

Late Papers

for the

Formal meeting of the

Kent Community Health NHS Foundation
Trust Board

in Public

to be held at 10am on

Thursday 25 May 2017

in

Room 6 and 7
Trinity House
110-120 Upper Pemberton
Eureka Business Park
Kennington
Ashford
Kent
TN25 4AZ

Committee / Meeting Title:	Board Meeting – Part 1 (Public)
Date of Meeting:	25 May 2017
Agenda Item:	2.2
Subject:	Annual Report from Audit and Risk Committee to Accounting Officer and Board
Presenting Officer:	Peter Conway, Audit and Risk Committee Chair

Committee Action - this paper is for:	Decision	Assurance	X
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Report Summary (including purpose and context):
<p>This report provides a summary of the work and decisions of the Audit and Risk Committee in the 2016/17 financial year including assurance that the terms of reference have been fulfilled and compliance with latest best practice.</p> <p>The report will be subject to amendment following the Committee meeting as the report cover activities including this meeting and will be presented to the Board for assurance.</p>

Proposals and / or Recommendations to the Board:
To note the report

Has the paper undergone an Equality Impact Assessment?
No. High level position described and no decisions required.

Relevant Legislation and Source Documents:

For further information or enquiries relating to this report please contact:	
Peter Conway, Non-Executive Director and Chair of Audit and Risk Committee.	01622 211900

ANNUAL REPORT FROM AUDIT AND RISK COMMITTEE TO ACCOUNTING OFFICER AND BOARD

1. Committee Role

The role of the Audit and Risk Committee (ARC) is to i) seek assurance that the financial reporting, risk management and internal control principles are applied, ii) maintain an appropriate relationship with the Trust's auditors, both internal and external and iii) offer advice and assurance to the Trust Board.

This assurance report provides the Kent Community Health NHS Foundation Trust Board and Accountable Officer with an overview of the proceedings and business of the ARC in the 2016-17 financial year in fulfilling this role.

The Committee met four times during 2016-17 (May, September, November and February) and a meeting in May 2017 to review 2016-17 Accounts; the three members attended the required minimum of 75%. In addition the Chief Executive Officer attended the meeting in May and November, the Medical Director attended in September with the Deputy Medical Director Arokia Antonysamay attending in November and February, Director of Finance attending three meetings and deputy, Gill Jacobs in the February meeting. Governors, Ken Rogers and/or Kate Wrotham observed meetings in May and November. The Chairman reported to the Board verbally and in writing after each meeting. A rolling forward plan was maintained setting out future agenda items for the year ahead. A self-effectiveness review was undertaken in May 2017 in accordance with the NHS Audit Handbook but based on specific narrative feedback rather than scored questions.

2. Financial Reporting, Risk Management and Internal Control

2.1. Financial Reporting

The 2016-17 Accounts were considered at the ARC meeting on 19 May 2017 and were recommended to the Board for approval. Preparatory work was undertaken in February with the review of the accounts timetable, materiality and significant risks that had not changed from the previous year and the draft Annual Governance Statement was considered and suggestions made for improvement

Compliance with Standing financial Instruction and Standing Orders were tested for exceptions, and assurances gained that there were only immaterial non compliances.

Single tender waivers and losses and special payments were reviewed with no notable issues.

Debtors greater than 90 days age were scrutinised as the trend had increased adversely during the year. Assurances on actions being taken are evidenced in a reduced aged debt reported at year end.

The Committee reviewed Standards of Business Conduct and found them to be satisfactory and the new IR35 arrangements (contractors' tax arrangements) were deemed low risk for Trust and being addressed.

Gifts, Hospitality and Sponsorship Reporting gave positive assurance. The auditors advised that the level of reporting was ahead of other Trusts.

The Committee were kept aware of pertinent policy, guidance & reports and consultations relating to financial matters from inter alia NHS England, the Department of Health, FTN, Kings Fund and NHS Improvement and these briefings. This included subjects such as developments in planning, governance and tariff, licence and inspection arrangements and the financial position in the NHS at large.

The Committee discussed and confirmed that the Trust was a 'going concern' with reference to the medium term financial plans, contractual and the liquidity position. This was done at the meeting in May 2017.

It was agreed that there were no accounting changes as a result of the loss of the Dartford, Gravesham and Swanley business to Virgin Care. This was because it did not constitute a discontinued operation.

The Committee gained assurances that the Trust had robust financial controls in place.

2.2. Risk Management

The Risk Management Strategy was reviewed and due to its length it was suggested and confirmed that a shorter summary was available. The risk management system was subject to wide ranging discussion by the Committee throughout the year.

The Committee undertook deep dives into the Board Assurance Framework (BAF) including reviewing the Community Information System where recommendations were made by the Committee, whistleblowing which was benchmarked as satisfactory to peers and off-payroll arrangements which was shown to be low risk.

A deep dive of cybersecurity was undertaken to consider best practice and gap analysis. The Committee's key conclusions were: remediation activity needs to be business not IT led, some of the proposed actions are not being implemented quickly enough and the Board should agree a cyber security risk appetite. This was subject to further Board debate following the Committee's reports and the action plan has been accelerated.

Sustainability and Transformation Plan (STP) governance and collaborative working was subject to a deep dive with the CEO in November. He assured the Committee that no STP decisions as yet had been made and any that needed sovereign Board agreement would come forward in a timely manner to the right forums, which is happening as routine Board business.

Change and transformation of service was also subject to a deep dive and was a risk because of ineffective clinical leadership. The Committee received positive assurance particularly the back to floor and devolved decision making. The Committee recognised cultural change could take up to five years.

The Committee requested that risk registers would be enhanced by greater explanation of delayed actions (removing the 'ongoing' status) and greater clarity around and joined up with the Sustainability and Transformation Plan. New risks were agreed with refocus of the CIS risk from activity reporting (where assurances now provided following review of the mitigations in place) to interoperability and Advanced Health and Care (AHC) relationship/support, cyber security and pressure ulcers.

The Committee received assurance from auditors that the Trust BAF remained strong and was used for determining the Internal Audit plan priorities.

The Committee received updates on clinical audit and were assured with overall performance benchmarks better than peers, supporting the considerable improvements seen over the last couple of years. As a result the target for annual completion of audit actions had been raised to 95 per cent. Positive assurance was received both from the Annual Report and the Quarterly Update. Research and Development was showing good

progress being made, although more remained to be done in terms of recruitment, operating procedures and embedding a more active research culture in the organisation. The Committee recommended this as a topic for a Board Strategy and Development day.

The Committee received key issues arising from Quality and Finance, Business and Investment (FBI) Committees to promote the cross fertilisation between committees.

2.3. Internal Control

The tracker of audit recommendations was reviewed on a regular basis to give assurances that management were taking timely actions.

The Committee received regular updates from the Corporate Assurance and Risk Management (CARM) and was attended by the Internal Audit and would do so on a regular basis. The Committee gained assurance from their work in updating policies and triangulation of data on claims, complaints and incidents.

The Committee reviewed the Monitor licence conditions (licence pricing and P1, P2 and P4 i.e. recording of information, provision of information to NHS Improvement and compliance with national tariff under licence; NHS Improvements information provision and fines) and assurance given that there were no concerns. The Committee considered this area low risk so deep dives will now be undertaken annually.

The Committee received regular legal claims and coroner's inquests reports and gained assurance that these were being effectively managed with appropriate level of expertise.

3. Relationships with the Trusts Auditors, External and Internal Audit

3.1. Trust Auditors

Committee members met with all auditors in private before each meeting so that unfettered discussions could take place and to build appropriate relationships.

3.2. External Audit

The Committee received regular external audit updates and best practice advice. The Committee reviewed the Auditors proposal for fees and recommended a one year extension of the contract to 2018 to the Council of Governors which was approved.

3.3. Internal Audit

The Committee agreed the Internal Audit plan with some changes after further consultation with the executive, CARM and the Quality Committee.

The Committee reviewed audit reports and the assurance status:

System	Substantial Assurance	Reasonable Assurance	Limited Assurance	No Assurance
Agency Pre-Employment Spot Checks		✓		
Assurance Framework and Risk Management Processes		✓		
CIS Benefits Realisation		✓		
Consultant Job Plans and Clinical Supervision			✓	
Contract Management		✓		
Critical Financial Assurance		✓		
CQC Process Review		✓		
Cyber Security Maturity			✓	
Data Quality of Key Performance Indicators		✓		
Information Governance Toolkit	✓			
Nurse Staffing Arrangements			✓	
Registration Authority and User Management	✓			
Serious Incidents Reporting Processes		✓		
Site Visits		✓		
Strategic Business Units		✓		

This was an improvement of the previous year:

Assurance Assessments	Number of Reviews	Previous Year
Substantial Assurance	2	2
Reasonable Assurance	10	9
Limited Assurance	3	4
No Assurance	0	0

The Committee ensured the adequacy of management responses to the recommendations made:

Urgent	Important	Routine
12	38	35

Specific scrutiny was made of limited assurance reports and the follow ups requested.

Contractual Arrangements for Medical Employees was a long running issue (both practice and documentation). Acting Medical Director provided verbal assurance that all risks have/are being addressed. Internal Audit will do a follow up to check remediation of the limited assurance report as is normal practice.

Cyber security is being addressed as described above and the Internal Auditors are providing assistance in identifying best practice and Nurse staffing arrangements' limited assurance follow up provided assurance this was now resolved following escalation to the Board.

The Counter Fraud plan was agreed.

The Committee had assurance that all Fraud alerts raised were actioned and that the Trust's 'Lessons Learnt' Newsletter was used to disseminate information and the amber ratings of the two standards from NHS protect tool were not unusual and as in 2015-16 these standards would require disproportionate resources.

The Committee also reviewed the Head of Internal Audit Opinion on the effectiveness of the system of internal control at its meeting in May 2017 which supported the Annual Governance Statement.

4. Advice and Assurance to the Trust Board

The Committee gave assurance to the Board on the development of the Annual Governance Statement.

The Committee highlighted the concerns around agency checks, cyber security and nurse staffing and actions were taken on these issues with an audit on agency checks providing reasonable assurance; the Board setting its risk appetite on the cyber security and the nurse staffing levels resolved following detailed review with relevant Directors.

The Committee recommended approval of the 2016/17 annual report and accounts to the Board.

Overall the Committee reported continued good progress on a range of fronts.

5. Self-Assessment and Terms of Reference

The Committee undertook a self-assessment on effectiveness in May 2017 and determined the Committee was working well.

Terms of reference were reviewed and agreed with a recommendation to add the authority to consider STP items if directed by the Board as the increasing importance of the STP and its positioning in terms of the Trust strategy, governance and risk reporting.

6. Conclusion

The Committee has fulfilled its Terms of Reference as approved by the KCHFT Board and substantially met the best practice guidance as set down in the Audit Committee Handbook and in the HM Treasury Audit and Risk Assurance Committee Handbook.

These embody five good practice principles under the headings of:

- Membership, independence, objectivity and understanding
- Skills
- The role of the Committee
- Scope of work
- Communication and reporting.

Peter Conway

Non-Executive Director and Audit and Risk Committee Chair

19 May 2017

Committee / Meeting Title:	Board Meeting - Part 1 (Public)
Date of Meeting:	25 May 2017
Agenda Item:	2.4
Subject:	2016/17 Annual Report and Accounts including the 2016/17 Annual Quality Report
Presenting Officer:	Gordon Flack, Director of Finance and Ali Strowman, Chief Nurse

Action - this paper is for:	Decision	<input checked="" type="checkbox"/>	Assurance	<input type="checkbox"/>
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Report Summary (including purpose and context)
These reports provide the Trust Annual Report and Accounts incorporating the Annual Governance Statement and the Annual Quality Report.

Proposals and /or Recommendations
The Board is asked to approve the Annual Report and Accounts including the Annual Quality Report

Relevant Legislation and Source Documents
Has an Equality Analysis (EA) been completed?
No. High level position described and no decisions required/no significant change. Papers have no impact on people with any of the nine protected characteristics*.
* Protected characteristics: Age, Disability, Gender Reassignment, Marriage and Civil Partnership, Pregnancy and Maternity, Race, Religion and Belief, Sex, Sexual Orientation.

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Welcome to our sixth annual report

Annual report and accounts 2016/17

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



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Appendix 1 Quality Report

A snapshot of our year

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

Our **5,100** staff had more than 3 million patient contacts.

Our community involvement grew to **12,557 public members**.



97.5% of our patients were satisfied with the care they were provided.



We retained our **GOOD** Care Quality Commission rating.



We kicked off a new health walk scheme in Maidstone.

We launched a My Health Check smartphone app for people to track their progress to a healthier lifestyle.



Hundreds of people took part in the Big Swale Health Check and had on-the-spot NHS Health Checks, health MOTs and advice on healthy lifestyles.

Catering and domestic teams at Faversham Cottage Hospital and Queen Victoria Memorial Hospital in Herne Bay secured five star ratings for hygiene.

We carried out big changes to make our community hospitals dementia-friendly, including painting toilet doors blue.



Born to move



Our pioneering NHS app Born to Move, designed to help parents with their newborn babies, hit more than **10,000 downloads**.

Our Stop Smoking Service was named as the third most successful programme in the UK for number of quits until November 2016.

Our Child Health Immunisation Team vaccinated thousands of youngsters in years one, two and three against the flu virus across Kent, Medway and East Sussex.



With our partners, we developed Home First – a new scheme for Kent that helps patients in our hospitals to get home sooner and safely.



98.8% of people were treated within **18 weeks** of referral to our consultant-led services.



We joined forces with Ashford council and Kent County Council to open One You – a health shop in Ashford.



We won contracts to provide new school health services in Kent.



100% of people had access to sexual-health clinic within 48 hours of contacting us.

Our specialist wound medicine centre officially opened at Victoria Hospital in Deal.



Kent Community Health
NHS Foundation Trust



The Performance Report

The Performance Report

Overview of performance

Welcome to our sixth annual report.

During the past six years, our trust has continued to grow and build on its excellent reputation of delivering a high-quality service to the people of Kent, East Sussex and parts of London. We have merged two predecessor organisations, aligned ourselves to clinical commissioning group boundaries, innovated in a number of areas and increased provision of services outside of Kent. Our relentless focus on quality has continued to ensure our services are safe and provide the best quality care for our patients.

A major player in delivery of the Kent and Medway Sustainability and Transformation Partnership, we have refreshed our strategic goals and values to ensure we are in the best possible shape to deliver all that is required of us.

Our focus remains our patients, our people and our partners.

Our Care Quality Commission rating remains as GOOD, following an inspection in June 2014. We're continuing to improve care and quality for our patients. We opened our third specialist wound centre using the latest technology to heal people faster, improved access to our services with a range of initiatives, including mobile podiatry, and worked with partners from the health, social care and voluntary sector to launch our Home First scheme to get people home safely and sooner from hospital.

At the end of this financial year, we published our new People Strategy at the same time as our NHS Staff Survey results were announced. We were delighted to see the improvements and staff remained more likely than their colleagues nationally to recommend the trust's services to friends and family and as a place to work. We hope our People Strategy will help to solve some of the challenges we face with the recruitment and retention of staff, which remains a challenge across the country.

We have worked hard to develop even stronger links with our partners. In east Kent, this has included signing a memorandum of agreement with East Kent Hospitals University NHS Foundation Trust, forging closer links with our clinical commissioning groups and GP partners, such as Ashford clinical providers, as well as with our local authority partners and community and voluntary organisations.

Our community involvement has continued to grow. At the end of March 2017, we had 12,557 public members, several newly appointed governors and involvement from patients on many of our committees and working groups. In March 2017, we held our first-ever event for members, focussing on diabetes.

We have been successful in retaining and winning business, for example, a three-year contract to provide a chronic pain service in Hillingdon, London and contracts to provide sexual health and podiatry services in Medway. Our Dental Services became one of the largest providers of community dental in the country, winning additional contracts in eight London boroughs.



Kent Community Health

NHS Foundation Trust

We retained the school health service for primary and secondary school-aged children across Kent and our contract for health improvement services was extended.

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

We hope you enjoy reading our annual report.

Kind regards

David Griffiths

Chairman:

Date

Paul Bentley

Chief Executive Officer:

Date

Overview: 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 2016/17 was £224million. We employ in the region of 5,000 members of staff in a wide range of clinical and support roles. We serve three million people; 1.5million living in Kent and 1.5million people outside of Kent.

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

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

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

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

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

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

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

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

Our mission, vision and values

Our mission is to provide high-quality, value for money community-based services to prevent people from becoming unwell, to avoid 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 choice by delivering excellent care and improving the health of our communities. Last year, we refreshed our values following feedback.

We now have four values:

Compassionate:

We put patients and our service users at the heart of everything we do. We're positive, kind and polite. We understand diversity. We're respectful, patient and tolerant.

Aspirational:

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

Responsive:

We listen. We act. We communicate clearly. We do what we say we will. We take account of other's opinions.

Excellence:

We strive to deliver the best care we can. We grow a culture of excellence in our teams. We challenge complacency.



The Kent and Medway Sustainability and Transformation Partnership (STP) describes how local services will evolve and become sustainable during the next five years. It looks to meet four key challenges:

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

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

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

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

Last year, we refreshed our strategic goals to respond to these challenges.

Our strategic goals:

1. **Prevention:** To support people to lead a healthier lifestyle by making sure all our staff have skills in prevention and make every contact count.
2. **Proactive community care:** To enhance the quality of life for people with long-term conditions by working with our partners and networks of GP practices to develop strong, proactive and connected health and social care teams.
3. **Credible alternatives to acute services:** To help people recover from ill health or prevent their health from declining by dedicating time and resource to our Home First scheme so more people are treated at home.
4. **Specialist services:** To provide high-quality accessible specialist community services, which play an integral part in local care.

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

Our enabling strategies help secure:

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

Overview: Going concern

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

- the trust does not have any plans to apply to the Secretary of State for dissolution
- the trust has cash balances forecast to be £18.5million to £20.7million during 2017-18
- the trust is forecasting a liquidity rating of 1 throughout 2017-18, the highest rating possible
- the trust has agreed contracts for 2017-18 with all clinical commissioning groups
- the trust has not agreed a working capital facility in 2017-18 (nor 2016-17) as this was unused in 2015-16 and not forecast as required, after considering possible downside scenarios.

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.

Performance analysis

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

Strategic goal 1:

To support people to lead a healthier lifestyle by making sure all of our staff have skills in prevention and make every contact count.

In April 2016, together with Maidstone Borough Council, we introduced a new health walk scheme to Maidstone, encouraging people of all ages and fitness levels to improve their health and wellbeing by stepping out once a week for a volunteer-led walk.

We launched a My Health Check smartphone app, in June 2016, for people to digitally record their health check results and track their progress to a healthier lifestyle. The app is free to download from the App Store or Google Play. It contains information and support on how to achieve and maintain a healthier lifestyle through quitting smoking, eating well and exercising regularly. It supports the national NHS Health Checks programme, which in Kent is co-ordinated by KCHFT.



We worked with Swale Clinical Commissioning Group to host a health day in Faversham. People were able to have an on-the-spot NHS Health Check, meet health trainers, be given advice on how to stop smoking, learn about physiotherapy and relaxation techniques, as well as collect information from Age UK.

In the summer, our Big Swale Health Check involved providing hundreds of on-the-spot NHS Health Checks, health MOTs and advice on healthy lifestyles to people across Swale in supermarkets, local leisure centres and pubs. The trust is confident that taking health checks and health improvement advice out to people in these locations helps to reach people.



Our Health Trainer Service has had a successful year working within Encompass, one of NHS England's Vanguards. Our Health Trainer set up home in Northgate Medical Practice, Canterbury to support clients with issues affecting emotional wellbeing, alcohol consumption, managing stress, healthy eating and exercise. All 149 clients reported better emotional and general wellbeing. The GP and health trainer have also been identifying patients who have attended an acute hospital more than three times in the last year to help reduce frequent inappropriate admissions to A&E. The scheme was praised by NHS England Chief Executive Simon Stevens on a visit who was very impressed with how the Vanguard and the Health Trainer Service are making a positive impact on patients' lives, health and wellbeing.

Our Health Trainer Service also teamed up with drugs and alcohol providers in the country, Turning Point and Change Grow Live (CGL) working jointly with more than 250 clients to tackle not only their addiction, but also their overall health and wellbeing. Other successful partnerships include working with Amicus Horizon to look at how health and housing are linked and working with Sheppey Prison and the prison resettlement team to support prisoners' health and wellbeing on release.

Our pioneering NHS app Born to Move, designed to help parents with their newborn babies, hit more than 10,000 downloads by summer 2016. The app supports parents through the first four stages of their baby's development – newborn, crawler, toddler and pre-school. Parents can personalise the app with their baby's details and receive tips on development, as well as helping them to make sure their child is ready for school.

In the autumn, our Stop Smoking Service was named as the third most successful programme in the UK for number of quits until November 2016. Kent had 828 quits from April to November 2016, compared with Lancashire with 1,123 quits and Hertfordshire, just four quits ahead on 832. By the end of the financial year, there had been 3,397 quits.

We delivered a weekly weight loss scheme in east Kent following a successful trial. Fresh Start is a free programme that can help people to reach a healthy weight and stay there.

In December 2016, our health visiting service, led by a group of 12 infant feeding leads, was awarded its UNICEF certificate of commitment and stage one pass, confirming we are prepared and have everything in place to ensure all our health visitors are equipped to support new mums to feed their babies. The Baby Friendly Initiative (BFI) is a worldwide programme, which aims to improve the standards of care for infant feeding in healthcare settings.



Also in December, Just Water, a joint initiative with South East Water was runner-up in the Education Communications Campaign category at the Chartered Institute of Public Relations Pride Awards for the South of England. The team used social marketing to tackle the issue of young people drinking energy drinks while at school.

In February 2017, we joined forces with Ashford Borough Council and Kent County Council's Public Health Team to open One You – a health shop in Ashford. It allows us to bring all our health improvement services under one roof so people can pop in and get a free NHS Health Check or health MOT, as well as take part in interactive games. Services include: Stop smoking support, healthy weight advice for adults and children, on-the-spot blood pressure checks, a weigh-in service, plus advice on a range of lifestyle issues.



We successfully won contracts in February 2017 to provide new school health services in Kent, which are being rolled out. Children, young people, families and schools can expect to see greater access and support for children and young people to help give them the best start in life. Kent County Council awarded two new contracts – the primary school public health service and the adolescent and targeted emotional wellbeing service. The contracts launched on 3 April 2017.

During 1 April 2016 – 31 March 2017

- 85.2% of new mothers received their health visiting check at six to eight weeks.
- 41,780 people had an NHS Health check, with 42% of those invited for a check taking up the offer.
- Our stop smoking service had 3,174 quits.
- 4,552 new clients were seen by KCHFT health trainers.
- There were 4,105 health walks with 44,457 people taking part.
- 846 took part in exercise referral schemes, with 712 people completing the course.
- Health improvement services attended more than 32 events with the Live well, live longer roadshow.

Strategic goal 2:

To enhance the quality of life for people with long-term conditions by working with our partners and networks of GP practices to develop strong, proactive and connected health and social care teams.

Hundreds of families and residents in and around Edenbridge gave their views to help shape the future of NHS care locally as the conversation began around bringing together services provided by Edenbridge Medical Practice and KCHFT, which provides services at Edenbridge and District War Memorial Hospital and in people's homes. Following a three-month listening exercise, West Kent Clinical Commissioning Group, KCHFT and the medical practice developed four possible options. Our preferred option is to develop a modern, purpose-built combined hospital/surgery on a new site with no inpatient beds, but plenty of space for additional clinical services, including day care beds and extra community support, with 140 parking spaces. The consultation ended on 26 April 2017 and the results are being considered.

Working with partners from the health sector, local government and the charity and voluntary sector, we successfully piloted a scheme to provide rapid and integrated care to local patients through the Thanet Acute Response Team, making sure they were treated in the right place and at the right time. The pilot was due to come to a close on 31 March 2017, but has been extended until June 2017.

The Docobo device, used to keep track of patients' observations and send text messages to alert health professionals involved in their care if abnormal readings appear, resulted in a 65 per cent drop in hospital admissions and a 68 per cent drop in 999 calls from the four care homes in Swale involved in a pilot, compared to the previous year. It was shortlisted for best use of technology and data in the Nursing Times Awards.

Our specialist wound medicine centre was officially opened at Victoria Hospital in Deal, in March 2017, by Chief Executive Paul Bentley. The centre, which was supported by a £20,000 donation by Deal Hospital League of Friends, will trial an innovative new app, which supports clinicians to heal wounds and pressure ulcers faster. Our wound medicine centres, which opened in Herne Bay and Sittingbourne, were shortlisted in the Nursing in the Community category in the Nursing Times Awards.



We teamed up with Kent Fire and Rescue Service in early 2016 to make a short film for anyone who carries out home visits to make them aware of signs to look out for in vulnerable people's homes.

During the winter, an innovative training package for care home staff reported a significant impact on the wellbeing of diabetic residents. Delivered by KCHFT, the one-day course educates and assures carers they are able to identify and act upon the early signs of a hypoglycaemic attack. At the end of 2016, the programme had been delivered to 70 colleagues across 23 care homes in east Kent, with the aim to make it available across Kent soon.

We carried out big changes to make our community hospitals dementia-friendly, including painting toilet doors blue and fitting blue frames and seats for the toilet so patients can clearly identify the bathrooms. At our hospitals in Faversham, Whitstable, Edenbridge and Herne Bay, we implemented dementia-friendly signage, which includes words and pictures to help patients navigate their way around the wards.

Our Child Health Immunisation Team vaccinated thousands of youngsters in years one, two and three against the flu virus across Kent, Medway and East Sussex.

In the winter, two consultant community physicians joined us to help provide specialist geriatric care to patients in east Kent. Doctors Shelagh O'Riordan, a specialist in falls prevention and Gwenno Batty, an expert in medical education and community rehabilitation, were tasked with supporting the development of an integrated care model for older people with complex needs, so all organisations in health and social care work better together for people living with long-term conditions.



During 1 April 2016 – 31 March 2017

- We achieved 93.7% of our target for face-to-face contacts with patients with long-term conditions and 102% of our target for intermediate care and rehabilitation patients.
- We exceeded our 4% target for patients who 'did not attend' appointments with a percentage of just 1.7%.
- Our new specialist wound medicine centre in Deal treated nearly 50 patients between October 2016 and March 2017.

Strategic goal 3:

To help people recover from ill health or prevent their health from declining by dedicating time and resource to our Home First scheme so more people are treated at home.

A vital part of our strategy, in line with the Five Year Forward View and the Kent and Medway Sustainability and Transformation Partnership, is to treat more people at home.

During the latter part of 2016, working with our partners, we developed Home First – a new scheme for Kent that helps patients in our hospitals to get home sooner and safely. It aims to give all patients, who are medically fit to be discharged, but may need some additional help, the support they need.

Under Home First, we set up single numbers in east and west Kent for health and social care professionals to discharge patients, which trigger Home First teams into action to ensure that the right support is in place.

Patients who are safe to go home, will be seen at home within hours and settled in. They will receive an assessment by a Home First Team within a couple of days. This team is made up of community nurses, therapists and social care professionals. Every patient has a personal care plan and this may include goals, support for carers and any equipment or self-help advice.

Patients who have no nursing needs, but who do need a short period of inpatient rehabilitation to achieve maximum independence, can be referred via pathway two to a community hospital.

In west Kent, we opened an eight-bed ward at Tonbridge Cottage Hospital, led by Therapy Lead Friederike Stenning, to provide intensive rehabilitation; it has already seen the length of stay reduce.

For patients who need a package of care or have more complex needs, additional social care beds have been funded. We want to reduce the number of patients who have to make decisions about going into long-term care, while they are in hospital. We worked with local providers so patients can be cared for in temporary placements while they decide what they want to do long-term.

To support this work, we made a number of other improvements. At the start of 2017, we started to lay the groundwork for introducing wifi access for patients and guests in our community hospitals, making it easier for patients to keep in touch with family and friends while they are in hospital.

In July 2016, catering and domestic teams at Faversham Cottage Hospital and Queen Victoria Memorial Hospital in Herne Bay secured five star ratings from the Food Standards Agency for hospital kitchen hygiene standards. A thorough inspection of the two sites took into account the cleanliness and hygiene of the kitchen, as well as the food hygiene and safety processes and how well the equipment and hazards were managed. The team prides itself on its patient-focused approach.





We helped to launch a smartphone app designed to cut waiting times at accident and emergency departments in east Kent. The WaitLess app combines current waiting times at all urgent care centres – drawn from the official NHS system – with up-to-the-minute travel information, to help people decide which urgent care centre to head to for faster treatment for minor injuries. Dr John Ribchester, Clinical Lead for Encompass MCP, came up with the idea after seeing a similar app in Valencia, Spain. By the end of 2016, the app had been downloaded 9,000 times – just a few weeks after it became available. The app is free to download from the App Store and Google Play.

During 1 April 2016 – 31 March 2017

- We exceeded our less than 15.9% target for people being readmitted to an acute hospital following care in one of our step down beds with just 13.6% needing to be readmitted.
- 99.9% of people waited less than four hours in our minor injury units.
- 98.8% 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 had 88.9% of our beds occupied, within our target of between 87 and 92%.
- The length of time patients needed to be in a community hospital ward decreased to 21.6 days, from 24.2 days.
- Our delayed transfers of care decreased from 13.8% to 11.8% against our target of 3.5%.

Strategic goal 4:

Specialist services: To provide high-quality, accessible, specialist community services.

We won the tender to provide a community chronic pain service in the London borough of Hillingdon. The three-year contract started on 1 July 2016. The service helps patients to receive alternative pain treatments, manage their pain more effectively and achieve long-term self-management.

In April 2016, South East DriveAbility, our service which provides assessments and adaptations to cars for people who are disabled or have other medical issues that make driving difficult, extended its service to a GP surgery near Eastbourne. The service also moved its base to Aylesford Logistics Centre.

We won the contract to deliver sexual health services in Medway for the next four years from October 2016. Services include testing and treatment for sexually transmitted infections at a central venue – 4 Clover Street in Chatham. We work with a range of partners to deliver the services, including Metro, Health Action Charity Organisation, Open Road and community pharmacies. Our bid included a 24-hour clinical advice line.

We won a three-year contract to provide podiatry services in Medway from 1 September 2016. Our team of podiatrists has a diverse skill mix spanning podiatry assistants to specialist podiatrists in musculoskeletal and vulnerable foot areas.

Our Orthotics Team was awarded a patent in Australia for its 3D printing of orthotics (insoles). This concept is unique to KCHFT and the patents in the UK and Australia mean the idea and orthoses are now protected by law.

In the autumn, our Dental Services, which already provide community, family and prison dentistry and oral health promotion in Kent and Newham, won additional community services in eight London boroughs. KCHFT was chosen as one of five providers for the multi-million pound contract, making it one of the largest providers of community dental services in the country. The trust competed against large London teaching hospitals, dental corporates and other NHS trusts to win the contract, which will provide services for vulnerable groups, including domiciliary care and extensive use of multi-surgery mobiles. In addition to special care and paediatric services, Dental Services won tenders to provide bariatric dental care and dental care for homeless people. The service began on 1 April 2017.

In 2016/17, the trust submitted 20 bids to retain or acquire new contracts, with a success rate of 63 per cent. These successful opportunities have a total contract value of £72,746,073.

We launched a mobile podiatry service in Maidstone in an effort to make the service more accessible and easier for patients to receive their foot care. Clinics, in a mobile unit, were launched at either Morrison's supermarket in Larkfield or the Tesco Extra in Aylesford. The mobile unit is



based at each supermarket for one day each week and works similarly to mobile blood banks and screening units. Patients who have more complex podiatry needs receive their foot care at our specialist clinic in Foster Street. Since launching in September, the unit has seen more than 1,550 patients.

We launched an adult community dietetics service in west Kent, providing prescribing support to GPs as well as nutritional advice. Commissioned by West Kent Clinical Commissioning Group, the team supports patients with conditions that include malnutrition; obesity; nutrition during cancer treatment; gut problems and more.

Learning disability community nurses Chris Hunter and Des Clarke were awarded the Helping People Stay Healthy Award by our partners at Kent County Council. The pair were rewarded for their work teaching people with learning difficulties how to live a healthy life.

During 1 April 2016 – 31 March 2017

- We won a £59million contract to deliver community dental services in London, providing services for vulnerable groups.
- More than 1,551 people were seen in our mobile podiatry unit in Maidstone.

Patient feedback

- **66,022** surveys, including the NHS Friends and Family Test, were asked across the trust.
- In 2016/17, we received feedback from **64,289** people receiving our care.
- **97.52%** of people who used our services in 2016/17 would recommend them to family or friends.
- We asked **23.95%** of patients in minor injury units and inpatient wards if they would recommend the service to friends and family, exceeding our target of surveying 20% of patients. Our Friends and Family Test Score was 96.55%, exceeding our target of 95%.

Safe care

- Our safety thermometer, which measures the level of harm free care in the trust, is better than our 95% target at 97.8%.
- We are 100% compliant with NICE guidance.
- There were seven incidences of Clostridium difficile, compared to one in the same period last year; however this is rising nationally.
- There were no incidences of MRSA attributed to the trust.
- There has been one never event.
- There were 10 falls resulting in fractures.
- There were 13 grade three and four attributable and avoidable pressure ulcers, which is the same as last year. Our target was fewer than 40.

Our charity

i care is the name of our registered charity that helps to provide services and items which cannot be funded by the NHS, to enhance patient care and boost patient and staff morale.

In December 2016, it launched its first charity appeal, the Gift of Play, aiming to raise around £28,000 to provide a new, fully-equipped sensory room at the Heathside Centre in Coxheath, Maidstone, for our Children's Therapies Team to use with patients.

The lighting, music and objects in sensory rooms stimulate the senses and are used extensively in disability support. At Heathside, the sensory space will help children who have severe, complex and life-limiting conditions.

Thanks to donations and legacies, i care provided two new hi-lo patient beds, at a cost of £4,000, for Victoria Hospital in Deal, as well as two new computer systems, costing around £13,000, for dementia patients staying in community hospitals in Faversham and Whitstable.

The charity provided three events for our volunteer health walk leaders, to say thank you for their hard work and commitment. More than 110 volunteers, who gave up their own time to lead health walks and help other people make positive lifestyle changes, came together.

More information about i care (Kent Community Health Charitable Fund) is available in our charitable fund annual report.



(You don't have to run in a chicken suit!)
If you have a great money-raising idea for our charity let us know.

Sustainability report

Our buildings

Our estates strategy sets out how we intend to deploy our estate so we are able to invest and respond to changes in service delivery and support sustainable development by optimising the size and location of our estate. This drives energy efficiency, waste reduction and supports a shift away from car travel to more sustainable and healthy transport alternatives.

Sustainable procurement

As a public sector organisation, the trust has a duty to take a leading role in promoting and embedding a culture of sustainable procurement.

The trust takes seriously its responsibility to sustainability and recognises that meeting the goals within the sustainability strategy will require fundamental changes in how the trust operates at all levels and across its estate.

The trust's sustainability strategy outcomes are:

- a 20% reduction in the amount of carbon produced by the trust by 2020, increasing to 50% by 2025
- zero waste to landfill
- increased use of technology to reduce unnecessary journeys
- planned journeys to be efficient and reduce overall mileage when staff must travel
- roll out of facilities to support use of electric vehicles
- invest in preventative and non-clinical healthcare, reducing the need for intervention by working closely with local authorities.

To make the health and social care economy financially viable the trust will work collaboratively with partner organisations to meet sustainability targets. For example, when providing services to the community it is sometimes necessary to share building occupation to ensure health and social needs are met. It is only through integrated working with other agencies and providers that we will be able to ensure sustainability is kept central to discussions of effective healthcare delivery.

The trust will be fit for sustainable delivery of 21st century healthcare. It will be supportive of innovation and compel positive change in services and staff.

Waste

Over the past year KCHFT has implemented a new total waste management contract as part of the South East NHS Waste Consortium, which is made up of six acute and non-acute NHS trusts. The new contract will have the following benefits:

- expected savings of £1.5million across all NHS organisations within the contract over the next five years
- zero waste to landfill assisting the NHS to reduce its environmental impacts
- domestic waste will be processed in a facility that provides power for 146,000 homes in Sittingbourne
- partnership working and sharing of best practice between organisations and contractor.

In addition KCHFT has:

- run an active waste management group, incorporating representatives from both clinical and non-clinical services
- re-organised the management of waste on site, returning some to the responsibility of NHS Property Services
- worked with clinical services to increase compliance in waste segregation activities
- completed an annual audit programme to monitor compliance across our sites, setting action plans to improve compliance where necessary.

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

Signed: Date:

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

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



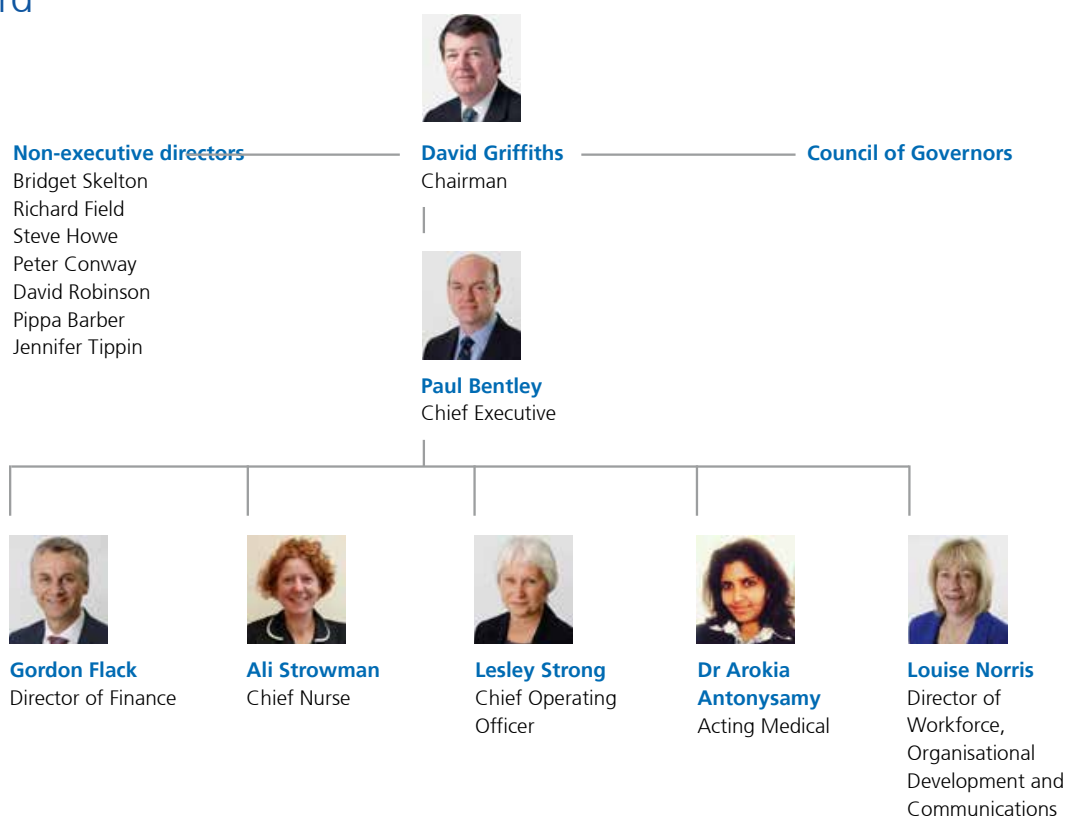
Kent Community Health
NHS Foundation Trust



The Accountability Report

The directors' report

Board



Since 1 April 2016:

- Nicola Lucey was director of nursing and quality until 26 August 2016, followed by Ruth Herron as acting director of nursing and quality until 9 October 2016. Ali Strowman was chief nurse from 10 October 2016.
- Dr Peter Maskell was medical director until 5 February 2017 followed by Dr Arokia Antonysamy as acting medical director.

Portfolios of executive voting board members include:

- the chief executive: Has overall executive accountability to the board
- the deputy chief executive/chief operating officer: Leads on operations
- the director of workforce, organisational development and communications: Leads on workforce and organisational development, communications and engagement
- the director of finance: Leads on audit, finance, performance, information management, commercial services and information technology

- the director of nursing and quality/chief nurse: Leads on clinical strategy, quality, clinical governance and is the director of infection prevention and control and safeguarding assurance
- the medical director: Leads the clinical strategy, quality, medical revalidation, clinical audit and research and development.

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

- Corporate services director: Includes regulatory framework, members and governors, governance and risk
- Director of operations, children and young people: Includes universal targeted and specialist children's services and estates – this post ceased on 1 February 2016
- Strategy and transformation director – this post ceased in 2016

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.

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

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

Directors' roles and responsibilities

David Griffiths, 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 than 12 years and was responsible during that time for leading a large number of assignments for FTSE100 and other large, complex organisations operating at board level. He is a fellow of the Institute of Chartered Accountants in England and Wales. On leaving Accenture, he established a portfolio of interests in the charitable and public sectors. Before becoming 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

Jen has extensive experience as a senior executive in a wide range of industries. Jen is the group organisation design and cost management director for Lloyds Banking Group.

Previously, Jen was managing director of business banking and a member of the Retail Executive Committee. She has a breadth of skills, including leading major transformational change, improving customer service and achieving strong commercial results. She is also group ambassador for the south east and chairman of Kent Community Health NHS Foundation Trust's Charitable Fund Committee. Jen lives in Hildenborough, Kent, with her husband and three young children.



Pippa Barber, Non-executive Director (from 1 December 2016)

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

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

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

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

She is a member of KCHFT's Quality Committee.



Bridget Skelton, Non-executive Director

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



Peter Conway, Non-executive Director

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

- 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 and the Department for Environment, Food and Rural Affairs
- trustee director of Citizens' Advice north and west Kent.



Previous roles include non-executive director and audit chair of NHS West Kent and independent member/Audit Committee roles with the Health and Safety Executive and the Child Maintenance and Enforcement Commission.

Richard Field, Non-executive Director

Richard has a professional background in the manufacturing sector with large multi-national organisations, including Unilever and Dalgety. His career has involved sales and marketing, general management and running manufacturing businesses and multi-site operations. He has 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 Fund Committee
- chair of Kent Community Health NHS Foundation Trust's Finance, Business and Investment Committee
- chairman of Age UK Canterbury
- chair 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.



Steve Howe CBE, Non-executive Director

Steve served for 39 years in the Royal Army Medical Corps. He joined as a soldier but later trained at the Royal Military Academy at Sandhurst. He went on to command medical regiments, field hospitals and medical groups on operations in the Balkans and the Middle East. He has held strategic and operational medical planning appointments in the UK, US, Australia and Supreme Headquarters Allied Power Europe (NATO). 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
- KCHFT's senior independent director
- KCHFT's non-executive director contact for Freedom to Speak Up
- school governor at Fulston Manor Academy and chair of Finance Committee
- former director of public affairs, Texaco
- former executive director communications and marketing with the Qualifications and Curriculum Authority (QCA)
- former non-executive director for Eastern and Coastal Kent Community Services.

Catherine Gaskell, Non-executive Director (to 6 April 2017)

Catherine Gaskell has worked in healthcare for 30 years. She has had chief executive and deputy chief executive positions and been director of nursing in community and mental health trusts. She carried out investigations and provided training in the acute sector. For the past five years, she has worked 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 with Understanding Modern Government.
- trustee of TalkEasy Trust (mental health promotion and anti-bullying awareness for teenagers).

Paul Bentley, Chief Executive

Before joining KCHFT as chief executive, Paul was director of workforce and communications at Maidstone and Tunbridge Wells NHS Trust from 2011.

He has worked in the NHS since 1987 and as an NHS director since 1998, leading on strategy, organisational development and workforce and communications. During this time he was also an interim chief executive in Surrey.

Paul did his graduate university education in the UK, before completing his post-graduate education in the USA. He lives in south west London with his wife and has three grown-up children.



Lesley Strong, Deputy Chief Executive/ Chief Operating Officer

Lesley trained as a general nurse in 1976 at Middlesex Hospital, London and then pursued a clinical career in the community as a health visitor and district nurse. She moved into a management role in the community sector in 1988 and has an MA in public sector management and a certificate in leadership. Lesley is:

- former primary care trust director of nursing and operations, for mid Sussex
- former director of children's services in West Sussex
- former chief operating officer in East Sussex
- former managing director, Greenwich Community Health Services.



Louise Norris, Director of Workforce, Organisational Development and Communications

Louise has more than 30 years' experience in NHS human resources and joined the trust from Central and North West London NHS Foundation Trust. She has an MBA and an MA in strategic human resources. Louise is:

- a fellow of the Chartered Institute of Personnel and Development
- a management side representative on the NHS Staff Council.



Louise lives with her husband in West Malling.

Gordon Flack, Director of Finance

Gordon has a professional background in NHS finance spanning 32 years and is a fellow of the Chartered Association of Certified Accountants. His finance experience spans health authorities (eight years), a combined mental health and community trust (four years), acute trusts (14 years) and community trusts (six years).

His responsibilities include capital, commercial development and performance, information technology, as well as audit and financial control.



Peter Maskell, Medical Director (to 5 February 2017)

Peter qualified from the Royal Free Hospital School of Medicine in 1995. He trained in general and elderly medicine at St Thomas' Hospital/Brighton and Sussex University Hospital.

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 does sessions as a stroke physician at Maidstone and Tunbridge Wells NHS Trust. Until 5 February 2017, his responsibilities at Kent Community Health NHS Foundation Trust included clinical strategy, quality, being the Caldicott Guardian, medical revalidation, clinical audit and research and development.



Dr Arokia Antonysamy Acting Medical Director (from 6 February 2017 until 31 March 2017)

Arokia is a consultant perinatal psychiatrist at Oxleas NHS Foundation Trust. With a wealth of experience, the mother-of-two from Bromley, is also clinical lead for mental health at the NHS Benchmarking Network.

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

She successfully completed her Master's degree in leadership and public health at the Manchester Business School and has been involved in management projects at local and national level. She has also worked as clinical director at Lancashire Care Foundation Trust.



Ruth Herron, Acting Director of Nursing and Quality (from 27 August to 9 October 2016)

Ruth has worked in the NHS for most of her career. She completed her general nurse training at Derby Royal Infirmary and since then has completed a range of additional clinical training. She has worked clinically in services related to adults, paediatrics, health visiting and sexual health. She has a degree in advanced clinical nursing, a clinical Master's degree and has completed the Nye Bevan leadership programme, which reflects the values of the NHS Constitution. Since moving to the trust in 2011, Ruth has supported significant transformation of services and led quality improvement initiatives, including improving end of life experience, reducing falls and preventing pressure harms. Ruth has further developed strong links with the trust's education partners, including the Kent universities and keenly encourages nurses to contribute to the evidence base of clinical care through research.



Ruth's key responsibilities include promoting and monitoring professional standards of nurses and allied health professionals and ensuring the delivery of safe, high-quality of care for the trust's patients. She regularly does a clinical shift and feels this allows her to hear the successes and concerns of staff and talk to patients. Ruth is married, has a grown-up daughter and lives in east Kent.

Ali Strowman, Chief Nurse (from 10 October 2016)

Ali joined the trust from her post as deputy nursing director at Dartford and Gravesham NHS Trust. Before that, she was at the Queen Victoria Hospital in East Grinstead for two years, also as deputy nursing director. Ali was selected by Chief Nursing Officer, Jane Cummings, to be clinical lead in the national Ebola Team at NHS England. Ali started training in 1991 as a general nurse in London and qualified in 1994. In 2003, she trained as a mental health nurse in Bristol.



As a dual-qualified nurse working in general nursing and mental health, Ali has a good experience of the challenges of delivering care in both settings. She has an MA in change management and has completed the Nye Bevan Programme with the NHS Leadership Academy. Shortly after her arrival at the trust, Ali created the #yesyoucan innovate challenge that encourages clinical teams to submit new, innovative ways of working which can be shared trust-wide. Ali lives in West Sussex.

Board and committee attendance

Formal Board

		May 16	Jul 16	Sep 16	Nov 16	Jan 17	Mar 17
David Griffiths	Chairman	✓	✓	✓	✓	✓	✓
Paul Bentley	Chief Executive	✓	✓	✓	✓	✓	✓
Pippa Barber	Non-executive Director (from 1 December)	N/A	N/A	N/A	N/A	✓	✓
Peter Conway	Non-executive Director	✗	✓	✓	✓	✗	✓
Richard Field	Non-executive Director	✓	✓	✓	✓	✗	✓
Steve Howe	Non-executive Director	✓	✓	✓	✓	✗	✓
David Robinson	Non-executive Director	✓	✓	✓	✓	✓	✓
Bridget Skelton	Non-executive Director	✓	✓	✓	✓	✓	✗
Jennifer Tippin	Non-executive Director	✓	✓	✓	✓	✓	✗
Arokia Antonysamy	Acting Medical Director (from 6 February)	N/A	N/A	N/A	N/A	N/A	✓
Gordon Flack	Director of Finance	✗	✓	✓	✓	✓	✗
Ruth Herron	Acting Director of Nursing and Quality (from 27 August to 9 October 2016)	N/A	N/A	✓	N/A	N/A	N/A
Nicola Lucey	Director of Nursing and Quality (to 26 August 2016)	✓	✓	N/A	N/A	N/A	N/A
Peter Maskell	Medical Director (to 5 February 2017)	✓	✓	✓	✓	✓	N/A
Louise Norris	Director of Workforce, Organisational Development and Communications	✓	✓	✓	✓	✓	✓
Lesley Strong	Deputy Chief Executive/ Chief Operating Officer	✓	✓	✗	✓	✓	✓
Ali Strowman	Chief Nurse (from 10 October 2016)	N/A	N/A	N/A	✓	✓	✗

Audit and Risk Committee

		May 16	Sept 16	Nov 16	Feb 17
Peter Conway	Non-executive Director (Chair)	✓	✓	✓	✓
Richard Field	Non-executive Director	✓	✗	✓	✓
Bridget Skelton	Non-executive Director	✓	✓	✓	✓
Gordon Flack	Director of Finance	✓	✓	✓	✗

Finance, Business and Investment Committee

		Apr 16	May 16	Jun 16	Jul 16	Aug 16	Sep 16	Oct 16	Nov 16	Jan 17	Feb 17	Mar 17
Richard Field	Non-executive Director (Chair)	✓	✓	✓	✓	✓	✓	✓	✓	✗	✓	✓
Paul Bentley	Chief Executive	✓	✗	✓	✓	✗	✗	✓	✗	✓	✓	✗
Peter Conway	Non-executive Director	✗	✓	✗	✓	✓	✓	✗	✗	✓	✓	✓
Steve Howe	Non-executive Director	✓	N/A	✓	N/A	N/A	✓	N/A	N/A	N/A	N/A	✓
Bridget Skelton	Non-executive Director	✗	✓	✓	✓	✗	✓	✓	✗	✓	✓	✗
Jennifer Tippin	Non-executive Director	✓	✓	✓	✓	✗	✓	✓	✗	✓	✓	✗
Gordon Flack	Director of Finance	✓	✗	✗	✗	✗	✓	✓	✓	✓	✓	✓
Lesley Strong	Deputy Chief Executive/ Chief Operating Officer	✓	✓	✓	✓	✓	✗	✓	✓	✓	✓	✓

Charitable Fund Committee

		Sept 16	Jan 17
Jennifer Tippin	Non-executive Director (Chair)	✓	✓
Richard Field	Non-executive Director	✓	✗
Gordon Flack	Director of Finance	✓	✓
Lesley Strong	Deputy Chief Executive/Chief Operating Officer	✗	✓

Quality Committee

		Apr 16	May 16	Jun 16	Jul 16	Sep 16	Oct 16	Nov 16	Dec 16	Mar 17
Steve Howe	Non-executive Director (Chair)		✓	✓	✓	✓	✓	✓	✓	✓
Paul Bentley	Chief Executive	✗	✗	✗	✗	✓	✗	✗	✗	✗
Pippa Barber	Non-executive Director (from 1 December 2016)	N/A	N/A	N/A	N/A	N/A	N/A	N/A	✓	✓
Richard Field	Non-executive Director	N/A	N/A	N/A	N/A	N/A	N/A	N/A	✓	N/A
David Robinson	Non-executive Director	✓	✓	✓	✓	✓	✓	✓	✓	✓
Arokia Antonysamay	Acting Medical Director (from 6 February)	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	✓
Ruth Herron	Acting Director of Nursing and Quality (from 27 August to 9 October 2016)	N/A	N/A	N/A	N/A	✓	N/A	N/A	N/A	N/A
Nicky Lucey	Director of Nursing and Quality (to 26 August 2016)	✓	✓	✓	✓	N/A	N/A	N/A	N/A	N/A
Peter Maskell	Medical Director (to 5 February 2017)	✓	✓	✓	✓	✓	✗	✓	✓	N/A
Louise Norris	Director of Workforce, Organisational Development and Communications	✓	✗	✗	✗	✓	✓	✓	✓	✗
Lesley Strong	Deputy Chief Executive/Chief Operating Officer	✓	✓	✓	✓	✓	✗	✓	✓	✗
Ali Strowman	Chief Nurse (from 10 October 2016)	N/A	N/A	N/A	N/A	N/A	✓	✗	✓	✓

Directors' report: Compliance statements

The directors' 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 emergency planning guidance 2005. The trust regularly participates in exercises and training with public sector partners.

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

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

The trust complies with HM Treasury's guidance on setting charges and the Confederation of British Industry better payments practice code. Details of compliance with the code are given in note 35 to the accounts on page 139. The trust has signed up to the prompt payments code.

As required by Section 43 (2A) of the NHS Act 2006 (as amended), the Board has satisfied itself that 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 page 92. 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.

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

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

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

Council of Governors

Elected public governors as at 31 March 2017



Ashford
John Fletcher
(from March 2017)



Canterbury
Vacant



Dartford
Gary Frost



Dover
Carol Coleman



Gravesham
Pete Sutton
(from March 2017)



Maidstone
David Price



Sevenoaks
Jo Naismith



Shepway
Jo Clifford
(from March 2017)



Swale
Amanda Green
(from March 2017)



Thanet
Jane Hetherington



Tonbridge and Malling
Sue Stephens
(from March 2017)



Tunbridge Wells
Mike Mackenzie
(from March 2017)



Rest of England
Anthony Moore

Retired governors



Ashford
David Nutley



Canterbury
Kate Wortham



Gravesham
Peggy Lawlor



Shepway
Alan Hewett



Swale
Ken Rogers



Tonbridge and Malling
Jack Wise



Tunbridge Wells
Graham Shaw



Corporate Services
Kathy Walters



Voluntary organisations
Jane Roberts

Elected staff governors



Adult Services
Sonja Bigg



Adult Services
Garry Denman



Adult Services
Claire Buckingham



Children and Families Services
Dr Mark Johnstone

Appointed governors



Public Health
Andrew Scott-Clark



Universities
Dr Susan Plummer

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

Elected public governors at 31 March 2017

Membership: Representation, and effectiveness

At the end of March 2017, the trust's membership stood at 12,557. This represents 0.91% of the population of Kent. The trust's aim is to achieve and maintain one per cent of Kent's population as members of the trust. We increased our overall membership by approximately 5.7% during 2016/17, from 11,885 at the start of April 2016 to 12,557 at the end of March 2017. NHS Improvement's requirement is to increase membership by a minimum of one per cent each year.

Areas where we need to increase our numbers to reach one per cent are:

- males
- white British, BME and Asian ethnicities
- 30 to 59-year-olds and over 90-year-olds
- people from working class backgrounds.

Geographical areas we need to increase membership include:

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

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 members receive our Community Health magazine by email or post.
- Almost 1,700 want to respond to surveys.
- Nearly 1,100 want to be invited to events.
- 450 want to comment on our leaflets.
- Nearly 250 want to be part of a panel or working groups.

The trust attended 17 membership recruitment events throughout the year, the biggest being the East Kent Skills Careers Day where 55 new members were recruited.

In March 2017, we held our first-ever event for members, focussing on the myths and facts about diabetes. KCHFT joined forces with East Kent Hospitals University NHS Foundation Trust (EKHUFT) in the event for our public members to learn about the condition. More than 70 public members attended and 12 partner organisations had a stall in the marketplace.

The event was also a great opportunity for our members to meet their local public governor. Both KCHFT and EKHUFT governors attended to talk to members in their constituencies about the role they play in the healthcare landscape – representing the interests of the public, giving local people, patients, staff and partners greater opportunity to be involved in the development of local NHS services.

Community involvement continued to grow. Every community hospital had a patient experience group and our volunteers continued to provide a valued service.

Understanding the views of governors and members

The trust has established effective governor induction and a continuing governor development programme which enables all members of the council to keep up-to-date with service delivery and issues around the STP. This also ensures that they develop their role as governors, representing their constituents in holding the trust to account for its performance.

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

Engagement with local groups and organisations

We held our first event for public members, in partnership with East Kent Hospitals, entitled 'Let's talk about Diabetes'. More than 80 people attended and there was positive feedback about the information stands, speakers and the expert panel who were there to dispel some common myths around diabetes. The presentations and question and answer session were live-streamed and subsequently this, along with short film about the charity Hypo Hounds have been viewed more than 1,800 times on social media – a great way of reaching people with an interest who were unable to attend.

KCHFT's Engagement Team attended a wide range of community events during the year, including events for carers, young people, older people, black and minority ethnic people and disabled people. This helped to raise awareness of KCHFT's services, resulted in us recruiting new trust members and led to us hosting a well-attended event for patients, carers, representatives from voluntary and community organisations and staff on the topic of loneliness and social isolation. The team organised focus groups on a range of topics from NHS identity to the future of school health services across Kent.

As a result, we developed a future model for the school health service, which includes suggestions such as team members wearing an identifiable uniform and a change in times and locations that the service is provided to better suit the lives of children and young people.

KCHFT continues to have an excellent relationship with Healthwatch Kent and following our engagement health check, Healthwatch Kent has decided to use our model of engagement as an example of best practice for other trusts.

Remuneration report

This remuneration report presents information from 1 April 2016 to 31 March 2017.

Annual statement on remuneration

The chief executive's performance against the agreed objectives was discussed. These were met in full and consequently the committee agreed that the 10% earn back should be awarded; the chief executive's salary having been reduced by 10%. At the same meeting, a pay award of one per cent was agreed for all posts covered by the Remuneration Committee, excluding the medical director and finance director.

The salary for the new medical director appointment was decided and views of ministers were sought.

The salary of the finance director was reviewed to reflect increase in portfolio and retention award.

There were no other substantial changes relating to senior managers' remuneration made during the year. No bonuses were paid during 2016/17.

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

Senior managers' remuneration policy

Policy on remuneration for executive directors

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

Pay component	How that component supports the trust's short and long-term strategy	How it operates	Maximum payable
Senior managers are entitled to a basic salary which is determined by the Remuneration Committee. The rates paid to individual directors are determined by the Remuneration Committee, which takes into account: <ul style="list-style-type: none"> • qualifications required for the role • spans of responsibility and accountability • performance • market forces. 	The trust believes that its senior managers should be fairly remunerated for their work. Trust salaries should be competitive and enable the trust to attract and in due course retain high calibre staff. However, salaries should not be overly high and should be positioned in the top quartile of salaries for similar organisations. The Remuneration Committee will reference its salaries to the NHS Providers survey of executive salaries and independent advice as required.	Salaries are reviewed against external NHS benchmarking and set at the lower end of the upper quartile for similar organisations, taking into account other factors including performance and qualifications. In the case of any salary above £142,500, the views of ministers are sought. A report is presented to the Remuneration Committee.	
Annual performance bonus scheme for directors comprising an annual uplift and a non-consolidated bonus described below		Subject to annual appraisal as for all staff. 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. 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 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. This 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 more than 25%

Pay component	How that component supports the trust's short and long-term strategy	How it operates	Maximum payable
		Those in categories A and B will receive, in addition to the annual uplift, a non-consolidated bonus payment, provided the essential criterion is met – for example, 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 and B non-consolidated bonus payments has been determined annually. In the current period of pay restraint, this provision is not being used.	
The annual uplift		As described above.	1%
Chief executive earn back	The trust believes that the chief executive should be properly remunerated for their work. Trust salaries should be competitive and enable it to attract high-calibre staff. However, salaries should not be overly high and should be positioned in the top quartile of salaries for similar organisations. The Remuneration Committee will reference its salaries to the NHS Providers' survey of executive salaries and independent advice, as required. Where applicable, views of ministers are sought.	An earn back scheme is applied. Annual salary is reduced by 10% each year. On the achievement of agreed objectives, the earn back is paid.	£15K

Each contract for directors gives the trust the right to deduct from a director's salary, or any other sums owed, any money owed to the trust. If, on termination of the appointment, the director has taken in excess of their accrued holiday entitlement, the trust is entitled to recover by deducting from any payments due. No provisions for the recovery of sums paid or for withholding of sums to senior managers have been made in the period. The trust's policy on senior managers' remuneration and its general policy on employees' remuneration differ only, in so far as other staff are on the Agenda for change or medical and dental pay scales, while directors' pay is determined outside of this framework.

The medical director is on a consultant contract not VSM and this has not changed in 2016/17. In addition to the consultant salary, a management responsibility allowance is paid. The total payment of £160,000 is capped to allow for increases within the consultant contract.

Policy on remuneration for non-executive directors

The remuneration for non-executive directors (NEDs) is set by the Council of Governors. No 'golden hellos', compensation for loss of office or other remuneration from the trust was received by any of the above during 2016/17. Non-executive members do not receive pensionable remuneration.

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

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

Pay component	Description	Application
Chairman basic pay	A spot rate salary £46,500	Trust's 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 is one standard contract for all directors excluding the medical director who is employed on a standard consultant contract. This puts the following obligations on the trust:

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

Policy on loss of office

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

Setting senior managers remuneration policy

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

The trust did not consult with employees when preparing the senior managers' remuneration policy.

The chief executive confirms 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's secretary.

Annual report on remuneration

Information not subject to audit

Remuneration Committee

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

The committee's members are the non-executive directors of the trust and the committee is chaired by the trust's chairman. Between 1 April 2016 and 31 March 2017 there were three meetings of the Remuneration Committee.

Remuneration Committee	Meetings attended 2016/17
David Griffiths	3
Richard Field	3
Peter Conway	3
Steve Howe	3
David Robinson	3
Bridget Skelton	2
Jennifer Tippin	1

The chief executive and HR director also normally attend meetings, except where matters relating to them are under discussion. NHS Providers' survey of executive salaries benchmarking data was used to assist the committee in their decisions.

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.

Service contracts

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

Senior manager	Date effective	Notice
Paul Bentley Chief Executive Officer	1 March 2016	6 months
Lesley Strong, Chief Operating Officer/Deputy Chief Executive Officer from 1 January 2017. Previously Director of Operations, Adults/ Deputy Chief Executive Officer	1 March 2015	6 months
Claire Poole Acting Director of Operations; Children and Young People until 31 December 2016	1 November 2015	3 months
Nicola Lucey Director of Nursing and Quality until 26 August 2016	1 June 2015	3 months
Ruth Herron Acting Director of Nursing and Quality from 27 August 2016 to 9 October 2016	1 September 2016	3 months
Ali Strowman Chief Nurse from 10 October 2016	10 October 2016	3 months
Peter Maskell Medical Director until 5 February 2017	1 March 2015	3 months
Arokia Antonyamy Acting Medical Director from 6 February 2017	1 March 2017	3 months
Gordon Flack Director of Finance	1 March 2015	6 months
Natalie Davies Corporate Services Director	1 June 2015	3 months
Nichola Gardner Director of Strategy and Transformation until 17 July 2016	1 March 2015	3 months
Louise Norris Director of Workforce, Organisational Development and Communications	7 July 2015	3 months

Non-executive director service contracts are fixed-term with the following unexpired terms as at the 31 March 2017:

Senior manager	Date effective	End date	Unexpired term
David Griffiths, Chairman	1 March 2017	29 February 2020	2 years, 11 months
Richard Field, Vice Chairman	1 April 2017	31 March 2020	3 years
Peter Conway, Non-executive Director	1 April 2015	31 March 2018	12 months
Steve Howe, Non-executive Director	1 April 2015	31 March 2018	12 months
David Robinson, Non-executive Director	1 October 2016	30 September 2019	2 years, 6 months
Pippa Barber, Non-executive Director	1 December 2016	29 November 2019	2 years, 8 months
Bridget Skelton, Non-executive Director	7 April 2016	6 April 2019	2 years
Jennifer Tippin, Non-executive Director	1 March 2017	29 February 2020	2 years, 11 months

Expenses of senior managers and governors

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

Directors and senior managers	Expenses* (rounded to nearest 100) £00	
	2016/17	2015/16
Marion Dinwoodie, Chief Executive Officer (left 30 November 2015)	-	22
Paul Bentley, Chief Executive Officer	25	-
Lesley Strong, Deputy Chief Executive and Director of Operations: Adults	35	31
Clive Tracey, Acting Director of Operations: Adults (to 31 March 2016)	-	35
Claire Poole, Acting Director of Operations: Children and Young People	37	6
Nicola Lucey, Director of Nursing and Quality	7	13
Ruth Herron, Acting Director of Nursing	-	-
Ali Strowman, Chief Nurse	9	-
Peter Maskell, Medical Director	27	30
Arokia Antonysamy, Acting Medical Director	1	-
Gordon Flack, Director of Finance	19	16
Natalie Davies, Corporate Services Director	25	18
Nichola Gardner, Director of Strategy and Transformation	4	23
Louise Norris, Director of Workforce, Organisational Development and Communications	19	18

David Griffiths , Chairman	33	20
Richard Field , Vice Chairman	12	14
Peter Conway , Non-executive Director	5	12
Steve Howe , Non-executive Director	16	20
David Robinson , Non-executive Director	7	15
Catherine Gaskell , Non-executive Director (left 6 April 2016)	-	17
Pippa Barber , Non-executive Director (from 1 December 2016)	6	-
Bridget Skelton , Non-executive Director	7	9
Jennifer Tippin , Non-executive Director	5	6
Total	299	325

*Taxable benefits are included within the Remuneration Table on page 54

There were a total of 21 executive and non-executive directors in post in the reporting period and 19 of these received expenses paid by the trust. The aggregate sum of directors' expenses comes to £29,886.33

The following expenses were paid to governors in the period:

Governors	Expenses (rounded to nearest 100) £00	
	2016/17	2015/16
Carol Coleman	10	-
David Price	2	-
Gary Frost	3	-
Graham Shaw (left 9 November 2016)	-	2
Jack Wise (left 16 December 2016)	2	1
Kate Wortham (left)	10	10
Ken Rogers (left 14 December 2016)	-	11
Marion Keates	-	3
Peggy Lawlor (left 9 November 2016)	-	5
Pete Sutton	0	-
Roisin Murray	-	4
Stuart Alexander	-	3
Total	27	39

There are a total of 21 governor positions. There have been 28 individuals working as governors within the year, with nine leaving and eight starting in the period. As at 31 March 2017, there were two governor positions vacant. In the reporting period, six governors received expenses paid by the trust. The aggregate sum of governors' expenses totals £2,708.30.

Name & Title	2016-2017 (12 months)					2015-2016 (12 months)						
	Salary & Fees	Taxable Benefits	Annual Performance-related Bonuses	Long term Performance-related Bonuses	All pension related benefits	Total	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) £s	(bands of £5000) £000	(bands of £5000) £000	(bands of £2500) £000	(bands of £5000) £000	(bands of £5000) £000	(Rounded to the nearest £100) £s	(bands of £5000) £000	(bands of £5000) £000	(bands of £2500) £000	(bands of £5000) £000
Marion Dinwoodie, Chief Executive Officer (left on 30/11/15)												
Paul Bentley, Chief Executive Officer (from 01/03/16)	150 - 155		15 - 20		0	165 - 170	10 - 15				0	10 - 15
Lesley Strong, Chief Operating Officer/Deputy CEO (from 01/01/17, previously Director of Operations, Adults/Deputy CEO)	125 - 130				0 - 2.5	130 - 135	125 - 130				150 - 152.5	275 - 280
Clive Tracey, Acting Director of Operations, Adults (from 07/12/15 to 31/03/16)							30 - 35	4,000			7.5 - 10	40 - 45
Mark Shepperd, Director of Operations, Children and Young People (left on 30/10/15)							60 - 65				0	60 - 65
Claire Poole, Acting Director of Operations, Children and Young People (from 01/11/15 to 31/12/16)	70 - 75	1,500			75 - 77.5	150 - 155	40 - 45	0			30 - 32.5	70 - 75
Nicola Lucey, Director of Nursing & Quality (left on 31/08/16)	45 - 50				10 - 12.5	60 - 65	115 - 120				7.5 - 10	125 - 130
Ruth Herron, Acting Director of Nursing (from 01/09/16 to 9/10/16)	5 - 10				5 - 7.5	15 - 20						
All Strowman, Chief Nurse (from 10/10/16)	50 - 55				77.5 - 80	125 - 130						
Peter Maskell, Medical Director (left on 05/02/17)	135 - 140				0	135 - 140	155 - 160				245 - 247.5	405 - 410
Arokia Antonyamsamy, Acting Medical Director (from 01/03/17)	5 - 10				2.5 - 5	10 - 15						
Gordon Flack, Director of Finance	125 - 130	6,700			137.5 - 140	270 - 275	110 - 115	8,200			0	120 - 125
Natalie Davies, Director of Corporate Services (from 01/06/15)	90 - 95				32.5 - 35	125 - 130	90 - 95				57.5 - 60	145 - 150
Nichola Gardner, Director of Strategy and Transformation (left 17/07/16)	25 - 30				10 - 12.5	35 - 40	90 - 95				57.5 - 60	150 - 155
Louise Norris, Director of Workforce, OD and Communications (from 08/07/15)	110 - 115				35 - 37.5	145 - 150	80 - 85				37.5 - 40	120 - 125

Information subject to audit

Name & Title	2016-2017 (12 months)						2015-2016 (12 months)				
	Salary & Fees	Taxable Benefits	Annual Performance-related Bonuses	Long term Performance-related Bonuses	All pension related benefits	Total	Salary & Fees	Taxable Benefits	Annual Performance-related Bonuses	Long term Performance-related Bonuses	All pension related benefits
	(bands of £5000) £000	(Rounded to the nearest £100) £s	(bands of £5000) £000	(bands of £5000) £000	(bands of £2500) £000	(bands of £5000) £000	(bands of £5000) £000	(Rounded to the nearest £100) £s	(bands of £5000) £000	(bands of £5000) £000	(bands of £2500) £000
David Griffiths, Trust Chairman	45 - 50	2,300				45 - 50	45 - 50	1,900			
Richard Field, Vice Chairman	15 - 20	1,200				15 - 20	15 - 20	1300			
Peter Conway, Non-Executive Director	15 - 20	500				15 - 20	15 - 20	1100			
Steve Howe, Non-Executive Director	15 - 20	1,600				15 - 20	15 - 20	2000			
David Robinson, Non-Executive Director	10 - 15	700				10 - 15	10 - 15	1400			
Catherine Gaskell, Non-Executive Director (left 06/04/16)	0 - 5					0 - 5	10 - 15	1600			
Pippa Barber, Non-Executive Director (from 01/12/16)	0 - 5	600				0 - 5					
Bridget Skelton, Non-Executive Director	10 - 15	700				10 - 15	10 - 15	900			
Jennifer Tippin, Non-Executive Director	10 - 15	500				10 - 15	10 - 15	600			

Information subject to audit

From 1 April 2016 to 31 March 2017, there were several changes in personnel.

- From 1 January 2017, Lesley Strong was appointed chief operating officer and deputy chief executive officer. Previously, she had been director of operations for adults and deputy chief executive officer.
- Claire Poole was acting director of operations for children and young people until 31 December 2016.
- Nicola Lucey left the trust on 26 August 2016 with Ruth Herron acting up to the vacant director of nursing and quality post from 27 August 2016 to 9 October.
- Ali Strowman started her role as chief nurse on the 10 October.
- On 5 February 2017 Peter Maskell left the trust, and Arokia Antonysamay has been acting medical director since 1 March 2017.
- Nichola Gardner left the trust on 17 July 2016.

The annual performance related bonus awarded to the chief executive officer outlined in the table above, has been granted in line with the CE earn back. Annual salary is reduced by 10% each year, on the achievement of agreed objectives the earn back is paid.

Included in the above table, the salary of the Dr Peter Maskell contains an amount totalling £75,067 paid in relation to his clinical role from 1 April 2016 to 5 February 2017.

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

Pension benefits

Name and Title	Real increase in pension at pension age for the time in post (bands of £2,500) £000	Real increase in pension lump sum at pension age for the time in post (bands of £2,500) £000	Total accrued pension at pension age at 31.03.17 (bands of £5,000) £000	Lump sum at pension age related to accrued pension at 31.03.17 (bands of £5,000) £000	Cash Equivalent Transfer Value at 01.04.16 £000	Cash Equivalent Transfer Value at 31.03.17 £000	Real increase/(decrease) in Cash Equivalent Transfer Value for the time in post £000	Employer's Contribution to stakeholder pension £000
Paul Bentley, Chief Executive Officer (from 01/03/16)	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
Lesley Strong, Chief Operating Officer/Deputy CEO (from 01/01/17, previously Director of Operations, Adults/Deputy CEO)	0 - 2.5	2.5 - 5	60 - 65	185 - 190	n/a	n/a	n/a	n/a
Claire Poole, Acting Director of Operations, Children and Young People (from 01/11/15 to 31/12/16)	2.5 - 5	10 - 12.5	30 - 35	90 - 95	491	601	83	n/a
Nicola Lucey, Director of Nursing & Quality (left on 31/08/16)	0 - 2.5	0 - 2.5	40 - 45	130 - 135	680	731	22	n/a
Ruth Herron, Acting Director of Nursing (from 01/09/16 to 9/10/16)	0 - 2.5	0 - 2.5	20 - 25	65 - 70	372	435	7	n/a
Ali Strowman, Chief Nurse (from 10/10/16)	2.5 - 5	5 - 7.5	25 - 30	65 - 70	261	391	61	n/a
Peter Maskell, Medical Director (left on 05/02/17)	0 - 2.5	0	35 - 40	100 - 105	567	613	39	n/a
Arokia Antonysam, Acting Medical Director (from 01/03/17)	0 - 2.5	0	0 - 5	0	0	35	3	n/a
Gordon Flack, Director of Finance	5 - 7.5	20 - 22.5	50 - 55	150 - 155	825	980	155	n/a
Natalie Davies, Director of Corporate Services (from 01/06/15)	0 - 2.5	0 - 2.5	20 - 25	55 - 60	279	309	30	n/a
Nichola Gardner, Director of Strategy and Transformation (left 17/07/16)	0 - 2.5	0 - 2.5	20 - 25	55 - 60	281	316	10	n/a
Louise Norris, Director of Workforce, OD and Communications (from 08/07/15)	0 - 2.5	5 - 7.5	40 - 45	125 - 130	751	816	65	n/a

Information subject to audit

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

The chief executive officer is not a member of the NHS pension scheme.

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 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 does not include the increase in accrued pension due to inflation, contributions paid by the employee, including the value of any benefits transferred from another scheme or arrangement. It uses common market valuation factors for the start and end of the period.

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

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

For 2016/17 the difference in CPI between September 2014 and September 2015 was negative at minus 0.1%. For calculation purposes, the trust has used an inflation rate assumption of 0.00% 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 the Greenbury pension guidance lists it as value of the consumer price index.

Fair pay multiple

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

The banded remuneration of the highest paid director in Kent Community Health NHS Foundation Trust in the financial year 2016/17 was £165k-170k (2015/16, £155k-160k).

This was 6.6 times (2015/16, 6.4 times) the median remuneration of the workforce, which was £25k (2015/16, £25k). The increase in the ratio from last period, between the remuneration of the highest paid director and the median remuneration is due to a change of the most highly paid director.

In 2016/17, one employee received remuneration in excess of the highest-paid director. Remuneration for this individual was £182k (2015/16, £197k).

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

Signed: Date:

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

Staff report

Having refreshed our values, we have now reviewed the behaviours we would (and wouldn't expect) expect to see aligned to those values. We have developed a managers' competency framework linked to these values with input from staff at all levels of the organisation. This framework has been used as a basis for recruitment assessment centres for prospective applicants to posts at Band 8 and above.

2016-17 brought big changes to the apprenticeship agenda, but we built on our existing successes with Nikole Love picking up the Level 2 non-clinical apprentice of the year accolade at Health Education England's (HEE) Kent, Surrey and Sussex Apprenticeship Awards.

We were given a further Healthy Business Award for our work towards looking after our colleagues' health and wellbeing. The accolade was for excellence in three areas: Healthy eating, health and safety and leadership.

During 1 April 2016 – 31 March 2017

- Overall, we exceeded our mandatory training target of 85%, achieving 94.7%.
- Sickness absence was above our 3.9% target at 4.30%
- Unplanned turnover exceeded our 8% target at 11.5% for the year which while above our target this has seen a marked decrease on last year's turnover.
- We did not quite reach our target of a less than 5% vacancy rate, at 7.5% but we have a robust recruitment and retention plan which is regularly monitored at senior level in the organisation.

Staff sickness absence

	2016-17	2015-16
Total working days lost	40,161	40,433
Total staff years	4,310	4,491
Average days lost	9	9

The above staff sickness data is provided centrally by NHS Digital using the statistics held within the ESR (electronic staff record) data warehouse. The above data is based on the 2016 calendar year and therefore represents a full year (12 months) for comparison purposes. The Department of Health considers the resulting figures to be a reasonable proxy for financial year equivalents. To further aid consistency the trust has also reconciled the centrally provided data to its own underlying local data.

The gender distribution of our workforce at 31 March 2017 is:

FTE	Female	Male	Total	% Female	% Male	% Total
Director	4.80	2.00	6.80	70.59%	29.41%	100.00%
Employees	3582.29	450.91	4033.20	88.82%	11.18%	100.00%
Senior manager	35.44	9.80	45.24	78.33%	21.67%	100.00%
Grand total	3622.53	462.71	4085.24	88.67%	11.33%	100.00%

Staff costs

	Permanent	Other	2016/17 Total	2015/16 Total
	£000	£000	£000	£000
Salaries and wages	121,925	3,275	125,200	131,203
Social security costs	10,176	204	10,380	7,912
Employer's contributions to NHS pensions	15,856	248	16,104	16,770
Termination benefits	115	-	115	344
Temporary staff - agency/contract staff	-	7,947	7,947	13,089
Total gross staff costs	148,072	11,674	159,746	169,318
Recoveries in respect of seconded staff	(54)	-	(54)	(147)
Total staff costs	148,018	11,674	159,692	169,171
of which				
Costs capitalised as part of assets	3	-	3	583

Average number of employees (WTE basis)

	Permanent	Other	2016/17 Total	2015/16 Total
	Number	Number	Number	Number
Medical and dental	59	1	60	62
Ambulance staff	-	-	-	-
Administration and estates	1,311	-	1,312	1,311
Healthcare assistants and other support staff	823	-	823	850
Nursing, midwifery and health visiting staff	1,276	-	1,276	1,408
Nursing, midwifery and health visiting learners	27	-	27	53
Scientific, therapeutic and technical staff	707	-	707	738
Social care staff	18	-	18	17
Agency and contract staff	-	148	148	235
Bank staff	-	124	124	81
Total average numbers	4,221	273	4,494	4,776
of which:				
Number of employees (WTE) engaged on capital projects	-	-	-	21

Exit packages

Reporting of compensation schemes - exit packages 2016/17

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

Reporting of compensation schemes - exit packages 2015/16

Exit package cost band (including any special payment element)	Number of compulsory redundancies Number	Number of other departures agreed Number	Total number of exit packages Number
<£10,000	5	16	21
£10,001 - £25,000	4	-	4
£25,001 - 50,000	2	-	2
£50,001 - £100,000	2	-	2
£100,001 - £150,000	-	-	-
£150,001 - £200,000	-	-	-
>£200,000	-	-	-
Total number of exit packages by type	13	16	29
Total resource cost (£)	£320,500	£55,700	£376,200

	2016/17		2015/16	
	Payments agreed Number	Total value of agreements £000	Payments agreed Number	Total value of agreements £000
Voluntary redundancies including early retirement contractual costs	-	-	-	-
Mutually agreed resignations (MARS) contractual costs	-	-	-	-
Early retirements in the efficiency of the service contractual costs	-	-	-	-
Contractual payments in lieu of notice	12	38	16	56
Exit payments following Employment Tribunals or court orders	-	-	-	-
Non-contractual payments requiring HMT approval	-	-	-	-
Total	12	38	16	56
of which:				
Non-contractual payments requiring HMT approval made to individuals where the payment value was more than 12 months' of their annual salary	-	-	-	-

Expenditure on consultancy

Consultancy expenditure was £440k for the year.

Off-payroll engagements

For all off-payroll engagements as of 31 March 2017, for more than £220 per day and that last for longer than six months

	2016/17 Number of engagements
Number of existing engagements as of 31 Mar 2017	-
of which:	
Number that have existed for less than one year at the time of reporting	-
Number that have existed for between one and two years at the time of reporting	-
Number that have existed for between two and three years at the time of reporting	-
Number that have existed for between three and four years at the time of reporting	-
Number that have existed for four or more years at the time of reporting	-
Number that have existed for between three and four years at the time of reporting	-
Number that have existed for four or more years at the time of reporting	-

For all new off-payroll engagements, or those that reached six months in duration, between 1 April 2016 and 31 March 2017, for more than £220 per day and that last for longer than six months

**2016/17
Number of
engagements**

Number of new engagements, or those that reached six months in duration between 1 April 2016 and 31 March 2017	-
Number of the above, which include contractual clauses giving the trust the right to request assurance in relation to income tax and national insurance obligations	-
Number for whom assurance has been requested	-
Of which:	
Number for whom assurance has been received	-
Number for whom assurance has not been received	-
Number that have been terminated as a result of assurance not being received	-

For any off-payroll engagements of board members, and/or senior officials with significant financial responsibility, between 1 April 2016 and 31 March 2017

**2016/17
Number of
engagements**

Number of off-payroll engagements of Board members, and/or, senior officials with significant financial responsibility, during the financial year.	-
Number of individuals that have been deemed "Board members and/or senior officials with significant financial responsibility". This figure should include both off-payroll and on-payroll engagements.	21

Health and safety performance

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

The trust has a Health and Safety Committee in place, which reports to the Corporate Assurance and Risk Management Group. Fire safety, water quality and medical gases sub groups report to the Health and Safety Committee to provide assurance of compliance with safety legislation.

During 2016-17, the trust did not receive any Health and Safety Executive (HSE) improvement notices, prosecutions or fees for interventions.

The trust reported 21 incidents which fell under the requirements of the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 2013 (RIDDOR). All these reports were submitted to the HSE within the required legal timeframes.

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

Occupational health

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

Counter fraud

The trust's counter fraud specialists provide professional expertise to tackle fraud, corruption and bribery and operate within a national legal framework for tackling fraud, corruption and bribery, with all work completed in accordance with legal standards and in compliance with guidance provided by NHS Protect. The trust's approach to counter fraud is documented in its counter fraud, corruption and bribery policy.

Equality and diversity

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

Equality is written into the trust's values framework. It ensures all our staff receive training in the subject and equality analysis and equality and diversity are embedded into trust policies. Additionally, the trust uses the Equality Delivery System 2 to record and evidence the work it does, annually publishing equality objectives on our public website. Staff networks promote and support staff who are LGBTQ, disabled and have religious beliefs, for example.

Communication with staff

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

On 1 April 2016, we launched our now award-winning social intranet, flo. This is accessed by all our staff and ensures that colleagues working in different departments can talk to each and can make cross-service referrals, as well as give colleagues working in different geographical areas the opportunity to share best practice via workspaces. The site receives around 113,000 page views every month, with the most visited area, our 'how to' guides, with an average of 26,000 monthly visits. More staff are now blogging – this includes a new weekly blog from our chief executive.



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

Our senior leadership team carries out 'back to the floor' visits. In 2016, we launched our #yesyoucan roadshow, led by the Executive Team, which aims to seek ideas to deliver more power and authority to frontline staff. We fed back the responses and answers to questions through our intranet and the campaign is continuing. We held more than 10 engagement sessions across our patch to talk about the Sustainability and Transformation Plan and seek staff views.

Our quarterly magazine Community Health – featuring case studies of good outcomes – has a readership of around 100,000 per edition and is available to staff, as well as the public.



Many of our staff also engage on our established social media profiles on Facebook, Twitter and YouTube. Our 4.2k followers on Facebook is greater than any other provider or NHS Trust in Kent. We also have 2,887 Twitter followers and our

YouTube videos have been viewed nearly 39,000 times.

We regularly review our communications with staff and carried out a survey in October last year to ask people about the methods we use as well as internal campaigns they remembered. A key campaign was our flu campaign, which achieved a higher take-up rate but we have also run campaigns last year including React to Red to raise awareness of how to tackle pressure ulcers, NHS Staff Friends and Family Test, Home First and Freedom to Speak Up.

Feedback from our internal communications survey revealed that nearly 78 per cent of respondents felt they could give feedback and of those six in 10 people said they had been able to make an impact.



NHS Staff Survey summary of performance

Of the 5,222 questionnaires sent out, 2,567 staff surveys were returned. The response rate for the trust was 55 per cent in 2016, which is above average when compared to other community trusts. There were many areas of improvement.

	Top five ranking scores			
	2015/16	2016/17		
	Trust	Trust	Benchmarking group (trust type) average	Trust improvement/deterioration
KF21. Percentage of staff believing that the organisation provides equal opportunities for career progression or promotion	91%	92%	90%	Improvement
KF17. Percentage of staff feeling unwell due to work related stress in the last 12 months.	37%	34%	38%	Improvement
KF30. Fairness and effectiveness of procedures for reporting errors, near misses and incidents	3.81	3.84	3.79	Improvement
KF29. Percentage of staff reporting errors, near misses or incidents witnessed in the last month	91%	93%	92%	Improvement
KF16. Percentage of staff working extra hours	69%	67%	71%	Improvement

Bottom 5 ranking scores				
	2015/16	2016/17		
	Trust	Trust	Benchmarking group (trust type) average	Trust improvement/deterioration
KF31. Staff confidence and security in reporting unsafe clinical practice	3.69	3.74	3.76	Improvement
KF2. Staff satisfaction with the quality of work and care they are able to deliver	3.80	3.83	3.85	Improvement
KF18. Percentage of staff attending work in the last three months despite feeling unwell because they felt pressure from their manager, colleagues or themselves	65%	63%	56%	Improvement
KF13. Quality of non-mandatory training, learning or development	3.99	4.04	4.08	Improvement
KF7. Percentage of staff able to contribute towards improvements at work	68%	69%	70%	Improvement

Last year the Board agreed that the action plan should focus on the five bottom ranking scores and where there had been a decline from the 2015 scores. In addition, the focus of work should be around engagement and a cultural shift to ensure the trust's values were translated into management and leadership actions.

Key finding	2015	2016	Ranking	Change
Percentage of staff agreeing that their role makes a difference to patients/service users	89%	90%	Average (2015 average)	No change
Quality of non-mandatory training, learning or development	3.99	4.04	Above average (2015 below average)	Increase
Percentage of staff able to contribute towards improvements at work	68%	69%	Average (2015 average)	No change
Staff confidence and security in reporting unsafe clinical practice	3.69	3.74	Average (2015 below average)	Increase
Percentage of staff feeling pressure in the last three months to attend work when feeling unwell	65%	63%	Below average (2015 below average)	No change

The good news is that the trust has improved in all areas it identified last year as key measures of success. Each locality and directorate has also been asked to analyse their specific findings and develop an action plan to address key areas of concern.

Our communications plan includes presentation of findings to key groups, such as the Board and communication to all staff groups, involving them in making sense of the findings and developing action plans for their areas. Findings are being discussed in each locality/directorate – including Corporate Services – with action plans developed, agreed and monitored. Overall, the survey findings for 2016 are very positive and there have been some real improvements year-on-year in some key areas, which we will build on in 2017/18.

There have been improvements on the scores these areas: Staff feeling able to contribute to improvements at work, feeling satisfied with the quality of care they deliver, an increase in their overall motivation at work. They are average when compared to other organisations. Our engagement score stayed the same. However, nationally scores fell for comparable organisations, so we increased to average, which again is moving in the right direction.

It is important that we continue to strive to improve all scores, actions are followed through so that staff understand that what they have to say really does matter and that as a trust we do listen and we do act on feedback. These findings and action plans need to be shared with staff and monitored on a regular basis.

NHS Foundation Trust Code of Governance

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

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	NHS Improvement Code of Governance reference	Kent Community Health NHS Foundation Trust disclosure
Board and Council of Governors	A.1.1	<p>The trust's Board meets 12 times per year and also attends five strategy and development days. The trust's Board meets formally in public every two months. There are 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's committees.</p> <p>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 NHS Improvement or other external body might also be considered. There has been no requirement to activate this process during 2016/17.</p>
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 27 to 28. The number of Board and committee meetings and a record of attendance is found on pages 37 to 39.
Council of Governors	A.5.3	Page 41 of this annual report identifies the members of the Council of Governors, the lead governor and their respective constituencies. The Council has formally met four times. It is due to continue formal quarterly meetings.
Board	B.1.1	The directors of the trust all meet the required independence criteria set out by NHS Improvement. The directors are identified on pages 29 to 36 of this annual report. All material pecuniary and non-pecuniary interests are declared and reported as per the trust's policy and regularly reported to the Board.

Board	B.1.4	The biographies of Board members are included in this report on pages 29 to 36. The Board has completed a self-assessment and considers that the skills and experience of the members gives an appropriate balance in order to effectively conduct its business. This is reviewed in an on-going way through the Nominations Committee.
Nominations Committee(s)	B.2.10	The Nominations Committee is a committee of the council, which is designed to consider the appointment or removal, succession planning and process for appraisal for non-executive directors. The committee does this by reviewing the overall balance and skills of all the non-executive directors and makes recommendations to the council for consideration. The Nominations Committee sat three times in the past year.
Chair/Council of Governors	B.3.1.	The job specification for the trust's chair defines the role and capabilities required and the expected time commitment. The chairman's other significant responsibilities are outlined in his biography on page 29 of this annual report. The Nominations Committee will oversee future appointments, as required.
Council of Governors	B.5.6	The mechanisms for canvassing members continue to develop. Election of governors – there is a process for electing new governors, which is conducted by an external election company (Election Reform Services). In the past 12 months, there were two public elections. and The council now consists of 13 publicly elected governors and five staff elected governors. The rest of the council currently consists of three appointed governors. All have been to one formal meeting of the council during the past 12 months.
Board	B.6.1	The Board is assessed for effectiveness and individual effectiveness assessments of Board members are conducted as part of the appraisal process. The Board collectively assesses its effectiveness after every formal meeting.
Board	B6.2	The Board and the governance processes have been reviewed during 2016/17 internally. As we received foundation trust status in March 2015 and the review is every three years, no further external reviews been commissioned. The Audit and Risk Committee takes responsibility for oversight of the governance process. It achieves this through internal audit, external audit, deep dives and the assessment of the risk profile of the organisation.
Board	C.1.1	The statement of the directors' responsibilities for the annual report and accounts is on page 40.
Board	C.2.1	This is covered in the annual governance statement included in this annual report.
Audit Committee/ Control Environment	C.2.2	This is covered in the annual governance statement included in this annual report. The independent auditor's report is on page 87.

Audit Committee/ Council of Governors	C.3.5	The appointment of the external auditor is considered every three years and was recommended and approved by the Council of Governors in November 2016 for a further year.
Audit Committee	C.3.9	This information is included in the trust's annual governance statement, included in this report.
Board/ Remuneration Committee	D.1.3	None of the trust's executive directors are released to serve on external appointments, such as non-executive directorships elsewhere.
Board	E.1.5	The members of the Board of Directors and, in particular the non-executive directors, will attend the meetings of the Council of Governors, as and when required, to develop an understanding of the views of the council and the trust's members about the trust. The Board will also take account of surveys and consultations canvassing the opinion of the membership.
Board/ Membership	E.1.6	The Board and council have approved the trust's membership strategy. The ongoing methodology for the NHS monitoring of effective member engagement and how representative of the community the trust serves is included in the trust's communications and engagement strategy. A Membership Committee has been established by the council to discharge this responsibility.
Membership	E.1.4	<p>The corporate services director oversees compliance with this requirement. The governors of the trust can be contacted by:</p> <p>email: kcht.governors@nhs.net phone 01622 211972 By post at: Governor Support Office Kent Community Health NHS Foundation Trust The Oast Unit D Hermitage Court Hermitage Lane Barming Maidstone Kent ME16 9NT</p>

NHS Improvement's Single Oversight Framework

Single Oversight Framework

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

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

Based on information from these themes, providers are segmented from 1 to 4, where 4 reflects providers receiving the most support, and 1 reflects providers with maximum autonomy. A foundation trust will only be in segments 3 or 4 where it has been found to be in breach or suspected breach of its licence. The Single Oversight Framework applied from quarter 3 of 2016/17.

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

Segmentation

The latest segmentation information (at 31 March 2017) places KCHFT in segment 1 (top scoring segment) which represents only 13% of NHS provider organisations in the country. Current segmentation information (including descriptions of each segment classification) for NHS trusts and foundation trusts is published on the NHS Improvement website.

Finance and use of resources

The finance and use of resources theme is based on the scoring of five measures from 1 to 4, where '1' reflects the strongest performance. The scores are then weighted to give an overall score. The results for KCHFT for Q3 and Q4 2016/17 in relation to the finance and use of resources metrics are presented below:

Financial criteria	Weight %	Metric	2016/17 Q3 score	2016/17 Q4 score
Financial sustainability	0.2	Capital service capacity	1	1
	0.2	Liquidity (days)	1	1
Financial efficiency	0.2	I&E margin	1	1
Financial controls	0.2	Distance from financial plan	1	1
	0.2	Agency spend	1	1
Overall scoring			1	1

Signed: Date:

Paul Bentley, Chief Executive Officer



Statement of Accounting Officer's Responsibilities

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

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

NHS Improvement, in exercise of the powers conferred on Monitor by the NHS Act 2006, has given accounts directions which require Kent Community Health NHS Foundation Trust to prepare for each financial year a statement of accounts in the form and on the basis required by those directions. The accounts are prepared on an accruals basis and must give a true and fair view of the state of affairs of Kent Community Health NHS Foundation Trust and of its income and expenditure, total recognised gains and losses and cash flows for the financial year.

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

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

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

Signed: Date:

Paul Bentley, Chief Executive Officer



Kent Community Health
NHS Foundation Trust

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Annual Governance Statement

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Annual governance statement – 1 April 2016 to 31 March 2017 Kent Community Health NHS Foundation Trust

(Organisational Code – RYY)

1. Scope of responsibility

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

2. The purpose of the system of internal control

The system of internal control is designed to manage risk to a reasonable level rather than to eliminate all risk of failure to achieve policies, aims and objectives; it can therefore only provide reasonable and not absolute assurance of effectiveness. The system of internal control is based on 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 year ended 31 March 2017 and up to the date of approval of the annual report and accounts.

3. Capacity to handle risk

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

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

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

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

Leadership and co-ordination of risk management activities is provided by the corporate services director and 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.

To give Board members grounding and greater understanding and clarity, there has been development in engaging each member with quality and safety walkabouts, understanding the patient journeys and pathways with case interrogation of individual case studies. The Board is also invited to the Executive Team and heads of service conferences where they meet senior management and discuss new service models, service improvements and innovations.

4. The risk and control framework

As accounting officer I have overall responsibility for risk management. Specific responsibilities are delegated to senior managers throughout the organisation. The Board oversees risks, establishes a risk appetite for high level risks on a risk-by-risk basis and encourages proactive identification and mitigation of risks.

The risk management strategy was presented to the Audit and Risk Committee in February for ratification and then to the Board in March 2017. The strategy explicitly describes the trust's approach to tolerating risks. The trust is continuing to implement and embed the principles contained in 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 2016/17 there has been a significant amount of work undertaken to manage, rationalise and ensure consistency of the risks identified through the risk management process.

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

- patient care may suffer if we are unable to recruit and retain a quality workforce, increasing reliance on agencies and resulting in an inability to capitalise on clinical leadership
- development of the Sustainability and Transformation Partnership is complex and wide ranging across many different organisations. Due to organisational structures, accountabilities and sphere of control, the trust may be unable to ensure the successful implementation of the whole system solutions required to deliver the trust's strategy for the right care in the most effective setting
- a risk that the trust will be unable to continue to meet cost improvement plan targets as detailed in 2017/18 plans
- that the organisation will not be able to implement the change and transformation of service due to poor morale and organisational culture due to ineffective clinical leadership and effectiveness of engagement with staff.

These risks continue to be managed through the risk management and assurance processes throughout 2016/17. Where appropriate, the trust will discuss risks which threaten the achievement of its objectives with commissioners, our partners in healthcare and social services, local authorities, voluntary bodies and through involvement of public (particularly members) and patients' representatives in the trust's business.

4.1 Care Quality Commission

Kent Community Health NHS Foundation Trust maintains its 'good' rating from the most recent Care Quality Commission (CQC) inspection in 2015. It is fully compliant with CQC registration requirements and 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 and assurance sources detailed further in this statement including internal and external audit.

In April 2016, a joint inspection by the CQC and Her Majesty's Inspectorate of Prisons (HMIP) reviewed our dental service at HMP Swaleside. No issues of concern were identified. In December 2016 the trust's children and young people's service in East Sussex participated in a joint inspection by the CQC and Ofsted. This review considered how effectively the local area identifies, meets the needs of and improves the outcomes of the wide range of different groups of children and young people who have special educational needs and/or disabilities. No significant issues were identified during inspection and the report is awaited.

Committee structure

Throughout 2016/17, the Board and its committees have met and were quorate on all occasions.

To discharge its duties effectively, the Board has a number of formally constituted Board committees with delegated responsibilities as set out within the 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.

4.2 The Quality Committee

The Quality Committee is a non-executive committee of the Board with delegated decision-making powers. The chief nurse, medical director and directors with operational portfolios attend meetings. Other individuals with specialist knowledge attend for specific items with the prior consent of the 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 purpose of the committee is to:

- support the Board in ensuring that quality is integral to the function of the organisation by providing an overview of the quality assurance and clinical governance issues identified that may influence the overall success of the organisation
- review all elements of the quality strategy, ensuring that the measures for success are implemented in the agreed timescales
- focus on quality and risk issues and to ensure that the appropriate governance structures, systems and processes are in place across the trust to assure performance and quality on behalf of the trust's Board
- ensure that there is clear strategic direction, strong leadership and transparent lines of accountability and that the organisation has the right systems from a patient perspective to deliver safe and effective services
- review specific issues where the Board requires additional assurance about the effectiveness of systems of internal control or areas where quality indicators highlight concerns
- performance manage and hold the Executive Team to account for delivery against safety requirements and developments
- advise the Board on the escalation of quality and safety risks on the corporate risk register/ Board assurance framework
- review the high level risks on the trust clinical risk register that relate to patient safety and recommend appropriate actions
- oversee the ratification and monitoring of clinical policy development and implementation.

4.3 The Audit and Risk Committee

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

The director of finance, corporate services director, head of internal audit, head of external audit and the local counter fraud specialist attend meetings. Other individuals with specialist knowledge attend for specific items with 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 trust Board about the reliability and robustness of the systems of internal control.

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

It is incumbent upon the Audit and Risk Committee to work closely with other committees of the Trust Board to ensure that all issues relating to finance, risk management and internal control are considered in a holistic and integrated way.

4.4 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/chief operating officer.

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

The overall objectives of the committee are to:

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

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

4.5 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's chairman. The chief executive and director of workforce, organisational development and communications will also normally attend meetings, except where matters relating to them are under discussion.

Responsible for setting the remuneration and conditions of service for the chief executive and other directors with Board responsibility who report directly to the chief executive and other directors, ensuring 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 will oversee the appointment of executive directors in accordance with standing orders. During these sittings, the committee will be known as the Executive Appointments Committee and the minutes should reflect this position.

4.6 Charitable Fund Committee

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

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

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

4.7 Council of Governors

The purpose of the Council of Governors is to represent the interests of Kent Community Health NHS Foundation Trust's members and the public in their individual constituencies. Governors hold the non-executive directors individually and collectively to account for the performance of the Board of Directors, ensuring that the trust meets its contractual responsibilities.

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

During 2016/17 the full Council of Governors met four times and a members' meeting was held in September.

4.8 NHS pension scheme

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

Despite errors being identified during 2016-17 with regards to employees not paying the correct contribution rates, relevant corrective action and associated recovery of underpaid contributions has been undertaken in year to ensure employees' contribution rates and pension records are now correct. SBS Payroll has confirmed that all corrective action related to KCHFT has been completed.

4.9 Sustainability

The trust's sustainability strategy is to be presented to the Board and includes assessments and carbon reduction delivery plans 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

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

The trust's strategic goals form the basis of the Board assurance framework. The strategic goals are linked to key risks, internal controls and assurance sources. Mitigating controls and assurances are recorded and monitored to deliver reasonable assurance for prevention of risks, deterrent to risks arising and management of current risks. 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 Corporate Services Director who produces regular reports on risk for review.

The end of year review of the Board Assurance Framework by the Head of Internal Audit has resulted in an opinion of reasonable assurance that the Board Assurance Framework is effective.

Clinical risk and patient safety are overseen by the Quality Committee, the director of nursing and quality, the medical director and the operational 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. It has also sought assurance on the progress of the action plans that were developed in relation to the trust's NHS Improvement Quality governance assurance framework score, and the Care Quality Commission's inspection of the trust. This assurance is reported to the Board.

Specialised risk management activities, for example information governance; emergency planning and business continuity; and health and safety, fire and security, are 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 received regular reports from the local counter fraud specialists which identified specific fraud risks and investigated whether there was evidence of those being exploited. No significant risks, classes of transactions or account balances were identified. The committee has focused some attention on the relationship between claims and the associated costs, and incidents reported.

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

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

5. Information governance (IG)

There have been 520 reported IG incidents in 2016/17 compared with 485 last year. Of these, 184 were incidents and the remaining 336 were near miss events.

Of the incidents, there was one serious untoward incident, which was categorised as sufficiently serious to be reported to the Information Commissioner's Office (ICO). We are awaiting the response from the ICO.

6. Annual Quality Report

The directors are required under the Health Act 2009 and the National Health Service (Quality Accounts) Regulations 2010 (as amended) to prepare quality accounts for each financial year. NHS Improvement (in exercise of the powers conferred on Monitor) has issued guidance to NHS foundation trust boards on the form and content of annual Quality Reports which incorporate the above legal requirements in the NHS Foundation Trust Annual Reporting Manual.

Each year, the trust consults the public and other stakeholders to align the priorities for the Quality Report to the risks, business objectives and national priorities.

During the year, as data is collected the trust reports quarterly to the Quality Committee and CCGs on progress with all metrics.

The draft Quality Report is presented to the Quality Committee, governors and the trust's Board for comments/additions. In addition, it is presented to all CCGs, Health Watch, Kent County Council and other stakeholders for comments.

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

A monthly review of all quality related information, including waiting list data and soft intelligence is carried out by the Executive Team, and queries are followed up by the Nursing and Quality Team who conduct quality reviews both proactively and reactively.

7. Review of effectiveness

As accounting officer, I have responsibility for reviewing the effectiveness of the system of internal control. My review of the effectiveness of the system of internal control is informed by the work of the internal auditors, clinical audit and the executive managers and clinical leads within the NHS foundation trust who have responsibility for development and maintenance of the internal control framework. I have drawn on the content of the quality report attached to this annual report and other performance information available to me.

My review is also informed by comments made by the external auditors in their management letter and other reports. I have been advised on the implications of the result of my review of the effectiveness of the system of internal control by the board, 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 internal audit reports which received limited assurance were:

- consultant job plans and clinical supervision
- nurse staffing arrangements
- cyber security maturity.

The trust has embarked on an extensive project to update the current cyber counter measures. This was in response to a question raised at ARC and an internal audit carried out in November.

Since then, the trust has carried out a risk assessment of the current countermeasures and developed a plan, in conjunction with TIAA, to upgrade technical counter measures and improve staff awareness to move the trust forward on the cyber security maturity model.

Regular updates are received at the Board and cyber security is now a standing agenda item on the IT Steering Group.

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

Director statements from executive directors and senior managers 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.

For the year 2016/17 the following significant issues have been identified:

Significant issue description:	Remedial action taken and plans for mitigation:
Vacancies and overspending on agency staff resulting in high costs and reduce control	<ul style="list-style-type: none"> • Implementation of retention strategy and action plan. Average time taken to recruit reduced to less than seven weeks • Community hospital staffing report to Board • The trust has met the trajectory for the reduction in agency staff and this is continuing
High levels of transfer of care delays impacting on whole system performance	<ul style="list-style-type: none"> • Community services directors linked into the Urgent Care Board and delayed transfer of care meeting(s) • Forging strong links with social care and a whole system approach • Implementation of Home First programme • Development of therapy-led units in community hospitals

In December 2016, the trust identified one never event as a result of wrong site surgery within the Dental Service. This involved a patient having the incorrect tooth extracted. The patient was offered ongoing support and advice and Duty of candour was implemented. Following a full investigation, a number of actions were recommended and implemented.

Conclusion

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

Signed: Date:

Paul Bentley, Chief Executive Officer

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 financial position of the Kent Community Health NHS Foundation Trust (the Trust) as at 31 March 2017 and of its expenditure and income for the year then ended; and
- the financial statements have been prepared properly in accordance with International Financial Reporting Standards (IFRSs) as adopted by the European Union, as interpreted and adapted by the NHS foundation trust annual reporting manual 2016/2017 and the requirements of the National Health Service Act 2006.

Who we are reporting to

This report is made solely to the Council of Governors of the Trust, as a body, in accordance with Schedule 10 of the National Health Service Act 2006. Our audit work has been undertaken so that we might state to the Trust's Council of Governors those matters we are required to state to them in an auditor's report and for no other purpose. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the Trust and the Trust's Council of Governors, as a body, for our audit work, for this report, or for the opinions we have formed.

What we have audited

We have audited the financial statements of Kent Community Health NHS Foundation Trust for the year ended 31 March 2017 which comprise the statement of comprehensive income, the statement of financial position, the statement of changes in equity, the statement of cash flows and the related notes.

The financial reporting framework that has been applied in their preparation is applicable law and the NHS foundation trust annual reporting manual 2016/17.



Overview of our audit approach

- Overall materiality: £4,462,000 which represents 2% of the Trust's gross operating costs;
- We performed a full-scope audit of Kent Community Health NHS Foundation Trust
- Key audit risks were identified as:
 - Occurrence of healthcare income and existence of associated receivables

Our assessment of risk

In arriving at our opinions set out in this report, we highlight the following risks that, in our judgement, had the greatest effect on our audit and how we tailored our procedures to address these risks in order to provide an opinion on the financial statements as a whole. This is not a complete list of all the risks we identified:

Audit risk	How we responded to the risk
<p>Occurrence of healthcare income and existence of associated receivables Over 95% of the Trust's income is from healthcare including income from NHS commissioners.</p> <p>The Trust invoices its commissioners throughout the year for services provided, and at the year-end estimates and accrues for activity not yet invoiced. Invoices for the final quarter of the year are not finalised and agreed until after the year-end and after the deadline for the production of the financial statements. This will involve further negotiation of contractual adjustments with commissioners.</p> <p>We, therefore, identified the occurrence of healthcare income, and existence of associated receivables as a significant risk requiring special audit consideration.</p>	<p>Our audit work included, but was not restricted to:</p> <ul style="list-style-type: none"> evaluating the Trust's accounting policy for recognition of healthcare income for appropriateness and consistency with the prior year; gaining an understanding of the Trust's system for accounting for healthcare income and evaluating the design of the associated controls; using an analysis provided by the Department of Health to identify any significant differences in healthcare income balances with contracting NHS bodies, and obtaining supporting evidence to confirm the validity of differences in excess of £250,000; agreeing, on a sample basis, amounts recognised in healthcare income to signed contracts; and agreeing on a sample basis, associated receivables at year end to subsequent cash receipts or alternative evidence. <p>The Trust's accounting policy on healthcare income, including its recognition, is shown in note 1.2 to the financial statements and related disclosures are included in note 3.</p>

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 economic decisions of a reasonably knowledgeable person would be changed or influenced. We use materiality in determining the nature, timing and extent of our audit work and in evaluating the results of that work.

We determined materiality for the audit of the Trust's financial statements as a whole to be £4,462,000, which is 2% of the Trust's gross operating expenses. This benchmark is considered the most appropriate because we consider users of the financial statements to be most interested in how it has expended its revenue and other funding.

Materiality for the current year is at the same percentage level of gross operating expenses as we determined for the year ended 31 March 2016 as we did not identify any significant changes in the Trust's operations or the environment in which it operates.

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 financial statements.

We determined the threshold at which we will communicate misstatements to the Audit and Risk Committee to be £223,000. In addition we will communicate misstatements below that threshold that, in our view, warrant reporting on qualitative grounds.

Overview of the scope of our audit

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 Trust's circumstances and have been consistently applied and adequately disclosed;

- the reasonableness of significant accounting estimates made by the Chief Executive as Accounting Officer; 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 incorrect based on, or 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.

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 sector bodies in the United Kingdom'. Our responsibilities under the Code of Audit Practice published by the National Audit Office on behalf of the Comptroller and Auditor General (the Code) and those standards 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 is sufficient and appropriate to provide a basis for our opinion.

We are independent of the Trust 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 Trust's business and is risk based, and in particular included an interim visit to evaluate the Trust's internal control relevant to the audit including relevant IT systems and controls over key financial systems.

Overview of the scope of our review of arrangements for securing economy, efficiency and effectiveness in the use of resources

We have undertaken our review in accordance with the Code, having regard to the guidance on the specified criteria issued by the Comptroller and Auditor General in November 2016, as to whether the Trust had proper arrangements to ensure it took properly informed decisions and deployed resources to achieve planned and sustainable outcomes for taxpayers and local people. The Comptroller and Auditor General determined these criteria as that necessary for us to consider under the Code in satisfying ourselves whether the Trust put in place proper arrangements for securing economy, efficiency and effectiveness in its use of resources for the year ended 31 March 2017, and to report by exception where we are not satisfied.

We planned our work in accordance with the Code. Based on our risk assessment, we undertook such work as we considered necessary.

Other reporting required by regulations

Our opinion on other matters required by the Code is unmodified

In our opinion:

- the parts of the Remuneration Report and Staff Report to be audited have been properly prepared in accordance with IFRSs as adopted by the European Union, as interpreted and adapted by the NHS foundation trust annual reporting manual 2016/17 and the requirements of the National Health Service Act 2006; and
- the other information published together with the audited financial statements in the annual report for the financial year for which the financial statements are prepared is consistent with the audited financial statements.

Matters on which we are required to report by exception

Under the ISAs (UK and Ireland), we are 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 Trust 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 we communicated to the Audit Committee which we consider should have been disclosed.

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 2016/17 or is misleading or inconsistent with the information of which we are aware from our audit. We are not required to consider whether the Annual Governance Statement addresses all risks and controls or that risks are satisfactorily addressed by internal controls; or
- we have reported a matter in the public interest under Schedule 10 (3) of the National Health Service Act 2006 in the course of, or at the conclusion of the audit; or
- we have referred a matter to the regulator under Schedule 10 (6) of the National Health Service Act 2006 because we had reason to believe that the Trust, or a director or officer of the Trust, was about to make, or had made, a decision which involved or would involve the incurring of expenditure that was unlawful, or was about to take, or had taken a course of action which, if followed to its conclusion, would be unlawful and likely to cause a loss or deficiency; 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 for the year ended 31 March 2017.

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

Responsibilities for the financial statements and the audit

What the Chief Executive, as Accounting Officer, is responsible for:

As explained more fully in the Statement of Accounting Officer's responsibilities, the Chief Executive, as Accounting Officer, is responsible for the preparation of the financial statements in the form and on the basis set out in the Accounts Directions included in the NHS foundation trust annual reporting manual 2016/17 and for being satisfied that they give a true and fair view. The Accounting Officer is also responsible for the arrangements to secure economy, efficiency and effectiveness in the use of the Trust's resources.

What we are responsible for:

Our responsibility is to audit and express an opinion on the financial statements in accordance with applicable law, the Code and International Standards on Auditing (UK and Ireland). Those standards require us to comply with the Auditing Practices Board's Ethical Standards for Auditors.

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

Certificate

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

Elizabeth Jackson
Associate Director
for and on behalf of Grant Thornton UK LLP

Grant Thornton House
Melton Street
Euston Square
London
NW1 2EP

25 May 2017

The graphic for 'Annual accounts' features the text 'Annual accounts' in white, centered between two white circular symbols. Each symbol is composed of two concentric arcs, resembling a stylized 'C' or a partial circle.



Foreword to the accounts

Kent Community Health NHS Foundation Trust

These accounts, for the year ended 31 March 2017, have been prepared by Kent Community Health NHS Foundation Trust in accordance with paragraphs 24 & 25 of Schedule 7 within the National Health Service Act 2006.

Signed: Date:

Paul Bentley, Chief Executive Officer

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

Statement of comprehensive Income for the year ended 31 March 2017

		2016/17	2015/16
	Note	£000	£000
Operating income from patient care activities	3	218,204	230,179
Other operating income	4	9,480	4,417
Total operating income from continuing operations		227,684	234,596
Operating expenses	5, 7	(223,108)	(231,158)
Operating surplus/(deficit) from continuing operations		4,576	3,438
Finance income	10	59	60
Finance expenses	11	(5)	-
PDC dividends payable		-	-
Net finance income/(costs)		54	60
Gains/(losses) on disposal of non-current assets	12	-	11
Surplus/(deficit) for the year from continuing operations		4,630	3,509
Surplus/(deficit) on discontinued operations and the gain/(loss) on disposal of discontinued operations	14	-	-
Surplus/(deficit) for the year		4,630	3,509
Other comprehensive income		-	-
Total comprehensive income/(expense) for the period		4,630	3,509

The notes on pages 99 to 139 form part of this account.

Statement of financial position as at 31 March 2017

	Note	31 March 2017 £000	31 March 2016 £000
Non-current assets			
Intangible assets	15	238	49
Property, plant and equipment	16	16,717	15,393
Trade and other receivables	21	68	154
Total non-current assets		17,023	15,596
Current assets			
Inventories	20	-	-
Trade and other receivables	21	18,345	14,506
Cash and cash equivalents	22	19,167	23,027
Total current assets		37,512	37,533
Current liabilities			
Trade and other payables	23	(23,247)	(29,300)
Other liabilities	24	(585)	(318)
Provisions	27	(3,584)	(1,022)
Total current liabilities		(27,416)	(30,640)
Total assets less current liabilities		27,119	22,489
Total non-current liabilities		-	-
Total assets employed		27,119	22,489
Financed by			
Public dividend capital		2,613	2,613
Revaluation reserve		766	766
Income and expenditure reserve		23,740	19,110
Total taxpayers' equity		27,119	22,489

The notes on pages 99 to 139 form part of this account.

The financial statements on pages 94 to 98 were approved by the Board on 25 May 2017 and on its behalf by:

Signed.....

Name: Paul Bentley, Chief Executive Officer

Statement of changes in equity for the year ended 31 March 2017

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

Statement of Changes in Equity for the year ended 31 March 2016

	Public dividend capital £000	Revaluation reserve £000	Income and expenditure reserve £000	Total £000
Taxpayers' and others' equity at 1 April 2015 - brought forward	2,613	766	15,601	18,980
Surplus/(deficit) for the year	-	-	3,509	3,509
Taxpayers' and others' equity at 31 March 2016	2,613	766	19,110	22,489

Information on reserves

Public dividend capital

Public dividend capital (PDC) is a type of public sector equity finance based on the excess of assets over liabilities at the time of establishment of the predecessor NHS 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 (see note 1.13).

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.

Statement of cash flows for the year ended 31 March 2017

	Note	2016/17 £000	2015/16 £000
Cash flows from operating activities			
Operating surplus/(deficit)		4,576	3,438
Non-cash income and expense:			
Depreciation and amortisation	5.1	2,591	2,276
(Increase)/decrease in receivables and other assets		(3,780)	(4,271)
Increase/(decrease) in payables and other liabilities		(6,694)	5,719
Increase/(decrease) in provisions		2,562	38
Net cash generated from/(used in) operating activities		(745)	7,200
Cash flows from investing activities			
Interest received		59	60
Purchase of intangible assets		(89)	-
Purchase of property, plant, equipment and investment property		(3,110)	(3,266)
Sales of property, plant, equipment and investment property		3	21
Net cash generated from/(used in) investing activities		(3,137)	(3,185)
Cash flows from financing activities			
Other interest paid		(5)	-
PDC dividend received/(paid)		27	213
Net cash generated from/(used in) financing activities		22	213
Increase/(decrease) in cash and cash equivalents		(3,860)	4,228
Cash and cash equivalents at 1 April		23,027	18,799
Cash and cash equivalents at 31 March	22	19,167	23,027

Notes to the accounts

Note 1 Accounting policies and other information

Basis of preparation

NHS Improvement, in exercising the statutory functions conferred on Monitor, is responsible for issuing an accounts direction to NHS foundation trusts under the NHS Act 2006. NHS Improvement has directed that the financial statements of NHS foundation trusts shall meet the accounting requirements of the Department of Health Group Accounting Manual (DH GAM) which shall be agreed with the Secretary of State. Consequently, the following financial statements have been prepared in accordance with the DH GAM 2016/17 issued by the Department of Health. The accounting policies contained in that manual follow IFRS and HM Treasury's 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.

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 Interests in other entities

NHS Charitable Fund

The NHS foundation trust is the corporate trustee of 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. However, the transactions are immaterial in the context of the group and transactions have not been consolidated. Details of the transactions with the charity are included in the related notes.

Note 1.2 Income

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

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

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

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 annual leave entitlement earned but not taken by employees at the end of the period is recognised in the financial statements to the extent that employees are permitted to carry-forward leave into the following period. Payments for overtime and enhancements are paid one month in arrears and the accounts presented incorporate an accrual for the cost of overtime and enhancements worked in March 2017, but to be paid in April 2017.

Pension costs

NHS pension scheme

Past and present employees are covered by the provisions of the NHS pension scheme. The scheme is an unfunded, defined benefit scheme that covers NHS employers, general practices and other bodies, allowed under the direction of Secretary of State, in England and Wales. It is not possible for the NHS foundation trust to identify its share of the underlying scheme liabilities. Therefore, the scheme is accounted for as a defined contribution scheme.

Employer's pension cost contributions are charged to operating expenses as and when they become due.

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

National Employment Savings Trust (NEST)

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

Note 1.4 Expenditure on other goods and services

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

Note 1.5 Property, plant and equipment

Recognition

Property, plant and equipment is capitalised where:

- it is held for use in delivering services or for administrative purposes
- it is probable that future economic benefits will flow to, or service potential be provided to, the trust
- it is expected to be used for more than one financial year
- the cost of the item can be measured reliably
- the item has a 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, had broadly simultaneous purchase dates, are anticipated to have similar disposal dates and are under single managerial control.
- items forming part of the initial equipping and setting-up cost of a new building, ward or unit, irrespective of their individual or collective cost.

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

Measurement

Valuation

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

Subsequent measurement is as follows:

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

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

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

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

- land and non-specialised buildings – market value for existing use (EUV)
- specialised buildings – depreciated replacement cost on the basis of a modern equivalent asset
- leasehold improvements – in respect of buildings for which the trust is a lessee under an operating lease will be depreciated over the lease duration (or other period deemed appropriate) and carried at depreciated historic cost, as this is not considered to be materially different from current value. Thus improvements are not revalued, and no indexation is applied as the adjustments which would arise are not considered material.

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

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

Subsequent expenditure

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

Revaluation gains and losses

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

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

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

Impairments

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

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

De-recognition

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

- the asset is available for immediate sale in its present condition subject only to terms which are usual and customary for such sales
- the sale must be highly probable, for example:
 - management is committed to a plan to sell the asset
 - an active programme has begun to find a buyer and complete the sale
 - the asset is being actively marketed at a reasonable price
 - the sale is expected to be completed within 12 months of the date of classification as 'held for sale'
 - the actions needed to complete the plan indicate it is unlikely that the plan will be dropped or significant changes made to it.

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

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

Depreciation

Items of property, plant and equipment are depreciated over their remaining useful economic lives in a manner consistent with the consumption of economic or service delivery benefits. The estimated useful life of an asset is the period over which the trust expects to obtain economic benefits or service potential from the asset. This is specific to the trust and may be shorter than the physical life of the asset itself. Estimated useful lives and residual values are reviewed each year end, with the effect of any changes recognised on a prospective basis. Freehold land is considered to have an infinite life and is not depreciated.

Property, plant and equipment which has been reclassified as 'held for sale' ceases to be depreciated upon the reclassification.

Useful economic lives of property, plant and equipment

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

	Minimum life	Maximum life
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 being sold separately from the rest of the trust's business or which arise from contractual or other legal rights. They are recognised only where it is probable that future economic benefits will flow to, or service potential be provided to, the trust, where the cost of the asset can be measured reliably and where the cost is at least £5,000.

Internally generated intangible assets

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

Expenditure on research is not capitalised.

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

- the project is technically feasible to the point of completion and will result in an intangible asset for sale or use
- the trust intends to complete the asset and sell or use it
- the trust has the ability to sell or use the asset
- how the intangible asset will generate probable future economic or service delivery benefits, for example the presence of a market for it or its output, or where it is to be used for internal use, the usefulness of the asset;
- adequate financial, technical and other resources are available to the trust to complete the development and sell or use the asset and
- the trust can measure reliably the expenses attributable to the asset during development.

Software

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

Measurement

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

Subsequently intangible assets are measured at current value in existing use. Where no active market exists, intangible assets are valued at the lower of depreciated replacement cost and the value in use where the asset is income generating. Revaluations gains and losses and impairments are treated in the same manner as for property, plant and equipment. An intangible asset which is surplus with no plan to bring it back into use is valued at fair value under IFRS 13, if it does not meet the requirements of IAS 40 or IFRS 5.

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

Amortisation

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

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:

Intangible assets – purchased	Minimum life	Maximum life
Software	1	5

Note 1.7 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 2016/17.

Note 1.8 Inventories

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

Note 1.9 Financial Instruments

Financial assets

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

Financial assets are initially recognised at fair value.

Financial assets are classified into the following categories:

- financial assets at fair value through profit and loss
- held to maturity investments
- available for sale financial assets
- 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's financial assets consist of accrued and invoiced receivables, and cash. The trust has not issued any loans.

Financial liabilities

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

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

Note 1.10 Leases

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

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

Note 1.11 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 NHS foundation trust pays an annual contribution to the NHSLA, which, in return, settles all clinical negligence claims. Although the NHSLA is administratively responsible for all clinical negligence cases, the legal liability remains with the NHS foundation trust. The total value of clinical negligence provisions carried by the NHSLA on behalf of the NHS foundation trust is disclosed at note 27.2 but is not recognised in the NHS foundation trust's accounts.

Non-clinical risk pooling

The NHS foundation 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 when the liability arises.

Note 1.12 Contingencies

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

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

Note 1.13 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. HM Treasury has determined that PDC is not a financial instrument within the meaning of IAS 32.

A charge, reflecting the cost of capital utilised by the NHS foundation trust, is payable as public dividend capital dividend. The charge is calculated at the rate set by HM Treasury (currently 3.5%) on the average relevant net assets of the NHS foundation trust during the financial year. Relevant net assets are calculated as the value of all assets less the value of all liabilities, except for (i) donated assets (including lottery funded assets), (ii) average daily cash balances held with the Government Banking Service (GBS) and National Loans Fund (NLF) deposits, excluding cash balances held in GBS accounts that relate to a short-term working capital facility, and (iii) any PDC dividend balance receivable or payable. In accordance with the requirements laid down by the Department of Health (as the issuer of PDC), the dividend for the year is calculated on the actual average relevant net assets as set out in the "pre-audit" version of the annual accounts. The dividend thus calculated is not revised should any adjustment to net assets occur as a result of the audit of the annual accounts. For 2016/17 the average carrying amount is negative and thus the trust is not obligated to pay a PDC dividend.

Note 1.14 Value added tax

Most of the activities of the NHS foundation 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 1.15 Corporation tax

The trust has determined that it 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 1.16 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 1.17 Third party assets

Assets belonging to third parties, such as 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 1.18 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 foundation trusts not been bearing their own risks, with insurance premiums then being included as normal revenue expenditure.

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

Note 1.19 Early adoption of standards, amendments and interpretations

No new accounting standards or revisions to existing standards have been adopted early in 2016/17.

Note 1.20 Standards, amendments and interpretations in issue but not yet effective or adopted

The HM Treasury FReM does not require the following standards and Interpretations to be applied in 2016/17. These standards are still subject to HM Treasury FReM interpretation, with IFRS 9 and IFRS 15 being for implementation in 2018/19 and the government implementation date for IFRS 16 still subject to HM Treasury consideration.

- IFRS 9 Financial Instruments – application required for accounting periods beginning on or after 1 January 2018, but not yet adopted by the FReM: Early adoption is not therefore permitted.
- IFRS 15 Revenue for Contracts with Customers – application required for accounting periods beginning on or after 1 January 2018, but not yet adopted by the FReM: Early adoption is not therefore permitted.
- IFRS 16 Leases – application required for accounting periods beginning on or after 1 January 2019, but not yet adopted by the FReM: Early adoption is not therefore permitted.

Note 1.21 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 27.1 provides further analysis of the provisions accounted.

Legal claims

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

Valuation of land and buildings (owned)

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

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

Note 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:

	2016/17	% of total
	£000s	revenue
Clinical commissioning groups	147,757	65%
Local authorities	45,340	20%
NHS England	17,955	8%
	2015/16	% of total
	£000s	revenue
Clinical commissioning groups	159,928	68%
Local authorities	34,585	15%
NHS England	25,784	11%

Note 3 Operating income from patient care activities

Note 3.1 Income from patient care activities (by nature)

	2016/17 £000	2015/16 £000
Community services		
Community services income from CCGs and NHS England	161,645	185,620
Community services income from other commissioners	56,473	44,498
All services		
Private patient income	86	61
Total income from activities	218,204	230,179

Note 3.2 Income from patient care activities (by source)

Income from patient care activities received from:	2016/17 £000	2015/16 £000
CCGs and NHS England	161,645	185,620
Local authorities	45,340	34,585
Other NHS foundation trusts	3,374	3,896
NHS trusts	4,745	3,515
Non-NHS: private patients	86	61
Non-NHS: overseas patients (chargeable to patient)	-	-
NHS injury scheme (was RTA)	371	395
Non NHS: other	2,643	2,107
Total income from activities	218,204	230,179
Of which:		
Related to continuing operations	218,204	230,179
Related to discontinued operations	-	-

Note 4 Other operating income

	2016/17 £000	2015/16 £000
Education and training	2,292	2,979
Charitable and other contributions to expenditure	118	113
Non-patient care services to other bodies	1,489	297
Sustainability and Transformation Fund income	3,212	-
Other income	2,369	1,028
Total other operating income	9,480	4,417
Of which:		
Related to continuing operations	9,480	4,417
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:

	2016/17 £000	2015/16 £000
Income from services designated (or grandfathered) as commissioner requested services	-	212,324
Income from services not designated as commissioner requested services	227,684	22,283
Total	227,684	234,607

In line with guidance from Monitor all foundation trusts' mandatory services were designated as commissioner requested services when licensing began. However, commissioners were required to review this designation by 1 April 2016 and, as a result, none of the trust's services provided in 2016/17 were designated as commissioner requested.

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

No land and buildings assets have been disposed of during the year.

Note 5.1 Operating expenses

	2016/17	2015/16
	£000	£000
Services from NHS foundation trusts	9	108
Services from NHS trusts	644	2,804
Services from CCGs and NHS England	2	-
Employee expenses - executive directors	1,263	1,250
Remuneration of non-executive directors	155	166
Employee expenses - staff	158,311	166,994
Supplies and services - clinical	20,064	23,535
Supplies and services - general	1,386	1,645
Establishment	6,017	5,314
Transport	5,474	4,820
Premises	8,051	5,349
Increase/(decrease) in provision for impairment of receivables	117	(53)
Drug costs	4,595	4,677
Rentals under operating leases	9,060	8,919
Depreciation on property, plant and equipment	2,561	2,254
Amortisation on intangible assets	30	22
Audit fees payable to the external auditor		
audit services- statutory audit	59	58
other auditor remuneration (external auditor only)	-	41
Clinical negligence	249	212
Legal fees	223	757
Consultancy costs	440	518
Internal audit costs	121	152
Training, courses and conferences	725	666
Patient travel	1	1
Redundancy	2,942	324
Hospitality	6	25
Insurance	167	183
Other services, eg external payroll	436	413
Losses, ex gratia & special payments	-	4
Total	223,108	231,158
Of which:		
Related to continuing operations	223,108	231,158

Note 5.2 Other auditor remuneration

	2016/17 £000	2015/16 £000
Other auditor remuneration paid to the external auditor:		
1. Audit of accounts of any associate of the trust	-	-
2. Audit-related assurance services	-	-
3. Taxation compliance services	-	-
4. All taxation advisory services not falling within item 3 above	-	-
5. Internal audit services	-	-
6. All assurance services not falling within items 1 to 5	-	-
7. Corporate finance transaction services not falling within items 1 to 6 above	-	-
8. Other non-audit services not falling within items 2 to 7 above	-	41
Total	-	41

Note 5.3 Limitation on auditor's liability

In accordance with the terms of engagement with the trust's 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 £2million in the aggregate in respect of all such services.

Note 6 Impairment of assets

No assets were impaired in 2016/17 (nil in 2015/16).

Note 7 Employee benefits

			2016/17	2015/16
	Permanent	Other	Total	Total
	£000	£000	£000	£000
Salaries and wages	121,925	3,275	125,200	131,203
Social security costs	10,176	204	10,380	7,912
Employer's contributions to NHS pensions	15,856	248	16,104	16,770
Termination benefits	115	-	115	344
Temporary staff - agency/contract staff	-	7,947	7,947	13,089
Total gross staff costs	148,072	11,674	159,746	169,318
Recoveries in respect of seconded staff	(54)	-	(54)	(147)
Total staff costs	148,018	11,674	159,692	169,171
Of which				
Costs capitalised as part of assets	3	-	3	583

Note 7.1 Retirements due to ill-health

During 2016/17 there were 4 early retirements from the trust agreed on the grounds of ill-health (7 in the year ended 31 March 2016). The estimated additional pension liabilities of these ill-health retirements is £270k (£274k in 2015/16).

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

Note 7.2 Directors' remuneration

The aggregate amounts payable to

	2016/17	2015/16
	£000	£000
Salary	893	857
Taxable benefits	15	19
Performance related bonuses	15	0
Employer's pension contributions	99	86
Total	1,022	962

Note 8 Pension costs

NHS schemes

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

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

a) Accounting valuation

A valuation of scheme liability is carried out annually by the scheme actuary (currently the government actuary's department) as at the end of the reporting period. This uses an actuarial assessment for the previous accounting period in conjunction with updated membership and financial data for the current reporting period, and are accepted as providing suitably robust figures for financial reporting purposes. The valuation of scheme liability as at 31 March 2017, is based on valuation data as 31 March 2016, updated to 31 March 2017 with summary global member and accounting data. In undertaking this actuarial assessment, the methodology prescribed in IAS 19, relevant FReM interpretations, and the discount rate prescribed by HM Treasury have also been used.

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

b) Full actuarial (funding) valuation

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

The last published actuarial valuation undertaken for the NHS pension scheme was completed for the year ending 31 March 2012. The scheme regulations allow for the level of contribution rates to be changed by the Secretary of State for Health, with the consent of HM Treasury, and consideration of the advice of the scheme Actuary and appropriate employee and employer representatives, as deemed appropriate.

The next actuarial valuation is to be carried out as at 31 March 2016. This will set the employer contribution rate payable from April 2019 and will consider the cost of the scheme relative to the employer cost cap. There are provisions in the Public Service Pension Act 2013 to adjust member benefits or contribution rates if the cost of the scheme changes by more than 2% of pay. Subject to this 'employer cost cap' assessment, any required revisions to member benefits or contribution rates will be determined by the Secretary of State for Health after consultation with the relevant stakeholders.

The trust's estimated annual contributions in relation to the NHS Pension Scheme for 2017/18 are £15,554k.

Other schemes

The trust participates in the National Employees Savings Trust (NEST) scheme as an alternative for those employees who are not eligible to join the NHS Pension scheme. NEST is a defined contribution scheme with a phased employer contribution rate, currently 1%.

Note 9 Operating leases

Note 9.1 Kent Community Health NHS Foundation Trust as a lessee

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

	2016/17 £000	2015/16 £000
Operating lease expense		
Minimum lease payments	9,060	8,919
Contingent rents	-	-
Less sublease payments received	-	-
Total	9,060	8,919
	2017 £000	2016 £000
Future minimum lease payments due:		
- not later than one year;	2,739	2,867
- later than one year and not later than five years;	6,786	6,482
- later than five years.	4,401	4,297
Total	13,926	13,646
Future minimum sublease payments to be received	-	-

Note 10 Finance income

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

	2016/17	2015/16
	£000	£000
Interest on bank accounts	59	60
Total	59	60

Note 11.1 Finance expenditure

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

	2016/17	2015/16
	£000	£000
Interest expense:		
Interest on late payment of commercial debt	5	-
Total interest expense	5	-

Note 11.2 The late payment of commercial debts (interest) Act 1998

	2016/17	2015/16
	£000	£000
Amounts included within interest payable arising from claims made under this legislation	5	-
Compensation paid to cover debt recovery costs under this legislation	-	-

Note 12 Gains/losses on disposal/de-recognition of non-current assets

	2016/17 £000	2015/16 £000
Profit on disposal of non-current assets	-	11
Loss on disposal of non-current assets	-	-
Net profit/(loss) on disposal of non-current assets	-	11

Note 13 Corporation tax

The trust has no corporation tax liability as outlined in note 1.15.

Note 14 Discontinued operations

The trust has no discontinued operations.

Note 15.1 Intangible assets – 2016/17

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

Note 15.2 Intangible assets – 2015/16

	Software licences £000	Intangible assets under construction £000	Total £000
Valuation/gross cost at 1 April 2015	71	22	93
Reclassifications	22	(22)	-
Valuation/gross cost at 31 March 2016	93	-	93
Amortisation at 1 April 2015	22	-	22
Provided during the year	22	-	22
Amortisation at 31 March 2016	44	-	44
Net book value at 31 March 2016	49	-	49
Net book value at 1 April 2015	49	22	71

Note 16.1 Property, plant and equipment – 2016/17

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

Note 16.2 Property, plant and equipment – 2015/16

	Land	Buildings excluding dwellings	Assets under construction	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000
Valuation/gross cost at 1 April 2015	1,472	7,280	314	1,474	566	7,813	629	19,548
Additions	-	348	158	449	-	2,206	117	3,278
Reclassifications	-	87	(289)	42	-	148	12	-
Disposals / derecognition	-	-	-	-	(80)	-	-	(80)
Valuation/gross cost at 31 March 2016	1,472	7,715	183	1,965	486	10,167	758	22,746
Accumulated depreciation at 1 April 2015	-	1,102	-	490	424	2,732	421	5,169
Provided during the year	-	757	-	230	103	1,069	95	2,254
Disposals / derecognition	-	-	-	-	(70)	-	-	(70)
Accumulated depreciation at 31 March	-	1,859	-	720	457	3,801	516	7,353
Net book value at 31 March 2016	1,472	5,856	183	1,245	29	6,366	242	15,393
Net book value at 1 April 2015	1,472	6,178	314	984	142	5,081	208	14,379

Note 16.3 Property, plant and equipment – 2016/17

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

Note 16.4 Property, plant and equipment financing – 2015/16

	Land £000	Buildings excluding dwellings £000	Assets under construction £000	Plant & machinery £000	Transport equipment £000	Information technology £000	Furniture & fittings £000	Total £000
Net book value at 31 March 2016								
Owned	1,472	5,856	183	1,245	29	6,366	242	15,393
NBV total at 31 March 2016	1,472	5,856	183	1,245	29	6,366	242	15,393

Note 17 Revaluations of property, plant and equipment

A revaluation exercise was undertaken of the trust's owned buildings and land in March 2017, to consider whether movement in the value of these assets for the 12-month period to 31 March 2017 had been material. This followed the last full revaluation exercise carried out as at 28 February 2015. Both revaluation exercises were completed by Stephen Boshier MRICS, of Boshier and Company Chartered Surveyors, an independent valuer.

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.

Having researched the movement in market value of healthcare property over the past 12 months in Kent, the valuer is of the opinion that there has not been a material change in the value of the trust's freehold operational assets during the 12-month period to 31 March 2017. The change in capital value over the period is limited to an increase of 0-5% and therefore deemed not a material movement.

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

Note 18 Investments – 2016/17

The trust has no investments (including investments in property). Nil for March 2016.

Note 19 Disclosure of interests in other entities

The trust has no interests in other entities other than those disclosed in note 1.1

Note 20 Inventories

The trust holds no material inventories.

Note 21.1 Trade receivables and other receivables

	31 March 2017 £000	31 March 2016 £000
Current		
Trade receivables due from NHS bodies	8,593	5,230
Receivables due from NHS charities	1	26
Provision for impaired receivables	(389)	(356)
Prepayments (non-PFI)	1,481	1,804
Accrued income	2,080	353
PDC dividend receivable	-	27
VAT receivable	612	209
Other receivables	5,967	7,213
Total current trade and other receivables	18,345	14,506
Non-current		
Prepayments (non-PFI)	68	154
Total non-current trade and other receivables	68	154

Note 21.2 Provision for impairment of receivables

	2016/17 £000	2015/16 £000
At 1 April	356	457
Increase in provision	188	(6)
Amounts utilised	(84)	(48)
Unused amounts reversed	(71)	(47)
At 31 March	389	356

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

Note 21.3 Analysis of financial assets

	31 March 2017		31 March 2016	
	Trade and other receivables	Investments & Other financial assets	Trade and other receivables	Investments & Other financial assets
	£000	£000	£000	£000
Ageing of impaired financial assets				
0 - 30 days	89	-	-	-
30-60 Days	-	-	-	-
60-90 days	19	-	6	-
90- 180 days	16	-	13	-
Over 180 days	265	-	337	-
Total	389	-	356	-
Ageing of non-impaired financial assets past their due date				
0 - 30 days	183	-	791	-
30-60 Days	388	-	404	-
60-90 days	98	-	462	-
90- 180 days	155	-	518	-
Over 180 days	85	-	795	-
Total	909	-	2,970	-

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

Note 22 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.

	2016/17	2015/16
	£000	£000
At 1 April	23,027	18,799
Net change in year	(3,860)	4,228
At 31 March	19,167	23,027
Broken down into:		
Cash at commercial banks and in hand	49	58
Cash with the Government Banking Service	2,118	5,469
Deposits with the National Loans Fund	17,000	17,500
Total cash and cash equivalents as in SoFP	19,167	23,027
Total cash and cash equivalents as in SoCF	19,167	23,027

Note 22.1 Third party assets held by the NHS foundation trust

The trust held no cash and cash equivalents which relate to monies held by the foundation trust on behalf of patients or other parties. Nil for 2015/16.

Note 23.1 Trade and other payables

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.

	31 March 2017 £000	31 March 2016 £000
Current		
NHS trade payables	555	724
Other trade payables	4,766	1,524
Capital payables	1,581	673
Social security costs	1,767	1,517
Other taxes payable	985	1,148
Other payables	2,075	2,240
Accruals	11,518	21,474
PDC dividend payable	-	-
Total current trade and other payables	23,247	29,300
Total non-current trade and other payables	-	-

Note 23.2 Early retirements in NHS payables above

There are no early retirement payables, Nil for 2015/16.

Note 24 Other liabilities

	31 March 2017 £000	31 March 2016 £000
Current		
Other deferred income	585	318
Total other current liabilities	585	318

Note 25 Borrowings

The trust has no borrowings. Nil for 2015/16.

Note 26 Finance leases

Note 26.1 Kent Community Health NHS Foundation Trust as a lessor

The trust has no finance lease arrangements. Nil for 2015/16.

Note 26.2 Kent Community Health NHS Foundation Trust as a lessee

The trust has no finance lease obligations.

Note 27.1 Provisions for liabilities and charges analysis

	Other legal claims £000	Redundancy £000	Total £000
At 1 April 2016	640	382	1,022
Arising during the year	199	3,456	3,655
Utilised during the year	(324)	(115)	(439)
Reversed unused	(270)	(384)	(654)
At 31 March 2017	245	3,339	3,584
Expected timing of cash flows:			
- not later than one year;	245	3,339	3,584
Total	245	3,339	3,584

The redundancy provision is a recognition of the expected redundancy costs associated with service changes. These are recognised following the development of detailed formal plans for service changes with uncertainties typically about which staff will be successful with re-deployment etc. The legal provision includes on-going Employment Tribunals and the provision for Liabilities to third Parties Scheme (LTPS) claims administered and informed by the NHSLA. See also accounting policy Notes 1.11 and 1.21.

Note 27.2 Clinical negligence liabilities

At 31 March 2017, £2,803k was included in provisions of the NHSLA in respect of clinical negligence liabilities of Kent Community Health NHS Foundation Trust (31 March 2016: £1,826k).

Note 28 Contingent assets and liabilities

	31 March 2017 £000	31 March 2016 £000
Value of contingent liabilities		
NHS Litigation Authority legal claims	(13)	(40)
Gross value of contingent liabilities	(13)	(40)
Amounts recoverable against liabilities	-	-
Net value of contingent liabilities	(13)	(40)
Net value of contingent assets	-	-

Note 29 Contractual capital commitments

	31 March 2017 £000	31 March 2016 £000
Property, plant and equipment	1,136	122
Intangible assets	-	-
Total	1,136	122

Note 29.1 Other financial commitments

The trust is committed to making payments under non-cancellable contracts (which are not leases, PFI contracts or other service concession arrangements) at 31 March 2017 as follows, analysed by the period during which the payment is made:

	31 March 2017 £000	31 March 2016 £000
not later than 1 year	652	703
after 1 year and not later than 5 years	1,003	149
paid thereafter	969	0
Total	2,624	852

Note 30 Defined benefit pension schemes

The trust has no defined benefit pension schemes.

Note 31 Financial instruments

Note 31.1 Financial risk management

Financial reporting standard IFRS 7 requires disclosure of the role that financial instruments have had during the period in creating or changing the risks a body faces in undertaking its activities. Due to the continuing service provider relationship that Kent Community Health NHS Foundation Trust (KCHFT) has with NHS and local authority commissioners and the way those commissioners are financed, the trust is not exposed to the degree of financial risk faced by business entities. Also, financial instruments play a much more limited role in creating or changing risk than would be typical of listed companies, to which the financial reporting standards mainly apply. KCHFT as an NHS foundation trust has limited powers to borrow or invest surplus funds and financial assets and liabilities are generated by day-to-day operational activities rather than being held to change the risks facing the organisation in undertaking its activities.

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

Currency risk

The trust is a wholly UK-based organisation with the great majority of transactions, assets and liabilities being in the UK and sterling based. The trust has no overseas

Interest rate risk

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

Credit risk

As the majority of the trust's revenue comes from contracts with other public sector bodies, the organisation has low exposure to credit risk. The maximum exposure as at 31 March 2017 is in receivables from customers, as disclosed in the trade and other receivables note. However the trust utilises external tracing and debt collection agencies, and court procedures, to pursue overdue debt.

Liquidity risk

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

Note 31.2 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 2017					
Trade and other receivables excluding non financial assets	16,864	-	-	-	16,864
Cash and cash equivalents at bank and in hand	19,167	-	-	-	19,167
Total at 31 March 2017	36,031	-	-	-	36,031
	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 2016					
Trade and other receivables excluding non financial assets	12,702	-	-	-	12,702
Cash and cash equivalents at bank and in hand	23,027	-	-	-	23,027
Total at 31 March 2016	35,729	-	-	-	35,729

Note 31.3 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 2017			
Trade and other payables excluding non financial liabilities	23,247	-	23,247
Total at 31 March 2017	23,247	-	23,247
	Other financial liabilities £000	Liabilities at fair value through the I&E £000	Total £000
Liabilities as per SoFP as at 31 March 2016			
Trade and other payables excluding non financial liabilities	29,300	-	29,300
Total at 31 March 2016	29,300	-	29,300

Note 31.4 Maturity of financial liabilities

	31 March 2017 £000	31 March 2016 £000
In one year or less	23,247	29,300
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	23,247	29,300

Note 31.5 Fair values of financial assets and financial liabilities at 31 March 2017

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

Note 32 Losses and special payments

	2016/17		2015/16	
	Total number of cases Number	Total value of cases £000	Total number of cases Number	Total value of cases £000
Losses				
Cash losses	-	-	1	8
Bad debts and claims abandoned	158	84	131	48
Total losses	158	84	132	56
Special payments				
Ex-gratia payments in respect of:				
- loss of personal effects	-	-	2	1
- personal injury with advice	7	51	1	10
- other	4	1	1	3
Total special payments	11	52	4	14
Total losses and special payments	169	136	136	70
Compensation payments received	-	-	-	-

Note 33 Events after the end of the reporting period

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

Note 34 Related parties

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

As at 31 March 2017 the trust has a receivable of £1k with Kent Community Health Charitable Fund whose Corporate Trustee is the trust's Board of Directors. The accounts of the charity are available separately and are not included in these accounts as per note 1.1.

	Receivables		Payables	
	31 March 2017 £000	31 March 2016 £000	31 March 2017 £000	31 March 2016 £000
Department of Health	-	27	-	-
NHS England and clinical commissioning groups	8,338	3,518	201	2,465
NHS trusts	1,118	1,447	1,454	1,833
NHS foundation trusts	1,123	836	1,847	1,097
Other DH bodies	47	543	5,077	6,763
NHS Shared Business Services		-	41	33
Local authorities	4,761	5,249	647	1,455
Other government departments*	17,673	17,766	4,826	4,860
Total	33,060	29,386	14,093	18,506

*includes short-term deposit with the HM Treasury National Loans Fund

	Income		Expenditure	
	31 March 2017 £000	31 March 2016 £000	31 March 2017 £000	31 March 2016 £000
Department of Health	-	-	-	2
NHS England and clinical commissioning groups	165,712	185,715	119	-
NHS trusts	5,050	4,037	3,726	6,688
NHS foundation trusts	3,743	4,058	3,810	3,921
Health Education England	1,810	2,339	6	-
Other DH bodies	1,358	110	11,365	7,872
NHS Shared Business Services	-	-	436	413
Local authorities	45,340	34,585	90	779
Other government departments*	-	-	26,484	24,682
Total	223,013	230,844	46,036	44,357

Note 35 Better payment practice code

Better payment practice code	2016/17 Number	2016/17 £000s
Non-NHS Payables		
Total Non-NHS trade invoices paid in the period	42,102	73,073
Total Non-NHS trade invoices paid within target	40,755	70,249
Percentage of NHS trade invoices paid within target	96.80%	96.14%
NHS Payables		
Total NHS trade invoices paid in the period	1,962	12,707
Total NHS trade invoices paid within target	1,782	10,699
Percentage of NHS trade invoices paid within target	90.83%	84.20%
Total		
Total Non-NHS and NHS trade invoices paid in the period	44,064	85,780
Total Non-NHS and NHS trade invoices paid within target	42,537	80,949
Percentage of Non-NHS and NHS trade invoices paid within target	96.53%	94.37%

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.



Kent Community Health
NHS Foundation Trust



Quality Report

2016 to 2017



 **we care** 

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Part one

1.1 Statement on quality from the chief executive

Welcome to our Quality Report for Kent Community Health NHS Foundation Trust for 2016-17.

Providing high-quality care for our patients is an absolute priority. It is central to our values and at the heart of our vision.

Our staff strive to provide excellent care and we continually aim to improve the quality of our services for our patients.

It has been a challenging year across the NHS. Nationally, our acute hospitals have seen a huge increase in people seeking treatment and, as a community trust, we are caring for more seriously unwell, vulnerable and frail patients who are more prone to infections, pressure ulcers and falls.

To meet these challenges, our dedicated teams have had to work even harder and we have introduced a number of initiatives to tackle these. For example, in the summer we introduced new training to improve identification and treatment of moisture lesions, which increase during hot weather and we are taking part in a national NHS Improvement project to reduce falls, which we are piloting in two of our community hospitals.

We know how important safe care and effective treatment is and this has been endorsed by the Care Quality Commission, which rated the trust as GOOD. However, we are not complacent and our Board closely monitors performance in every area of patient care and our Chief Nurse Ali Strowman is committed to improvements.

Significant progress has been made to improve our clinical effectiveness, with an increase in research and innovation. Nearly 300 patients were recruited to national research studies and innovation will be a key focus for 2017 – 2020.

We are a learning organisation, striving to learn lessons when care does not meet expectations and implementing changes to improve standards. We share lessons through our monthly improving patient care series, Board-led walkabouts, 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.

Our Board is also visible on our wards and spends time on the frontline shadowing staff to see the service from their eyes and also from the patient. Our chief nurse works clinically for a day every other week and other Board members take quality equally as seriously. For example, our Chief Operating Officer Lesley Strong recently spent a day with our community nurses in Paddock Wood, while our Corporate Services Director Natalie Davies rolled up her sleeves to join our domestic staff in Swale.

We are proud of our culture of compassionate care – and I see this with my own eyes when I visit the wards of our community hospitals or spend a morning with our teams.



Kent Community Health

NHS Foundation Trust

I am most proud of what our patients say and more than 97.5 per cent of our patients and clients would recommend the service they received from us, which is an increase on last year. We report our patient experience and complaints in public reports to the Board and on our websites. 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.

Our Council of Governors, made up of local people, staff and representatives from partners organisations, has a leading voice in the future of community services. We have signed up more than 12,500 members, who along with our staff, have a greater say in the running of our trust.

Our People Strategy, published in March 2017, sets out our dedication and investment to build a highly-competent workforce through education that can demonstrate courage to innovate and challenge to improve patient care.

We work closely with clinical commissioning groups, our health and social care partners, NHS England, NHS Improvement and the voluntary sector to deliver joined-up care which meets people's needs – and are ready to meet the challenges and opportunities set out in the Kent and Medway Sustainability and Transformation Plan, as well as in other areas where we provide services.

You can read 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 accounting 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.

Paul Bentley, Chief Executive:

Date:

Part two

Priorities for improvement and statements of assurance from the Board

2.1 Priorities for improvement

KCHFT is responsible for providing a wide range of community-based NHS services for adults and children in Kent. Our 5,100 staff deliver care in people's own homes, nursing homes, GP surgeries, clinics, community hospitals and in mobile units.

Our vision is to deliver excellent care and to improve the health of the communities we serve.

Our mission is to provide high-quality, value for money, community-based services.

Our goals are to:

- work with GPs in each locality to build high performing local integrated teams, based around groups of general practices, which prevent people from becoming unwell
- dedicate time, resources, expertise and leadership to fully implement the Home First service across Kent;
- ensure patients and clinicians have access to high-quality specialist community services
- make a step change impact in prevention and health promotion in Kent.

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

- patient safety
- clinical effectiveness – how well the care provided works
- patient experience – how patients experience the care they receive.

Our priorities last year

Each year, we develop our priorities for the coming year through consultation with our partners, service users and families.

Last year, we set out our priorities:

Patient experience

- Attract, retain and support the best staff, who feel valued and have access to development that meets their needs.
- To strengthen involvement and engagement with patients and their loved ones through strong communication, underpinning every decision made and their care.

Patient safety

- Support staff to provide the safest care to our patients by adopting the best practice evidenced through working with the Patient Safety Collaborative.

Clinical effectiveness

- To develop local and national relationships and partnerships that support the integrated working, which benefits the patient from the very young to the end-of-life.

These are underpinned by enabling workstreams that support quality care:

Enabling strategies

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

Quality achievements 2016-17

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

Section 3 of this report explains in more detail what we have achieved over the past year, and those areas we need to improve upon.

Patient experience

- **66,022** patient experience surveys completed across the trust.
- **47.4%** of all community hospital patients completed surveys sharing their experience.
- **97.52%** score for Friends and Family Test.
- **100%** NCMP offered to year R and year 6 children.
- Increase by **14.84%** of health checks completed.
- More than **3,100** four-week smoking quits.

Patient safety

- **0** avoidable pressure ulcers in children's community nursing.
- **24%** reduction in falls in community hospitals.
- **22%** reduction in falls with harms in community hospitals.
- **93%** of children seen within four weeks of referral to audiology.
- **5%** reduction in hospital acquired catheter associated UTIs and UTIs.
- **10%** reduction in safemed administration errors.
- **96%** compliance with infection prevention and control training.
- **90%** compliance with hand hygiene training.

Clinical effectiveness

- **254%** of the target number of patients enrolled in NIHR portfolio research studies.
- Improved staff survey scores for staff raising concerns, staff engagement, quality of appraisal and strategic aims of the trust.

Our priorities for 2017-18

Following consultation with our stakeholders, we have agreed the following quality priorities for the forthcoming year:

Patient experience

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

Patient safety

- **10%** reduction in falls with harm in our community hospitals.
- **20%** reduction in category 3 and 4 avoidable pressure ulcers acquired in our care.
- **10%** reduction in category 2 avoidable pressure ulcers acquired in our care.
- No more than **12** catheter associated urinary tract infection acquired in our care.

Clinical effectiveness

- To improve wound healing times by **5%** in our wound medicine centres.
- The Community Hospital Environments to work towards becoming dementia friendly as required by the Hospital Charter 2020, including Tier 2 training for staff in these areas.
- At least **200** patients enrolled in NIHR portfolio studies.

2.2 Statements of assurance from the Board

- 1.0** During 2016-17 Kent Community Health NHS Foundation Trust (KCHFT) provided and/or sub-contracted 45 relevant health services.
- 1.1** KCHFT has reviewed all the data available to them on the quality of care in all of these relevant health services.
- 1.2** The income generated by the relevant health services reviewed in 2016/17 represents 100% of the total income generated from the provision of relevant health services by KCHFT for 2016/17.
- 2.0** During 2016/17, three national clinical audit and no national confidential enquiries covered relevant health services that KCHFT provides.
- 2.1** During that period, KCHFT 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 national clinical audits and national confidential enquiries that KCHFT was eligible to participate in during 2016/17 are as follows:
- o Chronic obstructive pulmonary disease (COPD)
 - o Sentinel stroke national audit programme
 - o Diabetes foot care audit
 - o Confidential enquiries
 - o Chronic neurodisability focussing on cerebral palsy study.
- 2.3** The national clinical audits and national confidential enquiries that KCHFT participated in during 2016/17 are as follows:
- o National Chronic obstructive pulmonary disease (COPD)
 - o Sentinel stroke national audit programme
 - o National diabetes foot care audit
 - o Confidential enquiries
 - o Chronic neurodisability focussing on cerebral palsy study.
- 2.4** The national clinical audits and national confidential enquiries that KCHFT participated in, and for which data collected was completed during 2016/17 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
Statement on quality from the chief executive	Data collection in progress
Sentinel stroke national audit programme	N/A no set case number required
National diabetes foot care audit	Data collection in progress
National confidential enquiry title	
Chronic neurodisability focussing on cerebral palsy study	Not applicable: organisational survey completed by Allied Health Professional paediatric outpatient care. Not eligible for clinical audit element.

- 2.5-** KCHFT was not required to review any national audits due to none being published during the reporting period.
- 2.6**
- 2.7-** The reports of 99 local clinical audits were reviewed by the provider in 2016/17 and KCHFT intends to take the following actions to improve the quality of healthcare provided:
- 2.8**
- Podiatric surgery service is to introduce peer checking to make sure that medication, allergies and next of kin information have all been documented during the first consultation or at pre-operative assessment (P/038/16).
 - Heads of relevant services must update their risk registers to reflect the risk that arises as a result of a failure to demonstrate compliance with trust policy on obtaining written delegated consent (P/050/16).
 - The consent form for the use of acupuncture is to be revised to include two new tick boxes as prompts to provide patients with patient information leaflet and Visual Analogue Scale (P/017/16).
 - As a result of the lower limb audit, the tissue viability nurses will develop and distribute a standardised wound assessment pack for staff until this becomes available on the electronic patient record. This will support the management of wounds. The clinical pathway for wounds is to be re-launched (P/039/16A).
 - The Speech and Language Service will create a screening assessment for auditory discrimination to ensure clients meet criteria for entry to the service (P/023/16).
 - Monthly audits to be undertaken by long-term services and community hospitals to gain assurance that the pressure damage prevention model and prevention strategy has been fully implemented (P /009/16).
 - A learning resource pack for people with learning disabilities and their carers/families will be developed. This will help patients improve early identification of clinical conditions, improved pain symptom management and self-management of condition (P/ 040/16).
 - Health visiting services will increase awareness to clients about how to access the Domestic Violence and Abuse Service. All red books will have inserts with the information relating to domestic abuse included and will be provided at every visit after a family have moved into the area. In addition, awareness will be raised with all nursery nurses to ensure they know about the domestic abuse page in the red book (P/065/15).
- 3** The number of patients receiving relevant health services provided or sub-contracted by KCHFT in 2016/17 that were recruited during that period to participate in research approved by a research ethics committee is 131.
- 4** A proportion of KCHFT's income in the financial year 2016/17 was conditional on achieving quality improvement and innovation goals agreed between KCHFT and:
- West Kent Clinical Commissioning Group,
 - Dartford Gravesham and Swanley, and Swale Clinical Commissioning Group,
 - Thanet Clinical Commissioning Group,
 - South Kent Coast Clinical Commissioning Group, Canterbury and Coastal Clinical Commissioning Group, Ashford Clinical Commissioning Group,
 - High Weald Lewes and Haven Clinical Commissioning Group, and
 - NHS England
- through the commissioning for quality and innovation payment framework.
- Further details of the agreed goals for the financial year 2016/17 and for the following 12-month period are available upon request.

5-5.1 KCHFT is required to register with the Care Quality Commission and its current registration status is registered with no conditions.

The Care Quality Commission has not taken enforcement action against KCHFT during 2016-17.

7-7.1 Kent Community Health NHS Foundation Trust has not participated in any special reviews or investigations by the CQC during the reporting period.

8-8.1 KCHFT submitted 120,082 records during 2016/17 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:

- 99.9% for admitted patient care
- 99.6% for accident and emergency care.

The percentage of records which included the patient's valid General Medical Practice Code was:

- 100% for admitted patient care
- 99.12% for accident and emergency care.

9 KCHFT information governance assessment report overall score for 1 April 2016 to 31 March 2017 was 88% and was graded satisfactory (green).

10-10.1 KCHFT was not subject to the payment by results clinical coding audit during 2016-17 by the Audit Commission.

11 KCHFT will be taking the following actions to improve data quality: None required.

2.3 Reporting against core indicators

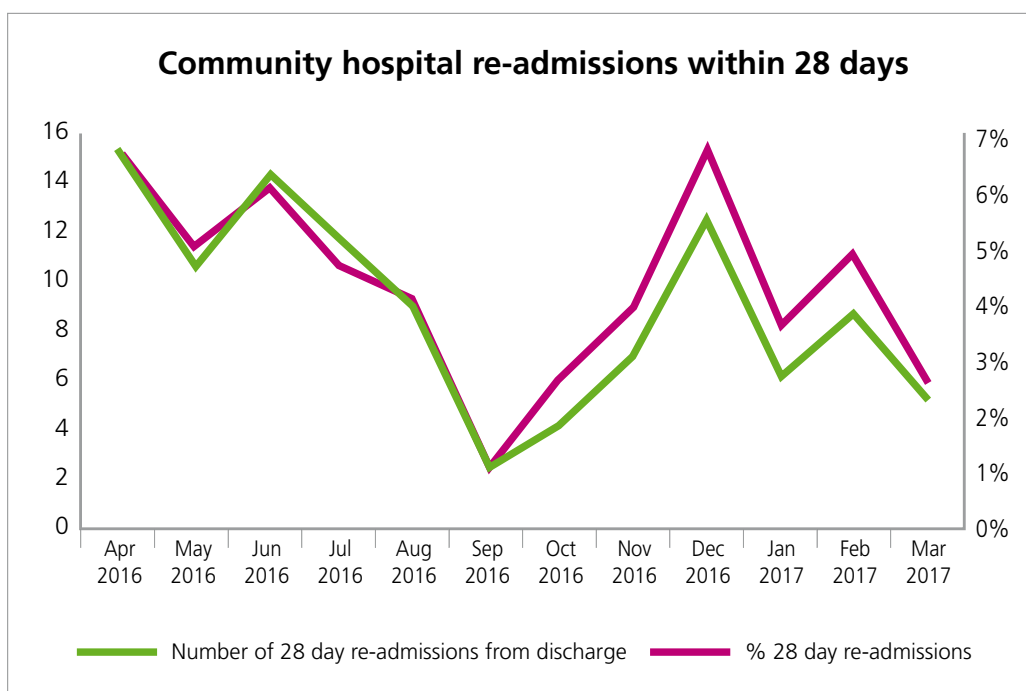
Indicator 19: Hospital re-admissions

The percentage of patients aged:

(i) 0 to 14 and

(ii) 15 or over

re-admitted to a hospital within 28 days of being discharged from a hospital is shown below:



KCHFT considers that this data is as described for the following reason:

The data is:

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

KCHFT has taken actions to improve this percentage and the quality of its services by regularly analysing performance and reviewing admission criteria.

Indicator 25: Patient safety incidents

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

	2015/16*	2016/17
Attributable patient safety incidents	1,736	1,667
Attributable patient safety incidents (causing severe harm or death)	9	4
Percentage causing severe harm or death	0.52%	0.24%

*The 2015/16 data has been updated post publication of the 2015-16 Quality Report.

KCHFT considers that this data is as described because the data is captured on the Datix system by the member of staff who discovered the incident, ensuring the data is first-hand information. The incidents are then subject to a comprehensive review process at multiple levels across the organisation validating the accuracy of the data.

To improve this number and the quality of its services, KCHFT:

- has implemented a tissue viability taskforce group to reduce the incidences of avoidable pressure ulcers within the trust
- is developing a multi-factorial falls risk assessment for patients admitted to our community hospitals with a training package to support the use of this
- is taking part in the NHS Improvement falls collaborative programme.

Part three

This section explains in more detail what we have achieved over the past year and those areas we need to improve upon.

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

The data reflects the change to our service provision from October 2016 when some of our services in north Kent transferred to Virgin Care.

Regulation: Care Quality Commission

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

Rating

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



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

Inspections 2016-17

In April 2016, a joint inspection by the CQC and Her Majesty's Inspectorate of Prisons (HMIP) reviewed our dental service at HMP Swaleside. The CQC identified longer than acceptable waiting times as an issue and the service has worked to improve these.

In December 2016, the trust's children and young people's service in East Sussex participated in a joint inspection by the CQC and Ofsted. This review considered how effectively the local area identifies, meets the needs of and improves the outcomes of the wide range of different groups of children and young people who have special educational needs and/or disabilities. No significant issues were identified during inspection and the report is awaited.

Patient experience

		2015-16	2016-17
End of life care	90% people achieve their preferred place of death	Achieved	Not achieved
	85% appropriate staff (in long-term conditions adult services) have had end-of-life specialist training	N/A	Achieved
Patient feedback	100% coverage of Friends and Family (FFT) test across services	Achieved	Achieved
	25% of patients admitted in our community hospitals completing surveys	Achieved	Achieved
	At least 48,000 surveys completed (reflects transfer of some services to another organisation)	Achieved	Achieved
	Maintain at least 96% score FFT across the trust	Achieved	Achieved
	90% of appropriate complaints (not multi-agency or specialist intervention) resolved within 25 days	N/A	Achieved
Sexual health	Develop a functioning public advisory group for all sexual health services across Kent and Medway	N/A	Achieved
	Roll out the Apple Tree service for patients with learning disabilities across Kent	N/A	Not achieved
Health visiting	Health visiting and Family Nurse Partnership: Improve client journey and experience through an agreed and implemented new service model by July 2017	Partially achieved	Partially achieved
	Stage 1 Baby Friendly Initiative (BFI) accreditation achieved: A: A minimum of 85% of the health visiting workforce including administrator and managers to receive BFI training within one year of starting stage 1 of the BFI accreditation process	N/A	Partially achieved
	B: 95% of breastfeeding status captured between six to eight weeks	N/A	Partially achieved
	C: Offer breastfeeding support sessions across the county to increase the maintenance of breastfeeding beyond the six to eight-week period	Not achieved	Not achieved

		2015-16	2016-17
School health	1. Central referral and access point with a centralised administrative function that will ensure all contact is via a single access point, leading to 20% increase in the number of referrals. 2. Central triage with appropriate allocation or signposting.	Not achieved	Achieved
	Full implementation of proactive National Child Measurement Programme (NCMP) follow up contact for all children in reception and year 6 who are above the 91st body mass index (BMI) centile across Kent: A: 100% NCMP offer for Year R and Year 6	Not achieved	Achieved
	B: 100% follow up contact for any child identified as above the 91st BMI centile.	Not achieved	Achieved
	C: Extra support/intervention by school health or appropriate onward referral to Health Improvement Team or specialists services in line with the healthy weight pathway	Not achieved	Achieved
	D: Decrease in the number of Year 6 children above 91st BMI centile who were identified as obese in Year R	Not achieved	Not achieved
	Increased uptake of the core school aged immunisation programme to children and young people not in school: Targeted five per cent increase in uptake of HPV, TD/IPV and MenACWY for children and young people not in school.	Not achieved	Partially achieved
Health checks	Improve the take up rate for health checks across Kent	Not achieved	Achieved
Stop smoking	3,100 four week quits	Not achieved	Achieved
	To increase the number of cross-referrals from the Stop Smoking Service into the other Health Improvement Services	N/A	Achieved
Continence Services	100% product request forms processed within two weeks on receipt of appropriate assessment	Achieved	Achieved
	To have a patient orientated outcome measure in place	N/A	Achieved
	To have clinical letters (written by nursing staff following patient contact) printed and posted to patient and appropriate clinicians within three days of appointment	N/A	Achieved
Specialist Children's Community Nursing Service	Improved partnership working for children with life-limiting illnesses with Ellenor Hospice; collaboration with all stakeholders, to develop new service specification for CCG agreement February 2017	No	Partially achieved
	Carers' survey of parents/carers and children to be undertaken	Not achieved	Achieved

The following sections describe each patient experience goal in more detail.

Patient experience

End of life care

Goals for 2016-17

1.	90% people achieve their preferred place of death	Not achieved	86.2%
2.	85% appropriate staff (long-term conditions adult services) have had end of life specialist training.	Achieved	85%

What is end of life?

The terms end of life care and palliative care are often used interchangeably by people. End of life care is used more frequently since the government released its End of Life Care Strategy in 2008. End of life care 'helps all those with advanced, progressive, incurable illness to live as well as possible until they die. It enables the supportive and palliative care needs of both patients and family to be identified and met throughout the last phase of life and into bereavement. It includes management of pain and other symptoms and provision of psychological, social, spiritual and practical support' (End of Life Care Strategy, Department of Health, 2008).

Over the past year, the trust's end of life care team has supported services to implement our End of Life Care Strategy, competency assess and train staff, implement the "just in case" medication boxes across the county and continue to work with other providers of care, such as ambulance services and hospices.

How did we perform in 2016-17?

1. This year we had a slight drop in the data recorded against 2015-16 figures, when we achieved 90% of people meeting their preferred place of death (PPD).

Throughout the year, we have undertaken work to improve recording of data on our electronic patient record, CIS. CIS has designated sections for recording end of life care and treatment including patients' wishes and whether PPD is met.

We ensure that important information relating to care is kept with people in their homes, to maintain continuity of care and improve cross-agency communication. Data is also held where systems have been commissioned to share patients' end of life wishes electronically. We hope this will increase the numbers of people dying in their preferred place of care.

Recent research highlights the challenges to achieving PPD data. People with three or more different diseases, such as respiratory and cardiac disease, were over a third more likely to die in hospital than

those who did not. The study also showed that deprivation independently increased the chances of dying in hospital. The national End of Life Care Strategy may have helped to move some deaths out of hospital, however, it still misses important groups (Higginson et al 2017).

A review of some of our patient records identified that some people who wished to die in hospital or hospice in fact died at home.

2. Specialist staff known as care facilitators have supported clinical teams to meet targets with strong support from operational managers. The number of staff trained is a significant improvement against 2015/16 figures.

While we have met the training target of 85% across the trust, in west Kent there are areas of lower compliance. This has been due to low uptake of training. We will therefore be targeting staff in this area to ensure they complete the training as a priority.

An extensive training programme has been in place and we made significant effort towards providing basic training in end-of-life care. The training included specialist areas such as communication skills at both fundamental and advanced level. The trust also provides training on the use of specialist equipment for providing specific end of life medication. There is also specialist training on the paperwork required to help people in planning to achieve a natural death. We have developed workbooks to support staff in their learning. There has also been work undertaken with learning disability teams to increase knowledge and skills, with 76 staff trained.

Staff can also undertake courses online and at the local hospices. There are also university accredited courses.

End of life training							
Locality	Advanced Communication	Fundamental Communication	Advanced Care Skills	Fundamental Care Skills	DNA CPR	Syringe Driver	Average
Ashford	97%	90%	97%	88%	100%	92%	94%
Canterbury	89%	94%	89%	94%	100%	91%	93%
South Kent Coast	92%	93%	96%	94%	95%	93%	94%
Thanet	94%	94%	94%	92%	100%	95%	95%
WK Cluster 5	50%	67%	50%	67%	77%	73%	64%
WK Cluster 4	100%	25%	100%	25%	100%	91%	74%
WK Cluster 3	78%	73%	78%	73%	72%	78%	75%
WK Cluster 2	81%	100%	81%	89%	91%	83%	88%
WK Cluster 1	81%	89%	81%	89%	91%	83%	86%
Average	85%	81%	85%	79%	92%	87%	85%

Patient experience

Friends and Family Test

Goals for 2016-17

1.	100% coverage of Friends and Family Test (FFT) across services.	Achieved	100%
2.	25% of patients admitted in our community hospitals completing surveys.	Achieved	47.4%
3.	At least 48,000 surveys completed (reflects loss of north Kent services).	Achieved	66,022
4.	Maintain at least 96% score FFT across the Trust.	Achieved	97.52%
5.	90% of appropriate complaints (not multi-agency or specialist intervention) resolved within 25 days.	Achieved	92%

What is the NHS Friends and Family Test?

The NHS Friends and Family Test (FFT) is a national measure of patient satisfaction. It should not be used as the only indicator of patient experience. However, it is one way to gauge how patients feel. It is a standard question asking whether, based on their experience of using the service, they would recommend it to their friends and family. There is also an option to make comments.

How did we perform in 2016-17?

1. All services across KCHFT ask the NHS FFT question in their patient experience surveys in accordance with the national guidance.
2. 1,052 patients completed our inpatient survey in the last year. This means that we have achieved a 47% response from those people receiving care in our community hospitals. Feedback is positive across the trust and we take appropriate action to address any comments or concerns where improvements can be made. An example of this is at our dental clinic at the Appleby Centre, Newham. Patients commented that the design of the reception area was causing issues when booking in and that they were finding it difficult to hear when being called for appointments. As a result of this feedback, the reception area was redesigned and a loudspeaker installed.
3. 66,022 surveys including the NHS FFT question have been asked across our organisation. Last year, we received 64,289 comments from people receiving our care.
4. 97.52% of our services used would recommend the service they have experienced. In 2015-16 the score was also high at 96.79% for the Friends and Family Test. This data is favourable when compared against other trusts.
5. Of the 336 complaints received during 2015/16, 27 were not resolved within the 25-day timeframe. We have, in the last year, introduced a more rigorous process, which includes review of high level complaints by our chief nurse and chief executive officer. Our complaints team works to support complainants with an open, non-judgemental approach and caring, effective manner.

Patient experience

Children's Services: Specialist Community Children's Nursing Service

Goals for 2016-17

1.	Survey of parents/carers and children to be undertaken – to review and improve the quality and quantity of patient experience and evaluate with actions by year end.	Achieved
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What is the Specialist Community Children's Nursing Service?

This team comprises paediatric nurses and children's support workers providing hands-on care and support to children and young people whose needs range from short-term illnesses to long-term disabilities or chronic health conditions and end of life care.

How did we perform in 2016-17?

KCHFT's Specialist Community Children's Nursing Service was set a payment-related target by our commissioners for 2016-17 (CQUIN). This was to collect feedback about carers' experiences of the children's community nursing services. The aim of the feedback is to improve services for children and their families, acknowledging the vital role that carers play in supporting children to live with their long-term conditions and remain in their own homes.

Carers were asked to review the existing carers' experience questionnaire and children's experience survey, and to submit comments and suggestions.

Following their recommendations, the survey was amended and uploaded onto our patient experience questionnaire database, Meridian.

In quarter four, carers and children were invited to provide feedback via the updated survey. A report has been developed to send to our commissioners regarding themes and trends. Parent/carer and children's feedback has been highly positive regarding this service.

Patient experience

Sexual Health Service

Goals for 2016-17

1.	Develop a functioning public advisory group for all sexual health services across Kent and Medway.	Achieved
2.	Roll out the Apple Tree service for patients with learning disabilities across Kent.	Not achieved

What is the Sexual Health Service?

This service has consultant-led teams of sexual health clinicians who offer high-quality, confidential sexual health services.

We provide integrated sexual health clinics across Kent and Medway that offer screening and treatment for sexually transmitted infections; contraception including long-acting reversible contraception; HIV treatment and care services; young people's services and sexual health promotion. Our clinics provide appointments and walk-in sessions across Kent and Medway.

We support pharmacies that are providing free emergency hormonal contraception to under 30-year-olds in Kent and deliver the national chlamydia screening programme in Kent, which provides opportunistic screening to under 25-year-olds.

Our specialist trained therapists also deliver psychosexual therapy services across Kent.

How did we perform in 2016-17?

1. The service has established two public advisory groups for sexual health services in Kent and Medway. This has increased the mechanisms to engage with public representatives to place them at the heart of service development.
2. Our Sexual Health Service has been working with key partners to develop the Apple Tree service, which will improve access to the service for those with learning disabilities. The Apple Tree service care pathways are being finalised and the service will go live in 2017/2018. The service has been unable to roll out the programme yet due to the capacity of the service and the need for enhanced public engagement.

Patient experience

Optimising health promotion and independence:

Health Improvement: Health checks

Goals for 2016-17

1.	Improve the take-up rate for health checks across Kent.	104.3%	Achieved
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What are health checks?

The NHS Health Check is a national risk assessment, awareness and management programme for those aged 40-74 living in England who do not have an existing vascular condition, and who are not currently being treated for certain risk factors. It is aimed at preventing heart disease, stroke, diabetes and kidney disease.

How did we perform in 2016-17?

- The goal for the health check programme was to increase on the number of health checks completed year-on-year.

2015/16 saw a decrease from the previous year (2014/15), however 2016/17 has seen performance improve.

The national expectation is an uptake of around 50% of the eligible population. However, our commissioners, Kent County Council (KCC), set a target of 46% for 2016/17 as this was seen as more realistic based on country-wide trends and eligible populations. These figures are in turn, reported to NHS England.

Based on national data, the service is ranked second in the country for the number of checks completed on a five-year rolling programme between 2013 and 2018.

At the end of the reporting period, the service achieved 104.3% of the target, which equals 42,130 checks performed. This is an increase of 14.84% compared to 2015/16.

Our 2017/18 target remains at 46% of the eligible population, which equates to 41,600 health checks.

	GP delivered checks	KCHFT delivered checks	Partnership delivered checks	Total delivered health checks
Ashford	3,316	371	144	3,831
Canterbury	5,726	216	29	5,971
DGS	3,910	2,126	552	6,588
South Kent Coast	5,556	800	174	6,530
Swale	2,023	874	64	2,961
Thanet	2,510	813	113	3,436
West Kent	9,940	2,403	411	12,754
Out of area/ not registered		10	49	59
	32,981	7,613	1,536	42,130

Patient experience

Optimising health promotion and independence:

Health Improvement: Stop smoking

Goals for 2016-17

1.	3,397 four-week quits.	Achieved	101% as at month 12
2.	To increase the number of cross-referrals from the Stop Smoking Service into the other Health Improvement Services.	Achieved	

Smoking cessation

Smoking cessation is offered through an abrupt cessation programme or a harm reduction, cut down to quit programme, where smoking is reduced over a four-week programme before setting a date to quit. Smoking cessation has an extremely positive impact on improving health and wellbeing of our communities.

How did we perform in 2016-17?

1. The service will overachieve on the 2016/17 target at year end with around 3,500 four-week quits which, due to the length of the quit programme and reporting schedules, will be finalised in the quarter four Department of Health (DH) return in June 2017 and so unavailable for inclusion in this report.

The goal was to meet the Key Performance Indicator (KPI) set by our commissioners, Kent County Council (KCC) to achieve 3,100-four week quits throughout 2016/17. This will be achieved by year end.

This data is governed by the Russell Standard stated in the service and delivery guidance 2014:

- Self-reported four-week quitter – A treated smoker who reports not smoking for at least days 15–28 of a quit attempt and is followed up 28 days from their quit date (-3 or +14 days).

The -3 or +14 day rule allows for cases where it is impossible to carry out a face-to-face follow-up at the normal four-week point (although in most cases it is expected that follow-up will be carried out at four weeks from the quit date). This means that follow-up must occur 25 to 42 days from the quit date (Russell Standard).

Each quarter the service reports data to the DH.

In the autumn, our Stop Smoking Service was named as the third most successful programme in the UK for number of quits until November 2016.

We are likely to achieve a similar number, if not more quits, than last year. The target is currently being negotiated for 2017/18 with KCC.

- There have been a steady number of cross-referrals into the other Health Improvement services throughout the year and a clear increase in some months. The goal was to increase the number of referrals into the other Health Improvement Services from the Stop Smoking Service. This has been achieved.

	Quarter 1 (Apr-Jun)		Quarter 2 (Jul-Sept)		Quarter 3 (Oct-Dec)		Quarter 4 (Jan-Mar)				
CCG	Quit dates set	Quits achieved	Quit dates Set	Quits achieved	Quit dates Set	Quits achieved	Quit dates set	Quits Achieved	Total quit dates set	Total quits	% quits achieved against annual Target
Ashford	107	56	119	60	138	78	199	73	563	267	5.93%
Canterbury	194	119	189	101	215	148	244	108	842	476	10.58%
DGS	262	127	225	113	214	105	237	83	938	428	9.51%
South Kent Coast	256	156	233	133	253	118	313	101	1055	508	11.29%
Swale	200	111	194	88	207	103	260	100	861	402	8.93%
Thanet	264	154	245	143	206	120	230	111	945	528	11.73%
West Kent	304	135	281	140	253	121	289	115	1127	511	11.36%
Total	1,587	858	1,486	778	1,486	793	1,772	691	6,331	3,120	69%

Patient experience

Optimising health promotion and independence:

Continence Service

Goals for 2016-17

1.	100% product request forms processed within two weeks on receipt of appropriate assessment.	Achieved	100%
2.	To have a patient-orientated outcome measure in place.	Achieved	
3.	To have clinical letters (written by nursing staff following patient contact) printed and posted to patient and appropriate clinicians within three days of appointment,	Achieved	100%

What are continence services?

Our Continence Service is a specialist nurse and physiotherapy service providing professional clinical advice, support and information directly to patients or indirectly to healthcare professionals/carers on continence promotion and the treatment and management of symptoms of bladder, bowel and pelvic dysfunction, including incontinence.

How did we perform in 2016-17?

1. The goal was to process all product request forms for continence products within two weeks of receipt at the product delivery service office. This was fully achieved, and was also fully achieved in the last financial year. Looking ahead to next year, the intention is to maintain our 100% success rate.
2. This goal was to locate and implement outcome measure tools to use in clinic. Measure yourself medical outcome profile (MYMOP) and international consultation incontinence questionnaire – Urinary Incontinence (ICIQ-UI) short forms are the tools to be used by the service. Work is now in progress to integrate these tools into the trust's patient record system, CIS. This will start during the first quarter of the next financial year.
3. The goal was to ensure all clinical letters were processed and posted within three days of receipt. The Administration Team reviewed all templates to ensure accuracy of data and reduce inputting time. Clinicians were instructed on appropriate content and structuring of letters to assist in speeding up admin process. The intention is to maintain our 100% success rate next year.

Patient experience

Optimising health promotion and independence:

Children's services: Health visiting and Family Nurse Partnership (FNP)

Goals for 2016-17

1.	Improved client journey and experience through an agreed and implemented new service model by July 2017.	Ongoing	
2.	Stage 1 Baby Friendly Initiative (BFI) accreditation achieved	On target to be met October 2017	69%
	A. A minimum of 85% of the Health visiting workforce including administrator and managers to receive BFI training within one year of commencing stage 1 of the BFI accreditation process.		
	B. 95% of Breastfeeding status captured between six to eight weeks.	Partially	Variance between quarterly submissions
	C. Offer breastfeeding support sessions across the county to increase the maintenance of breastfeeding beyond the six to eight-week period.	Not achieved	

What are the health visiting and family nurse partnership services?

Our Health Visiting Service is made up of health visitors, who are registered nurses or midwives with a specialised qualification in public health and the care and development of pre-school children. We work in line with the national Healthy child programme, which aims to promote optimal health and wellbeing for all children. We provide an essential service to children and families and work in local communities to promote health and reduce health inequalities.

We support families with a new baby or a child aged under five-years-old. We help you and your family to be healthy, both emotionally and physically. Working together with you, we provide advice, support and confidential health advice.

How did we perform in 2016-17?

1. The commissioning of the health visiting and family nurse partnership services were transferred from NHS England to the local authority, Kent County Council, public health commissioners, in October 2015.

Within a year of this transfer, the commissioning intention was to go out to the market through a competitive tender process.

It became apparent that there was a need to have a better understanding of the contribution of health visiting and family nurse partnerships to the wider determinants of health across Kent and their impact on public health outcomes. This led to an extension of the current contract for an extra 18 months with a detailed review of client pathways. This in turn has informed the development of the revised service specification that will be used for the tendering process in October 2017.

It is the commissioner's intention to have a new under-fives public health contract in place by April 2018.

2. A. The UNICEF Baby Friendly Initiative (BFI) is an evidence-based national quality standard for the management of infant feeding.

Although the service had health visitor leads with a special interest in infant feeding, health visiting had not sought the above accreditation.

The process started with the receipt of a certificate of commitment, closely followed by our assessment for stage one accreditation

Discussions during BFI training sessions highlighted conflicting messages relating to safer sleeping between the advice from UNICEF and the Lullaby Trust (a charity that offers support for family who have lost a child through sudden infant death syndrome). To ensure that consistent advice was given to all clients, up-to-date information was provided to the health visiting workforce.

- B. This goal to capture breastfeeding status was partially achieved as there was variance between quarterly submissions. Performance for this target is continuing to improve and the service aims to meet the requirement by quarter one 2017/18.
- C. We are working closely with commissioners to develop a breastfeeding support model with equitable access across Kent. The current provider of this service is a third sector organisation commissioned by KCC. The initial objective was to transfer this pathway to the health visiting service in 2016/17 financial year. Due to current contractual obligation restraints, the decision was made to consult on the future model prior to agreeing the provider. The intention is for this to be considered as part of the tendering process for under-five public health services in October 2017.

Patient experience

Optimising health promotion and independence:

School nursing

Goals for 2016-17

1.	A. Central referral and access point with a centralised administrative function that will ensure all contact is via a single access point, leading to 20% increase in the number of referrals. B. Central triage with appropriate allocation or signposting	Achieved	
2.	100% NCMP offer for Year R and Year 6.	Achieved	100%
3.	100% follow up contact for any child identified as above the 91st BMI centile.	Achieved	100%
4.	Extra support/intervention by school health or appropriate onward referral to Health Improvement Team or specialist services in line healthy weight pathway.	Achieved	
5.	Decrease in the number of Year 6 children above 91st BMI centile who were identified as obese in Year R.	Not achieved	
6.	Targeted 5% increase in uptake of HPV, TD/IPV and MenACWY for children and young people not in school.	Partially achieved	

What is the school nursing service?

Our School Nursing Service works to improve the general health and wellbeing of children, young people and their families to support children to get the best start in life. We provide this service in Kent and east Sussex.

The teams are led by school nurses who are qualified nurses, with specialist training in public health. They are supported by school staff nurses, school nurse assistants and administration support.

We work closely with health visitors, community paediatricians, schools and other services from local communities in a range of locations, including mainstream schools and special schools.

How did we perform in 2016-17?

- As part of the new contract all referrals and access to the school health service will be channelled through the Single Referral Point prior to the award and mobilisation of the specialist emotional health and wellbeing services contract by KCC in September 2017.

Once the new services are embedded, the intention across Kent is to have a Single Point of Access across all services covering the school health population from assessment, prevention, intervention and or treatment.

- 2 and 3: All children who are identified as above the 91st centile have been offered a proactive telephone call by our school health assistants using the Solihull Approach process and motivational interviewing skills to modify behaviour.
- 2 and 4: There has also been a multidisciplinary healthy weight pathway and standing operating procedure developed and this is being used to support clients accordingly.
- 5. This is the first academic year where the proactive telephone calls and referral as per the healthy weight pathway has been introduced. Unfortunately, we are unable to evaluate outcomes based on 2016 /17 data. The effectiveness of interventions leading to a decrease in BMI (body mass index) centile for Year 6 children based on the Year R measurements will not be available until 2020/21.
- 6. A new Immunisation Team was developed in 2016/17 and there was a need for transformation of all systems and processes. Previous uptake data recorded has not been reliable but robust structures are now in place for the 2016/17 academic year.

Patient experience

Optimising health promotion and independence:

Specialist Children's Community Nursing:

Goals for 2016-17

1.	Improved partnership working with Ellenor Hospice for children with life-limiting illnesses; collaboration with all stakeholders, to develop new service specification for CCG agreement February 2017.	Partially achieved
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How did we perform in 2016-17?

KCHFT's Specialist Children's Community Nursing received a payment related target (CQUIN) from commissioners for 2017/2018 to develop the relationship between KCHFT's Community Nursing Service in Dartford, Gravesham and Swanley and the Ellenor Hospice which provides end-of-life care in this area. The aim of this CQUIN is to promote continuity of care, clarity of role and responsibility and transition of children from one service to the other.

The service leads were to exchange service specifications and to open the lines of communication. A workshop was held with the teams to ensure clarity of roles and agree the transition of children between the services.

Joint caseload reviews are now undertaken to ensure continuity of care and that children and their family are seen by the right team at the right time.

The service specification has been updated to reflect the collaboration between the services and acknowledges Ellenor Hospice as a key stakeholder.

While the target has not been fully met, due to delays between the CCG and KCHFT, progress has been made to almost achieving this goal.

Patient safety

Goal summary

	Goal	2015-16	2016-17
Reduction in harm	Harm free care maintained above 98% (adults)	Achieved	Partially achieved
	10% reduction in falls in community hospitals	Achieved	Achieved
	10% reduction in harm from falls in community hospitals	Achieved	Achieved
	10% reduction in grade two attributable and avoidable pressure ulcers	Achieved	Not achieved
	20% reduction in grades three to four attributable and avoidable pressure ulcers	Achieved	Not achieved
	Continue to have no attributable/avoidable pressure ulcers within Specialist Children's Community Nursing Service	Achieved	Achieved
Reduce episodes of harm from infection	Report no more than five attributable cases of Clostridium difficile infection AND no level three lapses in care	Achieved	Not achieved
	Reduce hospital acquired catheter associated urinary tract infections and urinary tract Infections by a further 5%	Achieved	Achieved
	Ensure 100% compliance with MRSA screening	Not achieved	Not achieved
	Ensure zero tolerance of MRSA bacteraemias	Achieved	Achieved
	Ensure full compliance with infection prevention and control and hand hygiene training	Achieved	Achieved

	Goal	2015-16	2016-17
Medicines optimisation	Conduct three patient focus group sessions in 2016/17 to improve pharmacy services: 1. Patient medication information phone line. 2. Self-administration scheme in hospital. 3. Discharge from hospital to home.	N/A	Achieved
	80% prescribing compliance with dental antimicrobial formulary	N/A	Achieved
	10% reduction in SafeMed errors relating to administration errors involving wrong doses and wrong drugs	N/A	Achieved
	To improve the patient's experience of transfer of care from the acute trusts to community trust through collaborative working on medication related issues.	N/A	Not achieved
Vulnerable patients	90% of children will be seen within four weeks of referral to the audiology service	Not achieved	Achieved
	Implement and assure a procedure to ensure all young people under 16 identified at risk (safeguarding risk) are all followed up	N/A	Achieved
	To ensure that staff working in community hospitals (inpatients) receive tier 2 (intermediate) dementia training. 85% target identified by 2020.	N/A	Achieved
	The community hospital environments to work towards becoming dementia friendly as required by the Hospital Charter 2020.	N/A	Not achieved

Patient safety

Duty of candour

The Duty of Candour is a regulation from the Health and Social Care Act 2008, (Regulated Activities) Regulations 2014: Regulation 20 and became a legal obligation from April 2015.

The intention of this regulation is to ensure that providers are open and transparent with people who use services and other 'relevant persons' (people acting lawfully on their behalf) in general in relation to care and treatment. It also sets out some specific requirements that providers must follow when things go wrong with care and treatment, including informing people about the incident, providing reasonable support, providing truthful information and an apology when things go wrong.

The trust has robust systems to ensure Duty of candour is implemented for all moderate and severe harm incidents and any incidents resulting in death, which have been acquired in our care. To ensure our staff were aware of the process a series of face-to-face training sessions were provided. Information was cascaded to staff, shared on flo – our staff intranet – with links to the Nursing and Midwifery councils (NMC) Duty of candour guidance. Local guidance and support was provided by the Clinical Governance Team.

Duty of candour is implemented for all incidents (including complaints, comments and claims) which meet the criteria. The need to implement Duty of candour is highlighted to the manager in one of two ways – via the incident team once reported on Datix (the incident reporting system) or via the serious incident team if the incident is reported as a serious incident. The Duty of candour process is led by the head of service and recorded in the patient's notes.

The reporting of the Duty of candour is included within serious incident reports to the Quality Committee. This provides assurance to the trust and commissioners.

We have provided assurance to our quality committee that the Duty of candour has been implemented in 86 per cent of eligible incidents. Since April 2016, the threshold for Duty of candour was reached in 36 incidents and implemented for 31 of those incidents. The remaining 14% of Duty of Candour that was not reached/implemented had a full review with risk assessments completed.

The Duty of candour audit started in October 2015 and was completed in May 2016, with the action plan signed off by nursing and quality in June 2016. Last year's Duty of candour audit was deferred to 2017 and is due to start in May 2017 with results to follow.

Patient safety

Reduction in harm: NHS safety thermometer

Goals for 2016-17

1.	Reduction in severity and numbers of harm overall – 99% target.	Partially achieved	98%
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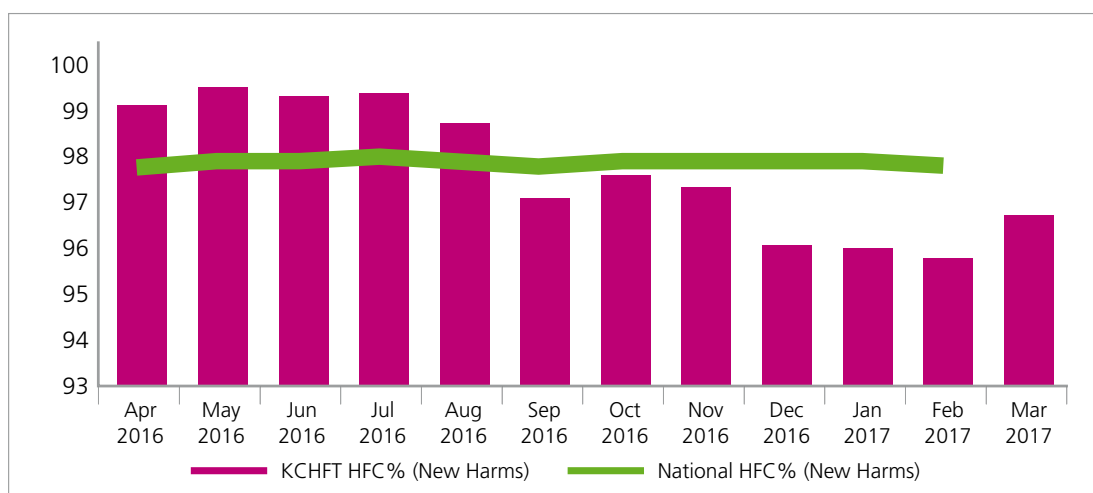
What is the NHS safety thermometer?

The NHS safety thermometer is a national prevalence survey. It is conducted on one day each month when our nurses review all relevant patients to determine if they have suffered any harm as a result of their healthcare. The categories they review include: catheter associated urinary tract infections (CAUTIs), falls, venous thromboembolism (VTE) and pressure ulcers. Their data is fed back to a national database, which is used for comparison and benchmarking. All data can be reviewed at www.safetythermometer.nhs.uk. The national target is that 96 per cent of patients are harm free; this applies to the overall score as well as each individual category. KCHFT has set a target that 99% of patients do not suffer new harms.

How did we perform in 2016-17?

1. We achieved this target last year at 99%, but slipped to a yearly average of 98 per cent for this year. This is still in line with the national average, which is also at 98 per cent for the year.

This drop in average occurred after a switch to data collection via CIS in September 2016 and some issues relating to data collection and accuracy. The drop in surveys can be partly attributed to the transfer of services in Dartford, Gravesham, Swanley and Swale to Virgin Care in October 2016. We continue to focus attention on improving both the number and quality of the returns and will be reviewing safety thermometer collection in May 2017.



KCHFT	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17
Total number of patients surveyed:	2945	2827	2867	2798	2872	1600	1281	1136	959	1010	1408	1171
Number & % of Patients 'Harm Free'	2918 99.1%	2813 99.5%	2847 99.3%	2782 99.4%	2836 98.7%	1553 97.1%	1250 97.6%	1105 97.3%	922 96.1%	970 96%	1349 95.8%	1132 96.7%
Ashford CCG: Patients surveyed	208	250	276	285	312	194	140	92	102	175	116	132
Number & % of Patients 'Harm Free'	207 99.5%	249 99.6%	276 100%	282 98.9%	309 99%	186 95.9%	133 95%	89 96.7%	99 97.1%	166 94.9%	111 95.7%	123 93.2%
Canterbury CCG: Patients surveyed	437	340	366	458	437	323	214	182	169	165	236	283
Number & % of Patients 'Harm Free'	434 99.3%	336 98.8%	363 99.2%	456 99.6%	431 98.6%	317 98.1%	209 97.7%	177 97.3%	159 94.1%	161 97.6%	224 94.9%	276 97.5%
South Kent Coast CCG: Patients surveyed	579	484	441	460	537	265	167	188	142	186	279	239
Number & % of Patients 'Harm Free'	575 99.3%	484 100%	441 100%	460 100%	534 99.4%	258 97.4%	165 98.8%	183 97.3%	137 96.5%	179 96.2%	267 95.7%	231 96.7%
Thanet CCG: Patients surveyed	382	385	423	432	420	293	265	247	155	70	271	89
Number & % of Patients 'Harm Free'	379 99.2%	382 99.2%	419 99.1%	430 99.5%	415 98.8%	285 97.3%	260 98.1%	242 98%	149 96.1%	67 95.7%	262 96.7%	86 96.6%

Patient safety

Reduction in harm: Falls

Goals for 2016-17

1.	10% reduction in falls in community hospitals.	Achieved	44	24% reduction
2.	10% reduction in harm from falls in community hospitals.	Achieved	18	22% reduction

Definition of a fall

In April 2015, KCHFT amended the “attributable” definition for falls occurring for patients in our care. If all interventions were in place at the time of the incident it was no longer defined as “attributable”.

How did we perform in 2016-17?

Falls acquired in our community hospitals			
	Year total 2015/16	Year total 2016/17	Actual % Reduction
Kent-wide	58	44	24%

Falls acquired in our community hospitals – locality		
	Year total 2015/16	Year total 2016/17
Canterbury	6	12
Dartford, Gravesham and Swanley	6	1
Swale	8	3
Dover, Deal and Thanet	12	1
West Kent	26	27

Falls acquired in our community hospitals with harms			
	Year total 2015/16	Year total 2016/17	Actual % Reduction
Kent-wide	23*	18	22%

*Please note this figure was reported as 25 in our 2015-16 Quality Report. Two incidents were included for Westbrook House, which have been removed from this year's figures, as this is not a KCHFT registered unit.

Falls acquired in our community hospitals – locality		
	Year total 2015/16	Year total 2016/17
Canterbury	3	5
Dartford, Gravesham and Swanley	5	1
Swale	2	1
Dover, Deal and Thanet	2	0
West Kent	11	11

The trust had a 10 per cent target for the reduction of all avoidable, attributable falls with harm across the community hospitals for 2016/17. Overall, there has been a 22 per cent decrease across the trust.

Overall, our community hospitals appear to be performing well against the national average for all falls per 1000 occupied bed days (OBD) – the KCHFT average is 6.23 falls per 1,000 OBD and the national average is 6.63.

Avoidable falls in community hospitals	Year total 2015/16	Year total 2016/17	Number of incidents per 1000 occupied bed days
Kent-wide	58	44	0.7

Avoidable falls	Year total 2015/16	Year total 2016/17	Number of incidents per 1000 occupied bed days
Edenbridge Hospital	2	4	1.0
Faversham Cottage Hospital	0	1	0.1
Hawkhurst Community Hospital	10	3	0.4
Livingstone Hospital	6	1	0.3
Queen Victoria Memorial Hospital	3	1	0.1
Sevenoaks Hospital	1	6	1.0
Sheppey Community Hospital	2	1	0.3
Sittingbourne Memorial Hospital	6	2	0.9
Tonbridge Cottage Hospital	13	14	2.0
Victoria Hospital (Deal)	12	1	0.2
Whitstable and Tankerton Hospital	3	10	1.6

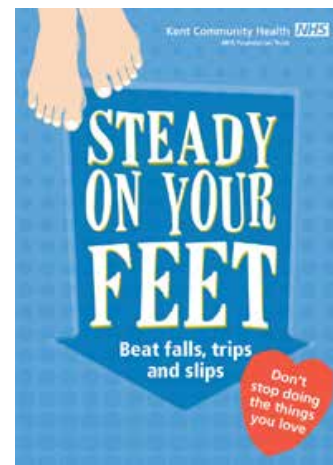
In relation to moderate and severe harms, the KCHFT average is 0.42 per 1,000 OBD, compared to the national average of 0.19 – see table below.

Avoidable falls in community hospitals with harms	Year total 2015/16	Year total 2016/17	Number of incidents per 1000 occupied bed days
Kent-wide	23	18	0.3

Avoidable falls	Year total 2015/16	Year total 2016/17	Number of incidents per 1000 occupied bed days
Edenbridge Hospital	1	2	0.5
Faversham Cottage Hospital	0	1	0.1
Hawkhurst Community Hospital	4	2	0.3
Livingstone Community Hospital	3	1	0.3
Queen Victoria Memorial Hospital	1	0	0
Sevenoaks Hospital	1	3	0.5
Sheppey Community Hospital	0	0	0
Sittingbourne Memorial Hospital	2	0	0
Tonbridge Cottage Hospital	5	4	0.6
Victoria Hospital (Deal)	4	1	0.2
Whitstable and Tankerton Hospital	2	4	0.7

The trust has developed a significant and extensive programme to embed falls prevention awareness across adult services, with a particular emphasis on the community hospitals. Through 2016-17 a falls bundle has been introduced which includes:

- “Steady on your feet” patient information booklet
- Falls prevention top tips cards for staff – promoting the seven key indicators for falls in people aged over 65
- “Don’t fall – call” posters for the community hospitals
- Multi-factorial falls risk assessment (MFRA)
- MFRA training narrated PowerPoint presentation for our staff
- Falls prevention twitter account – @fallskent
- Updated falls prevention driver diagram.



KCHFT is one of 21 trusts taking part in the NHS Improvement falls collaborative. This 90-day improvement programme aims to re-energise the falls prevention improvement movement and make sure providers have the information, skills and tools to reduce inpatient falls which result in injury and improve reporting and care.

Edenbridge and District War Memorial Hospital and Whitstable and Tankerton Community Hospital are our project sites and an improvement team will run the project, with the support of the chief nurse. This was launched at the end of January 2017 and will run until May 2017. The team has selected key areas to focus on for improvement. This included:

- accurate taking and recording of lying and standing blood pressure on admission so patients with postural hypotension are identified by the team
- making sure mobility aids are suitable and within reach so the person can mobilise safely
- making sure the call bell (or alternative) is within reach and the person understands how and when to use it, so they can get support or assistance as needed
- completing a bedside vision check on admission using the Royal College of Physicians’ bedside vision check so ward staff quickly assess a patient’s eyesight to help prevent them falling or tripping while in hospital.

The trust also held its inaugural falls prevention and awareness week in February 2017. As part of the week our teams across intermediate care and the community hospitals held a range of activities for patients, relatives and the local community. Our falls prevention resources were promoted at the One You shop in Ashford and at several supermarkets.

For 2017-18, the falls operational group will be divided into two – east and west Kent. This will allow more focus and analysis on relevant data/actions and ward specific issues.

Patient safety

Reduction in harm: Pressure ulcers

Goals for 2016-17

1.	10% reduction in grade 2, attributable and avoidable.	Not achieved	32	Increase of 10%
2.	20% reduction in grade 3-4 attributable and avoidable.	Not achieved	26	Increase of 100%

What is a pressure ulcer?

Pressure ulcers, previously known as bed sores, are a type of injury that affect areas of the skin and underlying tissue and are caused when placed under pressure over time. Their presentation can vary in severity from discoloured skin to open wounds.

How did we perform in 2016-17?

- Goal one:** 10 per cent reduction in grade 2 avoidable pressure ulcers

Avoidable grade 2 pressure ulcers	Year total 2015/16*	Year total 2016/17 to date
Kent-wide	29	32
Avoidable – category 2	Year total 2015/16*	Year total 2016/17 to date
Ashford CCG	4	2
Canterbury CCG	5	2
Dartford/Gravesham/Swanley CCG	1	0
South Kent Coast (Dover/Deal) CCG	3	1
South Kent Coast (Shepway) CCG	1	1
Swale CCG	2	2
Thanet CCG	5	13
West Kent CCG	8	11

2. **Goal two:** 20 per cent reduction in avoidable grade three and four pressure ulcers

Avoidable grade three and four pressure ulcers	Year total 2015/16*	Year total 2016/17
Kent-wide	13	26
Avoidable – categories three and four	Year total 2015/16*	Year total 2016/17 to date
Ashford CCG	0	3
Canterbury CCG	2	0
Dartford/Gravesham/Swanley CCG	0	0
South Kent Coast (Dover/Deal) CCG	2	5
South Kent Coast (Shepway) CCG	0	0
Swale CCG	1	2
Thanet CCG	6	10
West Kent CCG	2	6

*There are some slight variations between figures reported in the 2015-16 report and this report. This is due to categorisation changes following incident investigation, which took place after production of last year's report.

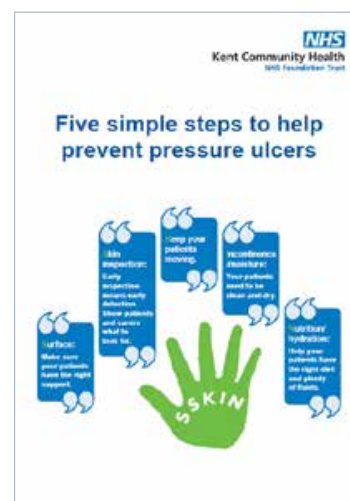
For the last two years, the primary focus for the organisation has been proactive care with an increased emphasis on prevention strategies and patient empowerment to effectively reduce the risk of patient harms acquired in our care. This was marked by a period of significant progress in 2015-16, with the introduction of a trust-wide programme to reduce pressure ulcer harms supported by the introduction of the SSKIN model (surface; skin; keep moving; incontinence; nutrition) to aid the identification of patients at risk to enable preventative measures to be put in place in a timely manner.

As a result of this focused approach, the organisation achieved a significant reduction in pressure ulcer harms for 2015-16 and met the required goals/trajectory for the organisation over and beyond our expectation.

The forecasts for 2016-17 were based on the trajectory outcomes from 2015-16.

Compared to other community organisations KCHFT is mid-way between the best and worst performers.

Unfortunately, KCHFT has not met the planned trajectories for 2016-17. Factors that may have influenced the increase in harms have been explored and will be considered as we plan for 2017-18.



There continues to be a significant drive to embed pressure ulcer prevention strategies including; the implementation of prevention and management clinical pathways for patients identified as at risk; and the introduction of the react to red model of care.

In response to the current situation, a pressure ulcer taskforce group has been established by the chief nurse with a clear focus on the prevention of acquired harms across the organisation. The group monitors the delivery of an overarching strategic plan using the common themes and trends in relation to pressure ulcer harms within KCHFT.



The trust actions for 2017-18 are:

- raise the profile of pressure ulcer harms and accountability within the quality and safety agenda
- raise assurance that pressure ulcer prevention strategies are implemented and visible at the front line in all services
- increase staff knowledge and awareness of pressure ulcer prevention via a continued programme of education and training
- implement a pressure ulcer risk stratification tool
- ensure our staff are competent in pressure ulcer prevention and management
- monitor pressure ulcer reporting
- provide assurance via the completion of trust-wide and locality based pressure ulcer audits.
- introduce a pressure ulcer pledge to embed harm free care.

Specialist Community Children's Nursing Service

Goals for 2016-17

1.	Continue to have no attributable/avoidable pressure ulcers.	Achieved	0
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How did we perform in 2016-17?

The services had no attributable pressure ulcers, however they have recognised there is a lack of robust preventative work. Issues regarding multi-team working have also been identified. This is currently being investigated via a root cause analysis.

A flow chart is being produced by a team of children's specialist nurses and therapists which are coordinating a meeting with KCHFT's pressure care lead to take this forward in May 2017.

Patient safety

Reduce episodes of harm from infection

Goals for 2016-17

1.	Report no more than five attributable cases of Clostridium difficile infection AND no level three lapses in care.	Not achieved	7 attributable Clostridium difficile infections, and 1 level 3 lapse in care.
2.	Reduce hospital acquired catheter associated urinary tract infections and urinary tract infections by a further 5%.	Achieved	114 hospital acquired UTIs. 14 hospital acquired CAUTIs.
3.	Ensure 100% compliance with MRSA screening.	Not achieved	99%
4.	Ensure zero tolerance of MRSA bacteraemia.	Achieved	0
5.	Ensure full compliance with infection prevention and control and hand hygiene training.	Achieved	IPC 96% HH 90%

How did we perform in 2016-17?

1. The national objectives for Clostridium difficile infections do not routinely apply to community providers. Therefore, objectives can be set locally and agreed with CCGs. In 2016-17, KCHFT followed the national guidelines in setting targets, which was to reduce our target by one case on the previous year's target, however, as we also reduced inpatient bed capacity through the year, this was further reduced to five cases. All cases of Clostridium difficile are investigated, and a root cause analysis undertaken. At this meeting a decision is reached about whether cases are deemed avoidable or unavoidable.

In 2015-16, we had one case of Clostridium difficile infection in west Kent, which was deemed unavoidable due to antimicrobial prescribing. This level of Clostridium difficile was unusually low and the previous year there had been nine reportable cases.

In 2016-17 five cases were deemed unavoidable and due to appropriate antimicrobial prescribing, however two cases were due to cross infection. In one case, the cross infection occurred within an acute hospital, but one case of cross infection was within a community hospital.

Of the seven cases in KCHFT, five cases were transferred to the community hospitals from an acute hospital within East Kent Hospitals University NHS Foundation Trust (EKHUFT).

KCHFT has investigated the internal cross infection and an action plan has been produced. The actions are being implemented, both locally within the ward where the incident occurred, but also sharing lessons learned across the organisation, starting with a hand hygiene campaign.



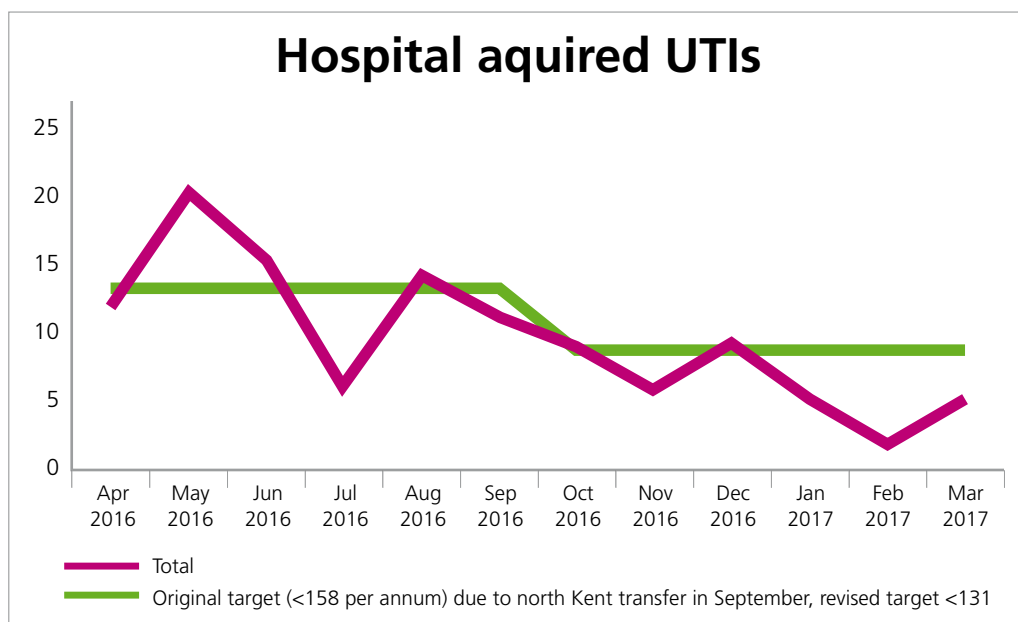
For 2017/18, the national objectives are to remain the same for 2016/17. Therefore, the target will be no more than five cases of Clostridium difficile Infection, and no level three lapses in care.

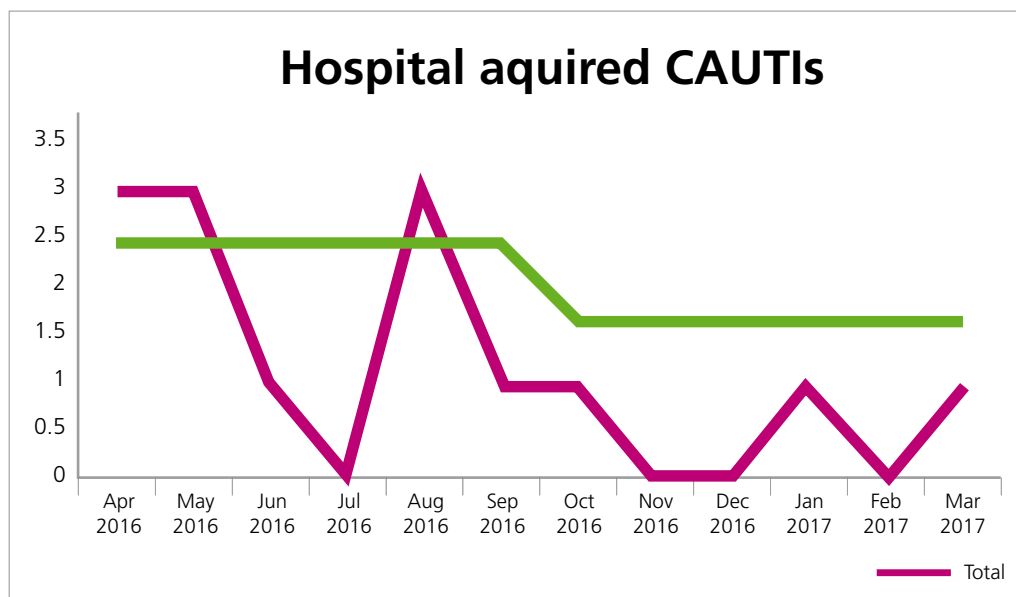
2. The original target for reduction in urinary tract infections (UTIs) was to have no more than 158 hospital-acquired infections, this was reduced to 131 cases when the numbers of inpatient beds reduced. For the whole year this target was exceeded. We recorded 114 cases, which is a significant improvement.

The original target for reduction in CAUTIs was to have no more than 29.5 cases, this was changed to no more than 25 cases when the inpatient beds reduced. For the year, this target was exceeded. We recorded 14 cases.

KCHFT focussed on effective implementation of catheter pathways and passports and challenged ward staff on all cases, sharing lessons learned through the trust CAUTI and UTI reduction group.

There is no national guidance on reduction of CAUTIs and UTIs. However, there is now a national focus on reduction of healthcare associated E-coli bacteraemias (blood infections) with a plan to reduce by 10 per cent in 2017/18. The highest cause of these infections is known to be urinary tract infections. Therefore, the focus on reduction of these infections is key to the overall reductions.





3. Expected compliance is that 100 per cent of patients admitted for surgery and 100 per cent of assessed 'high risk' patients admitted to our community hospitals are screened for MRSA. This has been achieved in podiatric surgery consistently. However, compliance has been 99 per cent in the community hospitals. This relates to two patients not being screened in a timely manner, due to the use of agency staff. Both these patients were subsequently screened and tested negative.
4. During the year, there were 10 MRSA bacteraemia cases recorded where KCHFT staff had provided care. All were investigated and full post infection reviews (PIRs) were undertaken jointly with the CCG and acute trust infection prevention and control leads, with the clinical staff involved in the patients care. No cases were attributed to KCHFT. The main learning identified for all involved was improved communication between different care providers.

In two cases the CCG infection prevention and control lead wrote to KCHFT to commend it for its care of the patients.
5. The target for training compliance is for 85 per cent of staff to be compliant throughout the year. This year, compliance to hand hygiene training for clinical staff fell slightly below the target to just below 85 per cent in November, December and January. However, full compliance has again been achieved, through link workers ensuring they train staff locally, with support from the IPC Team.

	Mar-17
Overall compliance Infection prevention and control	96%
IPC L1	99.90%
IPC L2	94.10%
IPC L3	95.50%
Overall compliance Hand Hygiene	90%
Hand Hygiene L1	98.90%
Hand Hygiene L2	89.60%
Hand Hygiene L3	88.60%

CCG	Location	No. patients meeting criteria for MRSA admission screen	No. patients screened	% Compliance for MRSA screens	Hospital acquired CAUTIs	Hospital acquired UTIs	Hand hygiene audit compliance	Essential steps audit compliance	Clostridium difficile toxin positive infections
Swale	Sittingbourne	2	2	100%	0	2	96%	Did not submit data	0
	Sheppey	10	10	100%	4	6	100%	100%	0
South Kent Coast	Deal	18	16	88%	0	3	100%	100%	1
West Kent	Sevenoaks	42	43	100%	2	7	100%	99%	0
	Tonbridge	10	10	100%	0	24	100%	100%	0
	Edenbridge	20	20	100%	2	7	100%	100%	1
	Hawkhurst	32	32	100%	1	17	97%	99%	0
DGS 01.04.16-31.08.16	Gravesham	3	3	100%	1	2	98%	Did not submit data	0
	Livingstone	25	25	100%	1	8	100%	100%	1
Ashford and Canterbury	Whit and Tank	5	5	100%	2	8	100%	100%	0
	Faversham	5	5	100%	0	17	100%	100%	0
	QVMH-Herne bay	12	12	100%	1	8	100%	100%	4 (1 level 3 lapse in care)

Patient safety

Medicines optimisation

Goals for 2016-17

1.	Conduct three patient focus group sessions in 2016/17 to improve pharmacy services: a. Patient medication information phone line b. Self-administration scheme in hospital. c. Discharge from hospital to home	Achieved
2.	80% prescribing compliance with dental antimicrobial formulary.	Achieved
3.	10% reduction in SafeMed errors relating to administration errors involving wrong doses and wrong drugs.	Achieved
4.	To improve the patient's experience of transfer of care from the acute trusts to community trust through collaborative working on medication related issues.	Not achieved

How did we perform in 2016-17?

1.
 - a. Work with the Patient medication phone line has progressed through consultation with patients, volunteer organisations and the Patient Engagement Team to consider how to improve the service for the patients benefit. The findings from the consultations will be taken forward into 2017-18 as a service development.
 - b. The self-administration medicines (SAM) policy in hospitals has been reviewed and implemented. The uptake of the SAM scheme is slow as patients are not remaining in hospital long enough to complete the scheme and other patients are not suitable for the scheme. The Hospital to Home project will be better placed to address medication adherence issues in some patients.
 - c. The discharge from hospital to home proposal was to identify high risk patients in hospital who will require additional support at home. Pharmacy technicians will follow-up high risk discharges either by phone or visit. Action: to broaden skills and experience and skills of hospital pharmacy technicians so they can work in both settings. Training has been completed and the pilot study started in west Kent to be reviewed in three months to assess value. If successful it will be rolled out across other areas. Joint working with the acute trusts and community pharmacies has resulted in greater cooperation and collaboration across sectors.



2. The SOEL health database has been redesigned to capture dentists' prescribing data and is now operational. The first audit data has been reviewed and the interim results show an improvement in all indicators compared with the previous year. The indicators measured are: use of custom screen, prescription recorded in patients' notes, indication for prescribing recorded, contraindications recorded and allergy recording. All these have improved over the past year. Most notably allergy recording has improved from 39 per cent to 73 per cent, which is a significant improvement in terms of patient safety and recording an indication has increased from 40 per cent to 56 per cent.
3. A 10 per cent reduction has been achieved in Safemed errors related to administration errors of wrong dose and wrong drug. The six-month nursing survey into the effectiveness of the PREPARE campaign shows a mixed response to the awareness of the campaign with some teams reporting they were unaware. All respondents so far stated they did not think it has made a difference to their practice as they were already following the correct process of administration of medicines. Results will be discussed at the trust's SafeMed meeting to decide on potential for re-launch and future actions.
4. We ran a pilot project designed between EKHUFT and KCHFT to provide seamless transfer of care from one ward in the acute trust to one ward in KCHFT. The initial pilot project did not provide enough data. Therefore, the pilot was redesigned to include different wards in EKHUFT that might result in more patients being discharged to KCHFT. Pilot work has resulted in evaluating what information on medicines is required on transfer and how technology can be effectively used. The chief pharmacists from EKHUFT and KCHFT are working closely together to develop the processes. Although the project did not meet the original target dates it has produced some good outcomes so far.

An agreement was made that EKHUFT drug charts will be used in KCHFT community hospitals providing seamless documentation on transfer so that transcribing new medicines drug charts is no longer required.

Patient safety

– improve pathways for vulnerable patients

Children's audiology

Goals for 2016-17

1.	90% of children will be seen within four weeks of referral to the audiology service.	Achieved	93%
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What is the Children's Hearing Service?

This service is a consultant-led audiology team offering hearing assessment and solutions for children from birth to 16-years-old in west Kent, Medway and Swale. Our paediatric audiologists have considerable training and experience in assessing and managing hearing impairment in children who have multiple conditions and who are difficult to test such as those with autistic spectrum disorder or attention deficit hyperactivity disorder.

How did we perform in 2016-17?

Our goal was to assess all babies referred from the Newborn Hearing Screening Service within four weeks. Three of the four CCGs achieved the target. Medway CCG's position remains the same as 2015-16. The main reason for being unable to achieve the target is the lack of venues within Medway to carry out the hearing assessments. We are currently working with the CCG to identify a suitable venue and anticipate an improved performance in 2017-18.

	2016-17 (at month 11)	2015-16
Swale	94.1%	80%
DGS	90.5%	84.9%
Medway	94.1%	83.4%
West Kent	93.4%	90.4%
Average	93%	85%

Patient safety

– improve pathways for vulnerable patients

Sexual health

Goals for 2016-17

1.	Implement and assure a procedure to ensure all young people under 16 identified at risk (safeguarding risk) are all followed up.	Achieved
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How did we perform in 2016-17?

1. The Sexual Health Service has implemented a procedure to make sure all young people under 16 identified at risk are followed up appropriately by the Sexual Health Service and action is taken when they do not attend any appointments.

Patient safety

– improve pathways for vulnerable patients

Dementia

Goals for 2016-17

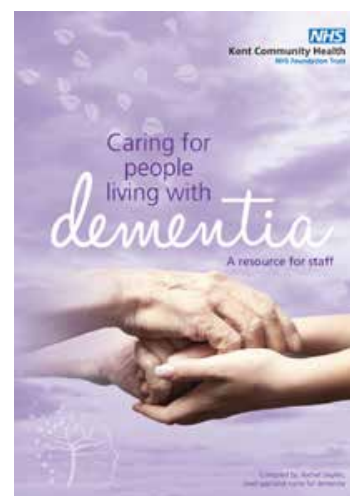
1.	To ensure that staff working in community hospitals (inpatients) receive Tier 2 (intermediate) dementia training. 85% target identified by 2020.	Achieved	3482%
2.	The Community Hospital Environments to work towards becoming dementia friendly as required by the Hospital Charter 2020.	Not achieved	

How did we perform in 2016-17?

1. The trust has until March 2020 to meet 85% compliance with tier 2 dementia training for inpatient staff, to meet the Hospital Charter 2020. The trust has 260 staff working in our hospitals that require this training. This means we must train 3.2 staff per month to train them all by 2020. To date, 148 of those staff have been trained, which is 3,482% of the target at April 2017.
2. Work has been undertaken to create dementia-friendly environments in our eight community hospitals. Signage has been installed to identify all patient areas. Toilet and bathroom doors have been painted dark blue so they contrast with other doors and are therefore more easily recognised by people with dementia and visual impairment. The community hospitals have dementia-friendly clocks that are designed to aid orientation to time within the ward environments.

Dementia crockery is available in Faversham Cottage Hospital to support people with dementia when eating and drinking.

Appropriate crockery has been identified for the remaining hospitals and an application for funding has been made. Faversham Cottage Hospital and Victoria Hospital, Deal, have orientation boards in their dayrooms. It is anticipated that there will be some improvement in the patient led assessment of the care environment (PLACE) results. Flooring remains a concern in the hospitals and is being replaced in Hawkhurst Community Hospital; however there are no plans for the remaining hospitals at this time.



Clinical effectiveness

Goal summary

	Goal	2015-16	2016-17
Research, innovation and evidence-based care	Annual plan established in line with strategy, agreed and implemented.	Achieved	Achieved
	Research Strategy 2017-2020 to be agreed.	N/A	
	At least 160 patients enrolled in NIHR Portfolio Research Studies.	Not achieved	Achieved
	To build on existing patient and public engagement in research.	Achieved	Achieved
	To develop capacity and capability within the trust to deliver portfolio studies and to develop own account research which may become portfolio studies.	Achieved	Achieved
NICE guidance	100% compliance evidenced at audit through NICEAssure (software for recording assessments of NICE guidance etc.)	Achieved	Partially achieved
Improving staff morale, recruitment and retention	Improve the quality of appraisal as measured by the national staff survey –an increase on survey 2015	N/A	Achieved
	To monitor safer staffing levels to maintain patient safety – review staffing with quality triangulation each month	Achieved	Achieved
	Improve the response rating in the staff survey so staff feel safe to raise concerns – an increase on survey 2015	N/A	Achieved
	Increase the staff engagement score from survey 2015	N/A	Achieved
	Staff are sighted on the strategic aims of the trust – increase per quarter	N/A	Achieved
Effective clinical care	Consistent care across all sexual health services with harmonisation of all clinical guidelines across Kent and Medway services	N/A	Achieved
	Increase access to advocacy and support for people living with HIV – pilot a peer support group in east Kent	N/A	Not achieved

The following sections describe each clinical effectiveness goal in more detail.

Clinical effectiveness

Increase research activity, innovation and evidence-based care

Goals for 2016-17

1.	Annual plan established in line with strategy, agreed and implemented.	Achieved	
2.	Research strategy 2017-2020 to be agreed.	Postponed	
3.	At least 160 patients enrolled in NIHR portfolio research studies.	Achieved	254%
4.	To build on existing patient and public engagement in research.	Achieved	
5.	To develop capacity and capability within the trust to deliver portfolio studies and to develop own account research which may become portfolio studies.	Achieved	

How did we perform in 2016-17?

- Significant progress has been made towards the annual plan this year including:
 - development of policies, procedures and Standard Operating Procedures relating to research and in areas of research governance e.g. auditing and monitoring of studies
 - key performance indicator (KPI) introduced for research as per Kent, Surrey and Sussex Clinical Research Network recruitment targets

masterclass held on collaborative research ideas

 - training sessions commissioned from University of Brighton and Canterbury Christ Church University
 - first meeting of all directorate research leads held.
- We have started to consult on the next iteration of the Research Strategy and the Clinical Audit Strategy. Innovation will be a key focus for the 2017-20 Research Strategy.
- At least 407 patients were recruited to national portfolio studies this year. This is 254 per cent of our target, which puts the trust in second place across Kent, Surrey and Sussex. We have an increasing number of new principal investigators (PI), including first time nurse PIs.
- We have recruited an additional patient representative. Work has included consultation on the next research strategy and attending patient and public events across the network alongside our research staff.

One of our patient representatives jointly ran one of the workshops at our Kent wide event.

The trust's work has been publicised in the patient and public magazine for the Kent, Surrey and Sussex Network, sharing real life stories of involvement in research.
- The organisation has doubled the number of staff who have completed Good clinical practice training in the past year.

Workshops for staff members, continued engagement with the research interest group and individualised support from our research facilitators is contributing to the development of home grown studies that will lead to toward research funding applications.

Clinical effectiveness

Compliance with NICE guidelines

Goals for 2016-17

1.	To ensure all technological appraisals are completed within three months of being issued.	Partially achieved	98.2%
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What is NICE?

The National Institute for Health and Care Excellence (NICE) provides national guidance and advice to improve health and social care. NICE issue monthly guidance and standards, which health and social care services are required to implement to ensure the best possible care is delivered.

How did we perform in 2016/2017?

The trust uses the NICEAssure database to monitor our compliance with applicable and relevant NICE guidelines.

From January 2016 (due April 2017) to December 2016 (due March 2017) there were 56 technological appraisals released by NICE. Of these, five were deemed applicable to the trust, of which four were fully compliant and one partially compliant with an action plan in place. This translates to 98.2 per cent compliance.

NICE technological appraisals are sent to the Medicines Management Service, which determines if they are relevant to the trust. The identified NICE lead then completes the required assessment and updates NICEAssure.

All NICE guidelines are reviewed at the trust's directorate quality meeting for final agreement on decisions made regarding NICE guidelines. The table below shows the breakdown of NICE Guidance released from January to December 2016.

Guidance Type	On-going (applicable to at least one service)	Archived (not applicable to any service)	Total
Clinical guidelines (CG)	21	8	29
Diagnostics guidance (DTG)	0	6	6
Highly specialised technology guidance (HST)	0	1	1
Interventional procedures guidance (IPG)	3	28	31
Medical technologies guidance (MTG)	0	3	3
NICE guidance (NG)	23	11	34
Public health guidance (PH)	1	0	1
Quality standard (QS)	35	7	42
Technology appraisal (TA)	5	51	56

Clinical effectiveness

Effective clinical care

Sexual health

Goals for 2016-17

1.	Consistent care across all sexual health services with harmonisation of all clinical guidelines across Kent and Medway services.	Achieved
2.	Increase access to advocacy and support for people living with HIV – pilot a peer support group in east Kent.	Not achieved

How did we perform in 2016/2017?

1. All sexual health services are delivered in line with the service specification associated with the contract. There are clinical guidelines to support the provision of safe care across Kent and Medway.
2. Terrence Higgins Trust (THT) has worked with KCHFT to develop a pilot programme in east Kent to increase access to advocacy and support for people living with HIV. Initial scoping work has been carried out. However, there has been limited interest in participating in a peer support programme. THT is seeking additional views of HIV patients to identify the need to develop a peer support programme during 2017-18.

Enabling strategies

Goal summary

	Goal	2015-16	2016-17
Education and training	To ensure 85% of newly recruited unregistered clinical staff complete the care certificate within first three months	N/A	Not achieved
	To ensure 85% of Active NMC registered mentors are in date with all mandatory training	Not achieved	Not achieved
Workforce	Improve the quality of appraisal as measured by the national staff survey –an increase on survey 2015	N/A	Achieved
	Improve the response rating in the staff survey so staff feel safe to raise concerns. An increase on survey 2015	Not achieved	Achieved
	Increase the staff engagement score from survey 2015	N/A	Achieved
	Staff are sighted on the strategic aims of the trust-increase per quarter	N/A	Achieved
Estates	To have a definitive site list for the trust across all services	Not achieved	Achieved
	For all core estate sites to be compliant for health and safety	Not achieved	Achieved
	To assess the estate in terms of patient and staff experience and identify those sites which fall short of aspiration	Not achieved	Achieved
	To increase co-location wherever practicable and possible to enhance the patient experience	Not achieved	Ongoing

	Goal	2015-16	2016-17
Partnership working	Assessment of benefits realisation including efficiency for CIS	Not achieved	Achieved
	To deliver interoperability with GP systems including anticipatory care plans and clinical correspondence	Not achieved	Partially achieved
	Refresh the mobile estate	Not achieved	Achieved
	To deliver a new wound care system to aid and support decision-making support for staff	Not achieved	Achieved
Clinical audit and research	Promote and support innovation from clinical audit and research, and in partnership with others in the health economy	Achieved	Achieved
	Launch narrated presentation to share innovation	N/A	Achieved
Innovation and transformation	Delivery of 32 business plans Identification of two year CIP	Achieved	Achieved
	All services receiving business planning or Thinking Differently skills packages	N/A	Achieved
	All community hospitals effectively using the Safer Patient Flow Bundle with Home First	N/A	Achieved
	Support the change management process, to clinic based practice, for the community nursing services through identified initiatives, such as the wound medicine project.	N/A	Achieved

Enabling strategies

Education and training

Goals for 2016-17

1.	To ensure 85% of newly recruited unregistered clinical staff complete the care certificate within first three months.	Not achieved	2.3%
2.	To ensure 85% of active NMC registered mentors are in date with all mandatory training.	Not achieved	61%

How did we perform in 2016/2017?

1. A total of 133 newly recruited unregistered clinical staff joined the trust since April 2016. Of these, only three have completed the care certificate within the first three months of their employment. Although more have since completed the care certificate, it was not within the first three months of employment.

To ensure this is completed within three months in future, an introduction to the care certificate was incorporated into corporate induction in February 2017. A follow-up will take place before month three to ensure completion.

We are also looking at the possibility of incorporating the care certificate into our apprenticeship programmes to further increase completion numbers. We plan to introduce an internal key performance indicator to encourage participation by existing staff.

The care certificate is governed by Health Education England around Cavendish and workforce development action plan.

2. We aim to ensure that all students are safeguarded in their practice with a mentor that is up-to-date with their training. We have assurance that our students who are based with a mentor have maintained mandatory training. We have processes in place to match students with up-to-date mentors, to review their mandatory training during their placement and to ensure they are placed with a compliant mentor.

Dartford, Gravesham, Swanley	17
West Kent	77
Ashford and Canterbury	33
Thanet	18
South Kent Coast	21
Swale	8
Medway	3
Other	96

Enabling strategies

Improve staff morale, recruitment and retention (workforce)

Goals for 2016-17

1.	Improve the quality of appraisal as measured by the national staff survey – an increase on survey 2015.	Achieved	Increase from 3.03 to 3.12
2.	Improve the response rating in the staff survey so staff feel safe to raise concerns – an increase on survey 2015.	Achieved	Increase from 3.69 to 3.74
3.	Increase the staff engagement score from survey 2015.	Achieved	Increase from 3.76 to 3.78
4.	Staff are sighted on the strategic aims of the trust – increase per quarter.	Achieved	Increase from 44% to 81%

How did we perform in 2016/2017?

1. The trust score for key finding 12 in the national staff survey was 3.03 in 2015 and increased to 3.12 in 2016. The goal was to improve the quality of appraisal as measured by the national staff survey when compared to the previous year. This score was in the trust's top five most improved scores and KCHFT score was average when compared to other similar organisations.
2. This is based on the staff survey key finding: Staff confidence and security in reporting unsafe clinical practice, which increased from 3.69 in 2015 to 3.74 in 2016. This was in the top five most improved scores for the 2016 survey. The goal was to improve the culture of staff raising concerns and providing an environment where they feel safe to do so. Not only has the score for this question moved from one of the trust's bottom scores in 2015 to a most improved score in 2016 but the trust has also appointed a freedom to speak up guardian to further develop this environment. We have just launched a campaign to encourage staff to raise concerns through a number of possible routes.
3. Our staff engagement score in the national staff survey increased from 3.76 in 2015 to 3.78 in 2016. While an improvement, this slight increase was not statistically significant and so the scores remained the same as the previous year's staff survey. However, when compared to other comparable organisations the trust has improved and has improved two questions associated with this key finding from below average to average.
4. Over this year a range of senior managers are asked how well they understand the strategic direction of the trust at our managers' events. The results have seen a mark increase from quarter two to quarter four.

Bullying and harassment: staff survey results

NHS England request inclusion of the following staff survey results in this report:

KEY FINDING 26. Percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months. The trust's score has not changed from the 2015 staff survey and remains average when compared to other similar organisations.

KEY FINDING 21. Percentage of staff believing that the organisation provides equal opportunities for career progression or promotion. While there has been no change in the trust's score for this key finding, it is in the top five ranking scores and above average when compared to similar organisations.

Safer staffing

Goals for 2016-17

1.	To monitor safer staffing levels to maintain patient safety –review staffing with quality triangulation each month	Achieved
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How did we perform in 2016/2017?

1. The goal set was to ensure that staffing on the wards was assessed and reported to the Board each month.

The Board receive monthly reports, which focus on the quality of care within the organisation and safe staffing is a fundamental part of this. The data is triangulated with data regarding incidents, patient experience, complaints and harms including pressure ulcers and falls.

The Board has received a monthly report and this has provided assurance that safe staffing is maintained and on the occasions when staffing is less than planned, robust mitigation is put into place.

Benchmarking with other organisations has taken place and demonstrated that staffing in KCHFT is in line with that of other providers.

The data shows that staffing remains a priority for the inpatient units and where there are challenges that action is taken to ensure patients are safe.

Enabling strategies

Estates

Goals for 2016-17

1.	To have a definitive site list for the trust across all services.	Achieved	100%
2.	For all core estate sites to be compliant for health and safety.	Achieved	97%
3.	To assess the estate in terms of patient and staff experience and identify those sites which fall short of aspiration.	Achieved	
4.	To increase co-location wherever practicable and possible to enhance the patient experience.	Ongoing	

How did we perform in 2016/2017?

1. The goal was to map our estate footprint and categorise each premise. Next year the plan is to maintain and keep this information up-to-date.
2. The goal was to achieve full compliance certification on in patient areas last year.
3. Patient led assessment of the care environment (PLACE) assessments have been carried out. Action plans have been produced are being followed up for completion as soon as possible.
4. An estates strategy document has been ratified by the Board. This year, we have achieved delivery against the estates strategy in terms of co-location and north, west and coast strategy.

Enabling strategies

Partnership working: implementation of the Community Information System (CIS)

Goals for 2016-17

1.	Assessment of benefits realisation including efficiency	Achieved
2.	Refresh the mobile estate.	Achieved
3.	To deliver interoperability with GP systems including anticipatory care plans and clinical correspondence.	Partially achieved
4.	To deliver a new wound care system to aid and support decision making support for staff	Achieved

What is CIS?

Our Community Information System (CIS) is an electronic community patient administration system with facilities to record all aspects of community patients' health interactions.

How did we perform in 2016-17?

- The implementation of the CIS system for all aspects of community clinical support needed to undergo a formal benefits review process. Our auditors undertook a review last year and the key findings were:
 - Governance structure in place with CIS governance group meeting monthly and reporting to the trust Board.
 - CIS Governance group with representation from the supplier Advanced Health and Care, senior trust management (IT, deputy chief executive, director of finance)
 - Robust monitoring at CIS governance group with supplier monthly highlight report and risks and issues log.
 - Staff engagement reported to be poor due to issues with hardware and connectivity at deployment.
 - Additional financial costs due to new laptop rollout due to underestimation of caseload file size.

As a result of these recommendations work continued to improve staff engagement as detailed below.

- A total of 2,000 devices have been deployed to date with a further 100 designated to be distributed. All except 50 of these remaining tablets have been allocated and scheduled for delivery. Protective cases have been acquired and are being supplied to users.

Users have reported significant improvement with the performance of the tablets and resolution of the problem of caseload downloads failing.

3. The Medical interoperability gateway (MIG) has been implemented on CIS and the system can now pull down relevant and authorised data from GP records to supplement the information available to clinicians.

MIG is not available on the tablets, which causes difficulties for clinicians during home visits. It is essential to have this to compete with the EMIS product being promoted by the CCGs. Advanced Health Care has yet to provide a definitive date for this.

The MIG is still not a two-way process as information from CIS cannot be passed back to the EMIS GP system.

4. The contract for the new wound care system has been signed and a project plan developed. As part of a six-month pilot, technical testing is underway on both the tablet and server applications; this is progressing well. User acceptance and training has already started as per project plan with a cascade approach having trained 'super-users'.

Enabling strategies

– Innovation and transformation

Clinical audit and research

Goals for 2016-17

1.	Promote and support innovation from clinical audit and research and in partnership with others in the health economy.	Achieved
2.	Launch narrated presentation to share innovation.	Achieved

How did we perform in 2016-17?

1. There have been a number of partnership events that KCHFT has participated in this year.

We attended the planning committee for the International Collaboration for Community Health Nursing Research symposium, held at the University of Kent in September 2016. It focussed on 'Changing populations, changing needs: Directions and models for community orientated primary care'. It attracted a large home and international delegation.

In August, KCHFT and Kent and Medway NHS and Social Care Partnership Trust (KMPT) joined forces to spark a day-long twitter conversation around the joint research needs of both physical and mental health. KCHFT's annual clinical audit and research conference in November included partners and speakers from across the Health economy.

KCHFT was part of the organising committee for a Kent-wide research event in January 2017. This event showcased local innovation.

A pilot known as the Cupris study was carried out with Medway. This study involved the use of an otoscope attached to a smartphone, communication system through an app. The aim is to improve healthcare experience and reduce unnecessary treatments for patients with learning disabilities.

2. Technology was used to develop a virtual resource in the form of narrated and filmed presentations to promote a lessons learned approach to practice and to support continuing professional development.

The following bank of narrated presentations have been produced:

- Tissue viability filmed presentation.
- Born to Move
- Frailty conference feedback
- Painting pain research
- Reasonable adjustment case study.



Enabling strategies

– Innovation and transformation

Transformation

Goals for 2016-17

1.	Delivery of 32 business plans and identification of two year CIP	Achieved
2.	All services receiving business planning or Thinking Differently skills packages.	Achieved
3.	Roll out and embed the Safer Patient Flow Bundle across all community hospitals.	Achieved

How did we perform in 2016-17?

1. As part of the NHS national efficiency the trust is expected to identify saving efficiencies, known as the cost improvement programme (CIP). This is in line with the NHS Five Year Forward view. This year, 41 business plans have been refreshed or produced and CIP savings identified to the value of £4.2 million.
2. As part of the business planning process it is vital that services understand the process and the reason why CIP is needed for the trust. Business planning awareness sessions have been delivered to 1,000 staff from 20 clinical services. Thinking differently sessions have also been completed with services.
3. SAFER is a set of activities to help eliminate unnecessary waiting and get patients home. It supports our Home First approach to get people to the place they call home, as soon as possible. It comprises an easy-to-understand set of actions and interventions, that when delivered together as part of a multidisciplinary approach, help to deliver the best possible care.

SAFER stands for:

- **S**enior review
- **A**ll patients to have an estimate discharge date
- **F**low of patient should happen as early as possible
- **E**arly discharge: Home before lunch
- **R**eview of patients weekly.

Our aim was to ensure that all community hospitals effectively use the 'Safer patient flow bundle' with the Home First model. All sites are now engaged and understand what SAFER is and the reasons for it. Board rounds have been introduced at all our community hospitals.



Enabling strategies

– Change management: the wound management project

Goals for 2016-17

1.	Support the change management process to clinic-based practice for the community nursing services through initiatives, such as the wound medicine project.	Achieved
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How did we perform in 2016-17?

A clinical model with supporting care pathways work has been developed and is being embedded across the trust.

Three wound management centres (WMCs) are now in place in Herne Bay, Deal and Ashford. Sevenoaks is expected to open in May 2017 with an enhanced integrated GP cluster service model. Work is progressing with the proposed Thanet site.

Software has been purchased to enable photographs and analysis of wounds and this is being rolled out across the trust, including the Vanguard site in Whitstable.

An e-clinics model within the WMC framework, supported by the wound Matric tool, has been defined and will be implemented.

Wound Infection Evaluation Tool predictive tool has been presented at the global World Union of Wound Healing Societies, and an article was published in The Journal of Wound Medicine.

Bespoke University of Kent – KCHFT training model continues to support the skills enhancement and competencies programme.

This section shows our performance against the relevant indicators and performance thresholds set out in the oversight documents issued by NHS Improvement. For our trust, this is only one indicator:

The maximum time of 18 weeks from point of referral to treatment (RTT) in aggregate – patients on an incomplete pathway:

	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	16/17
RTT Incomplete Pathways	99.90%	98.76%	99.64%	99.53%	99.64%	99.52%	99.95%	99.92%	99.91%	99.96%	99.72%	99.36%	99.65%

Annex 1

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

From: HOSC – Legal and Democratic Services – ST

Sent: 09 May 2017 11:06

To: 'Knox Alison'

Subject: RE: KCHFT Quality Report

Dear Alison

Thank you for the draft copy of Kent Community Health NHS Foundation Trust's Quality Account 2016/17. The Kent HOSC will not be providing a statement this year as the Committee has not been reconstituted following the election on 4 May; it will be reconstituted on 25 May which is after the deadline for comments.

The Committee looks forward to receiving future copies of the Quality Account.

Best wishes

Lizzy

Lizzy Adam

Scrutiny Research Officer

Strategic & Corporate Services (Governance & Law)

Kent County Council | Sessions House | Maidstone | Kent | ME14 1XQ

Tel: 03000 412000 | Email: elections@kent.gov.uk

Annex 2

Statement of directors' responsibilities for the quality report

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

NHS Improvement has issued guidance to NHS foundation trust boards on the form and content of annual quality reports (which 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 2016/17 and supporting guidance
- the content of the Quality Report is not inconsistent with internal and external sources of information including:
 - o board minutes and papers for the period 1 April 2016 to 25 May 2017
 - o papers relating to quality reported to the board over the period April 2016 to 25 May 2017
 - o feedback from commissioners dated 28 April 2017, with no responses received
 - o feedback from governors dated May 2017
 - o feedback from local Healthwatch organisations dated 28 April 2017, with no responses received
 - o feedback from Overview and Scrutiny Committee dated 9 May 2017
 - o the trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, dated May 2017
 - o the 2016 national staff survey
 - o the Head of Internal Audit's annual opinion of the trust's control environment dated May 2017
 - o CQC inspection report dated 2014
- the Quality Report presents a balanced picture of the NHS foundation trust's performance over the period covered
- the performance information reported in the Quality Report is reliable and accurate
- there are proper internal controls over the collection and reporting of the measures of performance included in the Quality Report, and these controls are subject to review to confirm that they are working effectively in practice
- the data underpinning the measures of performance reported in the Quality Report is robust and reliable, conforms to specified data quality standards and prescribed definitions, is subject to appropriate scrutiny and review and
- the Quality Report has been prepared in accordance with NHS Improvement's annual reporting manual and supporting guidance (which incorporates the Quality Accounts regulations) as well as the standards to support data quality for the preparation of the Quality Report.



Kent Community Health

NHS Foundation Trust

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

.....Date.....Chairman

.....Date.....Chief Executive Officer

Glossary

BFI	Baby Friendly Initiative
CAUTI	Catheter associated urinary tract infection
CCG	Clinical commissioning group
CIP	Cost Improvement programme
CIS	Community information system
COPD	Chronic obstructive pulmonary disease
CQC	Care Quality Commission
DH	Department of Health
EKHUFT	East Kent Hospitals University NHS Foundation Trust
EMIS	GP electronic records system
HH	Hand hygiene
HPV	Human papilloma virus
ICIQ-UI	International consultation incontinence questionnaire – urinary Incontinence
IPC	Infection prevention and control
KCC	Kent County Council
KCHFT	Kent Community Health NHS Foundation Trust
KMPT	Kent and Medway Social and Partnership Care NHS Trust
KPI	Key performance indicator
MENacwy	The meningococcal (Men) A, C, W and Y vaccine
MIG	Medical interoperability gateway
MRSA	Methicillin-resistant staphylococcus aureus
MYMOP	Measure yourself medical outcome profile
NCMP	National Child Measurement Programme
NICE	National Institute of Health and Clinical Excellence
NIHR	National Institute for Health Research
PLACE	Patient led assessment of the care environment
PPD	Preferred place of death
SAFER	Senior review; all patients to have an estimate discharge date; flow of patient should happen as early as possible; early discharge: home before lunch; review of patients weekly
SAM	Self-administration medicines
SSKIN	SSKIN care bundle (Surface; skin inspection; keep moving; incontinence; nutrition)
TD/IPV	Tetanus, diphtheria and polio vaccine
UTI	Urinary tract Infection
WMC	Wound management centre

Independent Practitioner's Limited Assurance Report to the Council of Governors of Kent Community Health NHS Foundation Trust on the Quality Report

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We have been engaged by the Council of Governors of Kent Community Health NHS Foundation Trust to perform an independent limited assurance engagement in respect of Kent Community Health NHS Foundation Trust's Quality Report for the year ended 31 March 2017 (the "Quality Report") and certain performance indicators contained therein against the criteria set out in the 'NHS foundation trust annual reporting manual 2016/17' and additional supporting guidance in the 'Detailed requirements for quality reports for foundation trusts 2016/17' (the 'Criteria').

Scope and subject matter

The indicators for the year ended 31 March 2017 subject to the limited assurance engagement consist of the national priority indicators as mandated by NHS Improvement:

- Percentage of incomplete pathways within 18 weeks for patients on incomplete pathways at the end of the reporting period
- The number of patient safety incidents reported within the trust during the reporting period, and the number and percentage of such patient safety incidents that resulted in severe harm or death

We refer to these national priority indicators collectively as the 'Indicators'.

Respective responsibilities of the directors and Practitioner

The directors are responsible for the content and the preparation of the Quality Report in accordance with the criteria set out in the 'NHS foundation trust annual reporting manual 2016/17' and supporting guidance issued by NHS Improvement.

Our responsibility is to form a conclusion, based on limited assurance procedures, on whether anything has come to our attention that causes us to believe that:

- the Quality Report is not prepared in all material respects in line with the Criteria set out in the NHS foundation trust annual reporting manual 2016/17 and supporting guidance;
- the Quality Report is not consistent in all material respects with the sources specified in NHS Improvement's 'Detailed requirements for external assurance for quality reports for foundation trusts 2016/17'; 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 2016/17' and supporting guidance and the six dimensions of data quality set out in the 'Detailed requirements for external assurance for quality reports for foundation trusts 2016/17'.

We read the Quality Report and consider whether it addresses the content requirements of the 'NHS foundation trust annual reporting manual 2016/17' and supporting guidance, and consider the implications for our report if we become aware of any material omissions.

We read the other information contained in the Quality Report and consider whether it is materially inconsistent with:

- Board minutes for the period 1 April 2016 to 25 May 2017;
- papers relating to quality reported to the Board over the period 1 April 2016 to 25 May 2017;
- feedback from Commissioners requested 28 April 2017 with no responses received;
- feedback from Governors dated May 2017;

- feedback from local Healthwatch organisations requested 28 April 2017 with no responses received;
- feedback from Overview and Scrutiny Committee dated 9 May 2017;
- the national staff survey dated 2016; and
- the Head of Internal Audit's annual opinion over the Trust's control environment dated May 2017.

We consider the implications for our report if we become aware of any apparent misstatements or material inconsistencies with those documents (collectively, the "documents"). Our responsibilities do not extend to any other information.

The firm applies International Standard on Quality Control 1 and accordingly maintains a comprehensive system of quality control including documented policies and procedures regarding compliance with ethical requirements, professional standards and applicable legal and regulatory requirements.

We are in compliance with the applicable independence and competency requirements of the Institute of Chartered Accountants in England and Wales (ICAEW) Code of Ethics. Our team comprised assurance practitioners and relevant subject matter experts.

This report, including the conclusion, has been prepared solely for the Council of Governors of Kent Community Health NHS Foundation Trust as a body, to assist the Council of Governors in reporting Kent Community Health NHS Foundation Trust's quality agenda, performance and activities. We permit the disclosure of this report within the Annual Report for the year ended 31 March 2017, to enable the Council of Governors to demonstrate they have discharged their governance responsibilities by commissioning an independent assurance report in connection with the indicators. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the Council of Governors as a body, and Kent Community Health NHS Foundation Trust for our work or this report, except where terms are expressly agreed and with our prior consent in writing.

Assurance work performed

We conducted this limited assurance engagement in accordance with International Standard on Assurance Engagements 3000 (Revised) – 'Assurance Engagements other than Audits or Reviews of Historical Financial Information' issued by the International Auditing and Assurance Standards Board ('ISAE 3000'). Our limited assurance procedures included:

- evaluating the design and implementation of the key processes and controls for managing and reporting the indicators;
- making enquiries of management;
- limited testing, on a selective basis, of the data used to calculate the indicators tested back to supporting documentation;
- comparing the content requirements of the 'NHS foundation trust annual reporting manual 2016/17' and supporting guidance to the categories reported in the Quality Report; and
- reading the documents.

A limited assurance engagement is narrower in scope than a reasonable assurance engagement. The nature, timing and extent of procedures for gathering sufficient appropriate evidence are deliberately limited relative to a reasonable assurance engagement.

Limitations

Non-financial performance information is subject to more inherent limitations than financial information, given the characteristics of the subject matter and the methods used for determining such information.

The absence of a significant body of established practice on which to draw allows for the selection of different but acceptable measurement techniques 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 2016/17' and supporting guidance.

The scope of our limited assurance work has not included governance over quality or non-mandated indicators which have been determined locally by Kent Community Health NHS Foundation Trust.

Our audit work on the financial statements of Kent Community Health NHS Foundation Trust is carried out in accordance with our statutory obligations and is subject to separate terms and conditions. This engagement will not be treated as having any effect on our separate duties and responsibilities as Kent Community Health NHS Foundation Trust's external auditors. Our audit reports on the financial statements are made solely to Kent Community Health NHS Foundation Trust's members, as a body, in accordance with paragraph 24(5) of Schedule 7 of the National Health Service Act 2006. Our audit work is undertaken so that we might state to Kent Community Health NHS Foundation Trust's members those matters we are required to state to them in an auditor's report and for no other purpose. Our audits of Kent Community Health NHS Foundation Trust's financial statements are not planned or conducted to address or reflect matters in which anyone other than such members as a body may be interested for such purpose. In these circumstances, to the fullest extent permitted by law, we do not accept or assume any responsibility to anyone other than Kent Community Health NHS Foundation Trust] and Kent Community Health NHS Foundation Trust's members as a body, for our audit work, for our audit reports, or for the opinions we have formed in respect of those audits.

Conclusion

Based on the work described in this report, nothing has come to our attention that causes us to believe that, for the year ended 31 March 2017:

- 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 2016/17 and supporting guidance;
- the Quality Report is not consistent in all material respects with the sources specified in NHS Improvement's 'Detailed requirements for external assurance for quality reports for foundation trusts 2016/17'; and
- the indicators in the Quality Report identified as having been the subject of limited assurance in the Quality Report have not been reasonably stated in all material respects in accordance with the 'NHS foundation trust annual reporting manual 2016/17' and supporting guidance.

Grant Thornton UK LLP
Chartered Accountants
London

25 May 2017

