

Agenda and Papers

for the

Formal meeting of the

Kent Community Health NHS Foundation
Trust Board

to be held at 10am on

Thursday 24 May 2018

In

The Committee Room

Tonbridge and Malling Council Buildings
Gibson House
Gibson Drive
Kings Hill
ME19 4LZ

Meeting of the Kent Community Health NHS Foundation Trust Board
to be held at 10am on Thursday 24 May 2018
The Committee Room, Tonbridge and Malling Council Offices, Gibson Building,
Gibson Drive, Kings Hill, West Malling Kent
ME19 4LZ

This meeting will be held in Public

AGENDA

1. STANDARD ITEMS

1.1	Introduction by Chair	Chairman	
1.2	To receive any Apologies for Absence	Chairman	
1.3	To receive any Declarations of Interest	Chairman	
1.4	To agree the Minutes of the Kent Community Health NHS Foundation Trust Board meeting held on 29 March 2018	Chairman	
1.5	To receive Matters Arising from the Kent Community Health NHS Foundation Trust Board meeting held on 29 March 2018	Chairman	
1.6	To receive the Chairman's Report	Chairman	Verbal
1.7	To receive the Chief Executive's Report	Chief Executive	

2. BOARD ASSURANCE/APPROVAL

2.1	To receive the Patient Story	Chief Nurse	
2.2	To receive the Quality Committee Chair's Assurance Report	Chair of Quality Committee	

2.3	To receive the Audit and Risk Committee Chair's Annual Report to the Board	Chair of Audit and Risk Committee
2.4	To receive the Charitable Funds Committee Chair's Reports to the Board: (i) Assurance Report (ii) Annual Report	Chair of Charitable Funds Committee
2.5	To receive the Strategic Workforce Committee Chair's Assurance Report	Chair of Strategic Workforce Committee
2.6	To approve the 2017/18 Annual Report and Accounts (i) 2017/18 Annual Quality Report (ii) Self-Certification with NHS Provider Licence	Director of Finance Corporate Services Director
2.7	To receive the Workforce Report	Director of Workforce, Organisational Development and Communications
2.8	To receive the Integrated Performance Report	Director of Finance Chief Operating Officer/ Deputy Chief Executive Chief Nurse
2.9	To receive the Monthly Quality Report	Chief Nurse
2.10	To receive the Finance Report Month One	Director of Finance
2.11	To approve the Committees' Terms of Reference (i) Audit and Risk Committee (ii) Charitable Funds Committee (iii) Finance, Business and Quality Committee (iv) Quality Committee (v) Remunerations and Terms of Service Committee (vi) Strategic Workforce Committee	Chairman

2.12	To receive the Interim Appointments following the Chair's Retirement Report	Corporate Services Director
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3. REPORTS TO THE BOARD

3.1	To receive the approved Minutes of the Charitable Funds Committee meeting of 25 January 2018	Chair of the Charitable Funds Committee
3.2	To receive the Quarterly Infection Prevention and Control Report	Chief Nurse
3.3	To receive the Quarterly Patient Experience and Complaints Report	Chief Nurse
3.4	To receive the Quarterly Mortality and Learning from Deaths Report	Medical Director
3.5	To receive the Six Monthly Freedom to Speak Up Report	Director of Workforce, Organisational Development and Communications
3.6	To receive the Comprehensive Information Governance Report	Corporate Services Director
3.7	To receive the Emergency Planning and Business Continuity Annual Report	Corporate Services Director
3.8	To receive the Staff Survey Report	Director of Workforce, Organisational Development and Communications

4. ANY OTHER BUSINESS

To consider any other items of business previously notified to the Chairman.	Chairman
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5. QUESTIONS FROM MEMBERS OF THE PUBLIC RELATING TO THE AGENDA

6. DATE AND VENUE OF NEXT MEETING

Thursday 26 July 2018
Kent Community Health NHS Foundation Trust Offices, Room 6 and 7 Trinity House, 110-120
Upper Pemberton, Eureka Business Park, Kennington, Ashford Kent TN25 4AZ

**Unconfirmed Minutes
of the Kent Community Health NHS Foundation Trust Board
held at 10am on Thursday 29 March 2018
in Oakroom, Oakwood House, Maidstone Kent ME16 8AE**

Meeting held in Public

Present: David Griffiths, Chairman
Pippa Barber, Non-Executive Director
Paul Bentley, Chief Executive
Peter Conway, Non-Executive Director
Richard Field, Non-Executive Director
Gordon Flack, Director of Finance
Steve Howe, Non-Executive Director
Louise Norris, Director of Workforce, Organisational Development and Communications
Dr Sarah Phillips, Medical Director
Bridget Skelton, Non-Executive Director
Lesley Strong, Deputy Chief Executive/Chief Operating Officer
Ali Strowman, Chief Nurse

In Attendance: Gina Baines, Committee Secretary (minute-taker)
Natalie Davies, Corporate Services Director

29/03/1 **Introduction by Chair**

Mr Griffiths welcomed everyone present to the Public Board meeting of Kent Community Health NHS Foundation Trust (the Trust).

Mr Griffiths advised that this was a formal meeting of the Board held in public, rather than a public meeting, and as such there would be an opportunity for public questions relating to the agenda at the end of the meeting.

29/03/2 **Apologies for Absence**

Apologies were received from Jennifer Tippin, Non-Executive Director.

The meeting was quorate.

29/03/3 **Declarations of Interest**

No conflicts of interest were declared other than those formerly recorded.

29/03/4 **Minutes of the Meeting of 25 January 2018**

The Board **AGREED** the minutes.

29/03/5 **Matters Arising from the Meeting of 25 January 2018**

The Board **RECEIVED** the Matters Arising.

29/03/6 **Chairman's Report**

There was nothing to report from the Chairman.

29/03/7 **Chief Executive's Report**

Mr Bentley presented the report to the Board for assurance.

Mr Bentley, on behalf of the Board, thanked all the staff for their tremendous effort in continuing to support and care for patients during the recent extreme winter weather.

Mr Field commented that he had attended the Trust's Children's Specialist and Learning Disabilities Conference earlier in the month. It had been the largest Trust conference to date with over 500 members attending and had provided an excellent showcase of what the Trust delivered to its patients.

The Board **RECEIVED** the Chief Executive's Report.

29/03/8 **Quality Committee Chair's Assurance Report**

Mr Howe presented the report to the Board for assurance.

In response to a clarification question from Mr Griffiths regarding the accurate use of the wording 'attributable' and 'unavoidable' when describing harms, Ms Strowman confirmed that there had been a move away from using attributable language. Instead, the wording 'inherited' or 'acquired' was now being introduced.

The Board **APPROVED** the 2018 Infection Prevention and Control Declaration.

The Board **RECEIVED** the Quality Committee Chair's Assurance Report.

29/03/9 **Audit and Risk Committee Chair's Assurance Report**

Mr Conway presented the report to the Board for assurance.

In response to a question from Mr Bentley regarding the timing of the paper to the Board Strategy and Development Day on the strategic options for the Trust around the Community Information System (CIS), Mr Conway suggested that it could be considered in May rather than April 2018.

With regards to the Sustainability and Transformation Partnership (STP) Risk Register, Mr Bentley agreed to pass the comments made by the Chair of the Committee to the Chief Executive of the STP. He commented that the risks were known. There was an issue around capturing them and updating the register.

Action – Mr Bentley

The Board **RECEIVED** the Audit and Risk Committee Chair's Assurance Report.

29/03/10 **Charitable Funds Committee Chair's Assurance Report**

Mr Field presented the report to the Board for assurance.

The Board **RECEIVED** the Charitable Funds Committee Chair's Assurance Report.

29/03/11 **Strategic Workforce Committee Chair's Assurance Report**

Ms Skelton presented the report to the Board for assurance.

In response to a comment from Mr Conway regarding the continuingly high staff turnover figures, Ms Skelton confirmed that this was a high priority for the Committee. It had asked for a plan to be produced with a trajectory of change. Ms Norris added that the Trust had benchmarked its turnover, vacancy and sickness rates against other community trusts, and had found that the Trust benchmarked favourably. The Trust would be participating in the NHS Improvement Retention Collaborative initiative and this would be led by Ms Norris and Ms Strowman. They would be developing an action plan which would set out a number of deliverables. Ms Skelton continued that the Committee had reviewed the Trust's benefits package and it had been found to be very competitive. It had been agreed that this needed to be better communicated to staff to raise their awareness.

In response to a question from Mr Griffiths regarding whether the movement of staff between different NHS organisations could be considered as positive rather than negative, Ms Skelton commented that this needed to be better understood. Some staff had left for promotion while others had left because of a negative experience. Ms Norris confirmed that this was being investigated. It was agreed that those staff who left within their first year of employment with the Trust needed significant focus.

The Board **RECEIVED** the Strategic Workforce Committee Chair's Assurance Report.

29/03/12 **Workforce Report**

Ms Norris presented the report to the Board for assurance.

There had been an error in the report and it would be republished.

Action – Ms Norris

In response to a question from Mr Field regarding how many staff would be expected to be rated as 'outstanding' in their annual appraisal, Ms Norris indicated that this would be approximately five per cent of the workforce. Work was underway with managers to educate them as to what was meant by this rating which included mandatory achievement of the staff member's core objectives. In response to a further question from Mr Field regarding the numbers involved in the talent management pool and how the programme would be resourced, Ms Norris explained that the numbers would be in the tens and systems were in place to manage the programme.

In response to a question from Mr Conway regarding whether there were any vacancy hotspots in the directorates, Ms Strong confirmed that there were some in the west Kent community hospitals and some in specific community nursing teams in east Kent.

The Board **RECEIVED** the Workforce Report.

29/03/13 **Integrated Performance Report**

Mr Flack presented the report to the Board for assurance.

Ms Strowman added that with regards to the End of Life Care Key Performance Indicator (KPI), she had undertaken some benchmarking of other similar trusts and had come to the conclusion that the KPI was not a strong indicator of the quality of end of life care. This was reflected because not all trusts recorded this data. She suggested that she would take this matter to the End of Life Care Steering Group who would endeavour to identify a more reflective quality metric.

Action – Ms Strowman

In response to a question from Ms Barber regarding the recent improvement in the Delayed Transfer of Care performance, Ms Strong explained that the winter months had been very focussed on maintaining patient flow. In both east and west Kent, discharge co-ordinators had been appointed who worked closely with the Trust's partner organisations to move patients on through the system. These roles were to become permanent and daily reporting would continue.

The Board **RECEIVED** the Integrated Performance Report.

29/03/14 **Monthly Quality Report**

Ms Strowman and Dr Phillips presented the report to the Board for assurance.

In response to a question from Ms Skelton regarding the reported drop in the number of medication incidents that month, Ms Strowman commented that the timing of the data for the report meant that the figures might not

report a full month's data. She expected that the February data would increase in the days following the closure of the recording period..

In response to a question from Ms Barber regarding the decrease in the number of patient surveys recorded at the Gravesham Minor Injuries Unit, Ms Strong explained that there had been a change in the leadership of the team at the unit. A new manager had recently joined and she would be addressing the issue.

In response to a question from Mr Conway regarding the falls that had been reported at West View and Westbrook integrated care centres, Ms Strowman confirmed that investigations were underway. Early findings had indicated that there had been good practice but it was unclear if the falls had been preventable. However, it was likely that the report would confirm that they were attributable. Ms Strong reminded the Board that both units were registered with the Care Quality Commission (CQC) under Kent County Council (KCC).

Ms Strong provided an update on the current status of the escalation beds that had been opened at Sheppey Community Hospital and elsewhere in east Kent during February 2018. In response to a question from Mr Griffiths regarding whether they had been a success, Ms Strong indicated their management had worked well, although it was recognised that there was a risk with putting in escalation beds per se.

The Board **RECEIVED** the Monthly Quality Report.

29/03/15 **Finance Report (Month 11)**

Mr Flack presented the report to the Board for assurance.

It was confirmed that, apart from the capital plan target, the Trust would meet its financial targets including its Cost Improvement Plan.

Mr Griffiths, on behalf of the Board, congratulated the work of the Executive Team in producing such excellent results.

The Board **RECEIVED** the Finance Report.

29/03/16 **2018/19 Finance Plan**

Mr Flack presented the report to the Board for approval.

The process to prepare the 2018/19 financial plan had been assured by the Finance, Business and Investment Committee who had given its approval of the final plan at its meeting the previous day. The Trust would meet its control total. With regards to the capital plan, this had been set closer to the level of expenditure that had been achieved in 2017/18.

Mr Field confirmed that the Committee had supported the plan and that the assumptions were robust.

In response to a question from Mr Conway regarding how the proposed national pay award would be managed within the budget, Mr Flack indicated that the budget reflected the most up to date guidance. Where services were commissioned through local authorities, it had been confirmed that monies would come direct to the providers.

The Board **APPROVED** the 2018/19 Finance Plan including the Final Revenue and Capital Budgets 2018/19 and the Capital Plan 2018/19.

29/03/17 **Standing Financial Instructions**

Mr Flack presented the report to the Board for approval.

In response to a question from Mr Bentley regarding whether it was appropriate for the Audit and Risk Committee to approve the debt write offs rather than the Executive Team, there was a general discussion which concluded that it was not appropriate. It was agreed that the Standing Financial Instructions would be amended to reflect the Committee's assurance role rather than a management role.

Action – Mr Flack

The Board **APPROVED** the Standing Financial Instructions, subject to the amendment.

29/03/18 **Minutes of the Charitable Funds Committee meeting of 25 October 2017**

The Board considered the Minutes of the meeting.

The Board **RECEIVED** the Minutes of the Charitable Funds Committee meeting of 25 October 2017.

29/03/19 **Quarterly Infection Prevention and Control Report**

Ms Strowman presented the report to the Board for assurance.

The Board **RECEIVED** the Quarterly Infection Prevention and Control Report.

29/03/20 **Quarterly Patient Experience Report**

Ms Strowman presented the report to the Board for assurance.

The Board **RECEIVED** the Quarterly Patient Experience Report.

29/03/21 **Risk Management Strategy**

Ms Davies presented the report to the Board for approval.

The Board **APPROVED** the Risk Management Strategy.

29/03/22 **Use of Trust Seal Report**

Ms Davies presented the report to the Board for assurance.

The Board **RECEIVED** the Use of Trust Seal Report.

29/03/23 **Patient Story**

The Ratcliffe family patient story was presented which described the care that the family had received from the Trust. Although there were many positive messages to take away from the video, the family had delivered some harder messages for the Trust to reflect on. These messages would be fed back into the service to see how it could improve further. Note: this agenda item was scheduled to be the first to be presented but technical issues led to it being taken on the agenda later than planned.

29/03/23 **Any Other Business**

There was no further business to discuss.

29/03/24 **Questions from members of the public relating to the agenda**

In response to a question from Ms Sue Stephens, Public Governor for Tonbridge and Malling regarding the closing of the Trust's dental services in Ramsgate which had been raised in Parliament earlier that week, Mr Bentley confirmed that the contract had come to a mutual end. There had been no criticism of the Trust in the delivery of the service. Ms Stephens observed that this was not her understanding of the question and answer in Prime Minister's Question Time, but Mr Bentley assured Ms Stephens twice that this was the case.

The meeting closed at 11.30am.

29/03/25 **Date and Venue of the Next Meeting**

Thursday 24 May 2018, The Committee Room, Tonbridge and Malling Council Offices, Gibson Building, Gibson Drive, Kings Hill, West Malling ME19 4IZ

MATTERS ARISING FROM BOARD MEETING OF 29 MARCH 2018 (PART ONE)

Agenda Item	Action agreed last meeting	By Whom	Current Status/Update
Audit and Risk Committee Chair's Assurance Report	To pass the comments made by the Chair of the Committee regarding the Sustainability and Transformation Partnership (STP) Risk Register to the Chief Executive of the STP.	Mr Bentley	Action complete. The STP Risk Register will be an agenda item at the STP Programme Board meeting in mid-May 2018.
Workforce Report	To republish the report.	Ms Norris	Action complete.
Integrated Performance Report	For the End of Life Care Steering Group to suggest an additional Indicator that better measures the quality of end of life care provided by the Trust.	Ms Strowman	The new indicator will be focussed on the number of EOL patients with a personalised care plan. This will be retrospectively collected to ensure all patients who have died are included in the data collection. Action complete.

Agenda Item	Action agreed last meeting	By Whom	Current Status/Update
Standing Financial Instructions	With regards to reflecting current practice in relation to the Audit and Risk Committee and debt write offs, to ensure that the Standing Financial Instructions reflect the Committee's assurance role rather than a management role.	Mr Flack	Action complete.

Committee / Meeting Title:	Board Meeting - Part 1 (Public)
Date of Meeting:	24 May 2018
Agenda Item:	1.7
Subject:	Chief Executive's Report
Presenting Officer:	Paul Bentley, Chief Executive

Action - this paper is for:	Decision	<input type="checkbox"/>	Information	x
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Report Summary (including purpose and context)
This report highlights key business and service developments in Kent Community Health NHS Foundation Trust in recent weeks.

Proposals and /or Recommendations
To note the report.

Relevant Legislation and Source Documents

Has an Equality Analysis (EA) been completed? No
Not applicable. High level position described and no decision required.
* Protected characteristics: Age, Disability, Gender Reassignment, Marriage and Civil Partnership, Pregnancy and Maternity, Race, Religion and Belief, Sex, Sexual Orientation.

Paul Bentley, Chief Executive	Tel: 01622 211903
	Email: p.bentley@nhs.net

CHIEF EXECUTIVE'S REPORT May 2018

As previously I wanted to highlight to the Board the following significant developments since my last formal report during the Board meeting in March 2018, my regular practice is to categorise the report into patients, our staff teams and partnerships.

Staff

1. Exercise Shakespeare

KCHFT took part in a multi-agency emergency exercise overnight at Bluewater on Sunday 29th April 2018. The staff members, led by the Medical Director, volunteered to play the roles of members of the public and had to react accordingly to the situations as they unfolded; this allowed the agencies involved the opportunity to practice and test their plans. The exercise created a further opportunity to work in collaboration with partner agencies to test the robustness of our plans.

2. We Care Roadshows

As part of our continuing work to support staff and drive improvement, we are running a series of roadshows at locations around the areas we serve to help teams to prepare for the internal inspection teams, which we label 'We care' team visits. These started at the beginning of April lasting until the end of May, and in total we will undertake 15 staff engagement sessions across Kent, London and East Sussex.

The We care initiative has our values at its heart and aligns with the Care Quality Commission's key lines of enquiry. Teams are given feedback and ratings ahead of the anticipated CQC inspection later this year; including areas of strength and areas for improvement.

To support this, feedback given by staff at the roadshows and visits is taken back by the Executive Team and senior managers to establish what assistance can be given. The results are publicised for colleagues to see, as well as being fed directly back to those who have commented or have a query.

Some really great feedback was received around IT and people's challenges, to which the IT Team responded quickly and efficiently, all making colleagues' lives that little bit easier.

3. Flo Fit

During April, we launched flo fit – KCHFT's alternative to the global corporate challenge (GCC) that the organisation took part in each spring to encourage people to take part in a steps challenge.

Flo fit was created and developed by the trust's Communications Team and is open to all staff. It not only has a spring challenge, but will operate all year round with lots of different ways to keep people walking and being active; helping health and wellbeing.

At the time of writing this report, more than 1,100 members of staff had signed up to take part, a fifth of our workforce. That is a 50 per cent increase on those able to take part in the last GCC, which had limited places. Flo fit means everyone can get involved, and promotes all team members taking a few more steps each day, and feeling the benefit, if we have a healthier workforce we can serve our patients more effectively.

Partnerships

1. New community network for community services

NHS Providers and Community First have launched a new network for the community services sector. The Community Network will ensure that community services have a strong, national voice in key debates and will focus on key policy issues that enable the delivery of high quality community care.

2. East London Foundation Trust Quality Conference

Dr Sarah Phillips attended the East London Foundation Trust Quality Conference together with Board Members. The visit was informative and the workshops were very useful. The trip provided an opportunity for the attendees to discuss their different Quality Improvement journeys.

3. Heart of Local Care Conference

Getting local care right for patients means health and social care professionals truly working as multi-disciplinary teams (MDTs) and cutting out the amount of jargon the NHS uses.

That was the key message KCHFT welcomed when more than 200 people from across the health and social care sector came together for the Heart of Local Care Conference. It highlighted excellent examples of multi-disciplinary team (MDT) working already in place, and explored how we can go further to deliver the benefits of multi-disciplinary teams.

Patients

1. #EndPJparalysis

Our teams in in-patient wards and units stepped up to the challenge in mid-April when they got stuck into the NHS-wide 70-day challenge to get patients up, dressed and mobile, which improves rehabilitation for those patients.

Staff, our patients and their relatives and carers have supported the project, with team members wearing pyjamas or gym clothing in a bid to get patients out of bed. The initiative also enabled the trust to remind people about its clothes bank appeal for in-patient sites that KCHFT operates.

2. Patient Experience Week

This was a national celebration of the importance of collecting feedback from patients and their families, so we can continually improve the services we provide. As part of the #Expofcare week, the Patient Experience Team visited a number of our sites to remind staff of the value of asking patients and service users to complete patient feedback surveys. Our chief nurse explained more in a short film on our intranet. We are keen to keep our patient satisfaction rate as high as the past financial year and also the quantity and quality of surveys.

Finally because it crosses all three areas, I wanted to formally say thank you to David Griffiths who is retiring as Chair of the Trust, the May Board will be his final board. David has been Chair of the Trust since it was formed, and before its formation Chaired a number of health organisations in Kent and Medway, over many years David has lead the Trust very successfully and highly compassionately I wish him a long, happy and well-deserved retirement.

Paul Bentley
Chief Executive
May 2018

Committee / Meeting Title:	Board Meeting - Part 1 (Public)
Date of Meeting:	24 May 2018
Agenda Item:	2.2
Subject:	Quality Committee Chair's Assurance Report
Presenting Officer:	Steve Howe, Chair of the Quality Committee

Action - this paper is for:	Decision	<input type="checkbox"/>	Assurance	<input checked="" type="checkbox"/>
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Report Summary (including purpose and context):
The paper summarises the Quality Committee meeting held on 17 April 2018.

Proposals and /or Recommendations:
The Board is asked to receive the Quality Committee Chair's Assurance Report.

Relevant Legislation and Source Documents:
Has an Equality Analysis been completed?
No. High level position described and no decisions required.

Steve Howe, Non-Executive Director	Tel: 01622 211900
	Email:

QUALITY COMMITTEE CHAIR'S ASSURANCE REPORT

This report describes the business conducted at the Quality Committee on 17 April 2018 setting out the Non-Executive Director challenges made and the assurances received, residual concerns and/or gaps in assurance, with work outstanding.

item	Key points Level of Assurance	Challenges	Next Steps to address Residual issues gaps in controls or assurance - work outstanding – who is accountable and when the work will be completed
Service Presentation - Born to Move Project	The committee noted the progress of the scheme since the time the concept was initially presented at the first Research and Development Conference. It has been operational across the whole of Kent since 2013. Julia Haynes was congratulated on being shortlisted for the Royal College of Nursing (RCN) National Awards for this project.	Recognising the difficulties in assessing short term benefits, the team were asked if there was a way to further demonstrate outcomes.	The University of Kent is associated with the project and is keen for it to be rolled out to a wider cohort. The RCN has conducted peer review as part of the National Awards process.
Patient Safety and Clinical Risk Group	The Chief Nurse presented the assurance report from the sub-committee.	Further assurance was sought regarding the high sickness rates in the Dental Service.	The Chief Nurse undertook to review sickness rates at the next performance reviews.

item	Key points Level of Assurance	Challenges	Next Steps to address Residual issues gaps in controls or assurance - work outstanding – who is accountable and when the work will be completed
		<p>It was requested that the Committee view the Local Safety Standards for invasive procedures to conclude the oversight of the Never Event Review.</p> <p>Clarity was sought over transfer of care concerns and whether failure to fully complete of holistic assessments reflected staffing pressures.</p>	<p>Video and Lessons presentation scheduled for May meeting – Dental Director.</p> <p>Ongoing monitoring.</p>
Serious Incident (SI) Report	The Chief Nurse presented the SI Report for the previous month.		
Quality Priorities	The Committee approved the Trust's Quality Priorities 2018/19.		The Committee Chair would commend the report to the Board.
Quarterly Mortality Report	The Medical Director presented the report for assurance.	It was asked whether the Multi-Disciplinary Team reviewed its own cases.	Pippa Barber, Non-Executive Director (NED) would attend a future Multi-Disciplinary Team meeting to gain further assurance about the review process.

item	Key points Level of Assurance	Challenges	Next Steps to address Residual issues gaps in controls or assurance - work outstanding – who is accountable and when the work will be completed
Patient Experience Group	The Deputy Chief Nurse presented the assurance report.	It was asked how the Trust would know the outcome of a request for pastoral support from a community hospital. It was noted that the operational Quality Improvement Network reviewed patient experience feedback at its meetings.	NEDs will continue to visit and observe Quality Committee sub-committees on an annual basis.
Clinical Effectiveness Group (CEG)	The Medical Director presented the report.	Medicines management and missed doses remain under close scrutiny by the Committee but no particular trends were identified.	Owing to an increased workload, the CEG would now meet on a monthly basis.
Clinical Commissioning Group Meetings	The report was presented by the Deputy Chief Nurse.	The Committee requested the views of the CCGs in regards to the Trust's performance in the area of quality.	The Chief Nurse will request feedback from the CCGs.
Terms of Reference (ToR)	The Committee conducted the annual review of TOR.		The TOR will be presented to the Board for ratification.
Effectiveness Review	The Committee reviewed the outcome of the annual effectiveness review.	There was debate as to whether the Committee could now meet on a two-monthly basis. It was decided that the committee would continue to meet ten times a year, but review the workload as the move from assurance to Quality Improvement matured.	

At the time of reporting there were 15 WTE Band 5 vacancies across West Kent community hospitals and high vacancy rates in both Ashford and Canterbury Long Term Condition teams. In some areas staff are working at 50% over SOP, but quality standards appear to have been maintained and triangulation of quality data has not identified areas of particular concern.

Recommendations for the Board:

The Board is requested to endorse the Quality Priorities 2018/19

Policies Ratified – there were no policies ratified.

Chair of the Quality Committee: SC Howe CBE
April 2018

Committee / Meeting Title:	Board Meeting – Part 1 (Public)
Date of Meeting:	24 May 2018
Agenda Item:	2.3
Subject:	Annual Report from Audit and Risk Committee (ARC) to Accounting Officer and Board
Presenting Officer:	Peter Conway, Audit and Risk Committee Chair

Committee Action - this paper is for:	Decision	Assurance	<input checked="" type="checkbox"/>
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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 2017 - 18 financial year including assurance that the terms of reference have been fulfilled and compliance with latest best practice.</p> <p>Subject to any final changes by the Auditors, the ARC recommends that the Annual Accounts, Letter of Representation and Governance Statement be signed. The Committee did not consider the Remuneration Report nor Annual Report because of timings.</p>

Proposals and / or Recommendations to the Committee:
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 2017-18 financial year in fulfilling this role.

The Committee met four times during 2017-18 (May, September, November and February) and a meeting in May 2018 to review the 2017-18 Accounts; two members attended the required minimum of 75% with one only attending 50%. In addition the Chief Executive Officer attended the meeting in May 2018, the Director of Finance attended all meetings and the Director of Corporate Services attended all but the May 2017 meeting; the Director of Workforce and OD and Communications attended in September and November with the Deputy Medical Director also attending in September. 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 2018 in accordance with the NHS Audit Handbook but based on specific narrative feedback.

2. Financial Reporting, Risk Management and Internal Control

a. Financial Reporting

The 2017-18 Accounts were considered at the ARC meeting on 16 May 2018 and are recommended to the Board for approval. Preparatory work was undertaken in February with the review of the accounts timetable, accounting policies that had not changed from the previous year and the draft Annual Governance Statement. The Committee also reviewed the Sustainability Strategy Action Plan and suggested that a succinct statement on the approach towards sustainability and social value would be sufficient within the Annual Report.

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.

The Committee reviewed Standards of Business Conduct and found them to be satisfactory.

The Committee received details of the registers for Gifts, Hospitality and Sponsorship and Interests and a report that the Trust continued to be compliant with the Fit and Proper Persons test, all giving positive assurance to the Committee.

The Committee was kept aware of pertinent policy, guidance and reports and consultations relating to financial matters from inter alia NHS England, the Department of Health and Social Care, NHS Improvement and other advisory 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 financial plans, contractual arrangements and the liquidity position. This was done at the meeting in May 2018.

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

b. Risk Management

The risk management system was subject to wide ranging discussion by the Committee throughout the year.

The Committee undertook a deep dive into the Trust's arrangements into **cybersecurity** following the cyber-attack affecting the NHS in early May 2017. Assurance was gained by the minimal impact on the Trust and the additional work being done in this area but requested the draft Cyber Security Policy was reviewed. The Committee also requested information on the assurances received from third party suppliers of software systems and that the full list of the Trust's systems should be reviewed and re-checked for cyber security. This was brought back to the Committee in September and the Committee received assurance on these matters including progress in implementing improved antivirus software, a communication plan, monitoring secure websites and patching servers and PCs. The Committee agreed to receive a further update at its meeting in February 2018 including assurance regarding the cyber security risks arising from connected partners and third parties. The update in February gave further assurance including the enhancements achieved through the cooperation over cybersecurity at the Sustainability and Transformation Partnership (STP) level.

The deep dive into the **New Models of Care** raised concerns that completion dates for actions had passed and the frequency of risks reported within community nursing. Further assurance was sought that risks were being mitigated. It was suggested that some risks could be tolerated and removed.

A deep dive of risk associated with **partnerships** was undertaken and a framework devised by executives in response to this deep dive. It was agreed for the Committee to consider generic and specific risks for the Trust in its emerging partnership working and have reviewed the Kent County Council partnership and the West Kent Collaborative alliance against this framework and gained assurance risks were properly managed.

A deep dive on the **quality and availability of training** was undertaken. The Committee noted the significant improvement in performance in the year particularly in the areas of Record Keeping and Consent training compliance.

A deep dive was undertaken **into dental services** and reviewed the service risks related to premises and the arrangements for the landlord to complete remediation work and gained assurance that the majority of the work had been completed and the risks reduced. The Committee also considered the delays with the procurement of Special Care and Paediatric Dental services in east Kent and how this was expected to impact the recruit to some posts but gained assurance that this was not a financial risk.

The **Sustainability and Transformation Partnership (STP) risk register** was subject to a deep dive. The Committee were not assured and raised this to the Board for review and to receive again in six months seeking improvements to assist pan-Kent health economy governance and risk management

A deep dive into the risk on the **Community Information System (CIS)** was received and the Committee noted the supplier of CIS, had confirmed that no further major development would be provided for the system which was not now being sold. The Trust had commenced a scoping exercise to replace the system and it was agreed the Board should be appraised and involved in the discussion on the strategic options. These have subsequently been discussed at the Board.

The Committee received assurance from the auditors that the Board Assurance Framework (BAF) was used for determining the Internal Audit plan priorities. Amendments to the BAF were made in response to the Committee's suggestion to ensure it accurately reflected the dynamic nature of risk and that closing risks and ensuring completion dates were current were reflected.

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

c. 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) which was attended by Internal Audit. The Committee gained assurance from their work in updating policies and triangulation of data on claims, complaints and incidents.

The Committee received regular legal claims and coroner's inquests reports, Health and Safety Executive (HSE) reporting, commercial claims and property related incidents and gained assurance that these were being effectively managed with appropriate level of expertise.

The Committee received updates on clinical audit and were assured that overall performance benchmarks were better than peers, evidencing the considerable improvements seen over the last couple of years. Positive assurance was received both from the Annual Report and the Quarterly Update. The Committee noted that there was a move to reduce the number of audits and increase the Plan, Do, Study, Act (PDSA) cycle in line with the new Quality Strategy. Research and Development was showing good progress being made. ARC requested an understanding of risks in clinical audit associated with the strategic move from Quality Assurance to Quality Improvement for consideration at a future meeting.

The Committee received reports on progress towards implementing the General Data Protection Regulations and noted the positive work by the Trust. However it was noted the elements affecting HR processes were behind expectation and sought further assurances including the route to compliance and then ongoing maintenance. The internal audit review of GDPR compliance will be scheduled for later in the year after mitigation plans have been implemented.

The Committee received a Data Integrity Annual and assurance received on the quality of data and confirmed that reports were received by the Quality Committee on specific quality indicators.

The Committee received regular Freedom To Speak Up (FTSU) Guardian Reports and were assured that the Trust had learnt from York Teaching Hospital NHS Foundation Trust's approach to staff engagement on raising concerns and the case study had shown that the Trust had good systems in place and matched with best practice.

The Committee sought assurances on how the findings and themes from the various cases were closed and/or remedied for consideration at a future meeting.

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

a. Trust Auditors

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

b. External Audit

The Committee received regular external audit updates and best practice advice. The Committee reviewed the Auditors proposal for fees and recommended the award of contract to Grant Thornton for three years (plus two year option) following a procurement exercise that the Committee recommended to, and was agreed by the Council of Governors in February.

c. Internal Audit

The Committee agreed the Internal Audit plan for 2018-19 with a reduced number of days (180 from 225) following some changes and after further consultation with the executive. TIAA were awarded a three years (plus two year option) contract following a joint procurement exercise with Kent and Medway NHS and Social Care Partnership Trust and Maidstone and Tunbridge Wells NHs Trust.

The Committee reviewed audit reports and the assurance status:

System	Substantial Assurance	Reasonable Assurance	Limited Assurance	No Assurance
Cyber Security Standards (carried forward from 2016/17)		✓		
Internal Assurance Processes at a Clinical Service Level (carried forward from 2016/17)		✓		
Data Quality of Key Performance Indicators		✓		
Follow Up of Nurse Staffing Arrangements		✓		
MiCAD Database (carried forward from 2016/17)			✓	
MiCAD Follow Up		✓		
IT Disaster Recovery		✓		
Nurse Revalidation	✓			
Information Governance Serious Incident Review		✓		
Pressure Ulcers		✓		
Information Governance Toolkit	✓			
Business Intelligence Reporting		✓		
Cost Improvement Plan		✓		
Follow Up of Consultant Job Plans & Clinical Supervision		✓		
Site Visits			✓	
Critical Financial Assurance		✓		
Assurance Framework and Risk Management Processes		✓		

This was a continuing trend of improvement on the previous years:

Assurance Assessments	Number of Reviews	Previous Year
Substantial Assurance	2	2
Reasonable Assurance	13	10
Limited Assurance	2	3
No Assurance	0	0

The Committee ensured the adequacy of management responses to the recommendations made which were reduced by 13 (15%) with notably only half the number of urgent recommendations compared to 2016-17:

Year	Urgent	Important	Routine
2017/18	6	30	36
2016/17	12	38	35

Specific scrutiny was made of limited assurance reports and the follow ups requested and as highlighted above the MiCAD follow-up provided reasonable assurance.

The objective of the site visits was to assess the adequacy of the processes in place to support a sample of areas covered by the Care Quality Commission (CQC). The review was completed in October and took into account dementia care, end of life care, falls, mental capacity and personalised care planning and how it was managed at Queen Victoria Memorial Hospital and Hawkhurst Community Hospital. Policies and procedures were not always implemented consistently with gaps in personalised care planning. ARC was concerned that this report was only being received in May and requested improvement in review processes. Assurance of remediation was given verbally and IA will visit again in September.

The Committee had assurance that all Fraud alerts raised were actioned and that the Trust’s ‘Lessons Learnt’ Newsletter was used to disseminate information. Counter fraud activity remains positive and effective and benchmarks well to others.

The Committee also reviewed the Head of Internal Audit Opinion on the effectiveness of the system of internal control at its meeting in May 2018 which supported the Annual Governance Statement with a minor amendment. The IA opinion was “Reasonable Assurance”

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 cyber security and the quality of the STP risk register and the need to have a strategic discussion on the replacement of CIS. The Board was also updated on the ongoing remediation work by NHS Property Services providing safe environment assurances.

The Committee reviewed the recommendations from the Deloitte Report on Gloucester Hospital Report and did not support rotational chairmanship of Committees due to the specialist expertise required and build up over time but did support wider executive attendance across committees.

The Committee recommends approval of the 2017/18 annual accounts to the Board. (subject to any final changes requested by the auditors between 17 May 2018 and the date of signing).

5. Self-Assessment and Terms of Reference

The Committee undertook a self-assessment on effectiveness in May 2018 and determined the Committee was working well. The Committee agreed guidance for attendees, presenters and report writers to enhance the effectiveness of the Committee's time and recommended to other committees to consider.

The ARC Chairman presented a paper on "Management of Risk in Government" as a high-level framework of good practice.

The Committee discussed whether there were any items that prompted further consideration and this prompted adding the Partnerships Risks as a standing agenda item and further benchmarking work on the BAF.

Terms of reference were reviewed and agreed including that the Clinical Effectiveness Group had the obligation to ensure that the Clinical Audit function was sufficiently resourced rather than being an ARC responsibility. Subsequently the Board changed the Standing Financial Instructions so that approval of debt write off was a Management Committee responsibility not ARC. The Terms of reference have been duly updated.

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 Handbook and in the HM Treasury Audit and Risk Assurance 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
Bridget Skelton
Richard Field
Non-Executive Director members of the Committee
16 May 2018

Committee / Meeting Title:	Board Meeting - Part 1 (Public)
Date of Meeting:	24 May 2018
Agenda Item:	2.4 (i)
Subject:	Charitable Funds Committee Chair's Assurance Report
Presenting Officer:	Jen Tippin, Chair of the Charitable Funds Committee

Action - this paper is for:	Decision <input type="checkbox"/>	Assurance <input checked="" type="checkbox"/>	x
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Report Summary (including purpose and context):
The paper summarises the Charitable Funds Committee meeting held on 27 April 2018.

Proposals and /or Recommendations:
The Board is asked to receive the Charitable Funds Committee Chair's Assurance Report.

Relevant Legislation and Source Documents:
Has an Equality Analysis been completed?
No. High level position described and no decisions required.

Jen Tippin, Non-Executive Director	Tel: 01622 211900
	Email:

CHARITABLE FUNDS COMMITTEE CHAIR'S ASSURANCE REPORT

The Charitable Funds Committee met on 27 April 2018.

The 2017/18 Finance Report was received and the Committee was provided with an update on how the Restricted and Unrestricted Funds had been spent during the year on the Trust's services. The restricted funds were made up of seven funds and started the year with a balance of £349k. The spend for 2017/18 was £77k (including £14k overheads) and the income £244k, leaving restricted funds of £516k at the year end. Faversham Cottage Hospital and the Heron Ward at Queen Victoria Memorial Hospital (QVMH) had particularly benefitted. The income within the Restricted Funds had increased significantly due to the receipt of two legacies. The first was the balance of a previous legacy now that the estate had been completed. This related to Faversham Cottage Hospital (£26k) and the second was a new legacy received of £215k for the benefit of Heron Ward at QVMH. The main spend from the Unrestricted Funds was for the Staff Awards and some of the dementia spend.

With regards to the marketing of the Charitable Funds, the Marketing and Communications Team have been focusing on raising the profile of the recently launched Sensory Room in Coxheath which had received considerably social media and press interest since its launch in September 2017. It had been the top story on the national NHS 70 website that week and Meridian News had requested to run a story on it as well.

Funds are being used to support the purchase of dementia related equipment and items for the community hospitals and community nursing teams. These have been well-received.

The Marketing and Communications Teams have done some excellent work supporting the launch of i Care. These activities had been funded by the Charitable Funds Committee but after some discussion, the Committee agreed that going forward, funding would no longer be provided but any work would be absorbed into the team's day to day budget.

The Committee received a presentation regarding the east Kent Restricted Fund. This fund was available to the east Kent Adult Services teams. Five sites had so far received funding and work was ongoing to invite further ideas from staff. Community teams in Dover had suggested the purchase of a number of items including head torches, ear irrigation machines and a bladder scanner. Funding from a legacy had led to some refurbishment on Heron Ward at the Queen Victoria Memorial Hospital and would include a touch down station, a new physiotherapy area, sensory garden and colour coded signage. These improvements had been extremely positively received with both staff and patients.

The Committee reviewed its Annual Report for the Charitable Funds Committee which is presented to the Board today.

The Committee conducted an annual review of its Terms of Reference which was approved.

Finally, the Committee discussed the questionnaire which would be sent to members to assess overall Committee effectiveness and approved the forward plan of agenda items.

Jen Tippin
Chair of the Charitable Funds Committee
May 2018

Committee / Meeting Title:	Board Meeting - Part 1 (Public)
Date of Meeting:	24 May 2018
Agenda Item:	2.4 (ii)
Subject:	Charitable Funds Committee Chairman's Annual Report
Presenting Officer:	Jen Tippin, Chair of the Charitable Funds Committee

Action - this paper is for:	Decision	<input type="checkbox"/>	Assurance	x
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Report Summary (including purpose and context)
This report provides a summary of the work of the Charitable Funds Committee in 2017/18 financial year including assurance that the Terms of Reference have been fulfilled and compliance with latest best practice.

Proposals and /or Recommendations
The Board is asked to note the 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.

Jen Tippin, Non-Executive Director	Tel: 01622 211900
	Email:

CHARITABLE FUNDS COMMITTEE CHAIR'S ANNUAL REPORT TO THE BOARD

During the year, the Committee met three times and was quorate each time. The Committee is made up of Non-Executive Directors, the Director of Finance and the Chief Operating Officer. Other representatives include Fund Managers, StaffSide representation, and a Governor.

The Committee has scrutinised the Charitable Funds' financial performance at each meeting and has been satisfied with the financial management shown by the Finance Team. The net assets of the Charitable Fund as at 31 March 2017 were £508k. Income during the year totalled £21k and included income from donations, and interest earned from bank accounts. Donations in the period totalled £20k. Expenditure during the period totalled £86k of which £28k was expended on patients' welfare and amenities and £20k on staff welfare and amenities. The expenditure on fundraising activities included approved financing of marketing activities carried out by the Trust's Communications department to support the Trust's charity i care.

With regards to the Charitable Funds investment strategy, funds are held as cash in the Government Banking Service account and on short-term investment (60 day notice deposit) with Shawbrook Bank Ltd. No grants were made to non-NHS organisations during the 2016/17 financial period and the Committee's policy on reserves management was adhered to. A review of the Bow Road property fund is currently being undertaken to assess further the restrictions placed on the fund. Charities Commission guidance has been received and legal advice is being sought with the view of utilising the funds further to the benefit of the surrounding areas. This work will be concluded shortly.

The Charitable Funds Report and Accounts 2016/17 were presented to the Committee in January 2018 and were approved. The accounts had been compiled in accordance with the applicable Accounting Standards in the UK and the Statement of Recommended Practice and charity regulations. An independent audit was carried out in November 2017 and no significant issues were identified.

During the year, the Committee received a presentation from the Fund Manager responsible for the Bow Road Charitable Fund. This gave the Committee the opportunity to be updated on how the fund was being spent for the benefit of the local community. The Fund Manager has emphasised her responsibility to discharge the funds to ensure that they are not retained by the Trust. Other Fund Managers will be invited to present to the Committee at its meetings in the future.

The Communications Team has been busy with increasing awareness amongst staff and the wider community of the Trust's charity i-care. The Charity has a dedicated section on the Trust's public website.

During the year, the Committee discussed the spread of the funds it had available to distribute and it was highlighted that the community services needed a boost to their funds rather than the Trust's community hospitals which already had access to restricted funds. Individual community hospitals also received funding from the local League of Friends charities. The Committee would continue to focus on this disparity and support any activities which would help to increase the funds available to community services

Finally, the Committee would like to thank all the patients and their relatives and the staff of the Trust who have made charitable donations and supported the Fund.

**Jen Tippin, Non-Executive Director
Chair, Charitable Funds Committee
May 2018**

Committee / Meeting Title:	Board Meeting - Part 1 (Public)
Date of Meeting:	24 May 2018
Agenda Item:	2.5
Subject:	Strategic Workforce Committee Chair's Assurance Report
Presenting Officer:	Bridget Skelton, Non-Executive Director

Action - this paper is for:	Decision	<input type="checkbox"/>	Assurance	x
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Report Summary (including purpose and context)
The paper summarises the Strategic Workforce Committee meeting held on 23 March 2018.

Proposals and /or Recommendations
The Board is asked to receive the Strategic Workforce Committee Chair's Assurance 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.

Bridget Skelton, Non-Executive Director	Tel: 01622 211900
	Email:

STRATEGIC WORKFORCE COMMITTEE CHAIR'S ASSURANCE REPORT

This report describes the business conducted at the Strategic Workforce Committee on 23 March 2018 indicating the Non-Executive Director challenges made and the assurances received, residual concerns and/or gaps in assurance, with work outstanding.

Workforce item	Report /key points	Challenges	Assurance	Residual issues gaps in controls or assurance - work outstanding with Timeframes
Workforce Report	The Committee discussed the issues behind the data presented in the Workforce report, with five areas still in red albeit an improving position with regard to turnover and sickness.	The report provided a status report but did not provide enough on the actions being taken to address the issues to give full assurance. Feedback that some managers had found Skype interviewing clunky.	Examples of action were explained e.g. the new analysis of absence due to stress, new ways to ensure more staff take up the flu vaccine next year, international recruitment campaign, and the programme of work looking at skills mix.	Conclusion of review to unblock any residual issues with regard to recruitment process and timeline, feedback to May Committee. Supporting paper to Workforce Report to describe actions and progress, addressing issues in workforce report, to form a regular submission to the Committee.

Workforce item	Report /key points	Challenges	Assurance	Residual issues gaps in controls or assurance - work outstanding with Timeframes
Workforce Report continued		Several cases of recruitment had taken a long time.		This should form a tracking document that describes actions, progress and achievements over the last two months, and set out what happening in the next two months against key workforce issues. Work is underway to look at how we can quantify the relative targeting between recruitment and retention at directorate and locality levels.
Staff Survey Report	Summary findings from the Staff Survey were shared and the initial interpretation of them discussed. We had a 62% response rate up 7% from 2016. Of 17 community trusts in the country we were ranked 7 th .	Disappointing that the 'engagement score' had not improved after the focus on this last year. Disappointing that the health and well being score was not higher with the energy and commitment to this.	The engagement score was good if one considers the scale of contract change impacted on several major services at the time of completion.	A local action plan is being put in place to address local findings, which will be collated and presented at the next Committee in May. Further attention to how Health and Well Being (H&W) activities are communicated, with the

Workforce item	Report /key points	Challenges	Assurance	Residual issues gaps in controls or assurance - work outstanding with Timeframes
<p>Staff Survey Report continued</p>		<p>Is there any correlation in other trusts with higher staff survey scores and lower amount of change, higher retention and lower vacancy levels.</p>	<p>Many staff do not recognise the Choir and other health activities as health and wellbeing.</p>	<p>aim of positively impacting the H&W CQUIN score in 2018. Focus more on 'you said we did' in all team and management communications.</p> <p>A piece of comparative work with the six higher rated Community Trusts to see if there are any lessons to learn or explanations for our scores, to come to May committee for information.</p>
<p>Benefits Package Comparison Report</p>	<p>A report setting out a comparison of benefits packages was presented.</p> <p>It demonstrated that we have a generous offering, especially with regard to pensions and sick pay.</p> <p>The only area we did</p>	<p>As the package looks so competitive how can we better use this information to retain and attract staff better.</p>	<p>Communications for both recruitment and existing staff are being prepared after the Management Committee have seen the findings.</p>	

Workforce item	Report /key points	Challenges	Assurance	Residual issues gaps in controls or assurance - work outstanding with Timeframes
	<p>not include was recommend a friend which is being looked at to potentially include.</p>			
Gender Pay Gap Report	<p>KCHFT will publish its Gender Pay Gap Report at the end of the month inline with other Kent Trusts.</p>	<p>Is the Communications written in such a way that staff understand the report is about gender pay which is different to equal pay?</p> <p>Have we looked at the communications to ensure we demonstrate a positive trajectory as this report will provide our base line to track improvement from?</p>	<p>The communication clearly explains the difference.</p>	<p>The trajectory against base line will be looked at before the communications are released at the end of this month.</p>
Retention Report	<p>A short explanation was received about the NHSI Retention Direct Support programme of work that we are part of, starting 5 April.</p>	<p>How will our findings, lessons learnt and impact be reported and measured?</p>		<p>A report will come to each Strategic Workforce Committee updating the Committee on progress, learnings and achievement.</p>

Workforce item	Report /key points	Challenges	Assurance	Residual issues gaps in controls or assurance - work outstanding with Timeframes
Enabling Black Minority Ethnic BME Nurse Progression Report	Findings were presented on how the Trust is performing against the six key priority actions identified by NHS England NHSI 'enabling BME Nurse and Midwife progression into Senior Leadership positions. Policy was presented for Ratification.	The definition of BME potentially distorts the statistics, although we understand why we have to use the National Definitions.	There is assurance in the first draft of the plan that there are examples of embedded good practice within the Trust, and areas for improvement have been identified.	The Workforce Equality group have further work to set aspirations for the Trust to be progressive in this area, and achieve better representation of the Trusts patient population.
Medical Appraisals and Revalidation Policy	Policy was presented for Ratification.			Structure and processes are sound need better compliance of application, being addressed through the Audit and Risk Committee and TIAA work.
Future Non-medical Prescribers Report	The need for more Non-medical Prescribers was presented and an explanation as to why we now have less.	There was recognition of the need, but questions raised about: Why they are going into Primary Care, How many we need and where, as well as need for novel ways to retain them once trained.		Further work is required to map out the need, cost and retention strategy then resubmit paper for July.

Workforce item	Report /key points	Challenges	Assurance	Residual issues gaps in controls or assurance - work outstanding with Timeframes
Advanced Clinical Practitioners Report	Received an update on the development of the Advanced Clinical Practitioners Role.	Very supportive of work achieved to date, questioning who will support these roles, with the need for further quality governance.	Further work is taking place to address these issues.	Following the 26 March 2018 meeting clarity on how their impact is being measured, the governance arrangements and retention strategy is required – July Committee.
Any Other Business: National Quality Guidance Tool on Capacity and Demand				
Response to Draft National Workforce Strategy Document	The committee noted the Response to the National Workforce Strategy suggesting ways to make it more focused and solution orientated, especially with regard to Apprentices, new roles, funding, and the national media negatively impacting on	Q: How do we stand against this National Guidance?	The Trust's Demand and Capacity work with Meridian has ensured we have tools and measures that either equate to or are better than those stated in the National Guidance.	Ms Strong to bring a report to the May Workforce Committee on the Meridian Productivity Work in East Kent.

Workforce item	Report /key points	Challenges	Assurance	Residual issues gaps in controls or assurance - work outstanding with Timeframes
Update on National Pay Review	recruitment. Received an update on the latest news with regards to the National 6% pay increase over three years			Implication of the Pay Review to come as a paper to the May committee with a plan for communication to staff, details on funding and other implications for consideration.

Items for the Board to specifically note:

Terms of Reference were reviewed, and a committee effectiveness review requested.

Items of focus at the next Committee in May include an ambitious proposal for Nurse Apprenticeship, findings from work looking at Job Skills mix with recommendations of how staffing of certain roles could change and a plan to provide further assurance of activity to address issues in the Workforce Report.

Recommend

The following policy was ratified:

- Medical Appraisal and Revalidation Policy.

**Bridget Skelton
Chair, Strategic Workforce Committee**

Committee / Meeting Title:	Board Meeting - Part 1 (Public)
Date of Meeting:	24 May 2018
Agenda Item:	2.6
Subject:	2017/18 Annual Report and Accounts including the 2017/18 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

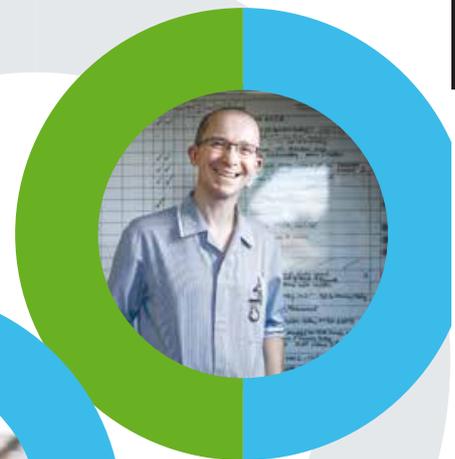
Has an Equality Analysis (EA) been completed?
No. High level position described and no decisions required/no significant change. Papers have no impact on people with any of the nine protected characteristics*.

* Protected characteristics: Age, Disability, Gender Reassignment, Marriage and Civil Partnership, Pregnancy and Maternity, Race, Religion and Belief, Sex, Sexual Orientation.
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Gordon Flack, Director of Finance	Tel: 01622 211900
	Email: Gordon.flack@nhs.net



Kent Community Health
NHS Foundation Trust



Welcome to our seventh annual report

2017 to 2018





Kent Community Health
NHS Foundation Trust

Annual report and accounts 2017 to 2018

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

@2018 Kent Community Health NHS Foundation Trust

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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**.



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

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



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



1,978 health MOTs were completed.

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



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



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

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



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

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



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



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

We opened a wound centre opened in Sevenoaks.



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



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



Kent Community Health
NHS Foundation Trust



The performance report

The performance report

Overview of performance

Welcome to our seventh annual report.

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

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

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

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

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

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

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

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

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

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



Kent Community Health

NHS Foundation Trust

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

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

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

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

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

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

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

We hope you enjoy reading our annual report.

Kind regards

David Griffiths

Chair:

Date

Paul Bentley

Chief Executive Officer:

Date

this page waiting for sign off

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 2017-18 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 more than two million contacts with patients a year; many of these are in their own homes and in other locations, including GP surgeries, nursing homes, clinics, community hospitals, minor injury units and children's centres.

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

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

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

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

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

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

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

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

Our mission, vision and values

Our strategy

Our vision

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

Our mission

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



Our values



Compassionate



Aspirational



Responsive



Excellent



The Kent and Medway Sustainability and Transformation Partnership

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

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

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

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

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

In the past 12 months, the STP has:

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

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



Our strategic goals:

Our goals

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



Our priorities for 2017-18

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

Supporting our strategic goals

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

Our enabling strategies help secure:

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

Overview: Going concern

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

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

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

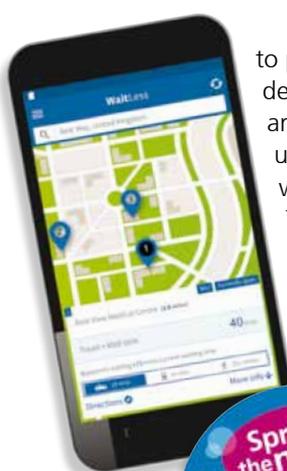
Performance analysis

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

Strategic goal one: Prevent ill health

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

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



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

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



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



Kent Community Health NHS Foundation Trust



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

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

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

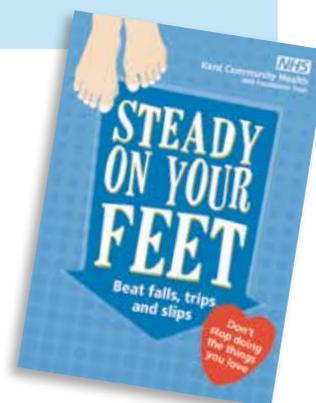
During 1 April 2017 – 31 March 2018

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

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

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

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



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

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

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

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

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

There was a 27 per cent reduction in grade three and four pressure ulcers in 2017-18, which achieved our target. There was a 44 per cent reduction in grade two pressure ulcers.





Kent Community Health NHS Foundation Trust



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

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

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



During 1 April 2017 – 31 March 2018

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

Strategic goal three: Integrate services

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

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

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



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

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

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

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

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





Kent Community Health NHS Foundation Trust



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

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

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

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

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

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

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

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

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



During 1 April 2017 – 31 March 2018

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

Strategic goal four: Develop sustainable services

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



We had our best year-to-date in terms of winning new business and retaining existing business for the trust, with an 83 per cent success rate. We were awarded 10 contracts during 2017-18, with two of these being retained business.

The overall contract value of these was almost £22.5million, with an annual contract value to KCHFT of almost £6.5million.

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

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

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



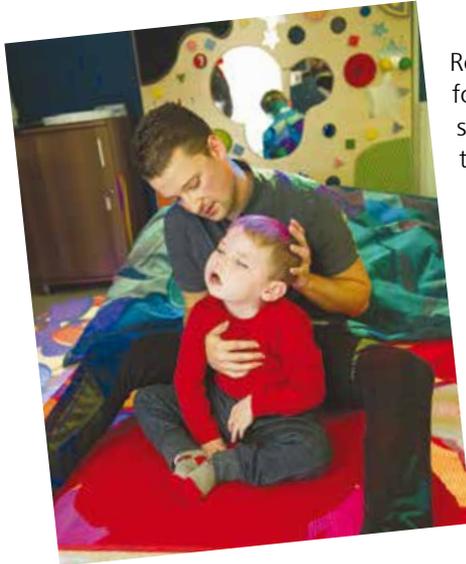
We worked with our health and social care partners in east Kent to launch A Different View; a recruitment campaign centred on driving interested job applicants to a single website that has vacancies from all partners. It focuses on the lifestyle you can enjoy by living on the coast on east Kent.

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





Kent Community Health
NHS Foundation Trust



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

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



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

During 1 April 2017 – 31 March 2018

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

Patient feedback

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

Safe care

- We are 100 per cent compliant with NICE guidance.
- There were four cases of Clostridium difficile infection reported – all were deemed unavoidable and due to appropriate antimicrobial prescribing.
- There were no incidences of MRSA attributed to the trust.
- There hasn't been any never events.
- There were seven falls resulting in fractures reported as serious incidents.
- There were 19 grade three and four attributable and avoidable pressure ulcers, which is a 27 per cent reduction from last year.

Our charity



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

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

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

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

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

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

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

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

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

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



Sustainability report

Our buildings and travel

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

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

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

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

Sustainable procurement

The trust takes its responsibility to procure goods and services sustainability seriously. As a public sector organisation, the trust is obliged to consider its wider impact in terms of the social value it can create by virtue of its actions, this will require fundamental changes in how the trust operates at all levels.

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

- A 20 per cent reduction in the amount of carbon produced by the trust by 2020, increasing to 50 per cent by 2025, with the eventual aim of meeting 2050 targets as soon as practicably possible.
- A step change in dealing with waste will lead to zero waste to landfill, the trust will meet its target of 50 per cent reduction in 2020.
- Increased use of technology to reduce unnecessary journeys, such as dialling into meetings using conference call where possible.

A part of this way of working is to be effective and sustainable by halving use of resources and doubling productivity.



Kent Community Health

NHS Foundation Trust

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

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

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

Signed: Date:

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.



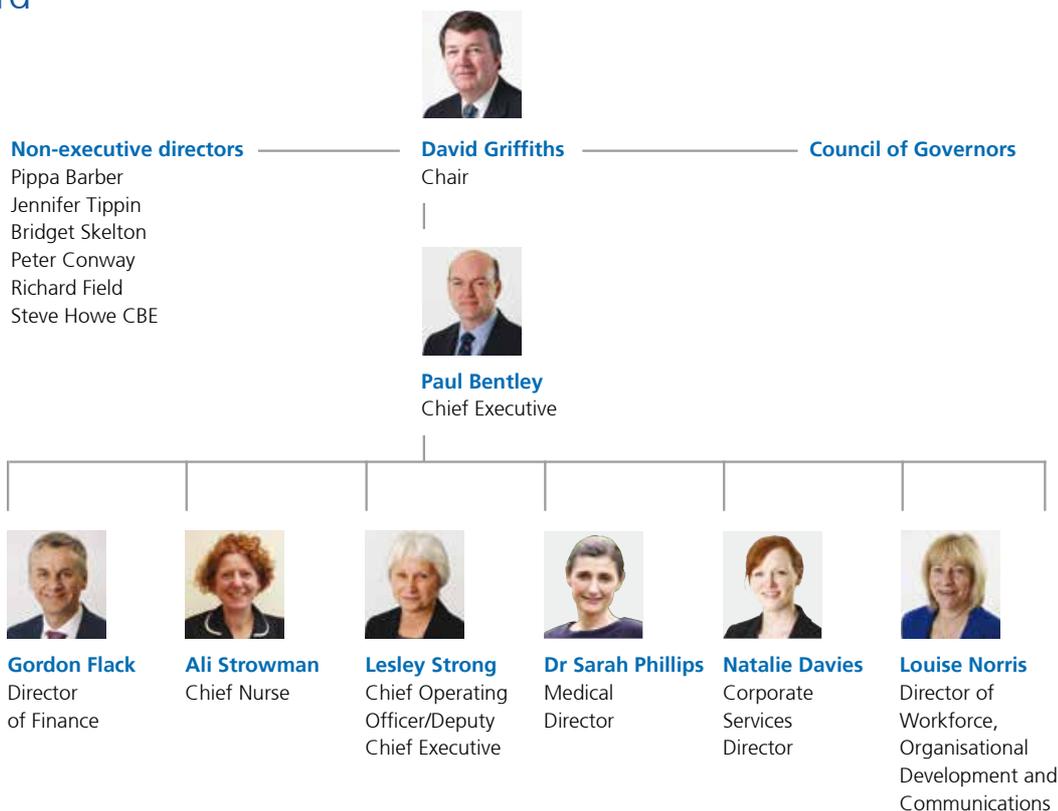
Kent Community Health
NHS Foundation Trust



The accountability report

The directors' report

Board



Portfolios of executive voting board members include:

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

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

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

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

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

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



Directors' roles and responsibilities

David Griffiths, Chair

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



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

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

Jen Tippin, Non-executive Director

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

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

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



Pippa Barber, Non-executive Director

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

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

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

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



Bridget Skelton, Non-executive Director

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

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

Bridget lives in Otterden, Kent.





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Peter Conway, Non-executive Director

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

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



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

Richard Field, Non-executive Director

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

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



Steve Howe CBE, Non-executive Director

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



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

David Robinson, Non-executive Director

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



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

David retired from the Board on 30 September 2017



Kent Community Health

NHS Foundation Trust

Paul Bentley, Chief Executive

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

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

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



Lesley Strong, Deputy Chief Executive/ Chief Operating Officer

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

Lesley is:

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



Gordon Flack, Director of Finance

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

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

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



Louise Norris, Director of Workforce, Organisational Development and Communications

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

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

Louise lives with her husband in West Malling.



Natalie Davies, Corporate Services Director

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

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

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



Sarah Phillips, Medical Director (from 10 April 2017)

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

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



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

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

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

Ali Strowman, Chief Nurse

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



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

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

**Dr Aroka Antonyamy, Acting Medical Director
(from 1 to 9 April 2017)**

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



Board and committee attendance

Formal Board

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

Audit and Risk Committee

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

Finance, Business and Investment Committee

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

Charitable Fund Committee

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

Quality Committee

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

Strategic Workforce Committee

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

Directors' register of interests

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

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

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

Better payment practice code

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

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

Council of Governors

Elected public governors as at 31 March 2018



Ashford
John Fletcher



Canterbury
Mary Straker



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



Dover/Deal
Carol Coleman



Gravesham
Pete Sutton



Maidstone
David Price



Sevenoaks
Jo Naismith



Shepway
Jo Clifford



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



Thanet
Jane Hetherington



**Tonbridge and
Malling**
Sue Stephens



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



Rest of England
Anthony Moore



Elected staff governors



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



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



Sonja Bigg



Claire Buckingham

Appointed governors



Universities
Dr Susan Plummer S



Public Health
Andrew
Scott-Clark

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

Elected public governors at 31 March 2018

Membership: Representation, and effectiveness

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

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

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

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

Geographical areas we need to increase membership include:

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

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

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

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

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

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

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

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

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

Understanding the views of governors and members

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

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

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

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

Engagement with local groups and organisations

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

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

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

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

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



Kent Community Health NHS Foundation Trust

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

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

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

Remuneration report

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

Annual statement on remuneration

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

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

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

Senior managers' remuneration policy

Policy on remuneration for executive directors

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

Pay component	How that component supports the trust's short and long-term strategy	How it operates	Maximum payable
Senior managers are entitled to a basic salary, which is determined by the Remuneration Committee. The rates paid to individual directors are determined by the Remuneration Committee, which takes into account: <ul style="list-style-type: none"> • qualifications required for the role • spans of responsibility and accountability • performance • market forces. 	The trust believes its senior managers should be fairly remunerated for their work. Trust salaries should be competitive and enable the trust to attract and, in due course, retain high-calibre staff. However, salaries should not be overly high and should be positioned in the top quartile of salaries for similar organisations. The Remuneration Committee will reference its salaries to the NHS Providers' survey of executive salaries and independent advice as required.	Salaries are reviewed against external NHS benchmarking and set at the lower end of the upper quartile for similar organisations, taking into account other factors including performance and qualifications. In the case of any salary above £150,000 ministers' views are sought. An earn back scheme is applied to the medical directors salary. Annual salary is reduced by 10% each year. On the achievement of agreed objectives, the earn back is paid. A report is presented to the Remuneration Committee.	
The annual uplift		As described above.	1%
Chief executive earn back	The trust believes the chief executive should be properly remunerated for their work. Trust salaries should be competitive and enable the trust to attract high-calibre staff. However, salaries should not be overly high and should be positioned in the top quartile of salaries for similar organisations. The Remuneration Committee will reference its salaries to the NHS Providers' survey of executive salaries and independent advice as required. Where applicable, views of ministers are sought.	An earn back scheme is applied. Annual salary is reduced by 10% each year. On the achievement of agreed objectives, the earn back is paid.	£15K

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

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

Policy on remuneration for non-executive directors

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

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

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

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

Service contract obligations

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

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

Policy on loss of office

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

Setting senior managers remuneration policy

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

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

Annual report on remuneration

Information not subject to audit

Remuneration Committee

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

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

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

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

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

Service contracts

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

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

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

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

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

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

Expenses of senior managers and governors

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

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

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

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

The following expenses were paid to governors in the period:

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

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

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

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

Information subject to audit

Name and title	2017-18						2016-17					
	Salary and fees (bands of £5,000) £000	Taxable benefits (to the nearest £100) £000	Annual performance -related bonuses (bands of £5,000) £000	Long-term performance -related bonuses (bands of £5,000) £000	All pension -related benefits (bands of £2,500) £000	Total (bands of £5,000) £000	Salary and fees (bands of £5,000) £000	Taxable benefits (to the nearest £100) £000	Annual performance -related bonuses (bands of £5,000) £000	Long-term performance -related bonuses (bands of £5,000) £000	All pension -related benefits (bands of £2,500) £000	Total (bands of £5,000) £000
Paul Bentley, Chief Executive Officer	150-155		15-20		0	165-170	150-155		15-20		0	165-170
Lesley Strong, Chief Operating Officer/ Deputy Chief Executive	130-135				17.5-20	145-150	125-130				0-2.5	130-135
Claire Poole, Acting Director of Operations, Children and Young People (from 1 Nov 2015 to 31 Dec 2016)							70-75	1,500			75-77.5	150-155
Nicola Lucey, Director of Nursing and Quality (left 31 Aug 2016)							45-50				10-12.5	60-65
Ruth Herron, Acting Director of Nursing (from 1 Sept 2016 to 9 Oct 2016)							5-10				5-7.5	15-20
Ali Strowman, Chief Nurse (from 10 Oct 2016)	120-125				172.5-175	290-295	50-55				77.5-80	125-130
Peter Maskell, Medical Director (left 5 Feb 2017)							135-140				0	135-140
Atokia Antonyamsy, Acting Medical Director (from 1 Mar to 9 Apr 2017)	0-5				0	0-5	5-10				2.5-5	10-15
Sarah Phillips, Medical Director (from 10 Apr 2017)	145-150		5-10		0	150-155						
Gordon Flack, Director of Finance	135-140	2,200			97.5-100	235-240	125-130	6,700			137.5-140	270-275
Natalie Davies, Corporate Services Director	90-95				30-32.5	120-125	90-95				32.5-35	125-130
Nichola Gardener, Director of Strategy and Transformation (left 17 Jul 2016)							25-30				10-12.5	35-40
Louise Norris, Director of Workforce, Organisational Development and Communications	110-115				15-20	125-130	110-115				35-37.05	145-150

Information subject to audit

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



Kent Community Health

NHS Foundation Trust

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

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

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

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

Pension benefits

Name and title	Real increase in pension at pension age (bands of £2,500)	Real increase in pension lump sum at pension age (bands of £2,500)	Total accrued pension at pension age at 31.03.18 (bands of £5,000)	Lump sum at pension age related to accrued pension at 31.03.18 (bands of £5,000)	Cash equivalent transfer value at 01.04.17 (bands of £5,000)	Cash equivalent transfer value at 31.03.188 (bands of £5,000)	Real increase in cash equivalent transfer value	Employer's contribution to stakeholder pension
Paul Bentley, Chief Executive Officer	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Lesley Strong, Chief Operating Officer/Deputy Chief Executive	0-2.5	2.5-5	65-70	195-200	N/A	N/A	N/A	N/A
Ali Strowman, Chief Nurse (from 10 Oct 2016)	7.5-10	17.5-20	35-40	85-90	391	527	132	N/A
Arokia Antonyamy, Acting Medical Director (from 1 Mar 2017 to 9 Apr 2017)	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Sarah Phillips, Medical Director (from 10 Apr 2017)	0-2.5	0	10-15	25-30	171	177	4	N/A
Gordon Flack, Director of Finance	5-7.5	15-17.5	55-60	170-175	980	1,151	161	N/A
Natalie Davies, Corporate Services Director	0-2.5	0-2.5	25-30	60-65	309	356	43	N/A
Louise Norris, Director of Workforce, Organisational Development and Communications	0-2.5	2.5-5	40-45	130-135	816	901	76	N/A

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

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

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

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



Cash equivalent transfer values

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

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

Real Increase in CETV

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

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

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

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

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



Fair pay multiple

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

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

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

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

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

Signed: Date:

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

Staff report

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

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

During 1 April 2017 – 31 March 2018

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

Staff sickness absence

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

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

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

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

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

Staff costs

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

Average number of employees (WTE basis)

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

Reporting of compensation schemes – exit packages 2017-18

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

Reporting of compensation schemes – exit packages 2016-17

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

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

Expenditure on consultancy

Consultancy expenditure was £429K for the year.

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

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

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

Health and safety performance

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

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

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

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

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

Occupational health

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

Counter fraud

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

Equality and diversity

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

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

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

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

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



Kent Community Health NHS Foundation Trust

Freedom to speak up

The trust has had a freedom to speak up guardian (FTSU) in post for more than 12 months. There is a range of promotional materials about speaking up.

Print materials were distributed across the patch for teams who work remotely, including postcards and posters. There was also a strong information campaign via our weekly news bulletin and on the intranet, which included ways to get in touch and how the FTSU guardian can help.

Between 1 April 2017 and 31 March 2018, the FTSU guardian logged and was involved in 18 cases. The guardian also made sure senior managers were aware of freedom to speak up and its importance by presenting to Management Committee, at the Council of Governors and in team meetings.

The trust has started to develop a freedom to speak up ambassadors' programme.



Be bold. Be brave. Speak up.

Communication with staff

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

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

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



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



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

We produce a digital weekly round-up of what is happening in the organisation, flo mail,

which is shared with all trust colleagues and our governors. We also produced a monthly Team Brief for managers to use in meetings to cascade key messages, plus add their own service specific news.

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

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



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

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

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

NHS Staff Survey summary of performance

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

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

	Key finding			
	Trust score 2017	Trust score 2016	National 2017 average for community trusts	Trust improvement/deterioration
KF31. Staff confidence and security in reporting unsafe clinical practice	3.72	3.74	3.80	No change
KF23. Percentage of staff experiencing physical violence from staff in past 12 months.	1%	1%	1%	No change
KF3. Percentage of staff agreeing their role makes a difference to patients/service users	89%	90%	90%	No change
KF13. Quality of non-mandatory training, learning or development	4.03	4.04	4.08	No change
KF1. Staff recommendation of the organisation as a place to work or receive treatment	68%	69%	70%	Improvement

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

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

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

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

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

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

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

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

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

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

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

NHS Foundation Trust Code of Governance

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

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

Disclosure relating to	NHS Improvement Code of Governance reference	Kent Community Health NHS Foundation Trust disclosure
Board and Council of Governors	A.1.1	<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 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 chair, as chair of both bodies, would initially seek to resolve the disagreement, if this is not successful, a joint committee of governors and directors would be established. If this committee's recommendations were unable to resolve the dispute, the Board would make a final decision. A referral to NHS Improvement or other external body might also be considered. There has been no requirement to activate this process during 2017-18.</p>
Board, Nomination Committee(s), Audit and Risk Committee, Remuneration and Terms of Service Committee	A.1.2.	<p>This annual report describes the roles and responsibilities of the Board on pages 31. The number of Board and committee meetings and a record of attendance are found on pages 39.</p>
Council of Governors	A.5.3	<p>Page 44 of this annual report identifies the members of the Council of Governors, the lead governor and their respective constituencies. The council has formally met four times. It is due to continue formal quarterly meetings.</p>

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

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

NHS Improvement's Single Oversight Framework

Single Oversight Framework

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

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

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

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

Segmentation

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

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

Finance and use of resources

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

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

Signed: Date:

Paul Bentley, Chief Executive Officer



Kent Community Health
NHS Foundation Trust



**Statement of accounting
officer's responsibilities**



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

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

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

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

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

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

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

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

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

Signed: Date:

Paul Bentley, Chief Executive Officer



Kent Community Health
NHS Foundation Trust



**Annual governance
statement**



Kent Community Health
NHS Foundation Trust

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

1. Scope of responsibility

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

2. The purpose of the system of internal control

The system of internal control is designed to manage risk to a reasonable level rather than to eliminate all risk of failure to achieve policies, aims and objectives; it can therefore only provide reasonable and not absolute assurance of effectiveness. The system of internal control is based on a continuing process designed to identify and prioritise the risks to the achievement of the policies, aims and objectives of Kent Community Health NHS Foundation Trust, to evaluate the likelihood of those risks being realised and the impact should they be realised, and to manage them efficiently, effectively and economically. The system of internal control has been in place in Kent Community Health NHS Foundation Trust for the year ended 31 March 2018 and up to the date of approval of the annual report and accounts.

3. Capacity to handle risk

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

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

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

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

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

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

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

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

4. The risk and control framework

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

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

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

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

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

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

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

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

4.1 Care Quality Commission

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

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

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

4.2 Committee structure

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

4.3 Quality Committee

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

The purpose of the committee is to:

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

Specific responsibilities of the Quality Committee include:

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

Providing assurance to the Board by:

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

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

4.4 Audit and Risk Committee

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

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

The purpose of the Audit and Risk Committee is to:

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

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

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

4.5 Finance, Business and Investment Committee

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

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

The overall objectives of the committee are to:

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

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

4.6 Remuneration and Terms of Service Committee

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

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

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

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

4.7 Charitable Funds Committee

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

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

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

4.8 Strategic Workforce Committee

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

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

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

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

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

4.9 Council of Governors

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

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

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

4.10 NHS pension scheme

As an employer with staff entitled to membership of the NHS Pension Scheme, control measures are in place to ensure all employer obligations contained within the Scheme Regulations are complied with.

This includes ensuring that deductions from salary, employer's contributions and payments into the Scheme are in accordance with the Scheme rules, and that member Pension Scheme records are accurately updated in accordance with the timescales detailed in the Regulations.

4.11 Sustainability

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

5. Information governance (IG)

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

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

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

6. Annual quality report

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

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

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

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

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

7. Review of effectiveness

As accounting officer, I have responsibility for reviewing the effectiveness of the system of internal control.

My review of the effectiveness of the system of internal control is informed by the work of the internal auditors, clinical audit and the executive managers and clinical leads in the NHS foundation trust who have responsibility for development and maintenance of the internal control framework.

I have drawn on the content of the quality report attached to this annual report and other performance information available to me. My review is also informed by comments made by the external auditors in their management letter and other reports. I have been advised on the implications of the result of my review of the effectiveness of the system of internal control by the Board, Audit and Risk Committee and Quality Committee and a plan to address weaknesses and ensure continuous improvement of the system is in place.

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

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

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

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

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

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

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

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

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

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

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

Conclusion

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

Signed: Date:

Paul Bentley, Chief Executive Officer

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

Report on the Audit of the Financial Statements

Opinion

Our opinion on the financial statements is unmodified

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

In our opinion the financial statements:

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

Basis for opinion

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

Who we are reporting to

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

Conclusions relating to going concern

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

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

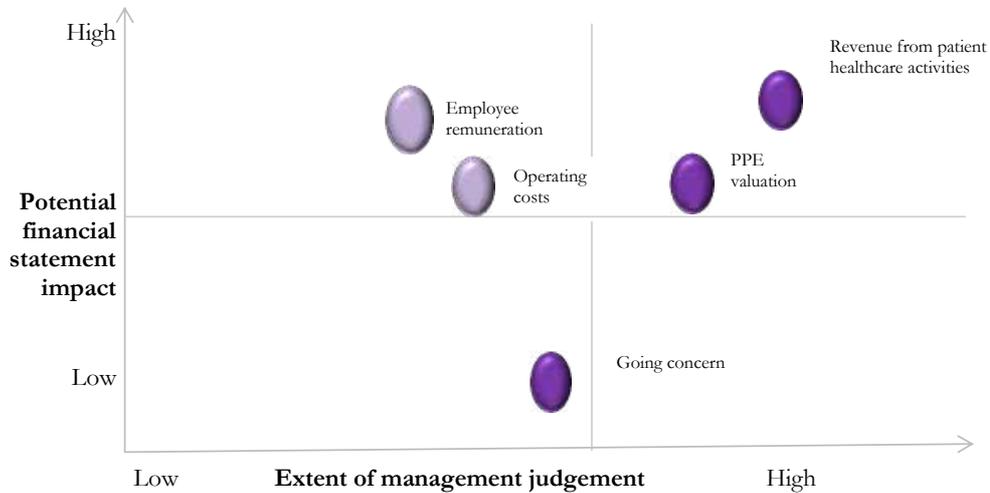


Overview of our audit approach

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

Key audit matters

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



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

Key Audit Matter	How the matter was addressed in the audit
<p>Risk 1 Obtaining assurance that the revenue from patient healthcare activities was not materially misstated</p> <p>Over 95% of the Trust's income is from patient healthcare activities, 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. Some invoices may involve further negotiation of contractual adjustments</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 health care income and evaluating the design of the associated controls; • using an analysis provided by the Department of Health to identify any significant differences in income balances with contracting NHS bodies, and confirming the validity of these differences; and • agreeing, on a sample basis, amounts recognised in income in the financial statements to signed contracts and invoices.

Key Audit Matter	How the matter was addressed in the audit
<p>with commissioners after the deadline for the production of the financial statements, although the risk is reduced where significant amounts of patient care income are received through block contracts, as for the Trust.</p> <p>We identified the risk that income from patient healthcare activities had not occurred, or had not been accurately stated, as a significant risk, and as the most significant assessed risk of material misstatement.</p>	<p>The Trust's accounting policy on income recognition, including income from patient healthcare activities, is disclosed at note 1.4 in the financial statements. An analysis of income from patient healthcare activities is disclosed at Note 3.</p> <p>Key observations Our audit work on this risk did not identify any significant issues.</p>

Our application of materiality

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

Materiality was determined as follows:

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

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

Overall materiality - Trust



An overview of the scope of our audit

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

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

Other information

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

In connection with our audit of the financial statements, our responsibility is to read the other information and, in doing so, consider whether the other information is materially inconsistent with the financial statements or our knowledge of the Trust obtained in the course of our work including that gained through work in relation to the Trust's arrangements for securing value for money through economy, efficiency and effectiveness in the use of its resources or otherwise appears to be materially misstated. If we identify such material inconsistencies or apparent material misstatements, we are required to determine whether there is a material misstatement in the financial statements or a material misstatement of the other information. If, based on the work we have performed, we conclude that there is a material misstatement of this other information, we are required to report that fact.

We have nothing to report in this regard.

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

- Fair, balanced and understandable **set out on page ...** in accordance with provision C.1.1 of the NHS Foundation Trust Code of Governance – the statement given by the directors that they consider the Annual Report and financial statements taken as a whole is fair, balanced and understandable and provides the information necessary for patients, regulators and other stakeholders to assess the Trust's performance, business model and strategy, is materially inconsistent with our knowledge of the Trust obtained in the audit; or
- Audit and Risk Committee reporting **set out on page ...** in accordance with provision C.3.9 of the NHS Foundation Trust Code of Governance – the section describing the work of the Audit and Risk Committee does not appropriately address matters communicated by us to the Audit and Risk Committee.

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

Under the Code of Audit Practice published by the National Audit Office on behalf of the Comptroller and Auditor General (the Code of Audit Practice) we are required to consider whether the Annual Governance Statement does not meet the disclosure requirements set out in the NHS foundation trust annual reporting manual 2017/18. We are not required to consider whether the Annual Governance Statement addresses all risks and controls or that risks are satisfactorily addressed by internal controls.

We have nothing to report in this regard.

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

In our opinion:

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

Matters on which we are required to report by exception

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

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

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

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

As explained more fully in the Statement of Accounting Officer's responsibilities [set out on page(s) x to x], the Chief Executive, as Accounting Officer, is responsible for the preparation of the financial statements in the form and on the basis set out in the Accounts Directions included in the NHS foundation trust annual reporting manual 2017/18, for being satisfied that they give a true and fair view, and for such internal control as the Accounting Officer determines is necessary to enable the preparation of financial statements that are free from material misstatement, whether due to fraud or error.

In preparing the financial statements, the Accounting Officer is responsible for assessing the Trust's ability to continue as a going concern, disclosing, as applicable, matters related to going concern and using the going concern basis of accounting unless the Trust lacks funding for its continued existence or when policy decisions have been made that affect the services provided by the Trust.

The Audit and Risk Committee are Those Charged with Governance.

Auditor's responsibilities for the audit of the financial statements

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

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

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

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

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

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

Responsibilities of the Accounting Officer

The Accounting Officer is responsible for putting in place proper arrangements for securing economy, efficiency and effectiveness in the use of the Trust's resources.

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

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

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

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

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



Report on other legal and regulatory requirements - Certificate

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

Signature

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

London
xx May 2017



Kent Community Health
NHS Foundation Trust



Annual accounts



Foreword to the accounts

Kent Community Health NHS Foundation Trust

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

Signed: Date:

Paul Bentley, Chief Executive Officer

Statement of comprehensive income for the year ended 31 March 2018

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

The notes on pages 109 to 153 form part of this account.

Statement of financial position as at 31 March 2018

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

The notes on pages 109 to 153 form part of this account.

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

Signed.....

Name: Paul Bentley, Chief Executive Officer

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

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

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

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

Information on reserves

Public dividend capital

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

Revaluation reserve

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

Income and expenditure reserve

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

Statement of cash flows for the year ended 31 March 2018

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

Notes to the accounts

Note 1 Accounting policies and other information

Note 1.1 Basis of preparation

NHS Improvement, in exercising the statutory functions conferred on Monitor, has directed the financial statements of the trust shall meet the accounting requirements of the Department of Health and Social Care group accounting manual (GAM), which shall be agreed with HM Treasury. Consequently, the following financial statements have been prepared in accordance with the GAM 2017-18 issued by the Department of Health and Social Care.

The accounting policies contained in the GAM follow international financial reporting standards to the extent that they are meaningful and appropriate to the NHS, as determined by HM Treasury, which is advised by the Financial Reporting Advisory Board. Where the GAM permits a choice of accounting policy, which is judged to be most appropriate to the particular circumstances of the trust for the purpose of giving a true and fair view has been selected. The particular policies adopted are described below. These have been applied consistently in dealing with items considered material in relation to accounts.

Note 1.1.1 Accounting convention

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

Note 1.1.2 Going concern

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

Note 1.2 Critical accounting estimates and judgements

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

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

Redundancy provision

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

Legal claims and other provisions

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

Valuation of land and buildings (owned)

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

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

Note 1.3 Interests in other entities

NHS Charitable Fund

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

Note 1.4 Income

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

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

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

Revenue grants and other contributions to expenditure

Government grants are grants from government bodies other than income from commissioners or trusts for the provision of services. Where a grant is used to fund revenue expenditure it is taken to the statement of comprehensive income to match that expenditure. The trust did not receive any government grants in 2017-18.

The value of the benefit received when accessing funds from the Government's apprenticeship service is recognised as income at the point of receipt of the training service. Where these funds are paid directly to an accredited training provider, the corresponding notional expense is also recognised at the point of recognition for the benefit.

Note 1.5 Expenditure on employee benefits

Short-term employee benefits

Salaries, wages and employment-related payments, such as social security costs and the apprenticeship levy are recognised in the period in which the service is received from employees. The cost of annual leave entitlement earned but not taken by employees at the end of the period is recognised in the financial statements to the extent that employees are permitted to carry-forward leave into the following period. Payments for overtime and enhancements are paid one month in arrears and the accounts presented incorporate an accrual for the cost of overtime and enhancements worked in March 2018 but to be paid in April 2018.

Pension costs

Past and present employees are covered by the provisions of the NHS pension scheme. The scheme is an unfunded, defined benefit scheme that covers NHS employers, general practices and other bodies, allowed under the direction of secretary of state, in England and Wales. The scheme is not designed in a way that would enable employers to identify their share of the underlying scheme assets and liabilities. Therefore, the schemes are accounted for as though they are defined contribution schemes.

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

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

National Employment Savings Trust (NEST)

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

Note 1.6 Expenditure on other goods and services

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

Note 1.7 Property, plant and equipment

Note 1.7.1 Recognition

Property, plant and equipment is capitalised where:

- it is held for use in delivering services or for administrative purposes
- it is probable that future economic benefits will flow to, or service potential be provided to, the trust
- it is expected to be used for more than one financial year
- the cost of the item can be reliably measured
- the item has cost of at least £5,000, or collectively, a number of items have a cost of at least £5,000 and individually have cost of more than £250, where the assets are functionally inter-dependent, had broadly simultaneous purchase dates, are anticipated to have similar disposal dates and are under single managerial control
- items forming part of the initial equipping and setting-up cost of a new building, ward or unit, irrespective of their individual or collective cost.

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

Note 1.7.2 Measurement

Valuation

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

Subsequent measurement is as follows:

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

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

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

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

Current values are determined as follows:

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

Subsequent expenditure

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

Depreciation

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

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

Revaluation gains and losses

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

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

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

Impairments

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

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

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

Note 1.7.3 Derecognition

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

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

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

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

Note 1.7.4 Useful economic lives of property, plant and equipment

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

	Minimum life	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 and the minimum life stated recognises the short-term nature of some of the leases in place.

Note 1.8 Intangible assets

Note 1.8.1 Recognition

Intangible assets are non-monetary assets without physical substance which are capable of being sold separately from the rest of the trust's business or which arise from contractual or other legal rights. They are recognised only where it is probable that future economic benefits will flow to, or service potential be provided to, the trust, where the cost of the asset can be measured reliably and where the cost is at least £5,000.

Internally generated intangible assets

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

Expenditure on research is not capitalised.

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

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

Software

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

Note 1.8.2 Measurement

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

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

Amortisation

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

Note 1.8.3 Useful economic lives of intangible assets

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

Intangible assets – purchased	Minimum life	Maximum life
Software	1	5

Note 1.9 Inventories

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

Note 1.10 Cash and cash equivalents

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

Note 1.11 Financial instruments and financial liabilities

Financial assets

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

Financial assets are initially recognised at fair value.

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

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

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

Financial liabilities

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

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

Note 1.12 Leases

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

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

Note 1.13 Provisions

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

Clinical negligence costs

NHS Resolution operates a risk pooling scheme under which the trust pays an annual contribution to NHS Resolution, which, in return, settles all clinical negligence claims. Although NHS Resolution is administratively responsible for all clinical negligence cases, the legal liability remains with the trust. The total value of clinical negligence provisions carried by NHS resolution on behalf of the trust is disclosed at note 25.2, but is not recognised in the trust's accounts.

Non-clinical risk pooling

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

Note 1.14 Contingencies

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

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

Note 1.15 Public dividend capital

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

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

A charge, reflecting the cost of capital utilised by the trust, is payable as public dividend capital dividend. The charge is calculated at the rate set by HM Treasury (currently 3.5 per cent) on the average relevant net assets of the trust during the financial year. Relevant net assets are calculated as the value of all assets less the value of all liabilities, except for

- (i) donated assets (including lottery funded assets),
- (ii) average daily cash balances held with the Government Banking Services (GBS) and National Loans Fund (NLF) deposits, excluding cash balances held in GBS accounts that relate to a short-term working capital facility, and
- (iii) any PDC dividend balance receivable or payable.

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

Note 1.16 Value added tax

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

Note 1.17 Corporation tax

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

Note 1.18 Foreign exchange

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

Note 1.19 Third party assets

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

Note 1.20 Losses and special payments

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

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

Note 1.21 Early adoption of standards, amendments and interpretations

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

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

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

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

Note 2 Operating segments

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

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

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

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

Note 3 Operating income from patient care activities

Note 3.1 Income from patient care activities (by nature)

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

Note 3.2 Income from patient care activities (by source)

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

Note 4 Other operating income

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

Note 4.1 Income from activities arising from commissioner requested services

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

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

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

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

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

Note 5 Operating expenses

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

Note 5.1 Limitation on auditor's liability

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

Note 6 Impairment of assets

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



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Note 7 Employee benefits

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

Note 7.1 Retirements due to ill-health

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

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

Note 7.2 Directors' remuneration

The aggregate amounts payable to directors were:

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

Note 8 Pension costs

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

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

a) Accounting valuation

A valuation of scheme liability is carried out annually by the scheme actuary (the Government Actuary's Department) as at the end of the reporting period. This utilises an actuarial assessment for the previous accounting period in conjunction with updated membership and financial data for the reporting period, and is accepted as providing suitably robust figures for financial reporting purposes. The valuation of the scheme liability as at 31 March 2018, is based on valuation data as 31 March 2017, updated to 31 March 2018 with summary global member and accounting data. In undertaking this actuarial assessment, the methodology prescribed in IAS 19, relevant FReM interpretations and the discount rate prescribed by HM Treasury have also been used.

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

b) Full actuarial (funding) valuation

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

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



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

Other schemes

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

Note 9 Operating leases

Note 9.1 Kent Community Health NHS Foundation Trust as a lessee

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

	2017/18	2016/17
	£000	£000
Operating lease expense		
Minimum lease payments	7,546	9,060
Contingent rents	-	-
Less sublease payments received	-	-
Total	7,546	9,060
	31 March	31 March
	2018	2017
	£000	£000
Future minimum lease payments due:		
- not later than one year;	2,632	2,739
- later than one year and not later than five years;	6,510	6,786
- later than five years.	5,664	4,401
Total	14,806	13,926
Future minimum sublease payments to be received	-	-



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Note 10 Finance income

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

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

Note 11.1 Finance expenditure

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

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

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

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

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

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

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

Note 13 Intangible assets 2017-18

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

Note 13.1 Intangible assets 2016-17

Note 13.1 Intangible assets - 2016/17

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

Note 14.1 Property, plant and equipment – 2017-18

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

Note 14.2 Property, plant and equipment – 2016-17

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

Note 14.3 Property, plant and equipment – 2017-18

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

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

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

Note 15 Revaluations of property, plant and equipment

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

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

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

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

Note 16 Investments – 2017-18

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

Note 17 Disclosure of interests in other entities

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

Note 18 Inventories

The trust holds no material inventories.

Note 19.1 Trade receivables and other receivables

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

Note 19.2 Provision for impairment of receivables

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

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

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

Note 19.3 Credit quality of financial assets

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

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

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

Note 20 Cash and cash equivalents movements

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

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

Note 20.1 Third party assets held by the trust

Note 20.1 Third party assets held by the trust

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

Note 21.1 Trade and other payables

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

Note 21.2 Early retirements in NHS payables above

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

Note 22 Other liabilities

	31 March 2018 £000	31 March 2017 £000
Current		
Deferred income	1,760	585
Total other current liabilities	<u>1,760</u>	<u>585</u>

Note 23 Borrowings

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

Note 24 Finance leases

Note 24.1 Kent Community Health NHS Foundation Trust as a lessor

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

Note 24.2 Kent Community Health NHS Foundation Trust as a lessee

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

Note 25.1 Provisions for liabilities and charges analysis

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

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

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

Note 25.2 Clinical negligence liabilities

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

Note 26 Contingent assets and liabilities

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

Note 27 Contractual capital commitments

	31 March 2018 £000	31 March 2017 £000
Property, plant and equipment	607	1,136
Intangible assets	-	-
Total	<u>607</u>	<u>1,136</u>

Note 28 Other financial commitments

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

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

Note 29 Defined benefit pension schemes

The trust has no defined benefit pension schemes.

Note 30 Financial instruments

Note 30.1 Financial risk management

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

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

Currency risk

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

Interest rate risk

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

Credit risk

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

Liquidity risk

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

Note 30.2 Carrying values of financial assets

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

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

Note 30.3 Carrying values of financial liabilities

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

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

Note 30.4 Fair values of financial assets and liabilities

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

Note 30.4 Fair values of financial assets and liabilities

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

Note 30.5 Maturity of financial liabilities

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

Note 31 Losses and special payments

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

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

Note 32 Related parties

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

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

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

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

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

Note 33 events after the end of the reporting period

There aren't any events after the end of the reporting period.



Quality Report
2017 to 2018



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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 2017-18.

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

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

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

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

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

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

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

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

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

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

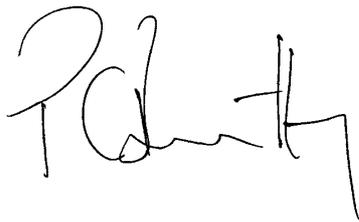
We did undertake some strong work on reducing pressure ulcers, so we were pleased that there was a 27 per cent reduction in grade three and four pressure ulcers in 2017-18, which achieved our target. Equally, the 44 per cent reduction in grade two pressure ulcers went beyond what we initially thought was achievable, which is good news for patients and demonstrates the continuing hard work of our teams to get it right.

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

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

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

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

A handwritten signature in black ink, appearing to read 'Paul Bentley', with a stylized, cursive script.

Paul Bentley
Chief Executive

Part two

Priorities for improvement and statements of assurance from the Board

2.1 Priorities for improvement

About our trust:

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

Kent Community Health NHS Foundation Trust (KCHFT) is one of the largest NHS community health providers in England, serving a population of about 1.4 million across Kent and 600,000 in East Sussex and London. We employ more than 5,000 staff, including doctors, community nurses, physiotherapists, dietitians and many other healthcare professionals. We became a foundation trust on 1 March 2015.

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

Mission:

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

Vision:

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

Values we care

We have four values:

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

Our goals are to:

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

Our quality strategy 2017 to 2020

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

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

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

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

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

This is known as the quadruple aim.

Quality is central to all we aspire to achieve:

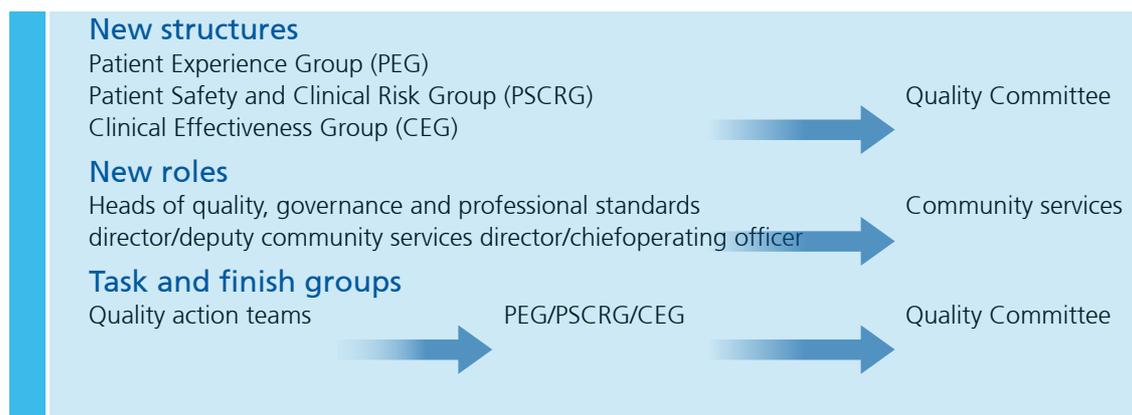
1. Patient experience - be nice to me.
2. Patient safety - do me no harm.
3. Clinical effectiveness - make me better, help me live with my condition and help me die in a way I choose.



Our objectives for quality are:

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

Delivering quality:



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

Summary against 2017-18 priorities

Our trust priorities for last year were:

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

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

Patient experience

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

Patient safety

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

Clinical effectiveness

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

Quality achievements 2017-18

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

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

Patient experience

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

Patient safety

- **41%** reduction in falls with harm within our community hospitals, exceeding our target.
- **27%** reduction in grades three and four pressure ulcers, achieving our target.
- **44%** reduction in grade two pressure ulcers, exceeding our target.

Clinical effectiveness

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

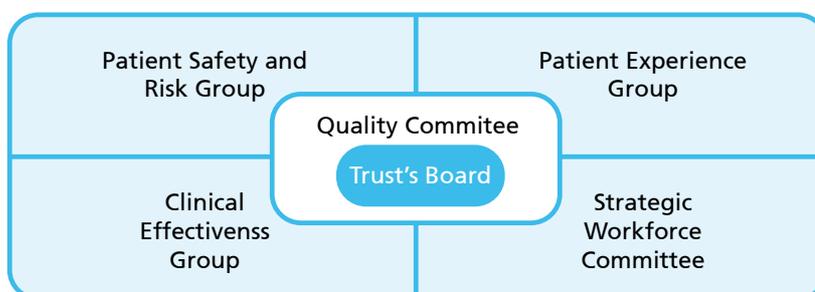
Our priorities for 2018-19

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

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

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

<p>Our patients' safety</p> <p>We will learn from incidents and complaints, improving the safety of our patients. We will introduce an improved methodology of patient centred investigation.</p> <p>We will:</p> <ul style="list-style-type: none"> involve families in all relevant RCA investigations for serious incidents survey patients and families on their involvement in investigations share serious incidents and complaints' stories at our quality improvement network <p>We need more staff trained in root cause analysis investigation training. There is a national agenda for shared learning and improving and we want to improve our processes.</p>	<p>Our patients' experience</p> <p>We will ensure our patients are co-leaders in their care, by working together with our patients and local population to improve our responsiveness.</p> <p>We will</p> <ul style="list-style-type: none"> develop and publish an involvement and experience strategy ensure all relevant patients have a personalised plan of care developed by competent staff: <p>We want to be responsive to the needs of our population. We have started personalised care planning across the trust, but have further work to do to embed. This is a CQUIN for us for 2018-19.</p>
--	--



Our clinical effectiveness

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

We will:

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

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

Our staff

We will improve recruitment and retention of our workforce.

We will

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

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

2.2 Statements of assurance from the Board

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Areas of good practice were:

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

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

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

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

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

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

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

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

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

2.3 Reporting against core indicators

Indicator 19: hospital re-admissions

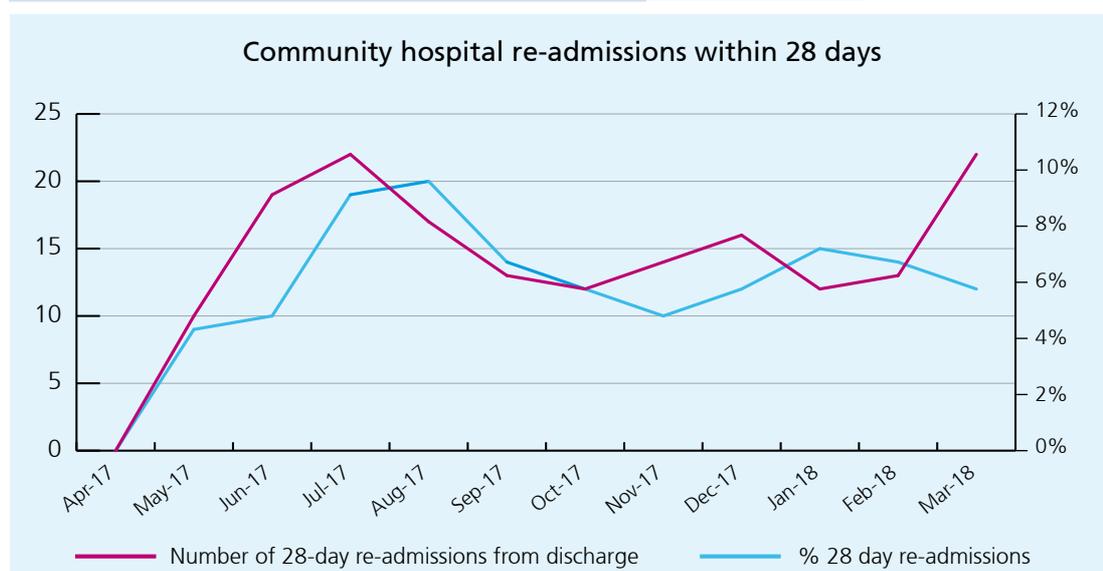
The percentage of patients aged:

- (i) 0 to 14 and
- (ii) 15 and over

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

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

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



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

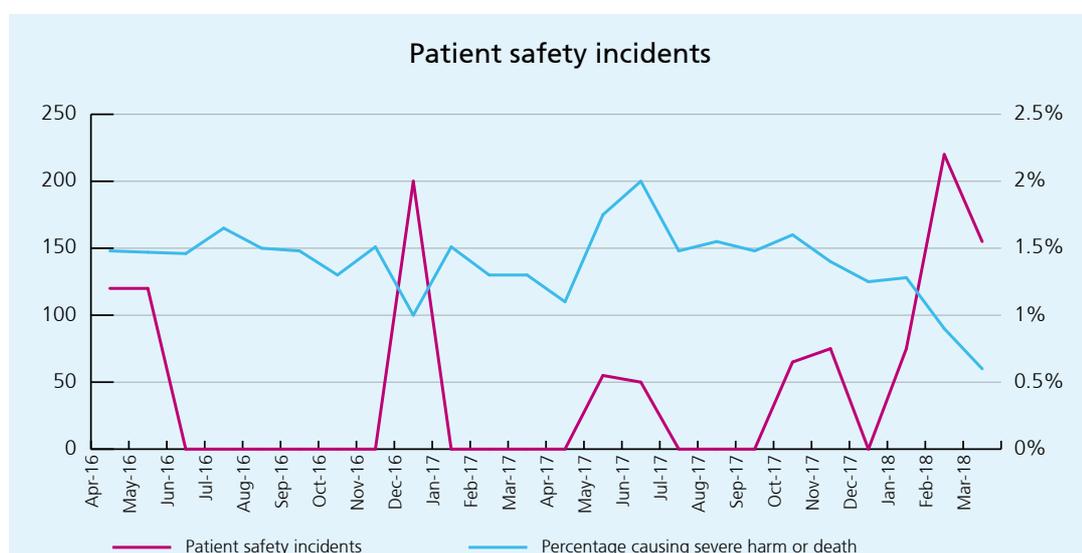
- regularly extracted and checked
- shared with services for validation
- collected at point of delivery in the majority of cases.

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

Indicator 25: Patient safety incidents

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

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



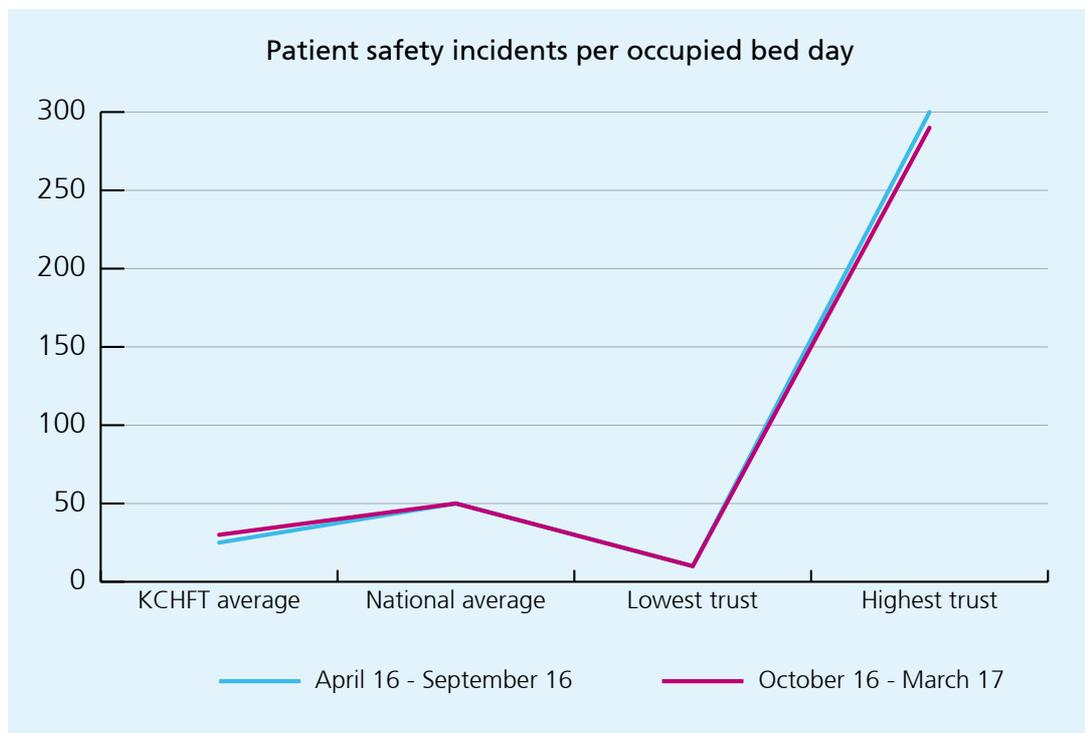
KCHFT considers this data is as described for the following reasons: It is captured on the Datix system by the member of staff who discovered the incident, ensuring the data is first-hand information.

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

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

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

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

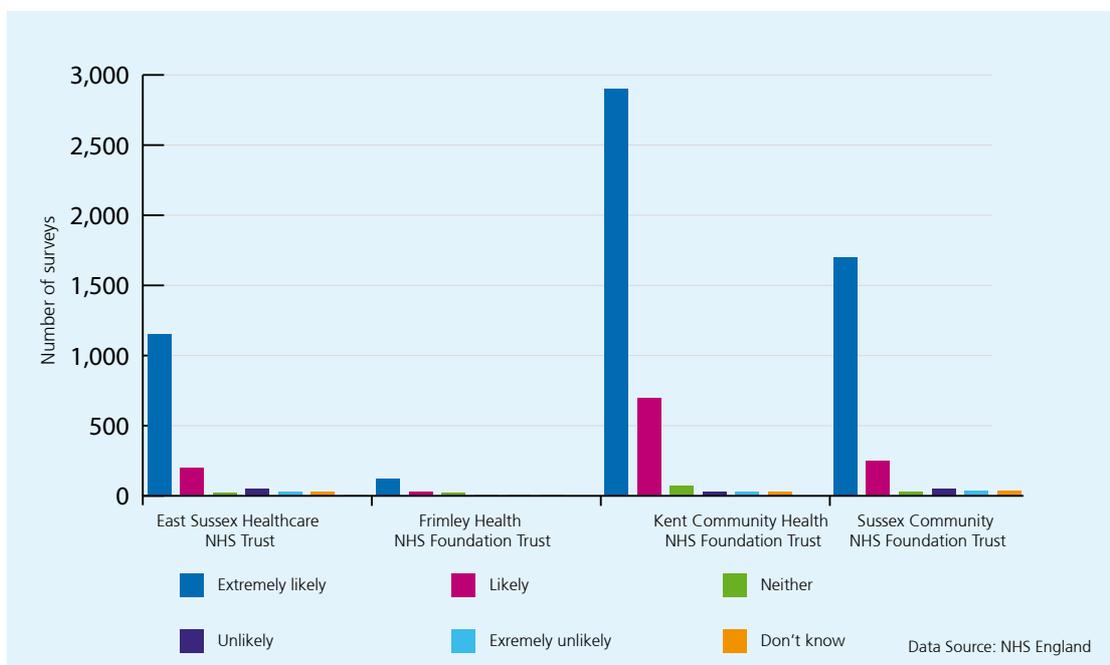
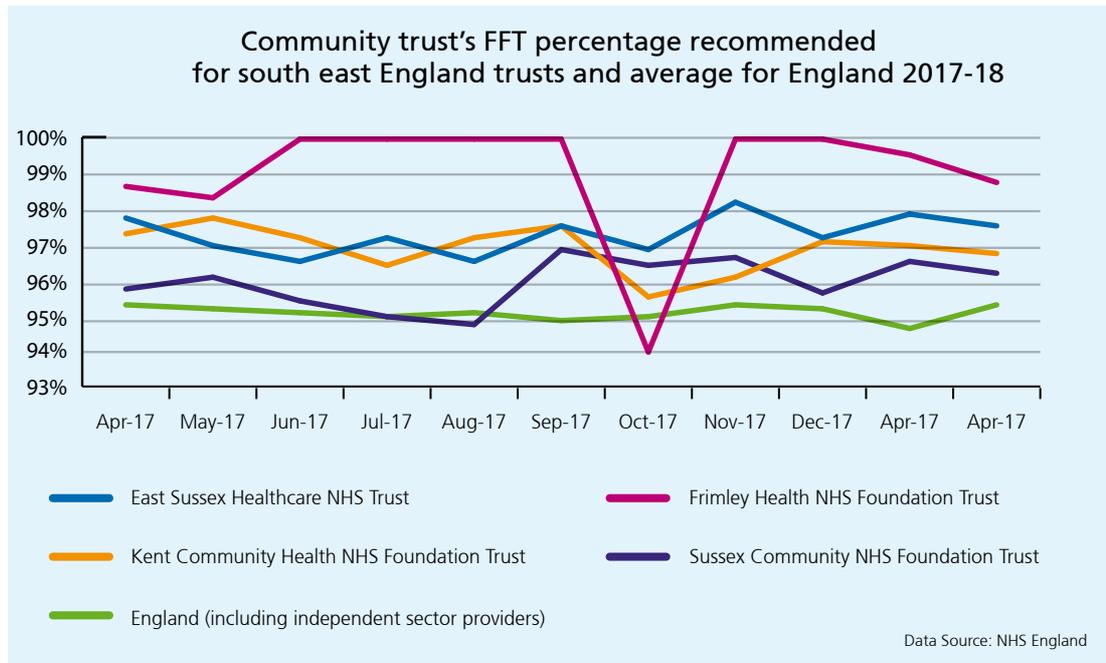


	April 2016 - September 2016	October 2016 - March 2017
KCHFT average	25	33
National average	48	46
Lowest trust	12	13
Highest trust	304	295

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

21 Friends and family test (FFT)

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



Part three

Overview of quality of care

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

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

Regulation: Care Quality Commission

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

Rating

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



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

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

Inspections 2017-18

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

We care visit programme

This year we reviewed and refreshed our internal assurance visit programme, designing new visit tools aligned with the CQC's key lines of enquiry and our own trust's CARE values.

This new model enables us to rate teams against our CARE values, using the CQC's rating methodology. It gives us a clear picture of where we are doing well and where we need to improve.

We had an ambitious aim to implement the programme during February 2018 and make sure all our services receive at least one visit and a rating by September 2018. We are progressing well with this target with about half of services rated by the end of April 2018.

The programme involves all levels and disciplines of staff in the trust, together with our governors, patient representatives and CCG colleagues. Those participating in a visit receive guidance, tools and training beforehand and are provided with a pre-visit data pack summarising the data we hold about the team or service. This includes complaints, incidents, risks and patient feedback.

During the visit, participants talk to staff, visit clinical areas and attend home visits with clinicians; giving a full picture of the standard of care being provided.

A meeting at the end of the visit enables all participants to share observations from the visit and contribute to a report and agree ratings.

After each visit, the hosting team is given feedback, a summary report, and a certificate displaying its ratings. The team is asked to produce an improvement plan and a re-visit is planned, depending on the rating.

Trust-wide areas for improvement are also identified and themes arising from the visits shared.



Compassionate

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



Aspirational

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



Responsive

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



Excellent

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

Patient experience

End of life care

Goals for 2017-18

Goal	% 2016-17	% 2017-18	2017-18 target	Outcome
Ensure a minimum of 95% of our patients die in their preferred place	86.2%	84.5%	95%	Not achieved

Our goal was to increase the number of patients who die in their preferred place of death.

Why this is important

This is a national indicator and is also considered an indicator for the provision of quality care.

Our vision is to be the leading provider and co-ordinator for end of life care, delivering excellent care - enabling those receiving end of life care to live as comfortably as possible through their last weeks and days of life and to be able to be supported to die in their place of choice.

What we did

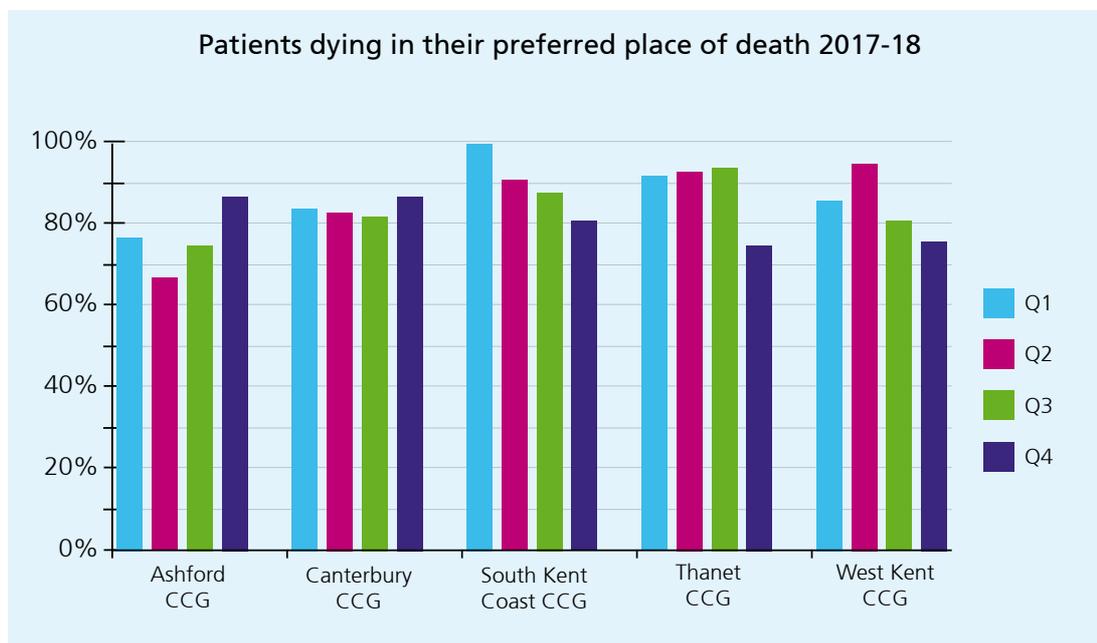
We aimed to improve data collection and the numbers of deaths recorded. We provided teams with a guide on how to enter this data and made clear that this is a priority for us.

What this means for you as a patient

An informed conversation will allow patients to decide where they would like to spend their last days.

What we achieved

Staff have made every effort to make sure that patients die in their preferred place of death. This this has not always been possible due to the patient's health or need for specialist care. Progress has been made in terms of accurate recording and this remains a priority for staff. Data from other sources, including patient experience is monitored closely to ensure high-quality end of life care is being delivered.



Patients dying in their preferred place of death 2017-18

	Q1	Q2	Q3	Q4	17/18
Ashford CCG	76.9%	66.7%	75.0%	87.0%	77.1%
Canterbury CCG	83.7%	82.5%	81.5%	86.5%	83.3%
South Kent Coast CCG	100.0%	90.6%	87.5%	81.0%	87.8%
Thanet CCG	92.0%	92.3%	93.3%	75.0%	89.2%
West Kent CCG	86.2%	95.3%	81.4%	75.0%	84.4%
Trust-wide	87.8%	85.5%	83.8%	80.9%	84.4%

Goal	Number 2016-17	Number 2017-18	2017-18 target	Outcome
Increase number of surveys from patients at the end of life, their carers and families to 40 surveys per quarter	Not measured	47 across the year	40 per quarter	Not achieved

Our aim was to increase the number of surveys completed by staff for patients at the end of life, their carers and families by promoting the survey and its importance.

Why this is important

We want to learn how we can improve end of life care and if our patients and their relatives are given the opportunity to share their experiences, this can help us do this.

What we did

We increased the skills of teams so they were confident to have a discussion with patients and their relatives about end of life care. We gave our end of life care champions additional training to enable them to support their teams.

We adapted the survey with staff and have promoted it to all teams. The feedback from surveys is reviewed at team meetings and a thematic analysis of the feedback is reported to the End of Life Steering Group.

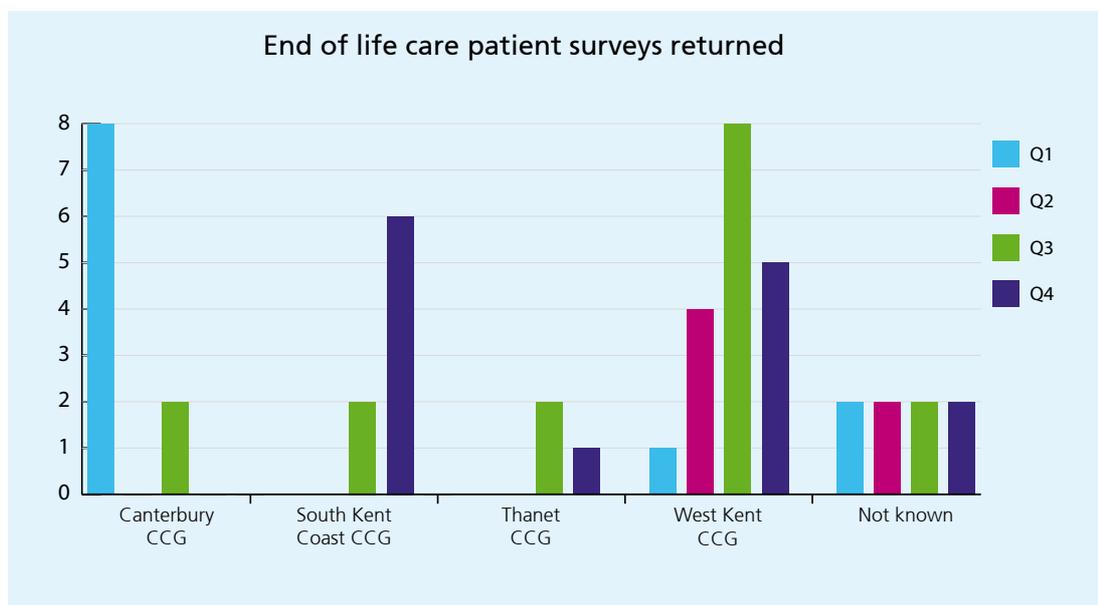
What this means for you as a patient

We want patients to feel that by sharing their experience they can improve care for other patients.

What we achieved

We increased the number of surveys being returned but did not achieve the target. We received 47 surveys across the year.

Different methods of collecting the experience of patients or their relatives at end of life are being explored to complement the traditional survey approach.



End of life care patient surveys returned

	Q1	Q2	Q3	Q4
Ashford and Canterbury CCG	0	0	0	0
Canterbury CCG	8	0	2	0
South Kent Coast CCG	0	0	2	6
Thanet CCG	0	0	2	1
West Kent CCG	1	4	8	5
Not known	2	2	2	2
Total	11	6	18	14

Patient experience

Patient feedback

Goal	Number 2016-7	Number 2017-8	2017-18 target	Outcome
Services to survey at least 10% of their caseload	Not measured	9% across the trust	10% per service	Not achieved

We wanted to increase the number of patient experience surveys completed, aiming for each service to survey a minimum of 10 per cent of their caseload.

Why this is important

KCHFT is committed to seeking feedback from patients, carers and families about the quality of the care they receive and to using this to improve our service. Increasing our survey returns across the organisation will enable us to make sure we are receiving feedback from a wide range of patients, carers and families.

What we did

We worked with individual services to find various ways to support feedback from particular service users.

Surveys are available in a variety of formats and are accessible in paper form and online. They are also available on wall-mounted handheld devices in our minor injury units and clinics. Staff working in the community now have surveys available on their handheld devices.

Additionally, we can now email service users with a survey.

While surveys are an effective method of obtaining feedback for most services, there are other methods which are more suitable for particular service users.

For example, feedback is obtained via our locally-held patient experience groups. Our website also promotes the completion of online feedback via other websites, such as NHS Choices and Care Opinion.

We have developed our public website making it easier for people to give us feedback in a variety of ways most suitable to them.

What this means for you as a patient

KCHFT is committed to listening to our patients, carers and families and is keen to involve them as partners to improve our service. Patients now have a greater number of ways of providing us with feedback.

What we achieved

During 2017-18 KCHFT received 63,912 surveys with an overall satisfaction rate of 97 per cent.

KCHFT surveyed nine per cent of caseload across the trust during quarters three and four. This varied depending on the individual service and the nature of service user. The highest number of surveys per caseload was achieved by community hospitals, which surveyed up to 59 per cent of their caseload.

Patient safety

Falls

Goals for 2017-18

Goal	Number 2016-7	Number 2017-8	% reduction	Outcome
10% reduction in falls with harm in our community hospitals	17	10	41%	Achieved

Our target was to reduce falls that result in harm in our community hospitals by 10 per cent.

Why this is important

Falls represent the most frequent and serious type of accident in people aged 65 and over and can cause serious injury and increased care costs. Research has shown that falls can be reduced by introducing assessments and interventions.

What we did

KCHFT took part in the NHS Improvement falls collaborative. Our aim was to improve falls prevention across all our inpatient sites, ensuring a multi-professional approach to falls prevention. We implemented quality improvement initiatives, which included:

- completion of a multi-factorial falls risk assessment on patients aged 65 or older or who are aged between 54 to 64 and are judged to be at a higher risk of falling because of an underlying condition; we followed NICE guidance CG161
- ensuring the call bell is within reach of each patient
- ensuring the appropriate mobility aid is within reach
- taking and reviewing lying and standing blood pressure on admission
- carrying out a medication review
- completing a bedside vision check
- developing a falls prevention personalised care plan with the patient and their family.

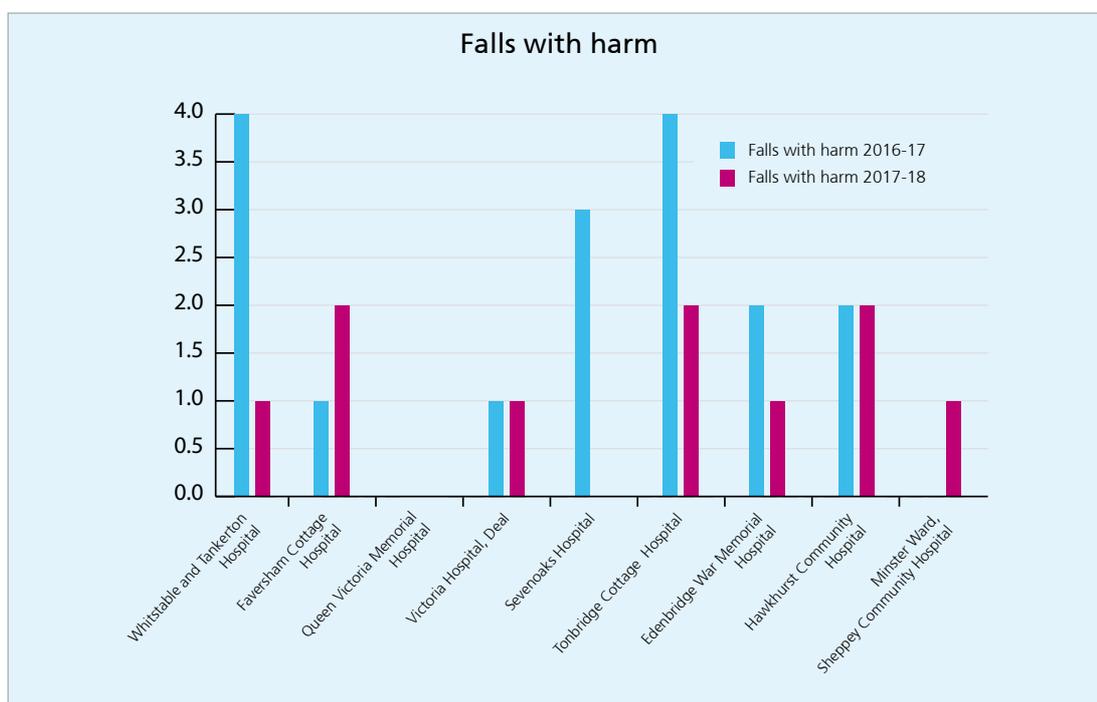
These improvement initiatives make up the trust-wide falls prevention improvement action plan. Progress against this plan is regularly reviewed by our Falls Prevention and Improvement Group.

What this means for patients

When our patients enter our inpatient sites across the organisation, assessments and interventions introduced through our quality improvement initiatives have reduced the risk of a fall resulting in harm.

What we achieved

In 2016-17, there were 17 avoidable falls with harm in community hospitals compared with 10 avoidable falls with harm in community hospitals during 2017-18, resulting in an overall reduction for the year of 41 per cent. The graph and table below details the locations of these falls for the past two years.



CCG	Location	Falls with harm 2016-17	Falls with harm 2017-18
Ashford and Canterbury CCG	Whitstable and Tankerton Hospital	4	1
	Faversham Cottage Hospital	1	2
	Queen Victoria Memorial Hospital, Herne Bay	0	0
South Kent Coast	Victoria Hospital, Deal	1	1
West Kent CCG	Sevenoaks Hospital	3	0
	Tonbridge Cottage Hospital	4	2
	Edenbridge and District War Memorial Hospital	2	1
	Hawkhurst Community Hospital	2	2
North Kent	Minster Ward, Sheppey Community Hospital	0	1
Total		17	10

The table here shows the number of falls with moderate to severe harm per occupied bed day (OBD). The national average is 0.19, placing KCHFT just below the average number at 0.18.

	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	YTD total
KCHFT occupied bed day	4,255	4,513	4,516	4,734	4,589	4,404	4,731	4,731	4,586	4,990	4,301	4,894	55,244
Avoidable patient falls with harm	0	3	1	0	1	0	0	2	0	1	1	1	10
Avoidable patient falls per 1,000 occupied bed days	0	0.66	0.22	0	0.22	0	0	0.42	0	0.20	0.23	0.20	0.18

Patient safety

Pressure ulcers

Goals for 2017-18

		Number 2016-7	Number 2017-8	% reduction	Outcome
1.	20% reduction in category 3 and 4 avoidable pressure ulcers acquired in our care	26	19	27%	Achieved
2.	10% reduction in category 2 avoidable pressure ulcers acquired in our care	32	19	44%	Achieved

We had two targets; to reduce category three and four avoidable pressure ulcers by 20 per cent, and to reduce category two avoidable pressure ulcers by 10 per cent.

What is a pressure ulcer?

Pressure ulcers, previously known as bed sores and an injury that affects areas of the skin and underlying tissue, are caused when placed under pressure over time. Their presentation can vary in severity from discoloured skin to open wounds.

Pressure ulcers develop when a large amount of pressure is applied to an area of skin over a short period of time. Or, they can happen when less force is applied but over a longer period of time. This could be from a number of causes, such as sitting or lying in one position without moving for too long, to friction caused by clothing, shoes and straps etc.

The extra pressure disrupts the flow of blood through the skin. Without a blood supply, the affected area of skin becomes starved of oxygen and nutrients. It begins to break down, leading to the formation of an ulcer.

Why this is important

This is a national initiative driven by NHS England to improve the quality and safety of patients receiving care. Each year, we set a reduction trajectory with the aim of reaching zero tolerance.

What we did

The primary focus for the organisation has been a continued proactive approach with an emphasis on prevention strategies and patient empowerment to effectively reduce the risk of patient harms acquired in our care.

This year, we introduced a new validated risk assessment screening tool PURPOSE T to support early identification of at-risk patients, enabling clinicians to plan and implement prevention strategies to lower the risk of harm. This tool was rolled out via a planned educational programme to all nurses and therapists at KCHFT.

To make sure our systems and processes to reduce pressure ulcer harm were robust, auditors carried out a detailed review of our training programmes; policies, procedures and pathways; incident reporting and monitoring processes.

The trust achieved reasonable assurance that our pressure ulcer prevention strategies were robust. Equally, an internal audit of clinical practice, in accordance with our pressure ulcer policy, offered significant assurance to the trust.

KCHFT regularly benchmarks performance against 17 other community trust providers in England, which identifies we are consistently below the national benchmark.

A staff and managers' pledge was launched, supported by the Executive Team, to demonstrate our commitment to reducing pressure ulcer harm.

Before the summer, there was a focused campaign to raise awareness of the effect of heat and moisture on the skin which could exacerbate pressure damage.

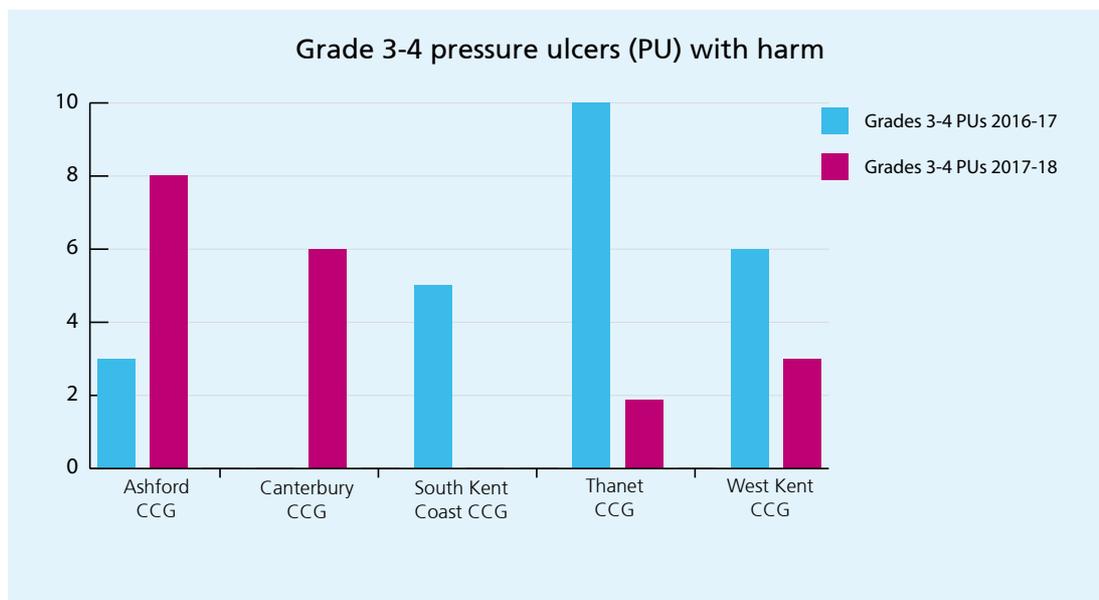
Our patients were given leaflets and coasters with clear prevention messages, including keep cool; keep hydrated and keep moving, resulting in no reported serious harms to our patients for four consecutive months.

What this means for patients

Patients under our care are at reduced risk of experiencing a pressure ulcer following our increased emphasis on prevention strategies.

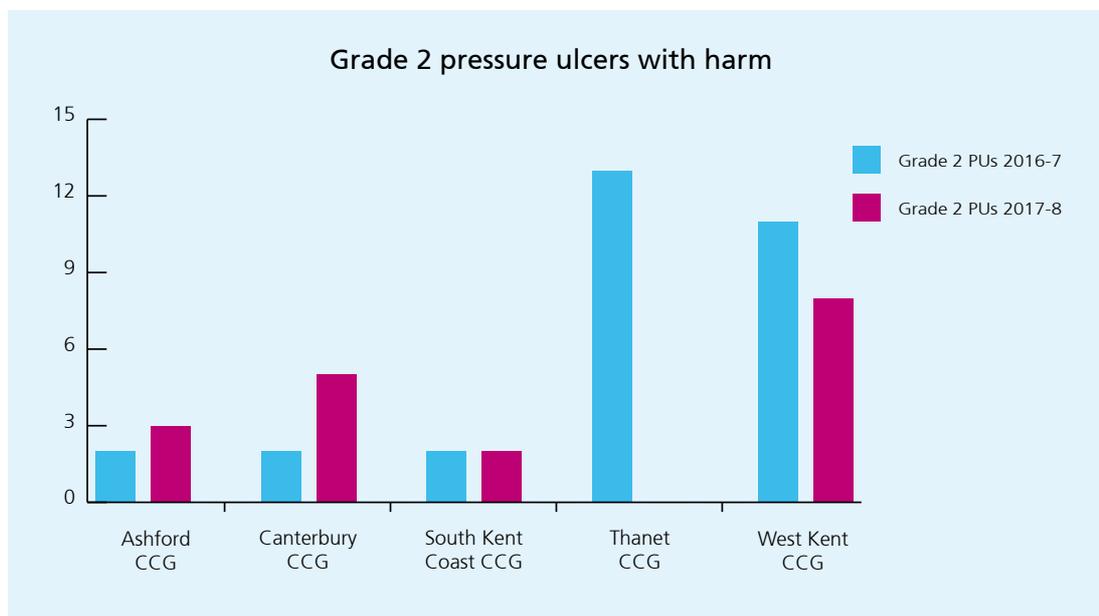
What we achieved

For the year 2017-18, we achieved a reduction of 27 per cent grade three and four attributable pressure ulcers, and a reduction of 44 per cent grade two attributable pressure ulcers. This exceeded our targets. A breakdown of the figures and comparison to last year can be seen in the tables here:



CCG	Grades 3-4 PUs 2016-17	Grades 3-4 PUs 2017-18
Ashford CCG	3	8
Canterbury CCG	0	6
South Kent Coast	5	0
Swale CCG	2	N/A*
Thanet CCG	10	2
West Kent CCG	6	3
Total	26*	19

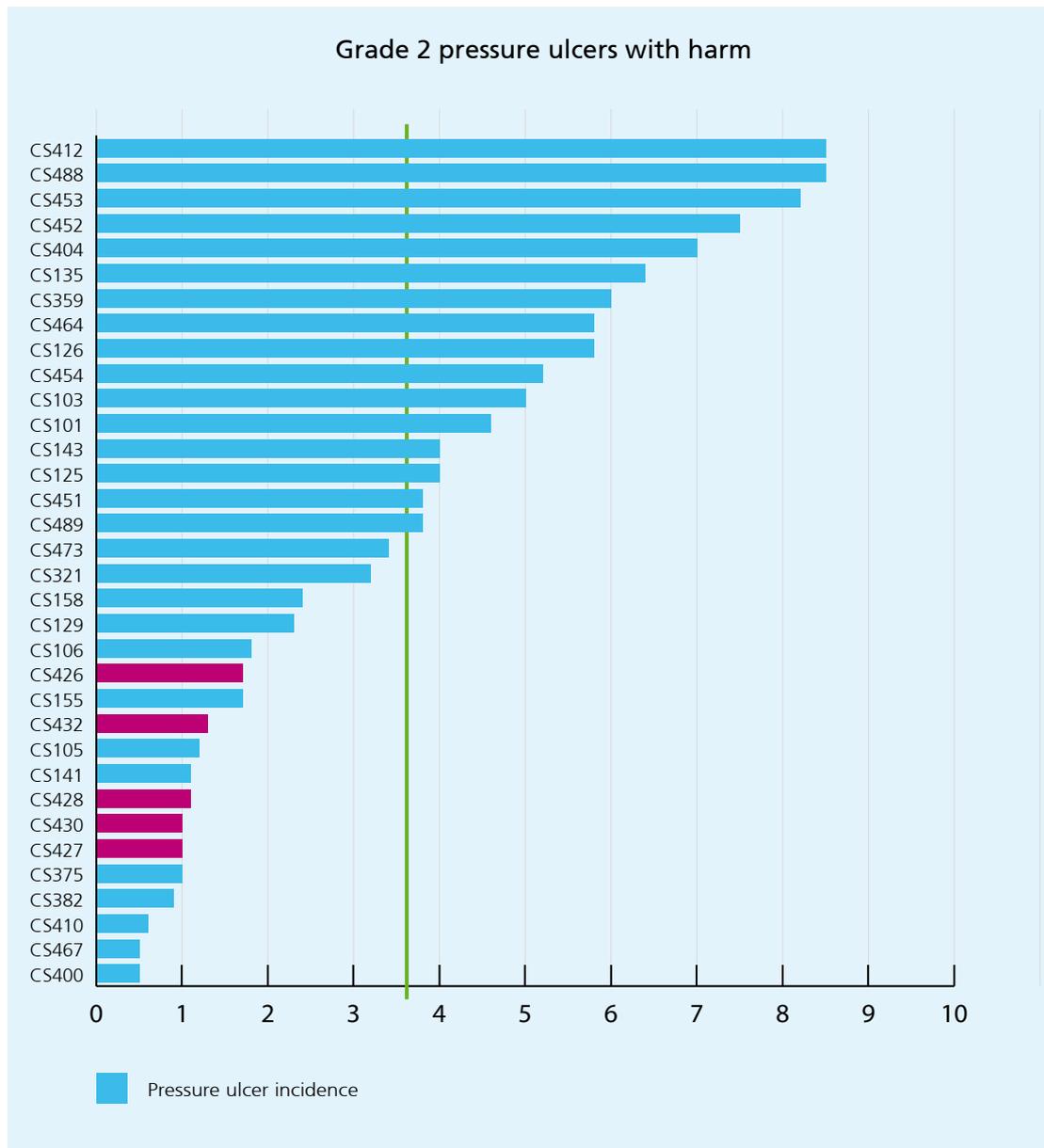
* The trust no longer provides services in Swale CCG's area, so this field is not applicable for 2017-18.



CCG	Grade 2 PUs 2016-17	Grade 2 PUs 2017-18
Ashford CCG	2	3
Canterbury CCG	2	5
South Kent Coast	2	2
Swale CCG	2	N/A*
Thanet CCG	13	0
West Kent CCG	11	8
Total	32*	18

* The trust no longer provides services in Swale CCG's area, so this field is not applicable for 2017-18.

KCHFT is a member of a community trust benchmarking group. The following graph shows the average number of pressure ulcers (all grades) for community nursing is 3.56 (mean) and 3.30 (median) for 2016-17.



Patient safety

Catheter-associated urinary tract infections (CAUTIs)

Goal	Rate per 100,000 occupied bed days (OBDs) 2016-7	Rate per 100,000 occupied bed days (OBDs) 2017-8	Comparison to target	Outcome
A 15% reduction of catheter-associated urinary tract infection acquired in our care	21.6	32.5	33% increase	Not achieved

The aim was to reduce CAUTIs in patients within the inpatient wards by 15 per cent compared to 2016-17 - using a rate comparison that allows for changes in bed occupancy, providing more accurate data and true trends (due to the closure of beds in 2016-17).

Why this is important

Catheter associated urinary tract infections are the highest single cause of healthcare-associated infections. Reducing these means more of our patients remain healthy, despite having a long-term invasive device. It is also acknowledged that CAUTIs are the highest single cause of healthcare-associated gram negative blood stream infections - a specific cause of sepsis. If we reduce the number of simple infections, we will reduce the number of people who develop sepsis.

What we did

Throughout the year, the number of CAUTIs increased, requiring a multi-modal approach to tackling the increase. The trust has implemented a full CAUTI/UTI reduction campaign, which dovetailed with a national programme to reduce infections. It was jointly launched with the Nutrition and Dietetics Team during National Hydration Week.

- The HOUDINI protocol has been implemented, providing staff with clear guidance on how and when to assess a patient's needs for a urinary catheter, and encouraging them to be removed.
- Staff testing algorithms were revised.
- To dip or not to dip guidance was provided for staff to encourage them to act on patients' clinical symptoms of potential infection, instead of traditional urine dipstick results - a type of indicative test that has historically been used to suggest infection; however, known to not be accurate for patients with urinary catheters.

- The trust’s catheter passport was revised and re-launched, providing further guidance for patients and staff on self-care and hygiene, as well as a central record for catheter changes and clinical interventions.
- There is collaborative working with colleagues in acute trusts and commissioning services to focus locally on training and education requirements for staff.

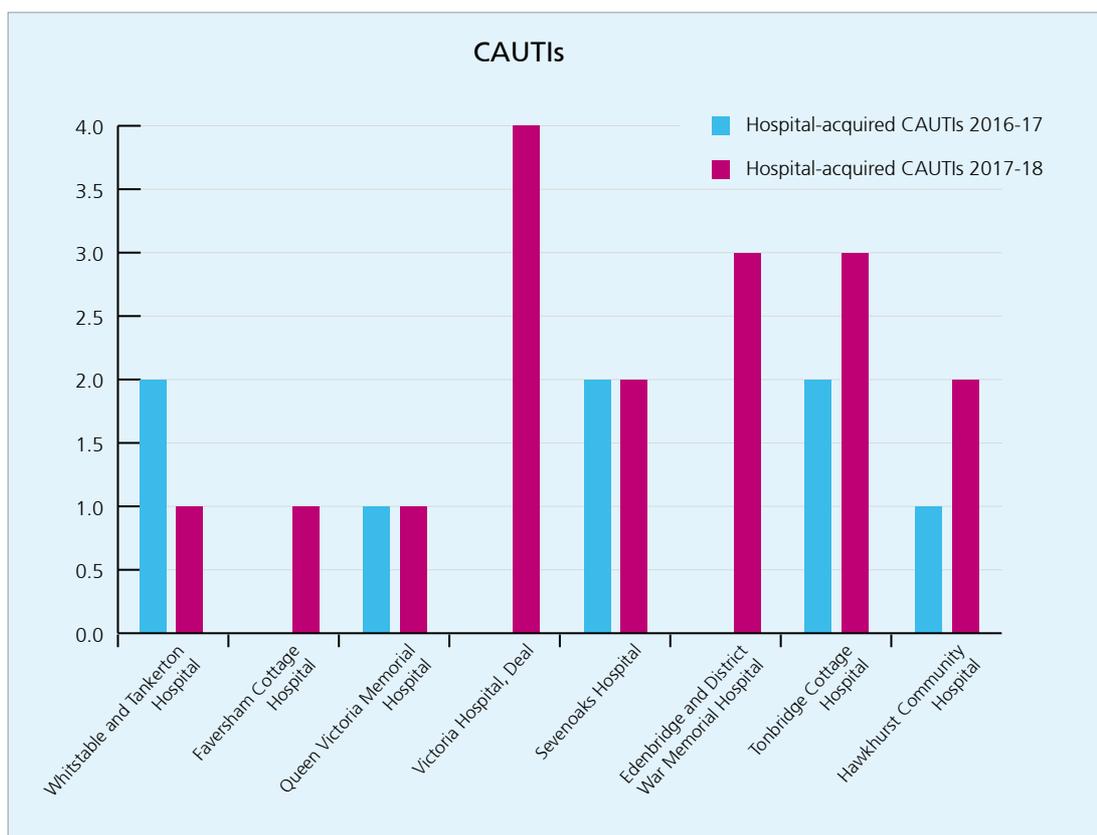
The campaign was not launched until the end of the year - owing to increasing CAUTIs at that time - and to complement national guidance and programmes, ensuring our guidance reflected the changing national guidance.

What this means for you as a patient

Staff are focussing on ensuring both they and patients have the information required to reduce the risk of catheter-associated infections

What we achieved

This target was not achieved this year, with 17 reported CAUTIs at the end of the year.,



CCG	Location	Hospital - acquired CAUTIs 2016-17	Hospital - acquired CAUTIs 2017-18
Ashford and Canterbury CCG	Whitstable and Tankerton Hospital	2	1
	Faversham Cottage Hospital	0	1
	Queen Victoria Memorial Hospital, Herne Bay	1	1
South Kent Coast	Victoria Hospital, Deal	0	4
West Kent CCG	Sevenoaks Hospital	2	2
	Tonbridge Cottage Hospital	0	3
	Edenbridge and District War Memorial Hospital	2	3
	Hawkhurst Community Hospital	1	2
Total		8*	17

* This figure was reported as 14 in our 2016-17 report as it included Gravesham Community Hospital, Livingstone Hospital in Dartford, and Sheppey Community Hospital, for which we are no longer the provider. These numbers have been removed for comparison purposes.

Clinical effectiveness

Wound management

Goals for 2017-18

Goal	Number 2016-7	Number 2017-8	2017-8 target	Outcome
To improve wound healing times by 5% in our wound medicine centres	Not measured	16%	5%	Achieved

The trust now has four operational wound management clinics (WMCs) in Sevenoaks Hospital, Victoria Hospital, Deal, Queen Victoria Memorial Hospital, Herne Bay and Vicarage Road Clinic in Ashford.

They are staffed by community nurses, educated to advanced wound care level and overseen by a tissue viability nurse.

We wanted to improve wound healing times in these clinics.

Why this is important

To improve patients' experience and reduce time and costs.

What we did

To maintain quality and assurance, the WMCs have been supported by our Tissue Viability Nurse Specialist with regular visits to manage complex patients, supervise practice and provide guidance. The WMCs are also supported by our central referral unit through telehealth.

A number of nurses in the WMCs studied for the University of Kent-accredited level 6 wound management module run by the trust to improve their knowledge and skills.

What this means for you as a patient

Patients are in discomfort for less time and require clinical intervention over a shorter period of time.

What we achieved

Excellent feedback has been received from patients and there has been a **16 per cent** improvement in healing rates, 11 per cent higher than the five per cent target.

Clinical effectiveness

Dementia

Goals for 2017-18

Goal	Training 2016-7	Training 2017-8	Target	Outcome
Community hospital environments to work towards becoming dementia friendly as required by the Hospital Charter 2020, including tier 2 training for staff in these areas	75%	89%	85%	Achieved

Our goal was to complete further work towards achieving dementia-friendly environments in our community hospitals and to ensure that staff have received tier two dementia training.

Why this is important

We want to ensure patients' dementia and cognitive impairment needs are met during their stay in our community hospitals. This will aid their rehabilitation to enable them to return to their home environment.

What we did

We introduced dementia champions across four community hospitals. The dementia champions are dedicated to ensuring patients with cognitive impairments and diagnosed dementia have their needs recognised and included in care planning. They also support in decision making and daily routines such as bathroom visits, dressing etc.

The baywatch campaign is also being implemented across the hospitals. This will replace the one-to-one support requirement as patients with similar impairments will be in bays of four. One staff member per shift will be designated to that bay. They will have a specific colour lanyard so other staff can identify them. These staff will work closely with the therapeutic worker to ensure continued stimulation for patients within their bays.

Therapeutic workers in each of the hospitals work with patients with dementia and cognitive impairments.

Dementia-friendly crockery is being rolled out across the community hospitals.

Patient activity groups are being re-evaluated to make sure they are less intimidating and more home-like.

Continued environmental improvements have been implemented to support patients' movement around the units, such as clearer signage with pictorial images, as well as colour and text friendly visuals.

What this means for you as a patient

This will reassure patients and their families that staff and the environments in our community hospitals are able to support them during their stay.

The environment improvements will make sure patients feel safe and relaxed during their rehabilitation before being discharged to their home environment.

What we achieved

In total, 89 per cent of staff received tier two dementia training and hospital environments have been improved.

Clinical effectiveness

Research

Goals for 2017-18

Goal	Number 2016-7	Number 2017-8	2017-8 target	Comparison to target	Outcome
At least 200 patients enrolled in NIHR portfolio studies	407	545	200	172%	Achieved

We wanted to increase the number of patients involved in National Institute of Health Research (NIHR) studies to at least 200.

Alongside this overarching target, we wanted to:

- increase the number of good clinical practice (GCP) trained staff to equip more clinical teams to be research-ready to open studies
- increase the number of non-medical principal investigators
- open and recruit to our first commercial study.

Why this is important

We want to offer patients and services the opportunity to contribute to national research studies.

What we did

We met clinical teams to discuss the importance of NIHR research studies and the opportunities for patients when we open these. This led to more staff wanting to complete their GCP training and an increased understanding of what opening an NIHR study involves. This has seen non-medical staff appreciate their role in opening and leading on studies relevant to their service.

We continued to submit expressions of interest for commercial studies, gaining increased experience of developing our response to enable us to stand out against more experienced trusts. We attended a network event, which helped us to identify what commercial companies seek when selecting new organisations. We are now able to promote the great work of our clinical teams to recruit to industry research.

What this means for you as a patient

This gives patients more opportunities to take part in national studies. This could lead to access to a new intervention or the opportunity to contribute personal voice/experience to a topic under investigation.

It also places the trust in a stronger position to open studies quickly and be more attractive to commercial companies with research-ready staff.

The trust is in a stronger position to open studies in an increased number of services.

The trust now has a positive history of recruiting to commercial research, putting it in a strong and attractive position to take on further commercial research.

What we achieved

We recruited well at the beginning of the year and quickly achieved our target of 200 quickly, so we ambitiously increased our target to 300. We also exceeded this target this year, with a final recruitment figure of 545.

The number of GCP-trained staff has increased year-on-year. In the past year an extra 20 staff have been added to the pool of research-ready staff.

There are now more non-medical principal investigators in the trust than medical, which reflects the demographics of the workforce.

In the past year, we have opened our first commercial study over two sites. We recruited to target, ahead of time and were recognised as the top recruiting trust in the country.

This section shows our performance against the relevant indicators and performance thresholds set out in the oversight documents issued by NHS Improvement. For our trust, this is only one indicator:

The maximum time of 18 weeks from point of referral to treatment (RTT) in aggregate - patients on an incomplete pathway:

	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18
RTT incomplete pathways	99.46%	98.74%	99.52%	99.35%	98.92%	98.74%	98.42%	97.40%	93.64%	94.06%	92.40%	88.68%

Annex 1

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

BURGESS, Jane (KENT COMMUNITY HEALTH NHS FOUNDATION TRUST)

From: ELLIS, Victoria (KENT COMMUNITY HEALTH NHS FOUNDATION TRUST)
Sent: 25 April 2018 15:23
To: HOSC@KENT.GOV.UK; healthscrutiny@eastsussex.gov.uk; enquiries@healthwatcheastsussex.co.uk; info@healthwatchkent.co.uk; REYNOLDS, Maria (NHS THANET CCG); BISSET, Dawn (NHS SOUTH KENT COAST CCG); PARKIN, Jooles (NHS CANTERBURY AND COASTAL CCG); CREATON, Tracey (NHS WEST KENT CCG); BOXALL, Marie (NHS SWALE CCG); LOCOCK, Gail (NHS SWALE CCG); KNIGHT, Sharon (NHS SWALE CCG); EKE, Nnenna (NHS BRENT CCG); VAUX, Sarah (NHS MEDWAY CCG); HOLLIS, Dawn (NHS ENGLAND); qualityaccount (KENT COMMUNITY HEALTH NHS FOUNDATION TRUST); Qualityinbox (NHS ASHFORD CCG); WILKINS, Paula (NHS WEST KENT CCG); COLLINS, Becky (NHS WEST KENT CCG)
Cc: GODDEN, Annie (NHS ENGLAND); PATEL, Rita (NHS ENGLAND); Andrew Scott Clark; Anna.Czepil@eastsussex.gov.uk; Quality (NHS THANET CCG); Quality (NHS SOUTH KENT COAST CCG)
Subject: KCHFT Quality Report
Importance: High

Dear Colleagues,

Please find attached the Draft copy of Kent Community Health NHS Foundation Trust's Quality Account 2017/18 for your review. I am sending this via email for speed as there is a limited time to review the content. If you would like a hard copy then please respond to this email and I will arrange that.

This draft reflects data available up to the end of the eleven month period; this will be updated with year-end data before publication on the 31st of May 2017.

The final layout, photographs and patient/carer stories will be added by the Communication's team prior to the final publication.

I invite all stakeholder's to review and comment. For West Kent Colleagues this is a 'Must Do' as commissioner of the largest population area.

Please respond by the 18th May 2017 if possible, to kcht.qualityaccount@nhs.net

Thank you in advance for your feedback,

Kind regards,

Vicky

Vicky Ellis
Assistant Director Clinical Governance
 Kent Community Health NHS Foundation Trust
 The Oast, Unit D, Hermitage Court
 Maidstone, Kent. ME16 9NT.

v.ellis1@nhs.net
 Tel: 01622 211919



Vicky Ellis
Assistant Director, Clinical Governance
Kent Community Health NHS Foundation Trust
The Oast, Unit D, Hermitage Court
Maidstone
Kent
ME16 9NT

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

Direct Dial: 03000 412775
Email: HOSC@kent.gov.uk
Date: 26 April 2018

Dear Vicky

Draft Kent Community Health NHS Foundation Trust Quality Account 2017/18

Thank you for offering Kent County Council's Health Overview & Scrutiny Committee (HOSC) the opportunity to comment on the Kent Community Health NHS Foundation Trust's Quality Account for 2017/18.

As the Committee did not formally scrutinise any services directly provided by the Trust in 2017/18, the Committee will not be making any comments on the Trust's Quality Account this year.

As part of its ongoing overview function, the Committee would appreciate receiving a copy of the finalised Quality Account for this year and hope to be able to become more fully engaged in next year's process.

Kind regards

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

NHS Dartford, Gravesham and Swanley CCG and NHS Swale CCG Statement

The Trust's draft Quality Account document was sent to the Clinical Commissioning Groups (CCGs) for consultation and comment. The CCGs have a responsibility to review the Quality Account of the Trust each year, using the Department of Health's Quality Account checklist tool to ascertain whether all of the required elements are included within the document.

The Trust's Quality Account flows consistently and is in a format that is clear and easily understood. The detail included is well structured and concise and follows a consistent format throughout. The report identifies areas of further improvement but does not state clearly why and how the organisation is planning to report back on progress to their patients and the public.

The CCGs confirm that all required data has been included within this document in relation to the NHS Services provided or sub contracted and is an accurate reflection of achievement with the exception of how the Trust's investigations and learnings from deaths have informed their quality improvement plans and how the provider is implementing the priority clinical standards for seven day hospital services. It is noted that KCHFT has worked hard to achieve many of the areas within the identified priorities during 2017/18 and the pressure ulcer and falls priorities have achieved the full expected outcome. The Quality Account could have been enhanced further by expanding on how the Trust anticipates continued focus and will strive to achieve these areas previously identified as priorities.

The Trust has identified four overarching priorities for 2017/18, which include projects within the themes of Patient Safety, Patient Experience and Clinical Effectiveness and aim to deliver demonstrable improvements in patient care through their 'quadruple aim' as aligned with the quality strategy objectives. It has outlined clearly the rationale but does not reference the current status and how each priority will be monitored and measured. The CCGs would welcome the opportunity to work with the Trust to ensure targets remain on track throughout the year and reported against at CCG level in the 2018/19 Quality Account, where appropriate but acknowledges that not all priority areas will be applicable to the services we commission.

The CCGs are in agreement with the areas selected by the Trust and recognise that the priorities identified are person and carer centred, appropriate and striving to be effective in improving quality, safety and patient care.

In conclusion, the report is well structured and highlights that the quality of patient care remains a clear focus for the Trust and at the forefront of its service provision.

The CCGs thanks the Trust for the opportunity to comment on this document and looks forward to further strengthening the relationships with the Trust through continued collaborative working in the future.



Zoe Hicks-John
Deputy Chief Nurse

Annex 2

Statement of directors' responsibilities for the quality report

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

NHS Improvement has issued guidance to NHS foundation trust boards on the form and content of annual quality reports, which incorporates the above legal requirements and on the arrangements that NHS foundation trust boards should put in place to support the data quality for the preparation of the quality report.

In preparing the Quality Report, directors are required to take steps to satisfy themselves that:

- the content of the Quality Report meets the requirements set out in the NHS foundation trust annual reporting manual 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 April 2017 to March 2018
 - o papers relating to quality reported to the board over the period April 2016 to March 2018
 - o feedback from commissioners: North Kent CCG (undated)
 - o feedback from governors dated May 2018
 - o feedback from local Healthwatch organisations not received
 - o feedback from Overview and Scrutiny Committee dated 26 April 2018
 - o the trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, dated May 2018
 - o the 2017 National Staff Survey
 - o the Head of Internal Audit's annual opinion of the trust's control environment dated 19 April 2018
 - o CQC inspection report dated September 2014
- the Quality Report presents a balanced picture of the NHS foundation trust's performance over the period covered
- the performance information reported in the Quality Report is reliable and accurate
- there are proper internal controls over the collection and reporting of the measures of performance included in the Quality Report, and these controls are subject to review to confirm that they are working effectively in practice
- the data underpinning the measures of performance reported in the Quality Report is robust and reliable, conforms to specified data quality standards and prescribed definitions, is subject to appropriate scrutiny and review and
- the Quality Report has been prepared in accordance with NHS Improvement's annual reporting manual and supporting guidance (which incorporates the Quality Accounts regulations) as well as the standards to support data quality for the preparation of the Quality Report.

The directors confirm to the best of their knowledge and belief they have complied with the above requirements in preparing the Quality Report.

By order of the Board

.....Date.....Chair

.....Date.....Chief Executive

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.....Chair

.....Date.....Chief Executive Officer

Abbreviations

CAUTI	Catheter-associated urinary tract infection
CCG	Clinical commissioning group
CEG	Clinical Effectiveness Group
CIS	Community Information System
COPD	Chronic obstructive pulmonary disease
CQC	Care Quality Commission
CQUIN	Commissioning for quality improvement and innovation
GCP	Good clinical practice
HOUDINI	Haematuria, obstruction, urology, decubitus sacral ulcer, input/output, nursing, immobility
KCC	Kent County Council
KCHFT	Kent Community Health NHS Foundation Trust
LeDeR	Learning disability mortality review programme
NAIC	National audit of intermediate care
NICE	National Institute of Health and Clinical Excellence
NIHR	National Institute for Health Research
OBD	Occupied bed day
PEG	Patient Experience Group
PSCRG	Patient Safety and Clinical Risk Group
PURPOSE T	Pressure ulcer risk assessment tool
QI	Quality improvement
RCA	Root cause analysis
SI	Serious incident
SSNAP	Sentinel stroke national audit programme
UTI	Urinary tract infection
WMC	Wound management centre

Independent Practitioner's Limited Assurance Report to the Council of Governors of Kent Community Health NHS Foundation Trust on the Quality Report

We have been engaged by the Council of Governors of Kent Community Health NHS Foundation Trust to perform an independent limited assurance engagement in respect of Kent Community Health NHS Foundation Trust's Quality Report for the year ended 31 March 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

to be replaced

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

to be replaced

body, and Kent Community Health NHS Foundation Trust for our work on 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

to be replaced

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

Grant Thornton UK LLP
Chartered Accountants
London

25 May 2017



Kent Community Health NHS Foundation Trust

Committee / Meeting Title:	Board Meeting - Part 1 (Public)
Date of Meeting:	24 May 2018
Agenda Item:	2.6
Subject:	2017/18 Annual Report and Accounts - Self - Certification for NHS Trusts
Presenting Officer:	Natalie Davies, Corporate Services Director

Action - this paper is for:	Decision	<input checked="" type="checkbox"/>	Assurance	<input checked="" type="checkbox"/>
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Report Summary (including purpose and context):

Proposals and /or Recommendations:		
<p>This is the second year NHS Trusts must self-certify. Although NHS trusts are exempt from needing the provider licence, directions from the Secretary of State require the NHS Trust Development Authority to ensure that NHS Trusts comply with conditions equivalent to the licence as it deems appropriate.</p> <p>The Single Oversight Framework (SOF) bases its oversight on the NHS provider licence. NHS trusts are therefore legally subject to the equivalent of certain provider licence conditions (including Condition G6 and Condition FT4) and must self-certify under these licence provisions.</p> <p>The Board is asked to certify the following conditions under the NHS Provider Licence and authorise the Chair to sign the self-certification on behalf of the Board, taking into account the views of Governors that they are satisfied with compliance.</p>		
NHS Provider Licence Condition	Confirmed	Not Confirmed
Condition G6(3) – The provider has taken all precautions necessary to comply with the licence, NHS Acts and NHS Constitution	√	
Condition FT4(8) – The provider has complied with required governance standards and objectives	√	

Relevant Legislation and Source Documents:
Kent Community Health NHS Foundation Trust Licence
Has an Equality Analysis been completed?
No. High level position described and no decisions required.

Natalie Davies, Corporate Services Director	Tel: 01622 211904
	Email: Natalie.davies1@nhs.net

SELF-CERTIFICATION WITH NHS PROVIDER LICENCE

1. Introduction

- 1.1. As required by its Foundation Trust licence, the Trust is required to self-certify whether or not they have complied with the conditions of the NHS provider licence (which itself includes requirements to comply with the National Health Service Act 2006, the Health and Social Care Act 2008, the Health Act 2009, and the Health and Social Care Act 2012, and have regard to the NHS Constitution), have the required resources available if providing commissioner requested services, and have complied with governance requirements.
- 1.2. This report describes the two conditions required by the NHS Provider Licence of which the Board is asked to sign off that they are satisfied with compliance against
 - 1 Condition G6(3) – Providers must certify that their Board has taken all precautions necessary to comply with the licence, NHS Act and NHS Constitution (31 May 2018)
 - 2 Condition FT4(8) – Providers must certify compliance with required governance standards and objectives (30 June 2018)
- 1.3. The Audit and Risk Committee (ARC) continues to receive a report into the conditions as part of the Trust's ongoing framework for maintaining oversight of compliance with all conditions of the NHS provider licence. This affirms the confidence of the committee that the Trust is compliant with its requirements and responsibilities to G6 and FT4.

2 **Condition G6 Systems for compliance with licence conditions and related obligations**

2.1 Criteria

The Licensee shall take all reasonable precautions against the risk of failure to comply with:

- a) The conditions of this Licence
 - b) Any requirements imposed on it under the NHS Acts, and
 - c) The requirement to have regard to the NHS Constitution in providing health care services for the purposes of the NHS
- 2.2 Without prejudice to the generality of paragraph 1, the steps that the Licensee must take pursuant to that paragraph shall include:
- a) The establishment and implementation of processes and systems to identify risks and guard against their occurrence; and

- b) Regular review of whether those processes and systems have been implemented and of their effectiveness
- 2.3 No later than two months from the end of each Financial Year, the Licensee shall prepare and submit to NHS Improvement a certificate to the effect that, following a review for the purpose of paragraph 2(b) the Directors of the Licensee are or are not satisfied, as the case may be that in the Financial Year most recently ended, the Licensee took all such precautions as were necessary in order to comply with this condition.
- 2.4 Evidence includes: The Board and supporting committees who receive regular reports and supporting data analysis covering patient safety, clinical quality, patient experience, workforce, performance and finance. The Board Assurance Reports, Internal Audit and External Audit Reports, Clinical Audit Reports, Patient Surveys, Staff Surveys, Board Assurance Framework (BAF), Internal Quality Reports, Executive We Care Visits and internal audit reports.
- 2.5 Of the internal audit reports, the board assurance framework and the data quality key performance indicators, again received a score of reasonable assurance

3 Condition FT4 NHS Foundation Trust Governance Arrangements

3.1 Criteria

The Licensee shall apply those principles, systems and standards of good corporate governance which reasonably would be regarded as appropriate for a supplier of health care services to the NHS. The Licensee shall establish and implement effective board and committee structures; clear responsibilities for its Board, for committees reporting to the Board and for staff reporting to the Board and those committees; and clear reporting lines and accountabilities throughout its organisation.

The Licensee shall submit to NHS Improvement within three months of the end of each financial year:

A corporate governance statement by and on behalf of its Board confirming compliance with this condition as at the date of the statement and anticipated compliance with this condition for the next financial year, specifying any risks to compliance with this condition in the next financial year and any actions it proposes to take to manage such risks.

3.2 Evidence includes:

- The Board has regard to such guidance on good corporate governance as may be issued by NHS Improvement.
- The Board implements effective Board and committee structures, clear responsibilities for its Board, for committees reporting to the Board and for staff reporting to the Board and those committees and clear reporting lines and accountabilities throughout its organisation.
- Annual Governance Statement as part of the Annual Report.

4 Recommendation

It is recommended that the Board endorses the Trust response 'confirmed' to both of the conditions and that electronic signatures for the Chairman and Chief Executive are applied to the statement.

Alicia Irvine
Assistant Director of Compliance
May 2018

Committee / Meeting Title:	Board Part 1 (Public)
Date of Meeting:	24 May 2018
Agenda Item:	2.7
Subject:	Workforce Report
Presenting Officer:	Louise Norris, Director of Workforce, Organisational Development and Communications

Action - this paper is for:	Decision	<input type="checkbox"/>	Assurance	<input checked="" type="checkbox"/>
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<p>Report Summary (including purpose and context):</p> <p>This report provides the Board with an update on the current workforce position as at April 2018. It includes performance on: vacancies, recruitment timescales, absence, turnover, bank and agency fill rates, agency usage (measured as shifts) and cost, training / appraisal compliance, suspensions, headcount, starters and leavers. This report is generally an 'exception' report; it contains narrative relating to those metrics against which KCHFT is performing below target in April.</p>
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<p>Proposals and /or Recommendations:</p> <p>The Board is asked to note this report.</p>

<p>Relative Legislation and Source Documents:</p> <p>None.</p>

<p>Has an Equality Analysis been completed?</p> <p>No. An EIA is not required for a report of this nature as the detail is monitored by the Workforce Committee.</p>

Louise Norris	Tel: 01622 211905
Director of Workforce, Organisational Development and Communications	Email: louisenorris@nhs.net

**WORKFORCE INFORMATION REPORT
REPORTING PERIOD APRIL 2018**

1. Report Summary

This report provides the Board with an update on the current workforce position as at April 2018. It contains performance information on a variety of metrics which includes absence, turnover, agency usage, vacancies and training compliance.

2. Overview

An overview is outlined on the table below; this indicates trends, targets and achievements. Data is comparative against the previous month and the trend lines show the direction of travel over the last six months (November to present). Each of the metrics has been rated to illustrate performance against the trust target where applicable.

Fig 1. Overview

Month	Apr-18			
Direction (Better/Worse)	Metric	Target	Current Position	6mth Trendline (Nov to Apr 2018)
▼	Turnover (12 mths to reporting month)	10.50%	18.42%	
▲	Absence (2017/18 cumulative)	3.90%	4.46%	
▲	Vacancies	5.00%	10.18%	
▼	Fill Rate Overall	No target set (rated on 75%)	88.92%	
▲	Fill Rate Bank (as % of those filled)	No target set (rated on 30%)	66.83%	
▼	Agency spend as a proportion of the trajectory (reporting month, with contingency)	100%	44.97%	
▲	Agency shifts - Framework agency used - compliant with price cap	100%	97.50%	
▲	Average Recruitment Time in Weeks (reporting month)	7	8.30	
▼	Statutory and Mandatory Training (adjusted % for 2 yr Prevent/WRAP target)	85%	94.65%	
▶	Number of suspended staff	No target set	3	
▲	Appraisals	85%	92.40%	
▼	Trust Headcount (as at end of reporting month)	No target set	4660	
▲	Number of Starters (reporting month)	No target set	67	
▼	Number of Leavers (reporting month)	No target set	68	
▼	% of leavers who are unplanned leavers (reporting month)	No target set	84.51%	
▲	% of leavers who are planned leavers (reporting month)	No target set	15.49%	

2.1 Future Targets

As part of our work on recruitment and retention (see turnover section below) NHS Improvements have recommended that we look to reduce our current turnover and vacancy figures by 2%.

We are also looking to reduce stress and anxiety related sickness by 10% which was recorded as 1.28% of our total sickness figure of 4.36% for last year.

It is proposed that the new targets for the Trust to achieve based on the figures reported in March are:

- Turnover Target 16.47%
- Vacancy Target 9.66%
- Stress and anxiety 1.15%

3. Performance Commentary

Turnover

Turnover has gradually increased over the last 12 months and although we did see a small reduction in April the figure is still above the Trust target of 10.50%. Nationally Community Trusts are reporting an average turnover of 17.11%. Trust Headcount has reduced from 4674 to 4660 since March a reduction of 14. Nationally community services are reporting a net loss of staff over the past 12 months of 1065.

Fig.2 Turnover Rates by Month

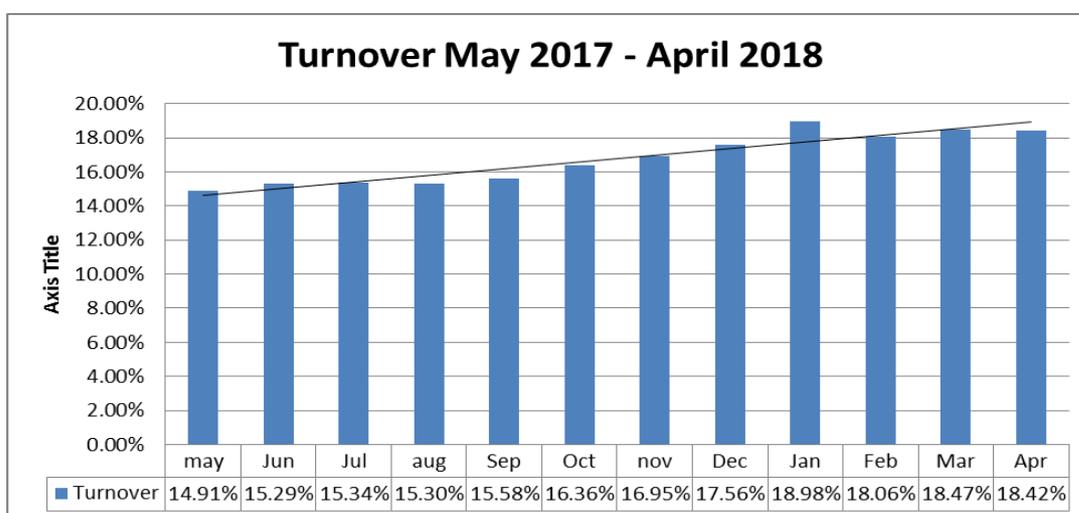


Fig 3. Directorate Turnover and Proportion

Directorate	Turnover %	Proportion %
Operations Directorate	18.76%	82.79%
IT	19.45%	2.92%
Nursing and Quality Directorate	24.62%	1.24%
Medical Director	13.90%	1.20%
HR, OD and Communications	19.88%	2.45%
Finance Directorate	13.32%	1.82%
Corporate Services Directorate	18.00%	1.27%
Estates	13.40%	6.31%

The table above illustrates turnover by directorate throughout the Trust over the last 12 months. Although some areas show a high turnover they are proportionally very small

parts of the organisation where a small number of changes will have a big impact on the turnover figures detailed.

Improved retention has wide ranging benefits in terms of quality of care delivered, workforce engagement and financial savings. The trust was invited to be part of the NHSI's retention support programme for nursing staff (cohort 3), which commenced in April 2018.

Our starting point

Between April 2017 to March 2018 320 nurses and health care assistants voluntarily resigned and left the Trust. This equates to:

- 26.67 resignations per month
- 6.14 resignations per week
- 56 had worked in the Trust for less than one year
- Eight had worked at the Trust for less than three months

Our provisional aim

It is proposed that a target reduction of 2% in turnover and vacancies be set.

- For an organisation of 1836 nursing staff, a 17.43% voluntary turnover rate would equate to 320 leavers per annum.
- A 2% improvement in Turnover would equate to a reduction of 37 leavers per annum.
- A 4% improvement in Turnover would equate to a reduction of 73 leavers per annum.

Our proposed approach

To enable the development of a targeted action plan we need to understand:

- What are the root-causes of the problem? – it is proposed that members of the Executive support focus groups and attend team meetings in May, June and July 2018 to discuss with staff how we can improve retention using a diagnostic tool created by NHS Improvement.
- In addition the Chief Nurse and Director of Workforce and Communications are contacting all staff who have tendered their resignation and not yet left the trust to have a confidential conversation to establish why they are leaving.

Starters and Leavers

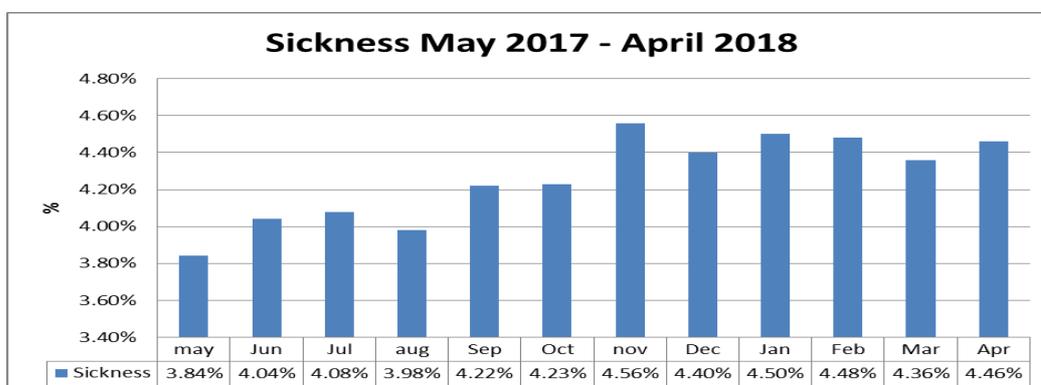
In April the Trust hired its second highest number of new starters in the last 12 months with 67 people joining the Trust. Over 50% were from NHS organisations with 14 new starters returning to the Trust after previous employment with KCHFT.

The average time to recruit timescale increased throughout April. The most significant delay is attributable to occupational health clearance. Work has been done to ensure that candidates are aware of the requirement to complete the electronic form as soon as possible and ongoing discussions are taking place with our occupational health provider on how timescales can be monitored more closely as well as ensuring the provider is acting within the realms of the contract Key Performance Indicators. The recruitment team is also reviewing processes of escalation to ensure that managers are fully aware of delays that are taking place and their options for action to move this forward.

68 staff left the Trust in April: 16% were retirements, 16% re-location and 13% cited work life balance as their reason for leaving. Almost 40% gave “no employment” as their future destination while 20% left for other NHS organisations.

Sickness Absence

Fig 4. Sickness Absence



Sickness remains above the Trust target of 3.90% and saw a slight increase from the 12 month accumulative figure recorded in March (4.36%). Nationally Community Service providers average a sickness rate of 4.68%. The monthly rate for April was recorded as 4%.

Fig 5. Sickness Absence by Directorate

Directorate	Sickness %	Proportion %
Operations Directorate	4.63%	82.79%
IT	3.63%	2.92%
Nursing and Quality Directorate	6.12%	1.24%
Medical Director	3.84%	1.20%
HR, OD and Communications	3.36%	2.45%
Finance Directorate	1.66%	1.82%
Corporate Services Directorate	1.93%	1.27%
Estates	4.51%	6.31%

Finance, IT, HR OD & Communications, Medical Director and the Corporate Services Directorates all recorded sickness below the Trust target. The Nursing and Quality Directorate and Operations Directorate recorded the highest rates at 6.12% and 4.63% respectively.

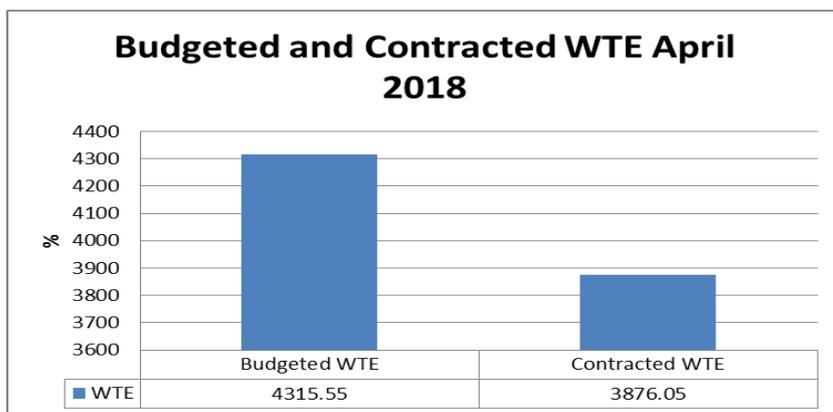
Fig 6. Sickness Reason

Absence Reason	%
S10 Anxiety/stress/depression/other psychiatric illnesses	28.49%
S12 Other musculoskeletal problems	15.59%
S13 Cold, Cough, Flu - Influenza	8.34%
S11 Back Problems	7.42%
S25 Gastrointestinal problems	7.18%
S28 Injury, fracture	7.13%

In April “Anxiety/stress/depression/other psychiatric illnesses” was recorded as the highest sickness reason with 28% of absence being recorded with this reason. “Colds, cough, Flu – Influenza” has gone from being the most numerous reason of absence reported to the Committee in February (40%) to 8% in April reflecting the end of the Flu season.

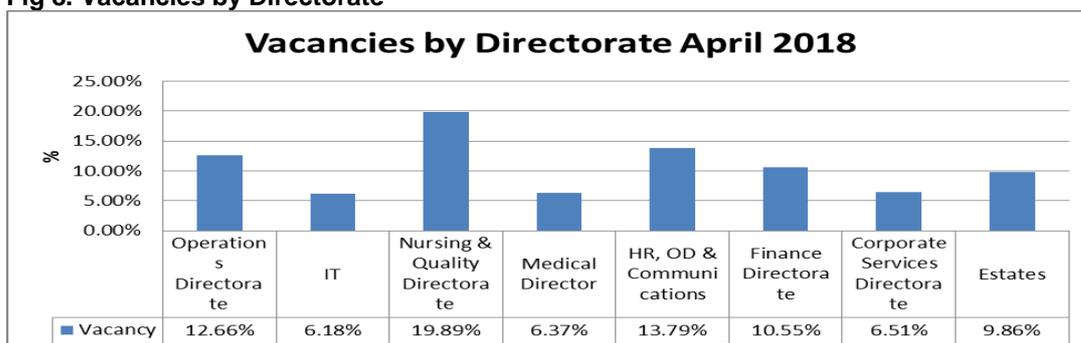
Establishment and Vacancies OLD DATA

Fig 7. Budgeted / Contracted FTE



Vacancy rates have fallen at the beginning of the new financial year with a reduction of over 1% in April. The current overall vacancy figure is 10.18%

Fig 8. Vacancies by Directorate

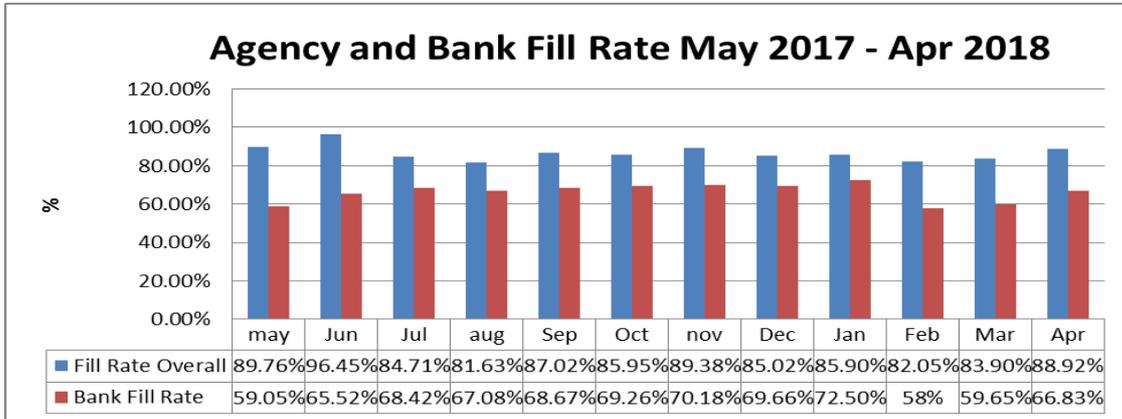


The highest number of vacancies was seen with Nursing and Quality followed by HR and OD and the Operations directorates.

Our International recruitment campaign has started with 2 days of interviews taking place over the past month. This has resulted in 4 offers being made. Further work is taking place with the agencies and services to set up regular dates for interviews over the coming year. Education and Workforce Development are also in discussions with other local Trusts investigating ways we can support our International Nurses with their application to join the Nursing and Midwifery Council register.

Temporary Staff Usage

Fig 9. Agency/Bank Fill Rate



The Trust fill rate increased by 5% between March and April and Bank fill rate increased to 66% from 59% in March.

There was an increase in the use of non-compliant price cap agencies to 2.5% (from 0.14% in March). Work is being done to reduce the usage of non – compliant agency workers. All non-compliant shifts have to be approved on a shift by shift basis by the Executive Director of the service. The only exceptions to this are Emergency Nurse Practitioner roles where no agency is supplying these roles at a compliant rate, but work is being done to reduce the rate on a gradual basis with the aim of gaining compliance by the end of the year. Also there are 4 workers that have been “block booked” in one locality until the end of May. All of this usage has been approved by the Executive Director after reviewing the risk of not having those workers in post.

Training Compliance

Fig. 10



Mandatory training increased from 94.8% in March to 94.9% in April and appraisals increased to 92.4%.

Direction (better, worse or no change)	Metric	Target	Current position	Current aggregated position	non
	Mandatory training compliance	85%	109.4%	94.9%	
	Essential to role compliance	85%	86.8%	N/A	
	Wasted spaces rate	11.1%	6.5%		
	Cancelled schedule rate	TBC	17.6%		
	DNA rate <u>(Absents)</u>	TBC	4.1%		
	Number of DNA's overturned	TBC	5	DNA Mitigation Requested Received	8

Whilst overall mandatory training has seen an increase in compliance there has been some upward and downward trends within individual training topics.

Fire for Community Hospitals has improved and is compliant at 85%.

Moving and Handling for clients has just dropped out of compliance at 84.5% and so classed as amber. The model for delivering this topic has recently been reviewed by the Operations Directorate and we are in the process of recruiting to a training post to support the current Moving and Handling Lead in delivering more in-house, central training courses. The Moving and Handling lead and the Quality Leads are also reviewing the current target audience for Client through risk assessment to determine if the refresher period could be longer than annual for some staff group.

Mental Capacity Act for Adults Services Level 1 has increased in compliance this month and is at 84.7%.

Dementia is the only aggregated training topic at present and has a target to reach 85% compliance by January 2020. We have exceeded this with Basic Dementia (90.2%) and are on our way to do the same for Level 2 currently sitting at 81.5%, we should reach target within the next 2-3 months if uptake continues as it currently is.

All other subjects in this area are green and maintaining levels well.

4. Conclusion

The Trust is embarking on a number of schemes to ensure sickness, turnover and vacancies are reduced in their work alongside NHS Improvement. International recruitment continues and the Trust is working with managers, applicants and occupational health to reduce current recruitment times.

5. Recommendations

The Board is asked to note the current position on workforce performance and the current actions being taken. In addition the Committee are recommended to agree to the changed KPI for turnover, vacancies and sickness (stress and anxiety).

Louise Norris
Director of Workforce, Organisational Development and Communications
May 2018

Committee / Meeting Title:	Board Meeting - Part 1 (Public)
Date of Meeting:	24 May 2018
Agenda Item:	2.8
Subject:	Integrated Performance Report (Part 1)
Presenting Officer:	Gordon Flack, Director of Finance

Action - this paper is for:	Decision	<input type="checkbox"/>	Assurance	<input checked="" type="checkbox"/>
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<p>Report Summary (including purpose and context)</p> <p>The Integrated Performance Report has been produced to provide the Board with a detailed overview of Kent Community Health NHS Foundation Trust's quality, safety and performance. The report has been produced in collaboration with the Executive Team and their support teams.</p> <p>The report has been split into two parts because of the commercial sensitivity of some of the data included.</p> <p>Part One of the report contains the following sections:</p> <ul style="list-style-type: none"> • Key and Glossary • Corporate Scorecard • Executive Summary: Narrative <p>Historic data has been provided to show trends, however, the availability of trend data varies between indicators as can be seen from the trend graphs. The trend graphs are designed to show a 12 rolling month view of performance for each indicator, but as stated this does depend on data availability.</p> <p>This report shows the year-end forecast position for all indicators.</p>

<p>Proposals and /or Recommendations</p> <p>The Board is asked to note this report.</p>
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<p>Relevant Legislation and Source Documents</p> <p>Not Applicable</p>
<p>Has an Equality Analysis (EA) been completed?</p> <p>No. High level position described and the paper has no impact on people with any of the nine protected characteristics*.</p>
<p>* Protected characteristics: Age, Disability, Gender Reassignment, Marriage and Civil Partnership, Pregnancy and Maternity, Race, Religion and Belief, Sex, Sexual Orientation.</p>

Nick Plummer, Assistant Director of Performance and Business Intelligence	Tel: 01233 667722
	Email: nick.plummer@nhs.net



Kent Community Health

NHS Foundation Trust

Integrated Performance Report - 2017/18
Part 1

May 2018
April 2016 - April 2018 data



Contents

Key & Glossary

Executive Summary: Scorecard

Executive Summary: Narrative

Page. 2

Page. 3

Page. 4

Key and Glossary of Terms

+ve = Positive - improvement on last month

-ve = Negative - A decline on last month

stat = Static - No Change



Off Target



As per KPI Target



On Target



Stretch target achieved

FOT Forecast Outturns are based on extrapolation of YTD position unless specified

KCHFT Corporate Scorecard 2017/18

Strategic Goals

1. Prevent ill health

KPI Ref	KPI Description	16/17	17/18	YoY Change	Target	RAG/ Variance	Aspiration	Bench Mark	Trend	KPI Ref	KPI Description	16/17	17/18	YoY Change	Target	RAG/ Variance	Aspiration	Bench Mark	Trend
1.1	Prevention: Stop Smoking - Nos. of 4 week Quitters (Kenwide); YTD performance against trajectory (%)	80.2%	89.5%	9.3%	100.0%	-10.5%	100.0%	N/A	-ve	1.4	Health Visiting - Increase the uptake of the 6-8 week assessment by 8 weeks	85.2%	91.0%	5.8%	85.0%	6.0%	90.0%	N/A	-ve
1.2	Prevention: Health Checks Carried Out (Kenwide); YTD performance against trajectory (%)	100.3%	100.2%	-0.1%	100.0%	0.2%	100.0%	N/A	-ve	1.5	School Health - Reception Children Screened for Height and Weight	93.9%	13.2%	-80.7%	90.0%	-76.8%	95.0%	N/A	+ve
1.3	Health Visiting - Increase the uptake of New Birth Visits by 14 days	85.8%	92.5%	6.7%	90.0%	2.5%	95.0%	N/A	-ve	1.6	School Health - Year 6 Children Screened for Height and Weight	95.4%	95.2%	-0.2%	90.0%	5.2%	95.0%	N/A	+ve

2. Deliver high-quality care at home and in the community

KPI Ref	KPI Description	16/17	17/18	YoY Change	Target	RAG/ Variance	Aspiration	Bench Mark	Trend	KPI Ref	KPI Description	16/17	17/18	YoY Change	Target	RAG/ Variance	Aspiration	Bench Mark	Trend
2.2	Newer Events: Number	1	0	-1	0	0	0	N/A	stat	2.14	Allied Health Professionals Referral to Treatment Times (RTT)	92.8%	95.9%	3.1%	95.0%	0.9%	98.0%	97.6%	-ve
2.3	Infection Control: C.Diff (Target <6 cases in year) (Target YTD)	7	4	-3	5	-1	5	N/A	stat	2.15	Access to GUM: within 48 hours (Monthly Target 100%)	100.0%	100.0%	0.0%	100.0%	0.0%	100.0%	N/A	stat
2.8	Contractual Activity: YTD as % of YTD Target	97.6%	97.6%	0.5%	100.0%	-2.2%	100.0%	N/A	-ve	2.16	Length of Stay (Median Average)	21.6	19.8	-1.7	21.0	-1.2	21.0	25.6	+ve
2.9	Trustwide Did Not Attend Rate: DNAs as a % of total activity	3.2%	3.7%	0.4%	4.0%	-0.3%	3.0%	4.0%	+ve	2.17	End of Life Care: Percentage of patients dying in their preferred place	86.3%	84.4%	-1.8%	95.0%	-10.6%	95.0%	83.2%	-ve
2.10	LTC/CT Response Times Met(%)	93.8%	96.6%	2.9%	95.0%	1.6%	98.0%	N/A	+ve	2.18	ADULTS - Outcomes: Percentage of outcomes achieved upon discharge for planned care and therapy services	85.0%	97.0%	12.0%	80.0%	17.0%	90.0%	N/A	-ve
2.11	Rapid Response: Percentage of referrals accepted (Trustwide)	91.5%	94.0%	2.1%	95.0%	-1.0%	98.0%	N/A	+ve	2.21	Patient Experience: Friends and Family Test (Patient Hosp.) - Response Rate	23.7%	18.8%	-4.9%	20.0%	-1.2%	30.0%	30.7%	-ve
2.12	Total Time in MIUs: Less than 4 hours	99.94%	99.84%	-0.1%	95.0%	4.8%	99.5%	99.5%	-ve	2.23	NICE guidance: New NICE Guidance reviewed within required timescales following review of publication.	100.0%	100.0%	0.0%	100.0%	0%	100.0%	N/A	stat
2.13	Consulting Led 48 Week RTT (Monthly Target 95%) - Incomplete Pathways	99.6%	96.7%	-3.0%	95.0%	1.7%	96.0%	96.8%	-ve										

3. Integrate Services

KPI Ref	KPI Description	16/17	17/18	YoY Change	Target	RAG/ Variance	Aspiration	Bench Mark	Trend	KPI Ref	KPI Description	16/17	17/18	YoY Change	Target	RAG/ Variance	Aspiration	Bench Mark	Trend
3.1	Delayed Transfers of Care as a % of Occupied Bed Days	12.1%	10.2%	-1.9%	9.5%	0.7%	3.5%	6.0%	-ve										

4. Develop Sustainable Services

KPI Ref	KPI Description	16/17	17/18	YoY Change	Target	RAG/ Variance	Aspiration	Bench Mark	Trend	KPI Ref	KPI Description	16/17	17/18	YoY Change	Target	RAG/ Variance	Aspiration	Bench Mark	Trend
4.2	Bed Occupancy: OBAs as a % of available bed days	88.6%	90.6%	2.3%	87.0%	3.6%	91.7%	87.9%	-ve	4.3	Income & Expenditure - Surplus (%)	1.7%	1.8%	0.1%	1.0%	0.8%	1.0%	1.0%	-ve

Be the Best Employer

KPI Ref	KPI Description	16/17	17/18	YoY Change	Target	RAG/ Variance	Aspiration	Bench Mark	Trend	KPI Ref	KPI Description	16/17	17/18	YoY Change	Target	RAG/ Variance	Aspiration	Bench Mark	Trend
5.1	Sickness Rate	4.30%	4.48%	0.15%	3.90%	0.55%	3.75%	4.30%	+ve	5.4	Mandatory Training: Combined Compliance Rate	94.7%	94.7%	0.0%	85.0%	9.7%	92.5%	88.4%	-ve



Kent Community Health
NHS Foundation Trust

Committee / Meeting Title:	Board Meeting - Part 1 (Public)
Date of Meeting:	24 May 2018
Agenda Item:	2.9
Subject:	Quality Report
Presenting Officer:	Ali Strowman, Chief Nurse

Action - this paper is for:	Decision	<input type="checkbox"/>	Assurance	<input checked="" type="checkbox"/>
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Report Summary (including purpose and context):
This report provides assurance to the Board on Patient Safety, Patient Experience and Patient Outcomes.

Proposals and /or Recommendations:
The Board is asked to note the report.

Relevant Legislation and Source Documents:
None
Has an Equality Analysis (EA) been completed?
No. High level position described and no decisions required.
* Protected characteristics: Age, Disability, Gender Reassignment, Marriage and Civil Partnership, Pregnancy and Maternity, Race, Religion and Belief, Sex, Sexual Orientation

Ruth Herron, Deputy Chief Nurse	Tel: 01622 211900
	Email: Ruth.Herron@nhs.net

QUALITY REPORT

1. Workforce Data and Quality Metrics

1.1. The shift fill rates for community hospital wards are set out below. The day fill rate for registered nurses (RN) was 94%, increasing from 93% in April. The night shift fill rate for RNs reduced slightly to 99% (April 102%). The Chief Nurse will provide commentary on any areas less than 95%.

Five hospitals had *day* shifts with an RN fill rate of below 95%, Edenbridge Hospital was 90%, QVMH was at 89.2%, Tonbridge Goldsmid 93.3%, Hawkhurst 93.3% and Sevenoaks was at 94.2%.

Only Hawkhurst hospital had a *night* fill rate of below 95%, at 93.3%.

Several wards had an overfill of non-registered staff, these staff were required to increase capacity when the RN shift fill rate was lower than planned, and to support safe care of patients when there were fluctuations in dependency.

	Day Fill Rate %		Night Fill Rate %		Day				Night			
	RNs	HCAs	RNs	HCAs	RNs		HCAs		RNs		HCAs	
					P hours	A hours	P hours	A hours	P hours	A hours	P hours	A hours
Faversham	102.5%	135.0%	100.0%	113.3%	900	922.5	1350	1822.5	660	660	660	748
Deal	98.3%	134.4%	100.0%	106.7%	900	885	1350	1815	660	660	660	704
QVMH	89.2%	91.8%	100.0%	96.7%	900	802.5	1470	1350	660	660	660	638
Whit & Tank	95.0%	128.0%	100.0%	103.3%	900	855	1125	1440	660	660	660	682
Sevenoaks	94.2%	111.7%	98.3%	100.0%	900	847.5	1350	1507.5	660	649	660	660
Tonbridge - Goldsmid	93.3%	106.7%	100.0%	133.3%	900	840	1125	1200	660	660	330	440
Tonbridge - Primrose (HCA% includes some RN activity)	N/A	121.1%	N/A	122.2%	0	0	1350	1635	0	0	990	1210
Hawkhurst	93.3%	117.2%	93.3%	103.3%	900	840	1350	1582.5	660	616	660	682
Edenbridge	90.0%	126.7%	96.7%	126.7%	900	810	900	1140	660	638	330	418
Total	94%	119%	99%	110%	7200	6803	11370	13493	5280	5203	5610	6182
	Over 90% Fill Rate		65% to 90% Fill rate				Less than 65%		Over 110%			

1.2. The fill rates for Westbrook and Westview integrated units are set out below. The Westbrook Unit is changing providers and will no longer be provided by KCHFT, the date for closing the present facility is 31st May 2018. Admissions were stopped in April and patient numbers have been reducing. Staffing has been amended accordingly. Westview has a high ratio of HCAs to support the 15 social care beds in the unit.

	Day Fill Rate %		Night Fill Rate %		Day				Night			
	RNs	HCAs	RNs	HCAs	RNs		HCAs		RNs		HCAs	
					P hours	A hours						
	Westbrook	94.4%	97.2%	88.7%	98.3%	930	877.5	1350	1312.5	682	605	660
Westview	98.3%	142.1%	100.0%	115.6%	900	885	1800	2557.5	660	660	990	1144

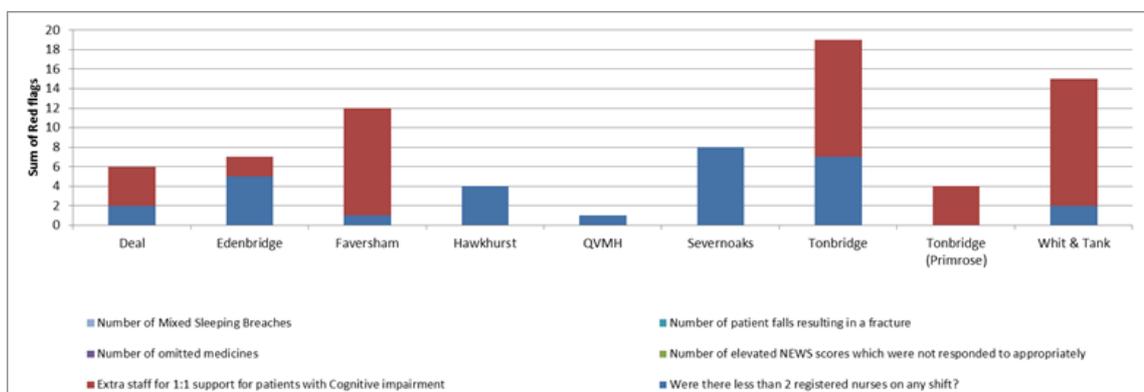
1.3. Acuity and dependency

Each ward undertakes a daily audit on acuity and dependency. Patient assessments are categorised into Red, Amber or Green, Red signifies a patient is heavily dependent and/or complex, amber signifies a patient will need moderate support with care, and green signifies minimal support is required and the patient is self caring in most respects. Data collection began on 5 April 2018 and all wards are now submitting data. This information will be added to the next quality report.

1.4. Quality indicators reported by each ward

Below is a summary of data related to quality indicators taken from the Beautiful IT System (previously known as red flag data). The data demonstrates that the majority of wards required additional capacity to care for patients with cognitive impairment. Other issues reported are the One RN shifts and these are detailed in 1.5.

Wards are now being asked to report sleeping and bathroom breaches (in terms of delivering single sex accommodation). More work is required to improve the accuracy of reporting and work is underway to support this.



1.5. One RN shifts

There were 66 occasions when there was One RN on a shift because the shift could not be filled by substantive or temporary staff (90 last month), this is rarely a full shift as staff on the neighbouring shifts stay late/start early. Edenbridge, Hawkhurst and QVMH had the most One RN shifts. Tonbridge Primrose is not included in this table as it is staffed by Assistant Practitioners.

	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18
Deal	12	3	3	6	11	11	2
Edenbridge	6	11	24	24	22	23	14
Faversham	7	2	5	0	2	2	2
Hawkhurst	4	7	8	15	10	13	12
QVMH	15	8	6	11	10	17	13
Sevenoaks	3	5	9	7	7	13	8
Tonbridge (G)	3	11	13	13	4	11	9
Whit&Tank	3	2	3	0	6	0	6
KCHFT	53	49	71	76	72	90	66

1.6. Incidents

As part of quality triangulation, incidents are monitored on shifts where 1 RN was recorded as being on duty. There were 11 incidents reported.

Hospital	Incident	Avoidable/Unavoidable	Harm
Tonbridge – Goldsmid	Pressure Ulcer (Grade 2)	Awaiting Investigation	Low
Edenbridge	Pressure Ulcer (Grade 2)	Awaiting Investigation	Low
Edenbridge	Fall	Unavoidable	None
QVMH	Medication error	Avoidable	None
Sevenoaks	Medication error	Avoidable	None
Tonbridge – Goldsmid	Fall	Awaiting Investigation	None
Tonbridge – Primrose	Medication error	Unavoidable	None
Tonbridge – Primrose	Fall	Unavoidable	None
Whitstable and Tankerton	Medication error	Awaiting Investigation	None
Whitstable and Tankerton	Medication error	Awaiting Investigation	None
Tonbridge – Goldsmid	Pressure Ulcer	Avoidable	Moderate

The Moderate Harm reported relates to a patient with bilateral leg ulcers who was found to have a pressure ulcer when their dressings were changed. This incident is being investigated.

The five avoidable medication errors that resulted in no harm related to the following:

- Allergy information had not been transcribed to drug chart two of two.
- One patient had a double dose of medication administered as a different strength was available in POD drawer, and this was not checked against the patient’s prescription.
- One patient missed a weekly dose of injectable medication because it was not added to the drug chart. This was administered once it was recognised and the patient suffered no ill effects. The ward has changed process so that weekly medication is written in the diary and on the handover sheet.
- A patient was given a dose of medication as prescribed, however the prescription had been previously incorrect and the nurse had not noticed the pharmacy technician’s correction on the chart. This incident is awaiting completion of the investigation.
- A loading dose of medication was administered five days prior to prescription and the prescription had not been signed by the prescriber. This has been addressed with staff the members who signed the drug chart and additional training provided.

1.7. Patients with Dementia

Wards are now reporting the number of patients who are admitted with cognitive impairment. Reporting is reliant on a specific window being competed on the CIS, and at present the data is incomplete. Ward staff have been reminded to complete this

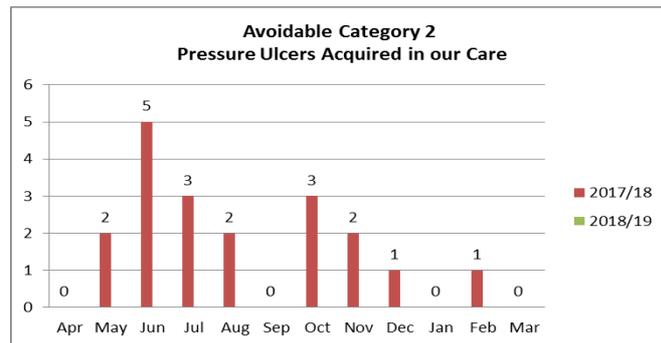
window for every patient. It is anticipated that accurate data will be available for the report next month.

1.8. Pressure Ulcers

The tables below compare our current position for avoidable pressure ulcers acquired within our care, with incidents in 2017/18. Figures may change following completion of investigations.

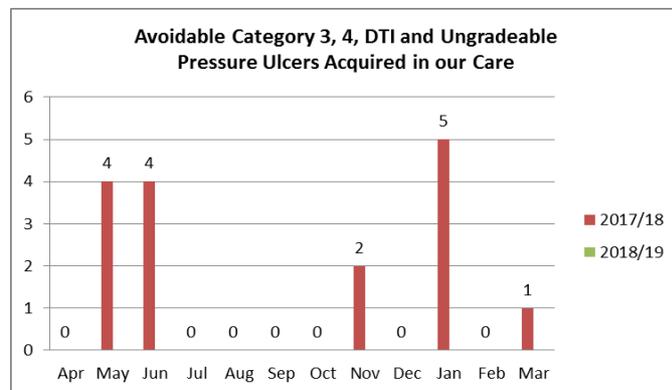
Category 2 Pressure Ulcers

There have been no avoidable category 2 pressure ulcers reported in April 2018.



Category 3, 4 or Ungradeable Pressure Ulcers

There have been no avoidable category 3, 4 or ungradeable pressure ulcers reported in April 2018.



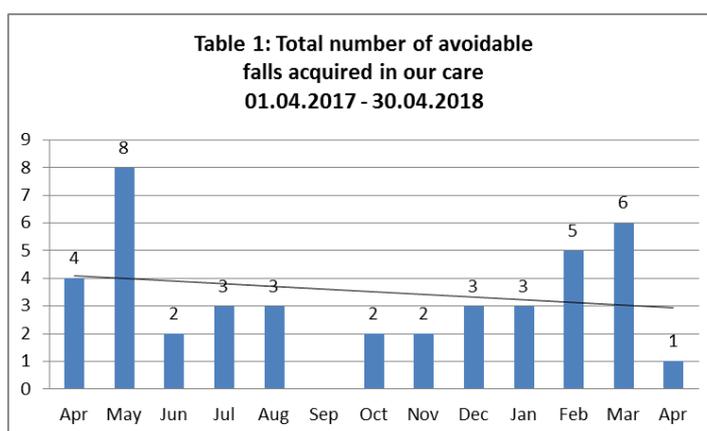
The Serious Incident (SI) team review all incidents with a level of harm recorded as moderate or above. However, to minimise delays in reporting pressure ulcers, every pressure ulcer incident is now reviewed regardless of level of harm to ensure that the correct level has been selected. If the level of harm is changed to moderate or above an email is sent to the investigator and the incident is recorded on the potential SI database until the investigation has been completed and SI status is determined.

1.9. Falls

There were 67 falls reported across KCHFT in April 2018, one of which was acquired in our care and was found to be avoidable - this is a decrease from the previous month where six falls were found to be avoidable.

- The one avoidable fall was a child in the waiting area of a clinic who fell when climbing onto a chair, sustaining low harm. It was reported as avoidable at the time of reporting due to a lack of signage in the waiting area, and it is under investigation
- A fall at a community hospital resulted in moderate harm. This incident was discussed as a potential serious incident and was deemed to be unavoidable. The patient had a previous undiagnosed health condition which caused him to suffer a seizure and fall. All the required care and treatment was provided appropriately and in a timely manner.

The below table demonstrates that there appear to be less falls during the summer months. A deep dive investigation on Falls reported between 2017-2018 is currently being undertaken, and this will inform the Falls Prevention Work plan for 2018-2019.



1.10. Medication incidents

A total of 16 avoidable medication incidents, acquired in our care, have been reported and investigated to date for April 2018 as set out in the below table. It should be noted that the most the current months number is likely to increase as incidents are investigated.

	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18
Actual	39	60	67	42	43	45	69	47	55	49	32	33	16
Near Miss	4	8	3	1	1	1	4	1	0	2	5	5	2

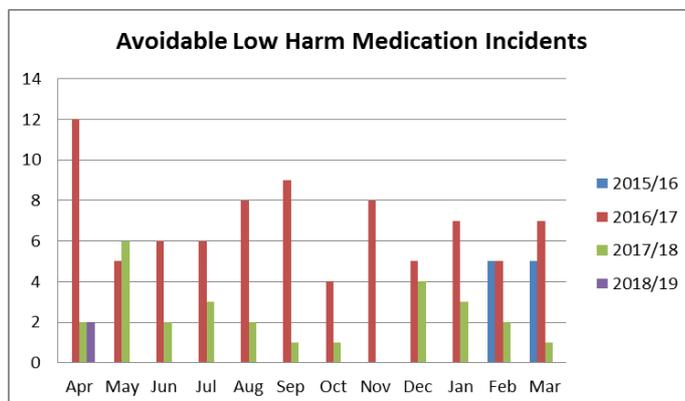
The highest reported category of avoidable incidents is omitted medication making up 33% (five) of the total number logged since the last report. The joint second highest reported category of avoidable incidents is wrong frequency and wrong quantity making up 17% (3) each of the total number.

Of the 16 avoidable incidents that occurred during April 2018:

- There were no incidents that resulted in 'moderate harm', 'severe harm' or 'death' of a patient.
- 94% (15) resulted in 'no harm' to the patient with the majority of these being omitted medication.
- 6% (equates to one patient) resulted in 'low harm' with this incident being wrong quantity. A patient received two doses of a medication on consecutive days instead

of weekly. Record keeping was a factor in this and has been addressed with the individuals concerned. The patient was monitored but remained well.

It is positive to see that there has been an overall reduction in low harm medication incidents over the last three years.



1.11. Infection Prevention and Control (IPC)

The two *Clostridium difficile* cases at the Whitstable and Tankerton Hospital were found to be different strains, and therefore proven not to be cross infection. The IPC team had already carried out root cause analysis on these cases, and the Clinical Commissioning Group has agreed to downgrade the SI that was declared. Both cases were deemed to be unavoidable and due to appropriate antimicrobial prescribing in the Acute Trust.

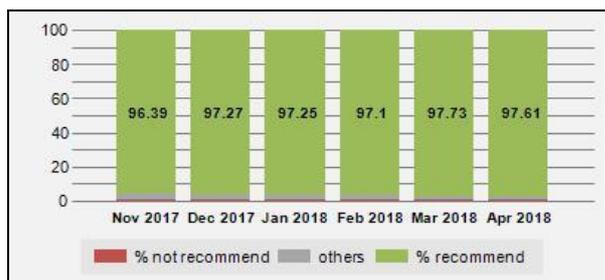
The Trust did not achieve the catheter associated urinary tract infection (CAUTI) reduction target in 2017/18, but there is clear evidence that when the education, training and the CAUTI campaign commenced the numbers of infections reduced. The Trust will continue to implement different elements of the reduction campaign, alongside the national campaign, in order to achieve a downward trend of CAUTIs in inpatient units. The aim for 2018/19 is to achieve a target of no more than 12 CAUTI cases, and to reduce urinary tract infections by 10%. This is part of the national focus on reducing gram negative bacteraemias. KCHFT is part of the NHSI gram negative collaborative group in East Kent.

2. Patient Experience

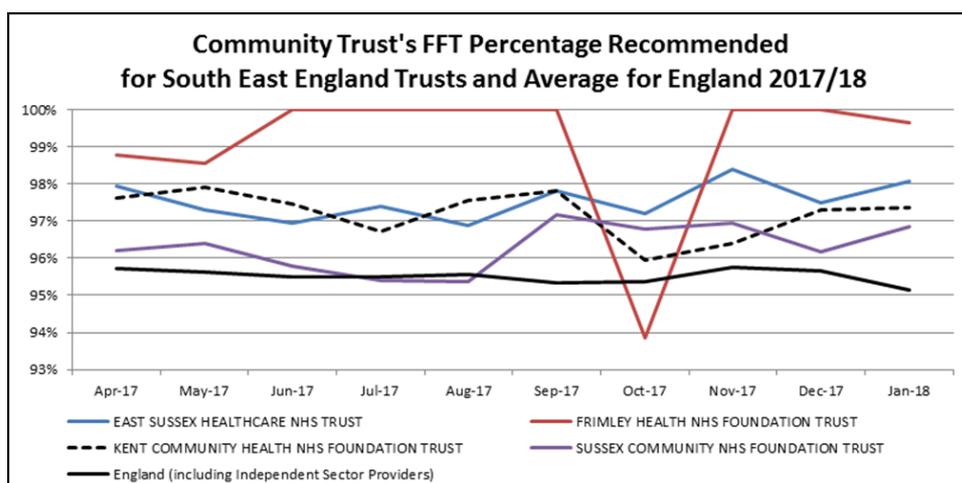
2.1. Meridian Patient Experience survey results

5,637 surveys were completed by KCHFT patients with a strong combined satisfaction score of 96.54% in April. This includes 1,862 short NHS Friends and Family Test (FFT) Minor Injuries Unit (MIU) surveys with a positive overall satisfaction score of 94.12%. Satisfaction levels remain consistently high. Survey numbers increased in April following a decrease throughout Q4.

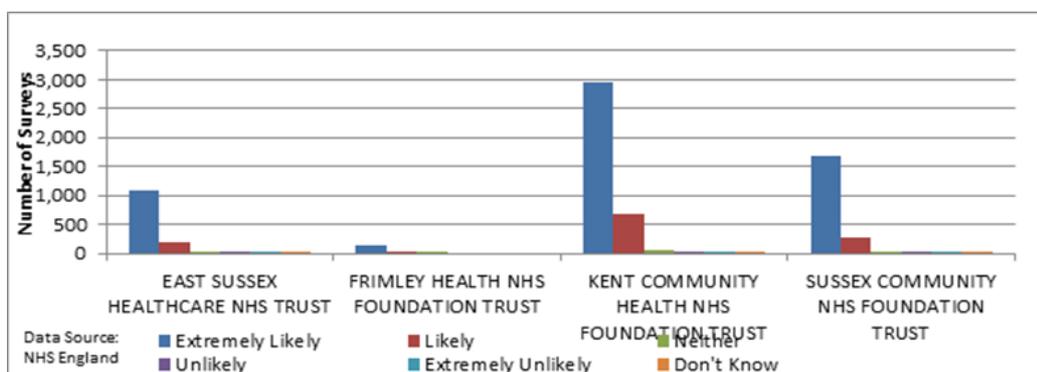
2.2 **The NHS Friends and Family Test (FFT)** score response comparison is shown below and satisfaction levels remain consistently high.



The Trust has benchmarked FFT scores with other Community Trusts and the below chart demonstrates that KCHFT compares favourably in terms of the percentage 'recommend' score.



The following table benchmarks KCHFT in terms of numbers of surveys and outcomes (February 2018 data). This demonstrates that survey numbers are high and score outcomes are similar.



2.3 NHS Friends and Family Test (FFT)

Trust wide results for April demonstrate that only 0.43% of our patients chose not to recommend the service they received. There were 22 'extremely unlikely' responses in comparison to 23 in March 2018. Three of these were given by children/young people and two because the patient/family/friends do not live in the area and would therefore not recommend the service to others. One is believed to have been answered incorrectly as the remainder of the survey feedback and comments were positive and no qualitative data was given for two.

The negative responses to the NHS FFT question in April are linked to the following themes:

- 2 x access service
- 2 x appointment system
- 3 x communication
- 1 x continuity of staff
- 1 x equipment
- 1 x facilities
- 1 x information
- 1 x nutrition / hydration
- 2 x staff attitude
- 2 x waiting times

Survey volumes had decreased slightly over recent months but numbers have increased in April, and are similar to the numbers of surveys in April 2017.

2.4 Experience of Care Week - 23 to 27 April 2018

Staff were asked to make extra effort to have conversations with their patients about their experiences of care, and to gather more feedback during Experience of Care Week. The Patient Experience Team visited Gravesham, Sheppey, Sevenoaks, Deal and Folkestone Minor Injury Units (MIUs) to talk to patients. These MIUs displayed specially designed barracudas and had trolley tokens, pens, key rings available as a thank you to patients for completing a survey or stopping to talk. The patients were generally delighted with their care and happy to give their feedback. Some of the MIUs collected a remarkable amount of feedback in April, possibly impacted by a backlog of surveys entered in April; however it is hoped that this momentum can be maintained. MIU staff were reminded of the importance of inputting any hard copy data in the month it is received to reflect the service provided at that time.

Minor Injury Unit	Survey volumes	
	March 2018	April 2018
Deal	123	□ 228
Edenbridge	108	□ 241
Folkestone	292	□ 283
Gravesham	145	□ 680
Sevenoaks	13	□ 223
Sheppey	215	□ 144
Sittingbourne	198	□ 192

2.5 Patient Advisory Liaison Service (PALS) Enquiries

The PALS Team received a total of 574 enquiries in April, a similar number compared to 576 in March 2018. There continue to be concerns raised by a number podiatry service users who have reported difficulties in accessing the service by telephone, and the Podiatry Service are continuing to work to resolve this.

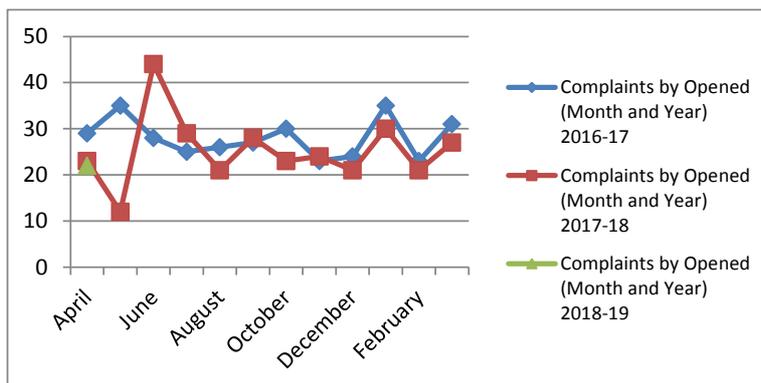
2.6 Compliments

An overall total of 151 compliments were recorded by the PALS team in April compared with 106 in March 2018. The new Meridian system for recording compliments is ready to go live. It is anticipated that this will make recording compliments an easier process for the clinical teams.

2.7 Complaints

During April 2018, 3,418 people answered the survey question '*If you recently raised a concern or complaint directly with this service, do you feel it was responded to and acted upon?*' The Trust wide satisfaction score was 93%, this is in line with the March figure of 92%.

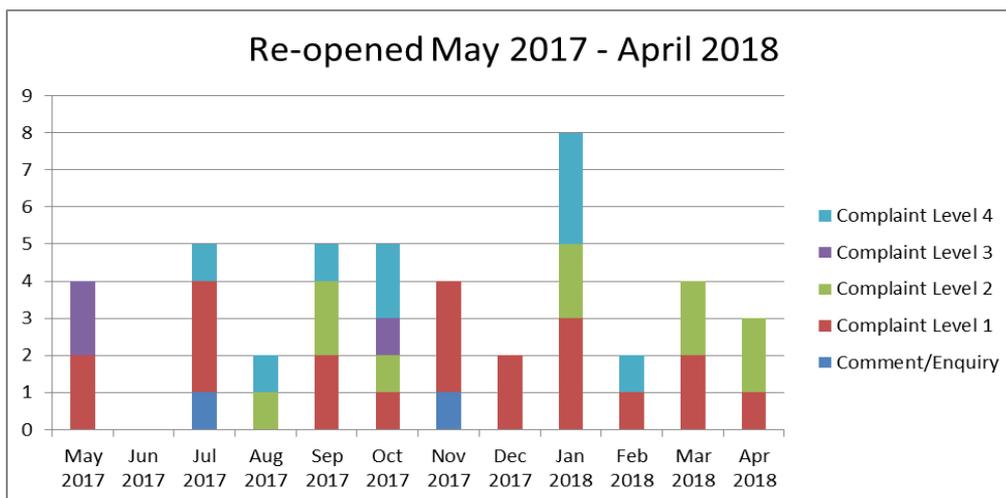
There were 22 level 1 to 4 complaints received in April, compared to 27 complaints in March.



During April 2018, 12 complaints were closed in total. All complaints were closed within the agreed timescales (100%), an increase on 94% in March 2018. There are currently no complaint cases with the Parliamentary and Health Service Ombudsman.

2.8 Re-opened comments and complaints from May 2017 to April 2018

The number of complaints reopened decreased by 1 in April and this continues to be a focus for improvement.



2.9 Lessons learned: Examples of actions completed in April from complaints and patient experience feedback

Comment/complaint	Service	Recommendation for improvement / action taken
Complaint	Health Checks	A patient was unhappy that although arrived before Health Check appointment still waited 20 minutes and had to leave without being seen for appointment. Unhappy with initial response from service when raised informally. Action taken: Service have created clear signs with contact information for the advisor. These will be displayed near Health Check clinic rooms in the event of the advisor leaving the room.
Comment	Health Visiting Service, Whitstable	A relative felt that her sister was not reassured by the health visitors when she had concerns about the colour of her baby's faeces. Was advised by the service to see her GP. Action taken: <ul style="list-style-type: none"> The service investigated and the outcome was that the health visitor did make a comprehensive assessment of the child with

Comment/complaint	Service	Recommendation for improvement / action taken
		<p>sound advice</p> <ul style="list-style-type: none"> The concern received that was from the perspective of the service user receiving the advice given, was shared with Whitstable health visiting staff for their reflection Staff will promote the Breast Feeding drop in clinic as a point of access for information and advice to all service users.

2.10 You said, we did (YSWD): feeding back changes that have been made to our patients

The YSWD examples shown below were uploaded onto the KCHFT public website during April for actions completed in March.

Service	You said	We did
Hawkhurst Community Hospital (Inpatients)	Some patients said the noise from the televisions in the single rooms disturbed them.	The League of Friends provided headphones for use in these rooms so patients can now watch their individual televisions without disturbing others.
Community Nursing, Canterbury East	A patient was not contacted by the service following a referral from their GP for a continence assessment.	The service looked into their management of continence assessments and additional staff have been given responsibility to complete new assessments. Clinics for non-housebound patients are now being held to avoid unnecessary delays.
Specialist Children's Bladder and Bowel Nursing Team (Continence Product Team)	A parent was unhappy with their child's assessment for continence products.	The service has changed the way they process referrals for continence products. Where appropriate, children now receive a 12 week toilet training programme before being referred for products. Any queries with the referral or assessment information will be discussed directly with clinical teams.

3. Patient Outcomes

3.1 Audit

The annual KPI target is for 95% of clinical audit recommendations to be implemented. This is achieved via a stepped target during the year and is slightly below target in April.

KPI Actions Target %	April >35
Due audit recommendations	43%
Target April >35%	
Actions overdue by more	0%
Target <=10%	
Actions overdue by more	2%
Target <=5%	

3.2 Clinical Audit Reporting

Dashboard and SBAR reporting was recently introduced for clinical audit. This relates to receiving the full report within a specified timeframe after receipt of dashboard reporting. This has been achieved this month.

KPI Target 50%	April
Receipt of full report within specified timeframe	55%

3.3 Research

KCHFT is set an annual target by the Kent Surrey and Sussex Clinical Research Network to deliver high quality national studies (known as portfolio studies) to local patients. This is a Key Performance Indicator for research. Data is being collected but is not available yet as the quarter is incomplete.

3.4 National Institute for Clinical Excellence (NICE)

The number of NICE guidance/ standards that were issued in April 2018 was fifteen.

The number of guidance/standards issued in December 2017 that were due for assessment in April 2018 was fourteen. Three of the guidance/ standards issued were deemed applicable to at least one service throughout the Trust.

Ali Strowman
Chief Nurse with contributions from the Nursing and Quality and Audit and Research Teams
May 2018

Committee / Meeting Title:	Board Meeting - Part 1 (Public)
Date of Meeting:	24 May 2018
Agenda Item:	2.10
Subject:	Finance Report Month 1
Presenting Officer:	Gordon Flack, Director of Finance

Action - this paper is for:	Decision	<input type="checkbox"/>	Assurance	x
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Report Summary (including purpose and context)

This report provides a summary of the financial position for Kent Community Health NHS Foundation Trust (KCHFT) for the month of April 2018.

The Trust achieved a surplus of £203k for the month which was £22k better than plan.

Key Messages

Surplus: The Trust achieved a surplus of £203k (11.9%) to the end of April. Pay and depreciation/interest have underspent by £1,086k and £10k respectively, partly offset by an overspend on non-pay £262k and an under-recovery on income of £813k.

Continuity of Services Risk Rating: EBITDA Margin achieved is 2.5%. The Trust scored 1 against the Use of Resources Rating, the best possible score.

CIP: £219k of savings has been achieved for the month against a risk rated plan of £349k which is £130k behind target.

Cash and Cash Equivalents: The cash and cash equivalents balance was £26,859k, equivalent to 46 days expenditure. The Trust recorded the following YTD public sector payment statistics 99% for volume and 98% for value.

Capital: Spend to April was £91k, representing 21% of the YTD plan. The full year plan is £3.5m and the Trust expects to utilise this in full.

Agency: Agency expenditure was below trajectory for April.

Proposals and /or Recommendations
--

The Board is asked to note the contents of the report.
--

Relevant Legislation and Source Documents
--

Monitor NHS Foundation Trusts Annual Reporting Manual NHS Manual for Accounts 2014-15
--

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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Gordon Flack, Director of Finance

Tel: 01622 211934

Email: gordon.flack@nhs.net

FINANCE REPORT – APRIL 2018 (MONTH 1 of 2018-19)

The Trust achieved a surplus of £203k for April which was £22k better than plan. The Trust is forecasting to achieve a surplus of £3.128 million in line with the plan for the year.

Dashboard

Surplus		Rag rating: Green		Use of Resource Rating		Rag rating: Green		CIP		Rag rating: Amber	
Year to Date	Actual	Plan	Variance	Year to Date Rating	Year End Forecast Rating	Year to Date Rating	Year End Forecast Rating	Year to Date	Actual	Plan	Variance
Year to Date £k	203	181	22	1	1	1	1	Capital Service Capacity			
Year End Forecast £k	3,128	3,128	0	1	1	1	1	Liquidity			
				1	1	1	1	I&E margin (%)			
				1	1	1	1	Distance from Financial Plan			
				1	1	1	1	Agency Spend			
				1	1	1	1	Overall Rating			
<p>The Trust achieved a surplus of £203k to the end of April.</p> <p>Pay and depreciation/interest have underspent by £1,086k and £10k respectively and non-pay has overspent by £262k.</p> <p>Income has under-recovered by £813k.</p> <p>The forecast is to deliver a surplus of £3,128k which is in line with the plan for the year.</p>											
Cash and Cash Equivalents		Rag rating: Green		Capital Expenditure		Rag rating: Amber		Agency Trajectories		Rag rating: Green	
Year to Date	Actual	Forecast	Variance	Actual/Forecast	Plan	Actual	Trajectory	Variance	Actual	Trajectory	Variance
Year to Date £k	26,859	26,199	660	91	429	£	£	£	£	£	£
Year End Forecast £k		26,573		3,485	3,485	282	628	346	38	106	69
<p>Cash and Cash Equivalents as at M1 close stands at £26,859k, equivalent to 46 days operating expenditure.</p> <p>Capital Expenditure year to date is £91k, representing 21% of the YTD plan. The full year plan is £3.6m and the Trust expects to utilise this in full.</p> <p>External Agency Expenditure (Inc. Locums) £k</p> <p>Locum Expenditure £k</p> <p>External Agency Expenditure (Inc. Locums) was £282k against £628k trajectory in April.</p> <p>Locum Expenditure in April was £38k against £106k trajectory.</p>											

1. Income and Expenditure Position

The position for April was £22k favourable compared to plan. The in-month performance comprised an underspend position on pay and depreciation/interest of £1,086k and £10k respectively, partly offset by an overspend position on non-pay of £262k and an under-recovery on income of £813k. The summary income and expenditure statement is shown below:

	APRIL ACTUAL £'000	APRIL BUDGET £'000	APRIL VARIANCE £'000	% VARIANCE
CCGs - Non Tariff	10,578	11,138	-560	-5.0%
CCGs - Tariff	246	310	-64	-20.6%
Charitable and Other Contributions to Expenditure	2	6	-3	-60.5%
Department of Health	0	0	0	0.0%
Education, Training and Research	112	178	-66	-37.2%
Foundation Trusts	254	284	-31	-10.7%
Income Generation	8	12	-5	-36.9%
Injury Cost Recovery	24	31	-6	-20.4%
Local Authorities	3,685	3,913	-228	-5.8%
NHS England	1,775	1,832	-57	-3.1%
NHS Trusts	502	496	6	1.2%
Non NHS: Other	129	129	0	-0.3%
Non-Patient Care Services to Other Bodies	78	57	21	36.9%
Other Revenue	285	93	192	206.2%
Private Patient Income	1	12	-11	-92.8%
Sustainability and Transformation Fund	124	124	0	0.0%
INCOME Total	17,803	18,616	-813	-4.4%
Administration and Estates	2,514	2,677	163	6.1%
Healthcare Assistants and other support staff	1,700	1,839	139	7.6%
Managers and Senior Managers	788	866	77	8.9%
Medical and Dental	768	802	34	4.2%
Qualified Nursing, Midwifery and Health Visiting	4,070	4,720	650	13.8%
Scientific, Therapeutic and Technical	2,430	2,570	140	5.4%
Employee Benefits	14	0	-14	-100.0%
CIP Target Pay	0	-32	-32	-100.0%
CIP Achieved (next year) Pay	0	0	0	100.0%
East Kent Savings	0	-67	-67	-100.0%
North Kent Savings	0	-6	-6	-100.0%
PAY Total	12,283	13,369	1,086	8.1%
Audit fees	5	5	1	9.5%
Clinical Negligence	47	47	0	0.0%
Consultancy Services	11	8	-3	-37.3%
Education and Training	65	67	1	2.2%
Establishment	1,242	818	-424	-51.8%
Hospitality	1	0	-1	-187.9%
Impairments of Receivables	0	0	0	0.0%
Insurance	2	2	0	-1.3%
Legal	11	26	15	58.3%
Other Auditors Remuneration	0	0	0	0.0%
Other Expenditure	13	9	-3	-37.6%
Premises	1,347	1,245	-102	-8.2%
Research and Development (excluding staff costs)	0	0	0	100.0%
Services from CCGs	0	0	0	0.0%
Services from Foundation Trusts	0	0	0	0.0%
Services from Other NHS Trusts	86	59	-28	-47.2%
Supplies and Services - Clinical	1,773	2,051	278	13.6%
Supplies and Services - General	84	102	18	17.7%
Transport	382	465	82	17.7%
CIP Target Non Pay	0	-98	-98	-100.0%
NONPAY Total	5,068	4,806	-262	-5.5%
EBITDA	452	440	12	2.7%
EBITDA %	2.5%	2.4%	-0.2%	
DEPRECIATION/AMORTISATION	259	265	6	2.3%
INTEREST PAYABLE	0	0	0	0.0%
INTEREST RECEIVED	10	6	4	61.7%
SURPLUS/(DEFICIT)	203	181	22	11.9%
SURPLUS %	-1.1%	-1.0%	-0.2%	

Table 1.1: Trust Wide variance against budget in month

2. Risk Ratings

The Trust has scored a 1 against this rating.

3. Cost Improvement Programme

Year to date CIP target (£k)	Year to date CIP Achieved (£k)	Year to date variance – negative denotes an adverse variance (£K)	Full year CIP target (£k)	CIP Achieved (£k)	Full year CIP forecast (£k)	Full Year Total CIP	Full year variance (£k) – negative denotes an adverse variance
349	219	-130	4,080	2,545	1,535	4,080	0

Table 3.1: Cost Improvement Programme Performance

The cost improvements required this year amount to £4,080k.

Achievement for April is 37% behind plan with £219k removed from budgets at month one against a risk rated plan of £349k. Of the total CIP removed from budgets for the year, all savings have been achieved recurrently.

The forecast is to deliver the full £4,080k CIP target.

4. Statement of Financial Position and Capital

	At 31 Mar 18 £000's	At 30 April 18 £000's	Variance Analysis Commentary
NON CURRENT ASSETS:			
Intangible assets	483	471	
Property, Plant & Equipment	14,933	14,799	
Other debtors	77	73	
TOTAL NON CURRENT ASSETS	15,493	15,343	
CURRENT ASSETS:			
NHS & Non NHS - Invoiced Debtors (net of bad debt provision)	12,354	12,104	
NHS Accrued Debtors	5,536	6,688	NHS Accrued Debtors
Other debtors	1,862	2,177	The in-month increase is principally due to M1 accruals for activity, yet to be invoiced
Total Debtors	19,752	20,969	
Cash at bank in GBS accounts	27,592	26,738	
Other cash at bank and in hand	41	121	
Deposit with the National Loan Fund (Liquid Investment)	0	0	
Total Cash and Cash Equivalents	27,632	26,859	
TOTAL CURRENT ASSETS	47,385	47,828	
CREDITORS:			
NHS & Non NHS - Invoiced Creditors falling due within 1 year	-2,856	-1,867	
NHS - accrued creditors falling due within 1 year	-2,898	-3,270	
Non NHS - accrued creditors falling due within 1 year	-13,765	-15,506	Non NHS - accrued creditors falling due within 1 year
Other creditors	-8,337	-7,290	The in-month increase is due to accruals for M1 NHSPS costs yet to be invoiced.
Total amounts falling due within one year	-27,857	-27,933	
NET CURRENT ASSETS	19,528	19,895	
TOTAL ASSETS LESS CURRENT LIABILITIES	35,021	35,238	Other creditors
Total amounts falling due after more than one year	0	0	The in-month decrease is in the main due to the payment of year-end capital creditors.
PROVISION FOR LIABILITIES AND CHARGES	-1,460	-1,473	
TOTAL ASSETS EMPLOYED	33,561	33,765	
FINANCED BY TAXPAYERS EQUITY:			
Public dividend capital	-2,612	-2,612	
Income and expenditure reserve	-30,256	-30,459	
Revaluation Reserve	-694	-694	
TOTAL TAXPAYERS EQUITY	- 33,561	- 33,765	

Table 4.1: Statement of Financial Position, April 2018

	Total Assets	Total Liabilities	Assets/ Liabilities
Apr-17	54,618	27,263	2.00
May-17	54,639	27,048	2.02
Jun-17	55,962	28,135	1.99
Jul-17	57,812	29,693	1.95
Aug-17	57,448	29,092	1.97
Sep-17	58,257	29,619	1.97
Oct-17	61,152	32,123	1.90
Nov-17	54,923	25,530	2.15
Dec-17	55,551	25,799	2.15
Jan-18	56,624	26,571	2.13
Feb-18	58,538	28,129	2.08
Mar-18	60,308	29,316	2.06
Apr-18	63,171	29,406	2.15

Table 4.2: Assets and Liabilities

5. Capital

The table below shows the Trust's total expenditure on capital projects for the year to date 2018-19. The Trust's total Capital Plan for 2018-19 is set at £3.5m.

Capital Projects	M1 Actual YTD £000's	M1 Plan YTD £000's	M1 Variance to plan	Full Yr Forecast	Full Yr Plan £000's	Full Yr Variance	Variance Analysis Commentary
Estates Developments	15	139	124	945	945	0	Spend in month relates to Hawkhurst Bungalow Works completed to date. YTD underspend in the main relates to the projects for the continuation of works at Hawkhurst Bungalow and Trinity House (atrium works).
Backlog Maintenance	63	255	192	705	705	0	Spend in month predominantly relates to installation of CCTV at MIU sites. Other spend is due to fire compartmentation works at Coxheath Centre and Foster Street. YTD underspend relates to the delayed commencement of Energy Efficiency works.
IT Rolling Replacement & Upgrades	7	20	13	1,412	1,412	0	Expenditure relates to continued investment in Windows & SQL servers compliance licensing.
Dental SBU	2	5	3	173	173	0	Spend relates to Dental OPG (X-Ray) Equipment.
Other Minor Schemes	4	10	6	250	250	0	In month expenditure relates to staff costs for the implementation of the new Learning and Development System.
Total	91	429	338	3,485	3,485	-	

Table 5.1: Capital Expenditure April 2018

Gordon Flack
Director of Finance
15 May 2018

Committee / Meeting Title:	Board Meeting - Part 1 (Public)
Date of Meeting:	24 May 2018
Agenda Item:	2.11
Subject:	Committees Terms of Reference
Presenting Officer:	Natalie Davies, Corporate Services Director

Action - this paper is for:	Decision	x	Assurance	
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<p>Report Summary (including purpose and context)</p> <p>The Terms of Reference for each of the following committees have been reviewed and approved.</p> <ul style="list-style-type: none"> • Audit and Risk Committee • Charitable Funds Committee • Finance, Business and Investment Committee • Quality Committee • Remuneration and Terms of Service Committee • Strategic Workforce Committee
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<p>Proposals and /or Recommendations</p> <p>The Board is asked to ratify the Terms of Reference.</p>

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

Natalie Davies, Corporate Services Director	Tel: 01622 211900
	Email: Natalie.davies1@nhs.net

TERMS OF REFERENCE

AUDIT AND RISK COMMITTEE

Document Control

Version	Draft/Final	Date	Author	Summary of changes
1.0	Draft	21.03.11	Craig Sharples	New Document
1.1	Draft	26.01.12	Craig Sharples	Minor amends to reflect organisational change
2.0	Final	26.09.12	Craig Sharples	Update administrative section of TOR. Update references to CFSMS to NHS Protect in TOR. Explicitly reference relationship with the Finance, Business and Investment Committee in TOR.
2.1	Draft	05.02.13	Anthony May	Added section 7, expanded section 5 to state frequency of attendance required and amended requirement for a quorum
2.2	Draft	Aug 2014	Natalie Davies	Clinical Audit and Counter Fraud

2.3	Draft	March 2015	Rob Field	Updated to reflect Foundation Trust Status
2.4	Draft	March 2015	Rob Field	Amendment to Section 1.2 Objectives Trust Governance. Reallocation of delegated decision-making from ARC to FBI Committee. Amendment to Section 5.3 Membership, Removal of reference to attendance.
2.5	Draft	February 2017	Gina Baines	Minor amendments: Trust logo updated. Job titles updated.
2.6	Draft	February 2018	Gina Baines	Removed reference to resourcing of the clinical audit function in Section 1.2 Objectives. Inclusion of Strategic Workforce Committee in the list of 5.4 Key Relationships. Removal of Section 5.11 Confidentiality.

Review

Version	Approved date	Approved by	Next review due
1.0	4 April	KCHT Board	April 2012
1.1	26.01.2012	KCHT Board	April 2012
2.0	Sept 2012	Audit and Risk Committee	Sept 2013
2.0	Sept 2012	KCHT Board	Sept 2013
2.1	Feb 2013	Audit and Risk Committee	Sept 2013
2.2	Sept 2014	Audit and Risk Committee	Sept 2015
2.3	March 2015	KCHFT Board	April 2016
2.4	March 2015	KCHFT Board	April 2016
2.4	February 2016	Audit and Risk Committee	February 2017
2.5	February 2017	Audit and Risk Committee	February 2018
2.5	May 2017	KCHFT Board	February 2018
2.6	February 2018	Audit and Risk Committee	February 2019

1. Role

The Audit and Risk Committee is a non-executive committee of the Board with delegated decision-making powers specified in these Terms of Reference.

1.1 Purpose:

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 Trusts auditors, both internal and external; and
- Offer advice and assurance to the Trust Board about the reliability and robustness of the process of internal control.

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.

1.2 Objectives:

Governance, Risk Management and Internal Control

The committee shall review the establishment and maintenance of an effective system of integrated governance, risk management and internal control, across the whole of the organisation's activities that supports the achievement of the organisation's objectives.

In particular, the committee will review the adequacy of:

- All risk and control-related disclosure statements (in particular the Annual Governance Statement and declarations of compliance with the Care Quality Commissions Essential Standards), together with any accompanying Head of Internal Audit statement, external audit opinion or other independent assurance, prior to endorsement by the Board.
- The underlying assurance processes that indicate the degree of the achievement of corporate objectives, the effectiveness of the management of principal risks and the appropriateness of the above disclosure statements.
- The policies for ensuring compliance with relevant regulatory, legal and code of conduct requirements.
- The policies and procedures for all work related to fraud and corruption as set out in the Secretary of State Directions and as required by NHS Protect.

In undertaking such review the Committee provides assurance to the Chief Executive and to the Board about fulfilment of the responsibility of the Trust's Accounting Officer, who under the terms of the National Health Service Act 2006 is held responsible to Parliament by the Public Accounts Committee for the overall stewardship of the organisation and the use of its resources.

In carrying out this work the committee will primarily utilise the work of Internal Audit, External Audit and other assurance functions, but will not be limited to these audit functions. It will also seek reports and assurances from directors and managers as appropriate, concentrating on the over-arching systems of integrated governance, risk management and internal control, together with indicators of their effectiveness.

This will be evidenced through the committee's use of an effective assurance framework to guide its work and that of the audit and assurance functions that report to it.

Internal Audit

The committee shall ensure that there is an effective internal audit function established by management that meets mandatory NHS Internal Audit Standards and provides appropriate independent assurance to the Audit and Risk Committee, Chief Executive and Trust Board. This will be achieved by:

- Consideration of the provision of the Internal Audit service, the cost of the audit and any questions of resignation and dismissal.
- Review and approval of the Internal Audit strategy, operational plan and more detailed programme of work, ensuring that this is consistent with the audit needs of the organisation as identified in the Assurance Framework.
- Considering the major findings of Internal Audit work (and management's response) and ensure co-ordination between the Internal and External Auditors to optimise audit resources.
- Ensuring that the Internal Audit function is adequately resourced and has appropriate standing within the organisation.
- Annual review of the effectiveness of Internal Audit.

Clinical Audit

The committee shall ensure there is an effective clinical audit function established by management.

This will be achieved by:

- Consideration of the Clinical Audit Strategy and Annual Plan to determine the scope, scale and focus of the plan meets Trust identified risk priorities.

- Assessment of the timeliness and effectiveness of management responses to clinical audit reports, drawing any deficiencies to the attention of the Quality Committee.

External Audit

The committee shall review the work and findings of the External Auditor and consider the implications and management's responses to their work. This will be achieved by:

- Consideration of the independence, appointment and performance of the External Auditor, as far as the Audit Commission's rules permit.
- Discussion and agreement with the External Auditor, before the audit commences, of the nature and scope of the audit as set out in the Annual Plan, and ensure coordination as appropriate, with other External Auditors of their local evaluation of audit risks and assessment of the Trust and associated impact on the audit fee.
- Review of all External Audit reports, including the report to those charged with governance, the annual audit letter before submission to the Trust Board and any work in the nature of audit work carried out outside the annual audit plan, together with the appropriateness of management responses.

The committee shall provide an opinion to the Council of Governors on the appointment of the external auditor at the end of the contracted period for its consideration.

Counter Fraud

The committee shall review the effectiveness and impact of Counter Fraud operations within the Trust. This will be achieved by:

- Review of independent assessments of the Counter Fraud service.
- Consideration, agreement and monitoring for assurance purposes of an annual programme of work balancing the need for proactive and reactive work.
- Review of Counter Fraud Service reports and recommendations determining whether appropriate management responses have been received.

Trust Governance

- Oversee the maintenance of an effective system of internal controls, assurance framework and management reporting and ensure that the Board is provided with evidence that risks are being appropriately identified, assessed, addressed and monitored.
- Monitor the implementation of Board policies on standards of business conduct.

- Consider the content of any report involving the Trust issued by the Public Accounts Committee or the Comptroller and Auditor General and review the management responses before presentation to the Board.

Financial Reporting

The committee shall review the Annual Report and Financial Statements before submission to the Trust Board, focusing particularly on:

- The wording in the Annual Governance Statement and other disclosures relevant to the Terms of Reference of the Committee.
- Changes in, and compliance with, accounting policies and practices.
- Unadjusted mis-statements in the financial statements.
- Major judgmental areas.
- Significant adjustments resulting from the audit.

Review of the completeness and accuracy of financial information provided to the Trust Board.

2. Accountability

The Audit and Risk Committee is accountable to:
KCHFT Board.

And accountable for:
The Audit and Risk Committee has no sub committees.

3. Decision Making

The Audit and Risk Committee is an Assurance Committee that has delegated authority from the Kent Community Health NHS Foundation Trust Board to provide assurance and hold the Executive to account for the corporate governance and internal control.

4. Reporting Arrangements:

The Audit and Risk Committee will ensure that the minutes of its meetings are submitted to Kent Community Health NHS Foundation Trust Board following each meeting and will report to the Board following each meeting. Any items of specific concern or which require Kent Community Health NHS Foundation Trust Board approval will be the subject of separate ad-hoc reports. The Committee will receive Chair-approved formal minutes from each of its subcommittees as soon as administratively possible.

5. Governance

5.1 Chair:

One Non-Executive Director will be appointed as Chair of the committee by the Trust Board Chair.

5.2 Secretariat:

The Corporate Services Director will act as Secretariat to the Audit and Risk Committee.

5.3 Membership:

The committee shall be appointed by the Board from amongst the non-executive directors of the Trust and shall consist of not less than three members. One of the members will be appointed chair of the committee by the Trust Board. The Chairman of the Trust should not be a member of the Audit and Risk Committee.

The Head of Internal Audit, Head of External Audit and the Local Counter Fraud Specialist, or their deputies, shall normally attend meetings. Other individuals with specialist knowledge may attend for specific items with the prior consent of the Audit and Risk Committee Chairman.

At least once a year the committee should meet privately with the External and Internal Auditors and the Local Counter Fraud Specialist.

The Chief Executive and other executive directors should be invited to attend, particularly when the committee is discussing areas of risk or operation that are the responsibility of that director.

The Chief Executive should be invited to attend, at least annually, to discuss with the Committee the process for assurance that supports the Annual Governance Statement.

5.4 Key Relationships:

- Quality Committee
- Finance, Business and Investment Committee
- Strategic Workforce Committee
- The Executive Committees

5.5 Quorum:

The meeting will be quorate if two Non-Executive Directors are in attendance.

5.6 Frequency of Meetings:

Meetings will be held not less than three times a year.
The Chair of the Committee can call extra-ordinary meetings as necessary.

5.7 Notice of Meetings:

Meetings of the Audit and Risk Committee, other than those regularly scheduled as above, shall be summoned by the secretariat to the Committee at the request of the Committee Chair.

5.8 Conduct of Business:

The agenda for each meeting will be circulated seven working days in advance, together with any supporting papers and will be distributed by the Secretariat.

5.9 Declarations of Interest:

The Committee Chair will ensure that all interests are formally declared by committee members prior to the commencement of the proceedings. In particular the declarations will include details of all relationships and other relevant and material interests (pecuniary and non-pecuniary) specifically related to the business to be transacted as per the agenda.

5.10 Minutes of Meetings:

The secretariat will record the minutes of the Audit and Risk Committee meetings, including the recording of names of those present and in attendance.

Minutes of the Audit and Risk Committee shall be circulated promptly to all members by the secretariat.

6. Approval and Review of Terms of Reference

The Committee will review these Terms of Reference at least once each year to reflect changes in NHS requirements or best governance practice.

7. Monitoring Compliance

What will be monitored	How will it be monitored?	Who will monitor?	Frequency
Achievement of objectives	Chair provides a written assurance report to the Board	Committee Chair Trust Board	Following each meeting.
Frequency of attendance	Attendance register of each meeting	Corporate Services Director will report to the Committee Chair	Annually

TERMS OF REFERENCE

CHARITABLE FUNDS COMMITTEE

Document Control

Version	Draft/Final	Date	Author	Summary of changes
0.1	Draft	11.01.12	Craig Sharples	New Document
0.2	Draft	12.01.12	Craig Sharples	Revised following Charitable Funds Committee meeting – Submitted to Board for ratification
0.3	Draft	16.03.15	Rob Field	Amended to reflect Foundation Trust status
0.4	Draft	March 2016	Gina Baines	Amended to include Governor as a member.
0.5	Draft	April 2017	Gina Baines	Amended point 5 attendance to include Fund Managers and Assistant Director of Communications and Marketing. Trust logo. Updated job titles
1.4	Draft	27.04.2018	Gina Baines	Section 5 – Confidentiality – to change to ‘The minutes... shall be made available to the public, through the Formal Board Part One papers’

Review

Version	Approved date	Approved by	Next review due
1.0	26.01.2012	KCHT Board	April 2012
1.1	26.03.2015	KCHFT Board	April 2016
1.2	March 2016	Charitable Funds	April 2017
1.3	April 2017	Charitable Funds	April 2018
1.3	May 2017	KCHFT Board	April 2018
1.4	April 2018	Charitable Funds Committee	April 2019

1. ROLE

The Charitable Funds Committee is a non-executive committee of the Board with delegated decision-making powers specified in these Terms of Reference.

Purpose:

The Charitable Funds Committee will act on behalf of the Corporate Trustee, in accordance with the Kent Community Health NHS Foundation Trust Standing Orders to oversee the charity's operation and to ensure that the administration of charitable funds is distinct from its 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.

Objectives:

The committee is delegated by the Board to undertake the following duties and any others appropriate to fulfilling the purpose of the committee (other than duties which are reserved to the Board alone):

- To ensure the Kent Community Health NHS Foundation Trust Charitable Fund is being managed and accounted for within the terms of its declaration of trust and Department of Health policy, including all legal and statutory duties, and in compliance with Charity Commission regulations. As a committee of the Board, in so far as it is possible to do so, most of the sections of the Standing Financial Instructions will apply to the management of charitable funds.
- To approve any new funds, the name and terms of reference of a Fund, and identify the nominated Fund Holder.
- To set and annually review the charity's reserves policy.
- To manage the investment of funds in accordance with the Trustee Act 2000.
- To determine the charitable fund's investment policy, including the selection of appropriate investment advisers and banking service provider.
- To monitor the performance of Investment Managers if appointed.
- To ensure funding decisions are appropriate and are consistent with Kent Community Health NHS Foundation Trust's objectives, to ensure such funding provides added value and benefit to the patients and staff of the Trust, above those afforded by the Exchequer funds.
- To receive regular monitoring reports on the utilisation of charitable funds by nominated fund budget-holders and take action to ensure Trust policy is implemented.
- To review and monitor Charity appeals and receive regular reports on the performance of all charitable fundraising activities.

- To implement as appropriate, procedures to ensure that accounting systems are robust, donations received are coded as instructed and that all expenditure is reasonable, clinically and ethically appropriate.
- To examine financial statements of the Charity and approve the annual accounts and report and ensure that relevant information is disclosed.
- To ensure that the Charitable Funds Committee membership is such that undue reliance is not placed on particular individuals when undertaking the duties of the Charitable Funds Committee Terms of Reference.
- To assure the Board that charitable funds are being managed and accounted for in terms with Trust and wider Charity Commission and Department of health policy.

2. ACCOUNTABILITY

Accountable to:

KCHFT Board.

Accountable for:

The Charitable Funds Committee has no sub committees.

3. DECISION MAKING

The Charitable Funds Committee is an Assurance Committee that has delegated authority from the Kent Community Health NHS Foundation Trust Board to provide assurance and hold the Executive to account for the corporate governance and internal control on the management of charitable funds.

4. MONITORING AND REPORTING

Monitoring Arrangements:

See in objectives above.

Reporting Arrangements:

The Charitable Funds Committee will ensure that the minutes of its meetings are submitted to Kent Community Health NHS Foundation Trust Board following each meeting and will report to the Board following each meeting. Any items of specific concern or which require Kent Community Health NHS Foundation Trust Board approval will be the subject of separate ad-hoc reports. The Committee will receive Chair-approved formal minutes from each of its subcommittees as soon as administratively possible.

5. GOVERNANCE

Chair:

One Non Executive Director will be appointed as Chair of the committee by the Trust Board Chair.

Secretariat:

The Corporate Services Director will provide the Secretariat to the Charitable Funds Committee.

Minutes of Meetings:

The secretariat will record the minutes of the Charitable Funds Committee meetings, including the recording of names of those present and in attendance.

Minutes of the Charitable Funds Committee shall be circulated promptly to all members by the secretariat.

Confidentiality:

The minutes (or sub-sections) of the Charitable Funds Committee, unless deemed exempt under the Freedom of Information Act 2000, shall be made available to the public, through the Formal Board Part One meeting papers.

7. APPROVAL/REVIEW OF TERMS OF REFERENCE

The Committee will review these Terms of Reference at least once each year to reflect changes in NHS requirements or best governance practice.

Terms of Reference V.6

Finance, Business and Investment Committee

Document Control

Version No.	Draft / Final	Date	Author	Summary of Changes
V.1	Draft	1 st Oct 2012	Gordon Flack	First draft of ToR for discussion at inaugural meeting of the FBI Committee on 12/10/12.
V.2	Draft	12 th Oct 2012	Gordon Flack	ToR amended with minor changes agreed at FBI Committee on 12.10.12.
V.3	Draft	25 th Oct 2012	Gordon Flack	ToR amended with change to clause on frequency of meetings agreed at Informal Board meeting on 25 th October 2012.
V.4	Final	29 th Nov 2012	Gordon Flack	ToR ratified at formal Board meeting on 29 th November but quoracy changed from four members to three, including at least one NED.
V.5	Draft	15 th Mar 2013	Gordon Flack	Proposed decision rights delegated by Board
V5.1	Final	15 th May 2013	Gordon Flack	Amends following FBI to recognise capital projects within overall approved budget and E&D
V6	Final	15 th February 2014	Gordon Flack	Amended to allow FBI to sign off Reference Costs return.
V6.1	Draft	16 th March 2015	Rob Field	Amended to reflect Foundation Trust status
V6.2	Final	25 th March 2015	Rob Field	Amendment to point 6.1 Finance, point 7. Additional point added to 6.1 Finance regarding procurement
V6.3	Draft	April 2016	Gina Baines	Amendment to point 4.2. any Board member could request a meeting.
V6.4	Draft	29 March 2017	Gina Baines	Updated Trust logo, job titles and reference to Monitor changed to NHS Improvement.
V6.5	Draft	28 March 2018	Gordon Flack	Amendment to point 2.1 with regards to inviting Executive Directors to

				meetings quarterly Amendment to point 2.2 - A quorum shall be three members, including at least two non-executive directors. Amendment to point 6.1 Finance regarding model contracts Amendment to point 6.3 Investments regarding bank mandates Amendment to point 7.3 with regards timing.
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Review

Version No.	Approved Date	Approved By	Next Review Date
6.1	26 March 2015	Board	April 2016
6.2	26 March 2015	Board	April 2016
6.3	April 2016	Finance, Business and Investment Committee	March 2017
6.4	March 2017	Finance, Business and Investment Committee	March 2018
6.4	May 2017	KCHFT Board	May 2018
6.5	March 2018	Finance, Business and Investment Committee	March 2019

FINANCE, BUSINESS AND INVESTMENT COMMITTEE TERMS OF REFERENCE

1. CONSTITUTION

- 1.1. The Board hereby resolves to establish a Committee of the Board to be known as the Finance, Business and Investment Committee (The Committee), which is to be directly accountable to the Board.
- 1.2. 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 £15m contract turnover in line with Trust Strategy and reviewing and then referring and recommending larger and novel bids to the Board for approval;
 - Review and approve capital investment decisions between £1m to £3m 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 £1m to £3m 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.
- 1.3. All procedural matters in respect of conduct of meetings shall follow the Trust's Standing Orders.

2. MEMBERSHIP

- 2.1. The members of the Committee shall be as follows:
- Two Non-Executive Directors
 - Chief Executive
 - Director of Finance
 - Deputy Chief Executive/Chief Operating Officer

The Medical Director and Chief Nurse to be invited to attend the committee on a quarterly basis.

- 2.2. A quorum shall be three members, including at least two non-executive directors.
- 2.3. The Chair of the Committee shall be one of the non-executive directors and shall be appointed by the Board. The second non-executive director shall deputise in the absence of the Chair.

3. ATTENDANCE AT MEETINGS

- 3.1. Executive directors and senior service leads will be invited to attend when the Committee is discussing issues relating to their area of responsibility.

3.2. All non-executives in addition to the members will be invited to every meeting of the committee and the full board will receive all papers.

4. FREQUENCY OF MEETINGS

4.1. The Committee will initially meet on a monthly basis and subsequently at least four times a year, when the Committee feels it is appropriate to reduce the frequency of meetings.

4.2. Any Board member may request a meeting if they consider that one is necessary.

5. AUTHORITY

5.1. The Committee is authorised by the Board to investigate any activity within its terms of reference. It is authorised to seek any information it requires from any employee and all employees are directed to co-operate with any requests made by the Committee.

5.2. The Committee is authorised by the Board to obtain outside legal or other independent professional advice and to secure the attendance of outsiders with relevant experience and expertise if it considers this necessary.

6. DUTIES

The duties of the Committee can be categorised as follows:

6.1. Finance:

- To scrutinise current financial performance and assess adequacy of proposed recovery plans to bring performance in line with plan (where necessary);
- To scrutinise projected financial performance with particular reference to reviewing sustainability against Board objectives on risk ratings and liquidity;
- To scrutinise annual financial performance and current projections;
- To review budget control framework, including budget setting and guidelines;
- To scrutinise proposed budgets (revenue and capital) and recommend adoption of final budgets by the Trust Board;
- To review proposed financial returns to NHS Improvement;
- To review strategic assumptions underpinning the Long Term Financial Plan and review the development of this plan;
- To review contract documentation with main commissioners, and development of any National Model Contracts with such commissioners;
- To assess, periodically, impact of different financial assumptions on the future financial position of the Trust, and to assess adequacy of mitigating actions to protect the future financial position of the Trust;
- To assess, periodically, the skills base within the Finance Department and the adequacy of Treasury and Management Accounting reporting;
- To advise on the development of financial policies including service line reporting and associated costing and development of tariff;
- To review implications of national financial policies, and changes therein, on the Trust;
- To review the Trust Cost Improvement Programme and assess whether the Trust has established robust PMO arrangements to ensure delivery and with regular reporting from the Trust CIP group meeting;

- To review and approve business cases between £1m and £3m within capital budget or annual revenue investment and recommend approval by the Trust Board for larger cases.
- To scrutinise decisions with reference to their impact on equality using resources such as the “Equality Analysis Toolkit”
- To approve the annual Reference Costs return on behalf of the Board.
- To scrutinise and review procurement activity.

6.2. Business

- To assess whether adequate systems are in place to ensure that financial considerations are properly incorporated within capital investment decisions;
- To scrutinise capital investment proposals for financial implications and consistency with strategic service plans;
- To review the Trust’s Annual and Strategic Business Plans;
- To receive, scrutinise and approve (£1m to £3m per annum) proposed service developments, including enhancements to existing contracts, to ensure proper financial evaluation including impact on the future risk ratings, making recommendations to the Board where larger than £3m per annum;
- To review the commercial strategy and individual bids and acquisitions, to ensure proper financial evaluation and approve those with a contract turnover up to £15m and in line with Trust Strategy and otherwise make recommendations to the Board;
- To review, periodically, market analysis undertaken on behalf of, or by, the Trust.

6.3. Investments

- To monitor adequate safeguards on investment of funds by approving:
 - List of institutions with whom funds can be placed;
 - Appointment of bankers and brokers;
 - Investment limits for each institution;
 - Investment types.
- To approve cash management and investment policies and test compliance with such policies;
- To approve any draw down of Working Capital Facility or Prudential Borrowing Limits;
- To review investment performance and risk.

7. REPORTING

- 7.1. The minutes of the Committee meetings shall be formally recorded and submitted to the following private or informal Board meetings.
- 7.2. The Chair of the Committee shall draw to the attention of the Board any issues that require disclosure to the full Board, or require executive action.
- 7.3. The Committee will report to the Board annually on its work.

8. ADMINISTRATION

- 8.1. The Committee will be supported administratively by the office of the Corporate Services Director, whose duties in this respect will include:
- Agreement of agenda with Chair and attendees and collation of papers;
 - Taking the minutes and keeping a record of matters arising and issues to be carried forward;
 - Advising the Committee on pertinent areas;
- 8.2. The agenda for each meeting will be circulated seven days in advance, together with any supporting papers and will be distributed by the Secretariat.
- 8.3. The Committee Chair will ensure that all interests are formally declared by committee members prior to the commencement of the proceedings. In particular the declarations will include details of all relationships and other relevant and material interests (pecuniary and non-pecuniary) specifically related to the business to be transacted as per the agenda.

9. APPROVAL / REVIEW OF TERMS OF REFERENCE

The Committee will review these Terms of Reference and assess performance against these at least once each year to reflect changes in NHS requirements or best governance practice.

TERMS OF REFERENCE

QUALITY COMMITTEE

Document Control

Version	Draft/ Final	Date	Author	Summary of changes
0.1	Draft	13 10 2011	Karen Proctor Director of Nursing and Quality	
0.2	Draft	17 01 2012	Stephen Robinson Director of Corporate Services	Format into KCHT Template. Amend to clarify role as Assurance Committee role.
0.3	Draft	12.7.2012	Karen Proctor Director of Nursing /Quality	Addition of groups reporting to committee and membership
0.4		27.09.2012	Director of Nursing/Quality	Changed membership and committee groups
0.5		27.09.2012	Director of Nursing/Quality	Changed reasonability for accountability to assurance
0.6		29.01.2013	Head of Risk Management	Amended to reflect NHSLA requirements
0.7		14.02.2013	Corporate Secretary	Amended Head of Health and Wellbeing to Health and Wellbeing Director
0.8	Draft	10.12.13	Corporate Secretary	Amended secretarial references Addition of reference to Finance, Business and Investment Committee Updating of HR Director title

0.9	Draft	5.5.14	Director of Nursing/Quality	Amended to reflect changes and assurance
1.0	Draft	16.3.15	Assistant Director of Assurance	Amended to reflect Foundation Trust status
1.1	Draft	07.03.2017	Assistant Trust Secretary	Amended Trust logo, job titles.
2.0	Draft	06.06.2017	Ali Strowman, Chief Nurse	Full revision
2.1	Draft	March 2018	Ali Strowman, Chief Nurse	Membership section – to add Deputy Chief Nurse. Confidentiality section removed from Section 5. Strategic Workforce Committee added to Section 5 Governance – Key Relationships.

Review

Version	Approved date	Approved by	Next review due
0.2	26.01.2012	KCHT Board	April 2012
0.5	27.09. 2012	Quality Committee	September 2013
0.9	03.06.2014	Quality Committee	June 2015
1.0	26.03.2015	Board	April 2016
1.0	08.03.2016	Quality Committee	March 2017
1.1	07.03.2017	Quality Committee	March 2018
1.1	25.05.2017	KCHFT Board	March 2018
2.0	12.09.2017	Quality Committee	March 2018
2.0	28.09.2017	Board	March 2018
2.1	17.04.2018	Quality Committee	March 2019

1.0 ROLE

Purpose:

The Quality Committee is established as a Committee of the Board of Kent Community Health NHS Foundation Trust (the Trust). The aim of the Quality Committee is to provide assurance to the Board of Directors that there is an effective system of risk management and internal control across the clinical activities of the organisation that support the organisation's objectives and the Trust's ability to provide excellent quality care by excellent people.

Objectives:

Specific responsibilities of the Quality Committee include:

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

Providing assurance to the Board by:

- Ensuring that the strategic priorities for quality assurance are focused on those which best support delivery of the Trust's quality priorities in relation to patient experience, safety of patients and service users and effective outcomes for patients and service users;
- Reviewing compliance with regulatory standards and statutory requirements, for example those of the Duty of Candour, the CQC, NHSLA and the NHS Performance Framework.
- Reviewing quality risks which have been assigned to the Quality Committee and satisfying itself as to the adequacy of assurances on the operation of the key controls and the adequacy of action plans to address weaknesses in controls and assurances;
- Reviewing the Annual Quality Report ahead of its submission to the Board for approval.
- Overseeing 'Deep Dive Reviews' of identified risks to quality identified by the Board or the Committee, particularly "Serious Incidents" and how well any recommended actions have been implemented.

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

Reviewing how lessons are disseminated, learnt and embedded in KCHFT.

Overseeing the ratification of clinical policies and any other formal clinical document where mandatory compliance is required.

2.0 ASSURANCE

Assurance to:
KCHFT Board.

Groups:
Patient Safety and Clinical Risk Group
Clinical Effectiveness Group
Patient Experience Group

3.0 DECISION MAKING

The Quality Committee is directly accountable to the Board of Directors. At each formal meeting the Chairman of the Quality Committee will report to the Board. Minutes of committee meetings will be reported directly to the Board of Directors.

The Quality Committee is authorised by the Board to investigate any activity within its terms of reference. It is authorised to seek any information it requires from any employee and all employees are directed to cooperate with any request made by the Quality Committee.

The Quality Committee is further authorised by the Board to obtain external independent professional advice and to secure the attendance of specialists with relevant experience and expertise if it considers this necessary.

4.0 MONITORING AND REPORTING

Monitoring Arrangements:
See in objectives above.

Reporting Arrangements:
The minutes of each Committee meeting will be reported to the Board of Directors. A summary of the minutes of each meeting will be included in the next public board agenda.

Where a significant risk emerges either through a report or through discussion at a Committee meeting, this will be reported to the Board by the Committee Chair. The outcomes of any 'Deep Dive Reviews' will be reported to the Board and any follow up action kept under review by the Committee.

The Quality Committee has three formal sub-groups- the Clinical Effectiveness Group; the Patient Safety and Clinical Risk Group and the Patient Experience Group and will receive reports from these groups monthly.

5.0 GOVERNANCE

Chair:
One Non-Executive Director will be appointed as Chair of the committee by the Trust Board.

Secretariat:
The Secretariat function will be provided by the Corporate Services Director.

The agenda will be prepared for the Committee Chair with input from the Committee members and other regular attendees, who may propose items for inclusion in the agenda. Items for inclusion in the agenda will be submitted a minimum of two weeks prior to the meeting. The agenda with associated meeting papers will be distributed to members of the Committee one week prior to the meeting. The date for the next meeting will be arranged and distributed to all members within one month of the meeting. The date for the next meeting will be arranged and distributed to all members with the draft minutes.

A standard agenda as follows will be used by the Quality Committee may include the following items:

- Apologies for absence
- Declarations of interest
- Minutes of last meeting
- Action log
- Presentation from a service on a quality improvement initiative
- Progress against Quality Priorities
- Summary assurance report from Clinical Effectiveness Group
- Summary Assurance report from Patient Safety and Clinical Effectiveness Group
- Summary assurance report from Patient Experience Group
- Committee reports for assurance
- Red flag and Early Warning Trigger Tool (EWTT) report
- Ratification of policies
- Any other business
- Date of next meeting

Membership:

The Members of the Quality Committee shall comprise three Non-Executive Directors, one of whom will be Committee Chair, the Chief Executive, the Chief Nurse, the Medical Director, Chief Operating Officer and Deputy Chief Nurse. In the absence of the Committee Chair and with the agreement of the other attending members' one of the other Non-Executive Directors will chair the meeting.

Executive Directors along with any other appropriate attendee will be invited to attend by the Committee Chair when the Committee is discussing areas of risk or operation that fall under their direct responsibility.

Key Relationships:

Audit and Risk Committee
 Finance, Business and Investment Committee
 Strategic Workforce Committee
 Executive Committee
 Management Committee

Quorum:

The quorum shall be four members, of which at least two must be Non-Executive Directors and two must be Executive Directors.

Frequency of Meetings:

The Quality Committee will hold a minimum of ten meetings each year to ensure it is able to discharge all its responsibilities.

Notice of Meetings:

Meetings of the Quality Committee, other than those regularly scheduled as above, shall be summoned by the Corporate Services Director at the request of the Committee Chair.

Conduct of Business:

The agenda for each meeting will be circulated seven working days in advance, together with any supporting papers and will be distributed by the Corporate Services Director.

Declarations of Interest:

The Committee Chair will ensure that all interests are formally declared by committee members prior to the commencement of the proceedings. In particular the declarations will include details of all relationships and other relevant and material interests (pecuniary and non-pecuniary) specifically related to the business to be transacted as per the agenda.

Minutes of Meetings:

The Assistant Trust Secretary will record the minutes of the Quality Committee meetings, including the recording of names of those present and in attendance.

Minutes of the Quality Committee shall be circulated promptly to all members by the Assistant Trust Secretary. All meetings will receive an action log (detailing progress against actions agreed at the previous meeting) for the purposes of review and follow-up.

6.0 APPROVAL / REVIEW OF TERMS OF REFERENCE

The Quality Committee will review these Terms of Reference on an annual basis as part of a self- assessment of its own effectiveness. Any recommended changes brought about as a result of the yearly review, including changes to the Terms of Reference, will require Board of Directors approval.

7.0 MONITORING COMPLIANCE WITH THESE TERMS OF REFERENCE

What will be monitored	How will it be monitored?	Who will monitor?	Frequency
Achievement of objectives	Chair provides a written assurance report to the Board	Committee Chair Trust Board	Bi-monthly to public Board
Frequency of attendance	Attendance register of each meeting	Assistant Trust Secretary will report to the Committee Chair	Annually

KENT COMMUNITY HEALTH NHS FOUNDATION TRUST

REMUNERATION AND TERMS OF SERVICE COMMITTEE

TERMS OF REFERENCE

1. ROLE

- 1.1 The Remuneration and Terms of Service Committee is constituted as a standing committee of the Trust Board and has no executive powers, other than those specifically delegated in these terms of reference. Its constitution and terms of reference are set out below and can only be amended with the approval of the Trust Board.

2. PURPOSE

- 2.1 The Remuneration and Terms of Service Committee shall have delegated authority from the Trust Board to set the remuneration, allowance and other terms and conditions of office for the Trust's Executive Directors and Senior managers not employed on national terms and conditions and to recommend and monitor the structure of remuneration.
- 2.2 In setting the remuneration and conditions of service for the Chief Executive, other Directors and Senior Managers, the committee shall take into account all factors which it deems necessary including relevant legal and regulatory requirements, the provisions and recommendations the Foundation Trust Licence and associated guidance from Monitor.
- 2.3 When required the committee will oversee the appointment of Executive Directors in accordance with Standing Orders.

3. DUTIES

- 3.1 To agree and keep under review the overall remuneration policy of the Trust.
- 3.2 To set the individual remuneration, allowances and other terms and conditions of office (including termination arrangements) for the Trust's Executive Directors and other Senior Managers reporting to the Chief Executive.
- 3.3 To recommend and monitor the structure of remuneration, including setting pay ranges.
- 3.4 To monitor and evaluate the performance of the Trust's Chief Executive against objectives and previous year and note forward objectives. Act as 'grandparent' to Executive Directors performance. Performance of other senior managers will be monitored and evaluated by their line managers.
- 3.5 To ratify where appropriate actions taken between meetings by the Chair of the Committee using delegated authority.



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- 3.6 In determining remuneration policy and packages, to have due regard to the policies and recommendations of NHS improvement and the wider NHS, and to adhere to all relevant laws and regulations.
- 3.7 To keep abreast of executive level remuneration policy and practice and market developments elsewhere in the NHS and in other relevant organisations, drawing on external advice as required.
- 3.8 To scrutinise and where appropriate authorise those Compromise Agreements, Settlements and Redundancy Payments which require the final approval by HM Treasury as well as any proposed termination payment to the Chief Executive or an Executive Director.
- 3.9 To receive regular reports on other Compromise Agreements, Settlements and Redundancies approved in accordance with Trust policies.
- 3.10 To receive an annual report on the outcome of the employer-based (local) Clinical Excellence Awards round.
- 3.11 In relation to other employees of the Trust, the Committee is responsible for:
- Approving any non-contractual payments that have to be reported to the HM Treasury (via Monitor);
 - Approving any business cases for redundancy for any staff reporting directly to the Chief Executive or any other Executive Director, or where the value exceeds £100k, or where the business case requires reporting to HM Treasury;
 - The structure, payment criteria and targets for any bonus or incentive scheme proposed by the executive;
 - Approving the terms and conditions for any staff outside of nationally agreed pay frameworks;
 - Considering and approving any payments in settlement of an employment tribunal claim
- 3.12 To undertake any other duties as directed by the Trust Board.

4. ROLE OF THE COUNCIL OF GOVERNORS

- 4.1 The Council of Governors is required to approve the appointment and proposed remuneration of the Chief Executive.

5. ACCOUNTABILITY

- 5.1 The Remuneration and Terms of Service Committee is accountable to the Kent Community Health Foundation Trust Board.
- 5.2 **Accountable for:**
The Remuneration and Terms of Service Committee has no sub committees.

TERMS OF REFERENCE

STRATEGIC WORKFORCE COMMITTEE

Document Control

Version	Draft/Final	Date	Author	Summary of changes
1.0	Draft	29.09.2017	Louise Norris, Director of Workforce, Organisational Development and Communications	
1.1	Draft	03.10.2017	Louise Norris, Director of Workforce, Organisational Development and Communications	Reformatted into Trust template
1.1	Final	22.11.2017	Louise Norris, Director of Workforce, Organisational Development and Communications	Language in purpose revised and inclusion of Ratification of Policies and membership to include Finance added.
1.2	Draft	23.03.2018	Louise Norris, Director of Workforce, Organisational Development and Communications	Section 5 Governance. 5.5 -to change to two Non-Executive Directors to be quorate.

Review

Version	Approved date	Approved by	Next review due
1.1	14.11.2017	Strategic Workforce Committee	March 2018
1.1	30.11. 2017	Board	March 2018
1.2	23.03.2018	Strategic Workforce Committee	March 2019

1. ROLE

The Strategic Workforce Committee is a committee of the Board with delegated decision-making powers specified in these Terms of Reference.

1.1 Purpose:

- The Strategic Workforce Committee (The Committee) is an assurance Committee. It will provide assurance to the Board on the organisational priority of creating and maintaining Kent Community NHS Foundation Trust as the place where people want to work, delivering high quality care to our patients.
- To keep abreast of the strategic context in which the Trust is operating in, the consequences and implications on the workforce.

1.2 Objectives:

The Committee is delegated by the Board to undertake the following duties and any others appropriate to fulfilling the purpose of the committee (other than duties which are reserved to the Board alone) in order to provide assurance on the following:

- Overseeing the development and implementation of the Trust's people strategy, ensuring that the Trust has robust plans in place to support the on-going development of the workforce;
- Reviewing the Trust's plans to identify and develop leadership capacity and capability within the Trust, including talent management;
- Ensuring that there is an effective workforce plan in place, to ensure that the Trust has sufficient staff, with the necessary skills and competencies to meet the needs of the Trust's patients and services users;
- Ensuring that the Trust continually reviews its workforce models, to reflect new roles and new ways of working to support delivery of the Trust's contractual obligations;
- Receiving and provide assurance that the Trust has an appropriate pay and reward system that is linked to delivery of the Trust's strategic objectives, outcomes and desired behaviours;
- Ensuring that the training and education provided and commissioned by the Trust is fully aligned to the Trust's strategy;
- Ensuring that there are mechanisms in place to support the mental and physical health and well-being of the Trust's staff
- Receiving information on strategic themes relating to employment issues, ensuring they are understood and actioned;

- Ensuring that the Trust is compliant with relevant legislation and regulations relating to workforce matters.
- Ensure that the Trust has appropriate workforce policies in place.

2. ACCOUNTABILITY

Accountable to:
KCHFT Board.

Accountable for:
The Strategic Workforce Committee has an Operational Workforce sub group that reports to it.

3. DECISION MAKING

The Strategic Workforce Committee is an Assurance Committee that has delegated authority from the Kent Community Health NHS Foundation Trust Board to provide assurance and hold the Executive to account for strategic workforce issues.

The Strategic Workforce Committee is authorised by the Board to investigate any activity within its terms of reference. It is authorised to seek any information it requires from any employee and all employees are directed to cooperate with any request made by the Strategic Workforce Committee.

The Strategic Workforce Committee is further authorised by the Board to obtain external independent professional advice and to secure the attendance of specialists with relevant experience and expertise if it considers this necessary.

4. MONITORING AND REPORTING

4.1 Monitoring Arrangements:

To ensure the Strategic Workforce Committee complies with its Terms of Reference, compliance will be monitored through the following methods:

What will be monitored	How will it be monitored?	Who will monitor?	Frequency
Achievement of Trust workforce strategy	Annual Board report	Board	Annual
Frequency of attendance	Attendance register of each meeting	Committee Secretary will report to the Committee Chair	Annually

4.2 Reporting Arrangements:

The Strategic Workforce Committee will ensure that the minutes of its meetings are submitted to Kent Community Health NHS Foundation Trust Board following each meeting and will report to the Board following each meeting. Any items of specific

concern or which require Kent Community Health NHS Foundation Trust Board approval will be the subject of separate ad-hoc reports. The Committee will receive Chair-approved formal minutes from each of its sub committees as soon as they are approved by the sub committee.

5. GOVERNANCE

5.1 Chair:

One Non Executive Director will be appointed as Chair of the committee by the Trust Board.

5.2 Secretariat:

The meetings will be minuted by the Committee Secretary. All other administrative matters will be co-ordinated by the PA to the Director of Workforce, Organisational Development and Communications.

5.3 Membership:

The Committee shall be appointed by the Board to ensure representation by non-executive and executive directors.

Members will include:

Chair	Non Executive Director
Other Members	Non Executive Director Director of Workforce, Organisational Development and Communications Chief Operating Officer Chief Nurse Medical Director Deputy Director of Workforce Deputy Director of Finance

Other officers will attend as required.

In the absence of the Chair, another Non-Executive Committee member will perform this role.

5.4 Key Relationships:

Audit and Risk Committee
The Executive Committees
Quality Committee

5.5 Quorum:

The quorum necessary for the transaction of business shall be three members, two of which must be Non-Executive Directors.

5.6 Frequency of Meetings:

Meetings will be held bi-monthly.
The Chair of the Committee can call extra-ordinary meetings as necessary.

5.7 Notice of Meetings:

Meetings of the Strategic Workforce Committee, other than those regularly scheduled as above, shall be summoned by the secretariat to the Committee at the request of the Committee Chair.

5.8 Conduct of Business:

The agenda for each meeting will be circulated seven working days in advance, together with any supporting papers and will be distributed by the Secretariat.

5.9 Declarations of Interest:

The Committee Chair will ensure that all interests are formally declared by committee members prior to the commencement of the proceedings. In particular the declarations will include details of all relationships and other relevant and material interests (pecuniary and non-pecuniary) specifically related to the business to be transacted as per the agenda.

5.10 Minutes of Meetings:

The secretariat will record the minutes of the Strategic Workforce Committee meetings, including the recording of names of those present and in attendance.

Minutes of the Workforce Committee shall be circulated promptly to all members by the secretariat.

6. APPROVAL / REVIEW OF TERMS OF REFERENCE

The Committee will review these Terms of Reference at least once each year to reflect changes in NHS requirements or best governance practice. These Terms of Reference will be approved by the Trust Board.



Kent Community Health
NHS Foundation Trust

Committee / Meeting Title:	Board Meeting - Part 1 (Public)
Date of Meeting:	24 May 2018
Agenda Item:	2.12
Subject:	Interim Appointments Following The Retirement of the Chairman
Presenting Officer:	Natalie Davies, Corporate Services Director

Action - this paper is for:	Decision	<input type="checkbox"/>	Assurance	<input type="checkbox"/>
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Report Summary (including purpose and context)
The attached sets out the proposed interim arrangements following the Chairman's retirement on 24 May 2018.

Proposals and /or Recommendations
The Board is asked to: <ul style="list-style-type: none">• Note the appointment of Richard Field as Interim Chairperson• Approve the appointment of Peter Conway as Interim Vice Chairperson• Support the appointment of Bridget Skelton as the Chairperson of the Finance, Business and Investment Committee

Relevant Legislation and Source Documents
Has an Equality Analysis (EA) been completed?
No. High level position described.

Natalie Davies, Corporate Services Director	Tel: 01622.211904
	Email: natalie.davies1@nhs.net

**INTERIM APPOINTMENTS
FOLLOWING THE RETIREMENT OF THE CHAIRMAN**

1. Situation

The Chairman of the Trust, David Griffiths, leaves the Trust at the end of May 2018. Despite an extensive search, the Trust will be left with the Chairman's role not being substantially filled on Mr Griffith's retirement. A further appointment process is underway with a likely completion date of September 2018.

In accordance with the Constitution and in recognition of effective governance principles, the following is proposed:

Vice Chairperson, Richard Field, will assume the role of Interim Chairman of Kent Community Health NHS Foundation Trust. In taking this role, Mr Field will no longer be a member of the Audit and Risk Committee.

Peter Conway, Non-Executive Director to be appointed to the role of Vice Chairperson.

The role of Chairperson for the Finance, Business and Investment Committee will be transferred to Bridget Skelton.

2. Recommendation

The Board is asked to:

- Note the appointment of Richard Field as Interim Chairperson
- Approve the appointment of Peter Conway as Interim Vice Chairperson
- Support the appointment of Bridget Skelton as the Chairperson of the Finance, Business and Investment Committee.

Natalie Davies
Corporate Services Director
18 May 2018

Committee / Meeting Title:	Board Meeting - Part 1 (Public)
Date of Meeting:	24 May 2018
Agenda Item:	3.1
Subject:	Charitable Funds Committee Minutes
Presenting Officer:	Jen Tippin , Chair of the Charitable Funds Committee

Action - this paper is for:	Decision	Assurance	x
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Report Summary (including purpose and context):
The paper presents the confirmed Minutes of the Charitable Funds Committee meeting of 25 January 2018

Proposals and /or Recommendations:
The Board is asked receive the confirmed minutes.

Relevant Legislation and Source Documents:
Has an Equality Analysis been completed?
No. High level position described.

Jen Tippin, Non-Executive Director	Tel: 01622 211900
	Email:

**CONFIRMED Minutes of the Charitable Funds Committee
held on Thursday 25 January 2018
in the Council Chamber, Sevenoaks Town Council Offices, Bradbourne Vale
Road, Sevenoaks TN13 3QG**

Present: Jennifer Tippin, Non-Executive Director (Chair)
Gordon Flack, Director of Finance
Lesley Strong, Chief Operating Officer/ Deputy Chief Executive
In Attendance: Gina Baines, Committee Secretary/Assistant Trust Secretary
(note-taker)

001/18 Introduction by Chair

Jennifer Tippin welcomed everyone present to the meeting of the Charitable Funds Committee meeting.

002/18 Apologies for Absence

Apologies were received from Carol Coleman, Public Governor, Dover and Deal and Richard Field, Non-Executive Director.

003/18 Declarations of Interest

There were no Declarations of Interest given apart from those formally noted on the record.

004/18 Minutes from the Meeting of 25 October 2017

The minutes were **AGREED** by the Committee.

005/18 2016/17 Charitable Funds Report and Accounts

Gordon Flack presented the report to the Committee for approval.

The Committee had previously received the draft Accounts at its October 2017 meeting. There had been some minor amendments. A cash flow summary was provided.

In response to a question from Jen Tippin regarding whether the Executive Team had felt that the investment in fundraising support from the Communications Team had been worthwhile, Lesley Strong indicated that this had not yet been discussed. She suggested that a cost benefit analysis

needed to be carried out.

The Accounts had been independently reviewed by the Trust's External Auditors, Grant Thornton. There was an anomaly relating to an incorrect payment to the Trust by the Royal Surrey County Hospital NHS Foundation Trust. This payment had been an error and had been refunded. It was not clear how it had come about.

With regards to the cash flow of the Restricted and Unrestricted Funds, overall the net movement had shown a reduction in funds. The majority of the movement had been in the Unrestricted Fund. An enquiry had been made to The Charities Commission with regards to broadening the remit of one of the Restricted Funds. A charitable bank account had been opened which provided a more attractive interest rate, although this was still modest. There were no conflicts of interest to report and no expenses had been paid from the funds.

In response to a comment from Jennifer Tippin regarding the reduction in the Unrestricted Funds, Gordon Flack suggested that a fundraiser would improve the level of the fund. No legacies had been received that year.

The Committee **APPROVED** the 2016/17 Charitable Funds Report and Accounts.

006/18 Any other business

In response to comments from Carol Coleman which had been received by Jennifer Tippin prior to the meeting, the Committee confirmed that there was no guarantee that the Trust Staff Awards would continue to be funded from the Unrestricted Funds. With regards to the proposal to the Staff Partnership Forum for a staff opt in for the Pennies From Heaven scheme, this had been considered by the Management Committee. There was no further information at that time regarding the appointment of a fund raising manager. These items would be discussed further at the April 2018 Charitable Funds Committee meeting. It was agreed to assess the value of the sponsorship and support activity of i Care at the April 2018 meeting with a view to deciding whether the funding should continue.

Action – Gordon Flack

The meeting ended at 9.20am.

007/18 Date and time of next meeting

Friday 27 April 2018, 10am, First Floor Meeting Room, The Oast, Hermitage Court, Hermitage Lane, Barming, Maidstone, Kent ME16 9NT

Committee / Meeting Title:	Board Meeting - Part 1 (Public)
Date of Meeting:	24 May 2018
Agenda Item:	3.2
Subject:	Quarterly Infection Prevention and Control Report
Presenting Officer:	Ali Strowman, Chief Nurse and Director of Infection Prevention and Control (DIPC)

Action - this paper is for:	Decision	<input type="checkbox"/>	Assurance	<input checked="" type="checkbox"/>
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<p>Report Summary (including purpose and context):</p> <p>This paper provides a summary of infection prevention and control activity between 1 March and 30 April 2018 with year end results, and new year aims.</p> <ul style="list-style-type: none"> • In 2017/18 there were 4 <i>Clostridium difficile</i> infections reported, the suspected cross infections were proven to be not related, RCA's identified all 4 cases to be unavoidable, and due to appropriate antimicrobial prescribing. For 2018/19 the KCHFT objective is to have no more than 4 cases of <i>Clostridium difficile</i> infection, with no level 3 lapses in care, in April there were none. • In 2017 / 18 there were no MRSA bacteraemias attributed to KCHFT, there were 5 where KCHFT staff provided care, all identified some learning for KCHFT, which is now being shared. There has been a change in national reporting and investigating of MRSA bacteraemias after April 1st 2018. There was one case of MRSA bacteraemia in April where KCHFT staff provided care, learning was identified for all healthcare providers. • Reported MRSA screening for elective and step up admissions was 100% in March, and 99% overall for the year, pertaining to one missed screen. In April 2018 compliance in hospitals was reported at 81% compliance, with 2 patients wound swabs being missed at Edenbridge. • In 2017/18, in Kent there were 1514 E-coli bacteraemias recorded, on investigation, KCHFT provided a level of care in 204 cases – main reasons for visits were catheter care, wound care and podiatry. The CCG's in Kent did not achieve the planned 10% reduction in 2017/18. • In 2018/19 KCHFT have implemented a CAUTI/UTI reduction campaign, which will run concurrently with the wound management projects and WIRE project, to tackle the areas where our patients are most at risk of developing gram negative bacteraemias.
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- The Assistant Director of IPC has been asked to become part of an East Kent collaborative to reduce Gram negative bacteraemias and attend NHSI and NHSE workshops.
- In 2017/18 the Trust did not achieve it's target for reducing UTI's and CAUTI's, however since implementing the reduction campaign there has been a significant drop – with NO Cauti's being reported in March and April 2018. The aim for 2018/19 is to reduce CAUTI's to no more than 12 healthcare associated cases, and no more than 82 UTI's in our community hospitals.
- The cleaning reports have improved over the year, and for the last quarter of 2017/18 all audited inpatient units achieved the target compliance of cleanliness (as per national standards) however, one unit was not audited in January.
- Trust Compliance with hand hygiene training was reported as 90%, and mandatory training 95% in March.
- The Trust was issued a Health and Safety Executive enforcement notice in relation to a case of contact dermatitis. IPC are working with the Trust Health and Safety team, Head of Employee Relations, Education and Workforce Development and PAM - the trusts occupational health provider to address actions required.
- In 2017/18 there were a total of 23 outbreaks, 9 Confirmed influenza / respiratory, 4 confirmed norovirus, 10 Diarrhoea / vomiting unknown cause and 1 norovirus outbreak in April.
- The Trust Staff Flu vaccination campaign concluded, with 59% of staff receiving the vaccine – the highest percentage compliance yet.
- The Water Safety Committee continues to meet to highlight gaps in assurance, and evidence risk reduction actions, currently compliance evidence has been provided for 97% of properties, with the Estates team chasing the remaining 3%.
- The Antimicrobial Stewardship committee continues to meet, currently focus remains upon collaborative working across Kent through CCG lead Antimicrobial stewardship groups.

Proposals and /or Recommendations:

For the Board to note the report.

Relevant Legislation and Source Documents:

Has an Equality Analysis been completed?

No. High position described and no decision required.

Lisa White	Tel: 01233667914
Assistant Director of Infection Prevention and Control	Email: lisa.white1@nhs.net

QUARTERLY INFECTION PREVENTION AND CONTROL REPORT

1. Introduction

The full content of this report was presented and discussed at the Quality Committee on 15 May 2018.

2. *Clostridium difficile*

Aim: The national objectives request that Trusts aim to reduce their cases by one compared to the previous target, therefore in 2018/19 the Trust aims to have no more than 4 cases of *Clostridium difficile* infections with no level 3 lapses in care.

The two cases previously identified as an SI owing to potential cross contamination at the Whitstable and Tankerton Hospital, were identified as different strains, therefore the SI was downgraded. As the Infection Prevention and Control team (IPC) have already undertaken Route Cause analyses and 'Period of Increased Incidence' investigations, with the CCG Infection prevention and control lead, actions are to be completed and managed locally.

3. MRSA

There has been a change in national reporting and investigating of MRSA bacteraemias. All cases will now be recorded as pre 48 hour onset or post 48 hour onset, with either the Acute Trust or CCG taking the lead on investigating and reviewing of potential lessons. This changes the way KCHFT will report going forward.

There has been one case of MRSA bacteraemia in April where KCHFT staff provided care alongside Primary care and Acute care, it was a pre 48hour onset of infection, and the investigating team identified potential improvements to the community / acute referral pathway for podiatry, for primary care, KCHFT and the Acute Trust. This action is being lead by the CCG IPC lead, and podiatry lead in KCHFT.

Reported MRSA screening for elective and step up admissions was 100% in March, and 99% overall for the year, pertaining to one missed screen. In April 2018 compliance in hospitals was reported at 81% compliance, with 2 patients wound swabs being missed at Edenbridge

4. Gram negative bacteraemias

There is no specific target for KCHFT in relation to Gram negative bacteraemias, as currently cases are not attributed, however, there is an aim to reduce E-coli bacteraemias by 10% annually to achieve the national target to reduce all health care associated Gram negative bacteraemias by 50% by 2021.(gram negative include predominantly E-coli, Pseudomonas and Klebsiella)

No CCG catchment in the KCHFT area achieved the 2017/18 10% reduction target. Across Kent in 2017/18 there were a total of 1514 reported cases of E-coli bacteraemia, and KCHFT staff provided care in 204 of these cases. Main reasons for KCHFT care input have been urinary / catheter care and wound care.

For 2018/19 KCHFT have implemented a CAUTI/UTI reduction campaign, which will run concurrently with the wound management projects and WIRE project, to tackle the areas where our patients are most at risk of developing gram negative bacteraemias.

As part of this ongoing plan for reduction, The Assistant Director of IPC has been asked to become part of an East Kent collaborative alongside staff from EKHUFT and East Kent CCG to attend NHSI and NHSE workshops, to assess, trial and review the pathways, projects and work that we are currently jointly working on, and implementing – including catheter passport, UTI/CAUTI pathway and Care home training packages.

5. CAUTI/UTI reduction

In 2017/18 the Trust did not achieve it's target for reducing UTI's and CAUTI's, however since implementing the reduction campaign there has been a significant drop – with NO Cauti's being reported in March and April 2018.

The aim for 2018/19 is to reduce CAUTI's to no more than 12 healthcare associated cases, and no more than 82 UTI's in our community hospitals.

6. Cleaning

Cleaning audit results have improved across the organisation with all areas audited achieving national standards of cleanliness

7. Training

The Learning and Development Department collect and collate all training figures on behalf of the IPCT – target - 85% compliance for all infection control training.

Trust Compliance with hand hygiene training was reported as 90%, and mandatory training 95% in March. Compliance amongst clinical staff was 88.5% for hand hygiene, and 93.8% for mandatory training. However some services are below target, and the IPC team are currently targeting those teams.

8. Flu campaign

The Trust Staff Flu vaccination campaign has concluded, with 59% of staff receiving the vaccine – the highest percentage compliance yet. A learning event was held by the 'flu team' at the near end of this season, and plans are already being commenced for next year flu season programme.

9. Health and Safety improvement notice

The Trust was issued a Health and Safety Executive enforcement notice in relation to a case of contact dermatitis. IPC have worked collaboratively with the Trust Health and Safety team, Head of Employee Relations, Education and Workforce Development and PAM - the trusts occupational health provider to address actions required.

10. Outbreaks and incidents

In 2017/18 there were a total of 23 outbreaks, 9 Confirmed influenza / respiratory, 4 confirmed norovirus, 10 Diarrhoea / vomiting unknown cause. Of these, whole wards were closed for 7 outbreaks –for the remaining outbreaks, they remained contained within individual bays. In April there was one norovirus outbreak.

Of these, whole wards were closed for 7 of the outbreaks – in all others, the outbreaks remained contained, and individual bays were closed, with the wards remaining open for admissions. This change in practice does not appear to have affected the length of outbreaks, and has allowed the whole health care economy to continue using beds in affected areas.

11. Water safety.

The Water Safety Committee continues to meet to discuss the assurances required, revise policies and protocols and identify gaps and actions where necessary. Currently the Trust has received 97% of data required for full assurance on water quality, safety and maintenance.

The focus of the group is now to ensure the Hydrotherapy user group re-commences, which are due by June 2018.

12. Antimicrobial Stewardship.

The Antimicrobial Stewardship committee continues to meet, and implement actions from the 5 year plan. The group are already planning activity and awareness raising for the forthcoming months.

Lisa White
Assistant Director of Infection Prevention and Control
16 May 2018

Committee / Meeting Title:	Board Meeting - Part 1 (Public)
Date of Meeting:	24 May 2018
Agenda Item:	3.3
Subject:	Quarterly Patient Experience and Complaints Report
Presenting Officer:	Ali Strowman, Chief Nurse

Action - this paper is for:	Decision	<input type="checkbox"/>	Assurance	<input checked="" type="checkbox"/>
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Report Summary (including purpose and context):
<p>This report provides the Board with assurance that the Trust is gathering patient feedback, responding to complaints and acting on feedback to improve services.</p> <ul style="list-style-type: none"> • Kent Community Health NHS Foundation Trust continues to receive a high number of survey returns in comparison with other Community providers with a consistent high satisfaction rate. • The Patient Experience Team continues to work with services to ensure they are able to obtain feedback from their service users. • Services continue to use patient feedback to improve delivery of care. • Numbers of complaints continue on a downward trend. • Quality Improvement work on the way the Trust manages Complaints is ongoing.

Proposals and /or Recommendations:
The Board is asked to note the report.

Relevant Legislation and Source Documents:
Has an Equality Analysis been completed?
No. High level position described and no decisions required.

Sue Mitchell	Tel 07393 240018
AD for Patient Safety and Experience	Email: s.mitchell13@nhs.net

QUARTERLY PATIENT EXPERIENCE AND COMPLAINTS REPORT

1. Introduction

- 1.1 This report provides the Board with assurance that the Trust is gathering patient feedback, responding to complaints and acting on feedback to improve services.
- 1.2 Kent Community Health NHS Foundation Trust is committed to improving patient experience. Our key values are to ensure good care that meets our organisational values: compassion, aspirational, responsive and excellence. This report details patient and service user feedback for Quarter 4, 1 January 2018 to 31 March 2018.
- 1.3 Data is taken from the Meridian surveys and is reported by team/locality. Complaints are recorded following the Trust's complaints process.

2. Patient Experience

2.1 Meridian data

2.1.1 The Trust's overall patient experience score for quarter 4 is **96.93%** based on **14,293** completed surveys. There was a decrease in survey returns compared with quarter 3 (15,070 surveys) where the satisfaction score was 96.85%.



2.2 Friends and Family Test (FFT)

2.2.1 The Trust's NHS Friends and Family Test (FFT) score demonstrates an extremely positive recommend rate of 97.39%, which is almost a 1% increase compared with the last quarter (96.46%).

2.2.3 12,881 people answered the FFT question, with a minority of 0.57% patients being unlikely or extremely unlikely to recommend the service they used. The table below compares the all quarters of 2017/18.

	Recommend	Not Recommend	Total Responses	Extremely Likely	Likely	Neither Likely or Unlikely	Unlikely	Extremely Unlikely	Don't Know
Q1 2017/18	97.66%	0.56%	16,824	13,887	2,544	193	46	49	105
Q2 2017/18	97.36%	0.68%	14,463	11,937	2,144	178	41	57	106
Q3 2017/18	96.46%	0.65%	14,408	11,627	2,271	280	43	51	136
Q4 2017/18	97.39%	0.57%	12,811	10,140	2,336	168	29	44	94

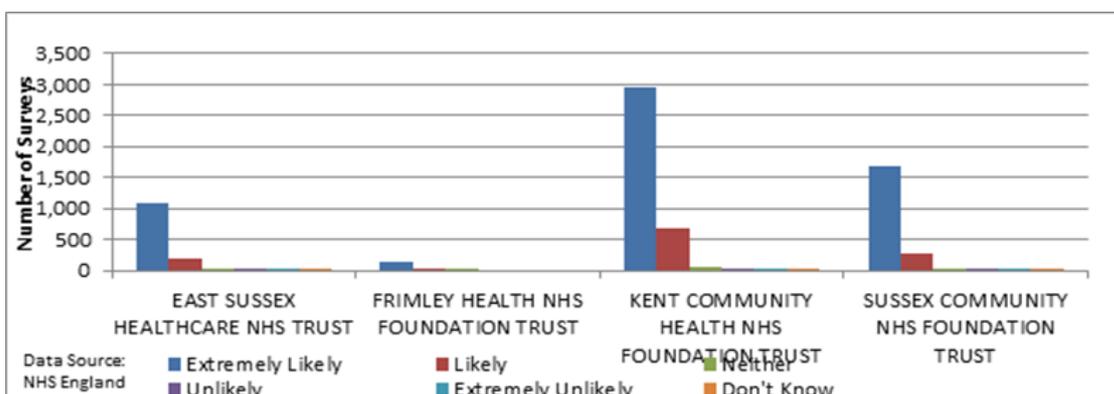
2.3 FFT Recommend Score

2.3.1 The FFT recommended score has remained relatively consistent over all quarters of 2017/18.



2.3.2 The FFT score findings demonstrate high levels of satisfaction within the services. All surveys which receive an unlikely or extremely unlikely response to the FFT question are included in reporting and teams take action and make improvements in response to negative feedback whenever possible.

2.3.3 KCHFT measures favourably against other Community Trusts in the region in terms of survey returns. The following table relates to February 2018 data.



2.4 Examples of improvements made in relation to negative feedback

Service	Comments made by client/patient and action taken by service
Children's Therapies	Children's Speech and Language Therapy (West Kent) A parent complained that following their child's paediatric dietetic consultation, no prescription letter request was sent to GP for calorie supplements, Action taken: Service will ensure administration is completed together on the same day by seeing fewer children but holding more clinics. SOP has been created to include new process re prescription requests to GPs.
QVMH, Herne Bay (Heron Ward)	Negative feedback received via inpatient surveys regarding lack of staff. Action taken: <ul style="list-style-type: none"> The service had an open day on 10.11.17 to encourage and interest members of the public in the roles of a Band 2 administrator, health care assistant and a Band 5 The service successfully recruited to all untrained posts as well as two registered nurses.

Rapid Response	<p>Maidstone/Malling - A relative was unhappy with the lack of night cover by the Rapid Response team and with attitude of staff member providing end of life care.</p> <p>Action taken: The staff member attended an Advanced End of Life Skills / Communication training.</p>
Children's Specialist Community Nursing	<p>Children's Community Nursing (Maidstone / Malling) Family was disappointed that the bowel washouts their child required were not carried out in the way that the family undertakes the procedure. Communication between the family and the nursing team was also not to the standard that the family expected.</p> <p>Action taken:</p> <ul style="list-style-type: none"> • Assessment meetings are now taking place within the school on a monthly basis. The meetings discuss new children and also those young people moving from day schooling to a residential placement. The children's needs are discussed and also who is the most appropriate person to visit with the keyworker from the health team to undertake a full 24 hour assessment to update the child's care plan and inform training. • The training has taken place. • Three nursing staff have undertaken the Crucial Conversations training course and 3 nursing staff are due to attend.
Hawkhurst Community Hospital	<p>Feedback received via inpatient survey regarding disturbance of TV noise from single rooms.</p> <p>Action taken:</p> <ul style="list-style-type: none"> • The League of Friends installed headphones for use with televisions in all side rooms • Staff actively encourage the use of the headphones.

2.5 Competencies

2.5.1 Patient experience is measured across seven key areas. The table below demonstrates overall scores with extremely positive responses.
n/a = no question on survey related to competency

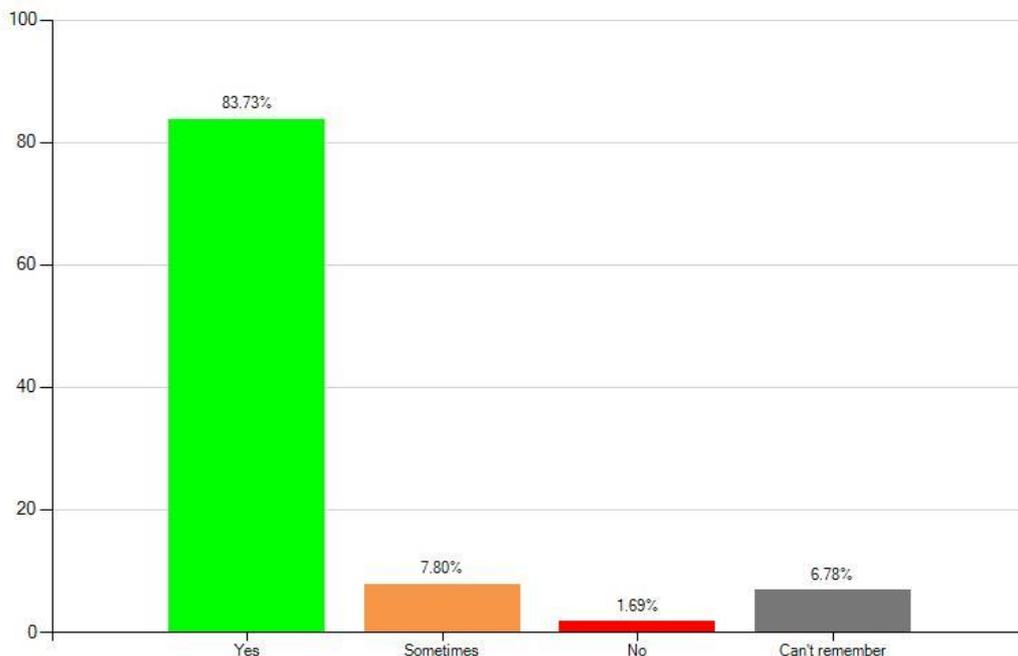
Locality	Returns	Communication	Co-ordinated Care	Equality and Diversity	Given necessary info	Involved in decisions about care and treatment	Listened to and worries taken seriously	Staff Attitude
Ashford	627	96.67%	88.19%	99.08%	97.76%	98.68%	98.06%	98.45%
Canterbury and Coastal	1124	98.84%	93.97%	99.53%	98.58%	98.59%	99.17%	99.41%
Dartford, Gravesham and Swanley	872	99.02%	n/a	99.86%	99.54%	98.73%	99.90%	99.73%

Locality	Returns	Communication	Co-ordinated Care	Equality and Diversity	Given necessary info	Involved in decisions about care and treatment	Listened to and worries taken seriously	Staff Attitude
South Kent Coast	1091	98.10%	89.90%	99.58%	97.47%	98.70%	98.71%	98.85%
East Sussex	474	98.70%	100.00%	98.89%	99.12%	100.00%	99.30%	99.24%
Maidstone, Malling, West Kent and Weald	1674	97.05%	96.14%	99.42%	96.81%	98.10%	98.65%	98.91%
Medway	518	98.63%	100.00%	98.64%	98.06%	98.64%	99.78%	99.41%
Other	577	98.42%	100.00%	98.41%	98.76%	98.02%	98.42%	98.96%
Swale	582	97.94%	90.00%	99.63%	99.06%	98.59%	99.19%	99.51%
Thanet	909	97.97%	91.29%	99.53%	96.71%	96.41%	98.98%	99.35%
Trust Total	8448	98.05%	93.07%	99.39%	97.90%	98.23%	98.99%	99.16%

2.5.2 There are two areas which are less positive. Ashford Teams – Co-ordinated care showed only 88.19% satisfaction rate and South Kent Coast Teams 89.9% respectively. These are the two questions linked to the co-ordinated care competency in the community nursing and intermediate care surveys. For community nursing survey – 590 patients answered these questions for Quarter 4. The charts below demonstrate that only small numbers of people answered negatively.

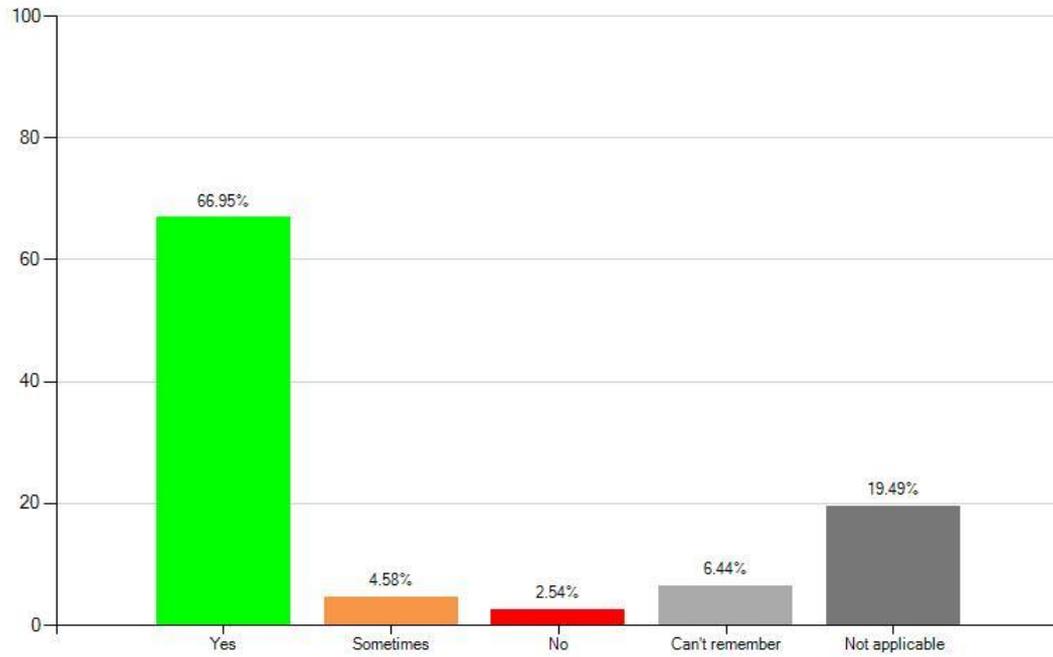
15. When assessing ALL your health and social care needs, did the different professionals supporting and caring for you in the community work well together?

Overall Meridian score for this question: 94.00% (based on 590 responses)



16. You will have a care plan describing how your needs will be met. Did the different professionals supporting and caring for you in the community work well together in setting up and agreeing this plan with you?

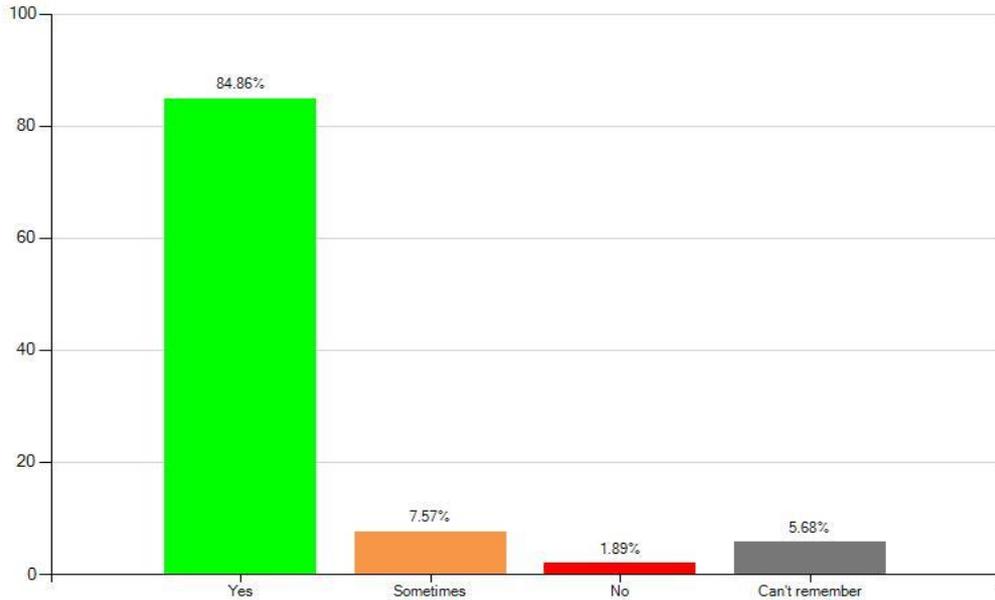
Overall Meridian score for this question: 93.48% (based on 590 responses)



2.5.3 For the intermediate care survey, 317 and 316 patients respectively answered these questions for quarter 4.

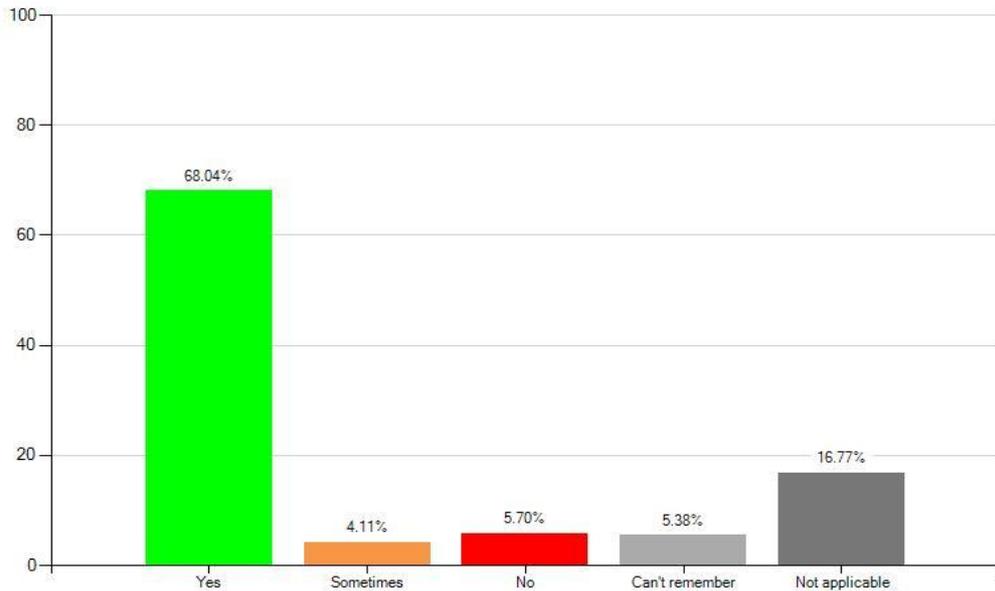
11. When assessing ALL your health and social care needs, did the different professionals supporting and caring for you in the community work well together?

Overall Meridian score for this question: 93.98% (based on 317 responses)



12. You will have a care plan describing how your needs will be met. Did the different professionals supporting and caring for you in the community work well together in setting up and agreeing this plan with you?

Overall Meridian score for this question: 90.04% (based on 316 responses)



2.6 Palliative Care Surveys

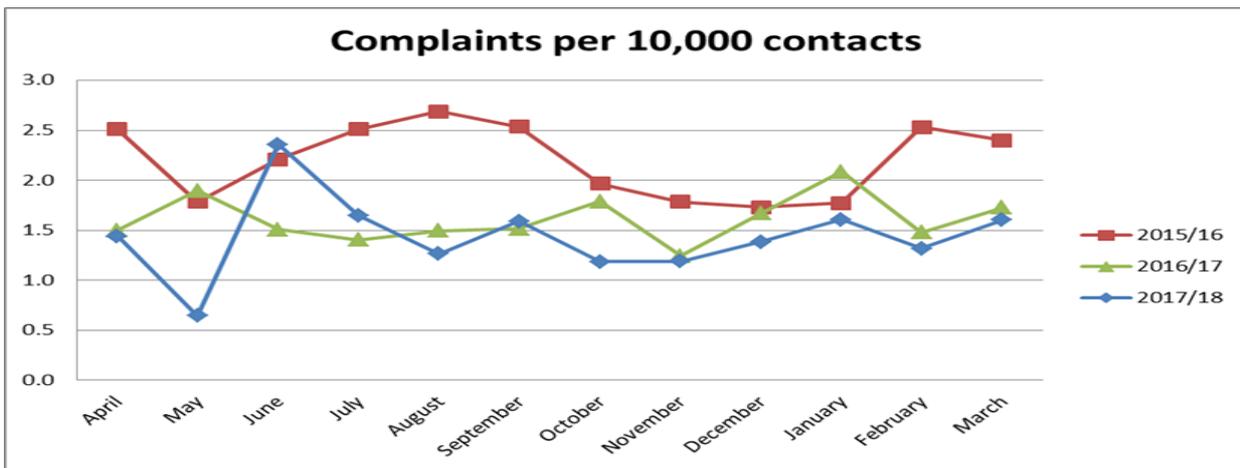
2.6.1 The Trust has a Quality Goal to increase survey feedback from patients receiving palliative care as well as their families and carers. Q4 saw a return of 14 surveys which is slightly less than Q3 (16). The results of these surveys are reported to the End of Life Steering Group for discussion and to identify areas for improvement. The Patient Experience Team is actively working with community nurses to help them increase their

feedback and recognising the specific challenges for this particular group of service users, the Patient Experience Team is arranging a series of 'Listening Events' in Summer 2018 for patients, carers and families currently receiving palliative and end of life care.

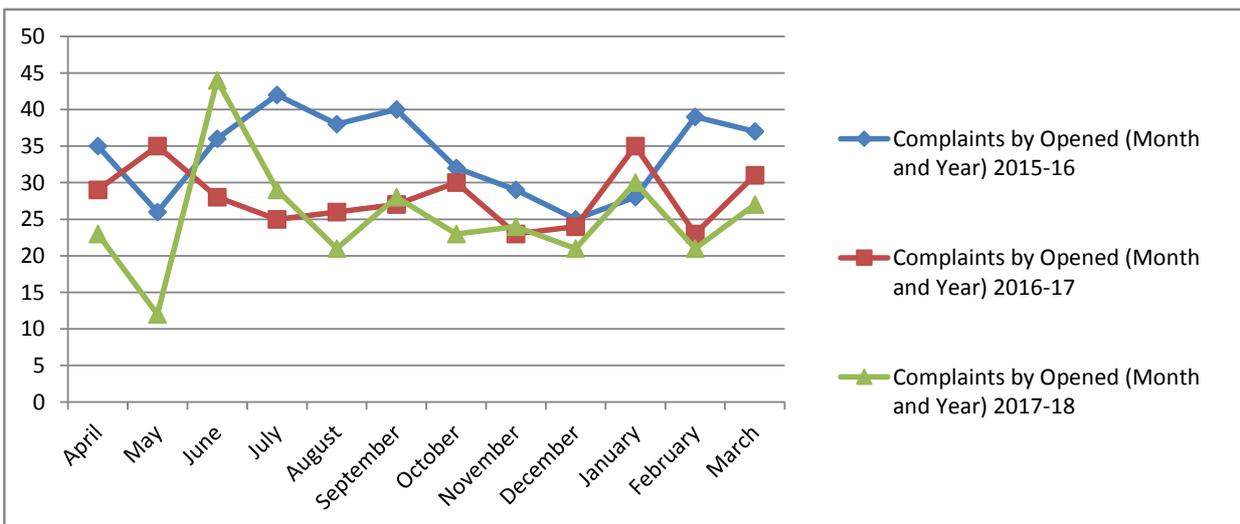
3. Complaints

3.0.1 During Quarter 4, 8,966 people answered the survey question '***If you recently raised a concern or complaint directly with this service, do you feel it was responded to and acted upon?***' The Trust wide satisfaction score was **93.64%**.

3.0.2 The graph below reflects the number of complaints per 10,000 contacts up to the end of March 2018. There have been 78 complaints in Q4 compared to 68 in Q3. 303 complaints were received in 2017/2018 in comparison with 336 in 2016/2017 showing a downward trajectory.



3.0.3 These results demonstrate that numbers year on year for Q4 have reduced slightly as there were 78 complaints in Q4 compared to 89 in Q4 last year.



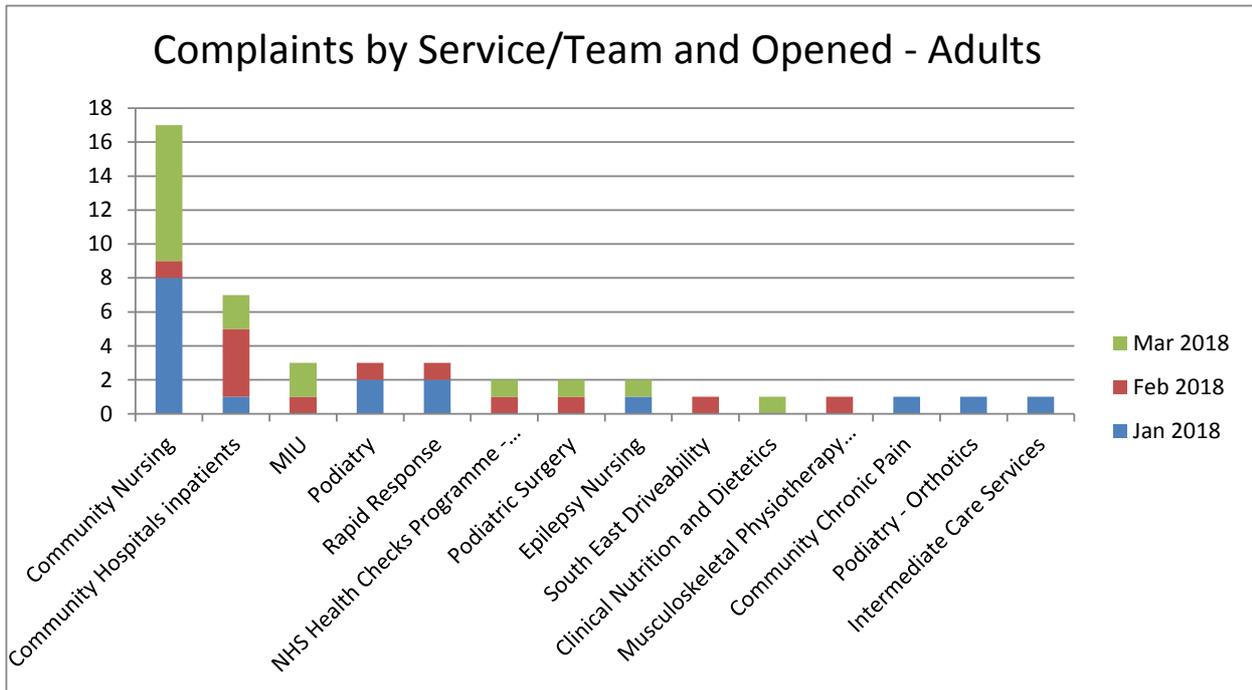
3.1 Benchmarking against other providers

3.1.1 KCHFT has benchmarked with other community trusts via the Benchmarking **Network and have a favourable number of complaints than others (appendix 1)**. This data reflects the information shared by Healthwatch who have confirmed that they receive very few negative comments about the Trust.

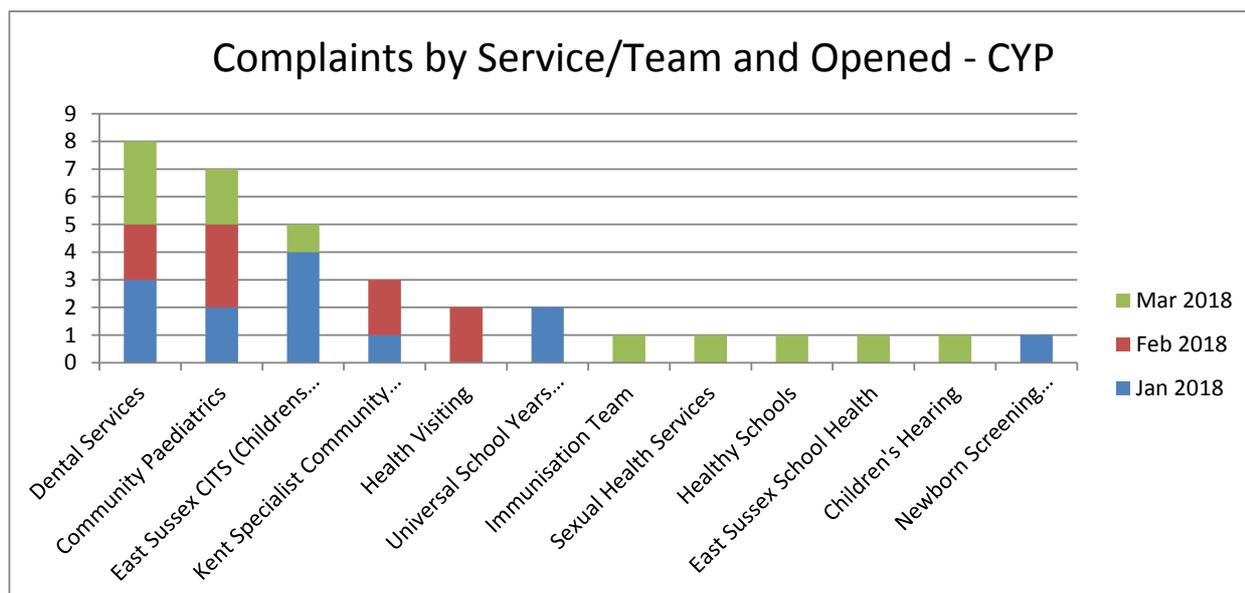
3.2 Complaints across services

3.2.1 The number of Q4 complaints by service is set out in the chart below. Community Nursing services continue to receive the highest number (17 in Quarter 4) as would be expected as they have the highest number of patient contacts (146,995). This is a complaints to contacts ratio of 0.01%.

3.3 Complaints in Adults services



3.4 Complaints in CYP and Dental Services



3.4.1 The Dental Service has seen a small reduction in numbers of complaints received from Q3 to Q4. There has been a greater than 50% increase in Community Paediatric complaints from three in Q3 to 7 in Q4. There has also been five East Sussex CITS complaints in Q4 compared to none in Q3. There are also a number of complaints for other services that did not have complaints in Q3. Overall for Dental and CYP services there has been an increase of 33% in Q4, as there were 22 complaints in Q3 and 33 in Q4.

3.5 Themes and details

3.6 Clinical Treatment

3.6.1 During the quarter there were 27 complaints that fell into this category, a significant increase from Q3 (16) but similar to Q2 (28). There were 19 for adult services and eight for children's services.

3.6.2 There were two complaints relating to missed fractures after attendance at a MIU.

- Sevenoaks – This complaint was raised to the Patient Safety team and following completion of the chronology a conference call was held and it was agreed not to raise as an SI.
- Folkestone – This complaint was raised to the Patient Safety Team and following early investigation it was concluded that no harm was caused by KCHFT.

3.6.3 There were two missed fractures complaints for Sittingbourne and Gravesham MIU in Q3.

3.7 Referrals, appointments, admissions, discharges and transfers

3.7.1 During the quarter there were 14 complaints in this category, there were eight in adult services and six in children's services.

3.7.2 Two of these were lack of appointments and support with the Epilepsy service.

3.8 Access to treatment and medication

3.8.1 During the quarter there were 12 complaints that fell into this category which was a slight reduction from Q2 and 3, which were both 16. Q4 had seven complaints for adult services, four for children's services and one for Dental).

3.9 Values and behaviours

3.9.1 During Q4 there were eight complaints that fell into this category (five in adult services, two in children's services and one in Dental); this is a decrease on Quarter 3.

3.9.2 Four of these were in relation to staff attitude.

3.10 Communication

3.10.1 During the quarter there were 18 complaints that fell into this category (nine in adult services, seven in children's services and two in Dental).

3.11 Ombudsman Cases

3.11.1 There have been no complaint cases referred to the Ombudsman during Q4.

3.12 Complaints Responses

3.12.1 During Q4 the Trust responded to 92.7% of all complaints within the timescale initially agreed. Ten complaints did not meet the deadline, five were less than a week late, one less than 10 days late and four over 20 days late. The reasons were delays in receiving the draft/information from service (six), delays in approval process (process).

3.12.2 Responses meeting agreed timescales will continue to be monitored. Improvements are being introduced which include a template detailing dates sent to those involved in the investigation, approval process and escalation to line managers when drafts are delayed from the investigating managers.

3.12.3 Complaints are to be acknowledged within three working days. In Q3 95.6% of complaints met this target. Three out of 68 complaints were not acknowledged in the agreed time period. In Q4 only one out of 78 was not acknowledged with three working days 98.8%. This was due to lack of communication to confirm who was acknowledging with the Clinical Commissioning Group. This is an improvement on the last quarter.

3.13 Complaints Process Feedback

3.13.1 In Quarter 4 there was just one response to the Trust's survey sent to complainants. This is a decrease on the seven surveys received in Q3. The complainant was happy with the complaints process, the way the complaint was handled and the outcome.

3.13.2 The complaints survey has been updated to ask questions to provide assurance that people's concerns and complaints are listened and responded to and are used to improve the quality of care. The survey is now being sent to complainants with a covering letter at the same time as their complaint response.

3.13.3 The acknowledgement letter has been updated to include a question about the complainant's preferred method of communication, a summary of the scope of the investigation, advice about being updated with timescales, reference to the Customer Care Policy and the opening hours of the Patient Experience Team office.

3.13.4 Complainants will also be advised that they may be asked for feedback on the complaints process once their complaint is resolved so that they can decline the possibility of being sent a survey.

4. The Patient Advice and Liaison Service (PALS) Team

4.1 The PALS Team received a total of 1,820 enquiries in Q4 with the following breakdown:

Directorate	Treatment, Access	Staff Attitude	General phone number enquiries	General PALS Enquiries	Total PALS Enquiries
Adults	23	5	705	171	904
Adults – Health Improvement & Self-Management	-	-	22	3	25
Children and Young People	13	1	407	103	524
CYP – Dental	1	1	34	-	36
CYP – Sexual Health	2	-	5	-	7
HR	-	-	32	7	39
Other Directorates	-	-	106	14	120
Other trusts or organisations or commissioning	-	-	138	27	165
TOTAL	39	7	1449	325	1820

4.2 Key themes from PALS feedback:

4.3 PALS continue to receive calls from service users who have received appointment letters and believe they are ringing the service to discuss their appointment.

4.4 Podiatry service users continue to report difficulties in accessing the service by telephone to book appointments and these calls account for a high number of the telephone contacts to PALS.

5. Compliments

5.1 Services are encouraged to log compliments. It is estimated that there is substantially more feedback that is not shared centrally and therefore the below table is a snapshot of the compliments across KCHFT.

Directorate	Written Compliments	Verbal Compliments	Total
Adults	134	36	170
Adults – Health Improvement & Self-Management	26	102	128
Children and Young People	36	66	102
CYP- Dental	3	-	3
CYP – Sexual Health	4	51	55
Other Directorate	2	2	4

TOTAL	205	257	462
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6. Patient reviews received via NHS Choices / Patient Experience Team email

6.1 There were **27** comments on NHS Choices during the quarter.

6.2 Positive

6.2.1 Twenty three of the reviews were regarding Care and Compassion, with 14 of these for the MIU's. The remaining nine were for a variety of services:
 Four of the reviews mentioned Dignity and Respect
 Two of the reviewers said felt they were listened to and two received good communication from staff.

6.3 Negative

6.3.1 Seven of the negative reviews were regarding Staff Attitude:
 Three x Dental Service (New Street Clinic, Sandwich)
 Two x MIU, Gravesham
 One x Phlebotomy, QVMH, Herne Bay
 One x Sevenoaks Hospital (service unknown)

6.3.2 Two of the other negative reviews were regarding the Dental Service being decommissioned at Churchill Centre, Ramsgate.

7. Improvements/Innovations

7.1 Complaints Handling Training

7.1.1 The Patient Experience Team designed e-learning training for all staff that describes exactly what to do if approached by someone raising a concern and/or wishing to make a complaint. This training is now live on ATP and the results of the quiz at the end of the training are being recorded by Learning and Development. Staff are expected to have undertaken this training before attending the half day face to face training designed for team leaders and managers.

7.2 Complaints Process/Handling

7.2.1 The team undertook a self-assessment exercise against the required standards for R4. They identified gaps in assurance and areas for improvement. The resulting Improvement Plan has the following four objectives:

- There is an active review of complaints and how they are managed and responded to.
- People who use the services are involved in the review.
- It is easy for people to complain or raise a concern and they are treated compassionately when they do so. There is openness and transparency in how complaints are dealt with. Complaints and concerns are always taken seriously, responded to in a timely way and listened to; improvements are made to the quality of care as a result of complaints and concerns.
- All staff know how to support people to raise a concern or make a complaint.

7.2.2 This plan has contains SMART actions and will be measured and monitored through the monthly Patient Experience Team meetings and reported to the Senior Nursing & Quality Meeting. An audit of complaints process management is due to be undertaken in Q2 of 2018/2019.

8. Key Quality Improvements

- 8.1 A small number of interested services have been offered the opportunity to pilot a new method for collecting patient feedback. Receptionists ask patients for their email address on booking in so that, with consent, a survey can be sent to them. This method could reduce the numbers of paper surveys, saving administrative time resources and increase the number of surveys received for certain services.
- 8.2 A Patient Experience Team generic email address kentchft.patientexperience@nhs.net has been made available on the 'Have your say' feedback page on the KCHFT public website. This email offers patients another method of giving their feedback. Compliments and concerns are being received and the team is responding and sharing with the services involved.
- 8.3 Links to NHS Choices and Healthwatch have been added alongside Care Opinion to the 'Have your say' feedback page on the KCHFT public website. This offers patients alternative ways to give their feedback and review the services they have used. A monthly report is to be provided by the Communications Team on how many clicks these different review sites have received.

9. Summary

- KCHFT continues to receive a high number of survey returns in comparison with other Community providers with a consistent high satisfaction rate.
- The Patient Experience Team continues to work with services to ensure they are able to obtain feedback from their service users.
- Services continue to use patient feedback to improve delivery of care.
- Numbers of complaints continue on a downward trend.
- Quality Improvement work on the way the Trust manages Complaints is ongoing.

10. Recommendations

- 10.1 The Board is asked to note the Report.

Sue Mitchell
Assistant Director, Patient Safety and Experience
15 May 2018

Committee / Meeting Title:	Board Meeting - Part 1 (Public)
Date of Meeting:	24 May 2018
Agenda Item:	3.4
Subject:	Quarterly Mortality and Learning From Deaths Report
Presenting Officer:	Dr Sarah Phillips, Medical Director

Action - this paper is for:	Decision	<input type="checkbox"/>	Assurance	X
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<p>Report Summary (including purpose and context)</p> <p>National guidance on learning from deaths requires KCHFT to collect and publish mortality data quarterly via a paper to the Public Board. The quarterly report must include mortality data and learning points. Guidance states this data should include the total number of the Trust’s in-patient deaths and those deaths that the Trust has subjected to case record review. Of these deaths subjected to review, Trusts need to provide estimates of how many deaths were judged more likely than not to have been due to problems in care. The dashboard included has been based on national suggested format. The first quarterly data set covering October to December 2017 was published on the Trust website in February 2018. The second quarterly report went the Mortality Surveillance Group (MSG) in April, then the April Quality Committee. This summary report is for the Trust Board to note in May, and future reports will come in July, November and January to the Trust Board.</p> <p>The MSG will also scrutinise a wider mortality data set provided by Dr Foster which will be reported to Quality Committee along with the Trust quarterly mortality data.</p> <p>As the Board is aware, KCHFT Mortality Review Policy was developed following the recommendations made by the National Guidance on Learning from Deaths (2017). Other national publications were also used to guide the content of the policy. The scope of reviews includes all community hospital inpatient deaths, all deaths in the community under the care of KCHFT’s ‘Home Treatment Service’, any patients who die under our care with serious mental health needs, all children and all patients with learning disability.</p> <p>As defined in the Policy, the Trust Board has overall responsibility for ensuring compliance with all legal and statutory duties, along with best practice including having an overview of the mortality review process and knowledge of the learning that emerges from the reviews that drive improvements in care.</p> <p>The focus of Trust mortality review is intended to be on meaningful learning and sharing ways to improve care.</p>

Proposals and /or Recommendations
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For assurance, and for decision as to whether quarterly reports should be reviewed at Board before being published on the Trust public website which would mean a delay after the end of each quarter.
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Relevant Legislation and Source Documents
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Has an Equality Analysis (EA) been completed?
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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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Dr Sarah Phillips, Medical Director

Tel: 01622 211922

Email: sarahphillips4@nhs.net

**QUARTERLY MORTALITY AND LEARNING FROM DEATHS REPORT
(January to March 2018)**

1. Introduction

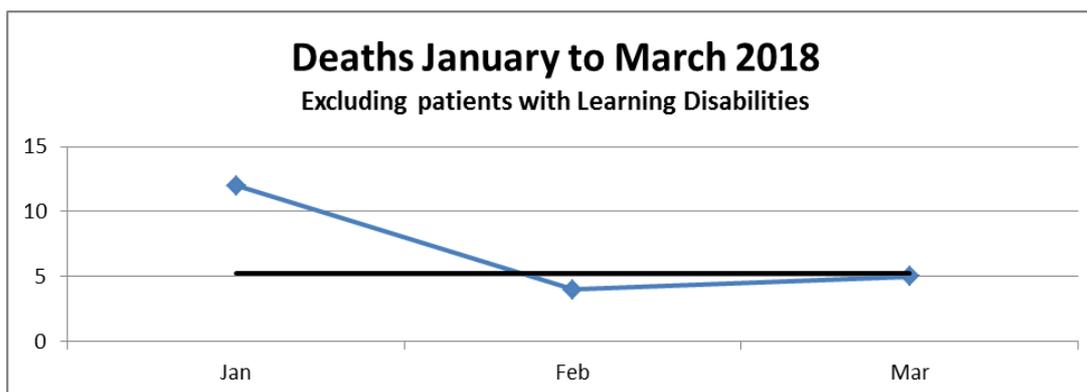
National guidance on learning from deaths requires KCHFT to collect and publish mortality data quarterly via a paper to the Public Board. The quarterly report must include mortality data and learning points. Guidance states this data should include the total number of the Trust’s inpatient deaths and those deaths that the Trust has subjected to case record review. Of these deaths subjected to review, Trusts need to provide estimates of how many deaths were judged more likely than not to have been due to problems in care.

2. March Dashboard

2.1 The dashboard below has been based on national suggested format.

Total Number of Deaths in Scope			Total Deaths Reviewed			Number of deaths judged to be more likely than not due to problems in healthcare	
This Month		Last Month	This Month		Last Month	This Month	Last Month
5		4	2		2	0	0
This Quarter (QTD)		Last Quarter	This Quarter (QTD)		Last Quarter	This Quarter (QTD)	Last Quarter
21		20	14		20	0	0
This Year (YTD)		Last Year	This Year (YTD)		Last Year	This Year (YTD)	Last Year
21		22	14		22	0	0

2.2 The graph below shows the number of deaths per month this quarter along with the average.



3. Learning from Mortality Reviews

3.1 The table below outlines key areas of learning identified in reviews completed this quarter, along with the actions taken. These are also reviewed in the monthly Mortality Surveillance Group.

Learning from Reviews	Comments/Actions
Nursing records on CIS but no doctor's notes in KCHFT documents present when conducting mortality review.	Medical Director has discussed documentation issues with Ward Matron; there are ongoing challenges at Deal including medical cover which are currently being addressed. A task and finish group is planned to examine documentation issues for patients in community hospitals
No written evidence that staff gave bereavement letter to relatives.	This is due to be discussed at the next Mortality Surveillance Group with a view to adding an appropriate place for staff to record this in the patient notes. To form part of the task and finish group scope of work regarding documentation.
Patient stayed too long in hospital (6 weeks) while an appropriate care home was being sourced; during this time the patient deteriorated and died.	Consultant Geriatrician who led this review to feed this back to teams and continue to work with teams on reducing unnecessary LOS and DTOC wherever possible.
Use of term "failed discharge" was used on numerous occasions in notes following discharge from Acute, when a more appropriate term would be "re-admitted."	Consultant Geriatrician who led this review to feed this back to teams to ensure that appropriate term is used.
Doctor's name not recorded against one of the medical entries in the patient notes.	This has been fed back to the Ward Matron at Deal who will remind all doctors to ensure that they record their name against all entries.

3.2 LeDeR Programme Reviews

KCHFT reports all Learning Disability deaths to the national LeDeR programme which looks at all care provided across multiple agencies. At the time of all deaths being reported to LeDeR from KCHFT, none (on preliminary review) have identified problems in care or being attributable to KCHFT

Sarah Phillips
Medical Director
09 April 2018

Committee / Meeting Title:	Board Meeting – Part 1 (Public)
Date of Meeting:	24 May 2018
Agenda Item:	3.5
Subject:	Freedom to Speak Up Guardian Report
Presenting Officer:	Louise Norris, Director of Workforce, Organisational Development and Communications

Action - this paper is for:	Decision	Assurance	x
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<p>Report Summary (including purpose and context)</p> <p>The report provides the Board with a summary of concerns raised by staff under the Freedom to Speak Up Policy from 1 November 2017 to 31 March 2018. These are the concerns logged by the Freedom to Speak Up Guardian.</p>

<p>Proposals and /or Recommendations</p> <p>To receive the report.</p>

<p>Relevant Legislation and Source Documents</p> <p>Freedom to Speak Up Policy</p>
<p>Has an Equality Analysis (EA) been completed?</p> <p>No. High level position described.</p>

Karen Edmunds, Freedom to Speak Up Guardian	Tel: 0300 123 4489
	Email: kchft.speakup@nhs.net

FREEDOM TO SPEAK UP GUARDIAN REPORT

1. Introduction

- 1.1 There are now more than 570 Freedom to Speak Up Guardians and Ambassadors across NHS organisations in England. Some of these are full-time posts, some part-time and some are added to people's day job. In the period up to March 2018, they had dealt with over 3,000 concerns, 1,240 of which related to patient safety issues and over 60 per cent related to unacceptable behaviour, including alleged bullying and harassment¹.
- 1.2 Sir Robert Francis QC has urged NHS Boards and managers to welcome staff raising concerns (whistleblowing), in the same way as staff are encouraged to report incidents. Kent Community Health NHS Foundation Trust's (KCHFT) policy is in line with the national Freedom to Speak Up (Whistleblowing) policy. This says that staff should initially try to raise concerns with their manager or a more senior manager, but if this does not lead to an investigation or action or the staff member feels this will not due to previous experience or other concerns, they can contact the Freedom to Speak Up Guardian for advice and support. It's all about creating a more open culture that puts patient and staff safety at the heart of what we do.
- 1.3 No-one should experience discrimination or be victimised for speaking up, but we know fear of this can prevent staff from doing so. Those who raise concerns via the Freedom to Speak Up process can expect to receive support and advice from the Trust's Freedom the Speak Up Guardian, as will managers with whom the concerns are raised. The role of the Freedom to Speak Up Guardian is to be impartial and ensure that a fair and timely investigation into concerns takes place and that outcomes, actions and learning are shared.
- 1.4 This report covers the period 1 November to 31 March 2018.

2. Summary of cases

- 2.1 Appendix 1 contains a summary of the 17 cases dealt with from 1 November to 31 March 2018, this compares to 11 in the previous six months. Four were informal and 13 required the FTSU Guardian to either escalate or support staff to escalate. The main themes of concerns raised to date are, as with the previous six months:
 - Attitude and behaviour of managers – alleged bullying culture
 - Apparent failure of middle managers to resolve concerns that are raised locally.

¹ Source: National Office of the Freedom to Speak Up Guardian

3. Fostering a culture of openness

3.1 The Freedom to Speak Up Guardian has a key role in fostering a culture of openness. In August, the Trust's Management Committee agreed that the FTSU Guardian could recruit a number of Speaking Up Ambassadors. We now have 16 ambassadors who have completed their induction. Their role is to:

- Encourage colleagues with concerns to speak up, by providing informal advice
- Sign-post to the FTSU Guardian for more formal advice/intervention
- Help to promote positive examples of changes that have occurred as a result of speaking up
- Be willing to speak up in a positive way and thereby be a role model for colleagues.

3.2 Staff who have sought advice from the FTSU Guardian generally express relief that they have been listened to. By being thanked for speaking up and by being assured that they will be supported, staff will begin to feel safer to speak up. A feedback survey has now been launched to ask all people who raise concerns whether given their experience they will speak up in future. This was launched in October 2017 and so far we have had three responses – all three said the support they received was 'very good', two said they would speak up again and one said they did not know.

3.3 There is a form on the Freedom to Speak Up page on flo that has been built in Datix, which allow staff to submit concerns anonymously or to provide their contact details. This form has not been used as people are emailing the FTSU Guardian direct, phoning, or being referred via Staffside.

3.4 The Trust was visited by The National Guardian, Dr Henrietta Hughes on 4 December 2017. Henrietta spoke with Paul Bentley as well as our FTSU Guardian Karen Edmunds and met a number of our ambassadors. She was impressed with our campaign and commitment to freedom to speak up.

3.6 Sarajane Poole, Head of Quality Governance and Professional Standards for Children and Young People, has been appointed as the interim Deputy Freedom to Speak Up Guardian as of 25 April 2018, in the absence of our FTSU Guardian who has been on sick leave since January. In this interim period, ambassadors have been providing vital support.

3.5 The National Office of the Freedom to Speak Up Guardian has surveyed FTSU Guardians and as a result produced a number of recommendations. The report can be viewed in full on their website: www.cqc.org.uk/sites/default/files/20170915_Freedom_to_Speak_Up_Guardian_Survey_2017.pdf

- 3.6 The National Office of the Freedom to Speak Up Guardian has briefed the Care Quality Commission (CQC) and provided guidance to inspectors and FTSU Guardians, as speaking up is now assessed as part of the Well Led domain.
- 3.7 We have reviewed KCHFT's practice against these recommendations to identify areas for improvement.
- 3.8 KCHFT is performing strongly against the majority of the 10 recommendations.
1. **Appointment:** Our FTSU was appointed rather than applied for the role. In other trusts, individuals were interviewed, and *appointment of a deputy could be done this way in future.*
 2. **Potential conflicts of interest:** All guardians and ambassadors, as requested do reflect on the potential conflicts that holding an additional role could bring. None of our 16 ambassadors hold roles in human resources. The number of ambassadors means that should a conflict of interest arise, another ambassador could support. *Appointing a non-executive director as a champion would strengthen alternative mechanisms.*
 3. **Local networks:** In Karen's Edmunds absence, we now have Sarajane Poole as an interim Deputy Freedom to Speak Up Guardian. Our network of ambassadors are from a range of staffing groups, clinical and non-clinical and a range of grades from Bands 2 to 8 to provide assurance that all staff have appropriate support and opportunity to speak up.
 4. **Diversity:** Our Speaking Up Ambassadors are diverse in age, but *not in ethnicity.* We have not yet asked for equality monitoring data. Staff were asked to volunteer for the training. There was no formal application form as we wanted busy clinical staff to be able to volunteer without adding to their workload.
 5. **Communication and training:** While we have a campaign and a range of campaign materials to support Freedom to Speak Up, the recent We Care Reviews suggest more needs to be done to raise the *profile of the role.* This has been a challenge in recent months with the absence of our guardian, but now a deputy is in place this can be re-launched. All induction training is evaluated, in line with this recommendation, and FTSU is included in corporate induction.
 6. **Partnership:** Our FTSU Guardian has been visiting team meetings on request to raise the profile of the role and develop good working relationships with all parts of the organisation, meeting regularly with Head of Employee Relations, Staffside, and the staff networks.
 7. **Access to senior leadership:** Our FTSU guardian has a bi-monthly meeting with the chief executive to discuss themes of recent cases.
 8. **Board reporting:** All FTSU cases are reported to the Board by the Director of Workforce, Organisational Development and Communications on behalf of the FTSU guardian. As recommended, the report includes measures of activity and impacts.

9. **Feedback:** A feedback survey is sent to everyone who raises a case with the FTSU guardian.
10. **Time:** The FTSU is given time to attend training and balances this against her existing role as head of engagement. This can be challenging at times. *Making the interim Deputy Freedom to Speak Up Guardian a permanent role could help support this on the Freedom to Speak Up Guardian's return.*

4. Recommendation

The Board is asked to note the report.

Julia Rogers on behalf of Karen Edmunds
Freedom to Speak Up Guardian
9 May 2018

Committee / Meeting Title:	Board Meeting - Part 1 (Public)
Date of Meeting:	24 May 2018
Agenda Item:	3.6
Subject:	Comprehensive Information Governance Report
Presenting Officer:	Natalie Davies, Corporate Services Director

Action - this paper is for:	Decision	<input type="checkbox"/>	Assurance	x
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<p>Report Summary (including purpose and context)</p> <p>Effective information governance is required to underpin confidential and secure patient care and provide the assurance required to address accessibility and transparency agendas.</p> <p>Kent Community Health NHS Foundation Trust (the Trust) continues to develop an Information Governance framework that delivers the necessary systems, processes and behaviours that support improved capture and sharing of information, whilst at the same time ensuring that those elements of IG relating to the secure and appropriate handling of confidential and sensitive information are also satisfied.</p> <p>This report has been prepared to provide assurance that the Information Governance Team has evidenced year on year improvements for the Trust in terms of compliance, performance against national benchmarks and through independent audit.</p>

<p>Proposals and /or Recommendations</p> <p>The Board is asked to continue championing IG throughout the organisation, through dissemination of positive messages and continued engagement with the training, policies and procedures.</p> <p>To note the forthcoming changes during 2017/18 to data protection regulations and full implementation of the GDPR by May 2018 and to ensure all services are aware of, and continue to develop their understanding of the new requirements.</p> <p>To note the level of compliance for the annual toolkit assessment, at 89%, and training compliance for the year ending 31 March 2018 at 88.5%.</p> <p>To note the level of substantial assurance, with no further recommendations, provided by TIAA following the mandatory annual IG Audit</p>

<p>Relevant Legislation and Source Documents</p> <p>GDPR, NHS Digital Information Governance Toolkit Assessment, Data Protection Act 1998 and Freedom of Information Act 2000</p>
<p>Has an Equality Analysis (EA) been completed? No. High level position described and no</p>

[Type text]

decision required.

Natalie Davies, Corporate Services Directorate

Tel: 01622 211904

Email: natalie.davies1@nhs.net

INFORMATION GOVERNANCE ANNUAL REPORT 2017/18

1. Introduction

Effective information governance is required to underpin confidential and secure patient care and provide the assurance required to address accessibility and transparency agendas.

Kent Community Health NHS Foundation Trust (the Trust) continues to develop an Information Governance (IG) framework that delivers the necessary systems, processes and behaviours that support improved capture and sharing of information, whilst at the same time ensuring that those elements of IG relating to the secure and appropriate handling of confidential and sensitive information are also satisfied.

This report has been prepared to provide assurance that the IG team has evidenced year on year improvements for the Trust in terms of compliance, performance against national benchmarks and through independent audit.

Furthermore the last year has seen extensive progress in revising policy and processes to effectively embed revised data protection legislation and data security principles, thus improving the rights of individuals accessing KCHFT services and improving the level of compliance in all those undertaking work on behalf of the Trust.

2. General Data Protection Act Regulation (GDPR)

A report was presented to the Audit and Risk Committee (February 2018) and the Board (March 2018) providing assurance on the level of compliance with the new regulation.

At the time of this report the Data Protection Act 2018 has still not been published. It is expected that the DPA18 will ensure continuity by putting in place the same data protection regime in UK Law, it will however be necessary to view both the GDPR and DPA 18 side by side in order to see the complete picture.

Enforcement of the GDPR will begin on the 25 May 2018. The national laws implementing the Directive in the UK will continue to apply until then.

The GDPR makes many important changes to EU data protection law, but it is not a complete departure from existing principles. Many of the concepts KCHFT is familiar with will continue to apply under the GDPR. KCHFT is therefore in a strong position in regard to data protection as it has, for many years had to demonstrate compliance with the law and NHS best practice. This position was supported with an external audit of current position in June 2016.

Over the last two years there has been a significant amount of work undertaken, looking at consent, communication, training, documentation, systems and documenting our accountability requirements. Whilst there is still work to do, while GDPR and UK law continue to evolve, KCHFT are able to demonstrate robust compliance.

Key stakeholders and experts in data protection, records management, information and cyber security, contracts and HR (all of whom are members of the IG Assurance Group) have focussed their efforts in the following areas:

- ensuring all staff are actively engaging with new local, national and EU guidance;
- training programmes for all staff;
- communicating changes with staff and patients in a simple and concise way;
- reviewing current legal basis for information sharing;
- ensuring privacy notices and information leaflets for both adults and children are in an easy to read format and accessible;
- producing an accountability database for KCHFT to demonstrate compliance to the Information Commissioners' Office (ICO);
- updating policies and processes;
- ensuring data subject rights are established and enforced;
- updating contractual documentation to ensure both data controller and processors are aware of their responsibilities; and,
- reviewing and updating all communication materials, policies and guidance.

3. **National Data Guardian - Data Security Standards**

There are 10 new data security standards the organisation are mandated to work to which are based around leadership, roles, responsibilities, processes and technology. The standards are the basis of the new Data Security and Protection assessment and are included in the revised Cyber, Network and Information Security Policy, which will be published by the 25 May 2018.

1. **Senior Level Responsibility:** There must be a named senior executive to be responsible for data and cyber security in the organisation. Ideally this person will also be the Senior Information Risk Owner (SIRO), and where applicable a member of the organisation's Board.
2. **Completing the Information Governance Toolkit:** In 2017/18, organisations are still required to achieve at least level two on the current IG Toolkit before it is replaced with a new approach (the new Data Security and Protection Toolkit), from 2018/19 onwards, to measuring progress against the 10 data security standards.

3. **Complete the General Data Protection Regulation Checklist:** NHS Digital will publish a checklist to support organisations in implementing the requirements of the General Data Protection Regulation which they will be required to comply with from May 2018. Organisations must complete this checklist to ensure they will be able to meet their legal obligations from May 2018, see Appendix A.
4. **Training Staff:** All staff must complete appropriate annual data security and protection training. This training replaces the previous Information Governance training while retaining key elements of it. It contains new sections on cyber security. Note: further discussions are being had with TIAA to review the current training programme to evaluate content and appropriateness.
5. **Acting on CareCERT advisories:** Organisations must act on CareCERT advisories where relevant to the organisation and confirm within 48 hours that plans are in place to act on High Severity CareCERT advisories, and evidence this through CareCERT Collect. They must identify a primary point of contact for the organisation to receive and coordinate the organisation's response to CareCERT advisories, and provide this information through CareCERT Collect.
6. **Continuity planning:** A comprehensive business continuity plan must be in place to respond to data and cyber security incidents.
7. **Reporting incidents:** Staff across the organisation report data security incidents and near misses, and incidents are reported to CareCERT in line with reporting guidelines.
8. **Unsupported systems:** The organisation must identify unsupported systems (including software, hardware and applications) and have a plan in place by April 2018 to remove, replace or actively mitigate or manage the risks associated with unsupported systems.
9. **On-Site Assessments:**
The organisation must undertake an on-site cyber and data security assessment if invited to do so by NHS Digital and act on the outcome of that assessment, including any recommendations, and share the outcome of the assessment with the commissioner.
10. **Checking Supplier Certification:** The organisation should ensure that any supplier of IT systems (including other health and care organisations) and the system(s) provided have the appropriate certification.

4. **Information Governance Toolkit Assessment (IGTA)**

The Trust uses the IGTA to measure its performance against IG requirements, and to confirm whether information is handled correctly, and protected from unauthorised access, loss, damage and destruction. The IGTA is based on an annual self-assessment with a performance based and year-end submission to the Department of Health.

The Trust has achieved a minimum level two performance across all requirements, with many areas attaining level 3. An important aim of the assessment is to demonstrate that the Trust is able to maintain the confidentiality and security of personal information, which in turn will increase public confidence.

The Trust's position has improved during 2017/18 to 89% compliance when compared to 2016/17, which was submitted at 88%.

The assessment for 2018/19 has been significantly overhauled and will focus primarily on electronic records, security, data protection, cyber security, awareness and training, together with system access controls, network security and associated security controls to protect the Trust from cyber-attacks. KCHFT have been fortunate to be involved in early testing and review with the opportunity to shape the new assessment when it is published in April 2018.

In addition there is also a new Directive on Security of Network and Information Systems (NIS Directive) ((EU) 2016/1148) which aims to achieve a high common level of network and information systems security across the EU in three ways:

- Improving cyber security capabilities at the national level.
- Increasing cooperation on cyber security among EU member states.
- Introducing security measures and incident reporting obligations for operators of essential services (OESs) in critical national infrastructure (CNI) and digital service providers (DSPs).

The KCHFT Cyber Security Specialist will provide assurance in regard to this Directive which was adopted by the European Parliament on 6 July 2016, and entered into force in August 2016. EU member states have until 9 May 2018 to transpose it into national laws.

5. **Information Governance Assurance Group (IGAG)**

The IGAG assures the Trust that data protection, confidentiality, information quality, records management, information security and the General Data Protection Regulation is effectively incorporated within the broader IG work-plan.

In conducting its work the Group develops and annually reviews the Information Governance Management Framework (IGMF) together with ensuring that the Trust has effective policies, procedures and management arrangements covering all aspects of IG in line with the overarching IGMF.

The group provide regular exception reports to the Corporate Assurance and Risk Management Group (CARM), which includes reporting to the Senior Information Risk Owner (SIRO) and the Caldicott Guardian (CG).

6. Information Governance Management Framework (IGMF)

In September 2017 the IGMF was reviewed and updated in accordance with the requirements of the IGTA. The IGMF was simplified through signposting to further information and updating of key personnel responsibilities.

7. Information Governance Training

Information Governance Training is mandated by the Department of Health and used to support evidence within the IGTA. Compliance with the training requirement is also a factor which the Information Commissioner's Office takes into account in any dealings with the Trust, as it is seen as an indicator of an organisation's IG and records management maturity.

The Board sets a compliance target of 85% of available staff, to account for long term sick leave, maternity leave and staff on secondment, and as of the 31 March 2018 the percentage of staff who have completed the training was 88.5%.

In 2017 NHS Digital commissioned a new e-learning IG Training Tool, however the new e-learning was considered by the IGAG members, and the Strategic Information Governance Networking Group (SIGN) to be too long and too complex for a majority of staff. A comparison was undertaken with the current IG assessment and it was found to contain all of the areas included in the e-learning but in a more concise way. The assessment is based on scenarios using real life events within the Trust to support learning from incidents and best practice. IG will continue to work with the Learning and Development team to ensure staff continue accessing the local IG assessment to maintain high levels of training compliance in the coming months. It has also been made a recommendation that TIAA independently audit the IG training programme, including the new Cyber Security elements in Q1 2018/19, to provide written assurance on the quality of the training delivered.

8. Annual IG Audit – TIAA

The annual mandatory audit was undertaken in two parts. The initial review in December 2017 and the follow up assurance work in February 2018.

The final audit report was published in January and the overall opinion was substantial assurance with no further recommendations, for the third year in a row.

9. Information Governance Internal Audits

In addition to the audit undertaken by TIAA the IG team have also conducted internal audits to provide assurance on compliance with, and implementation of, IG policies, processes, legislation and best practice.

During 2017/18 a total of 19 audits have been undertaken, primarily focussed on Specialist and Elective Services. The IG Team continues to work with services to ensure that any recommendations are implemented and compliance improved. Of these 6 have been awarded significant assurance and 13 have limited assurance with outstanding actions. Where limited assurance has been reported the service managers are aware of a time-limit to address any concerns and IG continue to support them in becoming fully compliant within a stipulated timeframe.

10. Information Governance Incidents

The table below reflects all IG incidents (actual and near miss) for the period April 2017 to March 2018 with a comparative summary for the previous year. Information was extracted on 24 April 2018.

From April 2017 to the end of March 2018 there has been an increase in overall incidents reported and specifically an increase in number of actual incidents reported. Analysis shows that breach of confidentiality incidents were the most reported. However, looking at the Services that reported the highest number of confidentiality incidents since April 2017 showed no significant trend (23 incidents from April to March being the highest number for a Service).

IG incidents are discussed at each IG Assurance Group. Analysis of the incidents showed that these are being reported by long-standing members of staff dispelling the theory that new starters were causing these incidents by lack of training and awareness within their role.

Apr 2016	May 2016	Jun 2016	Jul 2016	Aug 2016	Sept 2016	Oct 2016	Nov 2016	Dec 2016	Jan 2016	Feb 2016	Mar 2016	Total
57	46	42	49	51	53	42	43	35	39	49	55	561
Apr 2017	May 2017	Jun 2017	Jul 2017	Aug 2017	Sep 2017	Oct 2017	Nov 2017	Dec 2017	Jan 2017	Feb 2017	Mar 2017	
44	78	73	98	89	76	75	69	56	69	54	34	815

The total number of near miss incidents for the financial year was 566. The total number of actual incidents for this period was 249, which is a 27% increase on the same period last year.

The highest number of incidents by type was data quality (267) which included near miss and actual incidents. This led to 173 actual incidents of breaches of confidentiality which are defined as information going outside the Trust to the incorrect recipient e.g. letters or reports going to the wrong GP surgery, patient address, third party companies / emails going to the wrong address.

The following controls were put in place by the IG team to reduce the number of incidents from occurring.

- Direct liaison with the Service where there was insufficient detail in the management investigation to show why the incident happened and the lessons learned. This ensures that Services are disseminating the lessons to the team and that IG controls are tightened;
- Articles in the monthly IG newsletter highlighting bad practice and lessons learned; and
- Take the time, every time campaign – reminding staff to check data this includes blogs on the IG workspace and screen savers

The following controls have been put in place by these services to reduce the number of breach of confidentiality incidents from occurring:

- Speaking to staff involved (individuals and team where appropriate)
- Changes and/or additions to existing local procedures

11. **Information Governance Serious Incidents Requiring Investigation**

During 2017/18 there have been three Serious Incidents reported to the Information Commissioner's Office (ICO), however one was withdrawn as the investigation uncovered that the information belonged to East Kent Hospitals University NHS Foundation Trust. The second incident (June 2017) involved a box of Trust person identifiable information being found in an alleyway. The clinician responsible for leaving the information in the public domain was on annual leave prior to her last day with the Trust, as she had resigned. The case was referred to the clinician's professional body for appropriate action and no further action was taken by the ICO against the Trust. The final incident (March 2018) involved the inappropriate disclosure of information on a database to a software development company, whilst the recipient was correct the information sent was not and the email was insecure. The Root Cause Analysis report is being prepared and the incident reported to the ICO.

12. **Records Management**

In preparation for the new GDPR regulations, the team has drafted a comprehensive information asset register following guidance from the ICO. It now provides a snapshot of how much information (electronic and paper) we currently hold and where and the current technical/organisational security measures or contracts in place for each. This register will be maintained annually by the IGAG and key stakeholders from across the Trust.

It is envisaged that the management of clinical records will become far more efficient in the long term. The residual paper records currently stored in over 50,000 archiving boxes centrally will be reviewed and destroyed over the coming years in line with national retention guidelines to reduce the Trust's archiving budget further.

The IG team have continued to support a number of teams moving from sites in line with the Estates CIP Strategy. This has involved archiving a significant number of records as well as visually checking vacated sites to assure that no confidential information left behind which could lead to fines from the ICO.

Despite a 32% rise in Freedom of Information requests between January and December 2017, 99% were responded to within statutory timescales. This is an improvement compared to the same period in 2016 which saw 94% responded to within the timescales. Two Freedom Of Information appeals were received during 2017, internally reviewed and in both cases the original response was upheld. A further complaint has been received in February 2018 and again, following internal review, the correct process was followed for the original request.

13. **Privacy Impact Assessments (PIA)**

Privacy impact assessments (PIAs) are a tool to identify and reduce the privacy risks in any projects that information personal information. A PIA can reduce the risks of harm to individuals through the misuse of their personal information. It can also help to design more efficient and effective processes for handling personal data.

PIAs are currently a requirement of the Information Governance Toolkit, and will become law in May 2018 under the new Data Protection legislation. All Services must be aware of the need to complete this tool for the Trust to remain compliant with the law. The IG team will be launching a campaign in the coming weeks to raise awareness.

In 2017/18 there were 26 PIAs completed, which is a 50% increase on the same period last year, with a further nine currently in draft. Six were not required after the initial screening questions were completed and liaison with the IG team.

14. **NHS Mail 2**

2016 saw the transition of the secure NHS Mail facility to NHS Mail 2. The new and improved service resulted in larger capacity in-boxes and a host of other new facilities all of which are now available to staff. IG continue to enforce the Trust policy of sharing all personal confidential information via NHS mail and take all breaches of this policy seriously. All employees of the Trust are encouraged to manage their inbox appropriately to ensure capacity is not affected by poor records management. Following the decommissioning of the kentcht.nhs.uk accounts in February 2018 NHS Mail 2 is now the sole email facility for the Trust.

15. Information Risks and Senior Information Risk Owner (SIRO)

The role of SIRO is held by the Corporate Services Director. The deputy SIRO is the AD Compliance and is also the Chair of the IGAG. Reporting of all IG risks is via the Corporate Assurance and Risk Management Committee (CARM) and IG risks are also discussed at the IGAG.

The SIRO takes ownership of the Information Risk Policy, acts as advocate for information risk on the Board and provides written advice to the Accountable Officer and regularly receives a risk report at the Corporate Assurance and Risk Committee, which relates specifically to IT and information risks reported by the Information Asset Owners. The IG Compliance Manager also reports risks identified through the mapping of data flows in and out of the organisation.

16. Caldicott Guardian (CG)

Until the 28 February 2018 the operational CG was Dr Raj Nandi. During February the Director leadership for Caldicott Guardian transferred from the Medical Director to the Chief Nurse. The operational lead is George Noble, Consultant Community Physician. These revised arrangements have been formally recorded with the Department of Health and the Chief Nurse will be receiving appropriate training in the coming weeks.

17. Data Protection Officer (DPO)

In line with the revised data protection legislation the DPO role has been assigned to the Assistant Director for Compliance and training undertaken in April 2018.

18. Customer Services Feedback

An objective set for all support services is to request feedback on the quality and standard of the services offered and received. IG has developed a very concise satisfaction survey and has asked services to contribute to it. <https://www.surveymonkey.com/r/R8DRD5L>. The responses to date are:

- Customer services : Excellent / Very good – 100% (improved 16% on 16/17)
- Responsiveness: Excellent / Very good – 80% (reduced by 6% on 16/17)
- Knowledge: Excellent / Very good – 100% (improved 8% on 16/17)
- Training: Excellent / Very good – 100% (improved 12% on 16/17)
- Support: Excellent / Very good – 100% (improved 16% on 16/17)

19. Recommendations for the Board

The Board is asked to continue championing IG throughout the organisation, through dissemination of positive messages and continued engagement with the training, policies and procedures.

To note the forthcoming changes during 2017/18 to data protection regulations and full implementation of the GDPR by May 2018 and to ensure all services are aware of, and continue to develop their understanding of the new requirements.

To note the level of compliance for the annual toolkit assessment, at 89%, and training compliance for the year ending 31 March 2018 at 88.5%.

To note the level of substantial assurance, with no further recommendations, provided by TIAA following the mandatory annual IG Audit.

Natalie Davies
Corporate Services Director/Senior Information Risk Owner (SIRO)
May 2018

Committee / Meeting Title:	Board Meeting - Part 1 (Public)
Date of Meeting:	24 May 2018
Agenda Item:	3.7
Subject:	Emergency Planning and Business Continuity Annual Report
Presenting Officer:	Natalie Davies, Corporate Services Director

Action - this paper is for:	Decision	<input type="checkbox"/>	Assurance	<input checked="" type="checkbox"/>
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<p>Report Summary (including purpose and context):</p> <p>This report is to provide assurance to the Board that plans and systems are in place to meet the Trust's obligations with respect Emergency Preparedness, Resilience and Response and relevant statutory obligations under the Civil Contingencies Act 2004. The report sets out the Trusts state of readiness to respond to major incidents and disruptive events that impact on the delivery of services and performance.</p>
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<p>Proposals and /or Recommendations:</p> <p>The Board receives assurance of Kent Community Health NHS Foundation Trust's state of preparedness.</p>

<p>Relevant Legislation and Source Documents:</p> <p>Civil Contingencies Act 2004. NHS England Emergency Preparedness Framework 2013</p>
<p>Has an Equality Analysis been completed?</p> <p>No. High level position described and no decision required.</p>

Natalie Davies, Corporate Service Director	Tel: 01622 211900
	Email: natalie.davies1@nhs.net

EMERGENCY PREPAREDNESS RESILIENCE AND RESPONSE (EPRR)

ANNUAL REPORT APRIL 2017 – MARCH 2018

1. Introduction

This report describes the work undertaken in 2017/18 on the Trust's emergency preparedness in order to meet the requirements of the Civil Contingencies Act (CCA) 2004 and the NHS England Emergency Preparedness Framework 2015

The Trust has a mature suite of plans to deal with Major Incidents and Business Continuity issues. These conform to the CCA (2004) and current NHS guidance. All plans have been developed in consultation with partner organisations to ensure cohesion with their plans.

The report covers the following;

- The training and exercising programme delivered
- The continuing development of the emergency planning arrangements
- A summary of incidents the Trust has responded to

2. Risk Assessment

The CCA (2004) places a legal duty on responders to undertake risk assessments and publish risks in a Community Risk Register. The purpose of the Community Risk Register is to reassure the community that the risk of potential hazards has been assessed, that preparations are undertaken and that response plans exist. Those risks currently identified on the Kent Community Risk Register with a rating of very high include;

- Influenza-type disease (pandemic)
- Flooding
- Severe weather

As a result of risk assessments with internal services there has been progress made across services in pursuing the necessary actions to control and mitigate the risks. The Head of EPRR and the Resilience Officer have developed a close working relationship with services and assisted in the development of service level business continuity plans including detailed information on the Recovery Time Objectives and the Maximum Tolerable Period of Disruption for Information Technology across services.

Within this reporting period the Trust has met four times at the combined On Call/EPRR meeting. Attendance by relevant managers/staff at these meetings

has improved throughout 2017-18, senior management support is in place to ensure appropriate attendance at these meetings.

3. Compliance

EPRR remains a key priority for the NHS and forms part of the NHS Commissioning Board Framework (Everyone Counts; Planning for Patients), the NHS Standard Contract and the NHS Commissioning Board Emergency Planning Framework (2015).

A set of core standards for EPRR have been in place since April 2013. All organisations who receive NHS funding are asked to carry out a self-assessment against the NHS Standards for EPRR. KCHFT completed this exercise on August 29 and NHS England agreed with KCHFT's assessment that it was successful in meeting all of the requirements for rewarding 'substantial compliance' consistent with last year's assessment.

4. Partnership working

The Trust works in collaboration with a range of partner agencies through formal standing meetings and ad hoc arrangements. Formal committees of which the Trust is a member include the Kent and Medway Local Health Resilience Partnership (LHRP). The purpose of this group is to ensure that effective and coordinated arrangements are in place for NHS emergency preparedness and response in accordance with national policy and direction from NHS England – South, South East.

The LHRP work plan is delivered by the Trust as required. An area of responsibility agreed at the LHRP for the Emergency Preparedness leads across the county is accountability to the local authorities for the medical risk assessment of community events taking place; the Head of EPRR is responsible for the Dover authority.

5. Planning

5.1 Major Incident Plan

The Major Incident Plan is reviewed annually to ensure it continues to accurately reflect the role of the Trust in a major incident and how this role fits with the plans of other NHS organisations and the emergency services. The Major Incident Plan was reviewed in August 2017 and ratified by the Corporate Assurance Risk Management Committee on behalf of the Executive Management Team.

5.2 Emergency Resilience and Business Continuity Policy

The Emergency Resilience and Business Continuity Policy outlines how the Trust will continue to discharge core functions in the event of disruption to business operations. Each service has its own Business Continuity Plan which is reviewed annually. There is a rolling programme of review and work completed with the Minor Injury Units and the Community Teams and Hospitals.

5.3 Heatwave Plan

The Heatwave Plan for the Trust was updated as required for 2017. The Trust received health watch alerts for the period 1 June - 15 September 2017 and remained at Level 1 preparedness throughout this period. The plan allows for escalation of operational services, and specific actions would be implemented to safeguard patients and staff as necessary.

5.4 Lockdown Policy

The Trust is required to have lockdown plans for appropriate sites, such as the Community Hospitals. The Head of EPRR has developed a Lockdown policy and working collaboratively with the Head of Health, Safety and Security to embed this in to the Trust. The Trusts seven Minor Injuries Units are located on National Health Service Property Services (NHSPS) sites, the aim of each of these is to develop and embed multi occupancy Lockdown Plans, this has proved challenging with lack of engagement from NHSPS.

6. Training and Exercising

In order to comply with our obligations the Trust must undertake a number of emergency preparedness activities; these include a robust training programme facilitated by the Head of EPRR, in the current year the Kent Resilience Forum (KRF) facilitated the annual seminar with a focus on response of services following the major incidents in the United Kingdom in 2017, these included the Manchester arena attack and the Grenfell fire incident. KCHFT was widely represented with attendance from senior managers.

A rolling programme of exercises designed to test and develop our plans are undertaken. These are:

- a communication test every six months
- a desktop exercise once a year
- a major live exercise every three years

A gap analysis identified Hotel Services requiring EPRR training, therefore two training events have taken place in January and March 2018, feedback has been positive and developed interest amongst this group of staff with respect to EPRR.

The Head of EPRR in partnership with the Emergency Planning Officer from Maidstone and Tunbridge Wells NHS Trust facilitated training for staff employed in the Minor Injuries Unit (MIUs) on the management of a patient presenting with a possible radiation injury, This training has been cascaded to staff working in the MIU departments in preparation for the live exercises planned to take place from April 2017.

As part of Business Continuity (BC) week commencing 15 May 2017 the EPRR team met with staff at Trinity House, staff undertook a questionnaire and were allowed the opportunity to discuss BC and the impact on individual services. The learning from this will be evaluated by the EPRR team and used to develop BC awareness.

7. Exercises

To comply with the Emergency Preparedness Framework the Trust undertook a programme of exercises in 2017 as follows;

Live no notice exercises at the seven Minor Injury Units tested the response of a patient presenting with exposure to radiation.

A table top exercise on the 17 March 2018 involving Public Health England and other partner agencies, the aim was to test the Kent Surrey and Sussex Outbreak Control and the Kent and Medway LHRP Mobilisation of NHS Resources for responding to Health Protection Incidents and Outbreaks Plans.

East Kent On call managers and three on call directors for the Trust participated in a table top exercise on 13 October 2018 to test the response to a hospital evacuation, there were lessons identified for all staff who attended and these were shared across the Trust.

Live planned exercise of the Gravesham and Trinity House Incident Control Centres (ICC) took place in August and November, the appetite for this from the staff who attended demonstrated an assurance of professionalism, and lessons identified were documented in the report and shared with staff.

The EPRR team facilitated a table top exercise on 15 November 2018 attended by staff from the pharmacy department, the focus of this was the coordination of a mass distribution of antibiotics and how this would be managed, and lessons identified demonstrated the importance of this exercise and enhanced staff learning.

A high level rescue in association with Kent Fire and Rescue (KRFS) took place at Gravesham Hospital in November; the exercise allowed learning to be identified for KRFS and Gravesham Hospital. A live casualty was replaced with a 'dummy' for the rescue; the exercise was valuable to allow KRFS the opportunity to apply learning.

The Trust has exceeded these requirements in 2017/18.

8. Incidents

Throughout the year there have been a number of failures across the Trust which has involved implementation of Service Level Business Continuity arrangements.

On the 12 May 2017 parts of the NHS IT infrastructure were infected by a Cyber-attack. The Trust was not affected however over the weekend 13–14 May 2017 an incident response team was activated to manage the on-going works which took place within IT. There were no risks to patients and no reputational damage reported. NHS England requested data capture following on from this until the 19 May 2017.

The dental service in London experienced an evacuation of Vicarage Fields Shopping Centre and Car Park on the 24 May 2017, the Health Centre is adjacent to this facility, staffs were made aware of this incident from patients attending the clinic, all services were resumed after a short period following evacuation, staff and patients were reported as safe.

Manchester arena experienced a terrorist attack on the 22 May 2017, at this time the threat level for the United Kingdom was 'Severe', following on from this the threat level was increased to 'Critical' and remained as such for four days before returning to 'Severe'. At the time of 'Critical' NHS England convened a Strategic Coordination group and requested data across the health economy, there was no immediate impact on Trusts in Kent. Additional communication was sent to staff reminding them of Trust security procedure, this was facilitated with the on call press team and the on call managers, and the assurance was then communicated to NHS England and shared with partners.

On the 21 June 2017 Tonbridge Cottage Hospital underwent a generator test; however this caused a failure of the boilers and the fire panel. This critical incident evoked business continuity arrangements, and resolved after three days. There was no harm to the patients and no known reputational damage. Lessons identified from the incident involve an external partner responsible for maintenance of the building; this and other incidents involving this organisation are currently being investigated by the Corporate Service Director. Internal lessons learnt involve the escalation of information following an incident; this

requires staff education and can be addressed through staff training and awareness.

On the 24 August 2-18 the Trust was made aware of an individual displaying signs of Hepatitis A. This individual worked and lived on a farm and was subsequently admitted into hospital. The remaining 350 farm workers were to be offered the Hepatitis A vaccine; however the planning for such was limited to a few days. NHS organisations/Trusts and Public Health England participated in the successful planning and delivery of the vaccines, a formal debrief led by NHS England was held and lessons identified was shared at the next Local Health Resilience Partnership (LHRP) meeting.

On the 11 December 2017 the Trust was made aware of a Meningitis outbreak in Northfleet, alongside Public Health England the Trust successfully administered oral antibiotics to 60 children and 15 adults with only a few hours to achieve this target, following on from this the Trust vaccinated the same number, and a second booster vaccination clinic was carried out on the 24 January 2018. An internal debrief took place on 11 January 2018 and an external debrief 19 January 2018.

A confirmed Hepatitis A case was reported to the Trust on 5 February 2018 in the Folkestone area, after a meeting with Public Health England (PHE) and other partners it was agreed to vaccinate sixty year one children, this took place on 9 February 2018.

9. Summary

The Trust continued to develop its resilience arrangements throughout 2017/18 in 2018/19 this work will continue, ensuring the Trust maintains the ability to respond to emergencies and business continuity incidents.

Lessons learned and good practice have been identified and shared amongst staff. On-going embedding of the EPRR arrangements remains a key priority.

The focus for the continued development of the service in 2018/19 will be;

- To maintain compliance with the EPRR requirements
- To continue the planned works in respect of Lockdown
- To facilitate exercises for Clinical and Non Clinical Services

The Board is asked to note the progress of the service in 2017/18 and endorse the work programme for 2018/19.

Jan Allen
Head of Emergency Preparedness, Resilience and Response
02 May 2018



Kent Community Health
NHS Foundation Trust

Committee / Meeting Title:	Board Meeting - Part 1 (Public)
Date of Meeting:	24 May 2018
Agenda Item:	3.8
Subject:	Staff Survey Report
Presenting Officer:	Louise Norris, Director of Workforce, Organisational Development and Communications

Action - this paper is for:	Decision	Assurance	X
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<p>Report Summary (including purpose and context)</p> <p>Kent Community Health NHS Foundation Trusts' performance improved in one key finding which related to support from immediate manager. This demonstrates that the devolvement culture programme is having an impact.</p> <p>In total, 2,953 colleagues participated in the survey, which is a response rate of 62 per cent. This was a 7% increase from 2016.</p> <p>It revealed that our staff are more confident in reporting most recent cases of harassment, bullying or abuse than the average community trust (57%). 92% of our staff believe that the organisation provides equal opportunities, again higher than the average community trust. Staff confidence in reporting errors, near misses or incidents witnesses in the last month is high at 95%.Futhermore our staff report than the fairness and effectiveness of the procedures for reporting errors, near misses and incident is higher than for the average community trust. Whilst our staff work extra hours this is below the national average at 68%.</p> <p>Our overall staff engagement scored stayed the same as it was in 2015 at 3.78. In fact, the trust had many key findings that remained unchanged or, in some cases improved, where nationally, scores fell for comparable organisations.</p> <p>In 29 out of 32 key findings the trust was rated average or above. There was only three key finding where the trust was below average, compared nationally with other similar providers; which was around staff feeling unwell due to work related stress in the last 12 months, percentage of staff experiencing discrimination at work in the last 12 months and percentage of staff satisfied with opportunities for flexible working patterns.</p> <p>There are 17 community trusts in the country. We ranked 7th based on the survey results.</p>

2017-2018 Ranking	+/-	Community Trust Name
1	1	Cambridgeshire Community Services
2	1	Derbyshire Community Health Services FT
3	-	Sussex Community FT
4	4	Central London Community Healthcare
5	1	Hounslow & Richmond Community Healthcare
6	11	Lincolnshire Community Health Services
7	2	Kent Community FT
8	3	Shropshire Community Health
9	2	Hertfordshire Community
10	3	Leeds Community Healthcare
11	1	Wirral Community FT
12	2	Birmingham Community Healthcare FT
13	3	Norfolk Community Health & Care
14	1	Liverpool Community Health
15	6	Bridgewater Community Healthcare FT
16	12	Staffordshire and Stoke-on-Trent Partnership
17	5	Gloucestershire Care Services

Proposals and /or Recommendations

The Board is asked to note the results of the 2017 Annual Staff Survey.

Relevant Legislation and Source Documents

Has an Equality Analysis (EA) been completed?

No. This paper is for assurance only.

Louise Norris, Director of Workforce,
Organisational Development and
Communications

Tel: 01622 211905

Email: louisenorris@nhs.net

STAFF SURVEY REPORT 2017

1. Introduction

1.1 This report presents a summary of the findings of the 2017 National NHS Staff Survey conducted by Kent Community Health NHS Foundation Trust (KCHFT).

2. Results of the National Staff Survey 2017

2.1 All participating organisations must follow a standard methodology and must fulfil minimum requirements.

2.2 KCHFT decided to undertake a full census of staff for the 2017 survey which meant that 4801 staff were issued with a self-completion questionnaire. Like 2016 the full census data was used to enable benchmarking with similar organisations to take place. The results from the KCHFT questionnaires were used by the Picker Institute Europe to benchmark KCHFT with 17 other community trusts across England. These results are publicly available and used by the Care Quality Commission when assessing organisations relating to compliance with essential standards of quality and safety. The survey also demonstrates our delivery against the NHS Constitution.

2.3 The results are summarised and presented in the form of the 32 national Key Findings. The 32 Key Findings are structured under nine headings:

- Appraisal and support for development
- Equality and diversity
- Errors and incidents
- Health and wellbeing
- Working patterns
- Job satisfaction
- Managers
- Patient care and experience
- Violence, harassment and experience

The detailed report of the 2017 sample survey results for KCHFT can be downloaded from: www.nhsstaffsurveys.com

3. Key Findings of the 2017 survey results based on the KCHT census

3.1.1 Response Rate

Of the 4801 questionnaires sent out, 2953 staff surveys were returned. The response rate for the Trust was 62% in 2017 which is above average when compared to other community trusts.

3.1.2 The 2017 response rate for the Trust has increased from 2016 (55%). For each of the Key Findings, the Community Trusts in England were placed in order from 1 (top ranking) to 20 (bottom ranking).

3.2 Summary of Key Findings

The table below shows the year on year changes in Key Findings since the Trust has been running the survey:

Rating	2012	2013	2014	2015	2016	2017
Better than average	8	12	8	12	14	11
Average	15	10	16	10	17	18
Worse than average	5	6	5	7	1	3
Deteriorated		2	1	1	0	3
Improved		0	2	4	7	1

Table 1

3.2.1 It can be seen that in 2017 KCHFT the number of Key Findings in the 'better than average' category has decreased by three. Average scores increased by 1 to 18. Scores in the worst than average increased to 3. Three scores deteriorated and one score improved.

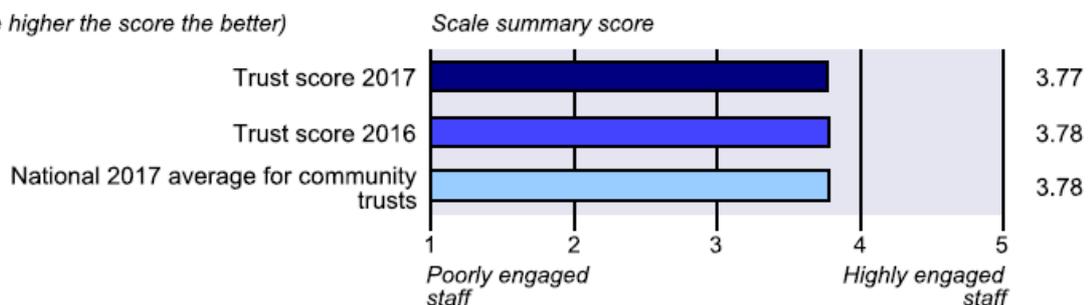
3.3 Overall Staff Engagement

3.3.1 The overall staff engagement score represents staff members' perceived ability to contribute to improvements at work, their willingness to recommend the organisation as a place to work or receive treatment, and the extent to which they feel motivated and engaged with their work. As detailed in Chart 1 below, the overall engagement score has not changed from 2016.

Chart 1

OVERALL STAFF ENGAGEMENT

(the higher the score the better)



3.3.2 This overall indicator of staff engagement has been calculated using the questions that make up Key Findings 1, 4 and 7. These Key Findings relate to the following aspects of staff engagement:

Key Findings	Change since 2016 survey	Ranking compared with all Community Trusts
Overall Staff Engagement	No change	Average
KF1. Staff recommendation of the Trust as a place to work or receive treatment	No change	Average
KF4. Staff motivation and work	No change	Average
KF7 Staff ability to contribute towards improvements at work	No change	Average

Table 2

3.3.3 Contributions to improvements

70% of staff agreed or strongly agreed that there are frequent opportunities for them to show initiative in their role, and 78% reported that they are able to make suggestions to improve the work of their team or department. A slightly lower proportion, 55%, said they are able to make improvements happen in their area of work.

3.3.4 Recommendation of the organisation

71% of staff agreed or strongly agreed that care of patients/service users is their organisation's top priority, and 58% said they would recommend their organisation as a place to work. When asked whether they would be happy with the standard of care provided by their organisation if a friend or relative needed treatment, 72% of staff agreed or strongly agreed.

3.3.5 Motivation and engagement

Over half of all staff (57%) reported that they often or always look forward to going to work, with 73% of staff feeling enthusiastic about their job. Seventy-eight percent of staff also felt that time passes quickly whilst they are at work.

3.4 Appraisals and Support for Development

- 3.4.1 This year's survey indicated that appraisals and development reviews are common within the Trust with 94% of all staff undergoing one in the last 12 months. The score is currently 3% above the bench mark for other Community Trusts.
- 3.4.2 Staff assessments of the quality of appraisals has improved. For example, 59% of staff who had had a recent appraisal said that it 'definitely' helped them to improve how they did their job.
- 3.4.3 With regard to the quality of non-mandatory training, learning or development, 83% of staff who had had recent training agreed that it had enabled them to perform in their role more effectively and a similar proportion (80%) felt that the training allowed them to provide a better experience for patients or service users.

3.5 Equality and Diversity

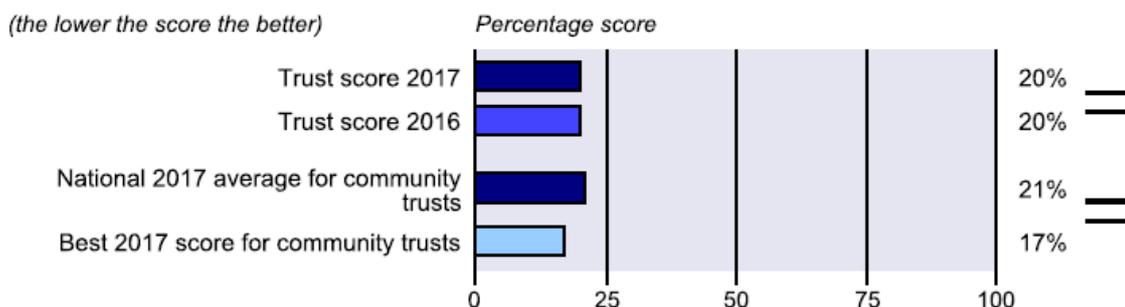
- 3.5.1 In 2017, 4% of staff reported that they have faced discrimination from patients or service users this has remained the same from the last report. The proportion of staff who reported facing discrimination from their team or managers was one percent higher at 6%.
- 3.5.2 Ninety-two percent of staff reported that they believe their organisation acts fairly with respect to promotion or progression.

3.6 Errors and Incidents

- 3.6.1 Our staff (20%) are less likely than the average Community Trust (21%) to witness potentially harmful errors or near misses or incidents. Our staff also report a high level of fairness and effectiveness of the reporting procedure. 11% of staff reported seeing an error or incident that could have harmed staff, while a quarter of staff (15%) witnessed an error or incident that could have harmed patients or service users. The majority (95%) of staff who had witnessed an error or incident said that it had been reported, either by themselves or by a colleague.

Chart 2

Percentage of staff witnessing potentially harmful errors, near misses or incidents in the last month



3.6.2 When asked whether our organisation treated staff involved in near misses, errors and incidents fairly, more than half of all staff (56%) reported that this is the case, but 38% responded that they ‘neither agreed nor disagreed’ and 3% said they ‘didn’t know’. Ninety- two percent agreed or strongly agreed that their organisation encourages staff to report incidents. When incidents are reported, 77% of staff felt that action is taken to prevent the incident happening again, and only 3% disagreed that this is the case. In addition, 70% of staff reported that their organisation gives feedback to staff about any changes that have been made in response to the reported incident, with 8% disagreeing that this happens.

3.6.3 Findings on unsafe clinical practice were similar, with 73% of staff feeling secure in raising any concerns they may have regarding clinical practice. Sixty-four percent of staff had confidence that their organisation would address their concerns if they were raised.

3.7 Health and Wellbeing

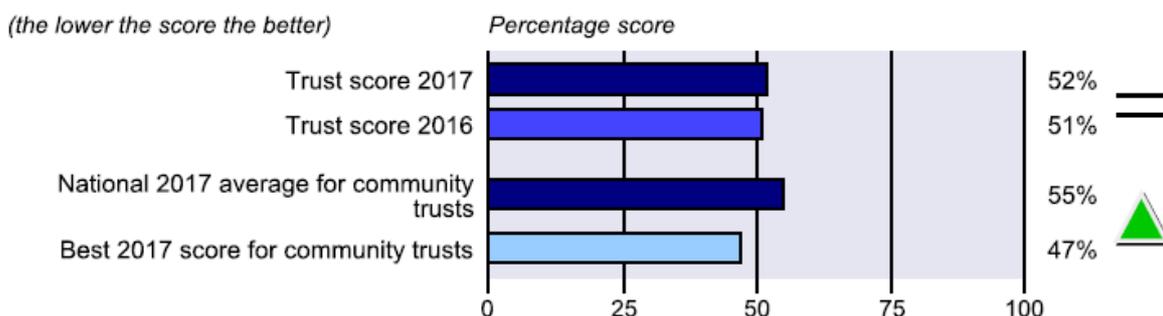
3.7.1 In the 2017 survey staff were asked about a number of aspects that contribute to the overall theme of health and wellbeing, including managerial and organisational interest in staff health, musculoskeletal problems, and stress. The majority of staff reported positively on organisational and managerial interest in staff health and wellbeing. Approximately three quarters of staff (75%) reported that their manager took a positive interest in their individual health and wellbeing, and 37% said that their organisation ‘definitely’ took positive action on health and wellbeing.

3.7.2 Overall, nearly a quarter (23%) of staff reported experiencing musculoskeletal (MSK) problems as a result of work activities.

3.7.3 In 2017 the proportion of staff who reported feeling unwell due to work related stress rose to 38%. 54% reported coming to work in the previous three months despite feeling unable to perform their duties or the requirements of their role. The majority of staff acknowledged that this was a result of pressure from themselves (94%) rather than from other colleagues (16%) or their manager (23%).

Chart 3

Percentage of staff attending work in the last 3 months despite feeling unwell because they felt pressure from their manager, colleague or themselves



3.8 Working Patterns

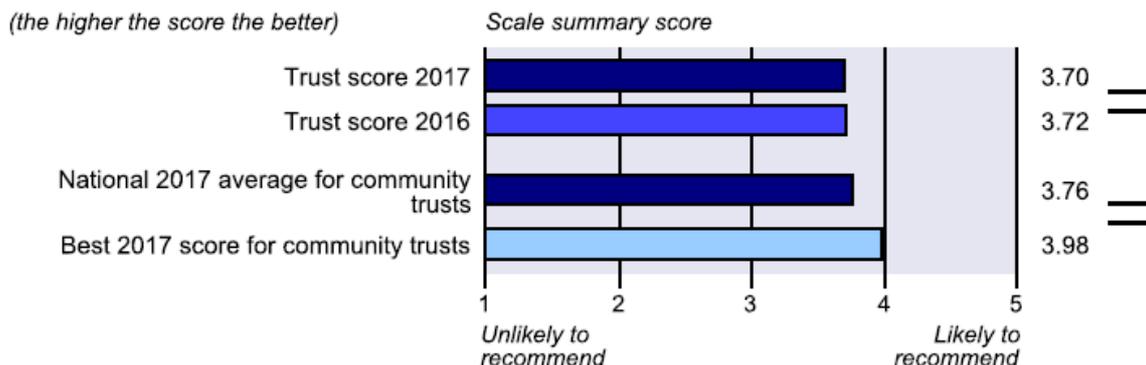
3.8.1 Fifty-six percent of staff were satisfied with the flexible working opportunities provided by their organisation. Sixty-one percent of staff reported working unpaid additional hours each week. The percentage of staff working any extra hours (paid or unpaid) has increased by 1% between 2016 and 2017.

3.9 Job Satisfaction

3.9.1 Staff recommendation of their organisation as a place to work or receive treatment has gradually increased since 2012 but did not change from 2015. Our staff are more likely to report effective team working than these in an average community trust. On a scale of one to five the average was 3.82 and our trust reported 3.90

Chart 4

Staff recommendation of the organisation as a place to work or receive treatment



3.9.2 Effective team working is an important component of staff experience, and the survey showed generally favourable results for questions on this topic. For example, 78% of staff agreed that their team has a set of shared objectives, with 73% of staff reporting that they felt their team meets often enough to discuss how effective they are at working together.

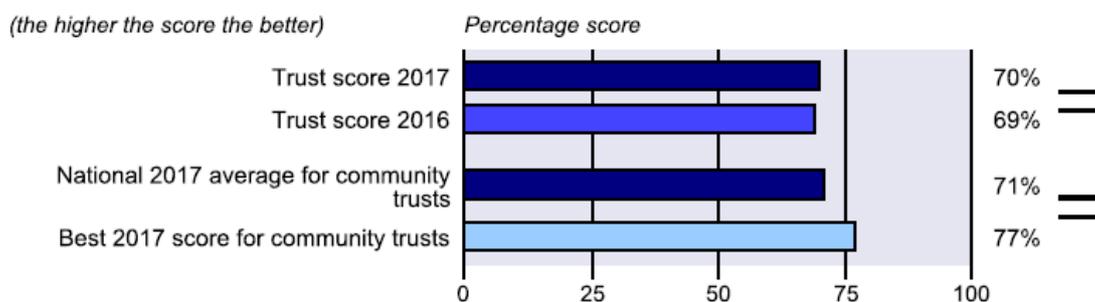
3.9.3 With regard to motivation 73% of staff reported feeling enthusiastic about their job, and 79% felt that time passes quickly whilst they are at work, with 59% reporting that they often or always look forward to going to work.

3.9.4 The majority (87%) of staff feel happy with the level of support they receive from their work colleagues. However, many staff felt unable to meet all the conflicting demands on their time at work: 41% agreed/ strongly agreed that they are able to manage these demands, whilst 33% disagreed. Furthermore, 62% of staff felt that they have adequate supplies or equipment to do their job effectively. In terms of understaffing 35% of staff agreed (and 44% disagreed) that there are enough staff at their organisation for them to do their job properly.

- 3.9.5 Thirty-two percent of staff reported that they are satisfied with their level of pay.
- 3.9.6 Staff in the NHS should be given the opportunity to be involved in their work and decisions that affect them. Three-quarters of staff (78%) agreed that they are able to make suggestions to improve the work of their team or department, with 70% feeling that there are frequent opportunities for them to show initiative in their role.

Chart 5

Percentage of staff able to contribute towards improvements at work

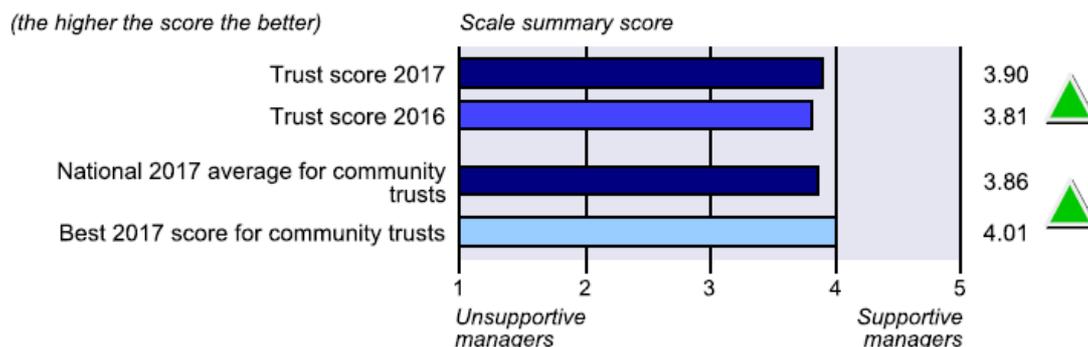


3.10 Managers

- 3.10.1 The survey included questions about the extent to which staff feel valued for their work and the recognition their personal contribution receives. This area was where the Trust saw the most improved results. Over two-thirds of staff (76%) agreed that they feel valued by their immediate manager.
- 3.10.2 Eighty percent of staff agreed that their immediate manager encourages their staff to work as a team and can be counted on to help with difficult tasks at work (76%). Fewer staff agreed that their immediate manager gives clear feedback (68%) and asks for staff opinions before making decisions that affect their work (60%).

Chart 6

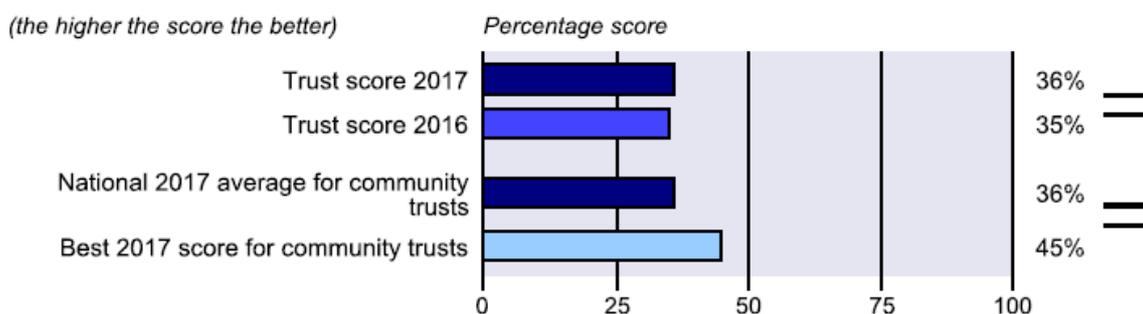
Support from immediate managers



3.10.3 Over four-fifths (88%) of staff reported that they know who the senior managers are at their organisation, less than half (42%) agreed that communication between senior management and staff is effective. Even fewer staff (35%) felt that senior management tries to involve staff in important decisions, and 35% reported that senior managers act on the feedback given by staff.

Chart 7

Percentage of staff reporting good communication between senior management and staff



3.14 Patient Care and Experience

3.14.1 Patient and service user experience is an important element of the services that NHS organisations provide. Ninety-seven per cent agreed that their organisation collates patient and service user feedback. Sixty-six percent of staff said that they receive regular updates on patient/service user experience in their team, whilst just over half (54%) said that this feedback is used to make informed decisions. The majority of respondents (76%) agreed that they are able to do their job to a standard they are personally pleased with, but somewhat fewer staff (63%) reported feeling able to deliver the care they aspire to. Ninety percent of staff agreed that their role makes a difference to patients/service users.

3.15 Violence, Harassment and Bullying

3.15.1 In 2017, 18% of staff reported that they have experienced physical violence from patients, relatives or members of the public in the last 12 months. In contrast, all staff who participated in the survey reported that they have never experienced violence from a colleague (99%) or their manager (100%) in the last 12 months.

3.15.2 Whilst 7% of staff have experienced physical violence from patients, relatives or the public in the last 12 months, a slighter higher proportion of staff (10%) reported experiencing harassment or bullying from other colleagues in the last 12 months.

3.16 Top and Bottom Ranking Scores for Key Findings

3.16.1 The table below identifies the top five Key Findings for KCHFT that are positive compared to other community trusts in England.

Key Finding	Trust Score 2017	National 2017 average for Community Trusts
KF21. Percentage of staff believing that the organisation provides equal opportunities for career progression or promotion	92%	88%
KF27. Percentage of staff / colleagues reporting most recent experience of harassment, bullying or abuse	57%	53%
KF30. Fairness and effectiveness of procedures for reporting errors, near misses and incidents	3.87	3.81
KF29. Percentage of staff reporting errors, near misses or incidents witnessed in the last month	95%	93%
KF16. Percentage of staff working extra hours	68%	71%

Table 3

3.16.2 Four of the five top ratings are above the national average for community trusts

3.16.3 The table below identifies the bottom five ranking scores for Key Findings that are least favourable compared with other community trusts in England.

Key Finding	Trust Score 2017	National 2017 average for Community Trusts
KF31. Staff confidence and security in reporting unsafe clinical practice	3.72	3.80
KF23. Percentage of staff experiencing physical violence from staff in last 12 months	1%	1%
KF3. Percentage of staff agreeing their role makes a difference to patients / service users	89%	90%
KF13. Quality of non-mandatory training, learning or development	4.03	4.08
KF1. Staff recommendation of the organisation as a place to work or receive treatment	3.70	3.76

Table 4

3.17 Largest local changes since 2016 Survey

3.17.1 Three Key Findings have deteriorated since the 2016 survey.

Key Finding	Trust Score 2016	Trust Score 2017
KF17. Percentage of staff feeling unwell due to work related stress in the last 12 months	34%	39%
KF20. Percentage of staff experiencing discrimination at work in the last 12 months	8%	9%
KF15. Percentage of staff satisfied with the opportunities for flexible working patterns	59%	56%

Table 5

3.17.2 One Key Finding has improved since the 2016 survey:

Key Finding	Trust Score 2016	Trust Score 2017
KF10. Support from immediate managers	3.81	3.90

Table 7

3.17.3 This Key Finding is also above the national average.

3.18 Focus on the bottom five ranking Key Findings scores as described in section 3.4.2 above.

3.18.1 This section looks at each of the bottom ranking scores Key Findings and breaks this down to individual question level.

Key Finding	Trust Score 2017	National 2017 average for Community Trusts
KF31. Staff confidence and security in reporting unsafe clinical practice	3.72	3.80

Table 8

3.18.2 This Key Finding is compiled from questions 13b and 13c.

Question	Trust Score 2016	Trust Score 2017	National 2017 average for Community Trusts
13b. I would feel secure raising concerns about unsafe clinical Practice.	73%	73%	77%
13c. I am confident that the organisation would address my concern.	64%	64%	64%

Table 9

Key Finding	Trust Score 2017	National 2017 average for Community Trusts
KF23. Percentage of staff experiencing physical violence from staff in the last 12 months	1%	1%

Table 10

3.18.3 This Key Finding is compiled from the answers to questions 14b and 14c.

Question	Trust Score 2016	Trust Score 2017	National 2017 average for Community Trusts
14b. Percentage of staff experiencing physical violence at work from managers in last 12 months	0%	0%	0%
14c. Percentage of staff experiencing physical violence at work from other colleagues in last 12 months	1%	0%	1%

Table 11

Key Finding	Trust Score 2017	National 2017 average for Community Trusts
KF3. Percentage of staff agreeing that their role makes a difference to patients / service users	89%	90%

Table 12

3.18.4 This Key Finding is compiled from the answers to question 6b.

Question	Trust Score 2016	Trust Score 2017	National 2017 average for Community Trusts
6b. Percentage of staff agreeing / strongly agreeing 'I feel that my role makes a difference to patients / service users'	90%	89%	90%

Table 13

Key Finding	Trust Score 2017	National 2017 average for Community Trusts
KF13. Quality of non-mandatory training, learning or development	4.03	4.08

Table 14

3.18.5 The Key Finding comprises of questions 18b, 18c and 18d.

Question	Trust Score 2016	Trust Score 2017	National 2017 average for Community Trusts
18b. It has helped me to do my job more effectively	84%	83%	85%
18c. It has helped me stay up to date with professional requirements	87%	87%	88%
18d. It has helped me to deliver a better patient/service user experience	81%	80%	84%

Table 15

Key Finding	Trust Score 2017	National 2017 average for Community Trusts
KF1. Staff recommendation of the organisation as a place to work or receive treatment	3.70	3.76

Table 16

3.18.6 The Key Finding is comprised of questions 21a, 21c and 21d.

Question	Trust Score 2016	Trust Score 2017	National 2017 average for Community Trusts
21a. Care of patients / service users is my organisations top priority	71%	71%	76%
21c. I would recommend my organisation as a place to work	59%	58%	57%
21d. If a friend or relative needed treatment, I would be happy with the standard of care provided by this organisation	73%	72%	73%

Table 17

3.19 Comparing 2017 Survey results against those areas targeted in the 2016 KCHT Action Plan

3.19.1 Last year the Board agreed that all directorates should focus on Key Findings bottom ranking scores and where there had been a decline from the 2016 scores. In addition that the focus of work should be around engagement and a cultural shift to ensure that the Trust values were translated into management and leadership actions.

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

Table 18

3.19.2 Whilst no areas decreased, disappointingly none of the actions taken have had a positive impact on the scores.

4. Benchmarking

4.1 There are 17 community trusts in the country. When comparing all of the key findings we are ranked 7th

2017-2018 Ranking	+/-	Community Trust Name
1	1	Cambridgeshire Community Services
2	1	Derbyshire Community Health Services FT
3	-	Sussex Community FT
4	4	Central London Community Healthcare
5	1	Hounslow & Richmond Community Healthcare
6	11	Lincolnshire Community Health Services
7	2	Kent Community FT
8	3	Shropshire Community Health
9	2	Hertfordshire Community
10	3	Leeds Community Healthcare
11	1	Wirral Community FT
12	2	Birmingham Community Healthcare FT
13	3	Norfolk Community Health & Care
14	1	Liverpool Community Health
15	6	Bridgewater Community Healthcare FT
16	12	Staffordshire and Stoke-on-Trent Partnership
17	5	Gloucestershire Care Services

5. Action Planning

- 5.1 Each locality and directorate has been asked to analyse their specific findings and develop an action plan to address key areas of concern where they are below the national average. Our communications plan includes presentation of key findings to key groups (Strategic Workforce Committee, Management Committee, JNCC). Findings are being discussed within each locality/directorate with action plans developed, agreed and monitored.
- 5.2 At a corporate level the focus of work will be on improving staff engagement and involvement to increase the overall engagement score. We will measure whether the actions are having an impact quarterly via the staff family and friends test with added questions measuring engagement. We will be having discussion at the Management Committee to agree what actions can be taken corporately and at a local level to improve communication and improve staff involvement in decision making above. One example is a campaign planned for April to reenergise team meeting and to improve communication flow to the front line.

A refer a friend proposal is being consider at the next Management Committee, together with a debate on what actions need to be taken to have a positive impact on:

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

6. Conclusion

- 6.1 Overall, the survey findings for 2017 are positive given the service changes that were implemented during 2017; however we are not moving any of the results enough. There has been a real improvement in relation to staff's perception of their managers. Our engagement score stayed the same.
- 6.2 It is important that we continue to strive to improve all scores; that there is ownership of actions and that these are followed through so that staff do understand that what they have to say really does matter and that as a Trust we do listen and we do act on feedback.

7. Recommendation

- 7.1 The Board is asked to:
- Note the results of the 2017 annual staff survey,
 - Take ownership of the results
 - Agree explicit plans at a local level to address areas that are below the national average.
 - Agree the corporate actions being taken to improve staff engagement and involvement

- Agree the proposed Management Committee debate

Louise Norris
Director of Workforce, Organisational Development and Communications
March 2018

Meeting of the Kent Community Health NHS Foundation Trust Board
to be held at 10am on Thursday 24 May 2018
The Committee Room, Tonbridge and Malling Council Offices, Gibson Building,
Gibson Drive, Kings Hill, West Malling Kent
ME19 4LZ

This meeting will be held in Public

AGENDA

1. STANDARD ITEMS

- 1.1 Introduction by Chair Chairman
- 1.2 To receive any Apologies for Absence Chairman
- 1.3 To receive any Declarations of Interest Chairman
- 1.4 To agree the Minutes of the Kent Community Health NHS Foundation Trust Board meeting held on 29 March 2018 Chairman
- 1.5 To receive Matters Arising from the Kent Community Health NHS Foundation Trust Board meeting held on 29 March 2018 Chairman
- 1.6 To receive the Chairman's Report Chairman
- 1.7 To receive the Chief Executive's Report Chief Executive

Verbal

2. BOARD ASSURANCE/APPROVAL

- 2.1 To receive the Patient Story Chief Nurse
- 2.2 To receive the Quality Committee Chair's Assurance Report Chair of Quality Committee

2.3	To receive the Audit and Risk Committee Chair's Annual Report to the Board	Chair of Audit and Risk Committee
2.4	To receive the Charitable Funds Committee Chair's Reports to the Board: (i) Assurance Report (ii) Annual Report	Chair of Charitable Funds Committee
2.5	To receive the Strategic Workforce Committee Chair's Assurance Report	Chair of Strategic Workforce Committee
2.6	To approve the 2017/18 Annual Report and Accounts (i) 2017/18 Annual Quality Report (ii) Self-Certification with NHS Provider Licence	Director of Finance Corporate Services Director
2.7	To receive the Workforce Report	Director of Workforce, Organisational Development and Communications
2.8	To receive the Integrated Performance Report	Director of Finance Chief Operating Officer/ Deputy Chief Executive Chief Nurse
2.9	To receive the Monthly Quality Report	Chief Nurse
2.10	To receive the Finance Report Month One	Director of Finance
2.11	To approve the Committees' Terms of Reference (i) Audit and Risk Committee (ii) Charitable Funds Committee (iii) Finance, Business and Quality Committee (iv) Quality Committee (v) Remunerations and Terms of Service Committee (vi) Strategic Workforce Committee	Chairman

- 2.12 To receive the Interim Appointments following the Chair's Retirement Report
Corporate Services Director

3. REPORTS TO THE BOARD

- 3.1 To receive the approved Minutes of the Charitable Funds Committee meeting of 25 January 2018
Chair of the Charitable Funds Committee
- 3.2 To receive the Quarterly Infection Prevention and Control Report
Chief Nurse
- 3.3 To receive the Quarterly Patient Experience and Complaints Report
Chief Nurse
- 3.4 To receive the Quarterly Mortality and Learning from Deaths Report
Medical Director
- 3.5 To receive the Six Monthly Freedom to Speak Up Report
Director of Workforce, Organisational Development and Communications
- 3.6 To receive the Comprehensive Information Governance Report
Corporate Services Director
- 3.7 To receive the Emergency Planning and Business Continuity Annual Report
Corporate Services Director
- 3.8 To receive the Staff Survey Report
Director of Workforce, Organisational Development and Communications

4. ANY OTHER BUSINESS

- To consider any other items of business previously notified to the Chairman.
Chairman

5. QUESTIONS FROM MEMBERS OF THE PUBLIC RELATING TO THE AGENDA

6. DATE AND VENUE OF NEXT MEETING

Thursday 26 July 2018
Kent Community Health NHS Foundation Trust Offices, Room 6 and 7 Trinity House, 110-120
Upper Pemberton, Eureka Business Park, Kennington, Ashford Kent TN25 4AZ

