.	End of January 2015

Adult Speech and Language Therapy, 3 December 2014

Area for improvement	Must/could	Action taken	Date completed
Audit prioritisation tool, with a weighting elements which could be used as a commissioning tool	Could	To develop the tool with the Performance team to monitor monthly compliance of meeting to triage waiting list	Tool produced and in use 31.01.15
Ensure all patient voice recordings have valid consent; ensure consent is appropriately recorded at each contact.	Must	• Consent forms available in each clinical room in new leaflet folders on the wall. • Team reminded of the use at locality meeting 11.03.15 • CIS available to audit compliance.	March 2015

Patient Safety; Learning from mistakes to improve safety
Goal 1: Measurable year on year improvement in every area of patient safety in community services.
Early Warning Trigger Tool (EWTT)

GOALS ACHIEVED
Goals for 2014/15

- To develop team-level reporting, as the aggregated score at locality level is masking team level sensitivity.
- Develop the escalation framework and rapid response support framework to support teams identified in need of improvement.

How did we perform in 2014/15?

An early warning trigger tool has been developed at team level to identify teams where quality performance is deviating from expected standards, to enable help and support to be targeted to provide a level of assurance of quality throughout the implementation of change and service redesign. The EWTT has been rolled out across all services at locality level and has been in place since October 2013.

Patient safety and ensuring patients suffer no harm is a key priority for the Trust and this tool helps to identify areas where safety may be compromised through a range of indictors. There are pockets of teams where we have had concerns during the year and rapid support, guidance, training, competency assessments, review, recommendations and actions of systems and processes and resource management has been provided. The outcomes of intensive support have improved the delivery of quality care and reduced harm to patients and improved patient and staff experience.

There are some key areas where there could be potential risks. Action plans are in place and on-going monitoring through the EWTT and a variety of assurance metrics

The thresholds of tolerance have been set with clear actions stipulated at all levels for the service/hospital. Clear action plans are put in place whenever there is a breach in standards.

With the development of the Quality Surveillance Meeting (QSM), the process and priorities for the Early Warning Trigger Tool have changed throughout 2014/15. There was a new goal of reviewing and updating the Early Warning Trigger Tool, which has been completed. Additionally, the tool has been rolled out to further teams within the Trust (Sexual Health, Children's Community Nursing and Community Paediatrics). A new process was introduced whereby all teams returned reports on actions and assurance.

The goals were met in the proposed format due to availability of data at team level, plus the amount of work involved to do this level of reporting. At the QSM, a new process was agreed so that if a locality was a cause for concern as highlighted at the QSM, the teams within that locality would be given a more detailed process to complete internally and feedback. EWTT was successfully reviewed and indicators added/removed and amended. Team level reporting was not possible centrally. The above escalation process has been implemented to cover this.

Clinical Effectiveness; develop integrated care pathways and ways of working
Goal 2: To improve outcomes by developing integrated care pathways ensuring the right care, right place, right person, right time
Improving End of Life Care 90% of patients die in their preferred place

GOALS ACHIEVED
Goals for 2014/15

- Improve written information and communication on support at end of life
- Implement the End of Life Strategy to improve the experience for patients and those close to them
- Ensure appropriate End of Life Care training for our staff
- Increase patient and carer engagement and feedback
- Use community information system to review standards of care
- Improve ways of involving and assessing carers needs
- Improve understanding patients of preferences and choices including spiritual and religious needs

How did we perform in 2014/15?

We have met people's preferred place of death in over 95% of people we have cared for. We have worked with patients and our communications team to produce new leaflets these include

- A Guide for patients using a syringe pump
- What happens and what to do when someone has died

We have continued the work already underway to make sure our staff have the appropriate training and the right skills available to provide the right care. We have employed four end of life care facilitators to support staff in caring for patients. These nurses provide training and work with staff to make sure they have the right skills to provide care. We have developed training packages for nurses, healthcare assistants and allied health professionals that we have validated. These tie in with competency documents for staff to ensure they have the right knowledge and skills for their roles.

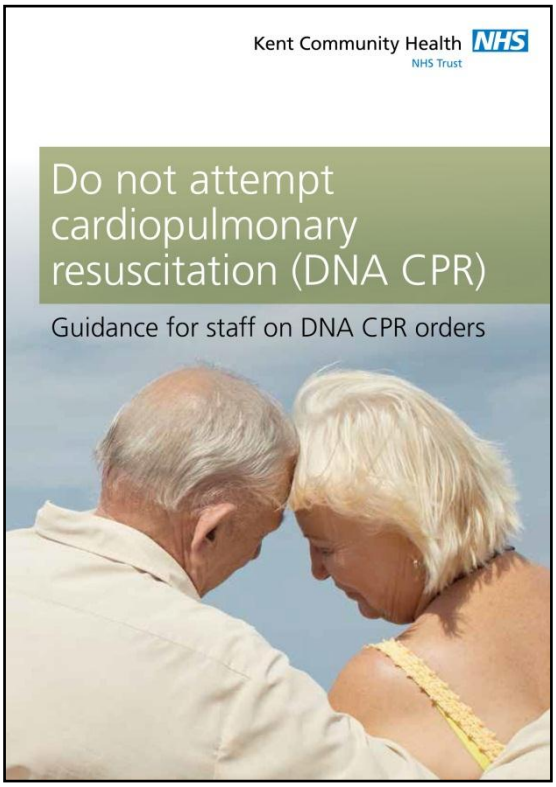
We have listened to our patients and the public regarding end of life care by having patient representation on our end of life steering group and by meetings inviting feedback. In May over the National 'Dying Matters' week we spoke to 72 people who shared their experiences with us.
We work in collaboration with our partner organisations and carers needs are assessed by our partners at voluntary action (VAM) who can help with providing extra support to carers and identify agencies who can provide extra help.

We have developed a training package on advanced care planning working with Canterbury Christchurch University college supported by our local hospices which has real patient experiences and guidance on how to explore and what are patients choices. With our new computerised patient information system we have made sure we have clear sections that record patients individual wishes including spiritual care.

We have met peoples preferred place of death in over 95% of people we have cared for. We have improved the opportunity for people's wishes to be listened to and therefore have increased the opportunity to understand their wants and wishes.

We have obtained National recognition for our work and have;

- Presented at the Royal College of Nursing Conference (March 2015) on our advance care planning training
- Gained recognition from CCGs wishing to replicate our documents (easy read patient information)
- Presented our carers needs assessment study at a research conference for Kent (October 2014)
- Presented our patient literature and training programmes at a Kent Surrey and Sussex wide meeting (March 2015)



Work with carers informed this guide for staff

Clinical Effectiveness; develop integrated care pathways and ways of working
Goal 2: To improve outcomes by developing integrated care pathways ensuring the right care, right place, right person, right time
Transfer of Care

GOALS ACHIEVED

Goals for 2014/15

- Audit Transfer of Care against the policy
- Complete implementation of Situation Background Action Recommendation (SBAR) - a communication model for handover across all services.
- 20% reduction of attributable transfer of care issues internally.
- Improve data capture to enable focus on quality improvements.
- Work with external partners to reduce the number of transfer of care issues that impact on patients.
- Increase intravenous support in the community to allow care closer to home
- Develop a patient held discharge passport.

How did we perform in 2014/15?

An audit of Transfer of Care against the policy was completed in September 2014 which provided assurance that staff work hard to provide effective Transfer of Care. Two hundred and forty eight patients were transferred to our services with only nine deemed inappropriate. Eighty five percent of patients transferred "out of hours" were done so without knowledge of the last time food or fluids were taken. Patients transferred out of hours are reported on Datix. It was not know when observations were last taken in forty eight percent of those transferred.

Recommendations made were to;

- Develop nutrition and hydration care plans with the dietetics teams and to develop staff awareness of the impact these have on patients
- To document patients last nutrition and hydration on the transfer document
- Ensure full assessment within twenty four hours of admission ensuring holistic care planning is continued

The audit was repeated in February 2015 and results are awaited.

In supporting timely discharge and transfers we have developed guidance and training for staff on care at transfer. We use a format known as SBAR (Situation Background Assessment Recommendation), a consistent communication tool format. There has been a hugely positive response to the roll out of SBAR within clinical and non-clinical teams, since face to face training started in June 2014. Staff can see the benefits of having a consistent format for communicating which ensures patient safety as all the relevant information is shared. The SBAR templates for correspondence and report writing have been developed and are in use across the organisation. The "Transfer of Care" and "Record Keeping" policies have also been updated to reflect the use of SBAR. For sustainability, SBAR e-learning training has been developed. SBAR has been rolled out to all services by April 2015

Data obtained from 2014-2015 will be used as a baseline as data is not available for 2013-2014. Data collection has been improved on Datix to include dates of transfers. It was agreed to focus on the incidences of transfers of care itself to identify solutions to patient safety and experience concerns, rather than to whom they were attributable.

We have collaborated with external partners to reduce the number of transfers of care issues that impact on patients. We share information with our commissioners and review individual cases to make sure we improve on our care at transfer.

We have developed a care standard for transfers of care and reviewed our policies and guidance in line with recommendations from the National Patients Safety Agency.

Intravenous therapy was facilitated in home or community settings by the safe delivery of medication to these locations and availability of appropriately trained staff in the community. Collaboration with our stakeholders promoted timely hospital discharges and prevent unnecessary admissions, allowing patients to be seen at home and at times continue their employed roles, reducing the risk of hospital acquired infection and of hospital readmissions. The Intravenous audit assured us that staff are compliant with recommendations for safe intravenous medication administration.
The patient held discharge passport was deemed not to be of benefit and so was not developed.

Clinical Effectiveness; develop integrated care pathways and ways of working
Goal 2: To improve outcomes by developing integrated care pathways ensuring the right care, right place, right person, right time
Morbidity and Mortality

PARTIALLY ACHIEVED
Goals for 2014/15

- Implementation of End of Life training
- Developing information leaflets for patients and relatives on end of life care planning and Do Not Resuscitate Orders
- To work in partnership with our commissioners and other health and social care providers to improve transfer of care
- To continue to review mortality and morbidity
- To implement standard mortality rate reviews in all community hospitals
- Revised competency based training for basic life support (BLS) will be included in clinical induction
- Revised BLS incorporating management and recognition of the deteriorating, patient, communication, National Early Warning Score and escalation and associated competencies to be rolled out.
- All clinical staff in Community Hospitals to have completed the revised BLS training and to be assessed as competent to achieve the 85% target by March 2015.

How did we perform in 2014/15?

End of Life training was implemented which includes recognising when a patient is at end of life, and competency assessments for clinical staff. We have employed four end of life care facilitators to support staff in caring for patients. These nurses provide training and work with staff to make sure they have the right skills to provide care. We have developed training packages for nurses, healthcare assistance and allied health professionals that we have validated. These tie in with competency documents for staff to ensure they have the right knowledge and skills for their roles.

We have developed information leaflets for patients and relatives on end of life care planning and Do not resuscitate orders. Information for staff has also been produced. We now use a Kent-wide document on advance care planning

In reviewing mortality and morbidity, we review all deaths in our community hospitals to make sure we provide safe and patient centred care. This is reviewed every three months by our quality committee and every death is reviewed by the Nurse Consultant and Director of Nursing with appropriate recommendations implemented as necessary.

To implement standard mortality rate reviews in all community hospitals, we review every death, and have worked with “Dr Foster” to benchmark our care against similar community care providers. We have employed end of life care facilitators who started in post in the Autumn of 2014. These staff will continue throughout 2015 to train and support our staff. We have not achieved our target of 85% of clinical staff trained in BLS; 64% was achieved. This training has now been introduced at Induction to bridge this gap.

Clinical Effectiveness
Goal 2: To improve outcomes by developing integrated care pathways ensuring the right care, right place, right person, right time
Pain management

GOALS ACHIEVED

Goals for 2014/15

- Progress a task and finish group to take a lead on pain management and assessment.
- Develop a practice standard for pain
- Identify and implement suitable assessment tools and pain scoring charts that can be utilised as the basis for effective pain management. The tools will be suitable for children and those with disabilities including blind people and those with dementia.
- Develop a training package on assessing and managing acute and chronic pain

How did we perform in 2014/15?

We are pleased to report that all goals have been achieved. The task and finish pain management and assessment group was formed with subsequent activity as planned. A draft Practise Standard for Pain was developed and is being reviewed before dissemination.

Pain assessment tools have been identified and will be included in the 2015-2016 audit cycle. The audit tool has been reviewed and will be re-launched for the next audit cycle.

The Chronic Pain team has developed the training packages for Pain Assessment and Medicine Management training for Independent Nurse Prescribers in relation to prescribing appropriate analgesia. These will be delivered in 2015-2016. Patients will benefit as their pain will be better assessed and managed by Trust staff following the opportunity for education and training.

The Community Chronic Pain service has won awards at a national level to develop projects relating to improvement of quality of life for patients, these are:

- Exercise programme for chronic pain patients
- Support Groups for chronic pain patients
- Knitting Group for Chronic pain patients (pictured below)
- External Neuromodulation clinics so patients can self treat

Clinical effectiveness
Goal 2: To improve outcomes by developing integrated care pathways ensuring the right care, right place, right person, right time
Dementia

PARTIALLY ACHIEVED

Goals for 2014/15

- Focus on community staff to complete dementia awareness training with a pre and post-audit dementia knowledge questionnaire.
- Continued support of community hospital staff to maintain development of the Butterfly Scheme and implementation of intermediate dementia training for clinical staff.
- Further development of the Dementia Care Pathway with information to support practitioners and people living with dementia and their carers/families.
- Easy access to relevant information and the creation of a blog regarding dementia.

How did we perform in 2014/15?

The focus over the year has been delivering Foundation Level Dementia Awareness Training to target teams including the majority of Adult Services. The dementia awareness training was developed and successfully validated through First Class Care. The face-to-face training is being delivered by two specialist nurses in dementia. The nurses were responsible for the development of the training and are able to adapt the training to the learning needs of staff on each occasion the training is delivered. An element of this training was the attendance at the Inside Out of Mind play at the Gulbenkian theatre in Canterbury. The play is based on ethnographic research of life on a long stage dementia ward, highlighting the struggles, challenges and joy of patients, families and staff within this environment. Post play workshops are being held in March/April 2015 to understand the impact of this innovative training method.

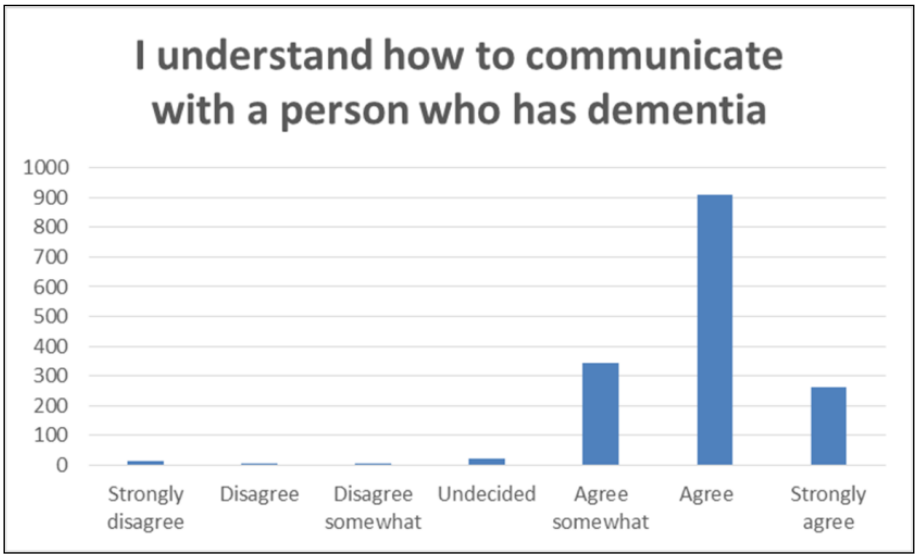
The Butterfly Scheme has been discontinued within the community hospitals and replaced with the forget-me not scheme. The Butterfly Scheme was beneficial for the staff, patients and family members regarding dementia, however it was not in line with local acute NHS trusts and national initiatives. The butterfly is not well recognised by the general public as being related to dementia, when the forget-me not flower used by the Alzheimer's Society, Dementia Friends and Dementia Friendly Communities is a more prominent symbol. The Nurse Consultant in Dementia has visited the community hospitals and discussed the change, with a positive response from staff. A member of the Dementia Steering Group who is a lay member with a husband who has dementia felt the forget-me not scheme was very helpful. The two schemes are similar just the image has changed from a butterfly to a forget-me not.

The dementia care pathway is still under development. The initial development of the dementia care pathway was to place this interactive resource on the staff intranet, as this information needs to be assessed while in a patient's home or away from staff bases enquires and applications for funding for an app are being explored instead.

A pilot version of the dementia care pathway has been developed and is being considered by the Dementia Steering Group.

Foundation level dementia awareness training was a CQUIN with 95% of hospital staff (2013-2014) and community adult services staff (2014-2015) completing the training.

The foundation level dementia awareness training has received exceptionally positive feedback from staff; with improved reported staff understanding. An added element to the training is that staff are meeting the Trust's nurses who specialise in dementia and are reporting feeling supported as they know who to contact should a challenging situation occur.



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Edenbridge Hospital staff with patients and black and white pictures of movie stars designed to help patients reminisce.

Clinical effectiveness
Goal 2: To improve outcomes by developing integrated care pathways ensuring the right care, right place, right person, right time
Children and Young People

PARTIALLY ACHIEVED

Goals for 2014/15

- Further expansion of the Family Nurse Partnership programme to increase capacity for 250 parents by March 2015.
- Increase Health Visitors to 342.2 by March 2015.
- Further develop the health visiting lead roles for CONI (Care of the Next Infant), Infant Feeding and Safeguarding
- Health visitor active learner training will continue to increase the training to 1000 staff
- Expand the existing Immunisation Team
- Introduce a Band 5 Development programme to support recruitment onto SCPHN programme and retention of staff
- Roll-out 'Clean and Dry' training to all School Nurses to support transition from early years to school
- Develop a transition pathway from Year 6 to Year 7
- Develop an integrated School Nursing/Healthy Schools framework for the delivery of HCP.
- Expand the delivery of the initial assessments core service across KCHFT

How did we perform in 2014/15?

- The Family Nurse Partnership has expanded, as planned and is now operational across seven (of twelve) districts. The Trust exceeded its target of 342.2 Health Visitors and had achieved 434.5 in post by 13th March 2015.
- Two teams made up of two supervisors and eleven family nurses expanded the existing Immunisation Team.
- Active Learner programme has been expanded as planned and will continue through 2016.
- Clean and Dry rollout to School Nurse teams has been delayed but is planned for 2016.
- The transition pathway from Year 6 to Year 7 is currently in development with School Nurses professional practice group.
- An integrated School Nursing/Healthy School framework for the delivery of HCP is in its final planning in final stages with integrated service rollout to commence in coming months.
- Initial assessments across KCHFT have been developed for all school aged children who have been referred for Initial Child Protection case conferences

Other achievements

- In recognition of the success of the Kent SN model, the School Nurse contract for East Sussex has been awarded to KCHFT.
- Two of our Health Visitors have been awarded the Fellowship of Institute of Health Visiting (only 150 awarded within a potential 10,000 Health Visitor national workforce). This is recognition of the innovation and advanced practice of our staff regarding the Active Learner programme and Domestic Abuse support for families.
- The Active Learner model has been published by the Department of Health and is being utilised in the Early Infant Foundation programme, championed by Graham Allan MP

Clinical Effectiveness
Goal 2: To improve outcomes by developing integrated care pathways ensuring the right care, right place, right person, right time
National Institute for Health and Care Excellence (NICE) Compliance with Assessments

GOALS ACHIEVED

Goals for 2014/15

- To implement new commissioned standards as identified by NICE

How did we perform in 2014/15?

The NICE process requires Technological Appraisals to be completed within a national three month deadline; these were all completed within the deadline.
The Medicines Management team complete pro-formas for those which are relevant to the organisation. They also have to provide confirmation for those not relevant. These have been completed and the evidence is retained by the Clinical Governance team; these were all completed on time and medication appropriately given.

For all other NICE processes, services are required to complete pro-formas within an organisationally agreed deadline. These are also retained by the Clinical Governance team.

We want to continue to work with our commissioners to develop pathways of care
As some NICE guidance processes require CCG or other organisational actions, the NICE Assure process will require services to review against this and allow for reporting to the CCGs which is to start in May 2015. NICE reports are to be sent to the CCGs.
NICE audits completed-additional audits are being planned, implemented, written up, awaiting action plans or being reviewed.

Project number	**Topic**	**Leading/ Initiating Directorate**	**If based on NICE, specify guidance number**
P/001/12	Review Health Assessments - P/001/12	Children & Young People	PH28
P/073/12	End of Life Care Nice Guidance compliance to include Liverpool Care Pathway P/073/12	N. & Q. Quality	QS13
P/074/12	Stroke Pathway P/074/12	Adult	QS2
P/012/13	To assess NHS Health Check outcomes for those patients that are classified as at medium risk - P/012/13	Health Improvement - Adults	PH25 and 38
P/013/13	Venous thromboembolism: reducing the risk audit - P/013/13	Adult	CG46
P/020/13	Sentinel Stroke National Audit Programme - P/020/13	Adult	CG68
P/024/13	Safe Management of IV therapy - P/024/13	N. & Q. Quality	CG139
P/025/13	Pressure Ulcer Reaudit - P/025/13	N. & Q. Quality	CG29

P/032/13	Chronic Obstructive Pulmonary Disease (COPD) - P/032/13	Adult	CG101
P/037/13	Infection Control Policies reaudit - P/037/13	N. & Q. Infection Control	CG139
P/038/13	MRSA screening reaudit - P/038/13	N. & Q. Infection Control	CG139
P/046/13	Recognising and responding to the deteriorating patient - P/046/13	N. & Q. Quality	CG50
P/048/13	Smoking Cessation CQUIN - P/048/13	Health Improvement - Adults	PH10
P/053/13	Prevention of Venous Thromboembolism (VTE) including assessment of risk - P/053/13	N. & Q. Quality	CG92
P/087/13	Dementia - P/087/13	N. & Q. Quality	QS1, QS30
P/104/13	Co-morbidities of ADHD and their management in Community Child Health in Tunbridge Wells P/104/13	Children & Young People	CG72
P/107/13	Adherence within the Podiatric Day Surgery Suite to the WHO (World Health Authority), Surgical Safety Checklist - P/107/13	Adult	CG92
P/011/14	WHO Surgical checklist 2014/15 - P/011/14	adult	CG92
P/022/14	Managing overweight and obesity among children and young people - P/022/14	Health Improvement - Adults	PH47
P/030/14	CQUIN Waterlow/ Nutrition - P/030/14	Adult	CG29, CG22
P/033/14	WHO Surgical checklist in Dental Day surgery P/033/14	Dental	CG92
I/002/10	Falls and bone health in older people - I/002/10	Adult	TAG 83/CG21
P/075/12	Falls audit P/075/12	Adult	CG21
P/001/13	To audit the Fresh Start Programme pathway to identify the proportion of clients achieving between 5 and 10% weight loss - P/001/13	Health Improvement - Adults	CG43
P/017/13	Osteoarthritis of knee audit -P/017/13	Adult	CG59
P/027/13	Reasons for Children Undergoing General Anaesthetic - P/027/13	Dental	CG112
P/044/14	DNACPR_Community Hospitals	N. & Q. Quality	QS13

Clinical effectiveness
Goal 2: To improve outcomes by developing integrated care pathways ensuring the right care, right place, right person, right time
Sexual Health

GOALS PARTIALLY ACHIEVED

Goals for 2014/15

- Increase access to HIV testing through roll out of point of care testing (POCT)
- Implement a new pathway and appropriate services for people with learning disabilities
- Implement electronic prescribing
- To continue to access the target population at risk of chlamydia, screen and treat

How did we perform in 2014/15?

Sexual Health Service provision is across Kent and Medway.

We achieved our goal to increase HIV testing through POCT, this is 4th generation HIV testing which offers results within 60 seconds at the central hub in East Kent (The Gate Clinic, Canterbury) as well as via GUM outreach services, which delivers targeted STI testing to high risk groups. Staff working within the service are currently undergoing training to allow further roll out to the remainder of the sexual health service during 2015. Patients have been able to be provided with HIV results within 60 seconds giving them improved access to care and treatment.

During 2014 significant work has been undertaken to develop a working group which aims to improve access and uptake of sexual health services by patients with a learning disability (PWLD). Kent Sexual Health Services have partnered with learning disability teams and have patient representation to oversee the launch of the “Apple Tree” service which will provide services tailored to meet the needs of PWLD including a logo to support the identification of sexual health services, a new resignation sheet and easy read information materials.

The service is working towards electronic transmission of HIV homecare prescriptions; this will enable staff who write prescriptions from the clinic location, which then can be accessed by KCHFT pharmacy for screening and checking before sending to the homecare pharmacy for dispensing and delivery. During 2014 the prescribing module was installed by Blithe and the pharmacy team have been working extensively with them to develop the prescription template.

This is now waiting to be finalised following a system upgrade during quarter 2 of 2015, and then will be piloted before implementation of the system, site by site in the East. Use of the system at The Riverside Clinic will then follow. Once electronic prescribing is implemented within sexual health, the processes for prescribing will be more efficient and therefore face to face contact time with patients will be increased.

Chlamydia is the most common Sexually Transmitted Infection (STI) amongst sexually active young people. KCHFT co-ordinates the delivery of the local Chlamydia Screening Programme (CSP) which predominately focuses efforts on ensuring that Chlamydia testing is embedded into core service delivery for example Sexual Health Services (including targeted sexual health outreach and termination of pregnancy services), General Practice and Pharmacy settings. Testing is also encouraged by wider non-health partners.

The Chlamydia screening target is set at local authority level (LA) for 2,300 per 100,000 diagnosis of the infection in those 15-24 years of age. There has been much discussion regarding the difficulties of achieving the target, across England just one third of LAs achieve this. To ensure this continues to be a universal screening programme rather than a targeted programme the target includes a required number of screens required to find the number of positives.

Data from April 2014 - January 2015 notes the service is off trajectory by 497 positives which comprises of a deficit on average of 41 positives per month. At the end of January 2015, a total of 38,717 screens had been undertaken against a target of 48,563. Of these screens a total of 3014 positives have been diagnosed against a target of 3511 demonstrating an overall positivity of 7.51%.

Last year in 2013/2014 the service undertook 51,341 screens of which 3,892 positive cases of Chlamydia were diagnosed (7.6% positivity). This represented an achievement of 92% of the target (4,233 positives). During 2014/2015 even achieving the same progress of that made in 2013-2014 has been a challenge. It is clear that the new, recently commissioned model will be improved and fit for purpose for Chlamydia screening.

We have treated 3,014 patients for Chlamydia infection, we have also undertaken complex contact tracing and will have treatment to ensure we treat partners to stop the onward spread of infection.

Patient experience; continue to develop integrated care pathways and ways of working
Goal 3: Measurable year on year improvement in patient experience, engagement and satisfaction
Improving Patient Feedback

PARTIALLY ACHIEVED

Goals for 2014/15

- Continually Improve patient experience
- Support services to make changes as a result of patient feedback including complaints and ensure that changes impact positively on "protected groups"
- Ensure all services have clear and accessible patient information both online and printed, e.g. community hospital booklet
- Support services to improve information to patients and carers about further support available
- To continue to improve KCHFT Friends and Family Test (FFT) score
- To improve engagement with hard to reach groups

How did we perform in 2014/15?

Metric Targets

- Patients undertake NHS Friends and Family test and the Trust achieves a result of 95% per month using the NHS England scoring (scoring revised from January 2015)
- Over 95% patient satisfaction in all service areas using Meridian surveys and at least 50% coverage
- Reduction in complaints implicating clinical care by 10% from 13/14

KCHFT Overall; April 2014 to March 2015

Recommend	Not Recommend	Total Responses	Extremely Likely	Likely	Neither Likely or Unlikely	Unlikely	Extremely Unlikely	Don't Know
97.43%	0.52%	56,534	45,021	10,035	770	169	125	388

- 94% of services are collecting patient feedback with at least 50% coverage across Kent
- There were four actions from patient experience covering two or more localities - Fresh Start Scheme, Health Walks and Stop Smoking Services
- % satisfaction score is based on 6 key indicators
- There were 109 clinical care complaints, compared to 110 in same period of 2013/14; we did not achieve our goal
- In 2014/5 a total of 254 standard leaflets/advice sheets have been produced from new or have been revised, 33 of which related to self-management.
- Foundation Trust membership has increased by 25.39% in 2014/15 – from 8,750 in March 2014 to 10,972 at the end of March 2015. Membership from black and minority ethnic communities has increased by around 25% overall – from 414 to 519.
- The age profile of members shows that with the exception of people aged under 19, membership has increased across all age groups

- The Trust engaged with different groups and organisations on a Kent-wide basis at 27 events, 20 of which related to people with 'protected characteristics'

CCG localities

Scores by locality from April 2014 to March 2015

	0% to 85%		85.1% to 89.99%		90% to 100%	Please note the benchmark for Staff Attitude and Equality and Diversity competencies is 95%

CCG	Returns April 2014 to March 2015	Average satisfaction score	Co-ordinated Care	Equality and Diversity	Given necessary information	Involvement in decisions about care and treatment	Listened to and worries taken seriously	Staff Attitude
Ashford	3,134	97.85	91.09%	99.41%	98.68%	99.02%	99.23%	99.68%
Canterbury and Whitstable	5,625	97.82	92.96%	99.32%	97.94%	98.74%	98.60%	99.36%
Dartford, Gravesham and Swanley	6,527	98.20	92.24%	99.69%	99.31%	99.29%	99.11%	99.61%
Dover, Deal and Shepway	4,834	97.64	91.20%	99.26%	98.18%	98.67%	99.19%	99.39%
East Sussex	370	98.48	-	97.28%	97.94%	97.78%	99.40%	100.00 %
Maidstone, Malling, West Kent and Weald	7,062	97.84	94.29%	99.23%	97.86%	98.17%	98.50%	99.00%
Medway	809	98.29	91.80%	99.75%	99.10%	99.63%	99.63%	99.88%
Other	705	98.2	-	96.41%	98.68%	98.48%	98.01%	99.42%
Swale	1,696	96.79	90.58%	97.89%	97.72%	97.66%	98.66%	98.26%
Thanet	2,726	98.27	95.03%	99.53%	98.11%	98.38%	99.19%	99.38%
Trust Total	**33,454**	**97.87**	**92.69%**	**99.24%**	**98.41%**	**98.68%**	**98.89%**	**99.32%**

Patient experience
Goal 3: Measurable year on year improvement in patient experience, engagement and satisfaction
Improve Nutrition and Hydration

GOALS PARTIALLY ACHIEVED

Goals for 2014/15

- 1000 KCHFT nursing and allied health professionals attended face to face nutrition and hydration training by March 2015
- 50% of Health care assistants to have accessed face to face nutrition and hydration training by March 2015
- Community hospitals to have Nutrition and Hydration information in discharge packs by August 2014and to audit nutrition and hydration practises by January 2015
- Reviewing crockery, placemats and food options for patients with dementia by October 2014
- An audit on the completion of MUST, referrals and nutritional care plans to completed by March 2015

How did we perform in 2014/15?

We have not achieved our goal to train staff with face to face training as planned. But we have developed and implemented a specialist skills module of which 125 staff undertook; with this additional education and training, staff are acting as champions to improve hydration and nutrition throughout our services. Face to face training is encouraged at Induction through action learning sets in addition to the e-learning module.

Following engagement with patients during Nutrition and Hydration Week 2014, a Community Hospital's Nutrition and Hydration Discharge Pack was developed and content approved at the Clinical Nutrition Steering Group in 2014. This pack is for nursing staff to offer to patients on discharge to support their awareness and involvement in maintaining their own nutritional status.

Coloured mats have been distributed to community hospital sites. The red mats offer an additional prompt to monitor patients food and drink intake, innovative yellow mats prompt patient to ask for help with eating and drinking if needed.

The new 'finger food' pictorial menu was developed in collaboration with Clinical Nutrition and Dietetics and Hotel Services. This is to be available alongside the updated spring/summer menu launched from April 2015 and publicised during Dementia Awareness week May 2015. The range of options in this menu meets national recommendations to support specific patients who may have difficulty with formal seated eating and prefer 'grazing' on 'easy to pick up' foods.

A Hydration Audit was repeated at the end of January 2015 in all Trust community hospital sites. A report and action plan is now underway led by community hospital matrons and Clinical Nutrition and Dietetics. MUST audits have been completed and results are being analysed before developing any recommendations to implement.

National recognition achieved included;

- Articles published in local newspapers following Nutrition and Hydration Week afternoon tea events 2014
- Trust participation in World Nutrition and Hydration week March 2015

- Original Hydration audit 2013 presented at Trust audit conference autumn 2014
- Trust Hydration awareness poster promoted at National Hospital Caterers conference 2014
- Clinical Nutrition and Dietetics participation in Malnutrition Task Force project 2014/15 working with multi-agencies to set up events and projects locally in Kent.

Red mats in community hospitals offer an additional prompt to staff to monitor patients food and drink intake.

Patient experience
Goal 3: Measurable year on year improvement in patient experience, engagement and satisfaction
Improving Health and Wellbeing

GOALS ACHIEVED
Goals for 2014/15

- Develop and implement Every Contact Counts strategy.
- Increase target numbers of smokers successfully quitting by developing and implementing a new Stop Smoking model with commissioners. The focus will be on behaviour change and harm reduction as well as quits.
- Enhance health improvement services for mental health clients addressing the recommendations within "Closing the Gap"
- Implement Electronic records for all services including Sexual health

How did we perform in 2014/15?

Making Every Contact Counts (MECC) roll out plan for embedding training within the organisation is being discussed at the Education and Workforce Group. This refers to the outcomes from the October workshops attended by staff where staff discuss how this will work in practice. Staff welcomed this training and knowing more about the health improvement services offered but also welcomed the opportunity to learn how to raise subjects that they do not feel confident in asking about, for example, weight or smoking. MECC was also presented at the First Class Care meeting, West Kent Locality Meeting and Specialist and Elective Managers meeting to help raise its profile.

The KCHFT Stop Smoking Service continues to provide both group intervention and 1 to1 support to service users who want to give up smoking. This work is delivered directly within local communities via quit clubs, rolling groups, and 1 to 1 interventions and via advisers based in GPs, Pharmacies, mental health settings, children's centres, hospitals and prisons. There is a telephone service available and we are currently working on development of a Skype service for housebound patients. Midwives are currently promoting the Babyclear initiative which involves CO readings for all pregnant women; those with a higher than average readings are referred into our service. The Cut Down to Quit pilot has been re-launched in Swale to encourage smokers to cut down before quitting completely. The results will be monitored and reported accordingly.

Nationally we are ranked 4th as a Stop Smoking Service. There has been an increase in the use of electronic cigarettes. We are working with Fertility Services to support women and their partners prior to undergoing IVF treatment. It is a requirement for them to have quit smoking for at least 3 months before being accepted for treatment.

A timetable of available community sessions is on Staffzone and in the Weekly Bulletin. This will enable us to we reach out to those KCHFT employees who, from previous experience and feedback, are reluctant to attend in-house sessions and feel more comfortable in community settings.

The specialist Mental Health Project Team is working very closely with Kent and Medway Primary Trust to support their smoke free status as at 1 April 2015.

The implementation of electronic patient records (EPR) will make a significant difference to the experience for patients and for their clinical care. By having records available electronically staff will be able to access a full patient history, they will also be able to ask a senior colleague working at a different site to review the clinical care and advise accordingly. The patient will not have to share their details repeatedly if they choose to access care in the different towns in Kent and will be assured that the staff caring for them have the full clinical information they require. Staff will also be able to fully evaluate patients risk taking behaviour.

Electronic records will also mean the patient's personal details are safer because there will be no need for manual transport of records or storage of hard copy notes. The patients in non health settings can now be assured their information is safer and there are no hard copies. Records are held on a central sexual health information system and can be accessed by staff wherever the patient chooses to access their care.

The sexual health service is well underway in the implementation of EPR, staff are undergoing training and competence assessments and outreach nurses are already using lap tops where they are on non NHS sites. There are some challenges regarding the strength of the server and there is a pause while this is upgraded, then the remainder of the service will move to EPR.

KCHFT staff promote the Stop Smoking Monster Quit Club.

Patient experience
Goal 3: Measurable year on year improvement in patient experience, engagement and satisfaction
Person Centred Care Planning

PARTIALLY ACHIEVED

Goals for 2014/15

- Implement person centred care planning in 50% of services

How did we perform in 2014/15?

We have partially achieved this goal, with the care planning being implemented but not yet within fifty percent of services. The project has gone live and will be continued in 2015-2016.

With varied professional groups including Nursing, Occupational Therapy (OT), Physiotherapy, Speech and Language Therapy (SLT), Dietetics, Pharmacy, Medicine and Rehabilitation Support Workers it is vital that any measure of clinical outcome not only encourages inter-professional working but is also person centered. The measure should be meaningful for the person, clinical team and the commissioners.

The East Kent Outcome System (EKOS) will be used as the clinical outcome framework. Through EKOS a Personalised Care Plan (PCP) will be developed with the person and their family, EKOS will also provide the outcome data which will demonstrate the clinical effectiveness of the clinical teams. EKOS promotes an inter-professional approach – moving away from the traditional model of uni-professional care planning/goal setting to an enhanced Personalised Care Plan (PCP) of where clinical outcomes can be measured. The intervention is shared and owned across the different team members, making every contact with the patient working towards their overall rehabilitation goal.

EKOS aims to:

- Promote recovery
- Deliver person centred rehabilitation
- Support a person's independence and choice
- Integrated care planning/goal setting

The person and their family/carers benefit through an enhanced person centered service, the focus moves to their choices and wishes.
Following an holistic assessment a Personalised Care Plan (PCP) is developed alongside the person and their family. The PCP included the baselines and targets for the person with a clear emphasis on what the clinical team will do and what the person will do.

The timescale and type of intervention is discussed with the person and family (e.g. number of physiotherapy or community nursing sessions delivered at home)

Improvement in function and levels of independence upon discharge for the person - EKOS will ensure that these improvements can be demonstrated and measured.

Improved joint working and communication across the professions - therefore better experience for the person and family (e.g. the team, person and family have a shared understanding of the personalised care plan / goals of the admission, timescale and who is responsible for key actions).

The PCP will be reviewed with the person to at key points through the intervention, including discharge, to ascertain the outcome for them.

With consent the PCP can be shared with key agencies to ensure a consistency of approach and to develop shared care.

Assurance and Governance
Goal 4: Promoting a culture of accountability and openness
Serious Incidents (SIs)

GOALS ACHIEVED
Goals for 2014/15

- No never events.
- Embedding learning from incidents
- The SI Team will engage with staff at focus groups to identify innovative methods of sharing lessons learned
- 20% reduction in reported SIs due to an intended reduction in pressure ulcer SIs
- SIs as a rate per occupied bed days/contacts will be reported quarterly to the Quality Committee and Trust Board to allow benchmarking with other similar providers
- The Being Open Policy will be audited

How did we perform in 2014/15?

We have achieved our goal of zero never events in 2014-2015. We have achieved a 13% reduction in serious incidents. We have achieved our goal to reduce Pressure Ulcer SIS (21%) and reduction (50%) in Information Governance SIs.

Following review, the Serious Incident team determined most staff prefer to learn from case studies. Case studies are provided in the Lessons Learnt section of the staff intranet and in the Weekly Bulletin sent to all staff. There is a Learning Lessons Trust-wide Action Plan in place. The SI/NICE Manager is working with the Communications Team to improve how we learn lessons from SIs and other areas such as complaints, safeguarding cases and claims across the organisation. In addition the organisation is looking at what barriers prevent learning. Services are required to embed the learning from Serious Incidents, as exampled;

- Learning from an SI has ensured new guidance is in place regarding no access to patient's homes to ensure appropriate, urgent action is taken when a patient is non-contactable.
- To prevent patient identifiable, sensitive information being sent to the wrong recipient, many services have reduced the numbers of faxes sent from the organisation and the Trust has been working with GP practices and acute trusts to reduce faxes being sent.
- The pressure ulcer policy has been updated which incorporates learning from SIs to assist in the reduction of pressure ulcer SIs. The SI process facilitated changes in the external equipment contractor processes to enable more timely equipment delivery, by demonstrating the impact that delays have on patients. Electronic requisitioning for this equipment was implemented.
- Bespoke training regarding documentation was developed and implemented by the Trust Solicitor.
- Being Open actions were re-audited and determined that staff, on the whole, were following the process. The exceptions when not implemented had been risk assessed in regards to Being Open. In November 2014 this was superseded by Duty of Candour and this will be audited in 2015.
- The SI/NICE Lead has been undertaking an SI investigation with NHS England which will lead to national learning relating to pressure ulcers in the community.
- Our Root Cause Analysis reports have been praised by four CCGs.

Assurance and Governance
Goal 4: Promoting a culture of accountability and openness
Information governance

GOALS ACHIEVED

Goals for 2014/15

- Implementation of a new Community Information System (CIS)
- Continued auditing of compliance with legislation and policy within working practice, and the continued promotion and delivery of training

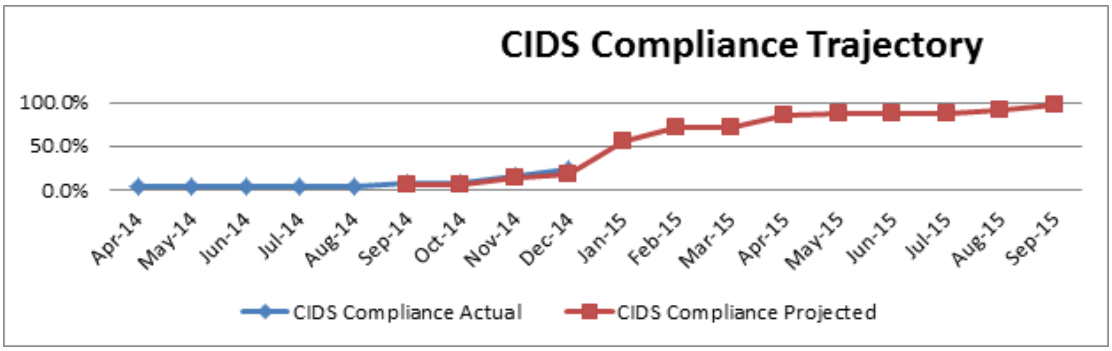
How did we perform in 2014/15?

The Community Information System Programme started in April 2012 and will bring over 4,000 of the Foundation Trust's clinical and administrative staff and managers online. CIS will provide the Trust with high quality, accurate, timely (including real time) information to support clinical work, contracting and performance monitoring/reporting. The approved programme plan, scheduled to complete at end September 2015, is progressing and remains on track.

- 147,502 patients currently have records on the system
- 2,806 staff have been trained and are registered users on the system
- 568 locations across Kent are online. All sites prepared, equipped where required, wireless enabled where applicable and tested
- 2,385 staff in Adult Community Services across the Trust have been issued with Android 7 inch tablet devices with the mobile working application

Each staged programme deployment ends with 'go live' (face to face patient contacts are managed, delivered and recorded through the system in real time), 'performance reporting' (performance data extracted solely from CIS and legacy systems are discontinued) and 'handover to BAU' (the service moves from the CIS programme to long term support from the Applications Team and is in a business as usual or BAU state). Adult Community Services across Kent were performance reporting entirely from CIS from 1 April 2015.

The illustration below outlines the trajectory for Community Information Data Set (CIDS) reporting against the CIS programme plan. The period from October to end April 2015 reflects the deployment to Adult Community Services. The position to the end of November 2014 shows KCHFT at 23.2% CIDS compliant, the increase due to performance reporting in Ashford Long Term Conditions, Pulmonary Rehabilitation and Cardiac Rehabilitation. This is ahead of the trajectory target of 18.1%.



KCHFT submitted the IG toolkit assessment in July and October 2014 and achieved a satisfactory rating, as the minimum level 2 was achieved across all requirements. At year end in March 2015 the toolkit was submitted at 84% as a satisfactory assessment. (Assessments are either satisfactory or unsatisfactory)

Information Governance Training has been maintained at a minimum of 85% throughout the year and it is 93% at the year end.

There were 105 audits undertaken in 2014/15. A clinical audit of record keeping was undertaken during Feb/ March 15 in services using paper records. Findings should be available by May 2015. Records of dental, podiatry and universal services have been audited as part of an on-going training/ audit package, led by the legal department. Service actions from the 2013/14 record keeping audit are continuing.

The number of serious incidents reported has reduced by 42% when comparing 2013/14 (12 SIs) and 2014/15 (7 SIs).

Assurance and Governance
Goal 4: Promoting a culture of accountability and openness
Clinical Audit

GOALS ACHIEVED

Goals for 2014/15

- Participate in national confidential enquiries
- The Trust will continue to develop the audit programme over the coming year

How did we perform in 2014/15?

In the last year KCHFT participated in the following National Confidential Enquiries:

- Lower Limb Amputation – organisational survey
- Mortality Review – organisational survey
- Sepsis – organisational survey

Planning for the annual audit programme runs from October to March when the programme is ratified at the Trust Clinical Audit Group. The programme is added to during the year in response to risk, organisational and commissioner priorities.

A Revised Clinical Audit Strategy 2014-17 was put in place to develop and improve the service. Key Performance Indicators are used to monitor the completion of due audit recommendations. KCHFTFT achieved 85% for 2013/14.

Results 2014/15

Indicator	2013-2014	2014-2015
Target	>80%	>85%
Due audit recommendations implemented	85%	90%

A case study on patient representatives in our Trust-wide Clinical Audit Group was published on the Healthcare Quality Improvement Partnership website in September 2014.

A Clinical Audit and Research Conference was held to promote shared learning.

KCHFT presented a workshop at HQIP's national conference. The workshop was titled: "Clinician Engagement for Quality Improvement – what other settings can learn from community services". We are held in esteem in terms of linking risk and clinical audit and our Medical Director and Head of Clinical Audit and Research were asked to present at a national clinical audit conference in March 2015.

We now report quarterly to the performance team for the Service Development Improvement Plan. This information is used for reporting our audit programme and actions identified from clinical audits to the CCGs. The majority of audits are undertaken across all the CCGs and are noted in section 2.2.

Additional CCG specific Audits

DGS	• Record-Keeping Dartford, Gravesham & Swanley Long Term Service. • Record-Keeping Dartford, Gravesham & Swanley Intermediate Care Service • CQUIN Waterlow/Nutrition • Re-audit CQUIN Waterlow/Nutrition • Wound Care
WEST KENT	• Record-Keeping West Kent Intermediate Care Service. • CQUIN Waterlow/Nutrition • Re-audit CQUIN Waterlow/Nutrition
ASHFORD AND CANTERBURY	• National COPD Audit programme: Pulmonary Rehabilitation record keeping audits for the following services: • Long Term Service Canterbury • Ashford Long Term Service • Ashford Intermediate Care Service • Canterbury & Coastal Long Term Service • Canterbury Intermediate Care Service
THANET	• 2 Record Keeping Long Term Service • Record Keeping South Kent Coast & Thanet Intermediate Service • National COPD Audit programme: Pulmonary Rehabilitation Audit (currently in progress)
SOUTH KENT COAST	record keeping audits for the following: • Intermediate Care Dover, Deal & Thanet • 2 for Long Term Service Dover & Deal • South Kent Coast & Thanet Intermediate Care Service • Shepway Long Term Service
SWALE	• 2 Record Keeping Audits for Intermediate Care Swale • CQUIN Waterlow/Nutrition • Re-audit CQUIN Waterlow/Nutrition • Wound Care
East Sussex	• Record Keeping East Sussex Children's Integrated Therapy Service

Assurance and Governance
Goal 4: Promoting a culture of accountability and openness
Research & Development

GOALS ACHIEVED
Goals for 2014/15

- Review of existing arrangements to embed robust research structures within KCHFT.
- Establishment/re-establishment of links within and without KCHFT to ensure stakeholder engagement.
- Raising the profile of research and ensuring lessons learnt approach to research findings.

How did we perform in 2014/15?

Gap analysis is undertaken and research priorities put in place. This is reported on a bi-monthly basis to the Research and Development (R&D) Committee.

Engagement has been prioritised and has included the appointment of 3 patient representatives to the R&D Committee.

A Clinical Audit and Research Conference was held on 31 October 2014. This included sessions on patient engagement and involvement in research and audit. This was supported by more than 90 attendees which included staff, patients, governors and non-executive directors.

The Kent Surrey and Sussex Clinical Research Network (KSS CRN) set us targets on recruitment and time for local study permissions.

- For 2014/15 recruitment target to portfolio studies of 100 – achievement was 131.
- Target for local study permissions is 15 days – KCHFT has an average study permission time of 4 days

KCHFT has established strong links with the KSS CRN and has received recurrent funding for a research nurse to support recruitment to portfolio studies.

Research activity has increased within the Trust enabling more patients to have access to research. The number of patients receiving relevant health services provided or subcontracted by Kent Community Health NHS Foundation Trust that were recruited during that period to participate in research approved by a research ethics committee is 1895. This includes interventional, observational and student studies.

Research Study activity 2014-2015

Study title	*Acronym*
REFORM: Multifaceted podiatry intervention for the prevention of falls in older people	REFORM
Predictors of Patient Uptake of Telehealth and Subsequent Abandonment	
Carer assessment study	
Feeding and Autoimmunity in Down's syndrome Evaluation Study	FADES
Mitogent Study V1	
Mapping Study: Phase 1 of a Longitudinal National Evaluation of Schwartz Centre Rounds: an intervention to enhance compassion in the relationships between staff and patients though providing support for staff and promoting their wellbeing	Schwartz Centre Rounds
Optimising pelvic floor exercises to achieve long term benefits.	OPAL
Patients' preferences for future HIV services.	HIV DCE
Understanding factors behind the late testing and diagnosis of HIV	IMPRESS Health 2
Dementia and managing oral pain.	
How do staff apply local policy in the care of pressure ulcers?	
Community Nursing Workforce Development Project Phase 2	Cassandra
A randomised controlled trial to enhance parental self-efficacy in undertaking dentally healthy child behaviours in order to prevent the development of dental caries in primary school children	bBarts
How physiotherapists classify and manage shoulder adhesive capsulitis.	
An Epidemiological ASD Study and Establishing a Research Database v1.0	ROCCA
ASD+ Study - Co-existing conditions in children with Autism Spectrum Disorder	
Early evaluation of the Integrated Care and Support Pioneers	
Parents' and professionals' opinions as to what children with four limb cerebral palsy understand about their condition	
Facilitating participation in children with 4 limb CP	HEAF
Helping people with aphasia have better conversations	
A Comparison of Organizational Cultures around Promoting Equity in Public and Hybrid Healthcare Organizations	
Mood and tiredness following a stroke	

Assurance and Governance
Goal 4: Promoting a culture of accountability and openness
Understanding Claims

GOALS ACHIEVED

Goals for 2014/15

- More involvement in training of staff, including clinical record keeping, statement writing and court skills in order to assist staff generally.
- To continue to collaborate with coroners with any cases for openness and learning
- To work with the clinical services to improve the quality of documentation.
- To work with the clinical services to map out consenting
- To triangulate and disseminate lessons learnt across the organisation following claims, inquests, complaints and incidents.

How did we perform in 2014/15?

Documentation and the law training is an essential to role training and provided by the legal team. This interactive training is designed to re-enforce the importance of record keeping, recap on standards, outlines where standards are not being met in practice, and discusses the challenges clinicians experience in practice. The challenges are fed back to senior management and the Trust's documentation steering group, for assessment and action. The impact of training is supported by clinical audit cycles. Training has been well received by staff.

Key services have been chosen in reviewing consenting arrangements, to undertake detailed review, benchmarking, and gap analysis. Action plans are devised target areas in need of improvement and strengthen processes and procedures ensuring that they are legally compliant. The team will then target community hospitals.

The legal team ensure that key risks appear on services' risk registers and contribute actively to the CARM Group, inputting into the CARM triangulation report. Individual clinicians also provide feedback following inquests and claims, by way of video clips, identifying key learning which are cascaded across the organisation.

We have worked closely with coroners, providing expert witnesses and collaborating with multiple providers to share learning

Assurance and Governance
Goal 4: Promoting a culture of accountability and openness
Care Quality Commission

Goals achieved

Goals for 2014/15

- The Trust will be inspected by CQC in June 2014 and aims to achieve "good" to "outstanding" rating.

How did we perform in 2014/15?

The Trust was inspected by the CQC in June 2014 and this resulted in an overall rating for the organisation of "Good". Five reports were published by the CQC, one for each of the four core services and one for the Trust overall. The ratings for each core service and each of the domains are shown in the table below and via this link: http://www.cqc.org.uk/provider/RYY

An action plan was developed following CGC feedback for areas in which we could make improvement. This action plan is now closed and we continue to work to achieve "outstanding" in future years..

The Trust received one compliance action in relation to the use of Do Not Attempt Cardiopulmonary Resuscitation Orders (DNACPR) and a number of areas in which it "must improve", "should improve" and "could improve".

The domain "Effective" was rated "Requires improvement" overall.

The core service "End of Life" was rated "Requires improvement" overall.

Enabling Strategies;
Goal 5: Improving delivery capacity and capability in all areas
Clinical Education and Standards

GOALS PARTIALLY ACHIEVED

Goals for 2014/15

- 95% of all clinical staff to have individual competency role profiles with relevant assessment tools
- Nursing and Midwifery Council (NMC) Mentors to maintain compliance at 85%
- Development of career pathways for unregistered workforce through the strategy
- 75% of newly appointed unregistered clinical support workers will be on a career development pathway by March 2015
- Increase of 25 Non-Medical Prescribers (NMP) within Long Term Conditions by March 2015
- Implementing Post Graduate Certificate in Community Health Care in partnership with University of Kent by September

How did we perform in 2014/15?

A competency framework campaign has occurred this year but no competency profiles have been formally assigned although Canterbury Long Term Conditions and Intermediate Care Services have signed staff against a ratified profile. Health Improvement services ratified their profile in March 2015.
We have not achieved our Nursing and Midwifery Council (NMC) mentor compliance level target which is 63%. This has been reviewed and reflects the turnover of staff and this will be ongoing work for 2015-2016
Career pathways development for the unregistered workforce remains with the HR operational group for consultation and when this is completed mapping of staff will start.
There is on-going work around the career pathway for bands 1-4 in partnership with learning and development and human resources to continually develop this clinical workforce.
We did not achieve our goal to increase Non Medical Prescribers; we gained fifteen prescribers but this was outweighed by the loss of 42 prescribers from our organisation. New checks are in place through recruitment to capture all new starters with relevant qualifications and opportunities have been increased to allow clinicians to gain access to a prescribing pathway to retain our non medical prescribing skilled staff
As well as supporting the traditional academic programmes delivered by our local Higher Education Institution partners in both clinical specialist and management programmes, KCHFT has become a validated provider of education with the University of Kent.

The Post Graduate Certificate in Community Studies started in September 2014 and consists of 3 mandatory 20 credit modules at Level 7 focusing on the main competencies of the community nursing workforce (Wound Medicine, Injectable Medicines and End of Life Care) utilising a work-based model approach. Although early days in its implementation, it has attracted external interest and we are looking at developing further modules to meet a wider audience in particular Allied Health and Primary Care Professionals
We are proud to have staff enrolled in clinical academic career pathways, with Masters in Clinical Research funded by the National Institute for Health Research. We also have a physiotherapist on the Internship which he is using to apply for the National Institute for Health Research (NIHR) funded PhD.

We have also been developing an in-house clinical leadership programme for our developing junior managers and leaders to supplement the current mentoring model that was externally commissioned last year (mentoring for quality improvement). The Quality Improvement Unit is a targeted approach to support the implementation of Quality Improvement. The Unit supports leaders in clinical practice to deliver quality improvement ensuring a high quality safe patient experience using a structured action learning set framework accumulating in a change management project within their immediate area of practice. Eight members of staff from Adult services have participated within this module in 2014.

We facilitated over 1,200 (525 placement blocks) placement weeks within the organisation supporting primarily pre-registered professional programmes funded by Health Education England across during 2014-15. We are extremely proud that we have received 98% glowing feedbacks from our student evaluations / feedback. The STEP (Step in to Placement) tool which is based on the 15 steps is being used as an early evaluation / induction tool for students. This allows us to proactively respond to concerns raised by students whilst in placement or shortly after the placement. All unfavourable comments are followed within the education assurance programmes and action plans are developed with clinical areas to further development their provision of a learning environment

Enabling Strategies; improving staff morale and recruitment and retention
Goal 5 Improving delivery capacity and capability in all areas
Workforce

GOALS PARTIALLY ACHIEVED

Goals for 2014/15

- Continue to focus on reducing our vacancy rate through a planned approach to recruitment and retention, decrease vacancies to less than 5%
- Reducing sickness absence to 4%, with a focus on short term absence
- Linking performance to pay for the rest of our organisation by April 2015.
- Improving our staff survey results through the implementation of our Staff engagement strategy using the results of our Friends and Family test for staff.

How did we perform in 2014/15?

KCHFT staff featured in our campaign

Recruitment has had a high focus this year and the Trust has reduced the vacancy rate from 7.5% in April to 5.4% by the end of January. This has been achieved through a number of measures including: This remains higher than we anticipated and we will continue to strive to 3% with:

- Local recruitment events throughout Kent
- Targeted marketing campaigns using social media, radio, local press and bus advertising
- Return to practice campaigns
- Overseas recruitment
- A reduction of almost 5 week in recruitment timescales from November 2013 to February 2015.

A number of retentions strategies are also in place but to date the turnover figure has yet to show a downward trend. These strategies include:

- Pension workshops to enable staff to understand how they can flex their pension and continue working
- A review of the 'exit' process for staff
- Review to the local induction process to include familiarisation with Trust systems and processes such as pay
- The implementation of a new culture strategy called 'Embedding a Positive Culture'

The early part of 2014 saw a significant reduction in the Trust's sickness absence rate reaching a low of 3.58 in the summer but the winter saw a steady increase of sickness in line with the general health of the wider population. Throughout the year we have continued with training for managers and carrying out Deep Dives in areas with particularly high absence rates. The rate at year end is 4.16%.

This year has seen the implementation of performance related pay for Bands 7 and above and this has required a significant shift in approach for staff and managers. Whilst the original plan was to roll this out to all staff from 1 April 2015 the decision has now been reached to add Band 6 staff only into this process for next year.
It is noted that here is no consistent direct correlation between Serious Incidences and staffing levels, although this doesn't exclude this on an individual basis.
KCHFT's staff survey results for 2014 shows that although staff engagement score remains average when compared to similar organisations there has been a slight increase in the score when compared to 2013's results. All other key findings have remained the same as last year with the exception of 2 which have seen a statically significant change and have improved. These are:

- The % staff feeling pressure to attend work when unwell in the last 3 months
- The fairness of incident reporting procedures.

There has been one deterioration which is in the number of staff who received equality and diversity training in the last 12 months but this is as a direct result of a decision made not to train staff every year when the legislation remains the same.

Enabling Strategies
Goal 5: Improving delivery capacity and capability in all areas
Transformation

Goals achieved

Goals for 2014/15

- **Transforming our models of care**: Support services to undertake service redesign to increase quality, patient experience and productivity, including Musco Skeletal services, intensive intermediate care, long-term conditions, and self-management services.
- **Transforming the times and places where we give care**: Supporting the development of a service led strategy through mapping opportunities for services to work collaboratively in community based buildings.
- **Transforming our people**: Develop and implement transformation skills package to improve skills of staff in undertaking service redesign and project management.
- **Transforming our clinical support systems**: Complete implementation of e-rostering by March 2015.

How did we perform in 2014/15?

Strategy and Business Planning: The main focus of the team has been to ensure all services have a robust five year strategic business plan in place with granular two year cost improvement plans in line with Monitor requirements. This clarifies the strategic direction for the services and gives the transformation team focus on where services need support in areas such as service redesign, change management etc. It also ensures the services are taking into account their future business needs in line with quality and financial governance. The team are facilitating the development of the Trust's five year strategy; engaging staff, patients and other stakeholders to develop the organisational direction in line with the "Five Year Forward View" and local commissioning intentions.

Skills Packages: To support development of services The Transformation team has developed a portfolio of 15 skills packages, aligned to the NHS Improving Quality tools. These support staff in a number of key areas with innovation and service change. The team has worked with other corporate services, in their design, to dovetail and avoid duplication. From April 2014 to February 2015 the team has spent 276 days engaging with over 65 teams, supporting change and innovation, business planning, service redesign, tendering and strategy development.

SBAR Consistent Communication Tool: There has been a hugely positive response to the roll out of **SBAR (Situation Background Assessment Recommendation)** which is a consistent communication tool within clinical and non-clinical teams, since face to face training commenced in June 2014. The SBAR templates for correspondence and report writing have been developed and are in use across the organisation. The "Transfer of Care" and "Record Keeping" Policies have also been updated to reflect the use of SBAR. For sustainability, SBAR e-learning training has been developed.

Health Roster: The roll out of Health Roster will be completed by June 2015. The use of an electronic roster ensures the organisation is able to monitor staffing levels in line with national requirements. It also helps to plan staffing levels in order to reduce the use of bank and agency cover.

Enabling Strategies
Innovation

Within KCHFT innovation is promoted through:

- Growth in research activity within KCHFT
- Supporting and enabling the change process as part of clinical audit.
- The diffusion of innovation from research, audit and other quality improvement activity within the Trust.

We have grown the research function in order to support increased research capacity and capability within the organisation. We have engaged with the Kent Surrey and Sussex Clinical Research Network who have provided funding for a Research Nurse to increase recruitment to portfolio studies.

All audit recommendations are followed through to completion to ensure that clinical audit results in changes to practice where required and improved patient outcomes.
By increasing research activity we have been able to offer more research studies to patients, thus bringing new and innovative ways of treating patients within our care as early as possible to those that need it.

By ensuring that all proposed clinical audit actions are implemented we have ensured that clinical audit results in innovation and service development.
Improved patient outcomes are at the heart of all KCHFT Clinical Audit and Research activity.

Audit results are presented at all Directorate Audit Groups and deep dives are undertaken at Trust Clinical Audit Group. Research results are presented at Trust Research Interest Group and discussed at Trust Research & Development Committee. There is an annual Clinical Audit and Research Conference.

- We have showcased our innovative approach to linking clinical audit with other risk and quality work streams by presenting at a National Audit Conference in March.
- Sexual Health presented at the" IMPRESS 2: Understanding factors behind the late testing and diagnosis of HIV" study conference which is a collaboration between Kent and Medway and the French region of Piccardy.

We have built strong links locally with the Kent Surrey and Sussex Clinical Research Network and cemented links with the South East Clinical Effectiveness Network. These networking activities are essential if we are to continually develop and innovate in the areas of clinical audit and research.

To support development of services The Transformation team has developed a portfolio of 15 skills packages, aligned to the NHS Improving Quality tools. These support staff in a number of key areas with innovation and service change. The team has worked with other corporate services, in their design, to dovetail and avoid duplication. From April 2014 to February 2015 the team has spent 263 days engaging with 65 teams, supporting change and innovation, business planning, service redesign, tendering and strategy development.

Enabling Strategies;
Productivity

Metric targets
Reduce the length of stay to 21 days in community hospitals

How is progress measured, monitored and reported?
Average LOS is measured monthly, and by hospital, through the inpatient report, as well as the Early Warning Trigger Tool and Board Report.

How did we perform in 2014-2015?

Unfortunately we did not meet this target; Up to the end of January 2015, the average length of stay across KCHFT's 12 Community Hospitals had reduced to 21.5 days but at year end was 22.5 days. Admission criteria tightening has resulted in a reduced length of stay closer to the target level for 2104/15. Pushing the length of stay down further is still proving difficult, mainly due to delayed discharges, where patients are able to return home, but delays in social care, or equipment, mean that they are staying longer than is necessary. Further development of the non-weight bearing and admission criteria should reduce the LOS further.

Monitor Risk Assessment Framework requires the following indicators and performance thresholds to be reported;

Indicator	Area on Monitor Sheet	Threshold	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15	Monthly average
18 week wait *	1	95%	100 %	100 %	100 %	100 %	100 %	100 %	100 %	100 %	100 %	100 %	100 %	100 %	100 %
Total Time in A&E: Less than 4 hours	4	95%	99.94%	99.93%	99.91%	99.90%	99.90%	99.83%	99.93%	99.97%	99.93%	99.96%	99.97%	99.98%	99.92%
Consultant Led 18 Week Referral to Treatment Times (incomplete pathways)	3	95%	96.92%	96.21%	98.93%	99.81%	99.68%	99.41%	99.92%	100.00%	100.00%	99.92%	100.00%	100.00%	99.23%
Consultant Led 18 Week Referral to Treatment Times	2	95%	98.54%	99.29%	99.31%	99.90%	99.18%	99.64%	99.23%	99.90%	99.80%	100.00%	100.00%	100.00%	91.23%
Allied Health Professionals Referral to Treatment Times (RTT)	2	95%	95.0 %	95.0 %	94.1 %	92.8 %	93.4 %	94.2 %	92.7 %	92.5 %	92.7 %	93.3 %	89.4 %	92.4 %	93.12%
Cids Compliance - RTT	21	50%	86.3 %	84.8 %	85.5 %	83.6 %	85.0 %	89.0 %	91.0 %	91.0 %	92.0 %	94.0 %	93.3 %	94.9 %	81.29%
Cids Compliance - Referrals	21	50%	100 %	100 %	100 %	100 %	100 %	100 %	100 %	100 %	100 %	100 %	100 %	100. %	100%
Numbers of Clostridium Difficile	16	<8	0	1	0	1	1	1	0	0	0	3	0	1	66.67
Access to healthcare for those with Learning disabilities	20	100%	100 %	100 %	100 %	100 %	100 %	100 %	100 %	100 %	100 %	100 %	100 %	100 %	91.67%

*As part of Monitor's audit of the Trust's indicators for 2014/15, the Consultant Led 18 Week Referral to Treatment Times (incomplete pathways) has been listed as "limited opinion". This is due to the nature of the indicator and the prior knowledge of the audit. The indictor is measuring the monthly percentage of patients on a consultant-led pathway who have been waiting less than 18 weeks. As such, it is calculated on a particular date each month and will change from one day to the next. The majority of the data (until CIS is fully rolled out) is manually collected and so we cannot go back and produce an auditable patient level list from previous months. In the future, a list will be saved each month to enable full compliance going forwards"

Annex 1 Statements from commissioners, local Healthwatch organisations and Overview and Scrutiny Committees

Requests for feedback from all CCGs were made on 17th April 2015 and were received as dated by their returned letters

Kent Community Health NHS
NHS Foundation Trust

Kent County Council
kent.gov.uk

Marion Dinwoodie
Chief Executive
Kent Community Health NHS Foundation Trust
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Hermitage Lane
Barming
Kent
ME16 9NT

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

Direct Dial: 03000 412775
Email: HOSC@kent.gov.uk
Date: 28 April 2015

Dear Marion

Draft Kent Community Health NHS Foundation Trust Quality Account 2014/15

In recent weeks, the HOSC has received a number of draft Quality Accounts from Trusts providing services in Kent, and may continue to receive more. I would like to take this opportunity to explain to you the position of the Committee this year.

Given the large number of Trusts which will be looking to the HOSC at Kent County Council for a response, and the standard window of 30 days allowed for responses, the Committee does not intend to submit a statement for inclusion in any Quality Account this year.

Through the regular work programme of HOSC, and the activities of individual Members, we hope that the scrutiny process continues to add value to the development of effective healthcare across Kent and the decision not to submit a comment should not be interpreted as a negative comment in any way.

As part of its ongoing overview function, the Committee would appreciate receiving a copy of your finalised Quality Account for this year and hope to be able to become more fully engaged in next year's process.

Kind regards

Robert Brookbank
Chairman
Health Overview and Scrutiny Committee
Kent County Council

Kent Community Health NHS
NHS Foundation Trust

NHS
Dartford Gravesham and Swanley
Clinical Commissioning Group

NHS
Swale Clinical Commissioning Group

Bramblefield Clinic
Grovehurst Road
Kemsley
Sittingbourne
Kent, ME10 2ST

Direct Line: 03000 425100
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Nicky Lucey
Director of Nursing and Quality
Kent Community Health NHS Foundation Trust
The Oast, Unit D
Hermitage Court
Hermitage Lane
Maidstone
ME16 9NT

8th May 2015

In response to Kent Community Healthcare NHS Foundation Trust's draft quality account submitted to NHS Dartford Gravesham and Swanley Clinical Commissioning Group, please find detailed below a statement in accordance with the National Health Service (Quality Accounts) Amendment Regulations 2012. This statement reflects the views of DGS CCG and Swale CCG as associate commissioners.

Dear Nicky

Statement from Dartford Gravesham and Swanley Clinical Commissioning Group and Swale Clinical Commissioning Group

The CCGs welcome Kent Community Healthcare NHS Foundation Trust's 2014/15 draft quality account and confirm that the content has been reviewed. The CCGs agree that the data is a true reflection of the progress made and is in line with national reporting requirements. The CCGs recognise the progress toward achieving the priorities outlined in the 2014/15 quality account and acknowledge the progress that the trust has made with regard to quality improvement and the outcome of the CQC inspection which rated the trust as good overall. Both Dartford Gravesham and Swanley (DGS) and Swale CCGs also congratulate the trust in achieving Foundation Trust status.

Nevertheless, both CCGs would have welcomed greater discussion within the 2015/16 quality account on areas of improvement which were not achieved during 2014/15, and how these will be taken forward under the priority areas identified for 2015/16. The CCGs note that a number of areas were also partially achieved and will follow up progress against these areas within the regular Clinical Quality Review Meetings which take place between the CCGs and KCHFT . In particular the need for a continued focus on workforce issues which represent a key concern for the CCGs, and which will remain a key area of focus for the CCGs during 2015/16. The CCGs would also have welcomed some discussion on the role of the rectification and remedial action process, implemented by DGS and Swale CCGs between June 2014 and January 2015, in order to improve the quality of adult community services; actions implemented under this process led to significant improvements to the quality of the community services delivered in these services in the North Kent areas.

NHS
Dartford Gravesham and Swanley
Clinical Commissioning Group

NHS
Swale Clinical Commissioning Group

The CCGs welcome the improvements in the uptake of training for safeguarding especially in relation to Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLs), and supports the trust's continued focus in this area in relation to community nursing services. The CCGs also acknowledges the improvements in respect of End of life and Dementia care detailed within the quality account. The CCGs recognise the trust's achievement in increasing incident reporting alongside the reduction in Serious Incidents reported. However, whilst the increase in severe harm from 0.2 – 0.4% (based on figures to the end of February 2015) may be related to an increase in reporting generally, the CCGs consider this to be of concern and will continue to follow up with the trust throughout 2015/16.

The CCGs support the priority areas for improvement identified within the quality account, which reflect areas which the CCG views as priorities for improvement for KCHFT. The CCGs will continue to work closely with the trust in order to support continued improvements for patients within the North Kent CCGs areas.

Yours sincerely

Geoff Wheat

Patricia Davies
Accountable Officer

Geoffrey Wheat
Chief Nurse

DGS and Swale CCGs

healthwatch Kent

Healthwatch Kent response Kent Community Health Foundation Trust's Quality Account

As the independent champion for the views of patients and social care users in Kent we have read your Quality Accounts with great interest.
Our role is to help patients and the public to get the best out of their local health and social care services and the Quality Account is a key tool for enabling the public to understand how their services are being improved. With this in mind, we enlisted members of the public and Healthwatch staff and volunteers to read, digest and comment on your Quality Account to ensure we have a full and balanced commentary which represents the view of the public.
On reading the Account, our initial feedback is that the account is still very lengthy and we would welcome an additional summary document to be produced to make the information more accessible to the public reading it. Having said this, in the majority of the document there is a structure and flow that means it is mostly easy to follow. Of particular note is the structure used to communicate the Goals set in 2014/15, with a user friendly format used to report progress being made.
To improve the Account for next year, and make it easier to understand, we would suggest ensuring that all references are clearly explained. For example in the CEO statement (which is largely easy to understand) much of the general public would not know what the six C's in Compassionate Care relate to. It must be acknowledged that a lot of the acronyms or jargon used within this document is now followed by a decode statement which is a big improvement from the previous Quality Account. Despite this it can still be hard for a reader to completely understand or follow the meaning of such terms.
The report references the Friends and Family Test (FFT), Leaflets and an increase in Memberships in the Patient Experience Section which is encouraging. It also states that there were 4 actions as a result of patient experience. However, we are keen to understand the other ways in which the Trust has engaged with the public and involved them in their decision making. There is also mention of 20 out of 27 interactions with organisations involving those with "protected characteristics". We would welcome more details on this and further information on how seldom heard groups are being engaged with.
Healthwatch Kent would like to take this opportunity to say that our dealings with the Trust over the past year have found them to be very patient focussed and consistently looking for ways to listen to the public.
In summary, we would like to see more detail about how you involve patients and the public from all seldom heard communities in decisions about the provision, development and quality of the services you provide. We hope to continue and develop our relationship with the Trust to ensure we can support you with this.
Healthwatch Kent May 2015

Kent Community Health NHS
NHS Foundation Trust

healthwatch
East Sussex

Tuesday, 12 May 2015

Dear Alison

RE: Quality Account

Attached is the response from Healthwatch East Sussex to the Quality Account for your services.

Yours sincerely,

J. L. Fitzgerald.

Julie Fitzgerald
Executive Director

Monday, 08 June 2015

Response to Kent Community Health NHS Foundation Trust (KCHFT) Quality Account on behalf of Healthwatch East Sussex

Healthwatch East Sussex (HWES) was very pleased to receive the Quality Account and to provide a response.

Our contact with patients who use KCHT services is very limited due to geographical differences; however we are developing relationships with Patient Experience and Public Engagement Team.

On reviewing the account we would support the priorities identified and the goals set to achieve year on year improvement, particularly around patient safety, patient experience and clinical effectiveness.

The account presents as an open and honest assessment of where improvements are required and as a learning organisation, there is a commitment to learn from incidents when care does not meet patient expectations. An example of this willingness to learn was experienced by Healthwatch East Sussex when a representative from Patient Experience and Public Engagement Team attended a recent Complaints Conference hosted by HWES.

For the year ahead, we would welcome further opportunities to develop our relationship with the Trust and would want to maintain a watching brief on the following areas:

- Achieving best value – especially with income from East Sussex Clinical Commissioning Groups (CCGs)
- Reducing medication errors
- Integrated pathways
- Learning from mistakes
- Improving assessment for Mental Capacity including Deprivation of Liberty Safeguards (DoLs)
- Staff morale

Julie Fitzgerald

Kent Community Health NHS
NHS Foundation Trust

NHS

South Kent Coast
Clinical Commissioning Group
NHS South Kent Coast Clinical Commissioning Group
Council Offices
White Cliffs Business Park
DOVER
Kent
CT16 3PJ

T: 03000 474700
E: southkentcoast.ccg@nhs.net

BY EMAIL

15 May 2015

Marion Dinwoodie
Chief Executive
KCHFT
The Oast
Unit D, Hermitage Court
Hermitage Lane
Barming
Maidstone
Kent
ME16 9NT

Dear Marion

Response to KCHFT Quality Account 2014/15

South Kent Coast CCG welcomes the Quality Account for 2014-2015. The data submitted has been provided at CCG level and outcomes for our residents can be clearly identified. The Quality Account appears to be accurate and meets the required content. In the future, the CCG would welcome data being provided in both numbers and percentages, in a way that promotes transparency and is statistically significant. The Trust did invite the CCG to comment on the setting of the priorities for improvement for 2015-2016 and the CCG will be happy to engage with the Trust regularly with the development of future accounts.

The Care Quality Commission inspection of the Trust in 2014 resulted in an overall rating of “Good”. The Trust appears to be working towards their compliance action and addressing the “requires improvement” domains.

The Quality Account 2014/15 acknowledges the outcomes for all priorities set. Most of the priorities were achieved. The CCG would like to see those priorities not achieved carried forward in to the work for 2015/16 to enable patient care to continue to be improved. The CCG does not recognise some achievements as documented when compared to information received and submitted to the CCG throughout the year e.g. reduction in pressure ulcer occurrence.

The CCG welcomes the Trust’s openness in acknowledging areas for service improvement. These triangulate with the CCG’s concerns raised during the year. These include the focus on staffing levels, workforce competence and safe services. The CCG is supporting the Trust in working through these. The CCG has continued to show an improvement in the NHS staff survey results.

The CCG welcomes the 2015/16 priorities and looks forward to working closely with the Trust to improve the experience and quality of patient care.

Yours sincerely

Hazel Carpenter

Accountable Officer

NHS South Kent Coast and Thanet CCGs

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.
Monitor has issued guidance to NHS foundation trust boards on the form and content of annual quality reports (which incorporate 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 2014/15 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 1st April 2014 to 28th May 2015
- Papers relating to Quality reported to the board over the period 1st April 2014 28th May 2015
- Feedback from commissioners dated April and May 2015
- Feedback from governors dated 21st May 2015
- Feedback from local Healthwatch organisations dated 12th May 2015 and 26th May 2015
- Requests were made to West Kent CCG on 17th April 2015 and a reminder on 21st May 2015 but the CCG have not responded
- Feedback from Overview and Scrutiny Committee dated 28th April 2015
- The trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, dated March 2015
- The 2014 national staff survey presented to the Board March 2015
- The Head of Internal Audit's annual opinion over the trust's control environment dated May 2015
- the Quality Report presents a balanced picture of the NHS foundation trust's performance over the period covered the performance information reported in the Quality Report is reliable and accurate
- There are proper internal controls over the collection and reporting of the measures of performance included in the Quality Report, and these controls are subject to review to confirm that they are working effectively in practice
- The data underpinning the measures of performance reported in the Quality Report is robust and reliable, conforms to specified data quality standards and prescribed definitions, is subject to appropriate scrutiny and review and the Quality Report has been prepared in accordance with Monitor's annual reporting guidance (which incorporates the Quality Accounts regulations) (published at www.monitor.gov.uk/annualreportingmanual) as well as the standards to support data quality for the preparation of the Quality Report (available at www.monitor.gov.uk/annualreportingmanual).

The directors confirm to the best of their knowledge and belief they have complied with the above requirements in preparing the Quality Report.
By order of the board

28.5.15 .....Date..... .....Chairman

28.5.15 .....Date..... .....Chief Executive

Annex 3

Independent Auditor's Limited Assurance Report to the Council of Governors and Board of Directors of Kent Community Health NHS Foundation Trust on the Quality Report

We have been engaged by the Board of Directors and Council of Governors of Kent Community Health NHS Foundation Trust to perform an independent limited assurance engagement in respect of Kent Community Health NHS Foundation Trust's Quality Report for the year ended 31 March 2015 (the "Quality Report") and certain performance indicators contained therein.

Scope and subject matter
The indicators for the year ended 31 March 2015 subject to limited assurance consist of those national priority indicators mandated by Monitor:

- percentage of incomplete pathways within 18 weeks for patients on incomplete pathways at the end of the reporting period, reported on page 77 of the Quality Report
- the number and percentage of patient safety incidents that resulted in severe harm and death, reported on page 16 of the Quality Report

We refer to these national priority indicators collectively as the 'indicators'.

Respective responsibilities of the directors and auditor
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' issued by Monitor.

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';
- the Quality Report is not consistent in all material respects with the sources specified in Monitor's 'Detailed guidance for external assurance on quality reports 2014/15'; 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' and the six dimensions of data quality set out in the 'Detailed guidance for external assurance on quality reports 2014/15'.

We read the Quality Report and consider whether it addresses the content requirements of the 'NHS Foundation Trust Annual Reporting Manual', 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 and papers for the period 1 April 2014 to 28 May 2015;

- Papers relating to Quality reported to the Board over the period 1 April 2014 to 28 May 2015;
- Feedback from the commissioners dated 8 May 2015 and 15 May 2015;
- Feedback from governors dated 21 May 2015;
- Feedback from local Healthwatch organisations dated 12 May 2015 and 26 May 2015;
- Feedback from Overview and Scrutiny Committee dated 28 April 2015;
- The Trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, dated March 2015;
- The 2014 national staff survey;
- The Head of Internal Audit's annual opinion over the Trust's control environment dated May 2015.

We did not test the consistency of the Quality Report with feedback from West Kent Clinical Commissioning Group as the draft Quality Report was sent to them for comment, in accordance with the timetable specified in the Regulations, but no response has been received at the time the Quality Report was signed. We have considered the consistency with the other relevant documents and are satisfied that there is no material risk of misstatement arising from this omission.

We consider the implications for our report if we become aware of any apparent misstatements or material inconsistencies with those documents (collectively, the "documents"). Our responsibilities do not extend to any other information.

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 and the Board of Directors of the Trust as a body, to assist the Council of Governors and Board of Directors in reporting Kent Community Health NHS Foundation Trust's quality agenda, performance and activities. We permit the disclosure of this report within the Trust's Annual Report for the year ended 31 March 2015, to enable the Council of Governors and Board of Directors 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 the Board of Directors 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
- Analytical procedures

- Limited testing, on a selective basis, of the data used to calculate the indicator back to supporting documentation
- Comparing the content requirements of the 'NHS Foundation Trust Annual Reporting Manual' to the categories reported in the Quality Report
- Reading the documents.

A limited assurance engagement is smaller in scope than a reasonable assurance engagement. The nature, timing and extent of procedures for gathering sufficient appropriate evidence are deliberately limited relative to a reasonable assurance engagement.

Limitations
Non-financial performance information is subject to more inherent limitations than financial information, given the characteristics of the subject matter and the methods used for determining such information.

The absence of a significant body of established practice on which to draw allows for the selection of different but acceptable measurement techniques which 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'.

The scope of our assurance work has not included governance over quality or non-mandated indicators, which have been determined locally by Kent Community Health NHS Foundation Trust.

Basis for qualified conclusion
For the indicator relating to the 'percentage of incomplete pathways within 18 weeks for patients on incomplete pathways at the end of the reporting period', Monitor's 'Detailed Requirements for Quality Reports' requires the indicator to be calculated based on the numerical average of the monthly data submitted by the Trust during the year. We have been unable to obtain and audit trail that supports the indicator value for the first 11 months of the year because the monthly data has not been retained by the Trust. As a result our testing was limited to data submitted for the last month of the year only. We were therefore unable to gain sufficient assurance to conclude that the indicator is reasonably stated in all material respects in accordance with the Regulations and the six dimensions of data quality set out in the Guidance.

Qualified conclusion
Based on the results of our procedures, with the exception of the matter reported in the basis for qualified conclusion paragraph above, nothing has come to our attention that causes us to believe that, for the year ended 31 March 2015:

- 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';
- the Quality Report is not consistent in all material respects with the sources specified above, and

- the indicators in the Quality Report subject to limited assurance have not been reasonably stated in all material respects in accordance with the 'NHS Foundation Trust Annual Reporting Manual'.

Grant Thornton UK LLP
Crawley
28 May 2015