Kent Community Health
NHS Foundation Trust

Formal meeting of the

Kent Community Health NHS Foundation Trust Board

In Public

7 September 2022

Supplementary Pack

2021/22 Annual Report and Accounts

2021/22 Quality Account

NHS
Kent Community Health
NHS Foundation Trust

we all played our part

we care

Welcome to our 11th annual report 2021 to 2022

Kent Community Health
NHS Foundation Trust

Annual report and accounts 2021 to 2022

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

Contents

Snapshot 2021 to 2022

A year where everyone played their part

Our amazing NHS colleagues and volunteers worked together to provide services across our communities while also delivering the national Covid vaccination programme. From new technology to holding a patient's hand when their loved ones couldn't, our teams have been incredible. Here's our snapshot of the year and the backdrop against which they delivered.

April

We start the year running five large-scale Covid-19 vaccinations centres. Our Thanet venue is the first to offer a pop clinic for teenagers who missed their HPV, meningitis or booster jabs due to school closures, vaccinating 300 children in one day.

By the end of the month, adults aged 40 are being invited to our centres and KCHFT had delivered 146k first Covid-19 vaccinations to people in Kent and Medway.

Gardening, playing games and listening to music – therapeutic workers are introduced to our community hospitals to support patients with their rehabilitation.

We begin work across Kent and Medway to introduce ReSPECT, a plan created with a patient to allow their treatment choices to guide their future care should they be unable to make their own decisions.

Our Personal Protective Equipment (PPE) store becomes a permanent fixture of the KCHFT Team and will go on this year to supply...

6,046 litres of hand gel

More than **three million masks**

344,107 gloves

10,980 lateral flow tests.

May

The Kent and Medway Care Record goes live at KCHFT giving clinical staff access to a joined-up view of patients' care and treatment.

We hosted a reflective virtual memorial event to remember and celebrate, people who had lost their lives through Covid. Throughout the year, community nursing and therapy teams cared for 4,346 end-of-life patients, going above and beyond. Many also stepped forward to take on extra shifts at this point, as second Covid-19 doses for over 50s were brought forward and younger cohorts were opened more quickly.

June

More than two million vaccinations are delivered with 900,000 adults in Kent and Medway double-vaccinated by the end of June. A pop-up Covid vaccination clinic is held in Canterbury with 1,000 young people vaccinated in just one day.

We pay tribute to our volunteers as part of Volunteer's Week for the incredible role they play caring for our patients, clients and services users. During the course of the year, our patient experience volunteers carried out 536 telephone surveys with housebound patients and seldom heard patient groups.

i care

i care funded 322 claims for team treats allowing colleagues to come together to recognise and celebrate their dedication and commitment during the past year.

July

The Tonbridge Cottage Hospital and Victoria Hospital in Deal buildings become part of the KCHFT estate as we continue to invest in our vital community services.

We launched our integrated website for children's therapy services and school health in East Sussex. The site provides a one-stop shop for parents, teachers and carers of children with additional needs.

It's mixed emotions as new Secretary of State for Health Savid Javid announced 19 July as end of lockdown. Teams at KCHFT and the rest of the NHS remain vigilant as we learn to live with Covid and do everything they can to protect patients and each other.

August

School-age Immunisations Team hold drive-through catch-up clinics for children who have missed out on vital vaccinations due to Covid.

We team up with Carers Support East Kent to open our carer's lounge online forum.

The name for Edenbridge Memorial Health Centre is revealed after 900 residents have their say.

September

KCHFT becomes one of just five pilot sites in the country to run a new wound programme.

October

Supported by local charities, including the League of Friends, Tonbridge Cottage Hospital was able to open their 1950s vintage tea room for dementia patients to enjoy.

Our community teams, such as our Home Treatment Service, Rapid Response and Long Term Condition Teams continue to go above and beyond to support people at home.

KCHFT's new Academy saw their first cohort of nursing associates celebrate their graduation alongside the Open University.

Almost 200 people attend our quality improvement conference.

"I've been boosted" staff flu and Covid booster campaign is launched to encourage our colleagues to have both jabs before winter.

November

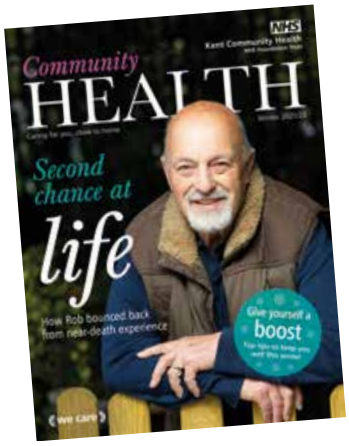
We welcome 19 qualified nurses from Nigeria and Ghana as part of an international recruitment campaign.

December

We open Camden Centre in Tunbridge Wells with teams working tirelessly throughout December and January to deliver vital Covid booster immunisations.

Our Paediatric Audiology Team sees nearly 100 children in one day reducing waiting lists developed during the Covid pandemic.

The School-Age Immunisations Service has vaccinated 30,000, 12 to 15-year-olds in Kent and Medway.



January

Our specialist Community Respiratory Team hit the headlines of our Community Health magazine after saving the life of Robert after near organ failure due to undiagnosed COPD.

Our One You Kent Teams continue their drive to support people to quit and by the end of the year have helped...

...2,665

people to kick the habit.

February

Dental teams across Kent and north east London reduce waiting lists thanks to new kit and procedures which reduce the risk of Covid spreading.

We celebrate our apprentices as part of apprenticeship week – with 52 apprentices completing their learning programmes and 59 enrolling onto an apprenticeship to start their journey.

March

Solar panels are installed at Victoria Hospital, Deal, to reduce the amount of carbon dioxide produced to run the hospital by 40 per cent.

KCHFT scoops four awards for involving and listening to patients at Healthwatch Awards.

We have the biggest response ever to our annual staff survey and results show our people are respected and valued.

We end the year with teams having delivered more than 800,000 vaccinations – 468,330 Covid-19 and the rest flu and part of the childhood vaccination programme.

Our health visitors have continued to support new mums with 16,172 visits.

We have delivered 1.5 million face-to-face appointments and 550,000 virtual appointments.

Overview of performance: Welcome to our 11th annual report

A year everyone played their part

The NHS always strives to be there when you need us – and we hope you feel our colleagues at Kent Community Health NHS Foundation Trust did just that, as we tackled the second year of a pandemic.

As we reflect on 2021/22, a year which continued to be one of the most challenging periods in the history of the NHS, we wanted to recognise the achievements of everyone.

Our people

Firstly, to our 5,028-strong workforce for their dedication, courage and sacrifices to deliver the very best care to our patients, clients and service users. They have reset services, started to tackle waiting lists, adapted to virtual consultations and home working, taken on extra shifts and stepped into unfamiliar roles when they needed to, to make sure our patient care and satisfaction rates remain high at 98 per cent.

We began the financial year at the height of the Covid vaccination programme, our five large-scale vaccination centres fully up and running, mass lateral flow testing in full swing and, like the rest of the NHS, KCHFT teams striving to innovate to find new ways to deliver high-quality care, faster.

At the end of the year, our community hospitals had cared for 2,264 patients, including 142 people with Covid, our urgent treatment centres and minor injury units had seen more than 140,000 people and our community teams had 1.5 million face-to-face contacts, while carrying out 550,000 virtual appointments.

As precautions across the country were relaxed in July, our colleagues couldn't. Our teams across Kent, Medway, East Sussex and parts of London, never stopped stepping up.

One of the many ways in which they have started to tackle waiting lists is with hugely successful catch-up immunisation clinics in the heart of our communities – making sure 335,000 children and young people were protected from childhood illnesses, while our health visiting teams created Covid-safe clinics to continue to offer support to families.

Quality improvement continued to be at the heart of everything KCHFT teams did – from projects to improve identification of children who are seriously unwell in our urgent treatment centres to investing in new kit to reduce dental waiting lists safely and being chosen as just one of five pilot sites in the country to run a new wound care programme.

And just when our teams thought they couldn't give anymore – more was always asked of them, as we tackled increased pressures from new Covid variants, like Delta and Omicron, which emerged at the start of winter 2021. In response to the prime minister's call to support the biggest, fastest booster vaccination campaign ever – we took swift action to mobilise our team and offer boosters to all by the end of January 2022.

As a result, some colleagues for the second-year running temporarily moved to support the vaccinations drive and we prepared for a wave of increasing hospital admissions as well as increasing the support to get people back home. Thanks to the innovations of the previous year, our 70-plus services were well prepared.

When our staff survey results were revealed in March 2022 – with our biggest response rate yet – we were pleased that in five of the seven people promises, KCHFT scored significantly higher when

compared to similar organisations. Colleagues told us we are compassionate, inclusive and they feel part of the team.

It was not a surprise to hear how battle weary they also feel. That is why we have also worked hard to recruit. This year, we welcomed 19 international nurses from Nigeria and Ghana and our first ever nurse associate celebrated their graduation from our new clinical academy.

Making it easier for our colleagues to bring their whole selves to work has been a key focus for us as we launched our Nobody Left Behind – our people, equity, diversity and inclusion strategy in November 2021. Our efforts to go further and faster to support our colleagues and improve their health and wellbeing will not stop in the years ahead, as we all learn to live with Covid.

We continue to play a leading role in the developing Kent and Medway integrated care system; winning awards for our work improving care for people with diabetes as part of the East Kent Health and Care Partnership, while working closely on new tele-tracking kits with our acute colleagues in west Kent to provide a smoother hospital discharge for patients, to name just two projects.

While our priority is the delivery of high-quality care, managing the money well means we can provide outstanding care and invest in what services our communities need. We're pleased to also report we remain in a strong, stable financial position, with the highest rating for our financial performance. That too, is down to the dedication of our teams.

Patients, public and partners

We'd also like to thank our patients, public and partners too for their unwavering support and for embracing partnership working with us, most notably;

- To our governors and non-executive directors for the helpful and valued challenge and insight they provide.
- To our volunteers who stepped forward to support us to deliver the most ambitious booster campaign vaccination in NHS history, who have helped us shape and refine our services and who have been vital in driving forward our sustainability strategy, helping to transform some of our community hospital gardens into places where we can grow our food.
- To everyone for getting their Covid booster and flu jab, regularly lateral flow testing, isolating when they needed to, for checking on and shopping for elderly relatives or neighbours, to all our key workers who have kept going no matter what to deliver the services we just can't do without – for every action each one of you has taken to keep each other safe.

The future

Our annual plan for next year has been co-developed with our people, patients and partners. They have asked us to go further and faster on moving forward with support for our colleagues and delivering our Nobody Left Behind strategy, reducing the rate of staff turnover, as well as the priorities of our quality strategy. This means committing to really listening and learning from our staff and our service users, carers and families and improving safety, clinical effectiveness and the experience of our services.

Embedding quality improvement will be a key part of our future; using insight from data and working with our partners to tackle joint challenges. Some key innovations will include expanding our virtual wards, improving urgent care services and taking a leading role in improving learning disabilities and autism services in Kent and Medway. We will also be leading on a digital transformation through the delivery of the Kent and Medway Care Record and continuing to invest in our buildings to improve the environment for our patients.

The pandemic has had a profound impact on the NHS and has driven faster and more wide-ranging changes than any other time in our history – but it's had a profound effect on all of us as people too. We couldn't have come through this without you.

Thank you to everyone for the part you played.

Signed .....

John Goulston
Chair

Date: 16 June 2022

Signed .....

Gordon Flack
Acting Chief Executive

Date: 16 June 2022

"I quickly came to realise what a very special team I had become part of, a truly multi-talented diverse team of superb professionals and volunteers, drawn not just from the NHS but all walks of life."

Covid vaccination volunteer

we pulled together

Who we are and what we do

Kent Community Health NHS Foundation Trust (KCHFT) was formed in April 2011. We are a large provider of NHS care in patients' homes and in the community. In July 2019, the trust was rated outstanding by the Care Quality Commission.

Our budget was £259.3m with £12.3m spent on the Covid response, including £10.5m related to the vaccination programme. Our year end accounts show expenditure of £271.7m.

We employ in the region of 5,028 (31 March 2022), 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.

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

Throughout 2021/22, we have continued to play our part in the national vaccination programme in Kent and Medway. KCHFT was the lead employer for the programme, supplying staff for local vaccination services as well as continuing to operate our own large vaccination centres in Folkestone, Gravesend, Chatham, Tonbridge and Ramsgate. Our incredible volunteers have supported our clinical teams across our large vaccination centres, and we recruited 2,500 staff to help deliver nearly two million vaccinations.

When the national vaccination programme was asked to provide vaccine boosters in December 2021, our teams were not deterred. Activity was increased in Chatham at the large Pentagon Centre site and the Camden Centre in Tunbridge Wells was opened just before Christmas. Our amazing teams worked tirelessly throughout December and January to deliver vital booster immunisations.

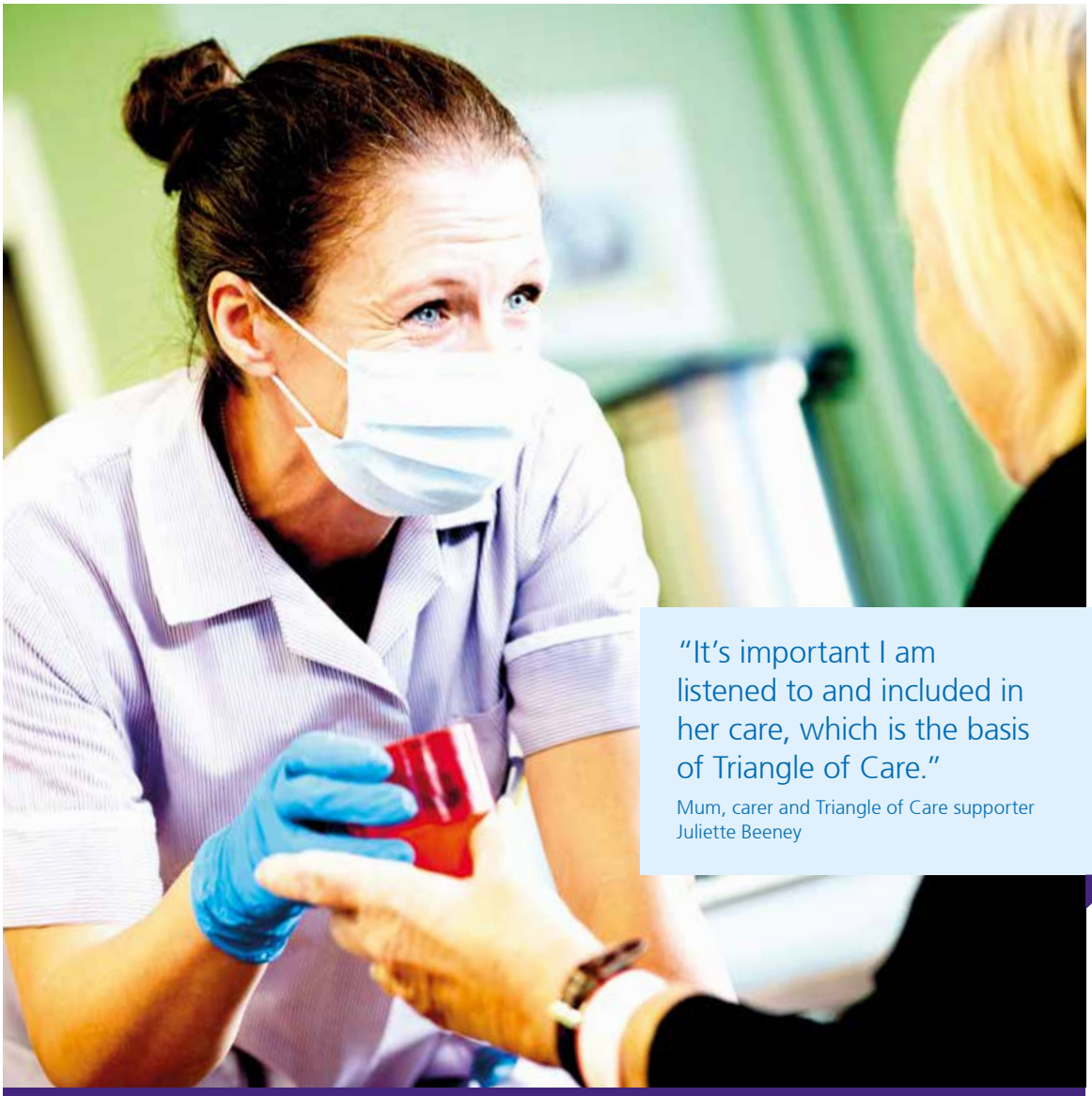
With Covid restrictions in place, many children missed out on more routine vaccinations. The Kent and Medway Immunisation Team toured the county in the summer, delivering catch-up immunisations to teenagers. They even provided a drive-through clinic to help.

Cathie Burton, Head of School Health and Immunisation said: "A lot of children have missed out on school-age immunisations this year due to school closures. Families could easily combine the vaccination with a trip to Westwood Cross or even a visit to the beach. It's more important than ever that young people get their routine immunisations to protect them from serious illness."

We were pleased to finally welcome patients back to face-to-face appointments as Covid restrictions began to be lifted. The technology we embraced throughout the pandemic continued to allow us to provide our patients with more options for appointments than ever. Together with innovative solutions to reduce waiting lists accumulated due to Covid, we have been able to deliver 1.5 million face-to-face appointments and 550,000 virtual appointments.

Across 2021/22, our workforce has continued to prove they not only deliver outstanding care but are worthy award winners too having been recognised by the Health Service Journal, Kent Housing Group's Excellence Awards and the Healthwatch Awards.

We couldn't be prouder of our dedicated and caring workforce who work hard every day to achieve the greatest reward of all, the hearts of the people they serve.



"It's important I am listened to and included in her care, which is the basis of Triangle of Care."

Mum, carer and Triangle of Care supporter Juliette Beeney

we engaged

Engagement with the public, patients, community groups and organisations

Involving patient, public, family and carers

The newly created Participation, Engagement and Patient Experience Directorate has continued to develop opportunities throughout the pandemic to make sure patients, service users and carers can use their own lived experiences to develop our services.

Due to the pandemic, the trust delivered the Expert Patients Programme (EPP) a little differently in 2021/22. The EPP helps people living with a long-term health condition to regain independence, manage everyday situations and boost mental health and wellbeing. It is led by an EPP co-ordinator and facilitated by volunteers, who are also living with a long-term health condition. The team changed how they facilitated the course to deliver it virtually, allowing people the opportunity to take the course from home with the support of a toolkit and a weekly group call. The EPP Team has also developed a new film to promote the course which is available on the trust website.

The People's Network has gone from strength-to-strength with members of the network – called Participation Partners – continuing to be involved in delivering involvement training, quality improvement projects and conferences, as members of governance groups, interview panels to recruit new colleagues, we care visits and producing Participation Matters – the People's Network's quarterly newsletter.

The Patient and Carer Council drives patient and carer involvement, participation, co-design and shared decision making and is co-chaired by the participation manager and a patient representative. The group receives reports about trust activities relating to participation, involvement and engagement and submits reports to the quality and workforce committees for assurance.

In 2021, KCHFT joined the Triangle of Care (ToC) membership scheme. ToC is a national scheme, led by the Carers Trust, to improve communication and involvement of loved ones, family, carers and people who provide an unpaid caring role in the care of their loved one. ToC was originally developed for mental health services and KCHFT is the first community trust (non-mental health service) to join as a member. The trust's Carers Steering Group, along with the Patient and Carer Partnership Team has led on the work to oversee the process, which has included recruiting 25 carers champions in community hospitals, developing support and information packs for carers, co-designing carer awareness training and supporting community hospitals with their development plans to improve their involvement of carers.

Thank you to our volunteers

In 2022, the trust was successful in applying for funding for volunteer discharge co-ordinators across nine community hospitals. The role will see volunteers supporting colleagues with the discharge process.

A pilot project has been introduced to increase patient feedback using volunteers to collect survey responses from patients and carers which services can act upon. The project is co-led by volunteers, who co-designed the processes. With an increase in patient feedback for podiatry and continence teams, the project is hoped to be expanded across more services.

The Patient and Carer Partnership Team hosted an event, in March 2022, to celebrate patient and carer involvement and participation. The event, held in Ashford, was attended by more than 60 people, including participation partners, staff and colleagues and was supported by One You, Healthwatch, Kent County Council and Imago. It was a celebration and an acknowledgment to the commitment and support of our participation partners who work together with the trust to improve and develop services.

The trust continues to provide translation services for anyone whose first language is not English and interpreting services for people who have a disability, sensory loss or impairment. A telephone interpreting service was available in the trust's vaccination centres throughout 2021, as well as an on-demand video British Sign Language (BSL) service. The centres also provided vaccination information leaflets in foreign languages, Braille, large print and easy read.

Working alongside East Kent Mencap, the trust continues to develop easy read patient information, including carers surveys and documents for the Special Schools Service. Members of the Learning Disability Group co-presented at the Patient Experience For Improvement Conference in March 2022, sharing their experience of being involved with easy read and other initiatives within KCHFT.

Healthy communities

In 2021, the Healthy Communities Project Kent was developed to help reduce health inequalities and barriers to care affecting migrant communities and ethnic minorities across the county.

The project began with an in-depth look at our population and communities so we could understand the areas we needed to target.

We also needed to understand the demographics of our patients and it became clear that we needed to improve patient ethnicity recording across our services. This work will give the trust an insight into health barriers and inequalities, and understand where health interventions are needed most.

Easy to access guides and resources were developed to support staff and the benefits of improved recording to individual services were explained helping to increase confidence in reporting. Developing e-learning, access to workshops and interpreting resources also helped to develop increased cultural awareness.

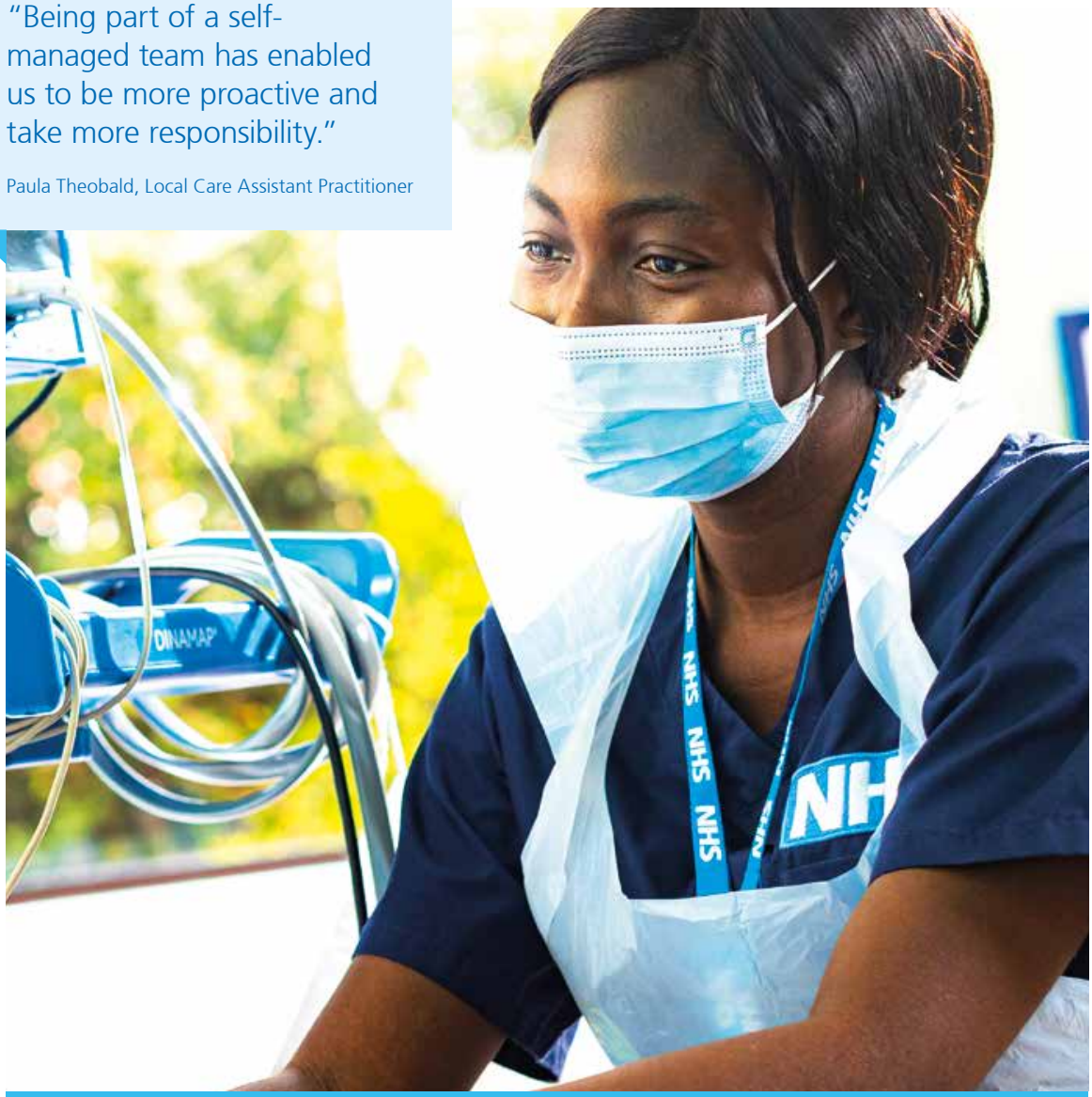
Our next step was to further develop trusting, sustainable relationships with our local communities and other stakeholders to encourage good engagement and information sharing. A steering group has also been developed which incorporates patients and their families, carers, members of the public and staff from a range of communities – including migrant and ethnic minority groups to reflect our diverse population. This group will allow members to share their lived experience of health inequalities and barriers, but will also act as a consulting group, providing thought and opinion on trust initiatives.

In addition, the project group aims to introduce a Migrant Communities Link Worker scheme, for members of staff throughout the trust to represent our communities in day-to-day meetings, practice and discussion. The Roma Mothers' Breastfeeding Support group will also be re-established.

Through networking and engagement, the project has continued to grow and establish itself, with highlights including presenting at the Healthy Communities Together Conference, hosted by the Social Enterprise Kent CIC, and co-creating and leading the National Ethnicity Recording discussion, which was attended by multiple trusts to share and learn how best to improve ethnicity monitoring. Throughout its two-year duration, the Healthy Communities Project Kent will continue to engage, enhance understanding of, and work towards reducing, health inequalities and barriers affecting migrant communities and ethnic minorities across Kent.

"Being part of a self-managed team has enabled us to be more proactive and take more responsibility."

Paula Theobald, Local Care Assistant Practitioner



we empower

Our mission, vision and values

Our mission

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

Our vision

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

Our values

We have four values:

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

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

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

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

Our goals

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

Our enablers

Digital

Having accessible and integrated technology.

People

Engaging, developing and valuing our people.

Environmental sustainability

Improving our environmental impact.

System leadership

Improving population health and wellbeing.

Partnership working across Kent and Medway

Health and care partners across Kent and Medway have continued the tremendous partnership working sparked by the pandemic to provide mutual aid to each other in all its forms and save lives.

The workforce has yet again gone above and beyond in their commitment and resolve to make sure that patients and service users received the care they needed whether in person, with safety measure in place, or digitally.

Community teams, primary care and community pharmacy colleagues have provided vaccinations to the Kent and Medway population and our staff. This unprecedented vaccination programme continues to protect people from getting seriously ill and contributed to being able to reduce the national restrictions on our daily lives. This would not have been possible without dedicated staff and courageous volunteers who were trained and asked to deliver vaccines at all hours, making it as accessible for the population to get their vaccines as soon as possible.

We have established our first Kent and Medway Provider Collaborative to jointly improve the health outcomes of those with learning disabilities and autism. This has already led to a new adult neurodevelopmental pathway and has a plan to swiftly expand this to all ages.

As the governance around the system partnership working embeds this year we will maintain the can-do attitude of the past two years which has demonstrated that by working together we can provide better lives for the people of Kent and Medway.

It was a big year for our charity, i care...

Steve Bamford, one of our HIV peer support group members completed a physical (not virtual!) Land's End to John O'Groats cycle ride to raise money for the HIV fund.

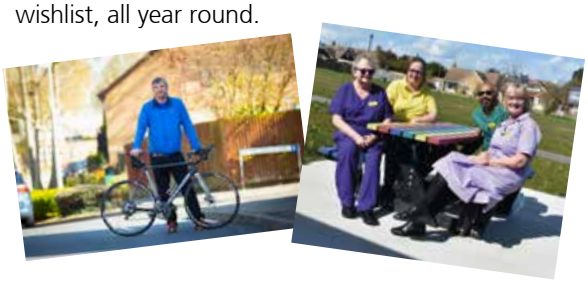
Steve was very active on social media, documenting his journey throughout the cycle ride and the total amount he raised in the end was £2,325 for i care. We covered Steve's story extensively in our magazine and our new online news channel, Commmunity Health Online.

Our teams benefited from some of the millions of pounds raised by Captain Sir Tom Moore in 2020 through the NHS Charities Together campaign and our own i care colleague wellbeing fundraising. This led to the 'team treat' scheme running throughout the summer and autumn of 2021, which saw NHS teams enjoying picnics, activities and days out together.

A total of 322 claims were made, valued at just more than £47,000.

We also launched a campaign to spend some of the health and wellbeing funds on new outdoor seating and furniture for our sites. Colleagues at all sites were encouraged to ask for outdoor seating equipment, and 27 were given the green light. The campaign was launched in June 2021 and coincided with the transition of estates to KCHFT which made the process of buying and installing outdoor seating much easier.

Our Christmas appeal 'The Gift of Play' was launched again in December 2021 with a film featuring six-year-old Max from Canterbury who benefits from the toys bought through the appeal during his sessions with the Children's Therapy Service. The toys can be purchased via our Amazon wishlist, all year round.



Going concern

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

An NHS foundation trust's assessment of whether the going concern basis is appropriate for its accounts should only be based on whether it is anticipated that the services it provides will continue to be provided with the same assets in the public sector. This is expected to be the case for NHS foundation trusts unless exceptional circumstances indicate otherwise. Where the continued provision of services in the public sector is anticipated to apply, there will not be any material uncertainties over going concern requiring disclosure.

After making enquiries, the directors have a reasonable expectation that the services provided by the trust will continue to be provided by the public sector for the foreseeable future. For this reason, the directors have adopted the going concern basis in preparing the accounts, following the definition of going concern in the public sector adopted by HM Treasury's Financial Reporting Manual.

The principle risks and uncertainties facing the trust are included in the annual governance statement.

"It's a really exciting time as our sustainability strategy starts to see tangible results; I am pleased we are stepping forward with our plans to make a healthier planet and healthier community."

Dr Dan Wright, Head of Sustainability at KCHFT

we grew

Sustainability report

In early 2021/22, the trust's Sustainability Team revised the Sustainability Strategy 2021/26, agreed in October 2020, to align with the national approach led by Greener NHS. This included reducing the strategy to a three-year period and adding several new themes into the Sustainability Team's scope.

The revised Sustainability Strategy 2021/24 and the 49 actions across 10 themes for 2021/22 is now available on the trust website. By March 2022, 90 per cent of targets (44) had been completed, with five outstanding targets incorporated into the 2022/23 action plan.

The themes are:

our people and system leadership

sustainable models of care

digital transformation

travel and transport

estates and facilities

medicines

supply chain and procurement

food and nutrition

adaptation

wildlife and biodiversity

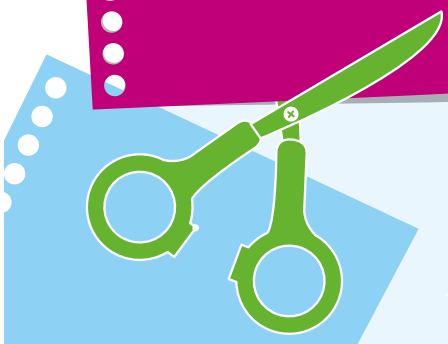
The trust reports sustainability updates in line with best practice guidance from the Task Force on Climate-Related Financial Disclosures, the Sustainability Accounting Standards Board and the Financial Reporting Council around healthcare-associated climate impact reporting.

However, these reporting frameworks do not cover other sustainability achievements including:

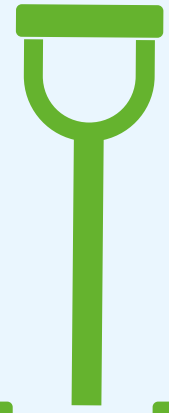
- meeting the criteria for accreditation as a Real Living Wage Employer, benefiting 219 of our full-time and part-time colleagues

- developing a tool to accurately calculate emissions associated with the privately-owned vehicles that complete business mileage for the trust

- a 50 per cent reduction in paper use across the trust between 2019/20 and 2021/22



- piloting a hospital kitchen garden at Hawkhurst Community Hospital aiming to reduce related food miles, improve nutrition for patients and providing a wellbeing space for patients and staff.

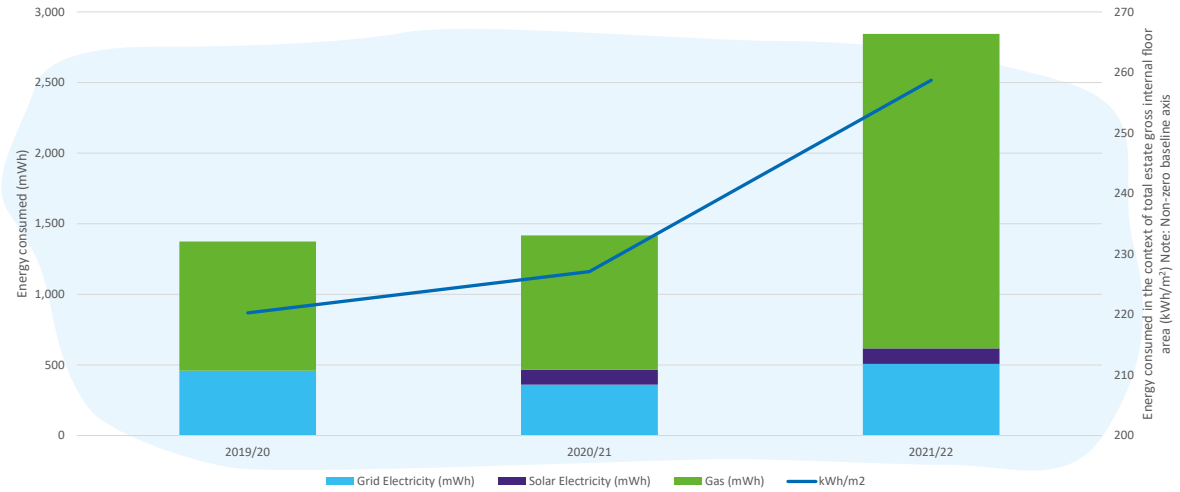


- a commitment to only using sustainably sourced paper where possible

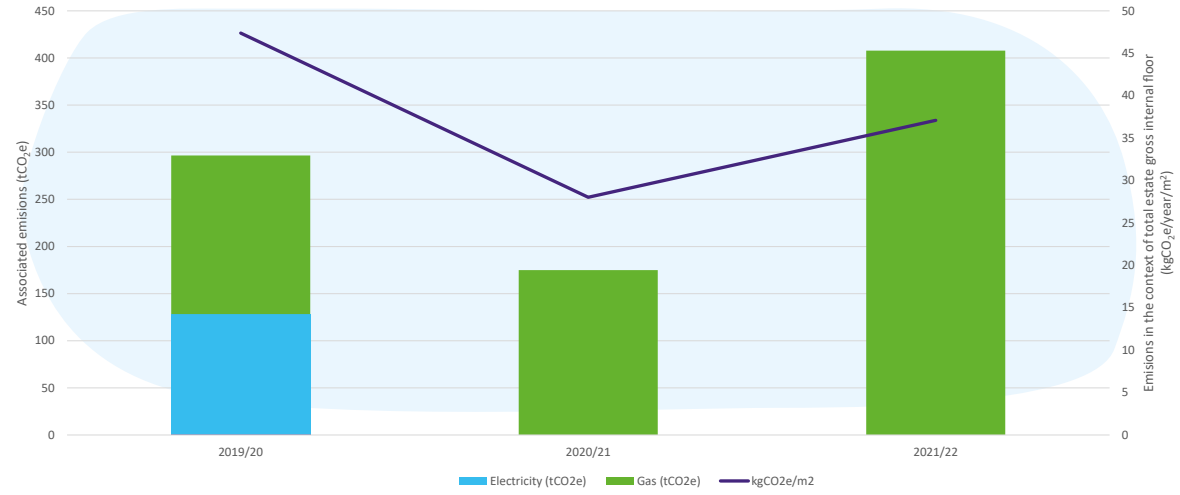
- completing a waste facilities audit at trust sites to support increased recycling across our buildings

The energy we use

- It is estimated that the trust was responsible for 408 tonnes of carbon dioxide equivalent (tCO2e). This is an increase of thirty-eight per cent compared to 2019/20.
- The increase in energy use-related emissions is due to the transfer of two large sites to trust ownership. The indoor space for which the trust are responsible almost doubled between 2020/21 and 2021/22, with gas demand for heating also increasing considerably.
- Despite the trust's growing site portfolio, the carbon intensity of estates, measured by calculating kilowatt hour (kWh) energy demand per square metre (m^2) of gross internal floor area, fell by 22 per cent.

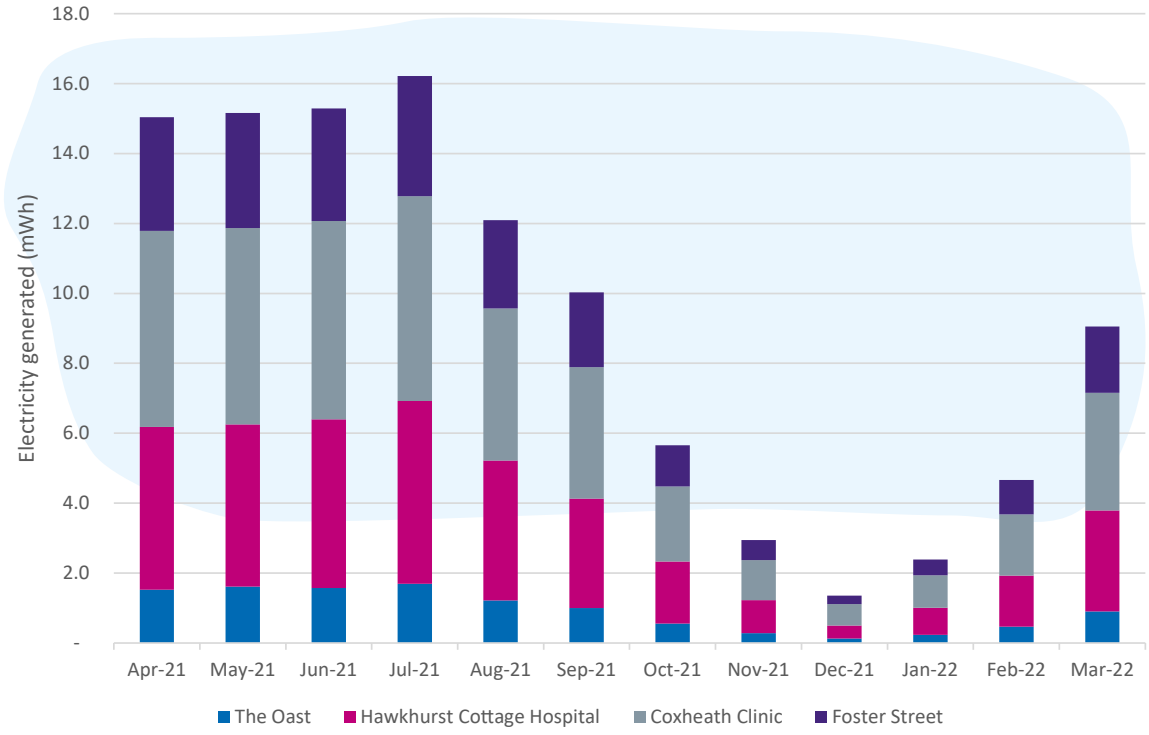


Gas and electricity use across the trust's sites increased in 2021/22 with the addition of large sites to the estates portfolio. Gross energy consumption and energy consumption per floor area increased between 2020/21 and 2021/22.

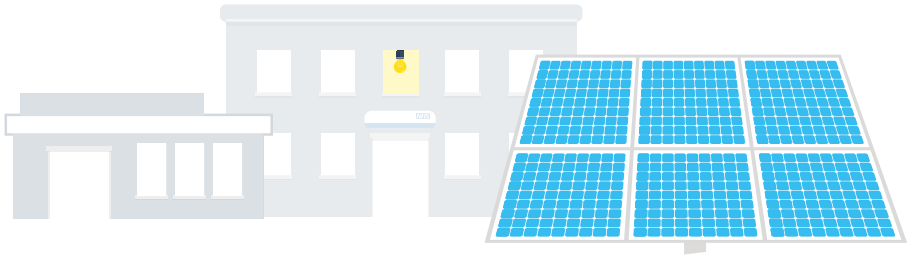


In line with increased consumption, associated emissions also increased in 2021/22 with the addition of sites to the trust's estate portfolio. The falling carbon intensity trust's sites is connected to sourcing electricity renewably and generating electricity locally using solar panels.

- All electricity for trust sites is bought through the Renewable Energy Guarantee of Origin (REGO) scheme resulting in 22 per cent of the trust's energy now being renewably sourced or generated locally through solar panels.
- Ongoing lighting energy efficiency upgrades across the trust will help to further reduce electricity consumption.
- Solar panels have been installed at Victoria Hospital in Deal, boosting the trust's ability to generate electricity on location.
- Generating electricity direct at trust sites has helped us to avoid over 25 tonnes of carbon emissions.

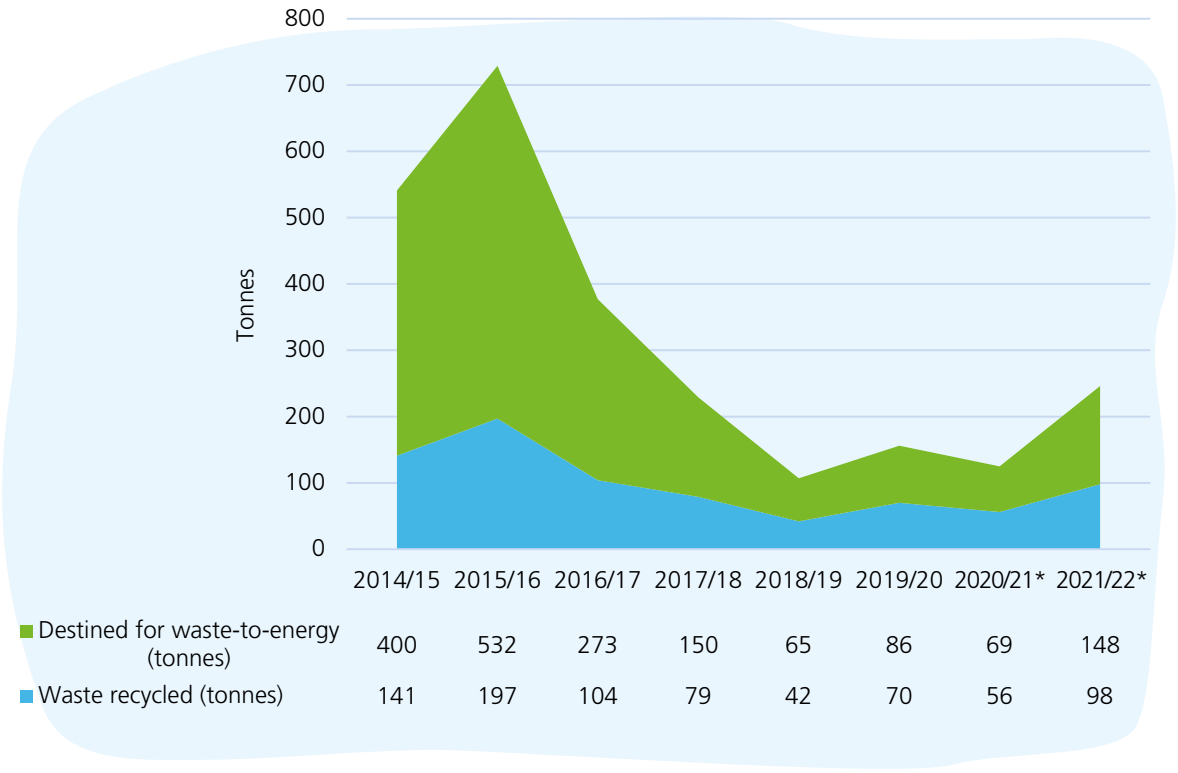


A visualisation of electricity generated through installed solar panels across trust sites over 2021/22.



The waste we generate

- Working with other NHS trusts in the area, the trust diverted 61 tonnes (38 per cent) of waste which would otherwise be sent to landfill for use in the energy from waste process and recycled 98 tonnes (62 per cent) of waste.
- Of the 117 tonnes of hazardous and non-hazardous medical waste we generated, 86 tonnes (74 per cent) were processed so that they could be used in the energy from waste process while the remaining 31 tonnes (26 per cent) was incinerated.
- We are committed to improve recycling facilities and increase awareness of the importance of recycling.



	2014/15	2015/16	2016/17	2017/18	2018/19	2019/20	2020/21*	2021/22*
Destined for waste-to-energy (tonnes)	400	532	273	150	65	86	69	148
Waste recycled (tonnes)	141	197	104	79	42	70	56	98

A visualisation of the change in waste totals and recycling percentage between 2014/15 and 2021/22. Please note that figures between 2014/15 and 2019/20 were collected by a third-party consultant, figures for 2020/21 were sourced from the Estates Return Information Collection (ERIC) report, while the 2021/22 data was sourced directly from the waste handling organisation.

Signed .....

Gordon Flack,
Acting Chief Executive Officer
Date: 16 June 2022

Accountability report

The directors' report

Board as of 31 March 2022.

Chair
John Goulston

Acting Chief Executive
Gordon Flack
(from January 2022)

Non-executive directors

- Sola Afuape (to January 2022)
- Pippa Barber
- Paul Butler
- Peter Conway
- Prof. Francis Drobniewski (to 31 January 2022)
- Bridget Skelton
- Nigel Turner
- Kim Lowe (from February 2022)
- Karen Taylor (from February 2022)
- Dr Razia Shariff, Associate Non-executive Director (from February 2022)

Council of Governors

Chief Operating Officer
Pauline Butterworth

Director of Corporate Services
Natalie Davies

Medical Director
Dr Sarah Philips

Chief Nurse
Dr Mercia Spare

Director of People and Organisational Development
Victoria Robinson-Collins
(Appointed October 2021)

Director of Strategy and Partnerships
Gerard Sammon

Gill Jacobs
Acting Director of Finance
(from January 2022)

Portfolios of executive members include:

- the *(acting)* chief executive: The accountable officer for the trust
- the *(acting)* director of finance: Leads on audit, finance, contracting and performance
- chief operating officer: Leads on operations and Covid-19 vaccination. Interim responsibilities: Business development and service improvement
- the director of people and organisational development: Leads on workforce and organisational development, communications and engagement (interim) and is the executive for the Black, Asian and Minority Ethnic Staff Network
- the chief nurse: Jointly leads on the clinical strategy, quality, clinical governance, infection prevention and control, safeguarding assurance, CQC nominated individual, Caldicott Guardian, is the operational senior responsible officer for Covid and is the executive sponsor for the LGBTQ+ Staff Network
- the medical director: Jointly leads on the clinical strategy, quality, medical revalidation, clinical audit, research and development, quality improvement and is the executive sponsor for the Menopause Staff Network
- the director of strategy and partnerships: Leads on the development of strategy, including organisational priorities. The role has a particular focus on the changes made by national policy, that of the Kent and Medway system and the trust's wider partnership work. The director also plays a key role in developing and maintaining relationships with stakeholder organisations and groups and is the executive sponsor for the Veterans' Staff Network. Interim responsibilities: Information management and technology, estates and facilities management
- the director of corporate services: Leads on regulatory framework, members and governors, governance and risk and environmental sustainability strategy
- the director of participation, experience and patient engagement: Leads on patient and carer engagement and experience as well as equality, diversity and inclusion. Executive sponsor for the Disability and Carers' Staff Network. Whilst this post is within the executive team, it is not part of the trust board hence they are not represented on the chart of directors.

During the time of the acting chief executive, the role of deputy chief executive is shared between all executives (except the acting director of finance) at the discretion of the acting chief executive.

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 four times a year.

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

Directors' roles and responsibilities

Executive directors

John Goulston

Trust Chair

Appointed November 2018

John is a father-of-three, from Beckenham, who has a wealth of experience working in non-executive and executive roles. John was also interim chair of Kent and Medway Integrated Care System (ICS) and is currently chair of NHS London Procurement Partnership. Formerly, John was chief executive of both acute and community health providers. He has been an executive director of NHS London, the strategic health authority for London, plus director of finance at two London teaching hospitals during his career.

During his time as chief executive at Croydon Health Services NHS Trust, John helped establish the One Croydon Alliance, a 10-year agreement to integrate services across health and social care for all. Aimed at increasing partnership working between Croydon's NHS, GPs, the local authority and the voluntary sector in the borough, the alliance seeks to give people greater control of their health and choice of services. Much of his early career was in Kent, working in Maidstone during the 80s. John's daughter is a doctor and his wife is a community physiotherapist.

John is also Chair of the Remuneration Committee.

Paul Bentley

Chief Executive

Appointed March 2016 to January 2022

Paul Bentley – named as one of the top NHS chief executives in the country by the Health Service Journal in 2021 – held the position of chief executive of Kent Community Health NHS Foundation Trust (KCHFT) from 1 March 2016 to January 2022.

Under Paul's leadership, KCHFT has held an 'outstanding' rating by the Care Quality Commission since 2019. In 2021, staff rated the organisation among the best in the country to work for in the annual NHS staff survey results and as one of the highest performing community trusts in the country in five areas.

Paul spearheaded improvements in patient satisfaction and staff engagement, as well as making sure the trust remained in financial balance; he is proud these have been delivered and enabled teams to work in different ways rather than be told what to do.

Passionate about partnerships, Paul was the senior responsible officer (SRO) for the East Kent Integrated Care Partnership, as well as SRO for community services transformation across the south east and was leading work to improve care for people with learning disabilities and autism in Kent and Medway. He also led the trust to sign partnership agreements with Kent County Council and Kent and Medway Health and Social Care Partnership Trust.

A father of three grown-up young people, Paul has a wealth of experience of not only NHS healthcare, but has also studied in the US. Before joining KCHFT, Paul was director of workforce and communications at Maidstone and Tunbridge Wells NHS Trust since 2011.

He has worked in the NHS since 1987 and as an NHS director since 1998 at various times leading on strategy, organisational development and workforce and communications. During this time, he was also interim chief executive of an acute trust in Surrey, and held the position of non-executive director for NHS Innovations South East.

He lives in south west London with his wife and dog. Paul's wife also works as a health consultant and his daughter is a junior doctor.

After six years as chief executive of KCHFT, Paul left the trust and joined the Kent and Medway Integrated Care Board as Chief Executive in January 2022.

Gordon Flack

Acting Chief Executive from January 2022

Appointed 2011

Gordon is a fellow of the Chartered Association of Certified Accountants (FCCA) and has a professional background in NHS finance spanning 38 years. Following an early career with health authorities, his director experience is with acute and community trusts and he has been at the trust since 2011. As finance director, his responsibilities include financial management and control, capital and audit, information management and technology, 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.

In recognition of his role as deputy chief executive, Gordon was appointed as acting chief executive in January 2022.

Pauline Butterworth

Chief Operating Officer

Appointed December 2019

Pauline, who is originally from Carnoustie, Scotland, joined the trust from East Sussex Healthcare Trust where she was the deputy chief operating officer since 2013. During that time, she was also programme director for transformation of urgent care at Hastings and Rother and Eastbourne and Seaford Clinical Commissioning Group. A trained clinician, Pauline worked as a therapist and manager in the USA and in paediatrics in Australia, before returning to the UK. She started with the NHS in 2008 and has worked across a breadth of services, including community, acute and commissioning, as well as social care.

Pauline is a member of Finance, Business and Investment Committee, Quality Committee and Strategic Workforce Committee.

Ali Carruth

Director of Participation, Experience and Patient Engagement

Appointed January 2020; previously Chief Nurse (Board)

Ali qualified as a registered general nurse in 1994. She completed a number of postgraduate studies and qualified as a registered mental health nurse in 2004. Ali graduated from the NHS Leadership Academy Nye Bevan Executive Healthcare Leadership Award in 2014. She has worked in the NHS for more than 30 years holding a variety of senior nursing posts in a number of trusts in London, Devon, Kent, Surrey and Sussex and as an executive director for more than seven years. Ali is passionate about making sure patients and their carers are equal partners in their care and receive the best experience possible while using our services. 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 wife and children.

Natalie Davies

Director of Corporate Services and Trust Secretary

Appointed 2015

Natalie has worked within the NHS in both acute and community settings for more than 21 years. As the Director of Corporate Services, Natalie has a strong background in corporate governance, risk management and compliance. Natalie has primary responsibility for a number of areas, including estates, facilities, legal, risk, compliance and environmental sustainability.

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

Natalie is a non-voting member of the Board. In February, Natalie took up a part-time secondment to the Kent and Medway Integrated Care System, at which time responsibility for estates and facilities was transferred to Gerald Sammon.

Gill Jacobs

Acting Director of Finance

Appointed January 2022

Gill joined the trust in 2015 as Deputy Director of Finance and has been interim Director of Finance since January 2022.

After working for an accountancy firm and completing a degree in management sciences, Gill joined the NHS financial management scheme in 1991 where she qualified as a chartered public finance accountant and has subsequently held a variety of senior finance roles in community, mental health and acute trusts in Kent and London.

Gill's responsibilities include financial management and control, capital, audit and performance and business intelligence.

Dr Sarah Phillips

Medical Director

Appointed 2017

Sarah is a GP at Newton Place Surgery in Faversham, Kent. Prior to joining KCHFT as the 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 has been 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 Kent and Medway Sustainability and Transformation Plan (STP) for Kent and Medway. Sarah's work on this board included reviewing issues around staff retention, the use of technology, buildings and estates, and clinical pathways such as maternity, paediatrics, end-of-life care and mental health.

Sarah is also a member of Quality Committee.

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 the NHS future plans met the health and social care needs of the communities it serves.

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

Victoria Robinson-Collins

Director of People and Organisational Development

Appointed October 2021

Victoria has many years of experience in acute, community and private sector. Before joining KCHFT, she was the deputy director of human resources (HR) at St Helens and Knowsley Teaching Hospitals. She moved into the health sector in the mid-2000s, when she joined East Midlands Ambulance Service as an HR practice development adviser.

She has worked in roles with Wirral Community Trust and East Lancashire Hospitals Trust as head of employment services where she designed and led the delivery of the Care to Make a Difference recruitment campaign for nurses. Since 2015, she has held positions including interim site director of people for Newham University Hospital leading on complex change initiatives and strategy develop programmes, including the hospital's response to the Care Quality Commission well-led and the Covid pandemic, as well as progressing the equality, diversity and inclusion agenda.

Since October 2020, she has been interim deputy director of workforce for Wirral University Teaching Hospitals NHS, leading the workforce and organisational development teams in organisational culture change, learning and development. She has a degree in English and a postgraduate diploma in human resource management.

She is married to Leif and has a son, Leighton.

Gerard Sammon

Director of Strategy and Partnerships

Appointed January 2020; previously director of strategy October 2018 (Board).

Before joining KCHFT, Gerard had spent more than 21 years in a number of NHS board and leadership roles including serving as an interim chief executive. In previous posts, he led system-wide changes and programmes of work with other health and care organisations that spanned north Kent and south east London and pioneered the introduction of group models into the NHS. He previously studied at King's College London, Ashridge Business School and was a member of the NHS Top Leaders Programme.

Gerard is also a member of Finance, Business and Investment Committee.

He is keen on coaching youth basketball and is married with three children.

Louise Norris

Director of Workforce, Organisational Development and Communications

Appointed July 2015 to January 2022

Louise has more than 30 years' experience in NHS human resources and has worked at regional, trust and primary care level. 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 was a member of Strategic Workforce Committee and retired from the trust in January 2022.

Dr Mercia Spare

Chief Nurse

Appointed January 2020; previously interim chief nurse

Mercia joined as permanent chief nurse in January 2020 following a 13-month secondment from NHS Improvement. Mercia has worked in the health service for 36 years and describes herself as a 'passionate champion of the NHS and the values it embodies'. Her clinical experience includes transplantation, coronary care, renal and cardiothoracic nursing. Mercia holds a Batchelor of Science degree in applied and human biology and a doctorate in clinical research. During her career Mercia has held a number of senior leadership roles within the NHS at both an operational and strategic level. She has led a number of large-scale national improvement projects and supported the development of a range of tools that have focused on improving the safety of patients. She has worked for a number of provider organisations including University Hospitals Birmingham NHS Foundation Trust, the Department of Health, the Trust Development Authority and NHS Improvement.

Mercia is a member of Charitable Funds Committee, Quality Committee and Strategic Workforce Committee.

Non-executive directors

Sola Afuape

Non-executive Director

Appointed December 2019 to January 2022

Sola has 20 years' experience advising, designing and implementing national, regional and local public sector programmes most notably delivering health inequalities and service improvements. She has been a chair of a national charity tackling social and health inequalities with a particular focus on mental health, for which she was awarded an MBE.

In the early part of her career, she held a number of advisory roles and worked across the Department of Health, Public Health England, Standing Commissioning on Carers and the Arts and more recently across a collaboration of CCGs as a lay advisor in integrated care and transformational workforce and organisation development.

She runs her own consultancy specialising in strategy, organisational development and equalities and conducting independent reviews across health and social care and the wider public sector for organisations, such as CafCass and the Nursing and Midwifery Council. She is also a special advisor for the Care Quality Commission and independent member of HM Courts and Tribunal Service London Advisory Committee.

Sola has a deep passion for the wellbeing of patients, their families and carers, staff and citizen voice, co-production and systems leadership.

- Member and Deputy Chair of Charitable Funds Committee
- Member of Finance, Business and Investment Committee
- Member of Quality Committee
- Member of Remuneration Committee
- Non-executive Director Lead for Freedom to Speak Up.

Paul Butler

Non-executive Director

Appointed March 2020

Paul is a chartered accountant with extensive management, financial and regulatory experience.

From 2001 to 2020, Paul had been managing director of Mid Kent Water and subsequently South East Water. Previously, Paul worked as group financial controller of Mid Kent Water and he has been a non-executive director of Water UK, the water industry trade body and Chairman of UKWIR, a research organisation for the water sector.

- Chair of Finance, Business and Investment Committee
- Member of Remuneration and Committee.

Pippa Barber

Non-executive Director

Appointed December 2016

Pippa Barber brings a wealth of experience with a strong clinical background and focus on governance, quality and improvement from nearly 40 years' experience in the NHS. She has spent the past 20 years in various board roles including most recently as a non-executive director. Pippa has significant past experience working in senior clinical roles including chief nurse and director, with a number of different organisations across the system – acute, community, primary care, clinical network, mental health and commissioning.

She currently also works as the independent nurse for a clinical commissioning group in London, where she maintains an essential focus on system learning, health inequalities, quality and performance and is a trustee for a Kent-based charity.

Pippa lives in Kent.

- Chair of Quality Committee
- Member and Deputy Chair of Audit and Risk Committee
- Member of Charitable Funds Committee
- Member of Remuneration and Committee
- Non-executive Director Lead for Mortality and Learning from Deaths
- Non-executive Director Lead for Freedom to Speak Up (from January 2022).

Peter Conway

Non-executive Director and Vice Chair (from May 2019)

Appointed March 2015

Peter has a professional background in banking and finance spanning 28 years, latterly as a finance director with Barclays Bank PLC. He has been a non-executive director with the NHS since 2006. He has held a portfolio of public sector roles including:

- non-executive director and audit chair, Rural Payments Agency
- non-executive director and audit chair, NHS West Kent
- independent member of the Audit Committees of the Home Office, Ministry of Justice, DEFRA, Health and Safety Executive and Child Maintenance and Enforcement Commission
- trustee director, Citizens Advice North and West Kent
- non-executive director with Kent and Medway NHS and Social Care Partnership Trust in 2020.

- Chair of Audit and Risk Committee
- Member of the Finance, Business and Investment Committee
- Member of Remuneration Committee.

Professor Francis Drobniewski

Non-executive Director

Appointed October 2018 (Designate): May 2019 (Board) to January 2022

Professor Francis Drobniewski divides his time between clinical practice, education and research. He is professor of Global Health and Tuberculosis (TB) at Imperial College, London, a consultant medical microbiologist and was a tuberculosis physician. He has worked in Europe, USA and Africa focussing on tuberculosis and other respiratory infections, HIV and antimicrobial resistance, and was director of the Public Health UK National TB Laboratory for 19 years. Francis was clinical TB adviser for the National Institute of Clinical Excellence (NICE) until recently and an adviser to the World Health Organisation (WHO).

Having spent 20 years as a consultant, Francis is keen to do more in strategic development of health services and public health. He has worked in acute services and public health and with community services and believes in keeping people out of hospital wherever possible.

- Chair of Charitable Funds Committee.
- Member and Deputy Chair of Quality Committee.
- Member of Strategic Workforce Committee.
- Member of Remuneration Committee
- Non-executive Director End-of-Life Champion.

Kim Lowe

Non-executive Director

Appointed February 2022

Kim has spent most of her career at John Lewis Partnership and for more than 36 years she has worked across people, customer service, employee engagement, human resources and business.

She progressed through various operational and general management leadership roles, being appointed managing director of John Lewis Bluewater in 2014. In 2007, she was appointed partnership board director and also as a member of the audit and risk remuneration committees. Her final role was to lead the pension review at John Lewis before leaving in 2020 to continue to build her portfolio non-executive director career in the public and private sector, including John Lewis Partnership, Central Surrey Health, Kent and Medway NHS and Social Care Partnership Trust as well as a council lay member at the University of Kent and joint trust chair of a school's academy trust in Medway.

Dr Razia Shariff

Associate Non-executive Director

Appointed February 2022

Razia has more than 25 years' experience in the social and public sector and in higher education at the national and local level in the UK. She has worked at management and strategic level for the past 15 years and has worked with marginalised communities throughout her career. Razia, who lives near Dover, is chief executive of Kent Refugee Action Network, a regional charity working with separated refugee and asylum seekers in the care system since 2016. She is also a member of the Children in Need South East Grants Panel. In 2020, she was awarded a PhD in international politics focusing on critical social moments and the capability approach. She has also worked with NICE to develop national guidance and has been trustee of the People's Health Lottery.

Bridget Skelton

Non-executive Director

Appointed March 2015 to March 2022

Bridget Skelton has 25 years' experience as a senior executive and board member in organisations in the legal, financial, management consultancy, retail, public and voluntary sectors. She brings particular know-how to support business transformation, enhance performance and manage cultural development and change. Bridget lives in rural Kent.

- Senior Independent Director
- Chair of Strategic Workforce Committee
- Member of Audit and Risk Committee
- Member and Deputy Chair of Finance, Business and Investment Committee
- Member and Deputy Chair of Remuneration Committee

Karen Taylor

Non-executive Director

Appointed February 2022

Karen has more than 20 years' experience leading research teams looking at the challenges facing health and publishing research into improving services for patients, carers and the public. She established Deloitte's UK's Centre for Health Solutions in November 2011. The centre is the independent research arm of Deloitte's Life Sciences and Health Care (LSHC). It practices and combines creative thinking, robust research and industry experience to develop evidence-based perspectives on some of the biggest and most challenging issues to help clients transform themselves and, importantly, benefit the patient. Her research reports include:

- Closing the digital gap:
- Shaping the future of UK healthcare;
- Time to care: Securing a future for the hospital workforce in Europe;
- Vital signs: how to deliver better healthcare across Europe;
- and The Future Awakens: life sciences and healthcare predictions 2022.

These reports focus on the emergence of new advanced technologies and the transformation of service delivery and experience of care.

Before joining Deloitte, Karen was the Director of Health Value for Money Audit at the National Audit Office for 13 years delivering more than 30 hard-hitting reports and to Parliament on health-related issues. In 2002, Karen received an OBE for her work on health value for money audit.

Karen is a member of the Institute of Chartered Public Finance and Accountants and has extensive experience in leading research into healthcare and life-science issues in the UK and internationally. She also spent 10 years as a non-executive director at Dartford and Gravesham NHS Trust, where she chaired the Audit Committee.

Nigel Turner

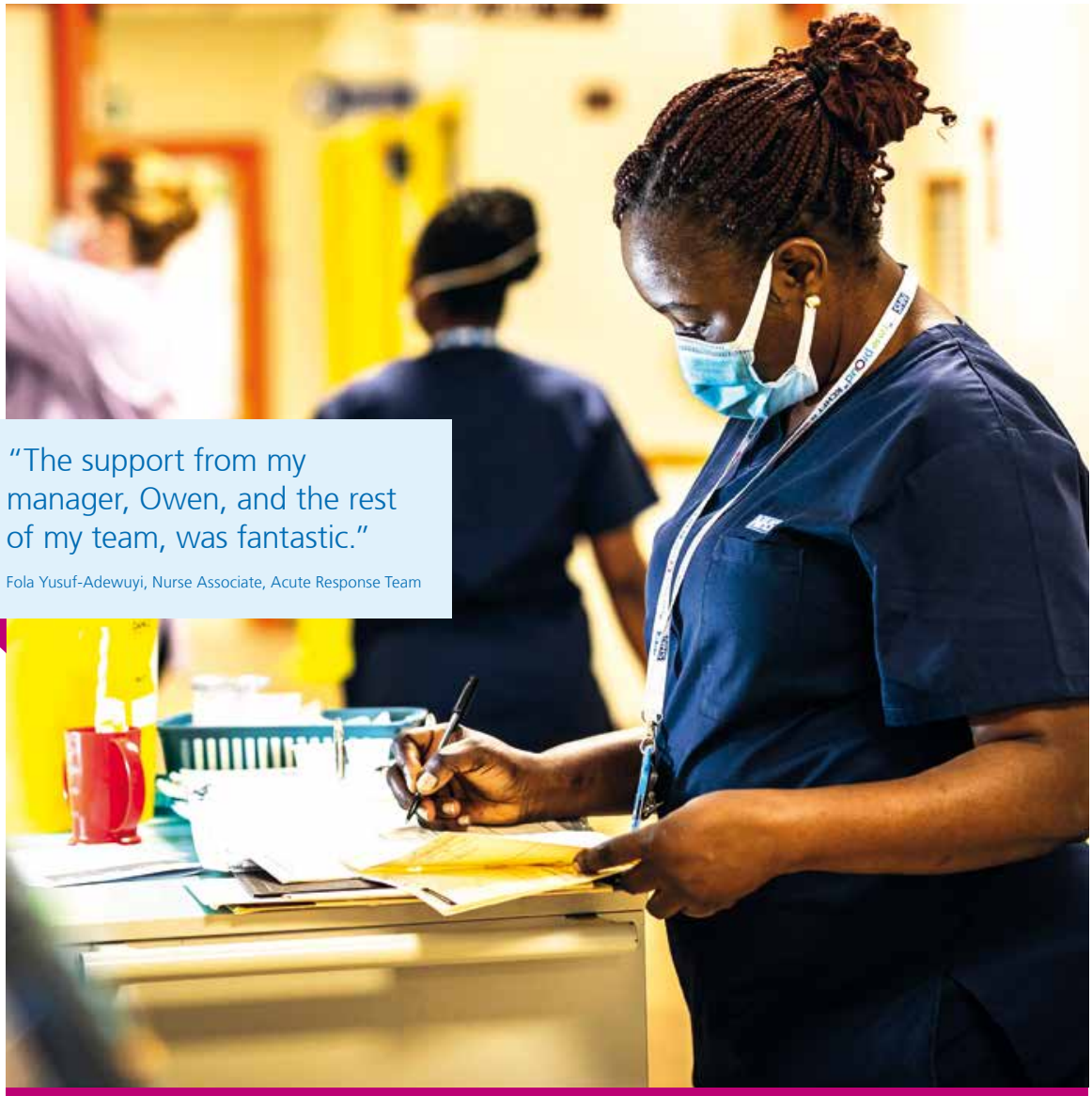
Non-executive Director

Appointed October 2018

Nigel is a group human resources director with a proven track record in leading contemporary transformational people-change in some of the most challenging UK organisational scenarios. His career has included leading the people agenda of the £400million digital transformation of Argos, before its sale to Sainsbury's. He also took the lead role for people in the government-funded modernisation of the Royal Mail, providing strategic support to the HR director at Northern Rock following the financial crisis and led the people strategy at Spire Healthcare.

He lives in Harrietsham, near Maidstone.

- Member of Quality Committee
- Member and deputy chair of Strategic Workforce Committee
- Member of Remuneration Committee.



"The support from my manager, Owen, and the rest of my team, was fantastic."

Fola Yusuf-Adewuyi, Nurse Associate, Acute Response Team

we supported

Board, council and committee attendance

Board, committee and Council of Governor meetings continued throughout the pandemic and were carried out virtually or in hybrid form. Virtual Board and Council of Governor meetings were made available to the public by MS Teams live events or recordings available on the trust's website.

Where a director is unable to attend a meeting, they receive papers in advance and have the opportunity to provide comments to the chair of the Board, or to the relevant committee chair.

	Formal Board	Audit and risk	Charitable funds	Finance, business and investment	Quality	Strategic workforce	Council of Governors
	A/B	A/B	A/B	A/B	A/B	A/B	A/B
Non-executive Directors							
John Goulston	12/12	1/0	1/0	3/0	3/0	2/0	4/4
Sola Afuape	6/9	0/0	2/2	5/5	6/7	0/0	2/0
Pippa Barber	12/12	5/5	3/3	1/0	9/9	2/0	4/0
Paul Butler	12/12	0/0	0/0	7/7	7/7	0/0	1/0
Peter Conway	11/12	5/5	0/0	6/7	1/0	1/0	0/0
Prof. Francis Drobniewski	8/9	0/0	3/3	0/0	6/7	4/5	3/0
Kim Lowe	3/3	1/0	0/0	1/0	2/0	1/0	0/0
Razia Shariff	3/3	0/0	0/0	0/0	0/0	0/0	0/0
Bridget Skelton	8/12	5/5	0/0	4/7	1/0	6/6	2/0
Karen Taylor	2/3	0/0	0/0	1/0	1/0	1/0	0/0
Nigel Turner	12/12	0/0	0/0	0/0	7/9	6/6	0/0
Executive directors							
Paul Bentley	9/9	1/0	0/0	0/0	0/0	1/0	2/0
Pauline Butterworth	11/12	0/0	0/0	4/7*	7/9*	4/6*	0/0
Natalie Davies	12/12	3/0	0/0	0/0	0/0	0/0	4/0
Gordon Flack	11/12	3/0	1/0	6/5	0/0	0/0	2/0
Gill Jacobs	3/3	1/0	0/0	2/2	0/0	2/0	0/0
Louise Norris	6/6	0/0	0/0	0/0	0/0	3/3	1/0
Dr Sarah Phillips	11/12	0/0	0/0	2/0	8/9*	0/0	0/0
Victoria Robinson-Collins	6/6	0/0	0/0	0/0	0/0	3/3	1/0
Gerard Sammon	12/12	1/0	0/0	7/7	0/0	0/0	1/0
Dr Mercia Spare	12/12	0/0	1/3	0/0	9/9	5/6*	0/0

A the total number of meetings the director attended

B the total number of meetings the director was eligible to attend as a member of the Committee or Board

***A representative attended for one meeting as follows:**

- Claire Poole, Deputy Chief Operating Officer attended the Finance, Business and Investment Committee on behalf of Pauline Butterworth
- Claire Poole attended the Quality Committee on behalf of Pauline Butterworth
- Claire Poole attended the Strategic Workforce Committee on behalf of Pauline Butterworth
- Dr Lisa Scobbie, Deputy Medical Director attended the Quality Committee on behalf of Dr Sarah Phillips
- Sive Cavanagh, Deputy Chief Nurse attended the Strategic Workforce Committee on behalf of Dr Mercia Spare

Directors' report: Compliance statements

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

The Board and Council of Governors comply with the fit and proper persons test.

The trust has in place a major incident plan that is fully compliant with the requirements of the NHS England Preparedness, Resilience and Response Framework 2015. The trust regularly participates in exercises and training with public sector partners. The trust's internal auditor produces an annual internal audit plan, which reviews the economy, efficiency and effectiveness of resources. The work programme is agreed and monitored by the Audit and Risk Committee.

Better payment practice code 2021/22

The trust is monitored against the Better Payment Practice Code (BPPC) which requires NHS organisations to pay all creditors within 30 days of receipt of goods or a valid invoice (whichever is later) unless other payment terms have been agreed. The trust's BPPC compliance statistics for 2021/22 is set out below:

Non-NHS payables	2021/22 number	2021/22 £000s
Total non-NHS invoices paid in the period	30,360	66,339
Total non-NHS invoices paid within target	25,567	58,160
Percentage of non-NHS invoices paid within target	84%	88%

NHS payables	2021/22 number	2021/22 £000s
Total NHS invoices paid in the period	1,166	14,537
Total NHS invoices paid within target	1,004	11,824
Percentage of NHS invoices paid within target	86%	81%

Total payables

Total non-NHS and NHS invoices paid in the period	31,526	80,876
Total non-NHS and NHS invoices paid within target	26,571	69,983
Percentage of non-NHS and NHS invoices paid within target	84%	87%

The trust is a signatory of the Prompt Payment Code (PPC) which sets standards for payment practices and best practice and is administered by the Office of the Small Business Commissioner.

The trust also continues to align with Cabinet Office direction in ensuring prompt payment practices.

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

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

Council of Governors as at 31 March 2022

Public governors

Ashford
Kathy Walters

Canterbury
Lynne Spencer

Dartford
Elaine Ashford

Dover/Deal
Carol Coleman

Gravesham
Dot Marshall

Maidstone
Alison Fisher

Sevenoaks
Gillian Harris

Folkestone and Hythe
Daniel Mott

Thanet
Tilly Harris

Rest of England
John Woolgrove

Swale
Brian Grove

Tunbridge Wells
Loretta Bellman

Tonbridge and Malling
Ruth Davies

Staff governors

William Anderson
Adult Services

Dawn Gaiger
Adult Services

Jan Allen
Corporate Services

Maria-Loukia Bratsou
Children and Families

Kimberley Lloyd
Health and Wellbeing

Appointed governors

Dr Susan Plummer
Kent Universities
(Stood down 31 March 2022)

Vacant
Public Health

John Norley
Age UK

Matthew Wright
Head Teachers' Association

Alison Carter
Kent Dementia Action Alliance

Public and staff governors are elected for a three year period.

Membership: Representation and effectiveness

The trust agreed a membership strategy for 2018 to 2021, which set out four objectives, linked to our communication and engagement goals, to make sure our members were fully informed and involved. This action plan is still in place today.

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

The four objectives are:

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

Understanding the views of governors and members

Throughout 2021/22, governors have been kept up-to-date virtually via the Council of Governors meetings, development sessions, informal governor meetings as well as sharing of information via email. An induction was also conducted virtually for new governors appointed in 2021. The trust has continued to support governors to make sure they have been able to develop their role, represent their constituents and hold the trust to account for its performance.

Governors are invited to one full day development session each year, as well as four morning sessions held before the council meetings. All sessions took place virtually during 2021, and were well attended by governors. These sessions are devoted to a range of topics including service presentations and Board Committee deep dive discussions.

Under ordinary circumstances, governors would usually be invited to attend a number of trust visits, internal reviews and engagement events in person throughout the year. However, due to the pandemic most of these events did not take place during 2021/22. Instead, governors were invited to observe Board meetings and other events, using MS Teams.

During 2021/22, our governors carried out a number of statutory duties including the approval of the remuneration and appraisal process for the chair and non-executive directors and the appointment of a new chief executive.

Governor support staff from Kent and Medway foundation trusts continued to meet virtually, to share best practice, discuss matters of interest and concern and to make sure they can offer a good and consistent support mechanism for their members.

As part of the Communications and Engagement Group, governors helped to shape the trust's Winter Wellbeing initiative held in the second week of December 2021.

The week-long campaign replaced previous 'let's discuss' events on key topics with members.

Content included advice on falls, slips and trips, urgent care services, staying well in winter, looking after yourself and your family and staying independent. The campaign reached a total of 65,448 contacts using a variety of media.

Remuneration report

This remuneration report presents information from the 1 April 2021 to 31 March 2022.

Annual statement on remuneration

Information not subject to audit.

The Chief Executive's and Medical Director's performance against the agreed objectives was discussed by the Remuneration Committee. These were met in full and consequently the committee agreed that there would be no claw back of salary. In addition performance related pay was agreed for all executives to mirror the cost of living award for Agenda for Change staff.

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

The Council of Governors reviewed the salaries for the trust Chair and the non-executive directors in January 2022 and they wished to maintain the remuneration at the current levels.

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 ensure the NHS receives benefit during the notice period. This could include undertaking special projects and short-term placements.

Pay component	How that component supports the trust's short and long-term strategy	How it operates	Maximum payable
Senior managers are entitled to a basic salary which is determined by the Remuneration Committee. The rates paid to individual directors are determined by the Remuneration Committee, which takes into account: • qualifications required for the role • spans of responsibility and accountability • performance • market forces	The trust believes that its senior managers should be fairly remunerated for their work. Trust salaries should be competitive and enable the trust to attract and in due course retain high calibre staff. However, salaries should not be overly high and should be positioned in the top quartile of salaries for similar organisations. The Remuneration Committee will therefore 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 the views of ministers are sought. A claw back scheme is in place for the chief executive's and medical director's salary. Should objectives not be achieved the salary is reduced by 10 per cent. A report is presented to the Remuneration Committee.	
The annual uplift		A cost of living, non-pensionable payment in October 2021 and March 2022 equivalent to three per cent of salary, mirroring all NHS staff covered by the Agenda for Change terms and conditions.	3 per cent of salary

Pay component	How that component supports the trust's short and long-term strategy	How it operates	Maximum payable
Chief executive earn back	The trust believes 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 therefore reference its salaries to the NHS Providers survey of executive salaries and independent advice, as required. Where applicable views of ministers are sought.	A claw back scheme is in place. Should objectives not be achieved the salary is reduced by 10 per cent.	10 per cent of salary
Performance related pay	To make sure the delivery of the trust strategic objectives a bonus payment can be made to the chief executive and deputy chief executive.	On the achievement of objectives.	Up to £17K

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 shall 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 paid during 2021/22. Non-executive members do not receive pensionable remuneration.

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

There are three levels of remuneration based on the level of commitment expected of the post holder: Trust Chairman; Chair of Audit and Risk, Quality and Finance, Business and Investment Committees, Strategic Workforce Committee 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 £13,800 for NEDs appointed prior to September 2019. For those appointed after this date £13,000 in line with NHSI guidance.	Four NEDs Three NEDs
Associate non-executive basic pay	A spot rate salary of £9,000.	One Associate NED
NED committee – chair responsibility	20 per cent uplift.	Quality Committee chair Strategic Workforce Committee chair Audit and Risk Committee chair Finance, Business and Investment Committee chair

Service contracts obligations

There is one standard contract for all directors. The chief executive's and medical director's contract includes a clause regarding claw back. In addition the chief executive and deputy chief executive's contracts include performance related pay. This standard contract puts the following obligations on the Trust;

- Review performance annually.
- Give reasonable notice of any variation to salary.
- To determine redundancy pay by reference to Part XI of the Employment Rights Act 1996. Any redundancy payment will be calculated in accordance with paragraphs 16.8 and 16.9 of the NHS terms and conditions of service handbook.
- To pay appropriate expenses incurred in the course of duties in accordance with the trust's travel and expenses policy.
- Annual leave follows standard NHS terms, likewise sickness.
- The notice period for all executive directors appointed post April 2015 except 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 for chief executive and all directors.
- Payments in lieu of notice are at the discretion of the trust.
- Senior manager's performance is relevant for loss of office when a material element of the business plan has not been delivered and then there can be dismissal without notice.

Setting senior managers' remuneration policy

The pay and conditions of employees (including any other group entities) were taken into account when setting the remuneration policy for senior managers.

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

The chief executive confirms that the remuneration report covers senior managers who have authority or responsibility for directing or controlling the major activities of the trust. These managers influence the decisions of the entity as a whole rather than the decisions of individual directorates or department.

The policy on diversity and inclusion used by the remuneration committee

As an employer for, and a provider of, health services in Kent, London and East Sussex the Remuneration Committee take the issues of fairness, rights and equality very seriously.

The Remuneration Committee undertakes an equality impact assessment on all polices and decisions.

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 chairman. Between 1 April 2021 and 31 March 2022 there were seven meetings of the Remuneration Committee.

Remuneration Committee	Meetings attended 2021/22
John Goulston	7
Peter Conway	6
Bridget Skelton	7
Pippa Barber	7
Francis Drobniewski	4
Nigel Turner	6
Paul Butler	7
Sola Afuape	5
Kim Lowe	0
Karen Taylor	0
Razia Shariff	0

The chief executive and director of people and organisational development also attend meetings by invitation; however, they are not present where matters relating to them are under discussion. Bevan Brittan have provided legal advice in relation to an employment tribunal settlement proposal. Kim Lowe, Karen Taylor and Razia Shariff have not attended any meetings due to joining the trust on the 1 February 2022.

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

Service contracts

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

Senior manager	Date effective	Notice
Paul Bentley, Chief Executive Officer (to 16 January 2022)	1 March 2016	6 months
Gordon Flack, Acting Chief Executive Officer (from 1 January 2022), previously Director of Finance and Deputy Chief Executive Officer	1 March 2015	6 months
Pauline Butterworth, Chief Operating Officer	16 December 2019	3 months
Ali Carruth, Director of Participation, Experience and Patient Engagement	6 January 2020	3 months
Mercia Spare, Chief Nurse	1 January 2020	3 months
Sarah Phillips, Medical Director	10 April 2017	3 months
Natalie Davies, Director of Corporate Services	1 April 2015	3 months
Louise Norris, Director of Workforce, Organisational Development and Communications (to January 2022)	7 July 2015	3 months
Victoria Robinson-Collins, Director of People and Organisational Development (from 18 October 2021)	18 October 2021	3 months
Gerard Sammon, Director of Strategy and Partnerships	1 October 2019	3 months
Gill Jacobs, Acting Director of Finance (from 1 January 2022)	1 January 2022	3 months
Claire Poole, Deputy Chief Operating Officer. Deputised for Chief Operating Officer from 8 November 2021 to 26 November 2021	8 November 2021	3 months

Non-executive director service contracts are fixed term with the following unexpired terms as at the 31 March 2022:

Non-executive directors	Date effective	End date	Unexpired term
John Goulston, Chair	1 November 2021	31 October 2024	2 years 7 months
Peter Conway, Vice Chair	1 April 2021	31 March 2022	-
Sola Afuape, Non-executive Director	1 December 2019	20 January 2022	-
Pippa Barber, Non-executive Director	1 December 2019	30 November 2022	8 months
Paul Butler, Non-executive Director	1 March 2020	28 February 2023	11 months
Francis Drobniewski, Non-executive Director	1 October 2018	24 January 2022	-
Bridget Skelton, Non-executive Director	7 April 2019	31 March 2022	-
Nigel Turner, Non-executive Director	1 October 2021	30 September 2024	2 years 6 months
Karen Taylor, Non-executive Director	1 February 2022	31 January 2025	2 years 10 months
Kim Lowe, Non-executive Director	1 February 2022	31 January 2025	2 years 10 months
Razia Shariff, Associate Non-executive Director	1 February 2022	31 January 2024	1 year 10 months

During the year John Goulston and Nigel Turner were re-appointed to the board, and it is their re-appointed dates reflected in the table above. Peter Conway's next term in office starts on 1 April 2022 following re-appointment.

Bridget Skelton, Francis Drobniewski and Sola Afuape left the trust during the year. Three new non-executive directors joined the trust on 1 February 2022; Karen Taylor, Kim Lowe, and Razia Shariff. Razia has joined as an Associate Non-Executive Director.

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	
	2021/22	2020/21
Paul Bentley, Chief Executive Officer (to 16/01/22)	–	4
Gordon Flack, Acting Chief Executive Officer (from 01/01/22), previously Director of Finance and Deputy Chief Executive Officer	–	–
Lesley Strong, Chief Operating Officer and Deputy Chief Executive Officer (to 05/12/19), returned to Executive Team 16/03/20 to 31/07/20	–	1
Pauline Butterworth, Chief Operating Officer	–	1
Ali Carruth, Director of Participation, Experience and Patient Engagement	–	–
Mercia Spare, Chief Nurse	–	3
Sarah Phillips, Medical Director	3	2
Natalie Davies, Director of Corporate Services	–	–
Louise Norris, Director of Workforce, Organisational Development and Communications (to 21/01/22)	–	1
Victoria Robinson-Collins, Director of People and Organisational Development (from 18/10/21)	50	–
Gill Jacobs, Acting Director of Finance (from 01/01/22)	–	–
Claire Poole, Deputy Chief Operating Officer. Deputised for Chief Operating Officer from 8 November to 26 November 2021	–	–
Gerard Sammon, Director of Strategy and Partnerships	–	2
John Goulston, Chair	14	9
Peter Conway, Vice Chair	3	3
Sola Afuape, Non-Executive Director (to 20/01/22)	3	2
Pippa Barber, Non-Executive Director	5	–
Paul Butler, Non-Executive Director	–	–
Francis Drobniewski, Non-Executive Director (to 31/01/22)	4	5
Kim Lowe, Non-Executive Director (from 01/02/22)	–	–
Razia Shariff, Associate Non-Executive Director (from 01/02/22)	–	–
Bridget Skelton, Non-Executive Director (to 31/03/22)	–	2
Karen Taylor, Non-Executive Director (from 01/02/22)	–	–
Nigel Turner, Non-Executive Director	–	5
Total	**82**	**40**

There was a total of 23 executive, non-executive directors, and associate non-executive directors in post in the reporting period 2021/22 and seven of these received expenses paid by the trust. The aggregate sum of directors' expenses totals £8,212.

The following expenses were paid to governors in the period:

Governors	Expenses (rounded to nearest 100) £00	
	2021/22	2020/21
Carol Coleman	2	2
Miles Lemon	-	1
Total	**2**	**3**

There are a total of 23 governor positions. There have been 28 individuals working as governors within the year, with six leaving and five starting in the period. As at 31 March 2022, there are 22 governors in post, with one vacant position. In the reporting period 2021/22, one governor received expenses paid by the trust. The aggregate sum of governors' expenses totals £222.

The remaining information in this report is subject to audit

Name and title	2021/22						2020/21					
	Salary and fees	Taxable benefits	Annual performance –related bonuses	Long–term performance –related bonuses	All pension –related benefits	Total	Salary and fees	Taxable benefits	Annual performance –related bonuses	Long–term performance –related bonuses	All pension –related benefits	Total
	(bands of £5,000) £000	(to the nearest £100) £	(bands of £5,000) £000	(bands of £5,000) £000	(bands of £2,500) £000	(bands of £5,000) £000	(bands of £5,000) £000	(to the nearest £100) £	(bands of £5,000) £000	(bands of £5,000) £000	(bands of £2,500) £000	(bands of £5,000) £000
Paul Bentley, Chief Executive Officer (to 16/01/22)	165 – 170	400	0 – 5		0	170 – 175	205 – 210				505 – 507.5	715 – 720
Gordon Flack, Acting Chief Executive Officer (from 01/01/22), previously Director of Finance and Deputy Chief Executive Officer	165 – 170	900	0 – 5		0	170 – 175	160 – 165		0 – 5		0	165 – 170
Lesley Strong, Chief Operating Officer and Deputy Chief Executive Officer (to 05/12/19), returned to Executive Team 16/03/20 to 31/07/20							20 – 25		0 – 5		0	20 – 25
Pauline Butterworth, Chief Operating Officer	130 – 135	600	0 – 5		25 – 27.5	160 – 165	130 – 135		0 – 5		50 – 52.5	185 – 190
Ali Carruth, Director of Participation, Experience and Patient Engagement	75 – 80	0	0 – 5		17.5 – 20	95 – 100	75 – 80		0 – 5		0	75 – 80
Mercia Spare, Chief Nurse	125 – 130	0	0 – 5		37.5 – 40	170 – 175	125 – 130		0 – 5		90 – 92.5	215 – 220
Sarah Phillips, Medical Director	180 – 185	600	5 – 10		47.5 – 50	235 – 240	170 – 175				25 – 27.5	195 – 200
Natalie Davies, Director of Corporate Services	110 – 115	600	0 – 5		10 – 12.5	125 – 130	105 – 110		0 – 5		12.5 – 15	120 – 125
Louise Norris, Director of Workforce, Organisational Development and Communications (to 21/01/22)	95 – 100	0	0 – 5		12.5 – 15	115 – 120	120 – 125		0 – 5		37.5 – 40	160 – 165
Victoria Robinson–Collins, Director of People and Organisational Development (from 18/10/21)	45 – 50	400	0		5 – 7.5	55 – 60						
Gerard Sammon, Director of Strategy and Partnerships	130 – 135	0	0 – 5		0	135 – 140	140 – 145		0 – 5		170 – 172.5	315 – 320
Gill Jacobs, Acting Director of Finance (from 01/01/22)	30 – 35	0	0		17.5 – 20	50 – 55						
Claire Poole, Deputy Chief Operating Officer. Deputised for Chief Operating Officer from 08/11/21 to 26/11/21	5 – 10	0	0		0 – 2.5	5 – 10						

*The annual performance related bonuses are non-consolidated bonuses issued in line with the annual cost of living pay uplift component outlined in the Policy on Remuneration for Executive Directors.
**The taxable benefits above are in relation to lease car benefits.

Name and title	2021/22						2020/21					
	Salary and fees	Taxable benefits	Annual performance –related bonuses	Long–term performance –related bonuses	All pension –related benefits	Total	Salary and fees	Taxable benefits	Annual performance –related bonuses	Long–term performance –related bonuses	All pension –related benefits	Total
	(bands of £5,000) £000	(to the nearest £100) £	(bands of £5,000) £000	(bands of £5,000) £000	(bands of £2,500) £000	(bands of £5,000) £000	(bands of £5,000) £000	(to the nearest £100) £	(bands of £5,000) £000	(bands of £5,000) £000	(bands of £2,500) £000	(bands of £5,000) £000
John Goulston, Chair	45 – 50					45 – 50	45 – 50					45 – 50
Peter Conway, Vice Chair	15 – 20					15 – 20	15 – 20					15 – 20
Sola Afuape, Non–executive Director (to 20/01/22)	10 – 15					10 – 15	10 – 15					10 – 15
Pippa Barber, Non–executive Director	15 – 20					15 – 20	15 – 20					15 – 20
Paul Butler, Non–executive Director	15 – 20					15 – 20	15 – 20					15 – 20
Francis Drobniewski, Non–executive Director (to 31/01/22)	10 – 15					10 – 15	10 – 15					10 – 15
Kim Lowe, Non–executive Director (from 01/02/22)	0 – 5					0 – 5						
Razia Shariff, Associate Non–executive Director (from 01/02/22)	0 – 5					0 – 5						
Bridget Skelton, Non–executive Director (to 31/03/22)	15 – 20					15 – 20	15 – 20					15 – 20
Karen Taylor, Non–executive Director (from 01/02/22)	0 – 5					0 – 5						
Nigel Turner, Non–executive Director (from 01/10/18)	10 –15					10–15	10–15					10–15

During the period 1 April 2021 to 31 March 2022 there have been a few changes in personnel to the executive team. Paul Bentley left the trust in January 2022, Gordon Flack has therefore been Acting Chief Executive Officer since this time, and Gill Jacobs has been Acting Director of Finance. Victoria Robinson-Collins joined the trust in October 2021 as Director of People and Organisational Development. Louise Norris left the trust and retired in January 2022. Claire Poole deputised for Pauline Butterworth when she was away for three weeks on a training course.

The trust remunerates Dr Sarah Phillips solely for her management role, as she does not undertake a direct patient care role with the trust.

With reference to the tables above the value of pension benefits accrued during the year is calculated as the real increase in pension multiplied by 20, less the contributions made by the individual. The real increase excludes increases due to inflation or any increase or decrease due to a transfer of pension rights. This value derived does not represent an amount that will be received by the individual. It is a calculation that is intended to provide an estimation of the benefit being a member of the pension scheme could provide. The pension benefit table provides further information on the pension benefits accruing to the individual.

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

Pension benefits

Name and title	Real increase in pension at pension age (bands of £2,500) £000	Real increase in pension lump sum at pension age (bands of £2,500) £000	Total accrued pension at pension age at 31.03.22 (bands of £5,000) £000	Lump sum at pension age related to accrued pension at 31.03.22 (bands of £5,000) £000	Cash Equivalent Transfer Value at 01.04.21 £000	Cash Equivalent Transfer Value at 31.03.22 £000	Real increase in cash equivalent transfer value £000	Employer's contribution to stakeholder pension £000
Paul Bentley, Chief Executive Officer (to 16/01/22)	0 – 2.5	0	70 – 75	210 – 215	1,627	1,301	0	n/a
Gordon Flack, Acting Chief Executive Officer (from 01/01/22), previously Director of Finance and Deputy Chief Executive Officer	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
Pauline Butterworth, Chief Operating Officer	0 – 2.5	0	25 – 30	0	367	406	20	n/a
Ali Carruth, Director of Participation, Experience and Patient Engagement	0 – 2.5	0	30 – 35	55 – 60	507	539	18	n/a
Mercia Spare, Chief Nurse	2.5 – 5	0 – 2.5	40 – 45	105 – 110	920	993	50	n/a
Sarah Phillips, Medical Director	2.5 – 5	0	25 – 30	25 – 30	385	437	31	n/a
Natalie Davies, Director of Corporate Services	0 – 2.5	0	35 – 40	65 – 70	544	569	9	n/a
Louise Norris, Director of Workforce, Organisational Development and Communications (to 21/01/22)	0 – 2.5	0	55 – 60	145 – 150	1,243	1,297	33	n/a
Victoria Robinson-Collins, Director of People and Organisational Development (from 18/10/21)	0 – 2.5	0	5 – 10	0	47	60	0	n/a
Gerard Sammon, Director of Strategy and Partnerships	0	0	45 – 50	105 – 110	924	889	0	n/a
Gill Jacobs, Acting Director of Finance (from 01/01/22)	0 – 2.5	0 – 2.5	40 – 45	80 – 85	645	740	18	n/a
Claire Poole, Deputy Chief Operating Officer. Deputised for Chief Operating Officer from 08/11/21 to 26/11/21	0 – 2.5	0 – 2.5	35 – 40	115 – 120	905	959	2	n/a

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

Gordon Flack's information is shown as n/a because he chose not to be covered by the pension arrangements during the reporting year.

Paul Bentley opted out of the pension scheme from May 2021, and Sarah Phillips opted out of the pension scheme from January 2022.

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 the disclosure applies. 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.

The inflation applied to the accrued pension, lump sum (if applicable) and CETV is the percentage (if any) by which the Consumer Prices Index (CPI) for the September before the start of the tax year is higher than it was for the previous September. The Consumer Prices Index up to September 2020 was 0.5 per cent. Therefore, for calculation purpose the trust has used an inflation rate of 0.5 per cent to calculate the real increases in pensions, lumps sums and CETVs over the period. This is in line with the latest Greenbury Pension Guidance.

Fair pay multiple

NHS foundation trusts are required to disclose the relationship between the remuneration of the highest-paid director in their organisation and the lower quartile, median and upper quartile remuneration of the organisation's workforce.

The banded remuneration of the highest-paid director in the organisation in the financial year 2021-22 was £185k-£190k (2020-21, £205k-£210k). The percentage change in the banded salary for the highest paid director is -12 per cent. Performance pay and bonuses have been issued to the highest paid director in 2021-22 but were not issued to the highest paid director in 2020-21, therefore a percentage comparison cannot be provided for this.

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

For employees of the trust as a whole, the range of remuneration in 2021-22 was from £18k to £259k (2020-21 £18k to £209k). The percentage change in average employee remuneration (based on total for all employees on an annualised basis divided by full time equivalent number of employees) between years is 3.15 per cent. One employee received remuneration in excess of the highest-paid director in 2021-22 (2020-21, no employee).

The decrease in highest paid director remuneration is as a result of the previous highest paid director leaving the trust in the year. The increase in the average employee remuneration is as expected in line with the NHS pay rise issued in 2021.

The remuneration of the employee at the 25th percentile, median and 75th percentile is set out below. The pay ratio shows the relationship between the total pay and benefits of the highest paid director (excluding pension benefits) and each point in the remuneration range for the organisation's workforce.

2021-22	25th Percentile	Median	**75th Percentile**
Total remuneration (£)	22,549	27,833	39,027
Salary component of total remuneration (£)	21,777	27,780	39,027
Pay ratio information (£)	8:1	7:1	5:1
2020-21			
Total remuneration (£)	21,892	27,416	38,617
Salary component of total remuneration (£)	21,142	25,939	37,890
Pay ratio information (£)	9:1	8:1	5:1

The decrease in the fair pay multiple from last financial year is as a result of the reduction in remuneration of the highest paid director.

Signed.....

Gordon Flack, Acting Chief Executive Officer
(On behalf of the Board)

Date: 16 June 2022

"I've done the work but I couldn't have done it without the support and guidance from all the health professionals."

Peter Silvey, patient

we delivered

Staff report

Our people have been truly amazing as they have battled for a second year with the gruelling challenges of the Covid pandemic, on top of delivering nearly half a million vaccinations as part of the Covid vaccination programme.

It has, once again, been an unprecedented year for everyone and during the most difficult of times, we are proud of our workforce for the outstanding care they have delivered to our patients and their unwavering dedication to be there for our communities when they need them most.

This year has also seen us develop our new three-year People, Equity, Diversity and Inclusion Strategy – Nobody Left Behind, which has been developed with our staff networks and reflects our ambition to become the best employer, by making sure all of our people have a positive and inclusive experience at work.

Our Clinical Academy continues to expand with new opportunities opening. We now have 90 apprentices in training, including nursing and allied health professionals. For the first time this year, we included physiotherapy apprentices within the academy. Of these, 10 are colleagues converting from assistant practitioner or nurse associate to registered nurses. We are truly growing our workforce of the future.

Key achievements in 2021/22

- Highest staff survey response rate ever achieved by the trust at 65 per cent.
- Exceeded our appraisal completion rate target of 85 per cent, achieving 94.2 per cent (as at January 2022).
- Exceeded our statutory and mandatory training target of 85 per cent, achieving 95.2 per cent (as at January 2022).
- Delivered more than 600,000 Covid vaccinations to the population of Kent and Medway.
- A low vacancy rate of 4.8 per cent (as at February 2022).
- Recruited a new director of people and organisational development.
- Recruited a new chief executive.
- Developed and launched our Nobody Left Behind – People, Equity, Diversity and Inclusion Strategy, including the launch of our Veterans' Network.
- Our first cohort of Nursing Associates graduated from the Nursing Academy.

The information in the following tables is subject to audit

Staff costs

	Permanent £000	Other £000	2021/22 Total £000	2020/21 Total £000
Salaries and wages	140,448	16,866	**157,314**	149,688
Social security costs	12,651	1,212	**13,863**	12,741
Apprenticeship levy	770	-	**770**	715
Employer's contributions to NHS pension scheme	26,795	1,659	**28,454**	26,894
Pension cost – other	47	1	**48**	48
Termination benefits	127	-	**127**	91
Temporary staff	–	4,386	**4,386**	6,913
Total gross staff costs	**180,838**	**24,124**	**204,962**	**197,090**
Recoveries in respect of seconded staff	(140)	-	**(140)**	(9)
Total staff costs	**180,698**	**24,124**	**204,822**	**197,081**
Of which Costs capitalised as part of assets	585	76	**661**	1,379

Total staff costs on the Covid-19 vaccination programme during 2021/22 was £8.5m (£2.4m 2020/21).

Staff numbers

Average number of employees (WTE basis)

	Permanent number	Other number	2021/22 Total number	2020/21 Total number
Medical and dental	79	4	**83**	85
Administration and estates	1,323	138	**1,461**	1,533
Healthcare assistants and other support staff	1,000	194	**1,194**	1,065
Nursing, midwifery and health visiting staff	1,128	155	**1,283**	1,250
Nursing, midwifery and health visiting learners	27	-	**27**	25
Scientific, therapeutic and technical staff	743	24	**767**	751
Healthcare science staff	15	**1**	**16**	**-**
Total average numbers	**4,315**	**516**	**4,831**	**4,709**
Of which Number of employees (WTE) engaged on capital projects	13	1	**14**	31

Total average number of employees on the Covid-19 vaccination programme during 2021/22 was 192 WTE (63 WTE 2020/21).

Gender distribution

The gender distribution of our workforce as at 31 March 2022 is:

Role	Female (FTE)	Female (%)	Male (FTE)	Male (%)	Total (FTE)	% Total
Director	6.00	75.00	2.00	25.00	8.00	100.00
Senior managers	17.90	78.17	5.00	21.83	22.90	100.00
Other employees	3,711.92	87.38	535.97	12.62	4,247.89	100.00
Grand total	**3,735.82**	**87.31**	**542.97**	**12.69**	**4,278.79**	**100.00**

Staff sickness absence

	2021-22
Total working days lost	45,921
Total staff years	4,300
Average working days lost (per WTE)	**11**

The above staff sickness data is provided centrally by NHS Digital using the statistics held within the ESR (Electronic Staff Record) data warehouse. The above data is based on the 2021 calendar year to align with the latest published statistics which can be found on the website of NHS Digital. The published statistics are then converted by the Department of Health and Social Care to ensure they meet the Cabinet Office reporting requirements for reporting in the public sector. The Department of Health and Social Care considers the resulting figures to be a reasonable proxy for financial year equivalents.

Staff turnover data

Staff turnover data can be found at NHS workforce statistics - NHS Digital

Staff policies and actions

Equality and diversity

Our Nobody Left Behind – People, Equity, Diversity and Inclusion Strategy was developed and launched this year. Linked to this, our Workforce Race Equality Standard (WRES), Workforce Disability Equality Standard (WDES) and Gender Pay Gap reports are ambitious action plans to achieve a truly inclusive workplace where everyone feels able to bring their whole selves to work.

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

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

Our Workforce Equality Group (WEG) has developed guidance for managers and colleagues on implementing reasonable adjustments and unconscious bias training has been embedded with our new recruitment and selection e-learning package.

Equality is written into KCHFT's values framework. It makes sure all our colleagues receive training in the subject, it uses equality analysis, and equality and diversity is embedded into all policies.

Additionally, we use the Equality Diversity System 2 (EDS 2) to record and evidence work we do and publish equality objectives annually on our website (www.kentcht.nhs.uk/equality-diversity). Staff networks promote and support staff from a black, minority or Asian (BAME) background, lesbian, gay, bisexual, trans, queer or questioning (LGBTQ+), people with a disability, those who have religious beliefs, people going through the menopause and veterans.

We are also working closely with Kent Supported Employment for the active recruitment of people with a disability. We were thrilled to be finalists in the Kent Excellence in Business Awards (KEiBA) for our work in this area, for the second year in a row.

We are proud to have been awarded Disability Confident Leader and will continue to work with our partners and people to make sure we maximise every opportunity to build the best and most diverse workforce possible.

Gender pay gap

You can find information about our gender pay gap on our website at www.kentcht.nhs.uk/workforce-equality-monitoring/ or via https://gender-pay-gap.service.gov.uk.

Freedom to speak up

The trust has had a freedom to speak up guardian (FTSU) in post all year – this person has a key role in fostering a culture of openness.

A campaign to promote the benefits of speaking up ran throughout the year, and will continue during 2022/23. The campaign sought to raise awareness of speaking up and included ways to get in touch, such as the dedicated email and phone line for colleagues to report their concerns. A review of the freedom to speak up service took place during 2021/22 and we are in the process of recruiting two freedom to speak up guardians who will work together to strengthen the service provided to our staff.

Between 1 April 2021 and 31 March 2022, the FTSU guardian logged and was involved in 17 new cases. Themes of the cases were discussed with the chief executive and a six-monthly report was presented to the Strategic Workforce Committee. The trust has a named non-executive director lead for freedom to speak up, who acts as an alternative source of advice and support for the guardian. Sola Afuape was the non-executive lead until January 2022 when Pippa Barber took the role as non-executive director lead.

The trust has a number of freedom to speak up ambassadors, and their role includes encouraging colleagues to speak up by providing informal advice, sign-posting and promoting positive examples of changes that have occurred as a result of speaking up.

Consultation with staff

KCHFT takes a consultative approach to engagement with staff. Our active Staff Partnership Forum is well attended by both Staff Side and senior leaders. All change proposals are taken to this forum for discussion as well as full staff consultation regarding any changes that will impact staff. Views from all parties are gathered and given due consideration before any final decisions are made.

Involvement of staff in trust performance

KCHFT has a robust performance reporting structure from the Board down with a clear line of accountability and monitoring. The trust Integrated Performance Report is supported by division level performance reports, which are produced monthly, then reviewed and discussed at Executive Performance Reviews. These division reports also include service level dashboards and, in some cases, include performance data for individual teams to allow services to have a clear understanding of their performance. Service leads are encouraged to share these reports within their teams to give colleagues an understanding of their role in performance and share accountability.

In addition, KCHFT has a business intelligence tool to give team leaders and managers access performance data on a more routine basis and share this information with their teams, or investigate areas of adverse performance.

A weekly snapshot of organisation performance is shared as part of Monday's all-staff messaging and on our intranet, flo, plus further metrics are shared monthly via Team Brief.

Health and safety performance

The trust fully meets all its obligations under the Health and Safety at Work etc. Act 1974 and various associated regulations. The trust has a Health and Safety Committee, which reports to the Corporate Assurance and Risk Management Group. Health and safety, fire, security, estates and moving and handling report into the Health and Safety Committee to provide assurance of compliance with safety legislation.

For 2021/22, the trust reported 17 incidents, which fell under the requirements of the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 2013 (RIDDOR). All but one of these reports were submitted to the Health and Safety Executive within the required legal timeframes.

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

Occupational health and counselling

Optima is our occupational health provider. It provides pre-employment screening, vaccinations, advice to managers following referral to support our staff, as well as numerous online resources available to both staff and managers to help them with their health and wellbeing needs.

Our staff counselling is provided by Staff Care Services and can be accessed by staff directly or via a management referral. The service is confidential. The initial four sessions are funded by the trust with the option to extend for more sessions, if necessary, with the agreement of the line manager.

Counter fraud and corruption

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

Staff survey

Staff engagement

Communication and engagement with a workforce of more than 5,000 people spread across Kent, Medway, East Sussex and London remained vital during the second year of a global pandemic.

The Communications Team produced an action plan in line with our overall staff goals to:

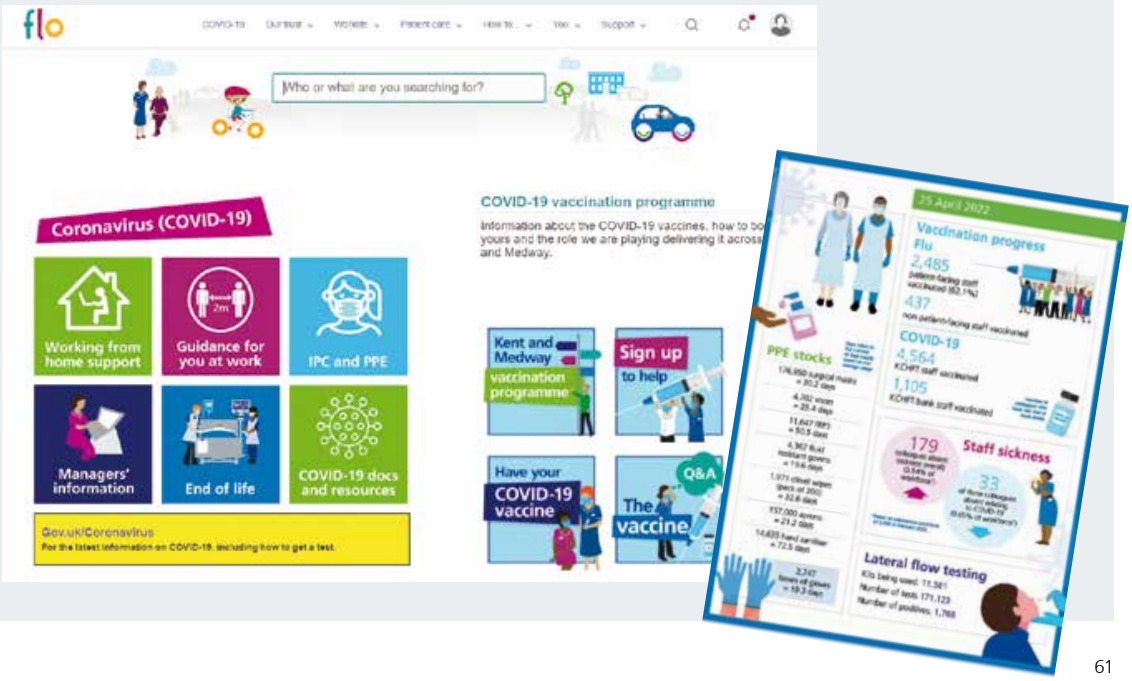
- increase the number of colleagues who say they feel able to make contributions about their service;
- increase year-on-year the number of colleagues who say they feel informed, involved and valued.

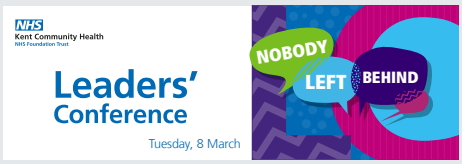
We used our branded intranet, flo (short for Florence Nightingale) to continue to communicate with colleagues. It is updated 24/7 and includes a dedicated section for new guidance and information. Our Covid-19 resource hub remained a vital tool during the past 12 months.

As well as policies, procedures, staff directory, publications and more, flo provides colleagues with the ability to communicate directly with others at all levels within the trust. During the pandemic, flo became increasingly important as a space to connect, share stories and support each other.

In addition to the Covid-19 resource hub, flo (which can be downloaded as an application) contains a dedicated 'You' section, focused on health and wellbeing support for colleagues.

Our approach to engagement was to make sure there were regular feedback mechanisms in place. In July 2021, we relaunched the Quarterly Staff Survey which includes the annual staff survey as part of a regular feedback process in addition to a range of other mechanisms. Feedback from these are shared with our Incident Management Meeting (IMM), made up of assistant and deputy directors across the trust, as well as the Executive Team with action plans developed in response.





Other innovations have included:

- Hello from Joe – a monthly bulletin containing health and wellbeing advice and information.
- Team brief – a monthly newsletter sent to all leaders to cascade at team meetings.
- Chat with the chief – a virtual drop-in session with members of the Executive Team
- Covid webinars – regular virtual meetings with experts in the trust
- Acting on feedback from the previous year's BIG Listen – a bi-annual survey to give colleagues the opportunity to tell us how they really feel about working for KCHFT
- Mini listens – on topics including clinical, care and quality and LGBTQ+ Listen
- Rock, paper, scissors – an internal engagement campaign to find out from colleagues what gets in the way of them doing their job.
- Leaders' conferences (one virtual and two face-to-face) – an update from our chief executive officer, a question and answer session and workshop discussions on chosen topics, which this year included digital and sustainability, preparing for winter, living in our world (equality and diversity), making colleagues' working lives easier and an engaging drama-based workshop around EDI to launch our strategy.
- Staff awards – more than 200 nominations were received and 75 attended a ceremony in October.
- Long Service Awards – 633 people were recognised for five, 10, 15, 20 and 25 years' service at a celebration tea in October.

Our rock, paper, scissors campaign resulted in a number of key improvements, including simplifying sign-off processes, launching of our first digital strategy taking into account feedback, reducing policies and introducing a smoother recruitment process.

In September 2021, KCHFT was highly commended by the Health Service Journal for staff engagement and its efforts to improve the health and wellbeing of its colleagues by making sure they had the opportunity to feedback and shape improvements. We were also shortlisted for the NHS Communicate Health and Wellbeing Award 2021.

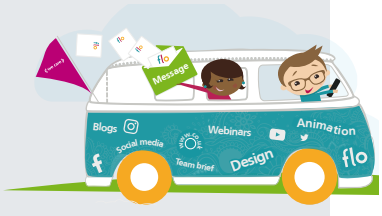
In March 2022 we ran an online internal communications survey which also included virtual and face-to-face drop-in sessions with more than 650 staff involved. The responses will help inform an action plan for the year ahead.

We have also made sure our colleagues have continued to be well supported throughout the year with access to multiple resources should they need them. These include:

- A dedicated section on our staff intranet called 'You', which sets out a range of wellbeing interventions for our staff to access. This includes videos on relaxation, breathing exercises, how to stay fit, our counselling service and Time to Change and wellbeing champions, a dedicated health and care staff support service including confidential support via phone and text message.
- Our #fillyourcup campaign aimed at encourage our colleagues to think about how they can look after themselves.

- Time for a treat campaign – for colleagues to claim a share of charitable funds to support their team's health and wellbeing.
- Specialist bereavement support
- Free access to mental health and wellbeing apps
- Group and one-to-one support, including specialist services to support our black, Asian and minority ethnic (BAME) colleagues
- Mental health resources and support including the partnership approach to the development of a Kent and Medway staff wellbeing support hub.
- Mental Health First aid training
- Webinars providing a forum for support and conversation with experts
- Coaching and mentoring support
- Online resources, toolkits and guidance on topics such as maintaining team and individual resilience; managing stress and maintaining routines; compassionate leadership in a crisis; and creating pause spaces to support teams working under pressure, REACT mental health conversation training for managers to enable them to support staff through compassionate, caring conversations about mental health and emotional wellbeing.
- Schwartz rounds
- Guidance on domestic abuse, debt management (including access to grants), managing media anxiety
- Physical wellbeing tips on working from home
- Deals and discounts
- Kent Together helpline
- Regular thanks from senior colleagues, including direct communications from the chief executive, chair and other members of the Executive Team.

A key part of our People Strategy has been our culture change programme and this will be a continued focus. We are developing a culture of trust, ownership and inclusivity, where people feel engaged and empowered to make decisions and act upon them and where everyone feels able to bring their whole selves to work.

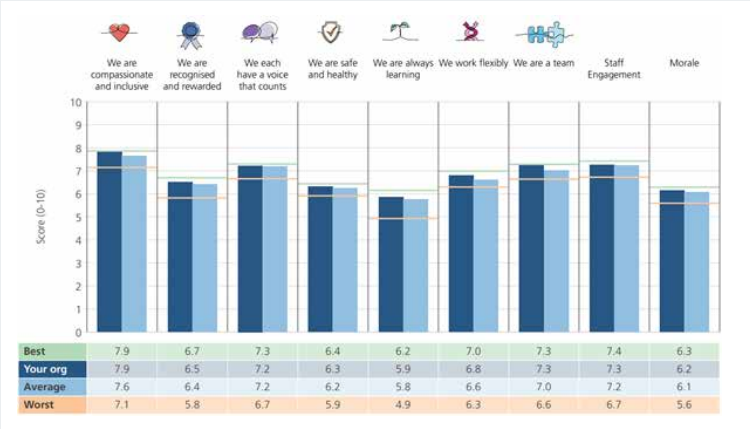


NHS staff survey

The NHS staff survey is conducted annually. The survey carried out in 2021/22 incorporated different indictor themes from previous years with results grouped into seven people promises and two themes. Results are based on a score out of 10 for certain questions with the indicator score being the average of those.

The response rate to the 2021/22 survey was 65 per cent, the highest the organisation has ever achieved.

Scores for each indicator together with that of the survey benchmarking group (other community trusts) for this year are presented below. A three-year comparison of data is not available in this format.



The below table shows the last three years staff survey result data using the previous indicator areas for comparison:

	2020/21		2019/20		2018/19	
	KCHFT	Benchmarking Group – other community Trusts*	KCHFT	Benchmarking Group – other community Trusts*	KCHFT	Benchmarking Group – other community Trusts*
Equality, diversity and inclusion	9.5	9.4 (best 9.5/worst 8.8)	9.5	9.4 (best 9.6/worst 8.8)	9.5	9.3 (best 9.6/worst 8.8)
Health and wellbeing	6.7	6.3 (best 6.7/worst 6.0)	6.4	6.0 (best 6.7/worst 5.4)	6.2	5.9 (best 6.5/worst 5.2)
Immediate managers	7.6	7.2 (best 7.6/worst 7.0)	7.6	7.2 (best 7.6/worst 6.9)	7.4	7.0 (best 7.6/worst 6.7)
Morale	6.7	6.5 (best 6.7/worst 6.1)	6.6	6.3 (best 6.7/worst 5.9)	6.2	6.1 (best 6.6/worst 5.7)
Quality of care	7.6	7.5 (best 7.9/worst 7.1)	7.6	7.4 (best 8.0/worst 7.1)	7.3	7.3 (best 8.0/worst 7.1)
Safe environment – bullying and harassment	8.8	8.5 (best 8.9/worst 8.0)	8.6	8.4 (best 8.7/worst 7.6)	8.6	8.4 (best 8.8/worst 7.1)
Safe environment – violence	9.8	9.7 (best 9.9/worst 9.6)	9.8	9.7 (best 9.9/worst 9.6)	9.8	9.7 (best 9.9/worst 9.6)
Safety culture	7.5	7.1 (best 7.5/worst 6.7)	7.3	7.0 (best 7.5/worst 6.5)	7.0	7.0 (best 7.3/worst 6.2)
Staff engagement	7.4	7.3 (best 7.5/worst 6.9)	7.4	7.2 (best 7.5/worst 6.6)	7.0	7.1 (best 7.5/worst 6.5)
Team working	7.4	6.9 (best 7.5/worst 6.6)	7.5	7.1 (best 7.5/worst 6.5)	7.2	6.9 (best 7.4/worst 6.5)

*best and worse scores in brackets

Key data highlights

- KCHFT scored better than the average in all categories with the exception of one which was an equal score to the average
- KCHFT was the best performing community trust in the benchmarking of two areas
- KCHFT had the highest response rate the organisation has ever achieved.

The top five largest declines in this year's survey were:

- There are enough staff at this organisation for me to do my job properly (-14.15 per cent)
- I look forward to going to work (-7.19 per cent)
- I am satisfied with the extent to which my organisation values my work (-6.59 per cent)
- I am able to meet all the conflicting demands on my time at work (-6.1 per cent)
- I am able to make suggestions to improve the work of my team / department (-5.44 per cent).

Other areas that were concerning where the number of responses showing:

- In the last 12 months I have personally experienced discrimination at work from patients/service users, their relatives or other members of the public.
- In the last 12 months I have personally experienced discrimination at work from a manager / team leader or other colleagues.
- I often/always find my work emotionally exhausting.
- I often/always feel burnt out because of my work.
- My work often/always frustrates me.

Future priorities and targets

Our approach will be to review and update action plans at both corporate and directorate level, to address the areas of the survey with the largest variance in comparison to other community trusts.

Particular corporate focus will include:

- a staff survey toolkit for leaders and managers to include a slide deck with headlines results, explanation of the work already being carried out to address these challenges and invite feedback on whether these solutions go far enough and if there are ideas about other actions we could take
- individual services reviewing their local information to understand hot spots and adding these to the toolkit to share with teams, services and directorates as appropriate
- the workforce equality group focussing on WDES, WRES and carer results
- the director of people and organisational development sharing the results with colleagues in an all-staff e-bulletin and vlog
- team talks including insights from local conversations shared via the trust communications team
- quality improvement task and finish groups being set up for new solutions and ideas
- case study examples of improvements to be part of the Executive Performance Review.

Summary of local surveys

Quarterly pulse survey

The Quarterly Pulse Survey, replaced the NHS Staff Friends and Family Test and was relaunched on 1 July 2021.

During the summer of 2021, 830 responses were received with regards to colleague feedback, mood and engagement. Colleagues asked for more updates on changing operations and ways of working and greater flexibility in working patterns.

During winter 2021, 350 responses were received highlighting some main themes including staff experiencing pressure at work, suffering burnout and stress.

A summary of the responses was provided to the Integrated Management Meeting (IMM) and Executive Team.

Staff were provided with the results in addition to the actions we were taking to address work pressures, such as international recruitment, making the most of apprenticeship opportunities, improvements to 'You' pages on the trust intranet and increased awareness of health and wellbeing initiatives.

"It really proved to me that humanity always comes together in times of crisis – I was really proud to have played my part in supporting that."

Ann Kent, Clinical Lead, Community Nursing

we improved

Trade union facility time disclosures

Table 1

Relevant union officials

Number of employees who were relevant union officials during the relevant period	FTE employee numbers
19	17.51

Table 2

Percentage of time spent on facility time

Percentage of time	Number of employees
0	10
1 – 50	9
51 – 99	0
100	0

Table 3

Percentage of pay bill spent on facility time

Provide the figures requested in the first column of the table below to determine the percentage of your total pay bill spent on paying employees who were relevant union officials for facility time during the relevant period.

	Figures
Provide the total cost of facility time	£22,280
Provide the total pay bill	£195,978,774.32
Provide the percentage of the total pay bill spent on facility time	0.0114%

Table 4

Paid trade union activities

As a percentage of the total paid facility time hours, how many hours were spent by employees who were relevant union officials during the relevant period on paid trade union activities?

Time spent on paid trade union activities as a percentage of total paid facility time hours
38 per cent

Expenditure on consultancy

The trust's expenditure on consultancy in 2021/22 was £335k (2020/21 £1,879k, of which £1,242k related to hosting the Sustainability and Transformation Partnership).

Highly-paid off-payroll worker engagements as at 31 March 2022 earning £245 per day or greater	Number of engagements
Number of existing engagements as of 31 March 2022	0
Of which…	
Number that have existed for less than one year at time of reporting.	0
Number that have existed for between one and two years at time of reporting.	0
Number that have existed for between two and three years at time of reporting.	0
Number that have existed for between three and four years at time of reporting.	0
Number that have existed for four or more years at time of reporting.	0

All highly-paid off-payroll workers engaged at any point during the year ended 31 March 2022 earning £245 per day or greater	Number of engagements
Number of off-payroll workers engaged during the year ended 31 March 2022	0
Of which…	
Not subject to off-payroll legislation*	0
Subject to off-payroll legislation and determined as in-scope of IR35*	0
Subject to off-payroll legislation and determined as out-of-scope of IR35*	0
Number of engagements reassessed for compliance or assurance purposes during the year	0
Of which: number of engagements that saw a change to IR35 status following review	0

* A worker that provides their services through their own limited company or another type of intermediary to the client will be subject to off-payroll legislation and the trust must undertake an assessment to determine whether that worker is in-scope of Intermediaries legislation (IR35) or out-of-scope for tax purposes

For any off-payroll engagements of board members, and/or, senior officials with significant financial responsibility, between 1 April 2021 and 31 March 2022	Number of engagements
Number of off-payroll engagements of board members, and/or, senior officials with significant financial responsibility, during the financial year.	0
Number of individuals that have been deemed 'board members and/or senior officials with significant financial responsibility' during the financial year. This figure must include both off-payroll and on-payroll engagements.	23

Exit packages

The information in the following tables is subject to audit

Reporting of compensation schemes – exit packages 2021/22

	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	29	**32**
£10,001-£25,000	2	3	5
£25,001-50,000	1	-	**1**
£50,001-£100,000	1	-	1
£100,001-£150,000	-	-	-
£150,001-£200,000	-	-	-
>£200,000	-	-	-
Total number of exit packages by type	**7**	**32**	**39**
Total resource cost (£)	£127,000	£146,000	**£273,000**

Reporting of compensation schemes – exit packages 2020/21

	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	2	20	**22**
£10,001-£25,000	-	-	**-**
£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	**4**	**20**	**24**
Total resource cost (£)	£91,000	£59,000	**£150,000**

Exit packages: other (non-compulsory) departure payments

	2021/22		2020/21	
	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	32	146	20	59
Exit payments following employment tribunals or court orders	–	–	–	–
Non-contractual payments requiring HMT approval	–	–	–	–
Total	**32**	**146**	**20**	**59**
Of which: Non-contractual payments requiring HMT approval made to individuals where the payment value was more than 12 months' of their annual salary	–	–	–	–

Disclosures set out in the NHS foundation trust code of governance

NHS foundation trust code of governance

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

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

Disclosure relating to	NHS Improvement Code of Governance reference	Kent Community Health NHS Foundation Trust disclosure
Board and Council of Governors	A.1.1	The trust's Board met 12 times in 2021/22; four of those meetings are held in public. During the Covid-19 pandemic, the public are unable to attend and the meetings are broadcast virtually. Five meetings are held to discuss trust strategy and board development. There are approved standing orders, standing financial instructions and a scheme of delegation in place. The annual governance statement describes the role of each of the Board's committees. The trust's constitution sets out how disagreements between the council and the Board would be resolved; the chair, as chair of both bodies, would initially seek to resolve the disagreement, if this is not successful, a joint committee of governors and directors would be established. If this committee's recommendations were unable to resolve the dispute, the Board would make a final decision. A referral to NHS England and NHS Improvement or other external body might also be considered. There has been no requirement to activate this process during 2021/22.
Board, Nomination Committee(s), Audit and Risk Committee, Remuneration and Terms of Service Committee	A.1.2.	This annual report describes the roles and responsibilities of the Board on pages 30 to 37. The number of Board, Council and committee meetings and a record of attendance are found on page 39.
Council of Governors	A.5.3	Page 41 of this annual report identifies the members of the Council of Governors, the lead governor and their respective constituencies. The council has formally met three times during 2021/22. It is due to continue formal quarterly meetings. The April 2021 meeting was cancelled due to Covid-19.
Board	B.1.1	The directors of the trust all meet the required independence criteria set out by NHS England and NHS Improvement. The directors are identified on pages 27 to 37 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 and are published on the trust's public website.
Board	B.1.4	The biographies of Board members are included in this report on pages 30 to 37. The Board has completed a self-assessment and considers that the skills and experience of the members gives an appropriate balance in order to effectively conduct its business. This is reviewed continually through the Nominations Committee.

Disclosure relating to	NHS Improvement Code of Governance reference	Kent Community Health NHS Foundation Trust disclosure
Board Council of Governors	B.2.2	Directors on the Board and governors on the Council of Governors meet the fit and proper persons test as described in the provider licence. The trust also abides by the updated guidance from the Care Quality Commission (CQC) regarding appointments to senior positions in the organisation subject to CQC regulations.
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 met twice in the past year. The April Nominations Committee was cancelled due to COVID-19.
Chair/ Council of Governors	B.3.1.	The job specification for the trust's chair defines the role and capabilities required and the expected time commitment. The Nominations Committee will oversee future appointments, as required.
Council of Governors	B.5.6	Mechanisms for canvassing members continue to develop. Election of governors – there is a process for electing new governors, which is conducted by an external election company (formerly Election Reform Services). In the past 12 months, seven public governors were elected. The council now consists of 13 publicly elected governors, five staff elected governors and four appointed governors. All governors have been to at least one formal meeting of the council during the past 12 months.
Board	B.6.1	The 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 29.
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 88.

Disclosure relating to	NHS Improvement Code of Governance reference	Kent Community Health NHS Foundation Trust disclosure
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 is a trust membership strategy. The methodology for NHS monitoring of effective member engagement and how representative it is of the community the trust serves is included in the communications and engagement strategy. The council has established a Communications and Engagement Committee to discharge this responsibility.
Membership	E.1.4	The trust's corporate services director oversees compliance with this requirement. The governors of the trust can be contacted by: email: kcht.governors@nhs.net phone 07468 700220 Post: Governor Support Office Kent Community Health NHS Foundation Trust The Oast Unit D Hermitage Court Hermitage Lane Barming Maidstone Kent ME16 9NT

Statement of accounting officer's responsibilities

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

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

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

In preparing the accounts and overseeing the use of public funds, 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
- confirm that the annual report and accounts, taken as a whole, is fair, balanced and understandable and provides the information necessary for patients, regulators and stakeholders to assess the NHS foundation trust's performance, business model and strategy and
- prepare the financial statements on a going concern basis and disclose any material uncertainties over going concern.

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 them to ensure that the accounts comply with requirements outlined in the above mentioned Act. The Accounting Officer is also responsible for safeguarding the assets of the NHS foundation trust and hence for taking reasonable steps for the prevention and detection of fraud and other irregularities.

As far as I am aware, there is no relevant audit information of which the foundation trust's auditors are unaware, and I have taken all the steps that I ought to have taken to make myself aware of any relevant audit information and to establish that the entity's auditors are aware of that information.

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.....

Gordon Flack, Acting Chief Executive Officer

Date: 16 June 2022

Annual governance statement

Annual Governance Statement

1 April 2021 to 31 March 2022
Kent Community Health NHS Foundation Trust
(Organisational Code – RYY)

1. Scope of responsibility

As accounting officer, I have responsibility for maintaining a sound system of internal control that supports the achievement of the NHS foundation trust's policies, aims and objectives, while safeguarding the public funds and departmental assets for which I am personally responsible, in accordance with the responsibilities assigned to me.

I am also responsible for making sure the NHS foundation trust is prudently and economically administered and resources efficiently and effectively applied. I acknowledge my responsibilities as set out in the *NHS Foundation Trust Accounting Officer Memorandum*.

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

During 2021/22, the organisation routinely reported on strategic, financial and operational matters.

2. The purpose of the system of internal control

The system of internal control is designed to manage risk to a reasonable level rather than to eliminate all risk of failure to achieve policies, aims and objectives; it can therefore only provide reasonable and not absolute assurance of effectiveness. The system of internal control is based on an ongoing process designed to identify and prioritise the risks to the achievement of the policies, aims and objectives of Kent Community Health NHS Foundation Trust, to evaluate the likelihood of those risks being realised and the impact should they be realised, and to manage them efficiently, effectively and economically. The system of internal control has been in place in Kent Community Health NHS Foundation Trust for the year ended 31 March 2022 and up to the date of approval of the annual report and accounts.

3. Capacity to handle risk

The Governance Framework of Kent Community Health NHS Foundation Trust is overseen by the trust Board, which comprises of executive and non-executive directors.

The Board's function is to:

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

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

In March 2015, the trust was authorised as a foundation trust and continues to assess itself to meet all of the requirements of the NHS Code of Governance. The Board and Audit and Risk Committee receive regular reports of organisational key risks and regularly review the trust's strategic risks contained within the Board Assurance Framework.

The trust has a proactive approach to risk management. The deputy director of corporate services and their team provide leadership, direction and co-ordination of all risk management activities with additional support from the Executive Team. During 2021/22, Kent Community Health NHS Foundation Trust's risk appetite continued to be fully tested and challenged in response to the ongoing Covid-19 pandemic situation and subsequent outcomes.

All staff have operational responsibility for risk management aligned to their individual roles. Risk management training is provided as part of new staff induction in addition to ongoing training updates for all existing staff.

Risk identification, prioritisation, mitigation or elimination occurs through assessment and grading using a nationally recognised matrix of impact verses likelihood. Incident reporting is a key factor in the continuing assessment of risk and plays a vital part in the instigation of practice change. Complaints and

other feedback from users and stakeholders are also used for subsequent change and reported to the Board.

Identifying sources of potential risk and proactively assessing such risks forms part of everyday working practice throughout the trust, this includes:

- identifying potential risk issues through incidents, near misses and complaints through the triangulation of data
- investigating and analysing root cause analysis
- discussion of risk and incident management through local governance agendas
- the incorporation of risk management in objective setting and staff appraisals
- monitoring the delivery and effectiveness of actions taken to control known risks by the Risk Team
- undertaking reflective practice from near misses, risk events, legal claims and complaints by sharing the lessons learned across the trust.

Given the ongoing system impact and challenges for maintaining quality services as a result of the Covid-19 pandemic, the trust has continued to review its risk appetite to make sure key decision making is supported moving forward.

To give Board members grounding, clarity and subsequently a greater understanding, engagement has continued with service reviews helping members understand patient journeys and pathways with interrogation of individual case studies. In addition, the Board is invited to leaders' conferences and executive and heads of service events where they meet senior management to discuss new service models, service improvements and innovations.

4. The Risk and Control Framework

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

The Risk Management Policy was presented to the Audit and Risk Committee in 2021 and describes the strategy for the trust's risk appetite and approach to managing and tolerating risks. The effective implementation of the strategy enables the delivery of a quality service and, alongside staff training and support, provides an improved awareness of the measures needed to prevent, control and contain risk.

The top risks that have a significant impact on the ability of the trust to deliver its strategic goals are documented in the Board Assurance Framework.

During 2021/2022 work has continued to manage, rationalise and ensure consistency of the risks identified through the risk management process. Key strategic risks (Board Assurance Framework) have been identified through strategic assessment, triangulation and business planning process. As of 31 March 2022, these are:

- the impact of the now paused mandate to implement Covid-19 vaccination as a condition of deployment for healthcare workers, and subsequent changes yet to be agreed by Parliament, will result in workforce gaps, shortages, impact on staff engagement and morale and legal claims
- the extended and ongoing response to Covid and reset may impact on staff stress levels, fatigue and morale to an extent that the delivery of services to patients could be compromised
- the system and partner plans to manage surge and reset could be insufficiently co-ordinated to meet the demand resulting in the system being overwhelmed and patients not receiving the services they need
- the ongoing operational pressures combined with staff shortages or skill mix issues as a result of managing high turnover alongside a deterioration in retention, vacancies, high acuity of patients and staff absence may result in unacceptable demands on staff and impact on safer staffing levels, a poorer service to patients and/or the need to limit services with the resultant impact on the system. The ongoing nature of the pressure described will impact on staff stress levels, fatigue and morale to an extent that the delivery of services to patients is compromised
- within the context of a heightened level of activity seasonal pressures, the Integrated Care System discussions and establishment could impact on the system ability to provide clarity and focus
- there is significant pressure on social care budgets. KCC's budget for 2022/23 includes 7.4 per cent of spending growth and £37.9million of savings and income to balance its budget. There is a risk that KCC will be unable to fund the 2022/23 pay award for KCC funded services because of its budget pressures. This is a risk of c. £1.2million.
- the transition in the Board at a time of significant system and organisational pressure may impact the Boards leadership of the organisation and the ability to respond effectively and in a focused way to the challenges impacting on organisational operation.

Risk management is a core component of job descriptions within the trust. Risk management training is an element of the staff induction programme and training updates for existing colleagues are also provided using a range of risk management processes. Risk management training includes clarity on staff roles and responsibilities for the identification, management and control of risk, along with the risk management process to be followed in relation to escalation and de-escalation of known risks.

All relevant risk policies and procedures are available to colleagues on the intranet.

Leadership and co-ordination of risk management activities is provided by the corporate services director, deputy director of corporate services, head of corporate operations and the risk management team with support from all members of the Executive Team.

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

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

The trust has published on its website an up-to-date register of interests, including gifts and hospitality, for decision-making staff within the past twelve months, as required by the 'Managing Conflicts of Interest in the NHS' guidance.

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

The trust has undertaken risk assessments and has plans in place which take account of the 'Delivering a Net Zero Health Service' report under the Greener NHS programme. The trust makes sure its obligations under the Climate Change Act and the Adaptation.

4.1 Risk Management during the pandemic

The pandemic has undeniably presented us with the opportunity to look at our processes objectively. Just as the trust has taken this time for a refreshed approach to its strategy and governance, our risk appetite and ambitions are also on the forefront of the 'reset and re-imagine programme'. Namely, the fundamental principles of our risk management strategy going forward will be:

- continue to deliver and embed the trust's defined risk appetite
- one to one risk management support for all staff
- embrace change and managing risks to shape the, 'new normal' – align risk appetite to our new strategic ambitions and clearly set out the process of embedding into operational and frontline approach.

5. Care Quality Commission

The trust is fully compliant with the registration requirements of the Care Quality Commission (CQC).

In 2019 the CQC carried out a full inspection of trust services, which concluded an overall 'outstanding' rating. This made Kent Community Health NHS Foundation Trust, at the time, the third community trust in the country to be outstanding overall and one of 23 provider trusts to be outstanding overall in England. We are the only community provider trust in the south east to have this rating, an award which remains valid in 2022.

6. The Governance Framework of the Organisation

6.1 Council of Governors

The Council of Governors represents the interests of our members and the wider public. It has two general duties; to hold the non-executive directors to account for the performance of the Board and to represent the views of the local population.

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 – brings valuable perspectives and contributions to the trust's activities and future planning.

Due to the pandemic and government restrictions, a digital annual members meeting was presented in September 2021, alongside the trust's annual general meeting. This can be viewed at www.kentcht.nhs.uk/annualmeeting

6.2 Trust Board

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

To give the Board members grounding and greater understanding and clarity there has been development in engaging each member with We Care reviews to help understand the patient journeys and pathways with interrogation of individual case studies. During the pandemic, We Care visits took place between May and December with non-executive directors in attendance. Non-executive directors also attended the virtual quality review panels, which identified the key lines of enquiry for further exploration during the visit.

The Board is also invited to leaders' conferences and executive and heads of service events where they meet senior management and discuss new service models, service improvements and innovations. These events took place virtually during the pandemic.

The role of the board has the following key functions:

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

The Board is made up of non-executive directors who use the skill and experience gained from the private, public and voluntary sectors to support the running of the trust, but who do not have day-to-day managerial responsibilities within the trust; and executive directors who are paid employees with clear areas of trust work responsibilities.

6.3 Committees of the trust's Board

The trust is supported by committees whose membership includes non-executive directors, directors and senior managers of the organisation. A formal update report for each committee is reported to the Board, regularly outlining the activity undertaken against the individual committee's terms of reference. During the pandemic, the committees continued to meet virtually. The committees are:

6.3.1 Audit and Risk Committee

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

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

The Audit and Risk Committee provides the board with assurance on key aspects including:

- system effectiveness of internal control and risk management
- effective internal audits and service reviews
- reviewing the findings of external audits and other significant assurance functions
- reviewing risks which have been assigned to the committee and providing assurance that assessments, key controls and action plans are suitable and sufficient to mitigate gaps in control measures to an acceptable level
- reviewing and reporting on the annual report and financial statements
- having oversight of specific risks on the Board Assurance Framework as assigned by the Board.

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

6.3.2 Charitable Funds Committee

This committee acts on behalf of the corporate trustee, in accordance with 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 oversees all aspects relating to charitable funds within Kent Community Health NHS Foundation Trust. The committee's main functions include:

- supporting and monitoring fundraising on behalf of the trust's charity
- developing and approving charitable funds guidelines and policies
- considering and managing charitable funds, applications and investments
- reviewing risks which have been assigned to the

committee and providing assurance that key controls and action plans are adequate to address gaps in controls.

6.3.4 Finance Business and Investment Committee

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

- receiving and approving financial strategy and policy documents
- monitoring the financial management of income and expenditure
- approving and monitoring the financial management of the balance
- approving and assessing commercial management issues
- scrutinising current financial performance and future financial plans
- monitoring performance against cost improvement plans
- scrutinising the development and implementation of service line reporting and service line management
- monitoring decisions to bid for business opportunities and approve those up to £15million contract turnover in line with trust strategy and reviewing and then referring and recommending larger and novel bids to the Board for approval
- reviewing and approving capital investment decisions between £1million and £3million within capital budget and the overall capital programme development, referring with recommendation, larger cases to the Board for approval
- reviewing and approving revenue business cases between £1million to £3million annual values and referring with recommendation, larger cases to the Board for approval
- approving Treasury Management Policy and scrutinising implementation
- reviewing risks which have been assigned to the committee and providing assurance that key controls and action plans are adequate to address gaps in controls.

6.3.5 Quality Committee

This is a committee of the Board with delegated decision-making powers. The chief nurse, the medical director, chief operating officer and the director of participation, experience and patient engagement are members. Other individuals with specialist knowledge attend for specific items with the consent of the chair. The committee invites clinical representatives to attend its meetings to provide assurance on key governance and risk issues and quality improvement.

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

- providing oversight of performance and risk of the trust strategic objectives/enablers preventing ill health and high-quality care as assigned to the committee by the Board
- ensuring that the strategic priorities for quality assurance are focused on those which best support delivery of the trust's quality priorities in relation to patient experience, safety of patients and service users and effective outcomes
- reviewing compliance with regulatory standards and statutory requirements, for example those of the Duty of Candour, the Care Quality Commission, NHS Resolution and the NHS Performance Framework
- overseeing 'We Care' visits associated action plans and risks
- reviewing quality risks which have been assigned to the Quality Committee and providing assurance that key controls and action plans are adequate to address gaps in controls
- reviewing the annual quality report ahead of its submission to the Board for approval
- overseeing deep dive reviews of identified risks to quality identified by the board or the committee, particularly serious incidents and how well any recommended actions have been implemented
- reviewing how lessons are disseminated, learnt and embedded in the trust from 'ward to board'
- overseeing the ratification of clinical policies and any other formal clinical document where mandatory compliance is required.

The trust's approach to quality is informed by listening to patient experience and understanding safety alongside delivering and maintaining services. This approach has been formally identified through trust values and strategic objectives with executive leadership and Board ownership.

6.3.6 Remuneration Committee

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

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

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

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

6.3.7 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 in, the consequences and implications on the workforce.

The Strategic Workforce Committee provides advice and assurance to the Board on all matters relating to workforce planning, strategy and pay and rewards. It is also responsible for organisational development including health and wellbeing and equality, diversity and inclusion.

The committee's main functions include:

- overseeing the 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
- reviewing the trust's plans to identify and develop leadership capacity and capability in the trust, including talent management
- ensuring that there is an effective workforce plan in place, so that the trust has sufficient staff with the necessary skills and competencies to meet the needs of patients and service 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 providing assurance that the trust has an appropriate pay and reward system linked to delivery of the organisation's strategic objectives, outcomes and desired behaviours
- ensuring the training and education provided and commissioned by the trust is fully aligned to the trust's strategy
- ensuring there are mechanisms to support the mental and physical health and wellbeing of trust staff
- receiving information on strategic themes relating to employment issues, ensuring they are understood and actioned
- ensuring the trust is compliant with relevant legislation and regulations relating to workforce matters
- reviewing risks which have been assigned to the committee and providing assurance that key controls and action plans are adequate to address gaps in controls
- ensuring the trust has appropriate workforce policies in place
- receiving and providing assurance that the trust has a robust freedom to speak up guardian process
- providing high level oversight of the delivery of the environmental sustainability strategy.

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

6.3.8 Executive Team

The Executive Team operates on behalf of the trust Board to ensure that Kent Community Health NHS Foundation Trust operates efficiently and effectively in the development and implementation of strategy, operational plans, policies and procedures. The Executive Team will peer review operating and financial performance; strategic, corporate and operational risk; discuss and quality assure documents and issues before they are reported to the trust Board and its committees. This provides the opportunity for cross directorate engagement and appropriate delegation of work:

- to ensure the effective operational management of the trust
- development of corporate and business strategy, operational plans, policies and procedures and objectives for recommendations to the trust Board and its committees

- provide a forum for key policy areas to be debated and refined
- ensure review of operational, financial, risk and performance of the trust
- validate all newly identified high risks to ensure risks are accurately described and rated
- ensure the trust remains fit for purpose by continuously reviewing effectiveness and efficiency of management and leadership
- formulate and implement service changes and developments
- seek ways to continuously improve the quality of working life for employees
- seek ways to continually improve the patient experience and engagement
- ensure effective partnership working across the health economy.

7. NHS Pension Scheme

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

This includes ensuring 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.

8. Sustainability

In support of the NHS Long Term Plan and sustainability agenda, our vision is to be a leading provider of outstanding low-carbon care to our patients and staff, which incorporates the seven elements of sustainability and resource efficiency. Our aim is to reduce our carbon footprint by 50 percent over the next five years.

In October 2020, Kent Community Health NHS Foundation Trust agreed a set of 41 actions as part of the trust's Sustainability Strategy 2021/26. At the core of this strategy is a focus on the health of the communities we serve now and for generations to come. The dedicated sustainability lead position has been created to progress and report against this strategy, consistent with our commitment to the NHS Long Term Plan and sustainability agenda. The trust's strategy targets five broad areas: Journeys, the built environment, supply, wildlife and biodiversity, and our people.

9. Workforce

The trust ensures that short, medium and long-term workforce strategies and staffing systems are in place which assures the Board that staffing processes are safe, sustainable and effective.

Assurance is provided through the trusts Strategic Workforce Committee, People Strategy, related key performance indicators and action plans. Workforce risks are also managed throughout the trust's committee structures.

The Executive Team receives a monthly report on safe staffing as does the Quality Committee. The Executive and Strategic Workforce Committee make sure this is reported to the Board. The requirements of the 2016 NQBs guidance is responded to in the safe staffing reports.

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

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

The Board delegated detailed oversight of the board assurance framework to the Audit and Risk Committee. This committee assesses the effectiveness of risk management by:

- managing and monitoring the implementation of the risk management strategy
- considering findings from internal and external audit reviews
- calling executive directors to account for their risk portfolios and monitoring the Board assurance framework at each of its meetings.

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

The end of year review of the Board Assurance Framework by the Audit and Risk Committee has resulted in an opinion of reasonable assurance that the board assurance framework is effective.

Clinical risk and patient safety are overseen by the trust Quality Committee, the chief nurse, the medical director and the operational director. The Board receives monthly quality reports encompassing the quality and patient safety aspects for the trust. The Quality Committee has focused on assurance that the trust is embedding the lessons identified from incidents across

the trust. It has also sought assurance on the progress of the action plans that were developed in relation to the trust's NHS Improvement Quality Governance Assurance Framework score, and the Care Quality Commission's inspection of the trust. This assurance is Kent Community Health NHS Foundation Trust's annual report, quality report and accounts 2021 to 2022, reported to the Board.

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

The Audit and Risk Committee receives regular reports from the Local Counter Fraud Specialist which identifies specific fraud risks and investigates whether or not there was evidence of those being exploited. No significant risks, classes of transactions or account balances were identified. The committee has focused some attention on the relationship between claims and the associated costs, and incidents reported.

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

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

11. Information governance

The trust takes all information governance incidents very seriously and, regardless of severity, are analysed and where appropriate categorised as a serious incident needing further investigation. For the period 1 April 2021 to 31 March 2022 there have been no serious incidents reported to the regulatory body, the Information Commissioner.

12. Data quality and governance

KCHFT has a range of measures in place to ensure and review data quality. At a high level we routinely monitor the national Data Quality Maturity Index (DQMI) which provides a data quality score across a number of patient level datasets. The trust also has various groups where data quality is either the focus or a standing agenda item, such as through the Information Quality Assurance Group or RiO which is the primary patient record system performance meeting. Additionally, the trust has routine targeted reporting from the systems that focus on highlighting issues of data quality, for example a weekly report and email is circulated which provides oversight of the current waiting list across services. Lastly, the trust's implementation of a Business Intelligence system (PowerBI) which provides trust-wide access to summary data and trends, enabling all members of the trust an opportunity to identify and feedback on data quality issues affecting the data. Health's data.

13. Emergency preparedness, resilience and response

The trust has a duty to prepare for emergencies and to have plans in place to ensure it returns to business as usual as soon as possible following an event. The trust has developed a comprehensive management framework to make sure it complies with the Civil Contingencies Act 2004, NHS Core standards of emergency preparedness, resilience and response and other guidance. The framework confirms the trust has demonstrated its preparedness through business continuity arrangements and these are regularly tested through a range of exercises.

For 2021/22, the trust gained full compliant status within the annual assurance assessment. The trust responded to the ongoing COVID–19 pandemic demonstrating resilience using its emergency planning and business continuity plans

14. Review of effectiveness

As Accounting Officer, I have responsibility for reviewing the effectiveness of the system of internal control. My review of the effectiveness of the system of internal control is informed by the work of the internal auditors, clinical audit and the executive managers and clinical leads within the NHS foundation trust who have responsibility for the development and maintenance of the internal control framework. I have drawn on performance information available to me. My review is also informed by comments made by the external auditors in their management letter and other reports. I have been advised on the implications of the result of my review of the effectiveness of the system of internal control by the Board, the audit committee (and risk/clinical governance/quality committee, if appropriate) and a plan to address weaknesses and ensure continuous improvement of the system is in place.

15. Conclusion

My review confirms that Kent Community Health NHS Foundation Trust has a sound system of internal control. The head of internal audit has assessed Kent Community Health NHS Foundation Trust and given the trust a rating of reasonable assurance overall which supports the achievement of the goals, vision, values, policies, aims and objectives of the organisation.

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

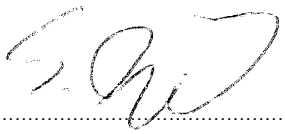
Director statements from executive directors and senior managers within the organisation who have responsibility for the development and maintenance of the system of internal control provide me with assurance. The Board Assurance Framework provides me with evidence that the effectiveness of controls that manage the risks to the organisation achieving its principal objectives have been reviewed and addressed.

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

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

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

For the year 2021/22, the COVID pandemic was identified as a significant issue. This is now being managed as business as usual.



Signed.....

Gordon Flack, Acting Chief Executive Officer

Date: 16 June 2022

NHS Oversight Framework

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

1. quality of care, access and outcomes
2. preventing ill health and reducing inequalities
3. finance and use of resources
4. people
5. leadership and capability.

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

Segmentation

The latest segmentation information available as at 31 March 2022 places Kent Community Health NHS Foundation Trust in segment one.

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

Signed .....

Gordon Flack, Acting Chief Executive Officer

Date: 16 June 2022

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 on financial statements

We have audited the financial statements of Kent Community Health NHS Foundation Trust (the 'Trust') for the year ended 31 March 2022, which comprise the Statement of Comprehensive Income, the Statement of Financial Position, the Statement of Changes in Equity, the Statement of Cash Flows and notes to the financial statements, including a summary of significant accounting policies. The financial reporting framework that has been applied in their preparation is applicable law and international accounting standards in conformity with the requirements of the Accounts Directions issued under Schedule 7 of the National Health Service Act 2006, as interpreted and adapted by the Department of Health and Social Care Group Accounting Manual 2021 to 2022.

In our opinion, the financial statements:

- give a true and fair view of the financial position of the Trust as at 31 March 2022 and of its expenditure and income for the year then ended;
- have been properly prepared in accordance with international accounting standards as interpreted and adapted by the Department of Health and Social Care Group Accounting Manual 2021 to 2022; 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, as required by the Code of Audit Practice (2020) ("the Code of Audit Practice") approved by the Comptroller and Auditor General. Our responsibilities under those standards are further described in the 'Auditor's responsibilities for the audit of the financial statements' section of our report. We are independent of the Trust in accordance with the ethical requirements that are relevant to our audit of the financial statements in the UK, including the FRC's Ethical Standard, and we have fulfilled our other ethical responsibilities in accordance with these requirements. We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our opinion.

Conclusions relating to going concern

We are responsible for concluding on the appropriateness of the Accounting Officer's use of the going concern basis of accounting and, based on the audit evidence obtained, whether a material uncertainty exists related to events or conditions that may cast significant doubt on the Trust's ability to continue as a going concern. If we conclude that a material uncertainty exists, we are required to draw attention in our report to the related disclosures in the financial statements or, if such disclosures are inadequate, to modify the auditor's opinion. Our conclusions are based on the audit evidence obtained up to the date of our report. However, future events or conditions may cause the Trust to cease to continue as a going concern.

In our evaluation of the Accounting Officer's' conclusions, and in accordance with the expectation set out within the Department of Health and Social Care Group Accounting Manual 2021 to 2022 that the Trust's financial statements shall be prepared on a going concern basis, we considered the inherent risks associated with the continuation of services provided by the Trust. In doing so we had regard to the guidance provided in Practice Note 10 Audit of financial statements and regularity of public sector bodies in the United Kingdom (Revised 2020) on the application of ISA (UK) 570 Going Concern to public sector entities. We assessed the reasonableness of the basis of preparation used by the Trust and the Trust's disclosures over the going concern period.

Based on the work we have performed, we have not identified any material uncertainties relating to events or conditions that, individually or collectively, may cast significant doubt on the Trust's ability to continue as a going concern for a period of at least twelve months from when the financial statements are authorised for issue.

In auditing the financial statements, we have concluded that the Accounting Officer's use of the going concern basis of accounting in the preparation of the financial statements is appropriate.

The responsibilities of the Accounting Officer with respect to going concern are described in the 'Responsibilities of the Accounting Officer and Those Charged with Governance for the financial statements' section of this report.

Other information

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

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

We have nothing to report in this regard.

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 in April 2020 on behalf of the Comptroller and Auditor General (the Code of Audit Practice) we are required to consider whether the Governance Statement does not comply with the disclosure requirements set out in the NHS Foundation Trust Annual Reporting Manual 2021/22 or is misleading or inconsistent with the information of which we are aware from our audit. We are not required to consider whether the Governance Statement addresses all risks and controls or that risks are satisfactorily addressed by internal controls.

We have nothing to report in this regard.

Opinion on other matters required by the Code of Audit Practice

In our opinion, based on the work undertaken in the course of the audit:

- the parts of the Remuneration Report and the Staff Report to be audited have been properly prepared in accordance with international accounting standards in conformity with the requirements of the Accounts Directions issued under Schedule 7 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, the other information published together with the financial statements in the annual report for the financial year for which the financial statements are prepared is consistent with the financial statements.

Matters on which we are required to report by exception

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

- we issue a report in the public interest under Schedule 10 (3) of the National Health Service Act 2006 in the course of, or at the conclusion of the audit; or
- we refer a matter to the regulator under Schedule 10 (6) of the National Health Service Act 2006 because we have reason to believe that the Trust, or an officer of the Trust, is about to make, or has made, a decision which involves or would involve the incurring of unlawful expenditure, or is about to take, or has begun to take a course of action which, if followed to its conclusion, would be unlawful and likely to cause a loss or deficiency.

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

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

As explained more fully in the Statement of the Accounting Officer's Responsibilities in respect of the accounts set out on page 76, the Acting Chief Executive, 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 2021/22, for being satisfied that they give a true and fair view, and for such internal control as the Accounting Officer determines is necessary to enable the preparation of financial statements that are free from material misstatement, whether due to fraud or error.

In preparing the financial statements, the Accounting Officer is responsible for assessing the Trust's ability to continue as a going concern, disclosing, as applicable, matters related to going concern and using the going concern basis of accounting unless the Accounting Officer has been informed by the relevant national body of the intention to dissolve the Trust without the transfer of its services to another public sector entity.

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

Auditor's responsibilities for the audit of the financial statements

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

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

Explanation as to what extent the audit was considered capable of detecting irregularities, including fraud

Irregularities, including fraud, are instances of non-compliance with laws and regulations. We design procedures in line with our responsibilities, outlined above, to detect material misstatements in respect of irregularities, including fraud. Owing to the inherent limitations of an audit, there is an unavoidable risk that material misstatements in the financial statements may not be detected, even though the audit is properly planned and performed in accordance with the ISAs (UK).

The extent to which our procedures are capable of detecting irregularities, including fraud is detailed below:

- We obtained an understanding of the legal and regulatory frameworks that are applicable to the Trust and determined that the most significant which are directly relevant to specific assertions in the financial statements are those related to the reporting frameworks (international accounting standards and the National Health Service Act 2006, as interpreted and adapted by the Department of Health and Social Care Group Accounting Manual 2021 to 2022).
- We enquired of management and the Audit and Risk Committee, concerning the Trust's policies and procedures relating to:
  - the identification, evaluation and compliance with laws and regulations;
  - the detection and response to the risks of fraud; and
  - the establishment of internal controls to mitigate risks related to fraud or non-compliance with laws and regulations.
- We enquired of management, internal audit and the Audit and Risk Committee, whether they were aware of any instances of non-compliance with laws and regulations or whether they had any knowledge of actual, suspected or alleged fraud.
- We assessed the susceptibility of the Trust's financial statements to material misstatement, including how fraud might occur, evaluating management's incentives and opportunities for manipulation of the financial statements. This included the evaluation of the risk of management override of controls and fraudulent expenditure recognition. We determined that the principal risks were in relation to:
  - journal entries which met a range of criteria defined as part of our risk assessment; and
  - expenditure recognition given the continued challenges of the pandemic in 2021-22
- Our audit procedures involved:
  - evaluation of the design effectiveness of controls that management has in place to prevent and detect fraud;
  - journal entry testing, with a focus on journals meeting a range of criteria defined as part of our risk assessment;
  - challenging assumptions and judgements made by management in its significant accounting estimates in respect of land and buildings valuations; and
  - assessing the extent of compliance with the relevant laws and regulations as part of our procedures on the related financial statement item.

- These audit procedures were designed to provide reasonable assurance that the financial statements were free from fraud or error. The risk of not detecting a material misstatement due to fraud is higher than the risk of not detecting one resulting from error and detecting irregularities that result from fraud is inherently more difficult than detecting those that result from error, as fraud may involve collusion, deliberate concealment, forgery or intentional misrepresentations. Also, the further removed non-compliance with laws and regulations is from events and transactions reflected in the financial statements, the less likely we would become aware of it.
- The team communications in respect of potential non-compliance with relevant laws and regulations, including the potential for fraud in revenue and/or expenditure recognition, and the significant accounting estimates related to the valuation of land and buildings included within the accounts.
- Our assessment of the appropriateness of the collective competence and capabilities of the engagement team included consideration of the engagement team's:
  - understanding of, and practical experience with audit engagements of a similar nature and complexity through appropriate training and participation;
  - knowledge of the health sector and economy in which the Trust operates; and
  - understanding of the legal and regulatory requirements specific to the Trust including:
    - the provisions of the applicable legislation;
    - NHS England's rules and related guidance; and
    - the applicable statutory provisions.
- In assessing the potential risks of material misstatement, we obtained an understanding of:
  - The Trust's operations, including the nature of its income and expenditure and its services and of its objectives and strategies to understand the classes of transactions, account balances, expected financial statement disclosures and business risks that may result in risks of material misstatement.
  - The Trust's control environment, including the policies and procedures implemented by the Trust to ensure compliance with the requirements of the financial reporting framework.

Report on other legal and regulatory requirements – 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 – the 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 2022.

Our work on the Trust's arrangements for securing economy, efficiency and effectiveness in its use of resources is not yet complete. The outcome of our work will be reported in our commentary on the Trust's arrangements in our Auditor's Annual Report. If we identify any significant weaknesses in these arrangements, they will be reported by exception in a further auditor's report. We are satisfied that this work does not have a material effect on our opinion on the financial statements for the year ended 31 March 2022.

Responsibilities of the Accounting Officer

The Acting Chief Executive, as 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. 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 undertake our review in accordance with the Code of Audit Practice, having regard to the guidance issued by the Comptroller and Auditor General in December 2021. This guidance sets out the arrangements that fall within the scope of 'proper arrangements'. When reporting on these arrangements, the Code of Audit Practice requires auditors to structure their commentary on arrangements under three specified reporting criteria:

- Financial sustainability: how the Trust plans and manages its resources to ensure it can continue to deliver its services;
- Governance: how the Trust ensures that it makes informed decisions and properly manages its risks; and
- Improving economy, efficiency and effectiveness: how the Trust uses information about its costs and performance to improve the way it manages and delivers its services.

We document our understanding of the arrangements the Trust has in place for each of these three specified reporting criteria, gathering sufficient evidence to support our risk assessment and commentary in our Auditor's Annual Report. In undertaking our work, we consider whether there is evidence to suggest that there are significant weaknesses in arrangements.

Report on other legal and regulatory requirements – Delay in certification of completion of the audit

We cannot formally conclude the audit and issue an audit certificate for Kent Community NHS Foundation Trust for the year ended 31 March 2022 in accordance with the requirements of Chapter 5 of Part 2 of the National Health Service Act 2006 and the Code of Audit Practice until we have completed our work on the Trust's arrangements for securing economy, efficiency and effectiveness in its use of resources.

Use of our report

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

Sarah L Ironmonger

Sarah Ironmonger, Key Audit Partner

for and on behalf of Grant Thornton UK LLP, Local Auditor

London

22 June 2022

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

In our auditor's report issued on 22 June 2022, we explained that we could not formally conclude the audit and issue an audit certificate for Kent Community Health NHS Foundation Trust (the 'Trust') for the year ended 31 March 2022, in accordance with the requirements of Chapter 5 of Part 2 of the National Health Service Act 2006 and the Code of Audit Practice, until we had:

- Completed our work on the Trust's arrangements for securing economy, efficiency and effectiveness in its use of resources. We have now completed this work, and the results of our work are set out below.

Opinion on the financial statements

In our auditor's report for the year ended 31 March 2022 issued on 22 June 2022 we reported that, in our opinion the financial statements:

- give a true and fair view of the financial position of the group and of the Trust as at 31 March 2022 and of the Trust's expenditure and income for the year then ended;
- have been properly prepared in accordance with international accounting standards as interpreted and adapted by the Department of Health and Social Care Group Accounting Manual 2021 to 2022; and
- have been prepared in accordance with the requirements of the National Health Service Act 2006.

No matters have come to our attention since that date that would have a material impact on the financial statements on which we gave this opinion.

Report on other legal and regulatory requirements – 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 – the 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 2022.

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

Responsibilities of the Accounting Officer

The Acting Chief Executive, as 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. 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 issued by the Comptroller and Auditor General in December 2021. This guidance sets out the arrangements that fall within the scope of 'proper arrangements'. When reporting on these arrangements, the Code of Audit Practice requires auditors to structure their commentary on arrangements under three specified reporting criteria:

- Financial sustainability: how the Trust plans and manages its resources to ensure it can continue to deliver its services;
- Governance: how the Trust ensures that it makes informed decisions and properly manages its risks; and
- Improving economy, efficiency and effectiveness: how the Trust uses information about its costs and performance to improve the way it manages and delivers its services.

We have documented our understanding of the arrangements the Trust has in place for each of these three specified reporting criteria, gathering sufficient evidence to support our risk assessment and commentary in our Auditor's Annual Report. In undertaking our work, we have considered whether there is evidence to suggest that there are significant weaknesses in arrangements.

Report on other legal and regulatory requirements – Audit certificate

We certify that we have completed the audit of Kent Community Health NHS Foundation Trust for the year ended 31 March 2022 in accordance with the requirements of Chapter 5 of Part 2 of the National Health Service Act 2006 and the Code of Audit Practice.

Use of our report

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

Sarah L Ironmonger

Sarah Ironmonger, Key Audit Partner

for and on behalf of Grant Thornton UK LLP, Local Auditor

London

2 September 2022

Annual accounts for the year ended 31 March 2022

Foreword to the accounts

Kent Community Health NHS Foundation Trust

These accounts, for the year ended 31 March 2022, 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 16 June 2022

Name Gordon Flack
Job title Acting Chief Executive

Statement of comprehensive income
for the year ended 31 March 2022

	Note	2021/22 £000	2020/21 £000
Operating income from patient care activities	3	252,297	247,487
Other operating income	4	19,733	21,804
Operating expenses	6, 8	(271,676)	(269,549)
Operating surplus/(deficit) from continuing operations		**354**	**(258)**
Finance income	11	37	–
Finance expenses	12	(2)	(13)
PDC dividends payable		(380)	–
Net finance costs		**(345)**	**(13)**
Surplus/(deficit) for the year from continuing operations		**9**	**(271)**
Surplus/(deficit) on discontinued operations and the gain/(loss) on disposal of discontinued operations		–	–
Surplus/(deficit) for the year		**9**	**(271)**
Other comprehensive income			
Will not be reclassified to income and expenditure:			
Impairments	7	(731)	(669)
Revaluations	15	1,272	468
Gain/(loss) arising from on transfers by modified absorption	34	5,521	420
Total comprehensive income/(expense) for the period		**6,071**	**(52)**

The notes on pages 104 to 137 form part of this account.

Statement of financial position
as at 31 March 2022

	Note	31 March 2022 £000	31 March 2021 £000
Non-current assets			
Intangible assets	13	7,768	1,453
Property, plant and equipment	14	27,899	24,650
Receivables	19	283	238
Total non-current assets		**35,950**	**26,341**
Current assets			
Inventories	18	–	–
Receivables	19	17,153	17,471
Non-current assets for sale and assets in disposal groups	20	1	295
Cash and cash equivalents	21	35,979	42,859
Total current assets		**53,133**	**60,625**
Current liabilities			
Trade and other payables	22	(23,267)	(31,942)
Provisions	26	(648)	(367)
Other liabilities	23	(4,975)	(4,526)
Total current liabilities		**(28,890)**	**(36,835)**
Total assets less current liabilities		**60,193**	**50,131**
Non-current liabilities			
Provisions	26	(1,109)	(718)
Other liabilities	23	(244)	–
Total non-current liabilities		**(1,353)**	**(718)**
Total assets employed		**58,840**	**49,413**
Financed by			
Public dividend capital		9,945	6,589
Revaluation reserve		4,618	1,166
Income and expenditure reserve		44,277	41,658
Total taxpayers' equity		**58,840**	**49,413**

The notes on pages 104 to 137 form part of this account.

The financial statements on pages 99 to 103 were approved by the Board on 16 June 2022 and signed on its behalf by:

Signed ..... Date 16 June 2022

Name Gordon Flack
Job title Acting Chief Executive

Statement of changes in equity
for the year ended 31 March 2022

	Public dividend capital £000	Revaluation reserve £000	Income and expenditure reserve £000	Total £000
Taxpayers' and others' equity at 1 April 2021 – brought forward	**6,589**	**1,166**	**41,658**	**49,413**
Surplus/(deficit) for the year	–	–	9	**9**
Gain/(loss) arising from transfers by modified absorption	–	–	5,521	**5,521**
Transfers by absorption: Transfers between reserves	–	2,911	(2,911)	**–**
Impairments	–	(731)	–	**(731)**
Revaluations	–	1,272	–	**1,272**
Public dividend capital received	3,356	–	–	**3,356**
Taxpayers' and others' equity at 31 March 2022	**9,945**	**4,618**	**44,277**	**58,840**

Statement of changes in equity
for the year ended 31 March 2021

	Public dividend capital £000	Revaluation reserve £000	Income and expenditure reserve £000	Total £000
Taxpayers' and others' equity at 1 April 2020 – brought forward	**2,889**	**1,199**	**41,677**	**45,765**
Surplus/(deficit) for the year	–	–	(271)	**(271)**
Gain/(loss) arising from transfers by modified absorption	–	–	420	**420**
Transfers by absorption: Transfers between reserves	–	168	(168)	**–**
Impairments	–	(669)	–	**(669)**
Revaluations	–	468	–	**468**
Public dividend capital received	3,700	–	–	**3,700**
Taxpayers' and others' equity at 31 March 2021	**6,589**	**1,166**	**41,658**	**49,413**

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 utilised by the trust, is payable to the Department of Health and Social Care as the public dividend capital dividend. The trust received additional PDC of £3,356k during 2021/22 following application to the Department of Health and Social Care for centrally allocated capital funding programmes (£3,084k Shared Care Record Scheme; £190k Provider Digitisation; £82k Targeted Investment Fund - Technology).

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 2022

	Note	2021/22 £000	2020/21 £000
Cash flows from operating activities			
Operating surplus/(deficit)		354	(258)
Non-cash income and expense:			
Depreciation and amortisation	6	4,958	3,767
Net impairments	7	84	373
(Increase)/decrease in receivables and other assets		291	291
Increase/(decrease) in payables and other liabilities		(7,883)	1,341
Increase/(decrease) in provisions		672	(603)
Net cash flows from/(used in) operating activities		**(1,524)**	**4,911**
Cash flows from investing activities			
Interest received		19	6
Purchase of intangible assets		(3,912)	(1,001)
Purchase of PPE		(4,453)	(9,768)
Net cash flows from/(used in) investing activities		**(8,346)**	**(10,763)**
Cash flows from financing activities			
Public dividend capital received		3,356	3,700
Other interest		(2)	(2)
PDC dividend (paid)/refunded		(364)	347
Net cash flows from/(used in) financing activities		**2,990**	**4,045**
Increase/(decrease) in cash and cash equivalents		**(6,880)**	**(1,807)**
Cash and cash equivalents at 1 April – brought forward		**42,859**	**44,666**
Cash and cash equivalents at 31 March	**21**	**35,979**	**42,859**

The notes on pages 104 to 137 form part of this account.

Notes to the accounts

Note 1 Accounting policies and other information

Note 1.1 Basis of preparation

NHS Improvement, in exercising the statutory functions conferred on Monitor, has directed that the financial statements of the trust shall meet the accounting requirements of the Department of Health and Social Care Group Accounting Manual (GAM), which shall be agreed with HM Treasury. Consequently, the following financial statements have been prepared in accordance with the GAM 2021/22 issued by the Department of Health and Social Care. The accounting policies contained in the GAM follow International Financial Reporting Standards to the extent that they are meaningful and appropriate to the NHS, as determined by HM Treasury, which is advised by the Financial Reporting Advisory Board. Where the GAM permits a choice of accounting policy, the accounting policy that is judged to be most appropriate to the particular circumstances of the trust for the purpose of giving a true and fair view has been selected. The particular policies adopted are described below. These have been applied consistently in dealing with items considered material in relation to the accounts

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 1.2 Going concern

These accounts have been prepared on a going concern basis. The financial reporting framework applicable to NHS bodies, derived from the HM Treasury Financial Reporting Manual, defines that the anticipated continued provision of the entity's services in the public sector is normally sufficient evidence of going concern. The directors have a reasonable expectation that this will continue to be the case.

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 Revenue from contracts with customers

Where income is derived from contracts with customers, it is accounted for under IFRS 15. The GAM expands the definition of a contract to include legislation and regulations which enables an entity to receive cash or another financial asset that is not classified as a tax by the Office of National Statistics (ONS).

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

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

Revenue from NHS contracts

The main source of income for the trust is contracts with commissioners for health care services. In 2021/22 and 2020/21, the majority of the trust's income from NHS commissioners was in the form of block contract arrangements. The trust receives block funding from its commissioners, where funding envelopes are set at an Integrated Care System level. For the first half of the 2020/21 comparative year these blocks were set for individual NHS providers directly, but the revenue recognition principles are the same. The related performance obligation is the delivery of healthcare and related services during the period, with the trust's entitlement to consideration not varying based on the levels of activity performed.

The trust also receives additional income outside of the block payments to reimburse specific costs incurred and, in 2020/21, other income top-ups to support the delivery of services. Reimbursement and top-up income is accounted for as variable consideration.

In applying IFRS 15 a number of practical expedients offered in the Standard and mandated by the GAM have been employed. These are as follows:

- As per paragraph 121 of the Standard the trust will not disclose information regarding performance obligations part of a contract that has an original expected duration of one year or less;
- The trust is to similarly not disclose information where revenue is recognised in line with the practical expedient offered in paragraph b16 of the Standard where the right to consideration corresponds directly with the value of the performance completed to date.

Note 1.4.1 Revenue grants and other contributions to expenditure

Grants and donations

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. Where a grant is used to fund capital expenditure, it is credited to the consolidated statement of comprehensive income once conditions attached to the grant have been met. Donations are treated in the same way as government grants.

Apprenticeship service income

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 from the trust's Digital Apprenticeship Service (DAS) account held by the Department for Education, the corresponding notional expense is also recognised at the point of recognition for the benefit.

Note 1.4.2 Other income

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

Note 1.5 Expenditure on employee benefits

Short-term employee benefits

Salaries, wages and employment-related payments such as social security costs and the apprenticeship levy are recognised in the period in which the service is received from employees. The cost of annual leave entitlement earned but not taken by employees at the end of the period is recognised in the financial statements. 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 2022 but to be paid in April 2022.

Pension costs

NHS Pension Scheme

Past and present employees are covered by the provisions of the two NHS Pension Schemes. Both schemes are unfunded, defined benefit schemes that cover NHS employers, general practices and other bodies, allowed under the direction of Secretary of State for Health and Social Care in England and Wales. The schemes are not designed in a way that would enable employers to identify their share of the underlying scheme's assets and liabilities. Therefore, the schemes are accounted for as though they are defined contribution schemes: the cost to the trust is taken as equal to the employer's pension contributions payable to the schemes for the accounting period. The contributions are charged to operating expenses as and when they become due.

Additional pension liabilities arising from early retirements are not funded by the schemes except where the retirement is due to ill-health. The full amount of the liability for the additional costs is charged to 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

Recognition

Property, plant and equipment is capitalised where:

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

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

Measurement

Valuation

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

Subsequent measurement is as follows:

- Assets held for their service potential and are in use (i.e. operational assets used to deliver either front line services or back office functions) are measured at their current value in existing use. For in use non-specialised property assets, current value in existing use should be interpreted as market value for existing use.
- Specialised assets are held at current value in existing use which is interpreted as the present value of the asset's remaining service potential, which is assumed to be at least equal to the cost of replacing that service potential.
- Assets held for their service potential but are surplus are valued at current value in existing use, if there are restrictions on the trust or the asset which will prevent access to the market at the reporting date. If the trust can access the market then the surplus asset is valued at fair value using IFRS 13.
- Assets which are not held for their service potential are valued in accordance with IFRS 5 or IAS 40 depending on whether the asset is actively held for sale.
- Assets which are not being used to deliver services and there is no plan to bring it back into use, with no restrictions on sale, and do not meet the IFRS 5 and IAS 40 criteria, these assets are considered surplus and are valued at fair value using IFRS 13.

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

Revaluations of property, plant and equipment are performed with sufficient regularity to ensure that carrying values are not materially different from those that would be determined at the end of the reporting period. Current values in existing use are determined as follows:

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

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

Properties in the course of construction for service or administration purposes are carried at cost, less any impairment loss. Cost includes professional fees and, where capitalised in accordance with IAS 23, borrowings costs. Assets are revalued and depreciation commences on assets when they are brought into use, other than grouped information technology (IT) assets. Depreciation commences on grouped IT assets on receipt by the trust and not when the separable parts are brought into use, as this is more practicable by alleviating the requirement to depreciate the assets individually.

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

Subsequent expenditure

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

Depreciation

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

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

Revaluation gains and losses

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

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.

De-recognition

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

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

Following reclassification, the assets are measured at the lower of their existing carrying amount and their 'fair value less costs to sell'. Depreciation ceases to be charged and the assets are not revalued, except where the 'fair value less costs to sell' falls below the carrying amount. Assets are de-recognised when all material sale contract conditions have been met.

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

Useful lives of property, plant and equipment

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

	Min life Years	Max life Years
Buildings, excluding dwellings*	1	35
Plant and machinery	1	12
Transport equipment	2	4
Information technology	1	10
Furniture and fittings	1	4

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

Note 1.8 Intangible assets

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

Software

Software which is integral to the operation of hardware, e.g. 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, e.g. application software, is capitalised as an intangible asset.

Measurement

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

Subsequently intangible assets are measured at current value in existing use. Where no active market exists, intangible assets are valued at the lower of depreciated replacement cost and the value in use where the asset is income generating. Revaluations gains and losses and impairments are treated in the same manner as for property, plant and equipment. An intangible asset which is surplus with no plan to bring it back into use is valued at fair value under

IFRS 13, if it does not meet the requirements of IAS 40 or IFRS 5.

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

Amortisation

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

Useful lives of intangible assets

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

	Min life Years	Max life Years
Software licences	1	5
Information technology systems	1	10

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 operating expenses.

In response to the COVID-19 pandemic, the Department of Health and Social Care (DHSC) centrally procured personal protective equipment and passed these to NHS providers free of charge. During 2021/22 the trust received £358k of items purchased by the DHSC (£3,669k in 2020/21).

In line with the trust's accounting policy for inventories, the deemed cost of these inventories was charged directly to expenditure on receipt with the corresponding benefit recognised in income (as referenced in Note 4 and Note 6).

Note 1.10 Cash and cash equivalents

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

Note 1.11 Financial assets and financial liabilities

Recognition

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

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

Classification and measurement

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

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

Financial assets and financial liabilities at amortised cost

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

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

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

Impairment of financial assets

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

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

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

Expected losses are charged to operating expenditure within the Statement of Comprehensive Income and reduce the net carrying value of the financial asset in the Statement of Financial Position.

Derecognition

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

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

Note 1.12 Leases

Leases are classified as finance leases when substantially all the risks and rewards of ownership are transferred to the lessee. The trust does not currently have any finance lease arrangements (as a lessor or as a lessee).

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. Lease incentives are recognised initially in other liabilities on the statement of financial position and subsequently as a reduction of rentals on a straight-line basis over the lease term.

Rental income from operating leases (where the Trust is the lessor) is recognised on a straight-line basis over the term of the lease. Initial direct costs incurred in negotiating and arranging an operating lease are added to the carrying amount of the leased asset and recognised as an expense on a straight-line basis over the lease term.

Note 1.13 Provisions

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

Clinical negligence costs

NHS Resolution operates a risk pooling scheme under which the trust pays an annual contribution to NHS Resolution, which, in return, settles all clinical negligence claims. Although NHS Resolution is administratively responsible for all clinical negligence cases, the legal liability remains with the trust. The total value of clinical negligence provisions carried by NHS Resolution on behalf of the trust is disclosed at note 26.1 but is not recognised in the trust's accounts.

Non-clinical risk pooling

The trust participates in the Property Expenses Scheme and the Liabilities to Third Parties Scheme. Both are risk pooling schemes under which the trust pays an annual contribution to NHS Resolution and in return receives assistance with the costs of claims arising. The annual membership contributions, and any "excesses" payable in respect of particular claims are charged to operating expenses when the liability arises.

Note 1.14 Contingencies

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

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

Contingent liabilities are defined as:

- possible obligations arising from past events whose existence will be confirmed only by the occurrence of one or more uncertain future events not wholly within the entity's control; or
- present obligations arising from past events but for which it is not probable that a transfer of economic benefits will arise or for which the amount of the obligation cannot be measured with sufficient reliability.

Note 1.15 Public dividend capital

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

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%) 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, with certain additions and deductions as defined by the relevant Department of Health and Social Care policy e.g. average daily cash balances held with the Government Banking Service."

This policy is available at https://www.gov.uk/government/publications/guidance-on-financing-available-to-nhs-trusts-and-foundation-trusts.

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

Note 1.16 Value added tax

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

Note 1.17 Corporation tax

The trust has determined that it is has no corporation tax liability on the basis it has no activities subject to corporation tax as all activities are core or related to core healthcare as defined in Health and Social Care Act legislation.

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.

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 Modified absorption accounting – transfer of former primary care trust assets to NHS providers

Transfers of former Primary Care Trust assets from NHS Property Services to NHS Providers under the DHSC asset transfer policy announced in May 2019, is accounted for via a modified absorption approach with the gain on transfer recognised directly in reserves (income and expenditure reserve).

For property, plant and equipment assets, the cost and accumulated depreciation balances from the transferring entity's accounts are preserved on recognition in the trust's accounts. Where the transferring body recognised revaluation reserve balances attributable to the assets, the trust makes a transfer from its income and expenditure reserve to its revaluation reserve to maintain transparency within public sector accounts.

Note 1.22 Early adoption of standards, amendments and interpretations

No new accounting standards or revisions to existing standards have been early adopted in 2021/22.

Note 1.23 Standards, amendments and interpretations in issue but not yet effective or adopted.

IFRS 16 Leases

IFRS 16 Leases will replace IAS 17 Leases, IFRIC 4 Determining whether an arrangement contains a lease and other interpretations and is applicable in the public sector for periods beginning 1 April 2022. The standard provides a single accounting model for lessees, recognising a right of use asset and obligation in the statement of financial position for most leases: some leases are exempt through application of practical expedients explained below. For those recognised in the statement of financial position the standard also requires the remeasurement of lease liabilities in specific circumstances after the commencement of the lease term. For lessors, the distinction between operating and finance leases will remain and the accounting will be largely unchanged.

IFRS 16 changes the definition of a lease compared to IAS 17 and IFRIC 4. The Trust will apply this definition to new leases only and will grandfather its assessments made under the old standards of whether existing contracts contain a lease.

On transition to IFRS 16 on 1 April 2022, the trust will apply the standard retrospectively without restatement and with the cumulative effect of initially applying the standard recognised in the income and expenditure reserve at that date. For existing operating leases with a remaining lease term of more than 12 months and an underlying asset value of at least £5,000, a lease liability will be recognised equal to the value of remaining lease payments discounted on transition at the trust's incremental borrowing rate. The trust's incremental borrowing rate will be defined by HM Treasury. For 2022, this rate is 0.95%. The related right of use asset will be measured equal to the lease liability adjusted for any prepaid or accrued lease payments.

For leases commencing in 2022/23, the trust will not recognise a right of use asset or lease liability for short term leases (less than or equal to 12 months) or for leases of low value assets (less than £5,000). Right of use assets will be subsequently measured on a basis consistent with owned assets and depreciated over the length of the lease term.

The trust has estimated the impact of applying IFRS 16 in 2022/23 on the opening statement of financial position and the in-year impact on the statement of comprehensive income and capital additions as follows:

	£000
Estimated impact on 1 April 2022 statement of financial position	
Additional right of use assets recognised for existing operating leases	45,556
Additional lease obligations recognised for existing operating leases	(45,617)
Changes to other statement of financial position line items	61
Net impact on net assets on 1 April 2022	**—**
Estimated in-year impact in 2022/23	
Additional depreciation on right of use assets	(6,309)
Additional finance costs on lease liabilities	(428)
Lease rentals no longer charged to operating expenditure	6,547
Estimated impact on surplus / deficit in 2022/23	**(190)**
Estimated increase in capital additions for new leases commencing in 2022/23	**1,676**

Other standards, amendments and interpretations

The following issued accounting standard has not yet been adopted by the HM Treasury FReM and are therefore not applicable in 2021/22:

- IFRS 17 Insurance Contracts – Application required for accounting periods beginning on or after 1 January 2021. Standard is not yet adopted by the FReM which is expected to be from April 2023 (early adoption is not permitted).

Note 1.24 Critical accounting estimates and judgements

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

The following are the bases for the estimations that management have used in the process of applying the Trust accounting policies and that have the most significant effect on the amounts recognised in the financial statements (note 26 provides further analysis of the provisions accounted):

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 advised by expert opinion within the trust.

Legal Claims and other provisions

The trust has received expert opinion from external advisers and within the trust as to the expected value, the assumptions on the timing of the associated cashflow and the 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 physical estate within the NHS and market factors.

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

Note 2 Operating segments

The trust operates as a single reportable segment, being the provision of healthcare. The Board of Directors, led by the Chief Executive, is the chief operating decision maker within the trust. It is only at this level that the overall financial and operational performance of the trust is measured.

The majority of income was received from Clinical Commissioning Groups, local authorities and NHS England. Income for patient care and other operating activities received from these bodies was as follows. There are no other parties that account for more than 10 per cent of total income:

	2021/22 £000	% of total income
Clinical commissioning groups	167,700	61.65%
Local authorities	43,085	16.24%
NHS England	34,510	12.69%
Total	**245,295**	**90.17%**

	2020/21 £000	% of total income
Clinical commissioning groups	162,748	60.44%
Local authorities	44,227	16.42%
NHS England	34,719	12.89%
Total	**241,694**	**89.75%**

Note 3 Operating income from patient care activities

All income from patient care activities relates to contract income recognised in line with accounting policy 1.4

Note 3.1 Income from patient care activities (by nature)

	2021/22 £000	2020/21 £000
Community services		
Block contract/system envelope income	190,374	185,234
Income from other sources (such as local authorities)	53,169	53,347
All services		
Private patient income	63	23
Additional pension contribution central funding*	8,691	8,131
Other clinical income	-	752
Total income from activities	**252,297**	**247,487**

*The employer contribution rate for NHS pensions increased from 14.3% to 20.6% (excluding administration charge) from 1 April 2019. Since 2019/20, NHS providers have continued to pay over contributions at the former rate with the additional amount being paid over by NHS England on providers' behalf. The full cost and related funding have been recognised in these accounts.

Note 3.2 Income from patient care activities (by source)

Income from patient care activities received from:

	2021/22 £000	2020/21 £000
NHS England	32,489	32,669
Clinical commissioning groups	166,576	161,448
Other NHS providers	7,312	7,007
NHS other	15	-
Local authorities	43,079	44,227
Non-NHS: Private patients	63	23
Injury cost recovery scheme	237	306
Non NHS: Other	2,526	1,807
Total income from activities	**252,297**	**247,487**
Of which:		
Related to continuing operations	252,297	247,487
Related to discontinued operations	–	–

Note 4 Other operating income

	2021/22			2020/21		
	Contract income	Non-contract income	Total	Contract income	Non-contract income	Total
	£000	£000	£000	£000	£000	£000
Research and development	161	–	**161**	–	–	–
Education and training	2,902	899	**3,801**	2,010	831	**2,841**
Non-patient care services to other bodies	2,889		**2,889**	4,454		**4,454**
Reimbursement and top up funding	10,517		**10,517**	9,814		**9,814**
Income in respect of employee benefits accounted on a gross basis	1,172		**1,172**	–		–
Charitable and other contributions to expenditure		376	**376**		3,696	**3,696**
Rental revenue from operating leases		112	**112**		–	–
Other income	705	–	**705**	999	–	**999**
Total other operating income	**18,346**	**1,387**	**19,733**	**17,277**	**4,527**	**21,804**
Of which:						
Related to continuing operations			**19,733**			**21,804**
Related to discontinued operations			–			–

Reimbursement and top-up funding represents the value of additional income received from NHS England outside of the block and system envelopes to reimburse specific costs incurred and other income top-ups to support the delivery of services. For 2021/22, this income (£10.5m) relates solely to the reimbursement of specific costs incurred by the trust in the operation of the COVID-19 vaccination programme during 2021/22. The costs of the COVID-19 vaccination programme are included in the trust's operating expenses in note 6.

Charitable and other contributions to expenditure includes £358k (£3,669k 2020/21) of income representing the benefit of the deemed cost of inventories (personal protective equipment consumables) received from the Department of Health and Social Care at nil cost during 2021/22. As outlined in note 1.9, the corresponding expense representing the deemed cost of these inventories has been charged directly to expenditure and is included in the Trust's operating expenses in note 6.

The education and training income presented as non-contract income represents the value of benefit arising from apprenticeship levy funded training received. The corresponding notional expense is recognised within education and training costs in note 6.

Note 5 Additional information on contract revenue (IFRS 15) recognised in the period

	2021/22 £000	2020/21 £000
Revenue recognised in the reporting period that was included in within contract liabilities at the previous period end	2,428	1,421

Note 5.1 Transaction price allocated to remaining performance obligations

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

Note 5.2 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:

	2021/22 £000	2020/21 £000
Income from services designated as commissioner requested services	–	–
Income from services not designated as commissioner requested services	272,030	269,291
Total	**272,030**	**269,291**

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

Note 6 Operating expenses

	2021/22 £000	2020/21 £000
Staff and executive directors costs	204,034	195,611
Remuneration of non-executive directors	165	190
Supplies and services - clinical (excluding drugs costs)	22,475	28,508
Supplies and services - general	2,021	2,165
Drug costs (drugs inventory consumed and purchase of non-inventory drugs)	4,235	4,211
Consultancy costs	335	1,879
Establishment	7,928	8,081
Premises	7,710	9,037
Transport (including patient travel)	3,436	3,063
Depreciation on property, plant and equipment	4,514	3,447
Amortisation on intangible assets	444	320
Net impairments	84	373
Movement in credit loss allowance: contract receivables / contract assets	7	41
Movement in credit loss allowance: all other receivables and investments	70	13
Fees payable to the external auditor		
audit services- statutory audit*	78	78
Internal audit costs	71	51
Clinical negligence	998	730
Legal fees	32	295
Insurance	176	162
Education and training	2,205	1,975
Rentals under operating leases	9,567	8,719
Redundancy	171	62
Hospitality	10	6
Losses, ex gratia & special payments	4	26
Other services, eg external payroll	350	374
Other	556	132
Total	**271,676**	**269,549**
Of which:		
Related to continuing operations	271,676	269,549
Related to discontinued operations	–	–

Supplies and services - clinical (excluding drugs costs) includes £358k (£3,669k 2020/21) deemed cost of inventories (personal protective equipment consumables) received from the Department of Health and Social Care at nil cost during 2021/22 and charged directly to expenditure on receipt (see also note 1.9 and note 4).

*The audit fees payable to the external auditor as presented in the above note include irrecoverable VAT.

Note 6.1 Limitation on auditor's liability

The auditor's liability for external audit work carried out for the financial year 2021/22 is limited to £2,000,000.

Note 7 Impairment of assets

	2021/22 £000	2020/21 £000
Net impairments charged to operating surplus/deficit resulting from:		
Changes in market price	84	373
Total net impairments charged to operating surplus/deficit	**84**	**373**
Impairments charged to the revaluation reserve	731	669
Total net impairments	**815**	**1,042**

The impairment values reported follow the revaluation exercise carried out of the trust's owned properties (land and buildings) as at 31 March 2022, and include an assessment of the current usage and occupation by the trust at the respective sites. The outcome of this independent assessment has been agreed by the trust's Estates Department.

The revaluation exercise undertaken as at 31 March 2022, included a physical review of the land and property transferred to the trust from NHS Property Services during 2021/22 (please also refer to Note 34 for further details of the transfers). As a result of this exercise, the impairment values presented include a reduction in the land value transferred of £451k, with the reported reduction in value primarily due to the difference in valuation methodology adopted by the trust and the previous owner (NHS Property Services).

Note 8 Employee benefits

	2021/22 £000	2020/21 £000
Salaries and wages	157,314	149,688
Social security costs	13,863	12,741
Apprenticeship levy	770	715
Employer's contributions to NHS pensions	28,454	26,894
Pension cost – other	48	48
Termination benefits	127	91
Temporary staff (including agency)	4,386	6,913
Total gross staff costs	**204,962**	**197,090**
Recoveries in respect of seconded staff	(140)	(9)
Total staff costs	**204,822**	**197,081**
Of which		
Costs capitalised as part of assets	661	1,379

The employer contribution rate for NHS pensions increased from 14.3% to 20.6% (excluding administration levy) from 1 April 2019. For 2021/22, NHS providers continued to pay over contributions at the former rate with the additional amount being paid over by NHS England on the providers' behalf. The increased cost in employer's contributions (2021/22 £8,691k and 2020/21 £8,131k) is recognised in full in the figures presented above, with the commensurate notional funding from NHS England for the respective year being recognised in note 3.1.

Total staff costs on the Covid-19 vaccination programme during 2021/22 was £8.5m (£2.4m 2020/21).

Note 8.1 Retirements due to ill-health

During 2021/22 there was 1 early retirement from the Trust agreed on the grounds of ill-health (4 in the year ended 31 March 2021). The estimated additional pension liabilities of these ill-health retirements is £6k (£248k in 2020/21).

These estimated costs are calculated on an average basis and will be borne by the NHS Pension Scheme.

Note 9 pension costs

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

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

a) Accounting valuation

A valuation of scheme liability is carried out annually by the scheme actuary (currently the Government Actuary's Department) as at the end of the reporting period. This utilises an actuarial assessment for the previous accounting period in conjunction with updated membership and financial data for the current reporting period, and is accepted as providing suitably robust figures for financial reporting purposes. The valuation of the scheme liability as at 31 March 2022, is based on valuation data as 31 March 2021, updated to 31 March 2022 with summary global member and accounting data. In undertaking this actuarial assessment, the methodology prescribed in IAS 19, relevant FReM interpretations, and the discount rate prescribed by HM Treasury have also been used.

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

b) Full actuarial (funding) valuation

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

The latest actuarial valuation undertaken for the NHS Pension Scheme was completed as at 31 March 2016. The results of this valuation set the employer contribution rate payable from April 2019 to 20.6% of pensionable pay.

The 2016 funding valuation also tested the cost of the Scheme relative to the employer cost cap that was set following the 2012 valuation. There was initially a pause to the cost control element of the 2016 valuations, due to the uncertainty around member benefits caused by the discrimination ruling relating to the McCloud case.

HMT published valuation directions dated 7 October 2021 (see Amending Directions 2021) that set out the technical detail of how the costs of remedy are included in the 2016 valuation process. Following these directions, the scheme actuary has completed the cost control element of the 2016 valuation for the NHS Pension Scheme, which concludes no changes to benefits or member contributions are required. The 2016 valuation reports can be found on the NHS Pensions website at https://www.nhsbsa.nhs.uk/nhs-pension-scheme-accounts-and-valuation-reports.

Other schemes

The trust participates in the National Employees Savings Trust (NEST) scheme as an alternative for those employees who are not eligible to join the NHS Pension scheme. NEST is a defined contribution scheme with a phased employer contribution rate, currently 3%.

Note 10 Operating leases

Note 10.1 Kent Community Health NHS Foundation Trust as a lessor

This note discloses income generated in operating lease agreements where Kent Community Health NHS Foundation Trust is the lessor.

	2021/22 £000	2020/21 £000
Operating lease revenue		
Minimum lease receipts	112	–
Contingent rents	–	–
Other	–	–
Total	**112**	**–**

The operating lease revenue recognised represents the 2021-22 occupancy charges for tenants at Victoria Hospital (Deal) and Vicarage Lane Clinic (Ashford) following the respective transfer of ownership of the sites to the trust from NHS Property Services during 2021-22. As at 31 March 2022, formal contracts to cover future periods of occupancy are still to be agreed with tenants and therefore information relating to future lease receipts has not been disclosed.

Note 10.2 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.

	2021/22 £000	2020/21 £000
Operating lease expense		
Minimum lease payments	9,567	8,719
Contingent rents	-	-
Less sublease payments received	-	-
Total	**9,567**	**8,719**

	31 March 2022 £000	31 March 2021 £000
Future minimum lease payments due:		
- not later than one year;	2,922	2,743
- later than one year and not later than five years;	6,351	5,411
- later than five years.	3,999	3,457
Total	**13,272**	**11,611**
Future minimum sublease payments to be received	**–**	**–**

Future lease commitments include only those leases with formal lease contracts in place as at 31 March 2022.

Note 11 Finance income

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

	2021/22 £000	2020/21 £000
Interest on bank accounts	37	–
Total finance income	**37**	**–**

Note 12 Finance expenditure

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

	2021/22 £000	2020/21 £000
Interest expense:		
Interest on late payment of commercial debt	2	2
Total interest expense	**2**	**2**
Unwinding of discount on provisions	**–**	**11**
Total finance costs	**2**	**13**

Note 12.1 The late payment of commercial debts (interest) Act 1998/Public Contract Regulations 2015

	2021/22 £000	2020/21 £000
Amounts included within interest payable arising from claims made under this legislation	2	2

Note 13 Intangible assets – 2021/22

	Software licences £000	Information Technology Systems £000	Intangible assets under construction £000	Total £000
Valuation/gross cost at 1 April 2021 – brought forward	**2,188**	**–**	**40**	**2,228**
Additions	885	3,084	91	4,060
Reclassifications	40	2,699	(40)	2,699
Disposals/derecognition	(20)	–	–	(20)
Valuation/gross cost at 31 March 2022	**3,093**	**5,783**	**91**	**8,967**
Amortisation at 1 April 2021 – brought forward	**775**	**–**	**–**	**775**
Provided during the year	444	–	–	444
Disposals/derecognition	(20)	–	–	(20)
Amortisation at 31 March 2022	**1,199**	**–**	**–**	**1,199**
Net book value at 31 March 2022	**1,894**	**5,783**	**91**	**7,768**
Net book value at 1 April 2021	**1,413**	**–**	**40**	**1,453**

Note 13.1 Intangible assets – 2020/21

	Software licences £000	Information Technology Systems £000	Intangible assets under construction £000	Total £000
Valuation/gross cost at 1 April 2020	**884**	**–**	251	**1,135**
Additions	1,081	–	40	**1,121**
Reclassifications	251	–	(251)	–
Disposals / derecognition	(28)	–	–	**(28)**
Valuation/gross cost at 31 March 2021	**2,188**	**–**	**40**	**2,228**
Amortisation at 1 April 2020	**483**	**–**	–	**483**
Provided during the year	320	–	–	**320**
Disposals / derecognition	(28)	–	–	**(28)**
Amortisation at 31 March 2021	**775**	**–**	–	**775**
Net book value at 31 March 2021	**1,413**	**–**	**40**	**1,453**
Net book value at 1 April 2020	**401**		**251**	**652**

Note 14 Property, plant and equipment – 2021/22

	Land £000	Buildings excluding dwellings £000	Assets under construction £000	Plant and machinery £000	Transport equipment £000	Information Technology £000	Furniture and fittings £000	Total 000
Valuation/gross cost at 1 April 2021 – brought forward	**1,118**	**12,301**	**3,543**	**3,335**	**185**	**17,226**	**1,009**	**38,717**
Transfers by absorption*	1,541	4,056	-	-	-	-	-	5,597
Additions	-	861	239	414	55	2,615	6	4,190
Impairments	(632)	(305)	-	-	-	-	-	(937)
Reversals of impairments	2	120	-	-	-	-	-	122
Revaluations	12	429	-	-	-	-	-	441
Reclassifications	-	13	(3,478)	195	55	510	6	(2,699)
Transfers to/from assets held for sale	295	-	-	-	**(10)**	-	-	285
Disposals / derecognition	-	(147)	-	-	-	(974)	(16)	(1,137)
Valuation/gross cost at 31 March 2022	**2,336**	**17,328**	**304**	**3,944**	**285**	**19,377**	**1,005**	**44,579**
Accumulated depreciation at 1 April 2021 – brought forward	-	**3,476**	-	**1,702**	**181**	**7,787**	**921**	**14,067**
Transfers by absorption*	-	76	-	-	-	-	-	76
Provided during the year	-	1,571	-	302	9	2,587	45	4,514
Revaluations	-	(831)	-	-	-	-	-	(831)
Transfers to / from assets held for sale	-	-		-	**(9)**	-	-	(9)
Disposals/derecognition	-	(147)	-	-	-	(974)	(16)	(1,137)
Accumulated depreciation at 31 March 2022	-	**4,145**	-	**2,004**	**181**	**9,400**	**950**	**16,680**
Net book value at 31 March 2022	**2,336**	**13,183**	**304**	**1,940**	**104**	**9,977**	**55**	**27,899**
Net book value at 1 April 2021	**1,118**	**8,825**	**3,543**	**1,633**	**4**	**9,439**	**88**	**24,650**

*Represents the transfer of Victoria Hospital (Deal, Kent), Vicarage Lane Clinic (Ashford, Kent) and Molehill Copse Clinic (Maidstone, Kent) from NHS Property Services. Refer to Note 1.21 and Note 34 for further information on the accounting policy and transfer.

Note 14.1 Property, plant and equipment 2020/21

	Land £000	Buildings excluding dwellings £000	Assets under construction £000	Plant and machinery £000	Transport equipment £000	Information Technology £000	Furniture and fittings £000	Total 000
Valuation/gross cost at 1 April 2020 – brought forward	**1,472**	**9,631**	**2,882**	**2,966**	**185**	**16,814**	**979**	**34,929**
Transfers by absorption**	247	205	-	-	**-**	-	-	**452**
Additions	-	1,978	3,207	173	-	3,589	30	**8,977**
Impairments	(641)	(401)	-	-	**-**	-	-	**(1,042)**
Revaluations	40	210	-	-	**-**	-	-	**250**
Reclassifications	295	678	(2,546)	196	**-**	1,377	-	**-**
Transfers to / from assets held for sale	(295)	-	-	-	-	-	-	**(295)**
Disposals/derecognition	-	-	-	-	-	(4,554)	-	**(4,554)**
Valuation/gross cost at 31 March 2021	**1,118**	**12,301**	**3,543**	**3,335**	**185**	**17,226**	**1,009**	**38,717**
Accumulated depreciation at 1 April 2020 – brought forward	-	**2,901**	-	**1,427**	**178**	**9,995**	**859**	**15,360**
Transfers by absorption**	**-**	32	**-**	-	**-**	-	-	**32**
Provided during the year	-	761	-	275	3	2,346	62	**3,447**
Revaluations	**-**	(218)	**-**	-	**-**	-	-	**(218)**
Disposals/derecognition	-	-	-	-	-	(4,554)	-	**(4,554)**
Accumulated depreciation at 31 March 2021	-	**3,476**	-	**1,702**	**181**	**7,787**	**921**	**14,067**
Net book value at 31 March 2021	**1,118**	**8,825**	**3,543**	**1,633**	**4**	**9,439**	**88**	**24,650**
Net book value at 1 April 2020	**1,472**	**6,730**	**2,882**	**1,539**	**7**	**6,819**	**120**	**19,569**

**Represents the transfer of College Road Clinic (Margate, Kent) from NHS Property Services in 2020/21.

Note 14.2 Property, plant and equipment financing – 2021/22

	Land £000	Buildings excluding dwellings £000	Assets under construction £000	Plant and machinery £000	Transport equipment £000	Information Technology £000	Furniture and fittings £000	Total 000
Net book value at 31 March 2022								
Owned – purchased	2,336	13,183	304	1,940	104	9,977	55	**27,899**
NBV total at 31 March 2022	**2,336**	**13,183**	**304**	**1,940**	**104**	**9,977**	**55**	**27,899**

Note 14.3 Property, plant and equipment financing – 2020/21

	Land £000	Buildings excluding dwellings £000	Assets under construction £000	Plant and machinery £000	Transport equipment £000	Information Technology £000	Furniture and fittings £000	Total 000
Net book value at 31 March 2021								
Owned – purchased	1,118	8,825	3,543	1,633	4	9,439	88	**24,650**
NBV total at 31 March 2021	**1,118**	**8,825**	**3,543**	**1,633**	**4**	**9,439**	**88**	**24,650**

Note 15 Revaluations of property, plant and equipment

A desktop valuation exercise was undertaken of the trust's owned buildings and land as at 31 March 2022, following the full valuation exercise (physical inspection) carried out on the same properties as at 31 March 2021. In addition, a full valuation exercise was also undertaken as at 31 March 2022 for the land and property of Victoria Hospital (located in Deal, Kent), Vicarage Lane Clinic (located in Ashford, Kent) and Molehill Copse Clinic (located in Maidstone, Kent), following the transfer of ownership of these sites to the trust from NHS Property Services during 2021/22. A desktop valuation was also obtained in respect of land owned by the trust at Four Elms, Edenbridge, Kent.

The trust's freehold estate consists of both specialised and non-specialised operational assets. In line with the RICs Valuation Global Standards, the basis for valuation used for the specialised operational assets is Depreciated Replacement Cost (DRC) method and the valuation methodology used for the non-specialised assets is Existing Use Value (EUV). Where buildings have been valued using the DRC method of valuation the assumption is that the 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.

The revaluation exercise was carried out over the period to the end of March 2022, with a valuation date as at 31 March 2022 and was completed by Eleanor Cook MRICS of Montagu Evans LLP, an independent valuer with sufficient experience and qualifications. The valuation was prepared in accordance with the requirements of the Royal Institute of Chartered Surveyors (RICS) Valuation Global Standards.

Note 16 Investments 2021/22

The trust has no investments (including investments in property). Nil for March 2021.

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 Receivables

	31 March 2022 £000	31 March 2021 £000
Current		
Contract receivables	14,631	14,561
Allowance for impaired contract receivables / assets	(70)	(67)
Allowance for other impaired receivables	(266)	(214)
Prepayments (non-PFI)	1,995	1,780
Interest receivable	18	-
VAT receivable	286	684
Other receivables	559	727
Total current receivables	**17,153**	**17,471**
Non-current		
Prepayments (non-PFI)	190	167
Other receivables	93	71
Total non-current receivables	**283**	**238**
Of which receivable from NHS and DHSC group bodies:		
Current	7,753	7,431
Non-current	93	71

Note 19.1 Allowances for credit losses

	2021/22		2020/21	
	Contract receivables and contract assets	All other receivables	Contract receivables and contract assets	All other receivables
	£000	£000	£000	£000
Allowances as at 1 April – brought forward	**67**	**214**	**31**	**238**
New allowances arising	24	87	23	96
Changes in existing allowances	4	10	26	-
Reversals of allowances	(21)	(27)	(8)	(83)
Utilisation of allowances (write offs)	(4)	(18)	(5)	(37)
Allowances as at 31 March 2022	**70**	**266**	**67**	**214**

Note 19.2 Exposure for credit risk

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

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

Note 20 Non-current assets held for sale and assets in disposal groups

	2021/22 £000	2020/21 £000
NBV of non-current assets for sale and assets in disposal groups at 1 April	295	-
Assets classified as available for sale in the year	1	295
Assets no longer classified as held for sale, for reasons other than sale	(295)	-
NBV of non-current assets for sale and assets in disposal groups at 31 March	**1**	295

The trust's freehold ownership of land at Four Elms, Edenbridge in Kent held for the purposes of a new health and wellbeing centre in Edenbridge is now to be retained by the trust in line with the proposed development agreement.

Note 21 Cash and cash equivalents movements

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

	2021/22 £000	2020/21 £000
At 1 April	**42,859**	**44,666**
Net change in year	(6,880)	(1,807)
At 31 March	**35,979**	**42,859**
Broken down into:		
Cash at commercial banks and in hand	31	35
Cash with the Government Banking Service	35,948	42,824
Total cash and cash equivalents as in SoFP	**35,979**	**42,859**
Total cash and cash equivalents as in SoCF	**35,979**	**42,859**

Note 21.1 Third party assets held by the trust

The trust held no cash and cash equivalents which relate to monies held by the Trust on behalf of patients or other parties. Nil for 2020/21.

Note 22 Trade and other payables

	31 March 2022 £000	31 March 2021 £000
Current		
Trade payables	852	602
Capital payables	1,506	1,621
Accruals	14,329	22,709
Social security costs	2,408	2,395
Other taxes payable	1,531	1,535
PDC dividend payable	17	1
Other payables	2,624	3,079
Total current trade and other payables	**23,267**	**31,942**
Total non-current trade and other payables	**–**	**–**
Of which payables from NHS and DHSC group bodies:		
Current	4,663	9,328
Non-current	–	–

Note 22.1 Early retirements in NHS payables above

There are no early retirement payables. Nil for 2020/21.

Note 23 Other liabilities

	31 March 2022 £000	31 March 2021 £000
Current		
Deferred income: Contract liabilities	4,375	3,926
Deferred grants*	600	600
Total other current liabilities	**4,975**	**4,526**
Non-current		
Deferred income: contract liabilities	244	-
Total other current liabilities	**244**	**-**

*In 2020/21, the trust received a grant (Community Infrastructure Levy Receipts) for £600k from Sevenoaks District Council. The grant is to be used for the purposes of the Edenbridge Integrated Health and Wellbeing Centre project. During 2021/22, the trust has continued to work in partnership with local Clinical Commissioning Group and other health partners in overseeing a project to appoint a developer (and subsequent owner) of a new health and wellbeing centre in Edenbridge to replace the existing Edenbridge Hospital and General Practice buildings. As at 31 March 2022, is yet to be utilised (in part or in full) with plans now in place to utilise the grant in financial years 2022/23 and 2023/24 in line with the build/project completion.

Note 24 Borrowings

The trust has no borrowings. Nil for 2020/21.

Note 25 Finance leases

Note 25.1 Kent Community Health NHS Foundation Trust as a lessor

The trust has no finance lease arrangements. Nil for 2020/21.

Note 25.2 Kent Community Health NHS Foundation Trust as a lessee

The trust has no finance lease obligations. Nil for 2020/21.

Note 26 Provisions for liabilities and charges analysis

	Legal claims £000	Redundancy £000	Other £000	Total £000
At 1 April 2021	**235**	**62**	**788**	**1,085**
Arising during the year	125	227	787	**1,139**
Utilised during the year	(99)	(127)	(83)	**(309)**
Reversed unused	(102)	(56)	-	**(158)**
At 31 March 2022	**159**	**106**	**1,492**	**1,757**
Expected timing of cash flows:				
– not later than one year	159	106	383	**648**
– later than one year and not later than five years	–	–	373	**373**
– later than five years	–	–	736	**736**
Total	**159**	**106**	**1,492**	**1,757**

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 1.13 and 1.24).

The provisions classified as other, in the main include a provision (£1,397k) for dilapidations liabilities for the trust's commercially leased properties. The dilapidations provision represents the estimated re-instatement costs/assessed liabilities required when the Trust is due to vacate the properties as advised by an external surveyor (BNP Paribas Real Estate).

Note 26.1 Clinical negligence liabilities

At 31 March 2022, £1,774k was included in provisions of NHS Resolution in respect of clinical negligence liabilities of Kent Community Health NHS Foundation Trust (31 March 2021: £3,910k).

Note 27 Contingent assets and liabilities

	31 March 2022 £000	31 March 2021 £000
Value of contingent liabilities		
NHS Resolution legal claims	(34)	(27)
Gross value of contingent liabilities	**(34)**	**(27)**
Amounts recoverable against liabilities	–	–
Net value of contingent liabilities	**(34)**	**(27)**
Net value of contingent assets	–	–

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

Note 28 Contractual capital commitments

	31 March 2022 £000	31 March 2021 £000
Property, plant and equipment	465	1,783
Intangible assets	–	–
Total	**465**	**1,783**

Note 29 Other financial commitments

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

	31 March 2022 £000	31 March 2021 £000
not later than 1 year	1,828	596
after 1 year and not later than 5 years	6,048	6,643
paid thereafter	-	1,232
Total	**7,876**	**8,471**

Note 30 Defined benefit pension schemes

The trust has no defined benefit schemes.

Note 31 Financial instruments

Note 31.1 Financial risk management

Financial reporting standard IFRS 7 requires disclosure of the role that financial instruments have had during the period in creating or changing the risks a body faces in undertaking its activities. Due to the continuing service provider relationship that the trust 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. The trust 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 trust'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 2022 is in receivables from customers, as disclosed in the trade and other receivables note. However the trust exercises effective credit control processes including utilising 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 trust funds its capital expenditure through internally generated cash and if/where applicable, the Department of Health and Social Care central funding programmes. The organisation is not, therefore exposed to significant liquidity risks.

Note 31.2 Carrying values of financial assets

	Held at amortised cost	Held at fair value through I&E	Held at fair value through OCI	Total book value
	£000	£000	£000	£000
Carrying values of financial assets as at 31 March 2022				
Trade and other receivables excluding non financial assets	14,965	-	-	**14,965**
Cash and cash equivalents	35,979	-	-	**35,979**
Total at 31 March 2022	**50,944**	-	-	**50,944**

	Held at amortised cost	Held at fair value through I&E	Held at fair value through OCI	Total book value
	£000	£000	£000	£000
Carrying values of financial assets as at 31 March 2021				
Trade and other receivables excluding non financial assets	15,078	-	-	**15,078**
Cash and cash equivalents	42,859	-	-	**42,859**
Total at 31 March 2021	**57,937**	-	-	**57,937**

Note 31.3 Carrying values of financial liabilities

	Held at amortised cost £000	Held at fair value through I&E £000	Total book value £000
Carrying values of financial liabilities as at 31 March 2022			
Trade and other payables excluding non financial liabilities	19,311	-	**19,311**
Total at 31 March 2022	**19,311**	-	**19,311**

	Held at amortised cost £000	Held at fair value through I&E £000	Total book value £000
Carrying values of financial liabilities as at 31 March 2021			
Trade and other payables excluding non financial liabilities	28,011	-	**28,011**
Total at 31 March 2021	**28,011**	-	**28,011**

Note 31.4 Maturity of financial liabilities

	31 March 2022 £000	31 March 2021 £000
In one year or less	19,311	28,011
In more than two years but not more than five years	-	-
In more than five years	-	-
Total	**19,311**	**28,011**

Note 31.5 Fair values of financial assets and liabilities

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

Note 32 Losses and special payments

	2021/22		2020/21	
	Total number of cases Number	Total value of cases £000	Total number of cases Number	Total value of cases £000
Losses				
Cash losses	1	-	4	1
Fruitless payments and constructive losses	1	1	-	-
Bad debts and claims abandoned	124	23	175	42
Total losses	**126**	**24**	**179**	**43**
Special payments				
Ex-gratia payments*	11	50	11	89
Total special payments	**11**	**50**	**11**	**89**
Total losses and special payments	**137**	**74**	**190**	**132**

*prior period numbers have been updated to include the "Flowers" judgment overtime corrective payments accrued in 2020/21.

Note 33 Related parties

All bodies within the scope of the Whole Government Accounts (WGA) are treated as related parties of an NHS foundation trust including the Department of Health and Social Care as the Trust's parent organisation. A list of the main entities (those with transactions or balances of more than £1m) within the scope of the Whole Government Accounts (WGA) with which the Trust has transacted with during the reporting period or has receivables or payables balances reported as at period end, are as follows:

NHS England
NHS Kent & Medway CCG
NHS East Sussex CCG
East Kent Hospitals University NHS Foundation Trust
Dartford and Gravesham NHS Trust
Maidstone and Tunbridge Wells NHS Trust
Health Education England
NHS Property Services
NHS Resolution
Kent County Council
Medway Council
East Sussex County Council
HM Revenue & Customs
NHS Pension Scheme

As at 31 March 2022, the Trust has a receivable of £2k with Kent Community Health Charitable Fund whose Corporate Trustee is the Trust's Board of Directors. The accounts of the charity are available separately and are not included in these accounts as per note 1.3.

Note 34 Transfer by modified absorption accounting

On 1 April 2021, the ownership of Victoria Hospital (located in Deal, Kent) was transferred to the Trust from NHS Property Services. On 1 January 2022, the ownership of Vicarage Lane Clinic (located in Ashford, Kent) and Molehill Copse Clinic (located in Maidstone, Kent) were also transferred to the Trust from NHS Property Services.

All three sites transferred during 2021-22 were former Primary Care Trust assets and therefore the transfer of ownership (land and buildings) have been accounted for via modified absorption approach, in accordance with the DHSC GAM.
On transfer, the cost and accumulated depreciation balances from NHS Property Services' accounts have been preserved on recognition in the Trust's accounts, with the gain on the transfers (£5,521k) being recognised directly in the income and expenditure reserve. In turn, the transferring revaluation reserve balances (£2,911k) attributable to the assets has been created via means of transfer from the income and expenditure reserve.

Transfer balances	Victoria Hospital (Deal) £000s	Vicarage Lane Clinic (Ashford) £000s	Molehill Copse Clinic (Maidstone) £000s	Total £000s
Gross book value	4,847	333	417	5,597
Accumulated depreciation	-	(28)	(48)	(76)
Gain on transfer (I&E Reserve)	**4,847**	**305**	**369**	**5,521**
Revaluation reserve	(2,553)	(190)	(168)	(2,911)
Net impact on I&E Reserve	**2,294**	**115**	**201**	**2,610**

Note 35 Events after the reporting date

On 1 April 2022, the ownership of Queen Victoria Memorial Hospital (located in Herne Bay, Kent) and Sevenoaks Hospital (located in Sevenoaks, Kent) was transferred to the trust from NHS Property Services. On 3 May 2022, the ownership of Dover Health Centre (located in Dover, Kent) was also transferred to the trust from NHS Property Services. All three sites are former Primary Care Trust assets and therefore the transfer of ownership (land and buildings) will be accounted for via modified absorption approach in April and May 2022 (financial year 2022/23).

The expected estimated gains on transfer of Queen Victoria Memorial Hospital, Sevenoaks Hospital and Dover Health Centre to be recognised in the trust's income and expenditure reserve in 2022/23 total £16.6m (Queen Victoria Memorial Hospital £5.8m, Sevenoaks Hospital £9.6m and Dover Health Centre £1.2m).

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Do you have feedback about our health services?

Phone: 0800 030 4550, 8.30am to 4.30pm, Monday to Friday
Text: 07899 903499
Email: kentchft.PALS@nhs.net
Web: www.kentcht.nhs.uk/PALS

Patient Advice and Liaison Service (PALS)
Trinity House
110-120 Upper Pemberton
Ashford
Kent
TN25 4AZ

If you need communication support or this leaflet in another format, please ask a member of staff or contact us.

NHS
Kent Community Health
NHS Foundation Trust

Quality account 2021/22

we all played our part

we care

we supported

Contents page

Part one: Introduction

Statement on quality from the acting chief executive

Welcome to the quality account for Kent Community Health NHS Foundation Trust for 2021/22.

As one of the largest community health trusts in the country, we strive to provide high-quality community-based services that enable people to live well at home. In 2021 we launched our three-year quality strategy which focuses on eight key objectives including strengthening our commitment to continuous quality improvement and driving patient and staff experience. As a community trust, we recognise the vital interdependencies between our organisation and our partners in the Kent and Medway Integrated Care System (ICS) if we are to drive quality across all patient pathways. We are committed to contributing to the delivery of the 2022/23 ICS priorities and active participation in the system quality group.

The second year of the pandemic was, again, a year where everyone played their part. A year, we continued to provide outstanding community services, while also delivering the national Covid-19 vaccination programme across Kent and Medway.

The pace set during the Covid-19 pandemic in 2020/21 did not diminish but refocused upon the vaccination programme and resetting services as we looked at how some of the positive changes made to our services during Covid-19 could be continued. Throughout 2021/22 we continued to offer patients the opportunity to attend virtual appointments if their care did not depend on needing to be seen face-to-face. We delivered more than 500,000 virtual appointments and 1.5million face-to-face appointments, always making sure our patients had a choice.

Some of our services used innovative approaches to tackling an increase in referrals accumulated during the height of the pandemic. Often small changes had the biggest impact. Clinics were held at weekends to see large numbers of patients in a short time to further their care while our dental services invested in new technology, which helped them to continue seeing patients, all the time keeping patients safe from Covid.

From birth to older years, KCHFT provides services across all ages. With a focus on prevention, we have seen an increase in the number of patients we have treated throughout 2021/22, helping to keep our communities healthy for generations to come.

We believe every child should receive the best start in life. Breastfeeding is an important part of the health and development of babies and their mothers, and is also linked to preventing health inequalities. Working with our children's centres in Kent, we delivered UNICEF baby friendly training and practical skills to health visiting and children's centre staff. We also supported 3,156 families, an increase of 42 per cent from the previous year, using the specialist infant feeding service.

By improving access to NHS Health Check, we have delivered 3,056 more health checks than 2020/21. Our One You Stop Smoking Service has seen a significant increase in the number of pregnant women who have chosen to use the service to stop smoking, protecting the future of both mother and baby.

At every contact we are always keen to understand how we can improve how we deliver our services. From April 2021 to March 2022, 87,929 NHS Friends and Family Test questions were answered with 99 per cent of people rating their overall experience as very good or good (this includes 47,609 responses for the Covid-19 vaccination survey).

Themes from complaints and other forms of patient feedback are really useful and help develop services making sure they meet the needs of those who use them. In 2021/22 we identified and supported seven quality improvement projects initiated by patient and carer feedback, which exceeded our existing commitment.

Friends, family, loved ones and carers are important in the care of our patients which is why it is so important for KCHFT to be part of the Triangle of Care (ToC) initiative run by the Carers Trust. ToC was launched across mental health trusts and KCHFT is the first community trust to start the accreditation programme. The initiative is being developed with our patient participation partners, carers and clinical teams working closely together to improve carer engagement.

The physical and mental health and wellbeing of

our KCHFT colleagues continued to be supported throughout the pandemic. Our ongoing aim is to make sure everyone can bring their whole self to work. To support this, we launched our Equity, Diversity and Inclusion Strategy – Nobody Left Behind. This three-year strategy will see a range of initiatives developed to help each of us recognise the talents we all bring, helping to make KCHFT the place to work.

Throughout the year, we delivered 17 listening events to support the emotional wellbeing of our colleagues and our staff survey results received the highest response rate to date.

I'm delighted we are now an accredited Real Living Wage Employer. In doing so, we uplifted the salaries of more than 200 full-time and part-time colleagues to at least the real living wage standard. Our commitment is extending further as we make sure all new contracts with service providers working on trust sites are paid the same real living wage standard.

These are just some examples of what we achieved in 2021/22, but please take a look at this quality account to understand some of the incredible work that has been achieved in our unwavering drive and focus on quality.

Best wishes,

Gordon Flack
Acting Chief Executive

Part two: Our quality priorities

Priorities for improvement

About our trust

We provide wide-ranging NHS care for people in the community, delivered in a variety of settings including people's own homes, health clinics, community hospitals, urgent treatment centres, minor injury units, nursing homes 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 1.4million across Kent and 600,000 in East Sussex and London. We employ more than 5,000 staff, including doctors, community nurses, allied health professionals, domestics, drivers, administrators and many other essential healthcare workers. We became a foundation trust on 1 March 2015 and were rated outstanding by the Care Quality Commission in 2019.

Our mission

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

Our vision

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

Our values

We have four values:

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

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

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

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

Our goals

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

Our quality strategy 2021/22 to 2024/25

We updated our quality strategy last year and have made progress towards our vision for outstanding quality and improvement as the focus and motivation for everything we do.

Our vision

Outstanding quality and improvement as the focus and motivation for everything that we do.

Our mission

Make sure staff are trusted, supported and empowered to drive quality and develop new ways of working.

Our aim

Continuously improve quality in line with the quadruple aim.

Our quadruple aim

1. Improving staff experience at work.
2. Reducing cost and increasing value for money and efficiency.
3. Enhancing patient experience.
4. Improving population health by better patient outcomes, safety and clinical effectiveness, and reducing health inequalities and harm.

To achieve this, we will:

- focus on continuous improvement
- make sure information drives continual quality improvement
- promote effective use of resources
- promote positive staff experience
- improve patient and carer experience
- reduce health inequalities
- prioritise patient safety
- promote clinical professional leadership.

Delivery of our quality strategy ambitions has focused on the following objectives and achievement of a number of milestones in year one which include:

Objective	Milestone
Focus on continuous improvement	• Expansion of the quality improvement (QI) training programme to include virtual QI learning (QI lite). • Introduction of Bitesize QI animations to facilitate understanding of QI tools. Bitesize animations include: Model for improvement, pareto, fishbone, driver diagrams, process mapping, run charts and smart aims. • Launch of KCHFT's innovation strategy so colleagues feel supported, nurtured and empowered to take ownership of the necessary mandate of innovation, adoption and spread.
Make sure information drives continual quality improvement	• Development of our analytics resource to support improvement. • Continuing to train staff around measurement for improvement.
Promote positive staff experience	• Bi-monthly Schwartz Rounds are delivered across the organisation. One of the rounds was dedicated to being 'at the sharp end' – this focussed on staff and volunteer experience of being involved in the vaccination programme. • Implementation of after-action reviews to build psychological safety.
Improve patient and carer experience	• Continued roll out of end of life care training to deliver proactive, personalised care for everyone identified as being in their last year of life. All training includes Gold Standard's framework: recognising dying, surprise question and personalise end of life care planning. • Working together groups have been established as the forum where co-production happens between frontline staff and members of our People's Network. Three working together groups were held in partnership with Kent County Council (KCC) to ascertain experiences of the discharge process across hospitals in Kent, with feedback from family carers from Faversham and Herne Bay community hospitals. Feedback from the discharge working together groups will be addressed as part of the Triangle of Care (ToC) process.
Reduce health inequalities	• A healthy communities project manager has been recruited to build relationships with external stakeholders. • Work is being carried out to form a steering group to increase participation from seldom heard voices. • A review of the Equality Impact Assessment (EQIA) process has been completed.
Effective use of resources	• A task and finish group was put in place to develop a digital vision for the organisation as part of the trust's digital strategy.
Prioritise patient safety	• Guidance has been put in place for managers to support staff in an incident. This incorporates requirement for patient safety joint team debrief meetings to make sure staff feel supported. • The trust has developed an implementation plan for the new patient safety incident response framework. However, national guidance is still awaited following feedback from early adopters of the framework.
Promote clinical professional leadership	• Continued support is provided to clinicians to develop as leaders by engaging in peer networks, action learning sets, coaching and mentoring and Schwartz Rounds. • Multiple examples of co-leadership in medically-led services with operations; multi-disciplinary teams working includes the frailty urgent response and virtual ward work in east Kent, and the Rapid Response Service and Home Treatment Service in west Kent. These are led by operational managers and lead nurse/allied health professionals.

Priorities for improvement 2022/23

The following table explains the 12 quality priorities for KCHFT for 2022/23. These priorities are aligned to the trust's strategic and quality goals and were identified based on current risks, national priorities, strategies and reviews and the NHS Long Term Plan.

The 2022/23 quality priorities were determined through a robust consultation process, which included a survey, engagement with services, governance groups and the Executive Team, with input from staff, stakeholders, patients and their families and carers.

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

Each individual quality priority has a lead who is responsible for overseeing the project and providing quarterly reports to the Quality Committee, a sub-committee of the board, with delegated decision-making powers.

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

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

A summary of next year's quality priorities and what we intend to achieve is shown on the next page.

Improving the safety of the people we care for	Improving clinical effectiveness	Improving the experience of the people we care for	Improving the experience of our people
People with a risk of developing pressure ulcers will receive preventative interventions. • 90 per cent of patients will have a risk assessment completed upon admission to our caseload and a follow up skin assessment.	Increase research capacity and capability. • We will develop a process that maximises the number of patients approached to take part in research studies.	Patients and service users will be involved in co-designing services. This is the second year of a two-year priority: Seven QI projects initiated by patient/service user feedback with patient/service user representation on the project group. Measured through Life QI.	We will support a culture where everyone is comfortable to be themselves. This will be a two-year priority: In year one: All colleagues will have equality, diversity and inclusion objectives included in their annual appraisal and cultural awareness training will be rolled out across the organisation. In year two: Colleagues who have experienced harassment or abuse at work is less than 10 per cent in all categories and comparable with or without a protected characteristic. Measured through WRES/DES.
Increase quality of care through the reduction of missed/deferred visits. • Decrease trust wide reported serious incidents where missed/deferred visits were a contributory factor by 50 per cent.	Increase the confidence and capabilities of our people to pursue innovation opportunities that result in better care for patients. • We will launch the Innovation Fellowship in partnership with the Academic Health Science Network and recruit a minimum of eight colleagues to the Innovation fellowship to identify and plan opportunities for innovation.	Improve the experience of people waiting for foot and ankle surgery through the better use of KCHFT surgery space. • 100 per cent of patients will receive a treatment review upon admission to the KCHFT caseload. • For 100 per cent of patients added to the *PASCOM system, clinical outcomes, patient experience and goals will have been achieved six months post-surgery.	We will attract and recruit colleagues who are representative of the communities we serve. This will be a two-year priority: In year one: Managers will receive inclusive recruitment training which incorporates coaching and interview skills, ethnically diverse panels will be used and a minimum of five colleagues will be recruited through Kent Supported Employment In year two: Applicants from a BAME background or have a disability, are as likely as comparator colleagues to be appointed.

Improving the safety of the people we care for	Improving clinical effectiveness	Improving the experience of the people we care for	Improving the experience of our people
Pilot a coordinated referral and booking for Kent families accessing tongue-tie procedures. 100 per cent of families will be offered: • Pre-procedure support – within 48 hours (urgent) and five days (routine). • Tongue-tie procedure appointment – within 10 working days. • Post procedure support – within five working days.	Improved access to the community paediatric service • 92 per cent of patients will have received an initial assessment within 12 weeks of referral.	Support the reduction of health inequalities by increasing contacts with vulnerable young people in East Sussex • Contacts with young people aged 16 to 19 will increase by 50 per cent from the 2021/22 baseline (5.9 per cent).	Pilot and implement a new model for clinical supervision across the Specialist Services and Public Health Division. • 100 per cent of staff will have attended four supervision sessions.

*PASCOM is comprehensive data collection tool used in podiatric surgery

Statements of assurance from the Board

During 2021/22, KCHFT provided and/or sub-contracted 47 health services and has reviewed the data from these services, which represents 100 per cent of the total income generated for 2021/22.

During 2021/22, five national audits and one national confidential enquiry covered relevant health services that KCHFT provides. KCHFT participated in all national clinical audits which it was eligible to participate in. They are:

- National Diabetes Footcare Audit (NDFA)
- Sentinel Stroke National Audit Programme (SSNAP)
- National Asthma and COPD Audit Programme (NACAP), Pulmonary Rehabilitation
- National Audit of Cardiac Rehabilitation
- Falls and Fragility Fracture Programme (FFAP)
- Child Health Outcome Review Programme (NCEPOD) transition from children to adult health services study.

The national clinical audits that KCHFT participated in, and where data collection was completed during 2021/22, are listed below alongside the number of cases submitted to each audit as a percentage of the number of registered cases, required by the terms of that audit or enquiry:

- National Diabetes Footcare Audit (NDFA) – 100 per cent (47 records, no minimum dataset)
- Sentinel Stroke National Audit Programme (SSNAP) – 100 per cent (523 records for stroke rehabilitation, 347 records for 6 months reviews, no minimum dataset)
- National Asthma and COPD Audit Programme (NACAP), Pulmonary Rehab – 100 per cent (371 records, no minimum dataset)
- National Audit of Cardiac Rehabilitation – 100 per cent (371 records, no minimum dataset)
- Falls and Fragility Fracture Programme (FFAP) – 100 per cent (three records, no minimum dataset).

The reports of four national clinical audits from the quality account list was reviewed by the provider in 2021/22 and KCHFT intends to take the following actions to improve the quality of healthcare provided:

- Sentinel Stroke National Audit Programme (SSNAP) – this review relates to the therapy and six months review data for January to June 2021 and July to December 2021. The Kent and Medway stroke development work focuses on delivering quality improvement through the Integrated Stroke Delivery Network (ISDN). Currently KCHFT is mapping services to the new model identifying any gaps. KCHFT is also working on improving quality of data through:
  - Recruitment of administration staff to support with SSNAP data collection following funding approval
  - Ongoing collaborative working with the Acute SSNAP team in east Kent
  - Ongoing liaison with acute teams that refer to KCHFT to ensure eligible patients are on SSNAP
  - The addition of a SSNAP window on RIO to support clinical staff with data collection
  - Production of a monthly SSNAP report by the Performance and Intelligence Team in order to support teams with data collection
  - Ongoing review of the SSNAP reports and discussions with the SSNAP leads in SSNAP meetings.
- NACAP, Pulmonary Rehabilitation – currently the service is performing at or above the national average for all metrics in the audit except for waiting times. We are in line with the national average for waiting times, however this is above the British Thoracic Society standards of 12 weeks. To improve waiting times for patients the service has developed a strategic plan to increase service capacity and reduce waiting times which is being shared with commissions to agree the required funding.
- National Audit of Cardiac Rehabilitation – a series of lifestyle talks has been developed and delivered over MSTeams for patients. This provided an alternative method of delivery whilst Covid-19 restrictions were in place.
- FFFAP – KCHFT has provided audit details for three patients who fell during the reporting period and sustained a fracture neck of femur. This is a 25 per cent reduction from the year before, when we provided audit details for four patients. The audit gave us 100 per cent compliance in relation to the three Key Performance Indicator's (KPI) set:
  1. 100 per cent of patients were checked for signs of injury before movement from the floor.
  2. 100 per cent used a safe manual handling method to move the patient from the floor.

3. 100 per cent had a medical assessment within 30 minutes of the fall.

To improve falls preventions interventions within the trust, there is a quarterly Falls Prevention Assurance Group where members collectively analyse falls data and soft intelligence in relation to national updates. The development of a falls strategy is to be discussed at this group.

The reports of the following national clinical audits have been delayed and, in some cases, data collection has been extended due to the Covid-19 pandemic. Nonetheless, improvements are taking place within KCHFT in relation to three national audits from the quality account list 2021/22:

- NDFA – KCHFT's Podiatry Team has submitted 47 audits for the NDFA over the past year. This was more than was expected due to NDFA organisers announcing at the start of the pandemic that these audits would be suspended but that any audit data would still be welcome. This audit suspension is expected to be lifted for 2022/23 reporting period.

  To improve the quality of healthcare provided, the Podiatry Team is working with the acute trusts to strengthen multi-disciplinary team (MDT) working across the county. The MDTs involve specialist podiatrists, diabetes consultants and nurses, vascular consultants and nurses and some have orthopaedic consultants and consultant microbiologists. They are designed to allow patients more timely access to more focused care for a diabetic foot ulcer in line with NICE guidance.

  The Podiatry Team is developing a wound review clinic which will include support from podiatry assistants with a view to ensuring the NDFA is completed for all new wounds – which should increase submissions. Kent and Medway Clinical Commissioning Group (CCG) did a peer review of the diabetic foot networks last year. We now have recommendations from the peer review to guide improving the pathways. These recommendations are to improve prevention as well as active management of the MDT's. The CCG has a workstream looking at the diabetic foot and implementation of the recommendations from the peer review.

The reports of 75 local clinical audits were reviewed by the local provider in 2021/22 and KCHFT intends to take the following actions to improve the quality of healthcare provided:

- Rapid Discharge Audit – the 2019 CQC report highlighted that there had not been an audit carried out to review the rapid discharge (fast track) continuing health care process. This year, the third audit was carried out (the first audit was conducted in 2020 to provide a baseline followed by a re-audit in 2020). There have been improvements in the quantity and quality of referrals made and an increase in the number of successful referrals. Continuing Health Care provided training to ensure that all nurses and Allied Health Professional's (AHPs) would recognise patients who would benefit from a referral and support to improve the quality of referral forms to prevent any delays in the delivery of care.
- End of Life Care (EoLC) Last Years of Life Audit – 2021 saw the first audit of this type carried out in the trust. This audit, alongside the Priorities of Care Audit, has been created to provide assurance on the areas identified in the National Audit Care at the End of Life (NACEL) as KCHFT have a low number of cases meeting NACEL criteria. In 2021, KCHFT used the Gold Standards Framework, Prognostic Indicator Guidance to include the "surprise question" on Rio, (the electronic patient record system) which prompts staff to ask whether they would be surprised if the patient was to die in the next year. The surprise question helps advanced care planning so that a patient's wishes can be considered. This audit provided a wide review of trust patients and indicated that 85 per cent of patients had a do not attempt cardio pulmonary resuscitation (DNA CPR) order recorded with a clear discussion on what they would like the outcomes to be in the case of an emergency. The outcome of this audit indicated that documentation windows could be made clearer and to improve standards we have included documentation processes at end of life care education sessions as well as developing a user guide for the end of life care windows on Rio.
- Priorities of Care Audit – this audit has been created to capture some of the other areas of the NACEL audit to provide a whole service viewpoint. This audit incorporated the 'just in case medicines box' procedures to ensure that appropriate medicines are being issued proactively to the dying patients. This initial audit provided limited assurance overall, but provided evidence of good practice in 98 per cent of patients' reversible conditions were considered, discounted or actioned. Over 90 per cent of patients had an initial and continued assessment. Evidence of communication with patient regarding being at end of life was apparent in 98 per cent of the cases reviewed. There has been trust wide education sessions and Rio user guide.

- Central Alert System (CAS) Ligature Alert Audit – to make sure the alert actions had been embedded in practice, the medical devices assurance manager undertook a clinical audit of the trust's community hospital wards, minor injury units and urgent treatment centres. Although limited assurance was gained from the audit itself, immediate action was taken by the head of health and safety, security and fire, supported by the head of medical equipment and procurement in response to the escalation of matrons. Training was delivered in June 2021 purchased from Kent and Medway NHS and Social Care Partnership Trust regarding the management of ligature incidents and use of ligature cutters. A senior clinical representative from each service attended this 'train the trainer' session. Training resources were provided to facilitate cascade training to all clinical colleagues within the community hospital wards, minor injury unit's and urgent treatment centres. The head of procurement sourced ligature cutter packs on behalf of services, providing a range of cutters for a variety of materials.
- Central Alert System (CAS) Polymer Gel Granules – this audit gained full assurance and recognised the following areas as good practice: Assurance polymer gel granules are no longer in circulation within community hospitals. Polymer gel for non-patient use – 97 per cent (e.g. spill kits, controlled drug destruction, use by cleaning staff) is kept secure and away from patients.
- Complaints Management Audit – this audit gained full assurance. There are robust processes in place for complaints management: 100 per cent of records were updated throughout following the standard operating procedure; 100 per cent of cases the process was followed and 100 per cent of cases the opening, acknowledgement and closing of records were all logged correctly. Accurate recording of complainants' preferred method of contact was noted and the reason given if not relevant. In 100 per cent of complaints that were extended, the complainant was notified of any delays.
- Deteriorating Patient National Early Warning System (NEWS 2) including Paediatric Early Warning System (PEWS) Audit – there are on-going improvements evidenced in the latest significant assurance audit. Good escalation of patients that had an increase in NEWS/PEWS score. 98 per cent of patients who had a score of two or more from their baseline score were assessed by a registered health care professional. Actions for continued assurance are; NEWS2 and PEWS to be implemented across all other community services to ensure standardisation of practice and a training package for PEWS in line with national guidance.
- School Health One Point (SHOP) East Sussex – the audit demonstrated difficulties with meeting the four-day KPI of contact with parent/carer or child from the service (43 per cent). A review of the outcome of pathways delays for individuals showed that there was no adverse impact on the children if all referrals were completed within seven days. Therefore, we negotiated an increase from four to seven days with commissioners for first contact and follow up appointments following assessment and is achieving this at 82 per cent (as of January 2022). In addition, they have made improvements to the way they allocated and book appointments. The service offers video consultations to facilitate this.
- Pressure Ulcer Audit SCCN – 100 per cent assurance was given across a number of areas including staff receiving yearly training in regards to pressure area care and pressure ulcers grade two and above were recorded on Datix. As part of this audit a new pain assessment tool is being piloted and implemented to improve consistency across SCCN. Improvement work includes training to make sure that records reflect that children's nutritional and hydration status is being assessed and that a pressure ulcer leaflet has been given to families/carers with risk of pressure ulcers.
- Children's Hearing Service record keeping – this audit identified a number of areas of good practice such as: 100 per cent of records included the date, time, venue, reason for appointment; 100 per cent of records audited identified the relationship of the person present to the child, evidence of consent and involvement of the carer and 100 per cent of the reports included recommendations and a plan of action. Actions for improvement as a result of this audit included adding a section in the report to prompt clinicians to document the voice of the child, the observations of the child and that in all appointments everyone present must be recorded in the report.
- Podiatry Record Keeping one-to-one peer review audit – the outcome of this audit resulted in the development of a central service crib sheet document for 'my plan'. The crib sheet will assist staff when completing the plan for every patient on podiatry pathways: wound, high risk and routine and increase compliance for future audit. As this audit provided limited assurance – a re-audit will be conducted by the service in 2022/23.

- Safeguarding Adults Audit – this is the second annual audit of Adult Safeguarding. The third audit is due to start in April 2022 with some of the required information being automated and reported from Rio. Safeguarding audits were carried out in more than 60 services across the trust spread over a two-year period until every action had been implemented through to completion. They demonstrated a good understanding of what constitutes safeguarding, self–neglect, mental capacity assessment (MCA) and the requirements that constitute consent, good care. There was evidence in the documentation of support with decision making that meets client's particular needs and the majority of staff sought support about a safeguarding concern. Improvements implemented during this period include:
  - interactive discussions at a safeguarding themed huddle to look at safeguards in relation to identified concerns
  - protected time for service Mental Capacity Act (MCA) link worker
  - completion of competencies by approved assessor
  - provision of appropriate supervision as required to increase confidence knowledge and skills
  - learning from case studies was shared
  - continued representation from KCHFT MCA/ safeguarding teams at weekly MDT meetings to advise and support staff accordingly
  - deprivation of liberty (DoLS) checklist to be displayed at nurses' stations
  - safeguarding audit is discussed for every new admission and has been added on to the whiteboard to ensure safeguarding assurance status is recorded.
  - updated online safeguarding training via trust learning portal, TAPs
  - safeguarding representative to attend primary care network (PCN) led team meeting every quarter
  - regular huddles to reinforce learning
  - crib Sheet developed for safeguarding triggers.

The number of patients receiving relevant health services provided or sub-contracted by KCHFT during 2021/22 who were recruited during that period to participate in research approved by a research ethics committee was 223.

The number of patients receiving relevant health services provided or sub-contracted by KCHFT during 2021/22 who were recruited during that period to participate in research approved by the Health Research Authority was 493.

The 2020/21 CQUIN scheme was suspended in line with NHS England/Improvement guidance owing to the Covid-19 pandemic. KCHFT delivered the staff flu vaccination programme, however this did not continue under the CQUIN indicator. Further details are available electronically at: NHS England » 2020/21 CQUIN

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

The CQC has not taken enforcement action against KCHFT during the reporting period.

KCHFT submitted 90,947 records during 2021/22 to the Secondary Uses Service for inclusion in the hospital episode statistics, which are included in the latest published data.

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

- 99.9 per cent for admitted patient care
- 99.7 per cent for accident and emergency care.

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

- 99.6 per cent for admitted patient care
- 99.1 per cent for accident and emergency care.

The most recent KCHFT data security and protection toolkit self-assessment (DSPT) 2020/21 reported an overall score of 'standards met' and all mandatory assertions were responded to and evidence provided. During the annual Transforming, Inspiring, Advising, Assuring (TIAA) audit for 2020/21, the trust was awarded substantial assurance, with no further recommendations. The assessment was, therefore, categorised as fully compliant at that time and was published on 26 May 2021. NHS Digital had extended the final March submission date to the end of June 2021, in response to the Covid-19 pandemic.

The 2021/22 annual TIAA audit of the DSPT and subsequent submission of the assessment is in May and June 2022, respectively. The national delay from the standard March submission date has been repeated for the 2021/22 assessment, that being the end of June 2022. Subsequently, there is still work being done on the 2021/22 assessment and it is not possible to provide an assurance position at the time of reporting.

KCHFT was not subject to the payment by results clinical coding audit during 2021/22 by the Audit Commission.

KCHFT has taken the following actions to improve data quality:

- by regularly analysing performance
- by regularly reviewing the data quality maturity Index
- reviewing admission and attendance criteria.

We are required to review and report the deaths of all inpatients in our community hospitals and during 2021/22 there were 54 deaths. This included the following number of deaths, which took place in each quarter of that reporting period: eight in the first quarter; eight in the second quarter; 16 in the third quarter and 22 in the fourth quarter. These were published on our website.

By 31 March 2021, 39 case record reviews, including 37 structured judgement reviews and zero investigations were carried out in relation to 54 of the deaths included in the previous item.

In no cases, was a death subjected to both a case record review and an investigation.

The number of deaths in each quarter for which a case record review or an investigation was carried out was eight in the first quarter; eight in the second quarter; 16 in the third quarter and 22 in the fourth quarter.

However, in response to Healthcare associated infections (HCAI) Covid-19 guidance relating to nosocomial deaths, all probable or definite nosocomial deaths were reviewed using the reporting and learning detailed on the trust's incident reporting system Datix. We reviewed our processes and completed duty of candour, where indicated.

One patient death, representing 1.85 per cent of all deaths during the reporting period, were judged to be more likely than not to have been due to problems in the care provided to the patient.

In relation to each quarter, this consisted of: zero for the first quarter; zero for the second quarter; zero for the third quarter; one representing 4.55 per cent for the fourth quarter.

These numbers have been estimated using the multidisciplinary mortality review process adapted for community use from the Royal College of Physicians (RCP) Structured Judgement Review process.

The continued need for work to embed the effective use of treatment escalation plans to improve advance care planning for patients at the end of their life, and in particular, awareness of and planning for the management of implantable cardioverter-defibrillator devices (ICD) was recognised. A more focused awareness of specific issues included effective recognition of end of life, particularly at transfer of care and the effective use of clinical monitoring and NEWS scores to support prompt escalation and recognition of active dying.

The actions taken in consequence of what has been learnt has included updating electronic record templates to include an alert for ICDs, staff training and patient safety alerts regarding ICDs and development of a wider project regarding a pathway for ICD deactivation at end of life.

A further case investigation following the actions relating to ICD deactivation has demonstrated a marked improvement in the proactive planning for appropriate end of life care. All community hospitals also now have stock of magnets for emergency ICD deactivation for use where clinically indicated. The trust is also part of a Kent and Medway wide project to adopt the use of the resuscitation council Recommended Summary Plan for Emergency Care and Treatment (ReSPECT) to enhance cross boundary recognition agreed clinical recommendations achieved by shared understanding between a person and clinician.

Transfer of care forms have been modified to add specific questions relating to end of life care and fast track training for discharge planning teams has been delivered.

NEWS 2 training focused on support for clinical decision making and appropriate escalation of deteriorating patients, alongside increased training resources for learning specifically for management of end stage heart failure at end of life.

To improve advance care planning for people at the end of their life, palliative care multidisciplinary meetings have been reinstated and the trust's end of life care nurse consultant has provided support to community hospital matron so that they can increase staff's confidence when completing treatment escalation plans

In all, one case record reviews and thirteen structured judgement reviews were completed after 1 April 2021, 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 to have been due to problems in the care provided to the patient. This number has been estimated using a multi-disciplinary mortality review process adapted for community use from the RCP structured judgement review form.

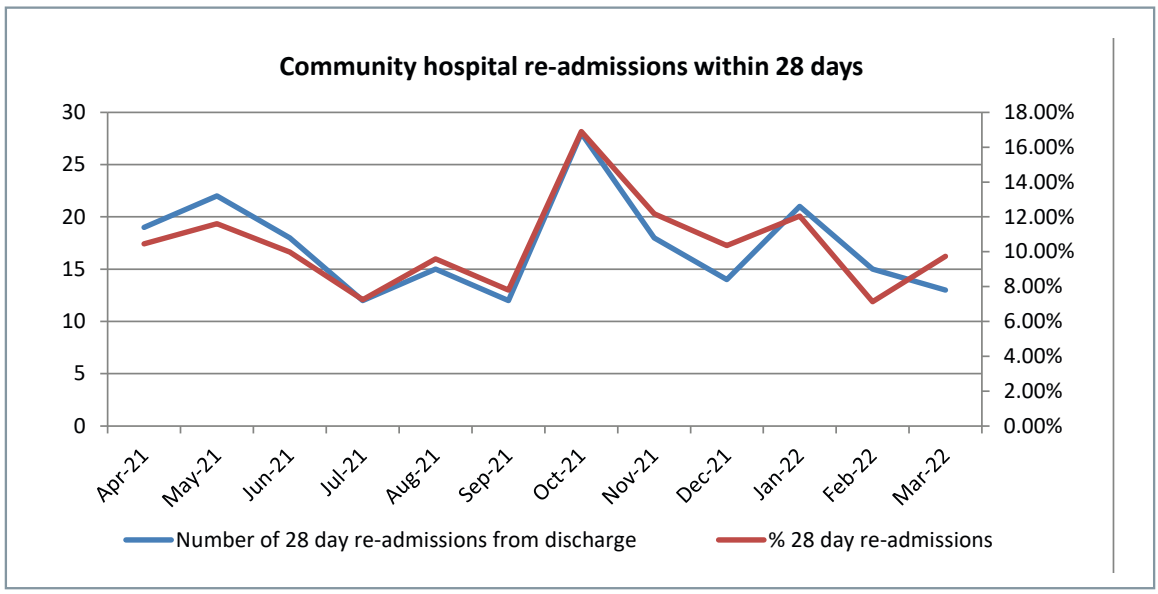
Reporting against core indicators

Indicator 19: Hospital re-admissions

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

	Apr 2021	May 2021	Jun 2021	Jul 2021	Aug 2021	Sep 2021	Oct 2021	Nov 2021	Dec 2021	Jan 2022	Feb 2022	Mar 2022
Number of 28-day readmissions from discharge	19	22	18	12	15	12	28	18	14	21	15	13
% 28 day readmissions	10.45	11.61	9.99	7.24	9.59	7.80	16.89	12.17	10.36	12.05	7.13	9.74

	2019/20	2020/21	2021/22
Number of 28-day re-admissions from discharge	134	135	207
Percentage 28-day re-admissions	5.31	4.91	4.91



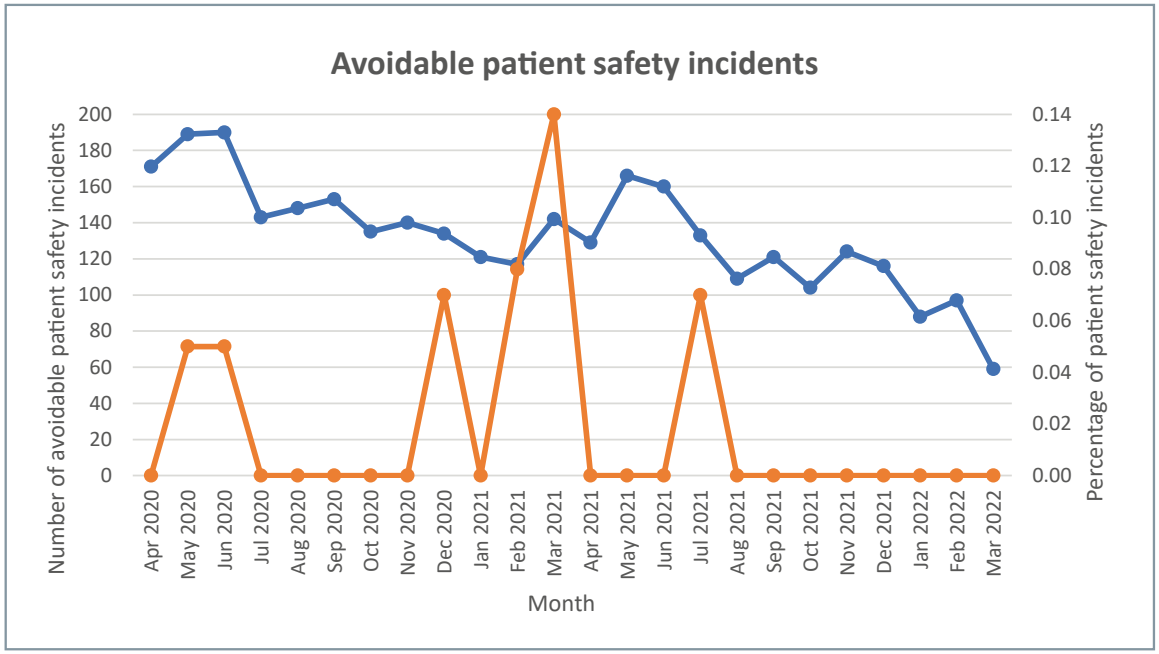
KCHFT considers this data is as described for the following reasons:

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

Indicator 25: Patient safety incidents

The number of patient safety incidents reported at KCHFT during 2021/22 and the number and percentage of such patient safety incidents that resulted in severe harm or death are shown here:

	2020/21	2021/22
Avoidable patient safety incidents	1783	1406
Avoidable patient safety incidents (causing severe harm or death)	5	1
Percentage of total patient safety incidents causing severe harm or death (%)	0.28	0.07



KCHFT considers this data is as described as it is captured on the Datix system by the member of staff who discovered the incident, making sure 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:

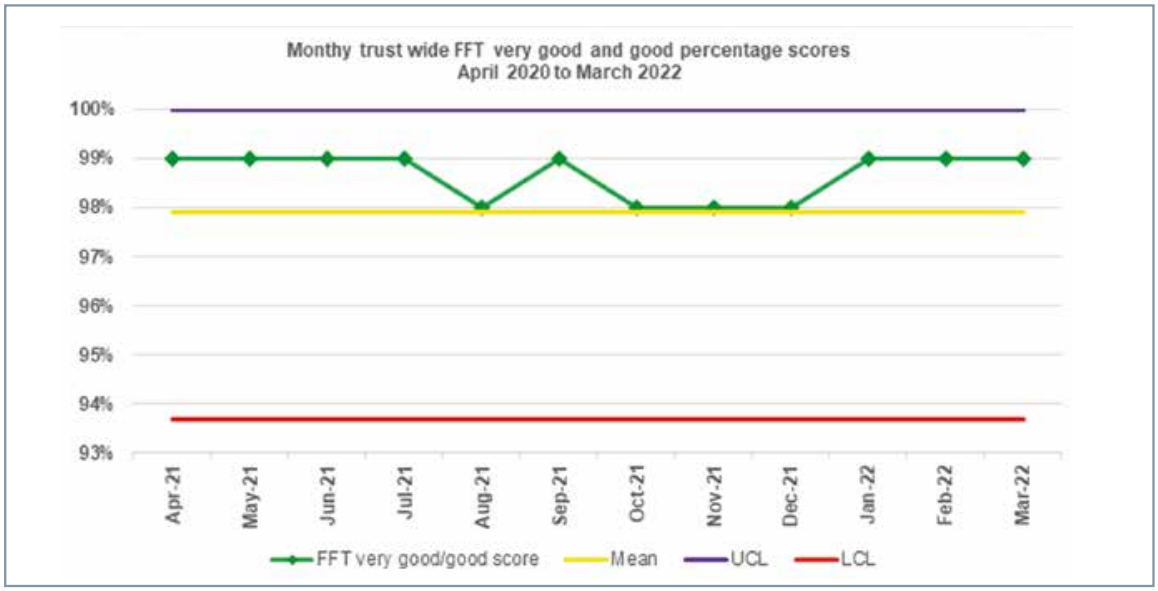
- developed a comprehensive risk and incident training package, which includes a webinar delivered to new starters
- regularly reviewed the incident reporting system to make sure information captured is relevant and improves patient safety
- enhanced the reports produced to include improvements. This has encouraged a positive patient safety culture where staff are able to see the benefits of reporting incidents
- shared learning from incidents at the trust's quality improvement network, supporting a positive safety learning culture
- triangulated learning from patient feedback, complaints, internal quality reviews, incidents, claims and developed QI programmes.

NHS Friends and Family Test (FFT)

KCHFT has continued to seek patient and service user feedback through the collection of the NHS Friends and Family Test (FFT).

From April 2021 to March 2022, 87,929 FFT questions were answered with 99 per cent of people rating their overall experience of the service they received as very good or good (this includes 47,609 responses for the COVID-19 vaccination survey).

The graph below shows the monthly, trust-wide FFT very good and good percentage scores between April 2021 and March 2022.



Referral to treatment (RTT) indicator

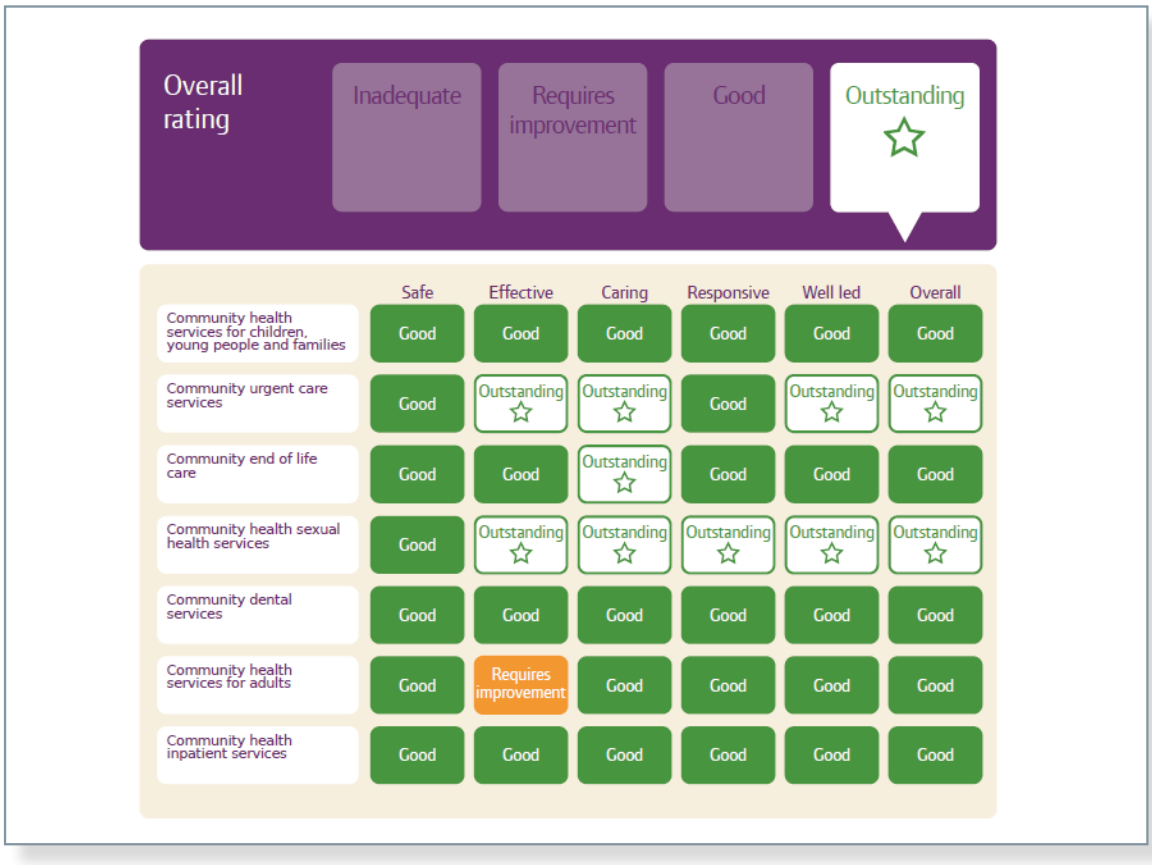
This section shows our performance against the relevant indicators and performance thresholds set out in the oversight documents issued by NHS Improvement. For our trust, this is only one indicator:

The maximum time of 18 weeks from point of referral to treatment (RTT) in aggregate – patients on an incomplete pathway:

	Apr 2021	May 2021	Jun 2021	Jul 2021	Aug 2021	Sep 2021	Oct 2021	Nov 2021	Dec 2021	Jan 2022	Feb 2022	Mar 2022
RTT incomplete pathways (%)	99.78	99.95	99.83	99.10	98.12	95.69	100	100	100	99.97	100	99.92

Regulation: Care Quality Commission

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



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

Rating

KCHFT was subject to a trust risk based CQC inspection in April and May 2019. The community urgent care, sexual health, end of life and dental services were reviewed as well as a trust wide well-led inspection. The CQC overall rating of KCHFT at this inspection was outstanding.

The CQC's Deputy Chief Inspector of Hospitals Dr Nigel Acheson said: "The trust's determination to develop a patient-centred culture has improved services. This has ensured that the overall rating has moved to outstanding."

"All the staff are completely deserving of this and it has been a real privilege for me to be associate with aspects of the trust." Pat Conneely, patient representative.

We care reviews

KCHFT has had an assurance visit program in place since 2014 and the we care review programme was introduced in 2018 as a supportive assurance programme to enable the delivery of high-quality care, through shared learning and quality improvement initiatives to make sure:

- the care we deliver supports the fundamental standards of the CQC
- there is increased transparency and assurance
- staff are confident to articulate their rationale for care delivery in peer review
- the use of trust data can reliably inform what is seen during a visit
- of the involvement of all KCHFT staff and stakeholders.

From 2018 when we care reviews were introduced there have been five scheduled review programmes which are outlined below:

- In 2018, 58 services were reviewed including all high-risk services to provide a baseline of our services in the first year of the we care review programme.
- In 2019, 30 services were reviewed which included six teams that were not visited the previous year. These services were identified from the outcomes of the 2018 programme.
- In 2019, the CQC undertook a risk-based trust wide inspection of KCHFT to the community end of life, community urgent care, community sexual health and community dental core services. Therefore, these core services were not included in the 2019 schedule.
- In 2020, the we care review programme was paused during the intense period of the Covid-19 pandemic. It recommenced in September 2020 and 16 visits took place to adult inpatient and long-term services.
- In 2021, 20 visits took place to the specialist children and young people, public health, specialist and elective divisions. This included two visits to community hospitals and two long term services that did not have their scheduled review in 2020 due to and winter operational pressures.

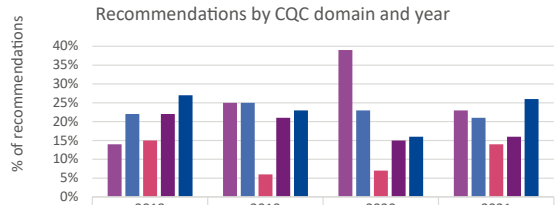
The we care review programme uses the CQC fundamental standards and key lines of enquiry (KLOE) as a framework to ensure consistency and parity of all visits.

During the visits, quality reviewers talk to staff and patents and, where possible, attend home visits with clinicians, so giving a full picture of the standard of care being provided. A collaboration meeting at the end of the visit enables all participants to share their observations from the visit and contribute to the report.

Of the 20 services that participated in a we care review in 2021, 45 per cent of services were rated outstanding overall and 55 percent were rated good. This is the first year since we care was introduced in 2018, where all services had an overall rating of good or outstanding.

To drive quality improvement, services develop an improvement plan based on the recommendations identified in the we care review report. The operational heads of quality, governance and professional standards are involved in the improvement process alongside support from the trust's QI colleagues. The improvement plans are monitored through divisional governance reports and themes are included in the bimonthly quality report which is presented to the Quality Committee.

The following chart details the areas from improvement identified according to domain over the course of the entire we care programme. This shows that in 2021 the distribution of recommendations across the domains was more consistent than in previous years and the greatest proportion of recommendations relate to the well-led domain.



	2018	2019	2020	2021
Safe	14%	25%	39%	23%
Effective	22%	25%	23%	21%
Caring	15%	6%	7%	14%
Responsive	22%	21%	15%	16%
Well-led	27%	23%	16%	26%

We care reviews offer teams with a psychologically safe space to discuss clinical practice as 95 per cent of staff reported that they were able to discuss this with quality reviewers.

The we care review program is a tested and successful process that provides assurance in line with the CQC inspection frameworks whilst driving quality improvement.

Freedom to speak up guardian

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

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

They will make sure:

- colleagues concerns are treated confidentially unless otherwise agreed
- colleagues receive timely support to progress their concern
- any indications that someone is being subjected to detriment for raising their concern is escalated to the board
- the organisation provides colleagues timely feedback on how their concern is being dealt with
- colleagues have access to personal support since raising their concern may be stressful.

The trust has a number of FTSU ambassadors and their role includes encouraging colleagues to speak up by providing informal advice, sign-posting and promoting positive examples of changes that have occurred as a result of speaking up.

A campaign to promote the benefits of speaking up ran throughout the year and will continue during 2022/23. The FTSU guardian continues to raise awareness of speaking up and shares ways to get in touch, such as the dedicated email and phone line for colleagues to discuss their concerns.

Between 1 April 2021 and 31 March 2022, the FTSU guardian logged and was involved in 17 new cases. Themes of the cases were discussed with the chief executive and a six-monthly report was presented to the Strategic Workforce Committee. The trust has a named non-executive director lead for freedom to speak up, who acts as an alternative source of advice and support for the guardian.

Part three: Overview of quality of care

This section provides an overview of the quality of care offered by KCHFT based on performance against the 2021/22 quality priorities we agreed and published in our 2020/21 Quality Account. It explains in more detail what we have achieved during the past year and those areas we need to improve upon.

Improving the **safety** for the people we care for

	Goal	Outcome
Patient safety	All patients who experience a delay to treatment due to national directives during the Covid-19 pandemic will receive a harms risk assessment.	**Achieved**

What is a clinical harms risk assessment?

Covid-19 has had an impact on the both demand and the ways in which healthcare is managed. When the pandemic emerged, management systems and adaptations were put in place to minimise the spread of Covid-19 which included reallocation of resource to meet the urgent care demands and safely treat patients.

Healthcare settings followed the national directive of NHS England/Improvement to manage the demand of the pandemic which included changes to the way in which we delivered our services. These included interventions being postponed, conducted online or in some cases cancelled in order to direct our response to urgent or high-risk patients. .

Why this is important

We recognise that these interventions will have had an effect on our patients and service users and in light of this, robust monitoring and recording processes were put in place to identify any clinical harm that our patients and service users may have been exposed to as a result of these interventions.

The harm review process was introduced to identify any adverse effects experienced by our patients and service users who experienced a delay to treatment due to national directives during the Covid-19 pandemic. This is specifically in relation to changes to their referring condition, the agreed management/treatment plan, medication regimen and available treatment options.

Our patient and service users whose service delivery was modified or delayed were reviewed upon their next appointment returning to services or at appropriate intervals if they continue to wait for treatment ('appropriate intervals' will be determined locally based on the nature of the service delivered and the clinical risks faced by patients, clients or service users).

We also recognise the psychological impact of both the Covid-19 pandemic and the effects of delays to treatment and therefore all harms assessments include a review of both psychological and physiological impacts.

What we did

The clinical harm review process prompts healthcare professionals to consider whether the impact of delayed or disruptions to a patient's or service users care caused them any ill consequences or harm. A framework for categorising harm was established to ensure consistency of the assessment which included professional autonomy so that any patient or cohort of patients identified by the services as needing a clinical harm review were included.

To do this, healthcare professionals would consider the following prompts:

- Was the patients' service previously delayed or modified due to Covid-19?
- Has any consequence been identified that required a moderate increase in treatment for the patient?
- Has the patient sustained a life changing injury as a result of the delay due to Covid-19?
- Has the patient been waiting longer than 52 weeks due to Covid-19 intervention?

A clinical harm lead was identified for each operational division and specialist area who would review the clinical harm assessment and report any moderate, severe/catastrophic harm or death due to a delay in service delivery. However, this work was not limited to risk assessment; if any harm was identified, the services would immediately implement the actions required to care for and treat the patient.

For KCHFT there were no instances where clusters of patients and service users experienced moderate, severe/catastrophic harm or death due to a delay in service delivery. However, should this have been a consequence of interventions put in place to direct the COVID-19 pandemic response, these would have been escalated to the deputy chief operating officer and chair of the integrated managers meeting, the chief nurse and medical director immediately. A review panel would then have been convened to review the cases collectively, discuss the service actions and agree the required organisational actions to reduce the risk of reoccurrence, ensure learning and Duty of Candour requirements.

For organisational monitoring and assurance, all clinical harm reviews were evaluated by the patient safety team before being presented to the Patient Safety and Clinical Risk Group which is a sub-group of the Quality Committee.

What this means for you as a patient

If you have experienced a significant wait or your treatment was cancelled due to interventions that have caused harm as a consequence of the practices we implemented in response to the Covid-19 national directive, we will make sure that this will be evaluated and that you get the treatment and services you require.

We will also learn from these experiences to mitigate any future risk and learn to improve both the safety and experience of our patients and service users.

What we achieved

100 per cent of clinical harm reviews were evaluated and no moderate, severe/catastrophic harm or death were experience by our patients and service users.

Improving the **safety** for the people we care for

	Goal	Outcome
Patient safety	Fully implement the after-action review process to apply early learning from incidents.	**Achieved**

What is an after-action review?

An after-action review (AAR) is a method of evaluation that is used when outcomes of an activity or event, have been particularly successful or unsuccessful. It aims to capture learning to prevent reoccurrence and enable focused discussions to help identify how we can do things differently.

The process encourages a multidisciplinary approach with a focus on quality improvement.

Why this is important

We are committed to deliver high quality care, to improve quality outcomes for our patients by adopting new tools to support how we learn from incidents in line with national guidance. The AAR evaluation method is advocated by the NHS England Patient Incident Response Framework (PSIRF) which outlines how healthcare providers should respond to patient safety incidents and when patient safety investigations should be conducted.

The focus of AARs is learning, not accountability; the aim is to provide a space where everyone feels comfortable to openly and honestly share their views and experiences in relation to what was meant to happen and what actually happened.

As this is a part of a national guidance, it will support the methodology of AAR being standardised across the NHS learning system, where providers can work together to mobilise and embed this way of learning.

What we did

The National PSIRF was reviewed and a presentation was shared at the Patient Safety Clinical Risk Group (PSCRG), where the benefits were discussed and an implementation method was agreed.

To understand how to successfully introduce AAR, the head of patient safety met with another NHS provider who had successfully implemented the AAR process.

The Patient Safety Team first launched the use of AAR in November 2020 where staff were provided with information on the format and purpose of the AAR meetings. This launch was facilitated virtually and was well attended with representation from KCHFT infrastructure support services such as safeguarding and tissue viability as these teams engage with operational teams daily and are therefore essential when considering how to enable learning across the organisation.

Between November 2020 and March 2021, 13 AARs took place. For timely learning from these reviews, the aim was to make sure that AARs were completed within two weeks, however only one of these were completed within two weeks.

From March 2021 the AAR process was refined using quality improvement (QI) methodology which enabled phased reviews of the AAR implementation process alongside supporting data to evidence the impact of the developments made. Plan Do Study Act (PDSA) methodology was used and improvements were made iteratively based on the outcomes of previous testing cycles and included reformatting the template and setting a timeframe for when the AARs were to be completed.

To measure progress, the AAR data was evaluated quarterly to determine whether this phase of the implementation was on track.

Throughout this process of implementation, we have recognised that despite the pandemic and the pressures from this, staff have remained engaged with this process of learning.

To share our implementation journey we have presented at the Kent and Medway community of practice group and to other NHS providers who are developing their implementation of AAR.

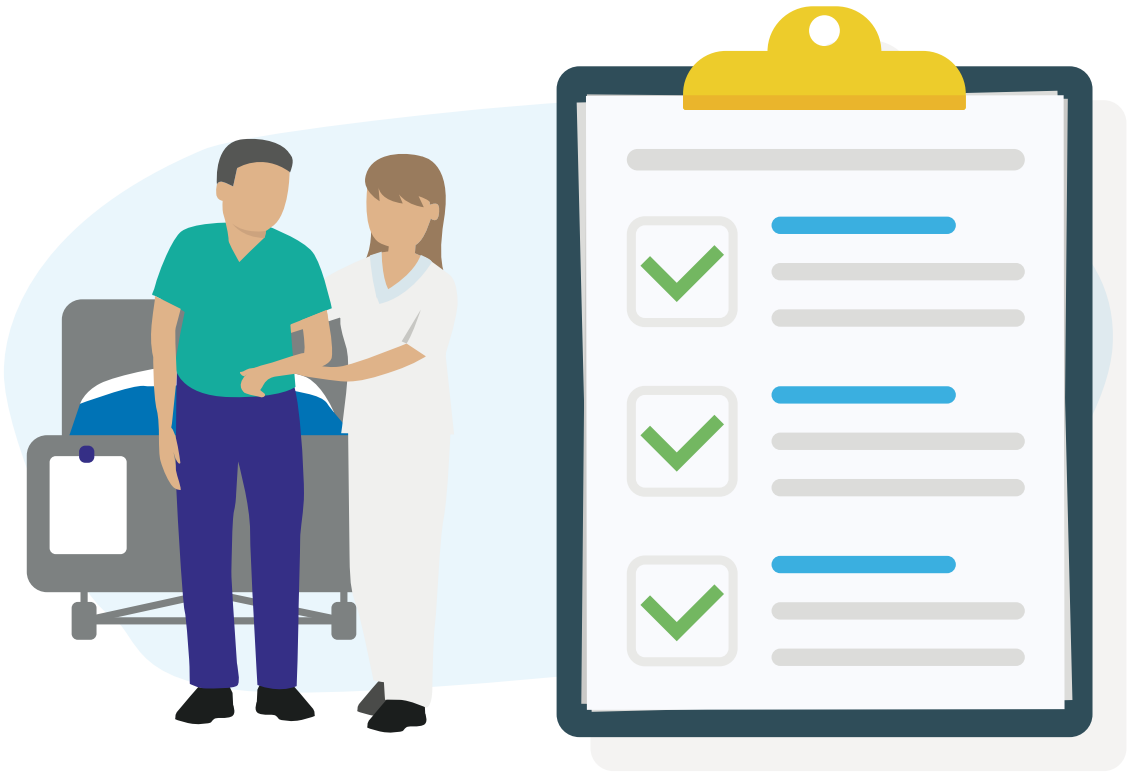
What this means for you as a patient

When things don't go as they should or mistakes have been made, we will say sorry and do our best to make sure that we learn. Having the AAR as part of our mandate will make sure that there is the opportunity for timely learning which will help safeguard against known risks and improve the quality of care provided to our patients and service users.

What we achieved

An evaluation of the AAR process has identified timely learning with quaitly improvements eveidenced with the development of standard operating procedures, guidance and policy reveiws alongside local action for multidisciplinary working. The collective data provides assurance that the implementation of AAR has been successful and creates further opportunties to grow as we continue to implement the PSIF.

For 2021/22, the proportion of AAR completed within two weeks increased from eight percent to 81 per cent. We acknowledge that where AAR were completed outside of the two week timeframe, this was in relation to resource directed to support the Covid-19 reponse. For 2022/23, we will maintain our ambition for all AAR to be completed within two weeks.



Improving the **safety** for the people we care for

	Goal	Outcome
Patient safety	Identify the determinants of missed/deferred visits in community services.	**Achieved**

What is a missed or deferred visit?

A missed visit is a one where a planned patient visit is omitted or delayed.

Why this is important

Missed care can be overlooked opportunities for prevention and a wider determinant of other quality issues such as delays to treatment and patient deterioration. Therefore, it is important for KCHFT to understand the scale and impact of missed visits in our community services.

A two-year quality priority was launched to identify the determinants of missed visits in community services:

- In year one, collect robust data on the numbers and drivers and begin to deliver QI projects to reduce missed/deferred visits.
- In year two, carry out monthly audit to determine the reduction in missed visits and increased quality of care.

What we did

A project group was set up to direct the quality priority and analyse the data to identify the drivers of missed visits in KCHFT community services to inform the quality improvement projects for year two.

There are two information systems which record missed and deferred visit information, our incident management system, Datix and the electronic patient record, Rio. However, Datix and Rio capture and record different elements; Rio is able to record deferred visits and Datix captures the reported patient safety incidents as a consequence of a missed visit. As there is no information system that records and synthesises the information for both missed and deferred visits it was agreed that data from each of these information systems would be analysed separately.

Rio

It was decided by the project group that data would be collected from Rio where there were two or more consecutively deferred visits, as single visits can be intentionally deferred based on clinical judgement. Also, the risk of harm increases when one or more visits are deferred.

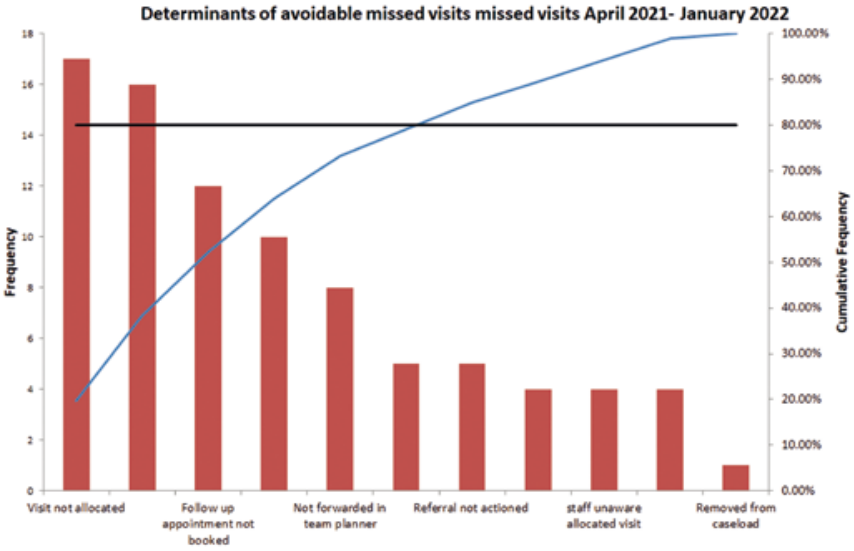
Datix

It was agreed by the group that missed visits data would be extracted from Datix to inform the analysis which were reviewed every quarter and the extract includes:

- a description of the incident
- if the incident was avoidable
- any action taken, the team
- the date of the incident
- the level of harm caused
- if there were any actions that could have been taken to avoid the incident.

This data was then used to identify the relationship between missed visits and patients sustaining harm. To do this, the reasons for missed visits were categorised and quality improvement, Pareto methodology was used to identify where interventions should be focused in order to make the most significant improvements in patient safety for our patients.

Evaluation of this data identified that the focus of these quality improvement projects should be to develop mechanisms for effective allocation of visits, which is represented in the following graph:



While data suggests the number of missed visits is low in relation to the total number of patient contacts delivered by services, we acknowledge that these are potential opportunities to detect early warning signs and identify where further support may be needed. Consequently, a review of all the serious incident root cause analysis reports from the previous five years were reviewed to assess whether a missed visit was a contributory factor. Between 2017/22, 9.2 per cent of all serious incidents had a missed visit as a contributory factor and in 2021/22, this was 16.6 per cent of all serious incidents.

Therefore, in 2022/23, quality improvement projects will be developed to refine allocation processes in community nursing teams to reduce the proportion of serious incidents with missed visits as contributory factor by 50 per cent.

What this means for you as a patient

Community nursing takes place in environments outside of a traditional hospital setting, which can be influenced by multiple elements. Through the analysis of the factors causing missed visits, we are now able to focus our attention on the areas identified as making the greatest improvement to reducing missed or deferred visits and improve patient safety.

This will mean that the patients are less likely to experience delays in scheduled visits.

What we achieved

Using quality improvement methodology, we have identified the factors influencing missed visits in our community core services and will now deliver and test improvement focused on reducing the incidence of missed visits.

Improving **clinical effectiveness**

	Goal	Benchmark	Target	Achieved	Outcome
Clinical effectiveness Increase recognition of patients in the last year of their life, empowering them to make decisions about their care.	80 per cent of relevant patients will have had a last days of life care plan completed.	35.6 per cent	80 per cent	52.4 per cent	Not achieved
	40 per cent of relevant patients will have had the "surprise" question completed in line with the gold standards framework.	18 per cent	40 per cent	31.3 per cent	Not achieved

What is the Gold Standards Framework and the Last Days of Life Care Plan?

The Gold Standards Framework was founded by Professor Keri Thomas OBE and is a leading provider for healthcare staff caring for people at the end of their life. The Gold Standards Framework developed proactive, identification guidance to enable clinicians to recognise when an adult might be at the end of their life. The aim of this guidance is to support healthcare professionals recognise when someone might be at the end of their life by asking the question, "would you be surprised if this patient were to die in the next few months, weeks of days?".

The Last Days of Life Care Plan is a personalised plan of care created between healthcare professionals and the patient and those that matter to them and ensures their comfort in accordance with their wishes.

Why this is important

About one per cent of the population die each year and the Covid-19 pandemic has led to an increase in the number of deaths from all causes above and beyond what we would have expected to see under "normal" conditions. While some deaths are unexpected, many more can be predicted. This can be a very difficult time, however if we are better able to predict when people are in their last year of life, proactive care planning can take place which leading to better, well-co-ordinated and high-quality care.

The One Chance to get it right report from the Leadership Alliance for Care of Dying People states that people are approaching end of life when they are likely to die within the next twelve months. Including those deaths that are imminent as well as those that are expected to die within 12 months.

End of life care enables supportive palliative and end of life care to be identified and met in the last phase of life. Effective end of life care improves the quality of life of the dying person and those that matter to them and this is achieved through: earlier recognition, assessment and treatment of symptoms and holistic assessment and support of psychological, social and spiritual elements of a patient care.

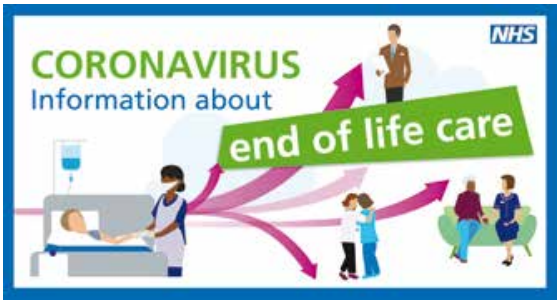
In order to recognise when someone might be at the end of their life we implemented the use of the Gold Standards Framework 'surprise question' to support healthcare professionals to potentially recognise when someone might be end of life and offer supportive conversations to enable advance care planning and ascertain future wishes including their views on care and treatment.

When someone is actively dying and in the last days of life we implement the last days of life plan of care to guide and support to deliver personalised end of life care to patients and support their families.

What we did

End of life care training was developed to support staff and provide them with the skills to recognise when a person is approaching the end of their life so that they may have compassionate conversations to make sure that the care and treatment planned includes the wishes of the patient and those close to them.

Further training was designed so that staff understood the 'surprise question' and how to complete Advance and Last Days of Life care plan documentation on the electronic patient record (EPR). EPR audits were developed and team managers now have the ability to monitor EPR for their team's caseload so that they can access this audit data at any time for assurance and to direct end of life care within their own teams.



Following a training review, further developments were made to help staff recognise when a person is in the last year of their life and these include:

- developing slides to detail how to document recognition of a dying person
- design of a user guide when staff complete end of life care documentation on the EPR and that these were shared with staff and added to the trust's intranet, flo
- design of an EPR end of life care documentation report to capture completion of the surprise question and last days of life care plan.

The progress and monitoring of these targets were reviewed at the End of Life Care Steering Group and the End of Life Care Champions Meetings.

What this means for you as a patient

By training our staff to recognise when someone might be approaching the end of their life, people are offered the opportunity to be involved in conversations about their future wishes, which means:

- those that matter to you and your family/carers have time to deal with the news and make plans
- you are less likely to be subject to unnecessary medical treatments
- proactive personalised planning at the end of life will include patient preferences and wishes and avoid sudden crisis and promote proactive symptom management such as pain
- co-ordinated community care can significantly reduce the likelihood of unwanted hospital admission and support people to die at their preferred location.

And, by training our staff to recognise when someone is actively dying we are able to ensure a last days of life plan of care is in place that captures how they wish to be cared for, who and what matters most to them and the place in which they wish to be cared for.

What we achieved

- We delivered 597 training sessions.
- We increased completions of the 'surprise question' from 18 per cent in April 2021 to 31.3 per cent in March 2022.
- We increased completions of the last days of life care plan from 35.6 per cent in April 2021 to 52.4 per cent in March 2022.
- We have developed the end of life care section on the Kent and Medway Care Record and this will be the Kent and Medway Electronic Palliative Care Coordination system. This record will be accessible by patients and healthcare staff including GP, paramedics, community nursing teams and hospices and will ensure that plans of care are shared and co-ordinated across the system preventing duplication for both the professional and the patient and their families and carers.

Improving **clinical effectiveness**

	Goal	Outcome
Clinical effectiveness	Identify the areas of health research most important for community nursing	**Achieved**

What does research look like in the NHS?

Research supports the development of new medicines and healthcare services. The support provided by the KCHFT research team includes:

- supporting clinical teams to start national research studies
- promoting involvement in research, organisational learning and circulating ideas and innovation from research
- making sure active research trials are delivered and governed to a high standard so that the research is valid.

Why this is important

More and more patients are treated outside of a traditional hospital setting and research is needed to identity the different ways to best deliver this care so that it is current and relevant to our patients, families, carers and the staff delivering it.

Currently, there is very little new research looking at the interventions and care delivered by community nurses and therefore we worked with the James Lind Alliance, which is a non-profit making initiative that brings patients, carers and clinical staff together, giving equal voice to each to identify what is important to them. In collaboration, we identified the uncertainties in evidence or unanswered questions people have, relating to community nursing to agree the top 10 community nursing research priorities.

What we did

We sought funding to employ a James Lind Alliance advisor and an information specialist and brought together a steering group to direct the project and make decisions which included representation from patients, carers, family members, the public, community nurses and chief nurses.

We issued two questionnaires, the first of which generated 333 responses and with the support of the information specialist, identified a further 900 questions. These questions were grouped and were then included into overarching research questions which were checked against evidence to see what questions could be answered. The unanswered questions then generated a second survey.

A workshop took place in September 2021 with a diverse group of healthcare professionals, members of the public, patients and carers which identified 18 areas of health research for community nursing. A final workshop took place in October 2021 to identify the top 10 areas of health research for community nursing and were then published:

Community nursing top 10

1. How can community nurse teams better meet the complex needs of patients with multiple health conditions?
2. How can community nurses promote shared care/self-care amongst patients, and support carers to provide some aspects of care (e.g. changing dressings)?
3. How can community nurse teams best contribute to the management of acutely ill patients at home? What difference does this make to hospital admissions?
4. What are the best ways for community nurses to involve unpaid carers, relatives and/or friends in decisions about their loved one's treatment and care?
5. How can community nurse teams work effectively with social services and care services to improve the quality of patient care?
6. How has community nursing changed in response to Covid-19? Are any of the changes (e.g. timed visits, new skills and working from home) worth keeping?
7. Does seeing the same community nurse(s) over time make a difference to the quality of patient care?
8. How can community nurses work effectively with other health professionals in hospitals and specialist community services to improve patient care?
9. What are the stresses on community nurses and what impact does this have on their health and wellbeing? How can this be improved?
10. How can nurses be encouraged to become community nurses and to stay in the profession?

The following questions were also discussed and put in order of priority at the final workshop

11. What is the optimum ratio of patients to staff in a community nurse team to ensure safe and effective care, and what is the ideal skill mix within the team?
12. How can community nurses best contribute to end of life care?
13. Can better tools be developed to assess whether community nurse teams have sufficient capacity to meet local demand?
14. How can a community nursing service best meet the health care needs of frail patients?
15. Do community nurses with specialist qualifications make a difference to the quality of patient care?
16. What are the best ways for community nurse teams to work with GP practices? How can partnership working between community and practice nurses be improved?
17. How can community nurses encourage and promote optimum health amongst their patients, e.g. to help people care for their skin and avoid ulcers?
18. What is the best way to organise the working day to ensure community nurses can meet patients' needs and have a manageable workload?

At all points in the process inclusivity was carefully considered and where this was not achieved, responses were weighted to amplify the voice of those who were underrepresented. This means that the final 10 include priorities for all and will enable researchers to focus on the benefit to patients.

What this means for you as a patient

By defining the research priorities for people accessing community nursing we will reduce the uncertainty of how best to treat and care for complex patients living with multiple health conditions such as heart failure, Chronic obstructive pulmonary disease (COPD), Parkinson's Disease and Diabetes to increase treatment options and provide high-quality care for people outside of a hospital environment whilst promoting independence.

What we achieved

We generated a list of priorities where research can be prioritised and progressed and provide evidence to improve the care delivered by community nursing services. As the NHS directive moves to provide greater medical care out of the hospital environment in the community, this evidence will be utilised to respond to the needs of patients, their families, carers and healthcare professionals alike.

Improving **clinical effectiveness**

	Goal	Benchmark	Target	Achieved	Outcome
Clinical effectiveness	Increase the number of health checks completed by five per cent, within core services, in the areas of greatest deprivation in Kent.	31.9 per cent	32.2 per cent	31.3 per cent	Partially achieved
Support people to live longer, healthier lives	Achieve an acceptance rate into the Smoke Free Service for pregnant women of 45 per cent.	43 per cent	45 per cent	37 per cent	Partially achieved

What is the NHS health check programme?

The NHS health check programme aims to prevent cardiovascular disease (CVD) and associated conditions through early assessment, awareness and management of individual behaviour and physiological risk factors and are available to all adults aged between 40 and 74.

What is the smoke free service?

The smoke free service offers professional support and help for people who wish to stop smoking and be smoke free for life.

Why this is important

Growing numbers of people are living with long-term conditions. Anticipatory care for the treatment of non-transmittable disease, such as CVD, is a means to address the demands on healthcare services through lifestyle interventions to reduce the likelihood of a person becoming ill in the future.

Evidence suggests that people with the highest risk of developing conditions such as CVD, often live in the areas of highest deprivation that seldom seek healthcare. Therefore, we need to explore other ways of engaging with these population to ensure they have equitable access to services.

Smoking in pregnancy or exposure to second hand smoke restricts oxygen and exposes the baby to harmful toxins. This can increase the risk of stillbirth, miscarriage, birth defects and the development of respiratory conditions amongst others.

In 2020/21, 69 per cent of all women wishing to stop smoking lived in the areas of greatest deprivation in Kent. Therefore, it is essential that we do more to increase contact with pregnant women to improve the health and wellbeing of babies, children and young people, whilst contribution to a reduction in health inequalities.

Based on this, we developed two areas of focus for 2021/22 to help people live longer, healthier lives which are outlined below:

- Increase the uptake of health checks by five per cent in the areas of greatest deprivation in Kent.
- Achieve an acceptance rate for pregnant women of 45 per cent in to the smoke free service.

What we did

NHS health checks

People who live in areas of greatest deprivation are more likely to experience poorer health outcomes due to inequitable access to healthcare services.

Nationally, and in our local area, deprivation is measured in the indices of English Deprivation which are based on 39 indicators. From these, relative deprivation is calculated and presented in deciles, whereby decile one represents the area of greatest deprivation and decile 10 the least.

For this quality priority, access to NHS health checks were targeted towards people living in deciles one to four. To do this, we worked with GP practices in these areas to identify patients with a greater risk of

developing CVD to ensure that our interventions were targeted towards the appropriate population group.

Once we had identified those with a greater risk, we sought to explore opportunities to engage with people and provide outreach services whilst the health diagnostics management system for the call and recall system was developed to increase uptake of the offer.

A funding proposal was agreed for the targeted pilot and recruitment took place to support human resource. During this time, further infrastructure developments were made, IT requirements were configured and communications packages were refined to support the project.

We delivered outreach and workplace clinics in a variety of settings which included: Stagecoach bus company, Kent Police, Your Leisure, East Kent Hospitals, Community hubs in Ashford, Sittingbourne, Romney Marsh and Gravesend, Compas charity Folkestone, Rockdale Housing association, Age UK Thanet, KCHFT staff groups, Canterbury Umbrella Centre, Primary and secondary schools, Men's Shed project, Men V Fat project, as well as supermarkets and pubs in targeted areas.

This made access to health checks more accessible by providing access to health checks in every day locations so that people don't have to go to their GP in order to be seen.

Smoke free service

Midwives provide care and support to women and their families whilst pregnant and this service is provided by our acute hospital partners. When a pregnant woman meets with their midwife during pregnancy, they will discuss lifestyles and provide evidence-based information, helping to make informed choices about options throughout pregnancy.

To increase the acceptance of the smoke-free service and reduce the proportion of women smoking whilst pregnant and beyond, smoking in pregnancy (SIP) midwives refer women to the KCHFT smoke free service. We worked closely with the smoking in pregnancy midwives to provide outcomes of the women who accept the service and to identify any issues or areas for quality improvement.

All pregnancy referrals were contacted three times as standard practice, and up to six times for when capacity allowed. The first contact with the woman is always made within 48 hours of referral and subsequent contacts within two weeks; where we are unable to contact the woman or they decline the service, we developed a letter and a new patient leaflet to provide information about the service and its offer.

We also extended our contact times until 7pm, between Monday and Friday, as we recognise people will need to speak with us outside of traditional working hours. Similarly, our Baby and Me, peer support group was moved from 10am to 6pm on a Tuesday to ensure that this service was available and to increase engagement and improve access.

Further work to increase engagement with the service included:

- development of a smoke free pregnancy leaflet for midwives to ensure information about our service is shared with pregnant women at every opportunity
- development of information videos for social media and the Kent County Council (KCC) website
- collaboration with SIP midwives to make sure that contact is made and feedback obtained from pregnant smokers who are able to be contacted or decline the service
- extended appointments to include a telephone call or home visit between 8am and 7pm
- MSTeams appointments during Covid-19 restrictions
- making use of the digital inclusion offer in Kent that provides service users without, access to mobile phones and tablets

Improving **clinical effectiveness**

- translation of three resources into Bulgarian, Polish and Hungarian to meet the needs of women who were unable to read English
- a professional poster with a personable photo of the smoke free advisor proving a visual introduction to the service. These were shared with midwives
- an advisor working in Swale alongside midwives' bookings clinics at the Seashells Children's Centre, which brings the total to six clinics across Kent
- the Ashford One You shop can be accessed as an alternative venue for face to face appointments
- agreement with commissioners to increase nicotine replacement therapy from 10 to 12 weeks, commencing in April 2022/23.

And, further work to improve access to the service included:

- implementing a weekly report for smoking in pregnancy midwives, proving referral outcomes including all those who have declined or have been unable to contact
- piloting a direct call booking clinic with the SIP midwife in east Kent, and following review we have adapted our way of working to be available to answer calls from midwives at four separate east Kent clinics. We also now work closely at three east Kent pregnancy booking clinics alongside midwifery to increase opportunities and maximise referrals
- implementing a pilot in west Kent where midwives can directly book appointments for pregnant women directly onto a shared outlook calendar. Following review of this pilot we adapted our working practices to co-locate at two children's centres which has been a more effective solution. The team can still be contacted directly by midwives
- active membership of the commissioning group operational meetings to create a dual pathway as part of the tobacco dependency pathway which is anticipated to launch in April 2022/23.

What this means for you as a patient

Access to preventative healthcare interventions are made easier by locating venues outside of the traditional healthcare environment. By understanding the needs of our local population, we have tailored our approach to delivering services to increase both engagement and uptake with the aim to prevent future long-term conditions.

What we achieved

We improved access to NHS health checks by delivering 3,056 more health checks in 2021/22 than in the previous year. Whilst we have not increased the number of health checks completed for people in deciles one to four, access for this population has been consistent which demonstrates support for outreach and workplace engagement which we will continue to develop in 2022/23.

We have increased the opportunity to engage in stop smoking services; working to remove the barriers experienced by people accessing our services by adapting the way in which we work and in relation to digital poverty. Whilst we did not reach the ambition of a 45 per cent acceptance rate of pregnant women referred to the service, we have seen a significant improvement in the number of pregnant women who stop smoking within the service which for 2021/22 was 96 per cent.

Although the pandemic has required adjustment and adaptation with regard to the delivery of NHS health checks and the smoke free service, it has also provided opportunities to widen the scope of connection within our populations as a result of public awareness of preventive health being raised.


NHS HEALTH CHECKS
If you're 40-74 you could get a FREE NHS Health Check*.
You'll be given your heart age, and a personal plan to help you achieve and maintain a healthy lifestyle.
*If you're not eligible for a full check ask for an on-the-spot health MOT instead.
Call 0300 123 1220 or visit www.oneyoukent.org.uk
NHS HEALTH CHECK

we checked

Improving the **experience** of the people we care for

	Goal	Benchmark	Target	Achieved	Outcome
Patient experience Patients will be involved in co-designing services	In year one: three QI projects will be initiated by patient/service user feedback with patient/service user feedback.	0 new project	Three QI projects	Seven QI projects	**Achieved**

What is co-design?

Co-design involves patients and service users in the design process and work with them to understand and meet their needs.

Why this is important

We are committed to learning from previous experiences to improve the services we provide. However, when we listen to our patients' stories, we can begin to understand the true impact of their experience.

Themes from complaints and other forms of patient feedback are really useful and to develop services that are responsive and meet the needs and expectations we must include patients, service users, their families and carers when designing services so that improvements can be truly meaningful.

This is a two-year quality priority, and in year one we said that we would develop three quality improvement projects initiated by patient or service user feedback and that patient/services users would have representation on these project groups.

What we did

Prior to 2021/22 there was no formal mechanism for identifying projects that originated from patient feedback or complaint. Therefore, the patient experience and engagement team worked with the KCHFT quality improvement team to identify potential QI projects at the point of receiving feedback/complaint and developed the monthly QI involvement group.

The QI involvement group gained traction and in quarter two, 2021/22, three QI projects were initiated:

1. Patient experience volunteers

Due to a lack of feedback from vulnerable house bound patients receiving care from the Podiatry and Continence Services, we launched a pilot project to increase patient feedback using volunteers to ensure that patients and carer views can be acted upon. We recruited patient experience volunteers who undertook patient surveys for the team. The project was co-led by the volunteers, who have been co-designed the processes, change ideas and are involved in the monthly monitoring the plan, do, study, act (PDSA) cycles for the project.

This project has enabled the domiciliary cohort of patients to have a voice and ultimately has increased the number of surveys the service has undertaken. This would not have been possible without the help and support of the patient experience volunteer. The data for November 2021 shows that 52 surveys were completed for the service, compared to 27 surveys in the previous month, before the patient experience volunteer commenced in role.

2. Bladder/bowel diary

A QI project was established by the Continence Service to re design the bladder diary which is completed by patients accessing the service. Feedback via a complaint and patient surveys indicated that the diary was complicated and there was no guidance how to complete it. This meant that patients have not been able to completely monitor the diary or been able to be fully involved in decisions about their care.

Information about the diary was sent to the People's Network and patients from the service, who provided

their views and suggestions for improvement to ensure that the diary was accessible and easy to use. From the feedback, the service is developing an accessible version to be ready for patient and carer review.

3. Impact of patient and carer involvement in our governance groups

We established a patient led QI project with the People's Network, to measure the impact of involvement from patient and carer representatives sitting on trust governance groups and to highlight the importance of working with patients with a lived experience. This project is being led by the patient and carer partnership team, along with members of the People's Network who initiated the project to ascertain the impact of their involvement.

A questionnaire has been co-designed with the People's Network to send out to governance groups. The questionnaire will ask members to identify patient or carer Participation Partners involved in the group and to evidence the impact of their involvement. To ensure that the project has the intended impact, it is now being monitored by our participation manager as part of their QSIR Practitioner training.

In quarter three, a further three projects were identified:

4. Improving the National Child Measurement Programme (NCMP) in Kent (School Health Service)

A QI project was established to improve parent experience of the NCMP process delivered by the school health service. The aim of the project was to reduce the number of complaints received and to drive an increased uptake of the school Tier 1 Healthy Weight Package of Care (POC). Feedback from parents and carers stated that the NCMP results letter was felt to create a barrier to engagement, particularly in relation to the post measurement letter where parents are informed if their child is overweight/ obese etc. The project was established to improve the client (parent) experience of the NCMP process delivered by the school health service.

Changes were made to the letter to avoid the use of stigmatising words 'overweight' and 'obese'. Instead parents were provided with their child's height and weight in a neutral way and signposted to the NHS BMI calculator. Parents still experienced negative emotions e.g. feelings of shock or denial associated with the letters and proactive calls but also reported feeling of relief at being able to discuss this with someone.

All parents reported that they had made some behaviour changes since receiving the proactive call. As a result, to the changes in the letter, there has been increased engagement from parents and families; 213 families accepted the offer of a three-month review phone call to check progress and offer ongoing support. Results from the three-month follow up call indicate proactive calls are effective at facilitating behaviour change within families.

5. African communities weight loss pilot

A QI project was set up with the Health Improvement Team. The aim is to increase the uptake of the adult health improvement weight loss programme amongst ethnic minorities groups. Focus groups were carried out with people from an African background who fed back that they wanted more support with weight loss. Recruitment for this project is currently taking place to enable to project to resume in April 2022 and will receive further updates in reporting for quarter one of 2022/23.

6. Improving communication and involvement with family and carers

A QI project was identified through patient and carers survey feedback to improve communication offered to family carers who are identified as providing a caring role to someone using trust services. The project, which is also a requirement under the ToC membership scheme, will support the development of carer packs for carers, ensuring they have information, advice and guidance to support their caring needs. The project was initiated by carers feeding back that they lacked information to support their needs. A family carer has been actively involved in co-design and implementation.

A task and finish group of carer champions, KCHFT staff and carers was established to develop a carers pack that

will be given out to identified family carers upon first contact with the service. The pack contains information for carers with regards to information to support them in their caring role, a copy of the carers survey "giving carers a voice" and information about the service and contact information. The pack is now available in our community hospitals with a spread sheet set up to specifically record the number of surveys given out.

In quarter four, a QI project was identified to improve the volume of carers survey in our community hospitals:

7. 'Giving carers a voice' phone trial

This QI project has been set up to increase the number of carer surveys completed in our community hospitals. This is an eight-week pilot QI project running from 16 February 2022 to 16 April 2022. The project is set over two community hospitals and has been initiated by carers who have reported not having an opportunity to feedback experiences. Carer champions have been undertaking surveys, during the afternoon of one day per week.

One hospital was able to undertake surveys over a one-week period due to operational demand and staff capacity. However, the hospital did see an increase of eight surveys in one week and there had been no surveys undertaken in the previous month. The QI pilot proved successful in increasing carers feedback. Therefore, it has been recommended for roll-out to all community hospitals with regular review to ensure continued impact' alongside completing paper copies and promoting through the carers packs.

We will monitor the amount of completed carers surveys through the carer's involvement steering group, the ToC improvement plan and the PDSA cycle.

Will continue to work with our patient experience coordinator to monitor the survey numbers weekly.

What this means for you as a patient

There is now a robust process in place where feedback from patients, carers and service users are able to initiate service improvement following QI methodology.

By acting on feedback and providing opportunities for patients and carers to be involved in QI projects, relationships with professionals will be improved gaining trust. Patients and carers will be able to share their experiences in ways that services can learn from them, enabling patients and their families to become more equal partners in their care.

Resulting improvements from the 10 projects will ensure that the patient and carer experience is more positive. Patients and carers will feel more involved in their care, feel listened to, have more confidence in the service and by listening and working with patients and carers we will go some way to reduce any negative feedback or complaints.

What we achieved

We have identified and supported seven QI projects initiated by patient and career feedback in year one which exceeds the requirement of three projects.

we encouraged

Improving the **experience** of the people we care for

	Goal	Baseline	Target	Achieved	Outcome
Improving the experience of those we care for. Support mothers to continue to breastfeed with their children for as long as they both wish.	One per cent increase in the rate of breastfeeding women when seen six to eight weeks post-delivery in line with UNICEF national infant feeding and public health outcomes framework.	46.69 per cent	47.15 per cent	48.67 per cent	**Achieved**

What is the breastfeeding rate?

Breastfeeding rate is the percentage on infants that are totally or partially breastfed at age six to eight weeks.

Why this is important

Kent Community Health Foundation Trust and Kent Children Centres believe that every child in Kent should receive the best start in life and breastfeeding can enhance this. Breastfeeding is important for the health and development of infants and their mothers, and is linked to the prevention of major health inequalities.

The provision of human milk is the most accessible and cost-effective activity available to public health which is known to prevent a range of infectious and non-transmittable diseases (NCDs), specifically gastroenteritis, childhood obesity, diabetes type two and maternal breast cancer. The World Health Organisation (WHO) recommends exclusive breastfeeding for the first six months of life, followed by continued breastfeeding with appropriate solids for up to two years and beyond. The UK has one of the lowest breastfeeding rates in the world with 80 per cent of infants' breast feeding at birth and one per cent exclusively at six months.

What we did

Evidence shows that good outcomes can be achieved if parents/carers receive expert information and support to develop relationships with their baby, enabling the early identification of breastfeeding challenges and help to be offered when needed.

To validate our data and ensure accurate reporting, we refined our data collection, electronic patient record and reporting processes. However, as our focus was to support the infant, their mother and their families we delivered UNICEF baby friendly training and practical skills assessment to health visiting and children's centre staff and competencies were assured using the UNICEF post training audit tool. The audit outcomes were used to improve the training package and these were also shared with internal colleagues and UNICEF to support the reaccreditation process.

To improve access to our service and support breastfeeding challenges we introduced virtual breast-feeding support sessions to ensure that guidance was available throughout the pandemic and upon relaxation of Covid-19 restrictions, introduced 24 appointment led, face to face breastfeeding support sessions.

We consulted on the infant feeding service to make sure that our offer reflected what was needed which allowed for the introduction of a new breastfeeding assistant practitioner and recruitment of additional lactation consultants. We also recruited a tongue-tie co-ordinator and implemented the co-ordination of tongue-tie services and the prioritisation of urgent cases.

This work will continue, collaborating with our partners in the Kent and Medway Integrated Care System and this work will include:

- update Unicef baby friendly initiative (BFI) training across Kent for both health visiting and children centre across Kent
- working with KCC to provide resources and support awareness of 'responsive feeding'
- collaborative working with midwifery colleagues to support, protect and promote breastfeeding across Kent
- Health Visiting and Infant Feeding Service to develop strategies to promote digital antenatal contact and 'hello baby' antenatal feeding sessions

- organised events across Kent in support of World breastfeeding week in partnership with all services including third party
- ongoing recruitment and training of KCHFT breastfeeding volunteers to support breastfeeding clinics.

What this means for you as a patient

Breastfeeding will give a child the optimum start in life. It is important for normal growth and development, it provides nourishment and health protection, it strengthens bonding and nurturing between parent/carer and infant, and promotes infant and maternal mental health.

We will support parents/carers to feel confident in their ability to breastfeed, to feel comfortable to breastfeed in public and for individuals, families and communities in Kent to see breastfeeding as the norm.

What we achieved

We supported 3,156 families referred into the specialist infant feeding service which for 2021/22 was an increase of 42 per cent.

There has been a 1.71 per cent increase in the rate of partially and fully breastfeeding women when seen at the six to eight weeks check post-delivery.

There has been a 0.88 per cent increase in the rate of fully breastfeeding women when seen at the six to eight weeks check post-delivery.

Improving the **experience** of the people we care for

	Goal	Benchmark	Target	Achieved	Outcome
Patient experience	The Patient and Carer Council to support 100 per cent of services to have an identified patient/ career voice in the delivery of care.	0 - New project	100 per cent	96 per cent	**Partially achieved**

What is the Patient and Carer Council?

The Patient and Carer Council is the vehicle that drives the cultural changes needed in participation, co-design, shared decision making and engagement across the trust and is chaired by a patient or carer with support from KCHFT.

Why this is important

This is the second year of a two-year goal to make sure our services are co-designed and developed by the people who use them, their families and unpaid carers. We want to make sure they are able to use their lived experiences of using our services to work with us and improve what we do.

Improving the experiences of the people we care for means there will be better participation and involvement; it will reset the balance, making sure patients, carers and their families are equal partners and have a strong voice in the way services are delivered and developed.

What we did

The actions taken to develop this quality priority in its first year are included in the 2020/21 Quality Account which showed that at the end of year one, 34 per cent of services had a patient or carer voice involved in the delivery of care.

To strengthen our approach to enable patients and carers to have a voice in the delivery of care, KCHFT joined as members of the Triangle of Care (TOC) to improve communication and involvement of family and unpaid carers. This is a three-year, accredited program where services initially undertake a self-assessment and develop an action plan to improve carer engagement.

As ToC members we have been able to develop our carer packs which are now placed within our community hospitals and are given to carers upon their first contact with our services. They contain information about; the service, named nurse contact, carers survey, caring for someone NHS England information, information about carers assessments and local and national carers support. This has been a quality improvement (QI) project and is monitored monthly using the plan, do, study, act evaluation process for QI project monitoring.

Alongside this we launched the 'giving carers a voice' survey with revised questions which align with the six ToC principles. We delivered our carer awareness training to 60 members of staff from a range of services and disciplines. Feedback has been positive with an increased understanding of carers and their needs and how we can better listen and involve them in not only the care planning process but in the wider development of services.

Whilst ToC provided an opportunity to develop and engage more closely with carers, we extended our offer to support the patient/carer voice through other projects:

- Delivering working together groups to the Children Speech and Language Service, Special and Elective Services, Podiatry Service, Community Paediatrics Service, learning Disability Service, Children's Therapy Services and Cardiac Rehab. The working together groups are a resource for staff to work together with patients, service users and families to co-produce service development initiatives and discuss issues arising from feedback.
- Transforming the Patient Engagement Network into our new People's Network. We designed new advertising material to increase membership and developed a quarterly newsletter to provide information on current involvement initiatives.

Members of the Peoples Network have changed their name from Patient and Carer Representatives to Participation Partners to reflect the partnership work they are involved across the trust working alongside services. Some of the work they have undertaken in the last two years includes:

- co-designing training for the complaints process
- involvement in some of our quality improvement projects, taking lead roles and working alongside staff directly
- designing and developing the participation patters quarterly newsletter
- part of a citizens panel set up by Kent and Medway CCG
- involved in research and development projects with the trust's Research Team
- taking an active part in we care visits
- taking part in delivering training
- co-designing 'bitesize' involvement training
- as part of a planning group to deliver KCHFTs first Patient and Carer Participation Awards Event where Participation Partners were recognised for their support in working to co-design, develop and improve services.

- We worked alongside our east Kent community services to set up the East Kent Community Engagement Group. Encompassing both hospital and community services, the group is open to service users, patients, carers, staff and colleagues. It meets monthly and has an active patient and carer voice. The group has undertaken some considerable work since inception, including; co-design a web page to advertise community services, co-developing a booklet for recording carers information.
- Delivered our co-designed patient and carer involvement training to over 80 members of staff and colleagues at the KCHFT QI conference. The training is available for staff and colleagues to access via the trusts e-learning system TAPs.
- We have continued to work with our patients and services users from our Learning Disability Easy Read Group, to ensure that information is accessible and easier to understand. We presented the work of the group to the National Patient Experience of Care Conference hosted by NHSI/E.

What this means for you as a patient

We want to improve participation and involvement for our patients and their families. By doing so, we will provide a variety of initiatives and opportunities for patients and families to have a voice in their care, to use their experiences and to share their views and ideas so they feel engaged as equal partners.

In delivering our involvement training, our staff will be able to confidently identify opportunities in a variety of ways for patients and carers to be involved in improving our services.

Through the Carers' Steering Group, we will be able to raise awareness across the trust of the vital role that carers and families play in supporting their cared for person. Staff will be able to make sure carers have better access and information about the support they need.

What we achieved

At the end of 2021/22, 96 per cent of services have an active patient or carer voice, taking part in service development.

Improving the experience of **our** people

	Goal	Target	Achieved	Outcome
Staff experience	Improve the experience of staff providing end of life care by enabling conversations about death and dying.	12	17	**Achieved**

What are listening and debrief sessions?

Listening and debrief sessions provide an opportunity to engage with staff to share their views and experiences and support psychological wellbeing.

Why this is important

In 2020, the number of people who died in England was just over 695,000 – an increase of 91,000 on the previous five-year average (604,000). There has also been a large increase in deaths at home, the majority of which were from causes other than Covid-19.

As caring professionals, we may experience grief after the death of a patient, or after the discharge of a dying patient. In the workplace, grief may be the result of a critical incident or traumatic event.

Listening and debriefing sessions allow individuals and teams the safe space to review such experiences, identify how they have been affected, what impact it had and the learning. This type of support can boost morale and job satisfaction.

What we did

To deliver the listening and de-brief sessions, a communications campaign was developed to engage staff with the notion of listening and debrief sessions so that they felt confident that they provided a safe space to discuss their experiences and offer a protected time for reflection.

To accommodate the working practices of staff, Covid-19 restrictions and to make sure the reach of the sessions could include staff from all areas of our geography, the decision was made to hold these sessions virtually, via MSTeams.

Following each session, feedback was sought from those who had attended which were used to make iterative improvements to the way in which these sessions were delivered.

The feedback we received illustrated how the debrief sessions had positively impacted emotional wellbeing and professional practice. In response to the question, what was good about the session, the responses include:

- The group were free to talk and made to feel comfortable sharing, with no judgement.
- Being able to have a safe place to discuss concerns.
- Hearing that other clinicians are feeling the same way and you are not alone.
- A non-judgemental safe space to speak freely.

What this means for you as a patient

Frontline staff are crucial to successful delivery of joined up care. They are the key point of contact between individuals, and carers and families, services and systems, so their perspective, experience and knowledge is indispensable.

Good workforce development means learning from everyone's experience and valuing what everyone has to say. Through listening and debrief sessions we are supporting and valuing the day to day work of frontline staff through peer support that encourages identification of feelings and learning for individuals. Feeling listened to can boost staff morale, reduce absence and influence their own working environment and ultimately provide positive experiences for patients.

What we achieved

We delivered 17 listening and debrief sessions to support the emotional wellbeing of our staff.

Improving the experience of **our** people

	Goal	Benchmark	Target	Achieved	Outcome
Staff experience Increase support and guidance to staff to improve knowledge and engagement with information governance standards.	Information governance training compliance will reach 90 per cent in year one and 92 per cent in year two	88.2 per cent	90 per cent	90.5 per cent	**Achieved**

What is information governance training?

Information governance (IG) guides all employees to make sure person-identifiable information is handled legally, securely, efficiently and effectively.

Given the nature of the information all staff handle on a daily basis, IG training is categorised as mandatory as it is essential for the safe and efficient delivery of service. All KCHFT staff are required to complete IG training every year.

Why this is important

The trust has a legal duty to comply with the UK General Data Protection Regulations and the Data Protection Act 2018, to ensure all person-identifiable information is handled legally, securely, efficiently and effectively. This means we must have in place processes and systems to meet those legal obligations and we must ensure staff to undertake annual IG training.

The trust also has to complete an annual Data Security and Protection Assurance Toolkit to evidence that the trust adheres to the 10 Data Protection Standards and is adequately protecting patient and staff identifiable data.

The training we deliver ensures that our staff meet the required standards and are confident and competent to handle data securely, but this priority is to look at the way in which we support our people to access this training, so that it can be completed in a timely and efficient manner.

What we did

Information governance training is delivered to staff upon appointment at corporate induction, staff are then required to access yearly refresher training via the trust's e-learning training system TAPS. The course is called Data Security and Awareness training and is a national training course provided by e-Learning for Health.

To increase compliance, we implemented a number of actions to improve the accessibility of training which included:

- To make sure staff knew when it was time to update their training and it could be easily accessed, we reviewed all internal 'how to' guides and IG policies.
- To support staff, we introduced a new phone line to process urgent IG queries and non-urgent queries were directed to the trust's online self-service portal.
- Reminders to complete annual IG refresher training were published in the IG newsletter, available on our staff intranet flo, in the trust-wide e-bulletin sent to all staff and personalised emails were sent to remind staff who were due to access refresher training.
- To identify and access training the correct training, IG training is now automatically loaded onto a staff member's training record, when it becomes due; staff no longer have to search the training archives to locate and load their training.
- Work is underway to deliver IG training to our volunteers and governors; this will be a mixture of online training provided through the national e-Learning for Health aimed specifically at volunteers as well as face to face training for volunteers who are not able to access online training.

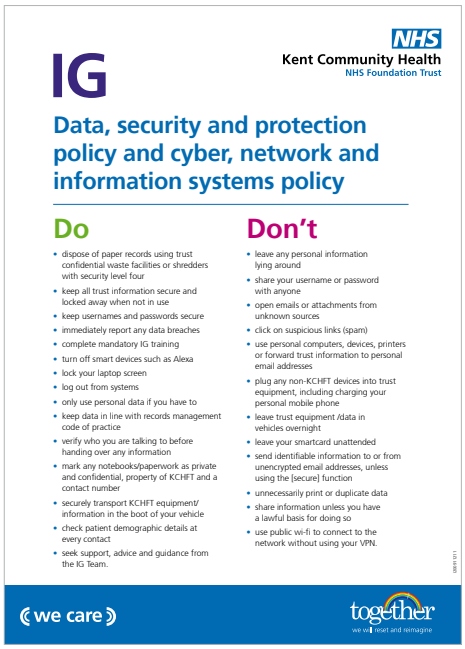
- The IG team reviews any IG incidents which are reported on the trust's incident reporting system and provides the investigator with advice and guidance to avoid the breach being repeated. This includes ensuring that their teams have completed their annual IG refresher training.

What this means for you as a patient

We are committed to protecting and respecting your privacy. We recognise the trust placed in us by individuals whose information we process. By staff completing their annual IG refresher training, you can be assured that staff understand their legal duty to meet this commitment.

What we achieved

We met the target and achieved 90.5 per cent training compliance.



Improving the experience of **our** people

	Goal	Outcome
Staff experience	KCHFT will be a living wage employer by March 2022	**Achieved**

What is the living wage?

The real Living Wage is the only UK wage rate that is voluntarily paid by almost 10,000 UK businesses who believe that their staff deserve a wage which meets every day need – like the weekly shop or a surprise trip to the dentist.

Why this is important

Unlike the National Living Wage which has been designed to ensure that full-time and part-time workers over the age of 25 earn at least 55 per cent of the median national wage, the annually revised Real Living Wage applies to all workers aged 18 and above and considers the actual cost of living through an independent calculation coordinated by the Living Wage Foundation.

Our commitment to become a Real Living Wage Employer is in strong alignment with our values into action approach and demonstrates our commitment to fair pay for our staff. This is also in recognition of our responsibility to act as an agent for change in our region by supporting our eligible service provider partners to also pay their staff the Real Living Wage.

What we did

The trust's governance structure approved the initiative to pay colleagues the Real Living Wage and work with eligible service providers to uplift the wages of external operatives at trust sites.

We analysed £4.9million of procurement expenditure between April 2019 and December 2021 and discussed with services across the trust to identify which providers at trust sites may have staff eligible for wage uplift.

We completed our Accredited Real Living Wage employer application to join a growing number of NHS trusts and clinical commissioning groups accredited as Living Wage employers.

What this means for you as a patient

As the first NHS trust in Kent and Medway to pay staff the Real Living Wage, this initiative is supporting us to attract and retain talented and highly qualified staff, which helps us to continue to provide community healthcare of the highest quality. Our choice to become an accredited Real Living Wage employer is indicative of how we are actively supporting the local economies of the communities we care for.

What we achieved

We are an accredited living wage employer and uplifted the salaries of 219 full time and part time colleagues to the real living wage standard. We are now committed to requiring that all new contracts with eligible providers of services that required operatives to be on-site to be paid the same living wage standard.

2021/22 quality priorities – what happens next?

The work carried out to improve the quality of our services through the ambitions of the 2021/22 quality priorities will continue. The quality priorities that have been achieved are embedded in practice and the projects that have not been achieved or partially achieved will continue as business as usual, monitored bi-monthly at the Quality Committee, to make sure full benefits will be realised for patients.

Abbreviations

ADHD	Attention deficit hyperactivity disorder
BAME	Black, Asian and Minority Ethnic
CARE values	Compassionate, aspirational, responsive, excellent
CCP-UK	Clinical Characterisation Protocol UK
CQC	Care Quality Commission
CQUINs	Commissioning for Quality and Innovation
EPR	Electronic patient record
DNACPR	Do Not Attempt Cardio-Pulmonary Resuscitation
DSPA	Data Security and Protection Assessment
FFFAP	Falls & Fragility Fracture Programme
FFT	Friends and family test
FTSU	Freedom to Speak Up
GP	General Practitioner
HCAI	Healthcare Associated Infections
HEF	Health Equalities Framework
HR	Human Resources
HSJ	Health Service Journal
IG	Information Governance
KCC	Kent County Council
KCHFT	Kent Community Health NHS Foundation Trust
KLOE	Key lines of enquiry
LD	Learning Disabilities
MENCAP	UK charity for people with a learning disability
MIU	Minor Injuries Unit
NACAP	National Asthma and COPD Audit Programme

NDFA	National Diabetes Footcare Audit
NEWS2	National Early Warning Scores (updated)
NHS	National Health Service
NHSI	NHS Improvement
PALS	Patient Advice and Liaison Service
PCP	Personalised care plans
PCR	Provider Collaboration Review
PEWS	Paediatric Early Warning Signs
PH	Public Health
PPE	Personal Protective Equipment
QI	Quality Improvement
QIA	Quality Impact Assessment
QSIR	Quality, Service Improvement & Redesign
RCP	Royal College of Physicians
RTT	Referral to treatment
SALT	Speech and Language Therapist
SBAR	Situation, Background, Assessment, Recommendation
SINBAD	Scoring system used to measure severity of ulcers for the NDFA
SSNAP	Sentinel Stroke National Audit Programme
TAPs	Training and Appraisal Performance system
TB	Tuberculosis
TEP	Treatment Escalation Plan
TIAA	The trust's auditors
UNICEF	United Nations Children's Fund
UTC	Urgent Treatment Centre

Annex 1

Statements from commissioners, local Healthwatch organisations and oversight and scrutiny committee.

NHS
Kent and Medway
Clinical Commissioning Group

Private and confidential

Dr Mercia Spare
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Sent via email

Nursing & Quality Directorate
Paula Wilkins
Executive Chief Nurse
NHS Kent & Medway
Headquarters
81 Station Road
Ashford
Kent TN231PP

24th May 2022

Kent and Medway CCGs KCHFT Quality Account Comments 21/22

Dear Mercia,

We welcome the Quality Account for Kent Community NHS Foundation Trust (KCHFT). Kent and Medway CCG confirm that this Quality Account has been produced in line with the National requirements and includes all the required areas for reporting

Your report clearly sets out your Quality priorities for 22/23 and includes your strategy for 2021 to 2025 including your quadruple aim and key areas of quality focus for the coming year.

The Annual Account demonstrates the overview of quality of care in 4 areas, which are improving the safety of the people we care for, improving clinical effectiveness, improving the experience of the people we care for and improving the experience of our people.

You have set twelve clear priorities for the coming year, aligned to the four aims of the Trust's Quality strategy. We note your efforts on engagement with services, governance groups, the Executive Team, staff, stakeholders, patients, their families, and carers, in discussing and agreeing the Trust's quality priorities for the coming year.

There is a thorough overview of the work that you have all undertaken this year with a focus on quality and clearly detailed what this means to patients, reading the report. Throughout the report you have provided clear and measurable recommendations and the report has a clear flow, that would be easy to follow for members of the public who may have an interest in reading this report. You have talked about the audits that you have undertaken and discussed how this supports identification of areas requiring improvement and detailed actions to improve the quality of healthcare provided.

The pandemic remained a pressure throughout 21/22 and yet your successes demonstrate your effective responsiveness to this challenging time. These include your delivery of the National covid19 vaccination programme across Kent and Medway. You maintained patient choice by delivering over 500,000 virtual appointments and 1.5 million face to face appointments. You also worked with children's centres across Kent to deliver UNICEF baby friendly training and practical skills to children's staff and Health visiting staff. There was also a 42% increase from the previous year of families using the specialist infant feeding service. You also improved access to NHS Health Checks and delivered this to 3,056 more services users than in 2020/21. There has been continued roll out of End-of-Life care training to deliver personalised care for everyone identified as being in their last year of life which includes the Gold Standard Framework. The work tackling Health Inequalities such as the Healthy Communities project, forming a steering group for the increased participation for seldom heard voices and the review of the equality impact assessment process are all recognition to your outstanding achievements.

Clinical Chair: Dr Navin Kumta
Accountable Officer: Paul Bentley

NHS
Kent and Medway
Clinical Commissioning Group

As we move to an Integrated Care Board from July 2022, we look forward to continuing our strong supportive relationship for the population of Kent with the provision of the outstanding quality of care. This report clearly sets out your vision for staff and service user support for the coming year and beyond. The CCG thanks KCHFT for the opportunity to comment on these accounts and looks forward to further strengthening the relationships with the organisation through continued collaborative working in the future.

Yours sincerely,

Paula Wilkins
Executive Chief Nurse
Kent and Medway CCG

Kent County Council
kent.gov.uk

Sent via email
victoria.stevens4@nhs.net
Vicki Stevens
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Date: 27 May 2022

Dear Vicki,

Kent Community Health NHS Foundation Trust Quality Accounts 2021/22

Thank you for offering Kent County Council's Health Overview and Scrutiny Committee the opportunity to comment on KCHFT's Quality Accounts for 2021-22. HOSC has received a number of similar requests from Trusts providing services in Kent, and we may well receive more.

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

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

Kind regards

Paul Bartlett
Chair, Health Overview and Scrutiny Committee
Kent County Council

healthwatch Kent

Healthwatch Kent response to the Kent Community Health NHS Foundation Trust Quality Account 2021/22

Healthwatch Kent is the independent champion for the views of patients and social care users in Kent. Our role is to help patients and the public get the best out of their local Health and Social Care services.

For several years now, local Healthwatch across the country have been asked to read, digest and comment on the Quality Accounts which are produced by every NHS Provider (excluding primary care and Continuing Healthcare providers).

We'd like to take this opportunity to support the Trust by setting out the areas we have worked together on in the past year:

- The Trust took part in a number of sessions that we organised to explore the feedback we have gathered from Carers whose loved one had recently been discharged from hospital. The Trust pledged to continue the conversations about how the system can improve the care and support they offer to Carers.
- We worked in partnership with the Trust to gather feedback from Trans & Non-Binary patients, listening to their feedback about the barriers they face to get healthcare. Their stories have been shared widely across the Kent & Medway health and care system. The Trust has established a Trans and Non-Binary Forum which was instrumental to this work.
- As a result of the feedback we shared about vaccination clinics, the Trust made several changes including improved privacy and access to British Sign Language interpreters and community spoken languages on their video and telephones systems.
- We attended their Patient and Carer Council meetings where we share the issues that we have heard from patients and carers.
- We contributed to the Trust's Healthy Communities Project, offering our insights and knowledge of health inequalities.
- We recognised the Trust's Quality Account as a leading example in Kent & Medway at our Healthwatch Recognition Awards this year.
- We've worked alongside a number of KCHFT colleagues within the East Kent and West Kent Health and Care Partnerships. For example, in East Kent we have worked collectively together on a Diabetes project where we ensured patient feedback was central to decisions about service improvements.

We have read the Quality Account with interest. Generally, it's well presented, makes sense, and gives the public a glimpse into the Trust performance over the last year.

As was the case last year we like the way the account sets out what each quality priority means for people using the service. We are encouraging all other organisations submitting quality accounts to follow this example.

Healthwatch Kent June 2022

Annex 2

Statement of directors' responsibilities for the quality account

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 and supporting guidance
- the content of the quality report is not inconsistent with internal and external sources of information including:
  - Board minutes and papers for the period April 2021 to March 2022
  - papers relating to quality reported to the board over the period April 2021 to March 2022
  - feedback from commissioners
  - feedback from local Healthwatch organisations
  - feedback from Overview and Scrutiny Committee
  - the 2021 national staff survey
  - CQC inspection report dated July 2019
- 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 above requirements in preparing the quality report.

By order of the Board.

16 June 2022 .....Date .....Chairman

16 June 2022 .....Date ..... Acting Chief Executive

Do you have feedback about our health services?

Phone: 0800 030 4550, 8.30am to 4.30pm, Monday to Friday
Text: 07899 903499
Email: kentchft.PALS@nhs.net
Web: www.kentcht.nhs.uk/PALS

Patient Advice and Liaison Service (PALS)
Trinity House
110-120 Upper Pemberton
Ashford
Kent
TN25 4AZ

If you need communication support or this leaflet in another format, please ask a member of staff or contact us.

we care

Our values
Compassionate **Aspirational** **Responsive** **Excellent**

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