NHS
Kent and Medway
NHS and Social Care Partnership Trust

ANNUAL REPORT 2017 18

Brilliant care through brilliant people

respect ◆ open ◆ accountable ◆ working together ◆ innovative ◆ excellence

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Welcome

We had a great start to the year. The Care Quality Commission (CQC) inspected our services in January and officially announced at the beginning of April that they rated us '**Good**' overall and '**Outstanding**' for caring. This was rightful recognition of the excellent work being carried out by staff across the organisation. Since hearing this news we have been working with our partners across Kent and Medway to continue to improve.

Now, more than ever, we need a coordinated approach to the provision of safe, quality services that further close the gap between physical and mental health. We are continuing to work with Kent police and we launched a street triage scheme in April last year. This focussed on providing the best and most appropriate care for those suffering in a crisis in Thanet. This scheme is the latest in a number of measures that KMPT and Kent Police have put in place to address mental health issues in police incidents in the county. The year-long pilot was recently extended and we hope it will demonstrate the need for similar schemes across the county.

In March we hosted a conference specifically looking at a variety of mental health related topics using a lifelong approach from birth to the frail and elderly. The conference: Better Together, a Collective Conversation Transforming Mental Health and Wellbeing, took the form of a conversation covering a range of topics including social isolation and loneliness, children and young people's mental health, perinatal (mother and baby care as well as suicide prevention), local care and crisis and liaison psychiatry. The event, attended by over 300 delegates, was a huge success and opened new doors for organisations to work together.

Nationally we are working with NHS Improvement's retention programme to help address the issues we are experiencing around the retention of staff. Recruitment continues to be a challenge with a broader market supply problem, particularly in relation to doctors and nurses. Recruiting and retaining the best staff is a major part of our People Plan and as part of our local retention plans we aim to make KMPT the best possible place to work so that we can retain the best people. In the last year we have initiated a number of new staff retention programmes and have several recruitment drives underway including recruiting nurses from Ireland. We were encouraged to receive this years' staff survey results which showed KMPT scoring significantly better than other mental health trusts on 29 of the questions asked. We also saw our overall staff engagement score increase from 3.73 to 3.76 with particular progress made in the areas of staff health and wellbeing, feeling able to raising concerns, staff engagement and leadership development.

We were disappointed that we ended the year with Care Quality Commission's inspectors finding that we had failed to consistently meet expected standards in our community services for adults. We took immediate action to address potential risks to quality and safety and put in place systems and assurances to prevent reoccurrence. We will, as always, review and learn using the knowledge we gain to improve the quality of our services.

We remain committed to improving mental health, learning disability and substance misuse services for the people we serve and look forward to another purposeful and productive year.

Andrew Ling
Chairman

Helen Greatorex
Chief Executive

THE PERFORMANCE REPORT

Annual overview

We support people in the communities of Kent and Medway, working with a range of partners, to deliver care and support to people in their own homes and from other community and hospital based premises. We have 66 buildings located on 33 sites. Our main hospital sites are:

Maidstone: Priority House and Trevor Gibbons Unit
Canterbury: St Martin's
Dartford: Greenacres

The trust was formed in April 2006 after the merger of East Kent NHS and Social Care Partnership Trust and West Kent NHS and Social Care Trust. KMPT carries out its work on behalf of eight local Clinical Commissioning Groups (CCGs), Kent County Council and NHS Specialist Commissioning. This reflects the distinct locality focus, which presents opportunities for local integration and innovation but also a challenge in terms of implementing countywide service solutions. KMPT covers a big county with a population of 1.8 million, which is spread across 1500 square miles. Our annual revenue is £181 million and we employ 3,264 staff plus 191 seconded employees.

One of the key challenges for us is our geography being spread out across a large number of sites. Having staff located in many different areas has challenged connections and engagement. However, we have a comprehensive organisational development programme in place, which includes leadership meetings and regular roadshows: 'The Big Conversation on the Road'.

Vision and values

Our vision is to deliver excellent care personal to you, delivering quality through partnership. Creating a dynamic system of care so that people receive the right help, at the right time, in the right setting with the right outcomes.

We will do this by:

- Consistently deliver an outstanding quality of care
- Recruit retain and develop the best staff making KMPT a great place to work
- Put continuous improvement at the heart of what we do
- Develop and extend our research and innovation work
- Maximise the use of digital technology
- Meet or exceed requirements set out in the Five Year Forward View
- Deliver financial balance and organisational sustainability
- Develop our core business and enter new markets through increased partnership working.
- Ensure success of our system-wide sustainability plans through active participation, partnership and leadership.

Vision - delivering quality through partnerships

Review of the year

Mental health street triage pilot introduced in Thanet

A street triage scheme was launched in April and focussed on providing the best and most appropriate care for those experiencing a crisis. The scheme involves qualified health practitioners accompanying police officers attending incidents involving someone in a mental health crisis in Thanet. The street triage scheme is the latest in a number of measures KMPT and Kent Police have put in place to address mental health issues in police incidents in the county. A Mental Health Concordat was set up in February 2014 to help all organisations involved gain a better understanding of mental health issues and work is currently underway in preparation of law changes which mean only in exceptional circumstances will adults presenting a mental health crisis be taken to police custody. The pilot has been extended until June 2018.

Paperless awards

In May our 'Electronic Notification Discharge Project' was shortlisted for the national 'Paperless Awards' which recognised, celebrated and rewarded exceptional progress towards the goal to becoming a paperless environment. We were one of only six organisations shortlisted for the 'Going Paperless Project of the Year'. KMPT received £5,000 worth of equipment from Wacom, who sell computer hardware and who sponsored the category at the awards.

Congratulations to the newly elected executives of the BME Forum

The Black Minority and Ethnic forum conducted a successful election of its new executives in June. Director of Transformation, Vincent Badu, who was invited to the forum as a guest, stressed the importance of how this group could help KMPT deliver on its objectives and also make a positive impact on patient care.

Trust is now a disability confident employer

KMPT achieved the Disability Confident Employer rating. This replaces the previous scheme of two ticks. The scheme encourages employers to successfully employ and retain disabled people and those with health conditions. KMPT is committed to providing work experience and employment to candidates with a range of conditions and offers a guaranteed interview to disabled applicants if they meet the minimum person specification for the post.

disability confident EMPLOYER

Staff breathe new life into vandalised garden

Patients and staff were left devastated when the garden area at the back of Darent House was left vandalised and after visiting the service, Director of Workforce and Organisational Development and Freedom to Speak Up Guardian (FTSUG), Sandra Goatley decided to spring into action to get the garden blossoming back to its former glory. She enlisted the help from her team and together they transformed the garden into an oasis of calm and tranquillity by removing the damaged furniture, debris, rubbish and general tidying up. Patients and staff now have a beautiful picnic area where they can enjoy their lunch in the sunshine and make full use of the new garden furniture. Discounts from local stores including Homebase were gratefully received as was the free compost paid for by a member of staff from the Sevenoaks Garden Centre.

Expansion of the Mother and Infant Mental Health Service (MIMHS)

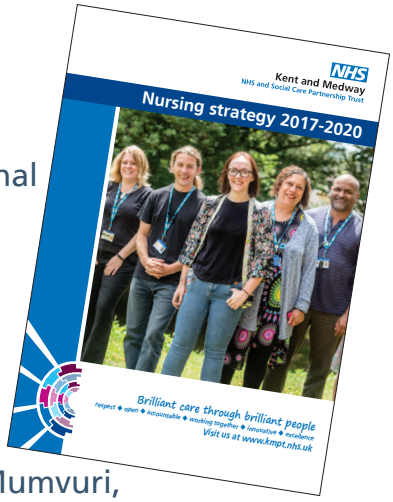
Following a successful bid to the Perinatal Mental Health Community Services Development Fund, MIMHS received funding to develop its community perinatal mental health service across Kent and Medway. The main impact on the development of the service has been:

- Direct access to the MIMHS service
- Care coordination of patients subject to CPA
- Care closer to home and better aligned with maternity and family support
- Additional staff recruited that has enabled regular provision of therapeutic and peer support groups in multiple community settings across the county
- Improved practical and occupational support to enable mental health recovery, development of parenting skills and maternal attachment, through dedicated nursery nurses and occupational therapy posts
- Integrated access to highly specialist psychological therapies, through the new dedicated psychology posts.

KMPT engages audience at STP 'One Year On' event

KMPT played a key role at the Kent and Medway Sustainability and Transformation Partnership's (STP) 'One Year On' conference held in October at the Great Danes Hotel in Maidstone. Helen Greatorex, Chief Executive and Responsible Officer for the STP Mental Health Workstream delivered a presentation on priorities for mental health across Kent and Medway and also took part in a discussion panel on health and social care collaboration in Kent and Medway.

First nursing strategy launched



A commitment to develop a professional strategy that clearly sets out our vision, aspirations and future direction for nurses was made by Executive Director of Nursing and Quality, Mary Mumvuri, when she took up position with KMPT in 2016 and launched a year later. The strategy has had both formal and informal input from a range of staff across the trust and includes patient and carers' feedback. The vision of the strategy is that our nurses will be amongst those that will lead mental health nursing into the 21st century, showing one another and the rest of the world how it can and should be done. The strategy focusses on four key strategic areas which include:

- Nursing and retention
- Career pathways, training and development opportunities
- Research, innovation, use of technology and quality improvement
- Nurses engagement and wellbeing.

Academic review praises KMPT fire setting initiative

An academic review of an award-winning Fire Setting Intervention Programme co-developed by KMPT has found it to be extremely effective for reducing deliberate firesetting. The programme for mentally disordered offenders was developed by KMPT and the University of Kent (UoK) with support from Kent Fire and Rescue Service who delivered two sessions around fire science and safety. Results from the evaluation highlighted that patients completing the programme made significant improvements post-treatment on fire-related measures and anger expression.

Molly wins national award

Molly, a pet therapy dog at the Frank Lloyd Unit in Sittingbourne won a prestigious national 'Unsung Hero' Award in the 'special mention category', which recognised the valuable work undertaken by her and her owner, Sarah Wale. Before the awards Molly was also interviewed with Sarah on the BBC Breakfast sofa by presenters Naga and Charlie.

Better Together 2018

A conversation, which took the form of an all-day conference with delegates who currently deliver and use mental health services in Kent and Medway, and other health and care partners, was hosted by KMPT in March. At this conference our Chief Executive, Helen Greatorex, pledged to provide all day psychiatric help in hospitals throughout Kent and Medway by March 2019 and this was endorsed by Kent and Medway Sustainability and Transformation Partnership's Chief Executive, Glenn Douglas. NHS England has set a 2021 deadline for this service to be provided in general acute hospitals across the country, which is called 'Core 24'. However, Kent and Medway could now be way ahead of other regions throughout England, pledging to go further and faster on making sure this service is in place.

Claire Murdoch, National Mental Health Director for NHS England and Tim Kendall, National Clinical Mental Health Director for NHS England took time out of their busy schedules to give delegates an overview of the national situation and their view of the immediate priorities for regions planning and delivering health and social care services across the country.

The event also included high profile speakers such as Jonny Benjamin MBE, an award-winning mental health campaigner whose global campaign to find the 'silent hero' who saved his life attracted international media coverage. Jonny's inspirational talk about his childhood, mental ill health and subsequent campaigning received a standing ovation. Mum and service user, Zoe Gibson, gave a powerful account of her perinatal mental ill health in pregnancy and her involvement in KMPT's new Mother and Baby Unit.

A marketplace featured a range of organisations from public and third sector partners, such as Rethink Mental Health; Blackthorn Trust, Age UK, Kent County Council 'Release the Pressure' and Sheppey Oasis Academy. Delegates included representation from NHS trusts throughout Kent and Medway and beyond, service users, carers, the police, schools, colleges and universities and representation from local and regional councils.

Engaging with our service users and carers

Getting involved

We are committed to continually improving the services we provide and recognise the importance of working with our service users and carers to understand how they experience our services and how we can improve. Some of the activity we have conducted this year in partnership with our carers and service users is:

Patient and Carer Consultative Committees

We host bi-monthly Patient Consultative Committees in the three regions of north Kent, east Kent and west Kent as well as two others; one covering west and north Kent and the other service East Kent. These meetings provide an opportunity for service users and carers to feedback any ideas or concerns they have about service delivery, and to engage with us about new service developments.

Co-production network

This network brings service users, carers, staff and other stakeholders together to collaborate on our service developments. Established in 2016 the network meets quarterly to review co-production activities whilst actual co-productive projects run between the network meetings. Co-production considered by the network during this year has included:

- Reviewing the template letters arising from community service delivery as part of the development of CAPA
- Further developing the therapeutic programme delivered for patients at St Martins Hospital, Canterbury
- Consulting on the developments of new safety planning cards to improve communication around safety
- Reviewing the development of the Recovery College pilot that will be initiated in September 2018.

Experts by Experience research group

This is a group of service users who meet monthly and support trust research and evaluation activity. As well as consulting on various research projects supported by the research team, the group has supported a service improvement project to look at care coordination in community services. The project used appreciative enquiry methods to look at the best of current practices and consider how these could be built upon. The group also supported an evaluation of the experience of service users accessing support from peer support workers.

Time to Change 2018

For the third year running we took part in a national mental health awareness campaign run by Time to Change with the aim of challenging stigma by encouraging the nation to talk openly about mental health. This year's theme was 'supporting people at work'. We hosted four events linked by video conference. 70 service users, carers, staff, and representatives from voluntary agencies gathered in Canterbury, Tunbridge Wells, Gillingham and Maidstone to share ideas on raising awareness and improving support for mental health. Helen Greatorex joined the event in Canterbury and talked about her own commitment to lead an organisation that supports people with mental health needs, challenge stigma and end discrimination relating to mental health.

Surveys of service users and carers

We participate in the annual community mental health survey that seeks feedback from a random sample of our service users around key aspects of their treatment and care. This year we also commissioned a survey of people accessing our inpatient services. Care groups are asked to produce an action plan to address any areas of concern highlighted through the surveys.

We also conduct an in-house survey of carers experience. This year we used a survey developed by Triangle of Care to seek feedback on how well carers are engaged as partners in caring for their loved ones.

Trust-wide patient experience measure

This year we committed to developing a trust-wide measure of patient experience. Whilst we have developed a Patient Reportable Experience Measure (PREM) in adult community services and were beginning to develop similar measures for other care groups, it was thought that a trust-wide PREM was required. A PREM was agreed by all care groups and has been used since December 2017. Results are shared monthly across the trust and services are required to respond to the feedback that they receive.

Managing our finances

This section describes how the trust is funded and how it manages its finances.

It describes how much funding we receive and where it comes from, as well as how we spend our money on providing services. You can also learn about how we pay our bills, our investment in capital projects and learn whether we have met our financial targets for 2017-18.

Summary of financial performance in 2017-18

This section summarises the financial performance for 2017-18 and the position of the trust as at 31 March 2018.

Within the context of a nationally challenging financial environment, the trust achieved both its planned deficit and the financial targets detailed below.

At the beginning of the financial year the trust agreed a control total with NHS Improvement of a deficit after technical adjustments of £2.8m (£2.9m before technical adjustments). The trust performed £0.2m within the control total and has therefore been allocated £1.4m of incentive and bonus Sustainability and Transformation Funding. The trust ended the year with a £1.2m deficit (£5.0m before technical adjustments). The technical adjustments excluded from the performance against the control total were £3.7m of property plant and equipment impairments, and £0.1m of depreciation on previous donated assets.

The table below sets out the financial performance against plan.

Table 1

	Plan 2017-18	Actual 2017-18	Variance 2017-18
Income	178,685	181,034	2,349
Expenditure	(175,745)	(180,928)	(5,183)
OPERATING SURPLUS	**2,940**	**106**	**(2,834)**
Finance cost	(1,568)	(1,569)	(1)
PDC dividends	(4,272)	(3,934)	338
Net gain on disposal of fixed assets	0	376	376
(DEFICIT)	**(2,900)**	**(5,021)**	**(2,121)**
Impairment	0	3,731	3,731
Depreciation on donated assets	66	66	0
(DEFICIT) ON A CONTROL TOTAL BASIS	**(2,834)**	**(1,224)**	**1,610**
Control total	(2,834)	(2,834)	0
Variance against control total	**0**	**1,610**	**1,610**

The key drivers for the deficit were:

- Significant use of agency staff to cover vacancies within the Acute Care Group due to high observation levels on wards and the provision of Place of Safety
- The above pressures were offset by underspending in the Forensic and Support Services mainly due to vacancies.

The accounting policies adopted follow International Financial Reporting Standards (IFRS) 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.

Income

The trust's clinical income in 2017-18 was £168.9m, which was £0.1m favourable to the plan. Other operating income was £12.1m which was £2.3m favourable to the plan predominately due to the additional £1.4m of incentive and bonus Sustainability and Transformation Funding the trust received for delivering its financial targets in 2017-18.

The trust continued to earn the majority of its core business income from the local Clinical Commissioning Groups (CCGs)which are Ashford CCG, Canterbury and Coastal CCG, Dartford, Gravesham and Swanley CCG, Medway CCG, South Kent CCG, Swale CCG, Thanet CCG, and West Kent CCG all under block contract. This accounts for 82 per cent of the trust clinical income. Specialist Services are commissioned via NHS England (12 per cent).

The partnership arrangement with Kent County Council, which enables single management of the workforce for the provision of adult services continued during 2017-18. The trust works closely with Medway Local Authority who is the provider of social care in the Medway locality, no formal partnership arrangement is in place.

Further details regarding income are identified on page 71, note 2 and 3 of the accounts.

Expenditure

Operating expenditure in 2017-18 was £180.9m. The trust spent £137m on pay costs during 2017-18. This represented 74 per cent of the trusts total operating expenditure. Pay costs can be split between £119m on substantive staff, £11.1m on bank staff and £6.9m on agency staff, which was within the cap set by NHS Improvement of £7.1m.

Pay was £1.5m favourable to plan at year end. The primary driver of this was due to vacancies in the substantive workforce across all services. The variance of £2.9m is offset by the use of temporary staffing to cover some of these vacancies.

Non pay was £6.7m adverse to plan at year end. The main driver of this was a £3.7m impairment on fixed assets.

The analysis of this expenditure can be found on page 72 note 4.1 of the accounts.

Cost improvement programme

The trust set a £7m cost improvement programme target for 2017-18. The trust delivered £5.6m of the planned savings and had an adverse variance of £1.4m to the plan at year end. With regards to the savings delivered, £3m were delivered on a non recurrent basis and £2.6m on a recurrent basis.

The full details are shown in the table below.

Table 2

Care Groups	2017-18		
	Plan (£000)	Actual (£000)	Variance (£000)
Acute Care Group	99	82	(17)
Older Peoples Care Group	335	150	(185)
Forensic Care Group	940	553	(387)
Community Recovery Care Group	1,723	1,082	(641)
Support Services	3,944	3,809	(135)
Total	**7,041**	**5,677**	**(1,364)**
Recurrent	4,003	2,638	(1,364)
Non recurrent	3,038	3,038	0

Capital expenditure

The trust spent £5.7m on capital expenditure in 2017-18, which represented an under spend against the capital resource limit of £627k. This is to be carried forward for schemes to be undertaken during 2018-19.

The most significant capital expenditure in the year was on the following items:

- £3.7m on modernising the acute inpatient facilities across two wards on the trust's Maidstone site. These will be fully completed during 2018-19
- £0.7m on smaller building and engineering projects to maintain the estate, including £250k on the on the Dartford site. This scheme will also complete during 2018-19
- £1m on information technology projects.

The trust disposed of two properties with a book value of £2.7m during the year. This part funded the trusts capital expenditure programme.

The trusts statutory duties

As an NHS trust, the trust has a number of statutory financial duties which are explained below.

Breakeven duty – (achieved)

Each NHS trust has a statutory duty to break-even taking one year with another, measured as the income and expenditure position adjusted for specific technical exclusions. This duty is formally measured over a three year period or a five year period if agreed with the Department of Health and Social Care. Year one of the three years will begin with the first accounting year from in which a cumulative deficit position greater than 0.5 per cent of turnover arises.

During 2017-18 the trust recorded a £1.2m deficit after technical adjustments. This resulted in a cumulative deficit of £0.6m, which is less than 0.5 per cent of turnover, and as such the breakeven duty has been met. Further detail is given in note 33 of the annual accounts.

Capital resource limit – (achieved)

The trust is expected to remain within its capital resource limit (a target on capital spending). During 2017-18 the trust underspent by £627k predominately due to a number of capital schemes being deferred until 2018-19. This was due to the late timing of the disposal of a building within 2017-18.

External financing limit – (achieved)

The trust is required to demonstrate that it manages its cash resources effectively by remaining within its external financing limit (a target on the amount of cash resource the trust can utilise). The trust met its target by undershooting against the limit by £4,513k. This was due to the underspend against the capital resource limit and the receipt of the property disposal on the last working day of the financial year.

Private finance initiative (PFI)

The use of private finance gives the trust more access to funding for capital developments than would otherwise be available. The trust has five PFI buildings that were built over a number of phases and were all part of the old Stone House Hospital re-provision. Details are provided in note 25.

Liquidity

The trust operates with very low levels of liquidity, which is acceptable under the current financial regime. Under the present arrangements, the majority of the trust's income is contracted to be received on the 15th of the month, which allows the trust to meet its main expenditure obligation (payroll) on the 24th of the month.

The trust has increased its cash holding to £5.1m as at the end of 2017-18 mainly due to the capital underspend and property disposal receipt. Given the overall pressure on the trust financial position cash management will remain a key focus during 2018-19.

In addition to the previous capital loan the trust took a revenue support loan from the Department of Health of £2.3m. As shown in note 19 of the accounts the amount outstanding on the two loans was £3.9m as at 31 March 2018.

Better payment practice code

The NHS Executive requires that trusts pay their non NHS trade creditors in accordance with the Confederation of British Industry (CBI) prompt payment code and Government Accounting Rules. The target is to pay at least 95 per cent of non NHS trade creditors within 30 days of receipt of goods or a valid invoice (whichever is the later) unless other payment terms have been agreed with the supplier.

The trust's payment policy is consistent with this requirement however due to the reduced liquidity during the year mainly as a result of the deficit; the level of compliance in 2017-18 was 91.7 per cent (based on volumes) and 98 per cent (based on values).

Further details of the trust adherence to the code can be found on at note 30 of the accounts.

Summary of financial risks

Summaries of the financial risks are outlined within the Annual Governance Statement on page 31.

Audit

The trust's external auditor is Grant Thornton. It conducted work during the year on audit services at a cost of £55k. This work included accounts, governance and performance work.

Provision of information to auditors

As far as the trust's directors are aware, there is no relevant information of which the trust's auditor is not aware and the directors have taken all reasonable steps that might properly be taken as directors to make themselves aware of any material audit information and to establish that the trust's auditor is aware of that information.

Going concern

International Accounting Standard 1 (IAS 1) requires the Directors to assess, as part of the preparation of the annual accounts, the trust's ability to continue as a going concern.

In accordance with the Department of Health's Group Accounting Manual, the accounts have been prepared on a going concern basis as the Directors do not intend, nor consider that it will be necessary, to apply to the Secretary of State for the dissolution of the trust without the transfer of the services to another entity, in the foreseeable future.

The trust's accounting policy regarding going concern (Note 1.1.2 to the accounts) contains further detail.

Looking forward to 2018-19

2018-19 will be an extremely challenging year financially for the trust. The trust has set a deficit plan of £1.9m, before technical adjustments, which includes receipt of £1.5m sustainability and transformation funding during 2018-19. To deliver this plan the trust will need to deliver a recurrent cost improvement programme of £6.7m (4 per cent). Additional efficiencies will need to be found to address the underlying deficit of £6.7m. The table below sets out the trusts financial plan for the year.

	Plan 2018-19
Income expenditure	180,735 (177,241)
OPERATING SURPLUS/ (DEFICIT) Finance cost PDC dividends	**3,494** (1,673) (3,744)
SURPLUS/(DEFICIT)	**(1,923)**
Depreciation on donated assets	94
SURPLUS/(DEFICIT) ON A CONTROL TOTAL BASIS	**(1,829)**
Control total	(1,829)
Performance against control total	**0**

The key movements from 2017-18 to 2018-19 are as follows:

- Recruitment to a number of key vacancies, some of which have not been covered by temporary staffing (£1.8m), removal of non recurrent incentive and bonus sustainability and transformation funding (£1.4m)
- 1 per cent contingency £1.8m as per national planning guidance
- Impact of inflation and growth £3.3m
- Full year effect and new emerging cost pressures £2m
- 2018-19 cost improvement programme (£6.7m).

The trust is planning a capital expenditure programme of £10.2m for the financial year. This consists of the following:

- The completion of the MBU (£1.25m)
- The completion of the Modernising Acute Inpatient Facilities – Boughton and Chartwell Wards (£0.4m)
- Samphire Ward £2m
- IM&T schemes £1.2m
- Modernising Acute Inpatient Facilities – Willow Suite £2.5m
- Other capital maintenance and minor schemes £2.8m.

The trust's accounts for 2017-18 have been examined by our external auditor, Grant Thornton, and their report is set out on page 51.

Review of performance

Our performance is monitored via its Integrated Quality and Performance Report (IQPR) which was reviewed in 2017-18 quarter 4 in preparation for a new report to be launched in 2018-19.

The report focuses on the measures outlined within the published Single Oversight Framework along with a range of other metrics designed to monitor trust and care group performance on a monthly basis. The new report covers a broader range of indicators with the aim of providing greater assurance of all elements of trust business. The report provides summary and, where appropriate, a more detailed breakdown of areas of under or over performance against these key agreed metrics along with details of actions in place and associated risks.

Initially the report will be available at trust level, with care group and team level monitoring to continue against the previous IQPR initially whilst the new report is embedded and expanded. This report provides a high degree of assurance to the board on performance against a balanced scorecard of regulatory, workforce, quality and finance performance targets. It provides the board with data visualisation, trend and trajectory analysis in order that board members understand which service areas are at risk of failing to meet targets in the future.

The use of an integrated approach to quality and performance is helping to ensure that a performance culture is implemented and embedded across care groups. Our performance management framework provides the overarching structure for provision of performance management information to care groups and the timeframes for performance review and action planning. It sets out the process that care groups will use to implement supportive actions for teams and individuals, and the process that will be followed where care group actions do not deliver the forecast improvement. These meetings combine review and challenge on care group progress with an opportunity to discuss issues of concern. This essentially leads to a from 'ward to board' oversight process where action plans are approved in advance of being reported to the board. More details about the IQPR can be obtained from the board papers online at www.kmpt.nhs.uk.

We have set out our performance against a number of our most significant KPIs in the following table. These KPIs are regularly reported to the board as part of the IQPR. Externally there is also a wide ranging set of performance metrics which are monitored by CCG commissioners through our performance review arrangements.

Ref.	Measure	Target	2017-18
1	**Regulatory targets**		
1.1	CPA patients receiving follow-up within 7 days of discharge	95%	94.7%
1.2	CPA patients receiving formal 12 month review	95%	90.1%
1.3	Delayed transfers of care	7.5%	7.6%
1.4	Admissions to inpatient services had access to CRHTs	95%	100.0%
1.5	Meeting commitment to serve new psychosis' cases by EIS 1	95%	127.4%
1.6	MHMDS data completeness: Identifiers	97%	99.7%
1.7	MHMDS data completeness: Outcomes for patients on CPA	50%	80.3%
1.8	EIP waiting time proxy (Referral to care coordinator in 2 weeks)	50%	79.1%

Sustainability

At KMPT, we are proud of our carbon reduction achievements. We have made great improvements through our Sustainable Development Management Plans – from renewable installations and behaviour change initiatives. As we look to the future, however, we are conscious that we are naturally reaching the end of the quick win opportunities and this is the time to challenge ourselves to tackle the difficult aspects of carbon reduction.

KMPT still continues to demonstrate its commitment to sustainability, reducing its carbon emissions and minimising its impact on the environment and climate change. According to our Sustainable Development Management Plan, there are compelling reasons to becoming a truly sustainable healthcare community:

- Financial gain – meeting government targets to avoid penalties, reducing costs and potentially generating income
- The opportunity to raise the trust's reputation as a socially responsible organisation; setting an example and seen to be actively supporting the wider community
- Healthy future - significant potential to make substantial contributions to the local population's physical and mental health. For instance reducing car use would result in decreased pollution with an associated reduction in respiratory diseases, fewer traffic accidents and a more active lifestyle helping to tackle obesity and reducing the risk of diabetes, heart disease and stroke as well as increasing a sense of mental well-being.

Sustainability continues to form an integral part of the trust core business. As the trust continues to reduce its carbon footprint, it is evident that corporate social responsibilities are taken seriously as well as recognising the importance of managing the environmental impact from its services and operations.

In promoting new and innovative projects, the trust will maintain a commitment to the NHS Carbon Reduction Strategy. The trust's progress is monitored through the Sustainable Development Management Plan. It sets out a strategy for emissions reductions and cost savings from those carbon emitting activities that KMPT can monitor and influence.

KMPT continues to make significant strides towards reducing its carbon emissions in line with its 34 per cent reduction on carbon utilisation by 2020 in accordance to the national NHS Carbon Reduction target.

By continuing to undertake the estate rationalisation programme, the trust will be ceasing to use a significant number of buildings. The decommissioning of these buildings has followed sustainability principles ensuring that where possible furniture and equipment is re-used within the trust.

Priorities and achievements

Building on objectives within our plan, we have achieved the following and there will

still be an ongoing focus on each area over the next year:

Energy

- Installation of Photovoltaic Panels across some of the estates ensuring that renewable energy will be utilised more widely
- Improved energy management across some parts of the estate through Building Management Systems. To facilitate active management and control of our energy consumption, including energy efficiency measures e.g. lighting and improved insulation and heating controls
- Where appropriate the potential for energy performance contracts to control costs and increase efficiency will be explored further.

Travel

- Success of Cycle to Work Scheme will enable active travel to be promoted more widely amongst NHS staff. This will contribute to the STP's obesity strategy, reduce the 5-10 per cent of deaths each year which are attributable to air pollution, and reduce sickness absences. For staff, the cycle purchase scheme and "Cycle to Work" schemes will be expanded as well as car and lift sharing schemes
- Travel plans in place for sites and an overall travel plan for the trust to be promoted more widely with specific initiatives such as car sharing.

Waste

- Working with waste management providers and the waste consortium to reduce the number of waste vehicle movements and waste going to landfill. Waste segregation schemes will be monitored and improved
- Other waste reduction, waste minimisation and recycling initiatives will be supported and expanded widely
- Public communications campaign will be conducted aimed at reducing waste, including medicines waste, will be conducted.

Procurement and commissioning

- Food sourced locally and sustainably where practicable to continue
- We will try to reduce the social and environmental impacts from the purchase, use and disposal of the products we procure. We will promote and maintain high standards of social, ethical and environmental conduct across our procurement activities and work with our suppliers to make sure they also adopt this approach.

Water

- There will be a further focus on leak reduction
- Promotion of water reduction behaviour change initiatives.

Infrastructure adaptation and buildings

- Continue to reduce backlog maintenance and operational risks
- Building management systems will be introduced and existing ones upgraded where necessary to ensure efficient control of building energy utilisation
- Estate rationalisation programmes will continue to drive a reduction in old and highly inefficient estate. The overall goal will be to make estate as energy efficient as possible.

Engagement and workforce development

- Green Champions programme

  Using existing programmes as a basis a network of green champions will be maintained and supported across the trust. Their role is to raise awareness of environmental issues within our working lives and to promote and maintain good housekeeping in our premises
- A bespoke behavioural change programme will be designed to

deliver a successful behavioural change programme to compliment the various initiatives established in 2015 in conjunction with the Energy Performance Contract. This program included the following:

- Information provided to staff and regularly updated via the intranet, it will focus on three key areas:
  - Educating and imparting knowledge and understanding of carbon reduction issues
  - Prompting voluntary collective action amongst staff and service users
  - Informing staff about carbon reducing initiatives introduced by the trust.

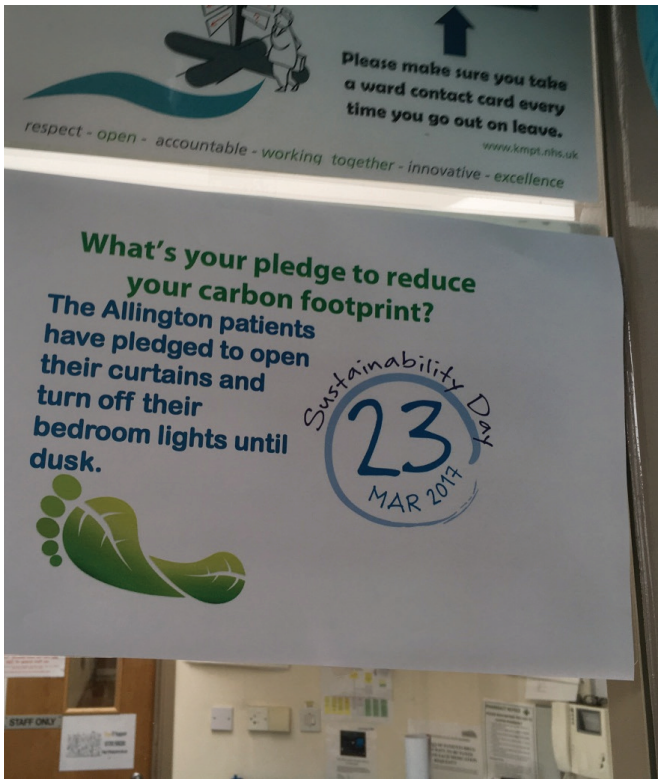
Innovation, technology and Research and Development

- Pull print services will be expanded and further promoted
- Video and teleconferencing facilities will be promoted further to reduce travel requirements.

Communication and awareness

Communication and awareness has been a major focus of the Sustainable Development Management Plan. A rolling programme of campaigns, concentrating on energy, green travel and waste and sustainable health and care system, are supported by a range of initiatives including workshops, posters, stickers, competitions, promotions.

The NHS Sustainability Day is a day for the celebration of the success currently in place within the NHS around sustainable development. It also provides an opportunity for staff, visitors and service users to understand how a better environment can improve their health. KMPT staff marked the day by having various awareness raising activities.



Forward planning

The trust continues to show some substantial growth on this agenda. More importantly over the coming year, we will be playing an important role as part of the STP process through building stronger links between sustainability and quality improvement as well as demonstrating the environmental, social and economic co-benefits of delivering new models of care through closely integrated services.

Our collaborative work with our partners will further enable us to create better outcomes for our communities and environment.

Helen Greatorex, Chief Executive

ACCOUNTABILITY REPORT

The directors' report

Our board of director's comprises the Chairman and seven non-executive directors (NEDS), and seven executive directors (EDs), all of whom are collectively responsible for our success. The Interim Director of Transformation and the Director of Workforce and Organisational Development are non-voting directors.

Executive directors are full-time employees and non-executive directors are appointed by the NHS Improvement. Executive directors manage the day-to-day running of KMPT and together with the Chairman and other non-executive directors they set our strategic direction and ensure its achievement of performance standards.

The board of directors bring a wide-range of experience and expertise to their stewardship of the trust and continues to demonstrate the vision, oversight and encouragement required to enable it to thrive.

During 2017-18 there were some changes to the composition of the board. Philip Cave, Executive Director of Finance, left KMPT in September 2017 and was replaced by Sheila Stenson.

Ivan McConnell Executive Director of Transformation and Commercial Development left in July 2017. Some elements of this post have been covered by Vincent Badu as Interim Director of Transformation.

Jacquie Mowbray-Gould joined KMPT as Chief Operating Officer in October 2017.

Chairman, Andrew Ling, was reappointed for a further two-year term in October 2017 and Vice Chair, Anne-Marie Dean, was reappointed for a further four years from November 2017.

Board membership 2017-18 – table 3

Non-executive directors	Executive directors
Andrew Ling	Helen Greatorex – Chief Executive
Anne-Marie Dean	Ivan McConnell – Executive Director of Transformation and Commercial Development*
Mark Bryant	Catherine Kinane – Executive Medical Director
Tom Phillips	Mary Mumvuri – Executive Director of Nursing and Quality
Rodney Ashurst	Philip Cave – Executive Director of Finance**
Jackie Craissati	Sandra Goatley – Director of Workforce and OD
Venu Branch	Vincent Badu – Interim Director of Transformation
Catherine Walker	Jacquie Mowbray-Gould - Chief Operating Officer***
	Sheila Stenson – Executive Director of Finance****

* Left July 2017
** Left September 2017
*** joined October 2017
**** joined the board November 2017

The Board

The board undertakes three key roles:

- Responsible for setting the strategic direction
- Responsible for formulating strategy, such as the clinical strategy
- Holds KMPT to account for the delivery of the strategy through seeking assurance that the systems of control are robust and reliable.

The general duties and responsibilities of the board are:

- To work in partnership with patients, carers, local health organisations, local government authorities and others to provide safe, accessible, effective and well governed services that meet the needs of patients, carers and KMPT's local population
- To ensure that KMPT meets the obligations of the population it serves, its stakeholders and staff in a way that is wholly consistent with public sector values, including the Nolan Principles of Public Life.

The board meets every other month and members of the public are welcome to attend these meetings. People who have experienced our services present to the board, enabling members to hear at first-hand how services work for users and carers, and areas of improvement.

Table 8 shows the attendance of every member of the board at board meetings held during 2017-18.

Director's attendance at board meetings 2017-18 – table 4

Non-executive directors 2017-18	Actual/possible
Andrew Ling	7/8
Mark Bryant	8/8
Tom Phillips	7/8
Anne-Marie Dean	7/8
Rodney Ashurst	6/8
Jackie Craisatti	8/8
Venu Branch	7/8
Catherine Walker	8/8

Executive directors 2017-18	Actual/possible
Helen Greatorex	8/8
Ivan McConnell	2/2
Catherine Kinane	7/8
Philip Cave	4/4
Mary Mumvuri	7/8
Sandra Goatley	8/8
Jacquie Mowbray-Gould	4/4
Sheila Stenson	4/4

Declarations of interests

We have an obligation under the Code of Conduct and Accountability for NHS boards to compile and maintain a register of interests of directors, which might influence their role. The register is available to the public, in accordance with the Freedom of Information Act. We are required to publish in this Annual Report the directorships of any member of the board in companies that are likely to, or seek to, conduct business with the NHS. Our register of interests is shown below:

Register of interests – table 5

Director	Position	Interest declared
Andrew Ling	Chairman	None declared
Anne-Marie Dean	Non-Executive Director	None declared
Mark Bryant	Non-Executive Director	Daughter works for Pembury Hospital as a midwife (Band 6). This is part of Maidstone and Tonbridge Wells NHS Trust.
Rodney Ashurst	Non-Executive Director	None declared
Tom Phillips	Non-Executive Director	None declared
Jackie Craissati	Non-Executive Director	Jackie's current company is on the NHS England framework for Independent Serous Incident Investigations. JC asked the board to note that a new Director of her company may be taking on an influential role in the South London Forensic New Model of Care implementation. This role was out with his role in her company and she assured the board that no conflict of interest would be created. JC is Trustee on the board of Samaritans.
Venu Branch	Non-Executive Director	None declared
Catherine Walker	Non-Executive Director	Health Education England (HEE) Lay Chair of the Consultant Appointments Committee at Kings College Hospital NHS Foundation Trust, London. Catherine works for Walkers Solicitors of which her husband, Ivan Walker, is the Principal. Walkers is an Employment law practice specialising in Pensions. Walkers acts for the majority of UK Trade Unions including a number of Trade Unions active in the Health sector. Walkers' Health sector Union clients are The Chartered Society of Physiotherapy, The Royal College of Midwives and the Prison Officers Association. (Walkers Solicitors do not act for the NHS but clients do negotiate with the NHS – declared to ensure full transparency.)
Helen Greatorex	Chief Executive Officer	Husband is Director of Talking Therapies and may compete for business in the trust's area.
Jacquie Mowbray-Gould	Chief Operating Officer	None declared
Sheila Stenson	Executive Director of Finance	None declared
Catherine Kinane	Executive Medical Director	Visiting Professor in the Faculty of Health and Wellbeing at Canterbury Christ Church University
Vincent Badu	Director of Transformation	None declared
Mary Mumvuri	Executive Director of Nursing and Quality	None declared
Sandra Goatley	Director of Workforce and OD	None declared

Performance appraisal

All board members are subject to annual appraisal to review performance against objectives and as members of a unitary board. The Chair is appraised by NHS Improvement in their capacity of oversight of non-executive board member appointments. KMPT has also appointed a senior independent director from among its non-executive members whose role includes assessing opinion on the Chair's performance. The Chairman appraises non-executive directors and the CEO appraises the executive directors. The Remuneration and Terms of Service Committee review all executive appraisals and agree the CEO appraisal based on the Chairman's assessment.

Non-executive directors

Andrew Ling, Chairman
BSc (Econ) – UCL, FCA

Andrew held a non-executive director position at Dartford and Gravesham NHS Trust since January 2008 and took up post at KMPT on 1 November 2011.

Andrew was appointed for his leadership skills and strategic experience and he will lead the trust in its quest to modernise and improve mental health services whilst achieving foundation trust status.

Andrew has a city background in finance and banking at Lloyds TSB Group where he held a variety of appointments including that of finance director of the Wholesale and International Banking Division from 1995-2004.

Andrew is also an economics graduate of University College London. He qualified as a Chartered Accountant with Price Waterhouse in 1978 where he spent the following 10 years. He is currently Finance Director for The Vintners' Company.

Mark Bryant
BA (Hons) Engineering, Cambridge University

Mark joined the board in October 2012. He was previously managing director for Accenture where he held a range of positions over 23 years and is now leading a cutting edge energy company. Mark has a range of management and commercial skills and experience of leading change. He is a non-executive director for two companies including an organic plantation in Brazil that has established a strong relationship in the local community, helping provide schooling for over 600 local children. Mark is Chair of the Finance and Performance Committee.

Tom Phillips
BSc (Hons) Physics, FCA (Fellow of Chartered Accountants)

Member of the Institute for Turnaround (MIFT)

Tom was appointed to the board in November 2012. Tom has previously held senior board roles as chief executive, chief operating officer and group finance director in commercial multi-site retail operations within the pharmacy and leisure sectors. Most notably, Tom spent 15 years as an executive board member of the Tote, a commercial organisation and also a statutory body. He is a non-executive director for two companies including an international language school charity. Tom is the Chair of the Integrated Audit and Risk Committee.

Rodney Ashurst
MBA Finance and Marketing, Diploma in French Studies

Rod joined the board in November 2012. Rod has a wealth of business experience, holding many senior and executive positions with BT plc over a 30 year period. He has a background in leading transformational programmes, commercial development and contract management. As part of his work at BT, Rod was seconded to Concert, an Anglo-American telecommunications joint venture, where he was based in Paris for five years, managing a team across about 12 countries. Rod is the Chair of the Remuneration and Terms of Service Committee, the Chair of the Workforce and OD Committee and Vice Chair of the Quality Committee.

Anne-Marie Dean
NHS Accelerated Management Development Programme, Kings Fund College Strategic Leadership Programme, Templeton College Oxford Global health challenges Judge Institute Cambridge.

Anne-Marie joined the board in November 2013. She has over 25 years' experience in the NHS, including roles as chief executive in the acute sector and director of strategy within a primary care trust, and brings extensive knowledge and experience in setting and delivering strategic agendas. She is currently Chairman of Healthwatch Havering, which is part of the Care Quality Commissions framework (CQC), is a Trustee of the charity One-in-Four and a volunteer with St. John's Ambulance. Anne Marie is Vice-Chair of the Workforce and OD Committee and a member of Finance and Performance Committee.

Dr Jackie Craissati MBE
Consultant Clinical and Forensic Psychologist

Jackie joined the board in May 2016. She is a Consultant Clinical and Forensic Psychologist and was previously Clinical Director of the Forensic and Prisons Directorate at Oxleas NHS Foundation Trust. Jackie has been a Trustee on the Board of Samaritans since 2014. After 26 years in the NHS, she left in January 2016 to set up her own not for profit community interest company - Psychological Approaches CIC - offering consultancy and training to those working with complex mental health and offending behaviour. Jackie retains a role as consultant advisor to the national offender personality disorder pathway, and ongoing academic links with the University of Nottingham and London. She has a special interest in developing innovative and evidence-based approaches to the community reintegration of individuals with complex psychological difficulties who may otherwise suffer social exclusion and poor outcomes.

Jackie is the Chair of the Quality Committee and a Vice Chair of the Integrated Audit and Risk Committee.

Venu Branch

Venu joined the board in August 2016 as an Associate Director and was appointed a Non-Executive Director in September 2016. Currently running a niche creative and organisational development consultancy, Venu's background is in director level posts in Non-Departmental Public Bodies within the public sector. These include the National Endowment for Science Technology and the Arts, Creative Scotland and the British Council. She has also worked

at executive director level in the charitable sector, including at Stonewall and the Nottingham Theatres Trust. Her public policy work includes, as the inaugural Chair of the East Midlands Cultural Consortium appointed by the Secretary of State to co-ordinate the 10 year cultural strategy for the region. She has been the Creative Director for the celebrations for Commonwealth Day in London and has been awarded the National Asian Woman of Achievement Award. Alongside her professional roles she has extensive board level experience this has included: Member of University College London's Museums and Heritage Committee; a Governor of Guildford Conservatoire and a Council Member of Loughborough University. She is currently a Fellow of the RSA; Co-Editor of the International Journal for Creativity and Human Development; and a Member of the European Cultural Parliament. She holds two visiting professorships, at Nottingham Trent University and the University of the West of Scotland. Venu is a member of both the Quality Committee and the Workforce & Organisational Development Committee. She is the Non-Executive Lead for 'Raising Concerns and Whistleblowing'.

Catherine Walker
Qualifications: MA Cantab (Law), Masters in European Law, Brussels.

Catherine Walker joined the board in August 2016 as an Associate Non-Executive Director until becoming permanent in December 2016. She is a member of the Finance and Performance Committee and the Integrated Audit and Risk Committee.

She qualified as a barrister and the majority of her early career was spent as an investment banker at NatWest and Schroders. She currently holds a judicial appointment with the Ministry of Justice hearing appeals on health and disability cases in Tribunal. She is Practice Director of a firm of solicitors and is on the Members Panel of the National Employment Savings Trust. She has an interest in educational standards and governance and held a long-term role as governor and director of an Academy Trust in Kent ranked outstanding by OFSTED. She is a Lay Representative for Health Education England involved in reviewing the quality of medical education in the London teaching hospitals.

Executive directors

Helen Greatorex
Chief Executive

Helen joined the trust in June 2016. She was Executive Director of Nursing and Quality at Sussex Partnership NHS Foundation Trust from 2002.

Her previous role was Executive Director of Nursing for West Sussex Health and Social Care NHS Trust. She started her career as a staff nurse at the Royal Free Hospital and has acquired significant experience of delivering high quality services over the years.

Professor Catherine Kinane
Executive Medical Director MB BCh BAO Dip Obs DCH MSc MRCGP MRCPsych Dip FMH. CCT GA and for Psychiatry

Appointed in March 2014, Catherine has worked in Kent mental health since 2004. Previously she worked in the independent sector. She trained in mental health in London hospitals and services, having trained as a General Practitioner in Ireland following graduation from University College Cork Medical School in 1987. A consultant psychiatrist by background, she is keen to further develop clinical leadership within the trust and foster innovation.

Philip Cave joined the trust as Executive Director of Finance in January 2015, he left in September 2017.

Ivan McConnell joined the trust in August 2013, he left in July 2017.

Sandra Goatley
Director of Workforce and OD Chartered Fellow CIPD

Sandra was appointed to the trust board as Director of Workforce and Organisational Development in March 2016. Sandra has worked for a number of organisations as HR and OD director covering both the private and public sector.

These include Amicus Horizon (social housing), Legal Services Commission (public sector) and the Morleys Stores Group (private sector). Whilst Sandra had not worked in the NHS previously she brings a wealth of HR and OD experience with a specific focus on employee engagement and change management.

Mary Mumvuri
Executive Director of Nursing and Quality
RMN, MSc Mental Health Studies, MSc Health Management

Mary started her career as a staff nurse in Lewisham and Guys Mental Health Trust. She has worked in senior nursing leadership roles, clinical governance and quality improvement across community and inpatient settings. Mary has extensive knowledge of mental health services having worked in a number of mental health and learning disability provider trusts in London and East of England. She joined KMPT from Cambridge and Peterborough Foundation Trust where she was the Deputy Director of Nursing and Quality.

Mary has a keen interest in quality improvement that is led by front line staff. Her strong values of fairness, transparency and equality have shaped her leadership style and she is passionate about ensuring that staff are developed, trained and supported to provide the best care possible.

Jacquie Mowbray-Gould
Chief Operating Officer

Jacquie trained as a mental health nurse in Newcastle, qualifying in 1991. Her previous position was with Devon Partnership NHS Trust, which provides a wide range of services to people with mental health and learning disability needs. Jacquie's first role there in 2011 was Managing Partner for the Older People's Service, however she was promoted to Deputy Chief Operating Officer after only 18 months. She left in November 2017 to join KMPT as Chief Operating Officer.

Sheila Stenson
Executive Director of Finance BA ACMA CGMA

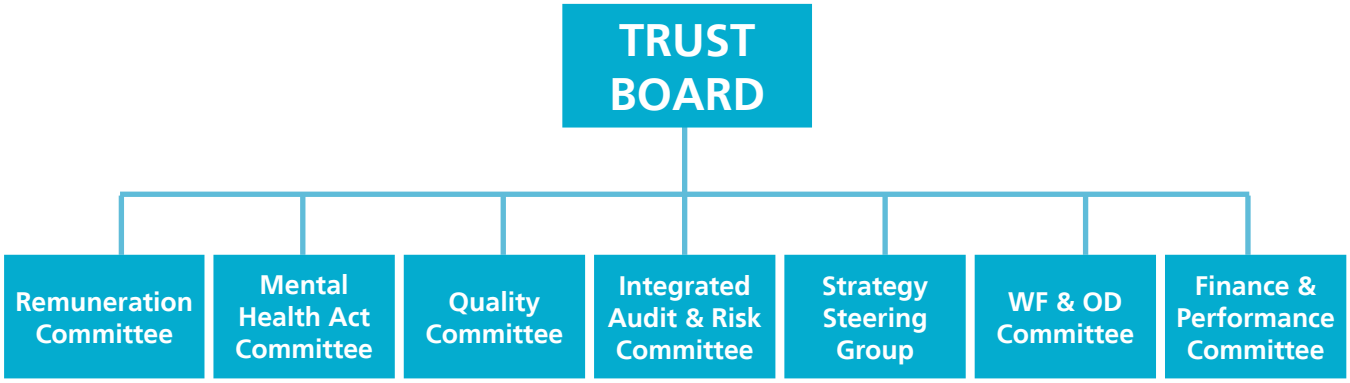
Sheila is an experienced senior finance professional who has fulfilled a variety of roles during her career in the NHS. She has a proven track record of working within financially challenged trust's and has worked for South London Healthcare NHS Trust (SLHT) Medway Foundation Trust (MFT) and most recently, Maidstone and Tunbridge Wells NHS Trust (MTW). She is a Chartered Management Accountant and has over fifteen years' experience in NHS Providers. She has led and been part of significant change in her NHS career, which includes service redesign, transformation, successful restructuring, implementing financial systems and governance and developing robust financial processes and controls. She joined KMPT from MTW where she was Deputy Director of Finance for Financial Performance and was awarded HFMA Deputy Director of Finance of the Year 2016.

Sheila graduated from the University of Sussex with a BA Honors Degree in Business Studies.

Board committees

The board has six permanent committees to support it in discharging its duties fully. In 2016-17 the board established a time-limited committee, the Strategy Steering Group, to oversee the development of the trust strategy and to ensure consistency with the Kent and Medway sustainability plans.

The chair of each committee presents a report at each formal board meeting. They also produce an annual report to board once a year which details the committees' activities.



A summary of each committee is detailed below:

Integrated Audit and Risk Committee

Audit is an essential element in the process of accountability for public money and makes an important contribution to the stewardship of public resources and the corporate governance of public services.

The Codes of Conduct and Accountability and the Integrated Governance Manual set out the requirement for every NHS board to establish an Audit Committee.

That requirement reflects established best practice in the private and public sectors and the constant principle that the existence of an independent Audit Committee is a central means by which a board ensures effective internal control arrangements are in place. In addition, the Audit Committee provides a form of independent check upon the executive arm of the board. The trust's Committee is the Integrated Audit and Risk Committee.

The Committee also sets the strategic direction for managing governance and risk and implementing a framework to ensure risk and governance issues are managed effectively throughout the organisation. It provides the board with a means of independent and objective review of financial and corporate governance, assurance processes and risk management across the whole of KMPT's activities. In addition the integrated audit and risk committee:

- provides assurance of independence for external and internal audit
- ensures that appropriate standards are set and compliance with them is monitored in non-financial, non-clinical areas that fall within the remit of the trust
- monitors corporate governance (e.g. compliance with the code of conduct, standing orders, standing financial instructions and maintenance of register of interests).

The Integrated Audit and Risk Committee met seven times during 2017-18. Attendance of two non-executive directors is required in order for the committee to be quorate. The committee was chaired by Tom Phillips for the duration of the 2017-18 periods. Jackie Craissati and Catherine Walker also sat on this committee. Mary Mumvuri is the executive lead for this committee alongside Sheila Stenson.

Integrated Audit and Risk Committee – table 6

Members	Actual/possible
Tom Phillips (Chair)	6/7
Jackie Craissati	6/7
Catherine Walker	6/7

Quality Committee

The committee obtains assurance on behalf of the board concerning all aspects of quality and safety relating to the provision of care and services, and that all patients have the best clinical outcomes and experience. In addition, the committee:

- Provides assurance to the board through consultation with the Integrated Audit and Risk Committee, that the structures, systems and processes are in place and functioning to support an environment for the provision and delivery of excellent quality health and social care services. This includes agreeing and monitoring the trust's Clinical Audit programme
- Assures the board that where there are risks and issues that may jeopardise the KMPT's ability to deliver excellent quality health and social care that these are being managed in a controlled and timely way
- Assures the board that KMPT is compliant with the Duty of Candour regulations
- The Quality Committee is monitoring the CQC Quality Improvement Plan following the CQC Comprehensive Inspection in January 2017.

The committee meets on a monthly basis and has two non-executive directors and two executive directors' members. The committee was chaired by Jackie Craissati. Rod Ashurst also sits on this committee, alongside Catherine Kinane and Mary Mumvuri (executive lead for quality). Two monthly meetings are held in workshop format with Care Group Medical and Quality leads attending.

Quality Committee – table 7

Members	Actual/possible
Jackie Craissati	9/9
Rodney Ashurst	6/9
Mary Mumvuri	8/9
Catherine Kinane	9/9

Finance and Performance Committee

The Finance and Performance Committee supports the board in its role with regard to finance and performance across the trust.

The committee enables the board to obtain assurance on all aspects of finance and resources relating to the provision of care and services, in support of ensuring the trust gets the best value for money and use of resources. This committee also:

- Assures the board, through consultation with the Integrated Audit and Risk Committee that structures, systems and processes are in place and functioning to support broad and long term Financial, IM&T and Estates Strategies and that it is managing its asset base efficiently and effectively.
- Assure the board that where there are risks and issues that may jeopardise the trust's performance in respect of its key financial performance targets that these are being managed in a controlled and timely way.

The committee meets on a monthly basis and is chaired by Mark Bryant for 2017-18. Catherine Walker is also a member of this meeting. The executive lead for the committee is Sheila Stenson and Jacquie Mowbray-Gould is also a member.

Finance and Performance Committee – table 8

Members	Actual/possible
Mark Bryant (Chair)	10/10
Catherine Walker	10/10
Sheila Stenson	4/4
Philip Cave	6/6
Jacquie Mowbray-Gould	4/4

Workforce and Organisational Development Committee

The role of the Workforce and Organisational Development Committee is to maintain a strategic overview of KMPT's workforce, educational and organisational arrangements of the trust, with a view to assessing their adequacy to provide a positive working environment for staff. This in turn enables the provision of high quality care and positive outcomes.

The committee meets on a bi-monthly basis. During 2017-18 the committee was chaired by Rod Ashurst. Venu Branch became a member of the committee when she joined in September. Sandra Goatley, is the lead director for this committee.

Workforce and Organisational Development Committee – table 9

Members	Actual/possible
Rodney Ashurst (Chair)	5/6
Venu Branch (Vice Chair)	5/6
Sandra Goatley	5/6

Remuneration Committee

The Remuneration Committee is responsible for ensuring there is a formal and transparent procedure for developing the policy and decision making framework for fixing the remuneration, terms of service and other benefits for senior management. In undertaking this role the committee will recommend and monitor the level and structure of remuneration for senior management not covered by agenda for change terms and conditions.

The Remuneration Committee consists of all the non-executive directors of the board and was chaired by Rod Ashurst Non-Executive Director. It meets at least annually and on an ad hoc basis as required. During 2017-18 the committee met twice.

Remuneration Committee – table 10

Members	Actual/possible
Rodney Ashurst (Chair)	2/2
Andrew Ling	1/2
Mark Bryant	2/2
Tom Phillips	1/2
Anne-Marie Dean	2/2
Jackie Craissati	2/2
Venu Branch	2/2
Catherine Walker	2/2

Strategy Steering Group – table 11

The Strategy Steering Group was set up in 2016 to oversee the development of the trust strategy and to ensure consistency with the Kent and Medway STP. The group is chaired by Vice Chair, Anne-Marie Dean. Tom Phillips is a member and the group is attended by the CEO, Medical Director and Director of Finance.

Members	Actual/possible
Anne-Marie Dean	5/5
Tom Phillips	4/5
Helen Greatorex	5/5
Catherine Kinane	2/2
Sheila Stenson	2/2

Mental Health Act Committee

The board agreed in March 2017 to establish a permanent committee to act as a focus for Mental Health Act activities and governance across KMPT. In 2017-18 the Committee was chaired by Jackie Craissati. Mary Mumvuri is the executive lead. The committee met four times in 2017-18.

Members	Actual/possible
Jackie Craissati	4/4
Mary Mumvuri	4/4

Annual governance statement

Scope of responsibility

As Accountable Officer, I hold responsibility for maintaining a sound system of internal control that supports the achievement of the organisation's policies, aims and objectives, whilst safeguarding the public funds and departmental assets for which I am personally responsible, in accordance with the responsibilities assigned to me. I am also responsible for ensuring that KMPT is administered prudently and economically and that resources are applied efficiently and effectively.

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 KMPT, to evaluate the likelihood of those risks being realised, the impact should they be realised and to manage them efficiently, effectively and economically. The system of internal control has been in place in KMPT for the year ended 31 March 2018 and up to the date of approval of the annual report and accounts.

Kent and Medway NHS and Social Care Partnership Trust (KMPT) serves a population of over 1.7 million and provides mental health, learning disability, substance misuse and other specialist services for people over the age of 16 who live in Kent and Medway. Our Early Intervention in Psychosis Services see young people from 14 years upwards. This is managed in four Care Groups: Acute, Community Recovery, Older Adult Services and Forensics and Specialist Services, all supported by a range of corporate teams.

As Accountable Officer I have in place partnerships and processes with other organisations. These include Clinical Commissioning Groups (CCGs), NHS Improvement (NHSI), the Local Authorities, Healthwatch, the Department of Health and other acute and mental health trusts. Some of the main fora for the transaction of these relationships are:

- Quarterly South of England NHS Chief Executives' Forum
- Regular Integrated Assurance Meetings (IAMs) with NHSI
- Performance Review Meetings with the CCGs
- Meetings with the Local Authorities through the Kent and Medway Partnership Board, Kent County Council Health Overview and Scrutiny Committee, Medway Council Overview and Scrutiny Committee, Kent Adult Services Group and a range of joint Planning Boards
- Regular meetings with the Accountable Officers of local CCGs and universities including the Kent, Surrey, Sussex Deanery.
- Sustainable Transformation Partnership Steering and Management Groups.

Capacity to handle risk

The trust board takes overarching responsibility for risk management. As Accountable Officer I ensure that sufficient resources are invested in managing risk and I have been supported in undertaking this role by the Executive Director of Finance and Performance and the Executive Director of Nursing and Quality.

The Executive Director of Nursing and Quality is the executive lead for clinical governance and the implementation of risk management. She ensures that the trust continues to have robust systems in place to comply with the objectives set out in its approved policies and procedures.

The Executive Medical Director is Responsible Officer for medical revalidation for the trust. These executive directors have a key role in the

development of quality standards across the trust and for maintaining effective integrated clinical governance.

The Executive Director of Finance and Performance has a specific role for leading strategic development and implementation of financial risk management (including anti-fraud and bribery), which includes oversight of the Standing Financial Instructions. The Executive Director of Finance is also the Senior Information Risk Officer and, as Chair of the Information Governance Group, is responsible for developing and implementing information risk management.

The non-executive committee members of the Integrated Audit and Risk Committee (IARC) play a key role in the internal control assurance processes. IARC scrutinising the effectiveness of management actions in mitigating risks through regular reviews of the corporate functions and Care Group risk registers, on a rolling basis in addition to the trust risk register. Board committees also have a responsibility for elements of the risk management system, with the Integrated Audit and Risk Committee providing assurance on its effectiveness.

Chaired by the Chief Executive, the Executive Assurance Committee (EAC) meets each month and ensures that KMPT maintains robust systems of governance, risk management and internal control that support the delivery of high quality patient-centred care.

KMPT recognises the important role all leaders across the trust have in developing a robust approach to risk management and ensuring it forms an integral part of good management practice and to be most effective should become part of the trust's culture. The provision of appropriate training is central to the achievement of this aim.

The trust's Risk Management Strategy provides the framework for the continued development and integration of the risk management process in the trust's strategic aims and objectives. It encompasses our risk management process and sets out how staff are supported and trained to enable them to identify, evaluate and manage risk.

Training on clinical risk management is included in the mandatory induction programme which all clinical staff participate in at the start of their employment with the trust. In 2017-18 managers and their nominated risk assessors were offered tailored further training on the principles and application of risk assessment and the tools used by the trust to identify, record, monitor and review risk.

The trust provides mandatory and statutory training that all staff are required to attend in addition to specific training appropriate to individual responsibilities, such as prevention and management of violence and aggression.

The trust seeks to learn from good practice through a range of mechanisms including benchmarking, clinical supervision and reflective practice, individual and peer reviews, performance management, continuing professional development, clinical audit, the application of evidenced based practice and reviewing compliance with risk management standards. There are formal mechanisms in place to ensure that external changes to best practice, such as those issued by the National Institute for Health and Clinical Excellence are incorporated in to trust policies and procedures.

The risk and control framework

The trust's Risk Management Strategy provides the framework for the continued development of the risk management process, building on the principles and plans linked to the trust's Assurance Framework, the Risk Register, the requirements of the Care Quality Commission and national priorities.

Progress was achieved in the year to mitigate key risks relating to the principal objectives of the trust. The risks identified as having the potential to have the greatest impact on the strategic objectives in 2017-18 were:

Financial overspend

The trust met and exceeded the Control Total planned deficit as agreed with NHSI. As a result of positive year end performance, NHSI allocated the trust a further allocation of £1.4m from the Sustainability and Transformation Fund which reduced the reported year end deficit to £1.2m (£5.0m before technical adjustments). The technical adjustments excluded from the performance against the control total are £3.7m of property plant and equipment impairments, and £0.1m of depreciation on previous donated assets. However being in a planned deficit position puts significant pressure on the organisation, a comprehensive action plan is in place to address this and the trust has proved it has the capacity to deliver against the plan.

New Care Models (Secure Services)

This risk reflects the changing landscape of service provision and is likely to have a significant impact on the trust's delivery of current care pathways in the Secure Care Group. There is a potential financial risk which relates to the trust income baseline with NHSE. The trust is actively involved in discussions with the NCM and separately with NHSE regarding the contract baseline. A clear governance process has been established for the NCM. The Director of Finance is the Executive lead and attends the NCM Board and Finance sub group. The trust's activity participation in the activity modelling group provides additional mitigation against this risk.

The trust has in place a process for the identification, assessment, and management of risks. This is a systematic approach which assesses the consequences and likelihood of each risk event, associated mitigations and allows for the identification of risks which could be considered unacceptable to the organisation. Areas of risk are triangulated using indicators including incidents, claims and performance metrics.

Risk registers owned by and or delegated to the Committees of the Board are regularly reviewed to ensure that the correct types and levels of risks are scrutinised for the maximum benefit to the organisation. Robust control mechanisms are in place, based upon the trust's organisational policies, protocols, strategies and procedures used to control, mitigate and monitor risk. Additional assurances are gained from the trust's organisational scheme of delegation which details who has oversight of risk via the Committee structure, trust-wide groups and sub-groups. Prevention of risk is achieved through the interface partnership working arrangements across the local health economy and in our joint commissioning arrangements.

The Local Counter Fraud Team provided by TIAA support the trust in the prevention, detection and investigation of alleged incidents of fraud, bribery and corruption. They have undertaken awareness training to all new starters at corporate induction and run publicity campaigns to highlight fraud in the NHS. They also advertise the Confidential National Fraud and Corruption Reporting Line through poster distribution, fraud staffzone page, promotional material and newsletter articles. The newsletter 'Fraudstop!' is circulated to all staff and distributed at the trust induction. The trust has a newly revised Counter Fraud Policy.

The risk and control framework incorporates a range of supporting systems and associated policies that provide a structured and consistent approach to the management of risk.

These include:

- Risk Management Strategy
- Risk Management Policy (and

associated guidance)

- Information Risk Management Framework and Policy
- Incident Reporting Policy
- Complaints Policy
- Serious Incidents Policy
- Investigations Policy
- Health and Safety Policy
- Learning from Experience Policy
- The bi-annual review of the Board Assurance Framework by the Integrated Audit and Risk Committee.

Staff are kept up to date with the key corporate and health and safety risks for their areas through a range of media including posters, team meetings and briefings, enabling them to identify and report any new issues. The risk team work closely with Care Groups to improve the quality and maintenance of their risk registers.

All risks are assigned an owner as well as a manager when they are identified. Committees of the board have oversight of a portfolio of risks relevant to them and receive regular reports for assurance. Where possible, risks are eliminated and where this is not possible, a selection of controls and actions are put in place to ensure that the likelihood or consequence of the risk being realised is lessened.

The use of a control calibration tool to ensure that all risks are graded appropriately and that the types and effectiveness of controls taken into account has had a positive impact in improving risk management and awareness. All risks are given a performance metric with measurable outcomes that show whether the controls are working.

The Board Assurance Framework document is refreshed annually at the beginning of each financial year and is reviewed at regular intervals. Its key elements include:

- Board agreed organisational objectives and identification of the principal risks that may threaten the achievement of these objectives
- Identifying the design of key controls intended to manage these principal risks
- Setting out the arrangements for obtaining assurance on the effectiveness of key controls across all areas of principal risk
- Identifying assurances and areas where there are gaps in controls and assurances
- Putting in place plans to take corrective action where gaps have been identified in relation to principal risks
- Maintaining dynamic risk management arrangements including a well founded risk register.

Based on my assessment of the Board Assurance Framework our three key priorities in its development will continue to be implemented in 2018-19 in order to enhance the internal control arrangements. The implementation of these objectives will further strengthen the board's visibility of the process of monitoring risk mitigation plans associated with its significant risks and as highlighted on the BAF. These priorities are to:

- Improve the organisations understanding of the process of risk management by demonstrating an improved quality of risk assessment, risk registers and control mechanisms.
- Improve the confidence of external stakeholders in our risk management process by enabling staff and managers to talk confidently about their risk profile by describing their risks and mitigations
- Establish a clear appetite for risk that can be used at all levels by management as a decision making tool.

The board will oversee the implementation of these priorities, whilst primarily taking assurance from the work of the board committees.

Risk management and internal control

The Risk Management Framework is supported by the processes in place to identify, assess, treat and monitor risks that materialise in clinical and corporate areas of the trust. The trust has established processes for managing risks that impact on the quality and safety of information, staff and patients.

As part of my review I also place reliance on the Head of Internal Audit's independent opinion of reasonable assurance, which substantiates this disclosure.

Head of Internal Audit Opinion (HoIA) on the Effectiveness of the System of Internal Control for the Year Ended 31 March 2018

The purpose of my annual HoIA Opinion is to contribute to the assurances available to the Accountable Officer and the board which underpin the board's own assessment of the effectiveness of the organisation's system of internal control. This Opinion will in turn assist the board in the completion of its Annual Governance Statement (AGS).

We note that the trust is forecasting a control total of £1.2m deficit for the year. Our opinion on the organisation's system of internal control has taken this factor into account.

My opinion is set out as follows:

1. Overall opinion;
2. Basis for the opinion; and
3. Commentary.

1. My overall opinion is that, except for the trust's ability to deliver their planned financial control total, **reasonable assurance** can be given that there is a generally sound system of internal control, designed to meet the organisation's objectives, and that controls are generally being applied consistently. However, some weakness in the design and/or inconsistent application of controls, put the achievement of particular objectives at risk.
2. The basis for forming my opinion is as follows:
   i. An assessment of the design and operation of the underpinning Assurance Framework and supporting processes; and
   ii. An assessment of the range of individual opinions arising from risk-based audit assignments, contained within internal audit risk-based plans that have been reported throughout the year. This assessment has taken account of the relative materiality of these areas and management's progress in respect of addressing control weaknesses.Additional areas of work that may support the opinion will be determined locally but are not required for Department of Health purposes e.g. any reliance that is being placed upon Third Party Assurances.

Additional areas of work that may support the opinion will be determined locally but are not required for Department of Health purposes e.g. any reliance that is being placed upon Third Party Assurances.

The Care Quality Commission and the fundamental standards

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

The trust has systems and procedures in place to maintain ongoing compliance with the CQC fundamental standards (Health and Social Care Act 2008), for the purpose of monitoring and continually improving the quality of healthcare provided to its patients.

The CQC carried out a second comprehensive inspection of KMPT in January 2017 and rated the trust as Good overall.

Eight out of ten of the trust's core services were rated as either Good or Outstanding.

A quality improvement plan was put in place for the two areas identified as Requires Improvement. The progress made with the implementation of this place was monitored on a quarterly basis by the trust's CQC Oversight Group and the Quality Committee.

The CQC Oversight Group is responsible for ensuring that trust services meet the required fundamental standards. This is led by the Executive Director of Nursing and Quality. This group now meets on a monthly basis and reports direct to the Quality Committee. This group is supporting the preparations for the CQC well-led inspection which is likely to take place in the later part of 2018. As part of the preparations, deep dives will be used to scrutinise the quality of care provided across all care groups and various support tools will be available for staff to utilise such as a self-assessment tool for the CQC's Key Lines of Enquiry (KLoE).

At the end of January 2018, the CQC conducted an unannounced focussed inspection of three Adult Community Mental Health Teams (CMHTs). Following the inspection visits the trust was issued with a Warning Notice for Regulation 12, Safe Care and Treatment and Regulation 17 Good Governance.

In relation to Regulation 12, the CQC found CMHTs were not providing care in a safe way that would prevent avoidable harm or risk of harm for patients. Staff working in these services were not consistently completing risk assessments, mitigating risks or working with others where responsibility for care was shared or transferred.

The CQC also found a governance structure that did not meet the requirements of Regulation 17. The structure did not allow concerns to be identified and acted upon so that services could be improved. Staff had not followed or monitored compliance with trust policies and procedures and there was a lack of oversight, audit and assessment of services.

In response to the CQC's feedback, immediate remedial action was initiated and continues.

Data security

The Executive Director of Finance is the Senior Information Risk Owner (SIRO) of the organisation, providing information risk management expertise at Board level. The SIRO oversees the consistent implementation of the information risk assessment process by Information Asset Owners, as described in the relevant ICT policies and procedures.

The Information Governance Toolkit and Information Risk Register are key enablers to embedding good practice, as well as identifying and managing key information risks. The Information Governance Department have put into place a range of appropriate policies, procedures and management arrangements to provide a robust framework for information Governance in accordance with the NHS Digital requirements.

During 2017-18, seven information governance breaches were reported to the Information Commissioner in line with national reporting requirements.

The trust was audited in February 2018 by its internal auditor, TIAA and given 'Substantial Assurance' for information governance management practices in relation to the toolkit. TIAA conducted an annual information governance audit which involved a detailed review of 15 of the 45 IGT initiatives and a trust-wide staff awareness survey. This year TIAA examined areas which have previously been considered high risk, including:

- Information governance training
- Asset management
- Legislation compliance
- Data quality management and auditing

The results of the survey will be used to inform and shape information governance training and awareness material as part of a new information governance awareness campaign.

My assessment of the information governance arrangements of the trust is informed by evidence to support the level 2 declaration on the 2017-18 information governance toolkit as well as the information governance assurance from the internal audit review, undertaken in the financial year. The trust anticipates successfully achieving level 2 in all 45 elements of the information governance toolkit and will therefore be rated as satisfactory.

In making this assessment I have also taken into account advice from the trust-wide Information Governance Group, the Caldicott Guardian, internal audit and external auditors and reviewed associated evidence of compliance. The role of Caldicott Guardian transferred to the Executive Medical Director. In addition, the roles of Chief Clinical Information Officer and Clinical Safety Officer (for IT System projects) were also taken by the Medical Director.

Significant issues – information governance serious incidents

The trust has identified the following as significant control issues for the 2017-18 period.

During the 2017/18 period there were seven information governance serious incidents regarding the loss or misappropriation of personal information. Lessons learned from the incident have been incorporated into the risk management process.

Incident 1

Trust equipment and paperwork was stolen from a staff member's car which resulted in the permanent loss of clinical information relating to a limited number of service users. The incident was reported to the Information Commissioners Office (ICO) and has been investigated. As a result of these investigations, and in line with the ICO's advice staff training, and policies have been updated and new systems introduced to mitigate future risks.

Incident 2

A number of emails containing clinical information were sent via an unsecured route, resulting in a near miss incident. This matter was reported to the ICO and has been investigated. Internal action has been taken against the individual involved, and policies updated in line with the ICO's advice.

Incident 3

A member of staff inappropriately accessed the clinical record of a service user for personal reasons. The incident has been reported to the ICO and is currently being investigated.. Upon completion of the internal investigation, a lessons learnt report will be produced and actions taken in line with ICO advice.

Incident 4

An administration apprentice inappropriately accessed the clinical records of a number of service users for personal reasons. This incident has been internally investigated, and all service users involved have been advised. The matter has also been reported to the ICO who are considering further criminal action against the individual involved. Based on lessons learnt, and current advice from the ICO an action plan has been put in place to improve security of information.

Incident 5

As part of a criminal investigation it was determined that a member of staff had accessed a number of clinical records for personal gain. This incident has been reported to the ICO, who have investigated and determined that the criminal investigation will take priority and have closed their case accordingly.

Incident 6

A member of staff inappropriately accessed the clinical record of a service user for personal reasons. The incident has been reported to the ICO and is currently being investigated by the trust. Upon completion of internal investigations, a lessons learnt report will be produced and actions taken in line with ICO advice.

Incident 7

An administration apprentice inappropriately accessed the clinical records of a number of service users for personal reasons. This incident has been internally investigated, and all service users involved have been advised. The matter has also been reported to the ICO who are currently investigating. Upon completion of ICO investigations further action may be taken in line with ICO advice.

The Pension Scheme arrangements

As an employer with staff entitled to membership of the NHS pension scheme, or auto-enrol into an alternative qualifying 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.

Equality, diversity and human rights

Control measures are in place to ensure that the organisation is compliant with its obligations under equality, diversity and inclusion plus human rights legislation. This includes provision of information to service users and staff that meets the statutory publication duties and best practice on inclusion initiatives.

The Workforce and Organisational Development Committee have received compliance assurance on a bi-monthly basis through a regular review of the workforce reports. The Quality Committee will monitor service user/carer impacting equality and diversity issues. The operational Equality and Diversity Steering Group and staff networks feed into the KMPT strategy. Plans are in place to meet the gender reporting and disability standards reporting requirements.

Counter fraud and anti bribery arrangements

KMPT has sound arrangements in place to ensure compliance with counter fraud and anti-bribery requirements, as set out in the Secretary of State directions. At an operational level, there are induction and refresher fraud and bribery awareness sessions for staff.

The Integrated Audit and Risk Committee receives regular progress reports on the delivery of the Local Counter Fraud Service (LCFS) work plan and investigative reports where appropriate. In addition, the Committee reviews anti-fraud and bribery trust policies and procedures.

The LCFS undertakes an annual review of fraud risk, feeding into a fraud risk assessment which drives the annual LCFS work plan. The Integrated Audit and Risk Committee takes assurance from this particular area of work, which ensures organisational objectives and investigative activities are appropriately investigated and concluded in a timely way to minimise potential future risks within the trust's systems of internal control.

In addition during 2017-18 2016-17 the recruitment procedures in relation to staff procured through agencies were reviewed to ensure third party checks on individuals are in line with KMPT policy. local procedures were reviewed with regard to single tender waivers and the use of corporate credit cards. Results were fed back to the Audit Committee who were able to benchmark local performance against other NHS providers.

Sustainability

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

The trust has a board-approved sustainable development management plan (SDMP) and continues to work towards reducing required energy consumption.

The trust continues to work with partners across Kent and Medway in developing areas of best practice, environmental training, and seminars on new technologies in order to actively explore new initiatives in reducing the carbon footprint, and employs the lead officer on sustainability in the STP process.

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

The trust ensures economy, efficiency and effectiveness through a variety of means including:

- A robust pay and non pay budget control system
- Financial and establishment controls
- Effective tendering procedures
- Continuous programme of quality and cost improvement

The board performs an integral role in maintaining the system of internal control, supported by the work of its committees, internal and external audit and its regulators.

Annual Quality Account

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

In preparing the Quality Accounts we have endeavoured to ensure that all information and data is accurate and provides a fair and balanced reflection of our performance this year. Our Board and Executive Management Team have sought to take all reasonable steps and exercise appropriate due diligence to ensure the accuracy of the data reported. The trust has reviewed all the data available to it on the quality of care in all of the NHS services it provides.

The quality governance framework and the data quality controls ensure the performance information reported in the Quality Account is reliable and accurate.

Assurance is provided by the robust internal controls over the collection and reporting of the measures of performance included in the Quality Account, and these controls are subject to audit and review to confirm that they are working effectively in practice.

The data underpinning the measures of performance reported in the Quality Account has been reviewed and tested to ensure it is robust and reliable, conforms to specified data quality standards and prescribed definitions. The Quality Account has been prepared in accordance with Department of Health guidance and subject to external audit.

Review of effectiveness

As Accountable Officer, I hold 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 KMPT who have responsibility for the development and maintenance of the internal control framework. I have drawn on the information provided in this annual report and other performance information available to me. My review is also informed by comments made by the external auditors in their management letter and other reports. I have been advised on the implications of the result of my review of the effectiveness of the system of internal control by the Board, the Audit and Integrated Risk Committee, Quality Committee, and a plan to address any weaknesses and ensure continuous improvement of the system is in place.

The board has an established process in place to undertake a formal and rigorous annual evaluation of its own performance and that of its committees.

The board internally evaluated itself against the CQC Well Led framework in February 2018 and the board development plan updated and developed. The implementation will be monitored directly by the board.

The board carries out its roles and responsibilities with the aid of a structured and focussed annual cycle of business, which takes into account the setting of strategy and the monitoring of key risks, performance, governance and quality issues. Service user and carer engagement is embedded within the annual cycle of business and presentations are invited at each formal board meeting.

The trust has put in place arrangements to meet the Fit and Proper Person requirement. These have been incorporated in recruitment procedure and in Annual Governance Declarations. All current board members have confirmed they meet the requirements to serve on the board of a healthcare organisation.

Board attendance for the 2017-18 period averaged a rate of 93 per cent. Formal board meetings were held monthly. Where appropriate, the board have also held informal meetings and Board seminars regularly throughout the year. In addition, a programme of facilitated development and strategy days are held throughout the year.

The board committee structure continues to be embedded within the trust. This continues to be enhanced by non-executive director chairmanship and board reporting arrangements. This arrangement has enabled the board to focus on its core business. The committees provide a formal report to the board after each of their meetings highlighting key issues and to receive feedback, which is reported at the next meeting of that board committee. This ensures timely monitoring of areas of responsibility delegated by the board to the committees through receipt of Chair assurance reports and minutes.

Conclusion

I have been advised on the implications of the result of my review of the effectiveness of the system of internal control by the trust board which is supported by:

- The Integrated Audit and Risk Committee which considers the annual plans and reports of External and Internal Audit
- The Quality Committee which ensures that comprehensive and robust systems and processes are in place for clinical governance and quality within the trust
- The executive management team which oversees the implementation of the strategic direction of the trust.

- The 2017-18 Quality Account disclosure and associated internal and external assurances in place to validate its accuracy, which include data quality verification, and associated board declaration and external audit review

In addition, the Head of Internal Audit has a mechanism for identifying and recording in Internal Audit reports gaps in controls that need to be addressed. Action plans have been agreed with senior managers and further details are recorded in the Internal Audit progress reports presented to the Integrated Audit and Risk Committee at each meeting.

The trust is reliant upon information system controls operated by third parties under contracts negotiated by the Department of Health and under which the trust has no contractual or other influence over the managed service providers. For the ESR Payroll and HR system, the Department of Health has put in place arrangements under which the trust received formal assurances about the effectiveness of internal controls.

My review confirms that Kent and Medway NHS and Social Care Partnership trust has a generally sound system of internal control that supports the achievement of its policies, aims and objectives.

On behalf of the trust board.

Helen Greatorex
Chief Executive Date: 23 May 2018

Statement of the chief executive's responsibilities as the accountable officer of the trust

The Chief Executive of NHS Improvement, in exercise of powers conferred on the NHS Trust Development Authority, has designated that the Chief Executive should be the Accountable Officer of the trust. The relevant responsibilities of Accountable Officers are set out in the NHS Trust Accountable Officer Memorandum. These include ensuring that:

- there are effective management systems in place to safeguard public funds and assets and assist in the implementation of corporate governance;
- value for money is achieved from the resources available to the trust;
- the expenditure and income of the trust has been applied to the purposes intended by Parliament and conform to the authorities which govern them;
- effective and sound financial management systems are in place; and
- annual statutory accounts are prepared in a format directed by the Secretary of State to give a true and fair view of the state of affairs as at the end of the financial year and the income and expenditure, recognised gains and losses and cash flows for the year.

To the best of my knowledge and belief, I have properly discharged the responsibilities set out in my letter of appointment as an Accountable Officer.

Helen Greatorex, Chief Executive

Date: 24 May 2018

Staff and remuneration

1. Nominations and Remuneration Committee

The Remuneration Committee is responsible for ensuring there is a formal and transparent procedure for developing the policy and decision making framework for fixing the remuneration, terms of service and other benefits for senior management. In undertaking this role the committee will recommend and monitor the level and structure of remuneration for senior management not covered by Agenda for Change terms and conditions. Further details of the committee can be found within the directors' report section of this document.

2. Executive Remuneration policy

The main duties of the committee are to discuss and advise the board on appropriate remuneration and terms of service for the Chief Executive, other executive directors and other senior employees particularly covering the following:

- All aspects of salary (including any bonuses), taking independent advice where appropriate and considering current benchmarking data for VSM roles of similar size and complexity to ensure the remuneration can be justified
- Provisions for other benefits, e.g. lease cars, relocation package and any enhancement of non-pay benefits such as annual leave
- Oversight of executive directors job descriptions
- Oversight and scrutiny of the appointment of interim executives
- Directors, ensuring HM Treasury (HMT) and NHS Improvement (NHSI) guidance is adhered to regarding seeking assurance on tax affairs
- Monitoring and evaluating performance, including receiving and reviewing the appraisal of the Chief Executive, conducted by the Chairman, and the appraisal of executive directors, carried out by the Chief Executive
- Ensure that a robust and effective process is in place to discharge the requirements of the Fit and Proper Persons Test for all existing and future director, or equivalent senior appointments, whether temporary or substantive
- Arrangements for termination of employment and other contractual terms
- Consideration of National guidance.

The Nominations and Remuneration Committee reviews salaries each year. In 2017-18 the committee decided that a 1 per cent pay award was appropriate. This is in line with overall increases in the NHS.

The only non-cash elements of executive remuneration packages are pension-related benefits accrued under the NHS Pensions Scheme. Contributions are made by both the employer and employee in accordance with the rules of the national scheme, which applies to all NHS staff in the scheme.

Each executive director has annual objectives, which are agreed with the Chief Executive. The trust's normal disciplinary policies apply to senior managers, including the sanction of summary dismissal for gross misconduct. Our redundancy policy is consistent with NHS redundancy terms for all staff.

3. Salary and pension entitlements of senior managers

a) Remuneration

Salary table – audited

	2017-18				2016-17			
Name and title	Salary (bands of £5k)	Expense payments (taxable) to nearest £100	All pension related benefits (bands of £2.5k)**	TOTAL (bands of £5k)	Salary (bands of £5k)	Expense payments (taxable) to near-est £100	All pension related benefits (bands of £2.5k)**	TOTAL (bands of £5k)
	£000	£00	£000	£000	£000	£00	£000	£000
Helen Greatorex - Chief Executive Officer	145-150	19	70-72.5	220-225	120-125	3	22.5-25	140-145
Philip Cave - Deputy Chief Executive / Executive Director of Finance	65-70	17	10-12.5	80-85	120-125	2	30-32.5	150-155
Catherine Kinane - Executive Medical Director	180-185	43	30-32.5	215-220	175-180	-	30-32.5	205-210
Mary Mumvuri - Executive Director of Nursing and Quality	115-120	33	0	115-120	95-100	1	-	95-100
Jacquie Mowbray-Gould - Chief Operating Officer	50-55	44	5-7.5	60-65	-	-	-	-
Ivan McConnell - Executive Director of Transformation and Commercial Development	65-70	0	2.5-5	70-75	115-120		27.5-30	145-150
Sandra Goatley - Director of Human Resources	115-120	14	25-27.5	145-150	115-120	1	25-27.5	140-145
Sheila Stenson - Executive Director of Finance	40-45	4	12.5-15	55-60	-	-	-	-
Vincent Badu - Interim Director of Transformation (Older Adult Services)	40-45	14	10-12.5	55-60	-	-	-	-
Andrew Ling - Chairman	20-25	1	0	20-25	20-25		-	20-25
Tom J Philips - Non Executive Director	5-10	0	0	5-10	5-10		-	5-10
Rodney Ashurst - Non Executive Director	5-10	5	0	5-10	5-10		-	5-10
Mark Bryant - Non Executive Director	5-10	18	0	5-10	5-10		-	5-10
Anne-Marie Dean - Non Executive Director	5-10	22	0	10-15	5-10		-	5-10
Venu Branch - Non Executive Director	5-10	16	0	5-10	0-5		-	0-5
Jackie Craissati - Non Executive Director	5-10	16	0	5-10	0-5		-	0-5
Catherine Walker - Non Executive Director	5-10	10	0	5-10	0-5		-	0-5

*Includes agency fees
** Annual increase in pension entitlement

The figures in the above table relate to the amounts received during the financial year.

For 2017-18 and 2016-17, there were no taxable benefits or annual or long-term performance-related bonuses.

Median remuneration is based on total permanent staff and full time annual salaries.

b) Pension benefits

Pensions table 2017-18 - audited

Name and title	Real increase in pension at pension age	Real increase in pension lump sum at pension age	Total accrued pension at pension age at 31 March 2018	Lump sum at age 60 related to accrued pension at 31 March 2018	Cash Equivalent Transfer Value at 1 April 2017	Real increase in Cash Equivalent Transfer Value	Cash Equivalent Transfer Value at 31 March 2018
	£000	£000	£000	£000	£000	£000	£000
Helen Greatorex - Chief Executive Officer	2.5 - 5	10 - 12.5	50 - 55	150 - 155	898	135	1042
Philip Cave - Deputy Chief Executive / Executive Director of Finance	0 - 2.5	0	20 - 25	50 - 55	269	35	307
Catherine Kinane - Executive Medical Director	0 - 2.5	5 - 7.5	45 - 50	135 - 140	841	83	932
Mary Mumvuri - Executive Director of Nursing and Quality	0	0	0	0	0	0	0
Jacquie Mowbray - Gould - Chief Operating Officer	0 - 2.5	0	30 - 35	75 - 80	511	25	541
Ivan McConnell - Executive Director of Transformation and Commercial Development	0 - 2.5	0	5 - 10	0	92	16	109
Sandra Goatley - Director of Human Resources	0 - 2.5	0	0 - 5	0	28	28	56
Sheila Stenson - Executive Director of Finance	0 - 2.5	0 - 2.5	20 - 25	50 - 55	243	30	276
Vincent Badu - Interim Director of Transformation (Older Adult Services)	0 - 2.5	0 - 2.5	15 - 20	30 - 35	198	27	227

Note: Ada Foreman was Acting Director of Finance from 6/10/2017 to 20/11/2017, her pension benefits have been excluded from the above table as the increase predominately related to her substantive Deputy Director of Finance post, and not the Acting Directorship.

Pensions table 2016-17 - audited

Name and title	Real increase in pension at pension age	Real increase in pension lump sum at pension age	Total accrued pension at pension age at 31 March 2017	Lump sum at age 60 related to accrued pension at 31 March 2017	Cash Equivalent Transfer Value at 1 April 2016	Real increase in Cash Equivalent Transfer Value	Cash Equivalent Transfer Value at 31 March 2017
	(bands of £2,500)	(bands of £2,500)	(bands of £5,000)	(bands of £5,000)	£000	£000	£000
Helen Greatorex - Chief Executive Officer commenced 06/06/2016	10-12.5	30-32.5	45-50	140-145	639	259	898
Angela McNab - Chief Executive left 19/04/2016	0-2.5	0-2.5	15-20	0-5	276	3	343
Philip Cave - Deputy Chief Executive / Executive Director of Finance	0-2.5	0-2.5	20-25	50-55	241	28	269
Catherine Kinane - Executive Medical Director	0-2.5	5-7.5	40-45	120-125	759	82	841
Malcolm McFrederick - Executive Director of Operations, Acting Chief Executive between 19/04/2016 and 05/06/2016 - Left 05/02/2017	0-2.5	2.5-5	15-20	50-55	324	54	378
Ivan McConnell - Executive Director of Transformation and Commercial Development	0-2.5	0-2.5	5-10	0-5	61	26	87
Sandra Goatley - Director of Human Resources	0-2.5	0-2.5	0-5	0-5	2	26	28

c) Loss of office

There were no directors who had loss of office in 2017-18.

d) Expenses of directors

The directors receive reimbursement of travel and incidental expenses incurred as a result of their duties to the trust. The values are shown on page 42.

e) Off payroll engagements

The trust had no off-payroll engagements as at 31 March 2018 and had no new off-payroll engagements between 1 April 2017 and 31 March 2018, for more than £245 per day and that last longer than six months.

f) Exit packages - audited

	2017/18		2016/17	
Exit package cost band (including any special payment element)	Number of compulsory redundancies	**Total Number of Exit Packages**	Number of compulsory redundancies	**Total Number of Exit Packages**
<£10,000	2	**2**	1	**1**
£10,001 - £25,000	5	**5**	2	**2**
£25,001 - 50,000	2	**2**	3	**3**
£50,001 - £100,000	0	**0**	2	**2**
£100,001 - £150,000	0	**0**	0	**0**
£150,001 - £200,000	0	**0**	1	**1**
>£200,000	0	**0**	0	**0**
Total number of exit packages by type	**9**	**9**	**9**	**9**
Total resource cost (£)	150000	**150000**	£427,970	**£427,970**

'Fair pay' (pay multiples) disclosures - audited

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

The banded remuneration of the highest paid director in the trust in the financial year 2017-18 was £180k-185k (2016-17, £175k - £180k). This was 8 times (2016-17, 8 times) the median remuneration of the workforce, which was £23,597 (2017-18, £20,962).

In 2017-18, 0 (2016-17, 0) employees received remuneration in excess of the highest-paid director/member. Remuneration ranged from £6k to £180k (2016-17 £3k-£179k).

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.

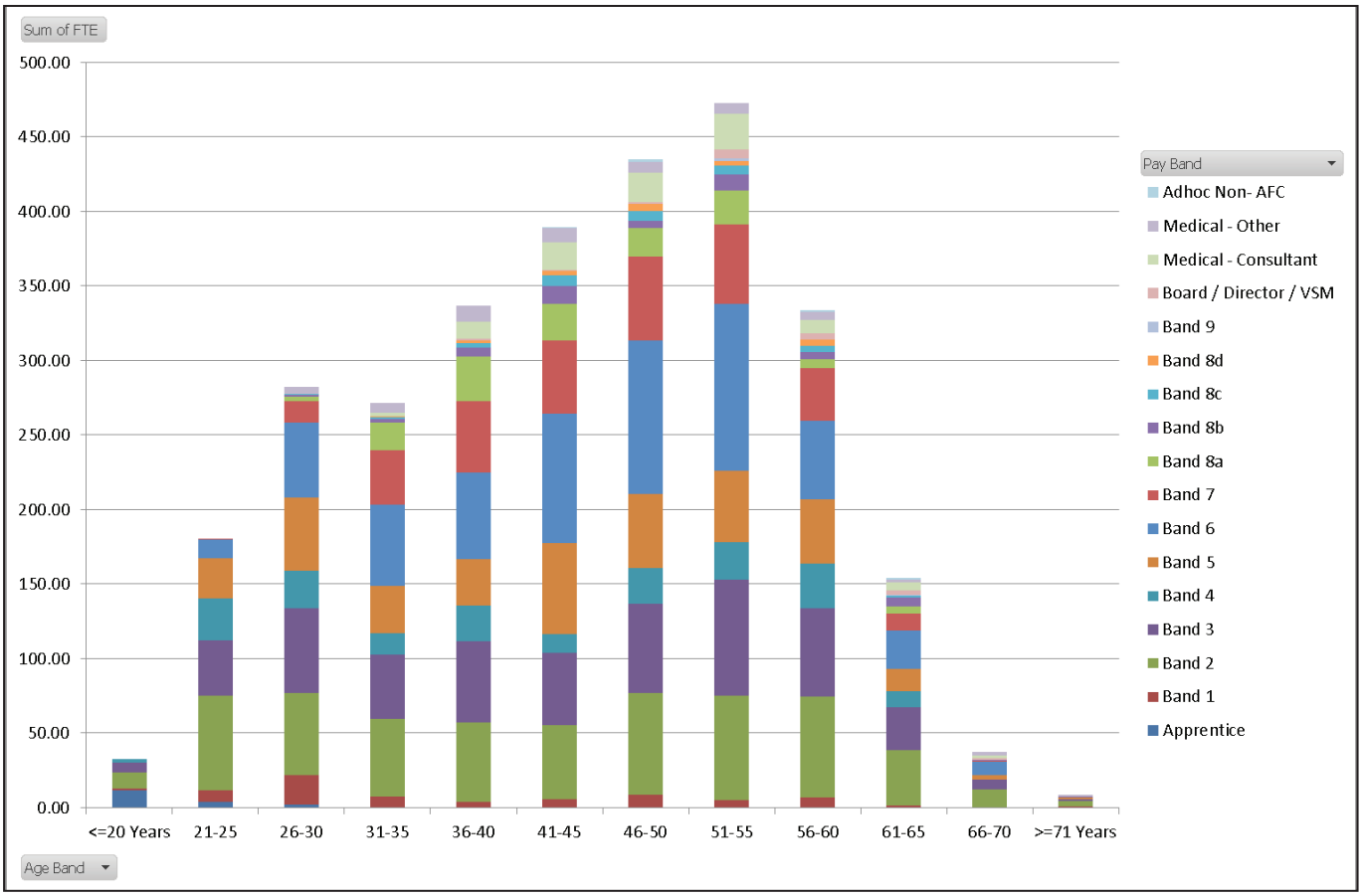
Staff report

Staff numbers by band and gender – audited - table 12

Sum of FTE			
	Female	Male	Grand Total
Apprentice	13.00	4.81	17.81
Band 1	50.40	18.53	68.93
Band 2	374.56	168.23	542.79
Band 3	379.24	101.34	480.58
Band 4	160.91	35.00	195.91
Band 5	274.47	86.52	360.99
Band 6	409.89	152.60	562.49
Band 7	228.24	78.36	306.60
Band 8a	93.05	36.20	129.25
Band 8b	35.05	13.31	48.36
Band 8c	16.75	12.85	29.61
Band 8d	11.76	6.00	17.76
Band 9	1.90	0.80	2.70
Board/Director/VSM	10.00	7.00	17.00
Medical - Consultant	39.10	52.30	91.40
Medical - Other	33.35	23.40	56.75
Adhoc Non-AFC	0.60	4.00	4.60
Grand Total	**2132.27**	**801.25**	**2933.52**

*Data is a snapshot from 31/03/2018 source ESR

Staff by age band



*Data is a snapshot from 31.03.2018 source ESR

Staff numbers by band and staff group – audited - table 13

Sum of FTE	Add Prof Scientific and Technic	Additional Clinical Services	Administrative and Clerical	Allied Health Professionals	Estates and Ancillary	Medical and Dental	Nursing and Midwifery Registered	Students	Grand Total
Apprentice			17.81						17.81
Band 1					19.08			49.85	68.93
Band 2		311.32	102.65		128.81				542.79
Band 3	4.60	297.73	167.59		10.67				480.58
Band 4	3.60	69.50	113.81		9.00				195.91
Band 5	12.27	5.83	61.17	39.38	8.00		234.36		360.99
Band 6	14.44	2.00	65.52	94.20	6.00		380.34		562.49
Band 7	63.51	2.91	44.01	44.19	1.00		150.99		306.60
Band 8a	55.41		31.64	7.80			34.40		129.25
Band 8b	21.55		15.80	1.91			9.10		48.36
Band 8c	19.31		9.00	0.80			0.50		29.61
Band 8d	6.76		9.00				2.00		17.76
Band 9	2.70								2.70
Board/Director/VSM			17.00						17.00
Medical - Consultant						91.40			91.40
Medical - Other						56.75			56.75
Adhoc Non-AFC	3.00			1.60					4.60
Grand Total	**207.14**	**689.28**	**654.99**	**189.87**	**182.56**	**148.15**	**811.68**	**49.85**	**2933.52**

*Data is a snapshot from 31/03/2018 source ESR

Staff costs are included as per note 6 in the Annual Accounts.

Staff turnover for 2017-18 was 16.61 per cent of which the majority was related to

Band 2, 3, Band 5 in particular within the nursing workforce. This is a reduction on the previous year of 1.49 per cent.

The tables above are based on extracts from the ESR system for the trusts permanent workforce, in addition the trust used 462 FTE of temporary staff in 2017/18 (2016/17, 478 FTE).

Staff by ethnicity - audited - table 14

Ethnic Origin	Sum of FTE	%	BME %
A White - British	2088.58	71.20%	
B White - Irish	35.91	1.22%	
C White - Any other White background	142.85	4.87%	
D Mixed - White & Black Caribbean	5.87	0.20%	
E Mixed - White & Black African	4.67	0.16%	
F Mixed - White & Asian	17.40	0.59%	
G Mixed - Any other mixed background	21.27	0.72%	
H Asian or Asian British - Indian	95.12	3.24%	
J Asian or Asian British - Pakistani	10.69	0.36%	
K Asian or Asian British - Bangladeshi	4.00	0.14%	**21.32%**
L Asian or Asian British - Any other Asian background	78.65	2.68%	
M Black or Black British - Caribbean	29.40	1.00%	
N Black or Black British - African	275.20	9.38%	
P Black or Black British - Any other Black background	28.07	0.96%	
R Chinese	4.80	0.16%	
S Any Other Ethnic Group	50.17	1.71%	
Z Not Stated	40.88	1.39%	
Grand Total	**2933.52**		

*Data is a snapshot from 31/03/2018 source ESR

c) Sickness absence data

We set a challenging target of 3.9 per cent staff absence rate for the trust in 2017-18. We achieved a rate of 4.98 per cent, which is consistent with 2017-18. We are committed to supporting staff when they are unwell and we must do all that we can to help them return to work.

d) Expenditure on consultancy
Please refer to note 4.1 in the Annual Accounts.

Staff policies applied during the year

Policies applied for giving full and fair consideration for employment made by disabled persons	The trust has a recruitment and selection policy, which sets out how KMPT ensures fair recruitment practices throughout the attraction, selection and recruitment of candidates. This is reviewed through the trust's electronic tracking 'TRAC' recruitment system.
Policies for continuing the employment of and for arranging training for employees who have become disabled persons during the period	KMPT adheres to the Equality Act 2010, and as such, line managers make reasonable adjustments and use referrals to the Occupational Health team to ensure the continued employment of employees who become disabled persons. In addition, the HR team provides direct support to staff affected and their managers.
Policies for the training, career development and promotion of disabled employees	There is equality of access to training for all staff.
Actions taken in the financial year to provide employees systematically with information on matters of concern to them as employees	The trust augmented its internal communications activities during the year, including the introduction of new Intranet system (i-connect).
Actions taken during the financial year to consult employees or their representatives on a regular basis so that the views of employees can be taken into account in making decisions which are likely to affect their interests	KMPT has regular meetings of its Joint Negotiating Committee and Local Negotiating Committees for formal discussions relating to staffing issues. As stipulated within the organisational change policy, collective consultations would be enacted where there are more specific issues affecting staff i.e. restructures.
Information on health and safety performance occupational health	During the year health and safety training was delivered to 95 per cent of staff. The trust has 85 keyworkers trained in moving and handling. The health and safety department undertakes audits on the whole hospital in conjunction with a staff side chair person. There are review meetings with the external occupational health provider, reviewing all elements of service, including nurse activity, turnaround times, patients failing to turn up for appointments and cancellations, medical activity, pre-employment screening, current management referral screening processes, and the production of medical reports. The performance of the service is regularly monitored via contract review meetings.
Information on policies and procedures with respect to countering fraud and corruption	The trust has a whistleblowing policy in place. TiAA provide support services to KMPT.

Helen Greatorex, Chief Executive

ANNUAL ACCOUNTS

Statement of directors' responsibilities in respect of the accounts

The directors are required under the National Health Service Act 2006 to prepare accounts for each financial year. The Secretary of State, with the approval of HM Treasury, directs that these accounts give a true and fair view of the state of affairs of the trust and of the income and expenditure, recognised gains and losses and cash flows for the year. In preparing those accounts, the directors are required to:

- apply on a consistent basis accounting policies laid down by the Secretary of State with the approval of the Treasury;
- make judgements and estimates which are reasonable and prudent;
- state whether applicable accounting standards have been followed, subject to any material departures disclosed and explained in the accounts.

The directors are responsible for keeping proper accounting records which disclose with reasonable accuracy at any time the financial position of the trust and to enable them to ensure that the accounts comply with requirements outlined in the above mentioned direction of the Secretary of State. They are also responsible for safeguarding the assets of the trust and hence for taking reasonable steps for the prevention and detection of fraud and other irregularities.

The directors confirm to the best of their knowledge and belief they have complied with the above requirements in preparing the accounts.

By order of the board

Helen Greatorex, Chief Executive Date: 24 May 2018

Sheila Stenson, Finance Director Date: 24 May 2018

Independent auditor's report to the Directors of the Kent and Medway NHS and Social Care Partnership Trust

Report on the Audit of the Financial Statements

Opinion

We have audited the financial statements of Kent and Medway NHS and Social Care Partnership trust (the 'trust') for the year ended 31 March 2018 which comprise the Statement of Comprehensive Income, the Statement of Financial Position, the Statement of Changes in Equity, the Statement of Cash Flows and notes to the Accounts, including a summary of significant accounting policies. The financial reporting framework that has been applied in their preparation is applicable law and the Department of Health and Social Care Group Accounting Manual 2017-18 and the requirements of the National Health Service Act 2006.

In our opinion the financial statements:

- give a true and fair view of the financial position of the trust as at 31 March 2018 and of its expenditure and income for the year then ended; and
- have been properly prepared in accordance with International Financial Reporting Standards (IFRSs) as adopted by the European Union, as interpreted and adapted by the Department of Health and Social Care Group Accounting Manual 2017-18; and
- have been prepared in accordance with the requirements of the National Health Service Act 2006.

Basis for opinion

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

Who we are reporting to

This report is made solely to the Directors of the trust, as a body, in accordance with Part 5 of the Local Audit and Accountability Act 2014. Our audit work has been undertaken so that we might state to the trust's Directors 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 Directors, as a body, for our audit work, for this report, or for the opinions we have formed.

Conclusions relating to Going Concern

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

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

Other information

The Directors are 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 course of our work including that gained through work in relation to the trust's arrangements for securing value for money through economy, efficiency and effectiveness in the use of its resource 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 on behalf of the Comptroller and Auditor General (the Code of Audit Practice) we are required to consider whether the Annual Governance Statement does not comply with the guidance issued by NHS Improvement or is misleading or inconsistent with the information of which we are aware from our audit. We are not required to consider whether the Annual Governance Statement addresses all risks and controls or that risks are satisfactorily addressed by internal controls.

We have nothing to report in this regard.

Opinion on other matters required by the Code of Audit Practice

In our opinion:

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

Matters on which we are required to report by exception

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

- we have reported a matter in the public interest under Section 24 of the Local Audit and Accountability Act 2014 in the course of, or at the conclusion of the audit; or
- we have referred a matter to the Secretary of State under Section 30 of the Local Audit and Accountability Act 2014 because we had reason to believe that the trust, or an officer of the trust, was about to make, or had made, a decision which involved or would involve the body incurring unlawful expenditure, or was about to take, or had begun to take a course of action which, if followed to its conclusion, would be unlawful and likely to cause a loss or deficiency; or

- we have made a written recommendation to the trust under Section 24 of the Local Audit and Accountability Act 2014 in the course of, or at the conclusion of the audit.

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

Responsibilities of the Directors and Those Charged with Governance for the financial statements

As explained more fully in the Statement of Director's Responsibilities, the Directors are responsible for the preparation of the financial statements in the form and on the basis set out in the Accounts Directions, for being satisfied that they give a true and fair view, and for such internal control as the Directors determine 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 Directors are responsible for assessing the trust's ability to continue as a going concern, disclosing, as applicable, matters related to going concern and using the going concern basis of accounting unless the trust lacks funding for its continued existence or when policy decisions have been made that affect the services provided by the trust.

The Integrated Audit and Risk Committee is Those Charged with Governance.

Auditor's responsibilities for the audit of the financial statements

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

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

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

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

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

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

Responsibilities of the Accountable Officer

As explained in the Statement of the Chief Executive's Responsibilities, as the Accountable Officer of the trust, the Accountable 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 Section 21(3)(c) and Schedule 13 paragraph 10(a) of the Local Audit and Accountability Act 2014 to be satisfied that the trust has made proper

arrangements for securing economy, efficiency and effectiveness in its use of resources and to report where we have not been able to satisfy ourselves that it has done so. We are not required to consider, nor have we considered, whether all aspects of the trust's arrangements for securing economy, efficiency and effectiveness in its use of resources are operating effectively.

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

Report on other legal and regulatory requirements – Certificate

We certify that we have completed the audit of the financial statements of Kent and Medway NHS and Social Care Partnership Trust in accordance with the requirements of the Local Audit and Accountability Act 2014 and the Code of Audit Practice.

Darren Wells
Engagement Lead
for and on behalf of Grant Thornton UK LLP

2nd Floor
St John's House
Haslett Avenue West
Crawley
RH10 1HS

Date

Annual accounts for the year ending 31 March 2018

Statement of Comprehensive Income for the year ended 31 March 2018

	Note	2017/18 £000	2016/17 £000
Operating income from patient care activities	2	168,932	168,652
Other operating income	3	12,102	14,451
Operating expenses	4.1	(180,928)	(180,549)
Operating surplus/(deficit) from continuing operations		**106**	**2,554**
Finance income	9	14	11
Finance expenses	10	(1,583)	(1,522)
PDC dividends payable		(3,934)	(4,238)
Net finance costs		**(5,503)**	**(5,749)**
Other gains / (losses)	11	376	(380)
Retained (deficit) for the year		**(5,021)**	**(3,575)**
Other comprehensive income			
Will not be reclassified to income and expenditure:			
Impairments	5	(4,498)	0
Revaluations	14	1,308	(1,462)
Total comprehensive (expense) for the period		**(8,211)**	**(5,037)**
Finance performance for the year			
Retained (deficit) for the year		(5,021)	(3,575)
Add back all I&E impairments / (reversals)		3,731	0
Add back IFRIC 12 adjustment		0	198
Remove capital donations / grants I&E impact		66	66
Adjusted retained (deficit) - control total basis		**(1,224)**	**(3,311)**

The reported performance of the trust £5m deficit differs from the financial performance of £1.2m deficit due to allowable technical adjustments.

The notes of pages 60 to 92 form part of this account.

Statement of Financial Position as at 31 March 2018

	Note	31 March 2018 £000	31 March 2017 £000
Non-current assets			
Intangible assets	12	984	1,518
Property, plant and equipment	13	139,906	149,891
Trade and other receivables	15	533	622
Total non-current assets		**141,423**	**152,031**
Current assets			
Trade and other receivables	15	8,523	8,038
Non-current assets held for sale / assets in disposal groups	16	5	0
Cash and cash equivalents	17	5,083	1,484
Total current assets		**13,611**	**9,522**
Current liabilities			
Trade and other payables	18	(15,086)	(12,268)
Borrowings	20	(1,633)	(1,588)
Provisions	22	(672)	(696)
Other liabilities	19	(45)	0
Total current liabilities		**(17,436)**	**(14,552)**
Total assets less current liabilities		**137,598**	**147,001**
Non-current liabilities			
Borrowings	20	(15,754)	(17,387)
Provisions	22	(1,600)	(1,814)
Total non-current liabilities		**(17,354)**	**(19,201)**
Total assets employed		**120,244**	**127,800**
Financed by			
Public dividend capital		113,993	113,339
Revaluation reserve		14,764	18,887
Other reserves		(4,701)	(4,701)
Income and expenditure reserve		(3,812)	275
Total Taxpayers' equity		**120,244**	**127,800**

The notes on pages 60 to 92 form part of these accounts.

The financial statements on pages 55 to 92 were approved on behalf of the board by the Integrated Audit and Risk Committee on 23rd May 2018 and signed on its behalf by

Helen Greatorex, Chief Executive Date: 24 May 2018

Statement of Changes in Equity for the year ended 31 March 2018

	Public dividend capital £000	Revaluation reserve £000	Other reserves £000	Income and expenditure reserve £000	Total £000
Taxpayers' equity at 1 April 2017	**113,339**	**18,887**	**(4,701)**	**275**	**127,800**
Retained (deficit) for the year	0	0	0	(5,021)	**(5,021)**
Other transfers between reserves	0	(417)	0	417	**0**
Impairments	0	(4,498)	0	0	**(4,498)**
Revaluations	0	1,309	0	0	**1,309**
Transfer to retained earnings on disposal of assets	0	(517)	0	517	**0**
Public dividend capital received	654	0	0	0	**654**
Taxpayers' equity at 31 March 2018	**113,993**	**14,764**	**(4,701)**	**(3,812)**	**120,244**

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

	Public dividend capital £000	Revaluation reserve £000	Other reserves £000	Income and expenditure reserve £000	Total £000
Taxpayers' equity at 1 April 2016	**111,864**	**20,714**	**(4,701)**	**3,485**	**131,362**
Retained (deficit) for the year	0	0	0	(3,575)	**(3,575)**
Other transfers between reserves	0	(365)	0	365	**0**
Revaluations	0	(1,462)	0	0	**(1,462)**
Public dividend capital received	1,475	0	0	0	**1,475**
Taxpayers' equity at 31 March 2017	**113,339**	**18,887**	**(4,701)**	**275**	**127,800**

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 as the public dividend capital dividend.

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

Other reserves
Errors identified following a merger in 2006 are charged to an "Other Reserve". The Department of Health and Social Care do not alter the initial Public Dividend Capital value so this reserve is the means of identifying the over statement.

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

Statement of Cash Flows for the year ended 31 March 2018

	Note	2017/18 £000	2016/17 £000
Cash flows from operating activities			
Operating surplus		106	2,554
Non-cash income and expense:			
Depreciation and amortisation	4.1	6,347	6,701
Net impairments	5	3,731	0
Decrease in receivables and other assets		(140)	1,603
Increase / (decrease) in payables and other liabilities		1,775	(4,049)
(Decrease) in provisions		(293)	(732)
Net cash generated from / (used in) operating activities		**11,526**	**6,077**
Cash flows from investing activities			
Interest received		14	11
Purchase of intangible assets		(18)	0
Purchase of property, plant, equipment and investment property		(4,550)	(3,136)
Sales of property, plant, equipment and investment property		3,280	8
Net cash generated (used in) investing activities		**(1,274)**	**(3,117)**
Cash flows from financing activities			
Public dividend capital received		654	1,475
Movement on loans from the Department of Health and Social Care		(800)	1,500
Capital element of finance lease rental payments		(140)	(132)
Capital element of PFI, LIFT and other service concession payments		(647)	(628)
Interest paid on finance lease liabilities		(102)	(111)
Interest paid on PFI, LIFT and other service concession obligations		(1,370)	(1,294)
Other interest paid		(58)	(70)
PDC dividend (paid)		(4,190)	(4,281)
Net cash generated (used in) financing activities		**(6,653)**	**(3,541)**
Increase / (decrease) in cash and cash equivalents		**3,599**	**(581)**
Cash and cash equivalents at 1 April - brought forward		**1,484**	**2,065**
Cash and cash equivalents at 31 March	17.1	**5,083**	**1,484**

Notes to the Accounts

Note 1 Accounting policies and other information

Note 1.1 Basis of preparation
The Department of Health and Social Care 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 2017/18 issued by the Department of Health and Social Care. The accounting policies contained in the GAM follow International Financial Reporting Standards to the extent that they are meaningful and appropriate to the NHS, as determined by HM Treasury, which is advised by the Financial Reporting Advisory Board. Where the GAM permits a choice of accounting policy, 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 accounts.

Note 1.1.1 Accounting convention
These accounts have been prepared under the historical cost convention modified to account for the revaluation of property, plant and equipment, intangible assets, inventories and certain financial assets and financial liabilities.

Note 1.1.2 Going concern
The financial statements have been prepared as a going concern and the trust will continue to operate for the foreseeable future. In approving the trust's financial statements, the board has made an assessment, and has satisfied itself that it is appropriate to prepare the financial statements on the going concern basis.

The trust has incurred a deficit (after technical adjustments) of £1.2m and has prepared its financial plans and cash flow forecasts for the coming financial year with a forecast deficit of £1.8m for 2018/19 as it moves towards financial sustainability.

These deficits have an impact on the cash position of the trust, and the trust may require a small loan to facilitate the timing of the 2018/19 capital programme.

Contracts covering the financial year 2018/19 have been signed with commissioners which gives certainty around the income forecasts.

As directed by the Department of Health and Social Care Group Accounting Manual 2017/18, the directors have prepared the financial statements on a going concern basis as they consider that the services currently provided by the trust will continue to be provided in the foreseeable future.

Note 1.2 Critical accounting judgements and key sources of estimation uncertainty
In the application of the NHS 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.

Note 1.2.1 Critical judgements in applying accounting policies
Any critical judgements, apart from those involving estimations (see below) that management has made in the process of applying the NHS trust's accounting policies and that have the most significant effect on the amounts recognised in the financial statements, are annotated where applicable in the notes to these accounts.

The main areas of critical judgement are:
The assessment of the expectation on the trust ability to continue as a going concern, and
The valuation under a Modern Equivalent Asset on an Alternative Site basis for the land values.

Note 1.2.2 Sources of estimation uncertainty
Key assumptions concerning the future, and other key sources of estimation uncertainty at the end of the reporting period, that have a significant risk of causing a material adjustment to the carrying amounts of assets and liabilities within the next financial year when arising, will be disclosed within the relevant note. The disclosure will include the nature of the assumption and the carrying amount of the asset/liability at the balance sheet date, sensitivity of the carrying amount to the assumptions, expected resolution of uncertainty and range of possible outcomes within the next financial year. The disclosure will also include an expectation of changes to past assumptions if the uncertainty remains unresolved.

Material areas including estimations with the 2017/18 accounts are as follows:
Property Plant and Equipment see Note 1.6, relating to alternative site valuation of non functional land.
PFI see Note 1.6.5
Accruals see Note 1.5
Provisions see Note 1.11

Note 1.3 Income

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

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

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

Revenue grants and other contributions to expenditure
Government grants are grants from government bodies other than income from commissioners or trusts for the provision of services. Where a grant is used to fund revenue expenditure it is taken to the Statement of Comprehensive Income to match that expenditure.

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

Note 1.4 Expenditure on employee benefits

Short-term employee benefits
Salaries, wages and employment-related payments such as social security costs and the apprenticeship levy are recognised in the period in which the service is received from employees. The cost of annual leave entitlement earned but not taken by employees at the end of the period is recognised in the financial statements to the extent that employees are permitted to carry-forward leave into the following period.

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

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

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

Note 1.5 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 1.6 Property, plant and equipment

Note 1.6.1 Recognition
Property, plant and equipment is capitalised where:

• it is held for use in delivering services or for administrative purposes
• it is probable that future economic benefits will flow to, or service potential be provided to, the trust
• it is expected to be used for more than one financial year
• the cost of the item can be measured reliably; and either
• 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; or

• items form part of the initial equipping and setting-up 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.

Note 1.6.2 Measurement
Valuation
All property, plant and equipment assets are measured initially at cost, representing the costs directly attributable to acquiring or constructing the asset and bringing it to the location and condition necessary for it to be capable of operating in the manner intended by management. All assets are measured subsequently at current value.

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

Revaluations of property, plant and equipment are performed with sufficient regularity to ensure that carrying amounts are not materially different from those that would be determined at the end of the reporting period. Current values in existing use are determined as follows:
● Land and non-specialised buildings – market value for existing use.
● Specialised buildings – depreciated replacement cost, modern equivalent asset basis.

HM Treasury has adopted a standard approach to depreciated replacement cost valuations based on modern equivalent assets and, where it would meet the location requirements of the service being provided, an alternative site can be valued. All land and buildings are restated to current value using professional valuations in accordance with IAS 16 every five years and in the intervening third year by a 'desk top' review, or on the completion of a material refurbishment scheme.

The 5 year professional valuations are carried out by local independent valuers. The valuations are carried out in accordance with the Royal Institute of Chartered Surveyors (RICS) Appraisal and Valuation Manual in so far as these terms are consistent with the agreed requirements of the Department of Health and Social Care and HM Treasury. In accordance with the requirements of the Department of Health and Social Care, a full asset valuation took place in March 2015.

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, borrowing costs. Assets are revalued and depreciation commences when they are brought into use.

The carrying value of existing assets at that date will be written off over their useful remaining lives and new fixtures and equipment are carried at depreciated historic cost as this is not considered to be materially different from fair value.
An item of property, plant and equipment which is surplus with no plan to bring it back into use is valued at fair value under IFRS 13, if it does not meet the requirements of IAS 40 of IFRS 5.

Modern Equivalent Asset on a Alternative Site Basis
In 2017/18 the trust adopted the alternative site for its land valuations. The valuation assumption within note 13.1, relating to the Land values, is to adopt the methodology appropriate for a Modern Equivalent Asset on an alternative site basis whereby the trust would not hold more land than is necessary for the delivery of services. This follows the economic principle of substitution. Without affecting services some land at each of the four sites can be identified as non functional and, therefore, excluded from an MEA valuation.

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 trust 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. 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. Assets in the course of construction and residual interests in off-Statement of Financial Position PFI contract assets are not depreciated until the asset is brought into use or reverts to the trust, respectively.

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

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

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

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

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

Note 1.6.3 Derecognition
Assets intended for disposal are reclassified as 'held for sale' once all of the following criteria are met:

- the asset is available for immediate sale in its present condition subject only to terms which are usual and customary for such sales;
- the sale must be highly probable 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 dropped or significant changes made to it.

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

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

Note 1.6.4 Donated and grant funded assets

Donated and grant funded property, plant and equipment assets are capitalised at their fair value on receipt. The donation/grant is credited to income at the same time, unless the donor has imposed a condition that the future economic benefits embodied in the grant are to be consumed in a manner specified by the donor, in which case, the donation/grant is deferred within liabilities and is carried forward to future financial years to the extent that the condition has not yet been met.

Note 1.6.5 Private Finance Initiative (PFI) and Local Improvement Finance Trust (LIFT) transactions

PFI and LIFT transactions which meet the IFRIC 12 definition of a service concession, as interpreted in HM Treasury's FReM, are accounted for as 'on-Statement of Financial Position' by the trust. In accordance with IAS 17, the underlying assets are recognised as property, plant and equipment, together with an equivalent finance lease liability. Subsequently, the assets are accounted for as property, plant and equipment and/or intangible assets as appropriate.

The annual contract payments are apportioned between the repayment of the liability, a finance cost and the charges for services.

The service charge is recognised in operating expenses and the finance cost is charged to finance costs in the Statement of Comprehensive Income.

The annual unitary payment is separated into the following component parts, using appropriate estimation techniques where necessary:

a) Payment for the fair value of services received;
b) Payment for the PFI asset, including finance costs; and
c) Payment for the replacement of components of the asset during the contract 'lifecycle replacement'.

Services received

The fair value of services received in the year is recorded under the relevant expenditure headings within 'operating expenses'

PFI Asset

The PFI assets are recognised as property, plant and equipment, when they come into use. The assets are measured initially at fair value or, if lower, at the present value of the minimum lease payments, in accordance with the principles of IAS 17. Subsequently, the assets are measured at current value in existing use.

PFI liability

A PFI liability is recognised at the same time as the PFI assets are recognised. It is measured initially at the same amount as the initial value of the PFI assets and is subsequently measured as a finance lease liability in accordance with IAS 17.

An annual finance cost is calculated by applying the implicit interest rate in the lease to the opening lease liability for the period, and is charged to 'Finance Costs' within the Statement of Comprehensive Income.

The element of the annual unitary payment that is allocated as a finance lease rental is applied to meet the annual finance cost and to repay the lease liability over the contract term.

An element of the annual unitary payment increase due to cumulative indexation is allocated to the finance lease. In accordance with IAS 17, this amount is not included in the minimum lease payments, but is instead treated as contingent rent and is expensed as incurred. In substance, this amount is a finance cost in respect of the liability and the expense is presented as a contingent finance cost in the Statement of Comprehensive Income.

Lifecycle replacement

Components of the asset replaced by the operator during the contract ('lifecycle replacement') are capitalised where they meet the NHS trust's criteria for capital expenditure. They are capitalised at the time they are provided by the operator and are measured initially at their fair value.

The element of the annual unitary payment allocated to lifecycle replacement is pre-determined for each year of the contract from the operator's planned programme of lifecycle replacement. Where the lifecycle component is provided earlier or later than expected, a short-term accrual or prepayment is recognised respectively.

Where the fair value of the lifecycle component is less than the amount determined in the contract, the difference is recognised as an expense when the replacement is provided. If the fair value is greater than the amount determined in the contract, the difference is treated as a 'free' asset and a deferred income balance is recognised. The deferred income is released to operating income over the shorter of the remaining contract period or the useful economic life of the replacement component.

Note 1.6.6 Useful economic lives of property, plant and equipment

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

	Min life Years	Max life Years
Buildings, excluding dwellings	30	60
Plant & machinery	5	10
Transport equipment	7	7
Information technology	5	5
Furniture & fittings	5	10

Finance-leased assets (including land) are depreciated over the shorter of the useful economic life or the lease term, unless the trust expects to acquire the asset at the end of the lease term in which case the assets are depreciated in the same manner as owned assets above.

Note 1.7 Intangible assets

Note 1.7.1 Recognition

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

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.

Note 1.7.2 Measurement

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

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

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

Amortisation

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

Note 1.7.3 Useful economic lives of intangible assets
Useful economic lives reflect the total life of an asset and not the remaining life of an asset. The range of useful economic lives are shown in the table below:

	Min life Years	Max life Years
Information technology	5	5
Licences & trademarks	5	5

Note 1.8 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 3 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.

In the Statement of Cash Flows, cash and cash equivalents are shown net of bank overdrafts that are repayable on demand and that form an integral part of trust's cash management. Cash, bank and overdraft balances are recorded at current values.

Note 1.9 Financial instruments and financial liabilities

Recognition
Financial assets and financial liabilities which arise from contracts for 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, are recognised when, and to the extent which, performance occurs, i.e., when receipt or delivery of the goods or services is made.

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

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

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

Financial assets and financial liabilities at "fair value through income and expenditure"
Financial assets and financial liabilities at "fair value through income and expenditure" are financial assets or financial liabilities held for trading. A financial asset or financial liability is classified in this category if acquired principally for the purpose of selling in the short-term. Derivatives are also categorised as held for trading unless they are designated as hedges.

Loans and receivables
Loans and receivables are non-derivative financial assets with fixed or determinable payments which are not quoted in an active market.

The trust's loans and receivables comprise: cash and cash equivalents, NHS receivables, accrued income and "other receivables".

Loans and receivables are recognised initially at fair value, net of transactions costs, and are measured subsequently at amortised cost, using the effective interest method. The effective interest rate is the rate that discounts exactly estimated future cash receipts through the expected life of the financial asset or, when appropriate, a shorter period, to the net carrying amount of the financial asset.

Interest on loans and receivables is calculated using the effective interest method and credited to the Statement of Comprehensive Income.

Other financial liabilities
All other financial liabilities are recognised initially at fair value, net of transaction costs incurred, and measured subsequently at amortised cost using the effective interest method. The effective interest rate is the rate that discounts exactly estimated future cash payments through the expected life of the financial liability or, when appropriate, a shorter period, to the net carrying amount of the financial liability.

They are included in current liabilities except for amounts payable more than 12 months after the Statement of Financial Position date, which are classified as long-term liabilities.

Interest on financial liabilities carried at amortised cost is calculated using the effective interest method and charged to finance costs. Interest on financial liabilities taken out to finance property, plant and equipment or intangible assets is not capitalised as part of the cost of those assets.

Impairment of financial assets
At the Statement of Financial Position date, the trust assesses whether any financial assets, other than those held at "fair value through income and expenditure" are impaired. Financial assets are impaired and impairment losses are recognised if, and only if, there is objective evidence of impairment as a result of one or more events which occurred after the initial recognition of the asset and which has an impact on the estimated future cash flows of the asset.

For financial assets carried at amortised cost, the amount of the impairment loss is measured as the difference between the asset's carrying amount and the present value of the revised future cash flows discounted at the asset's original effective interest rate. The loss is recognised in the Statement of Comprehensive Income and the carrying amount of the asset is reduced through the use of an irrecoverable debt provision.

Note 1.10 Leases
Leases are classified as finance leases when substantially all the risks and rewards of ownership are transferred to the lessee. All other leases are classified as operating leases.

Note 1.10.1 The trust as lessee

Finance leases
Where substantially all risks and rewards of ownership of a leased asset are borne by the trust, the asset is recorded as property, plant and equipment and a corresponding liability is recorded. The value at which both are recognised is the lower of the fair value of the asset or the present value of the minimum lease payments, discounted using the interest rate implicit in the lease.

The asset and liability are recognised at the commencement of the lease. Thereafter the asset is accounted for an item of property plant and equipment.

The annual rental is split between the repayment of the liability and a finance cost so as to achieve a constant rate of finance over the life of the lease. The annual finance cost is charged to Finance Costs in the Statement of Comprehensive Income. The lease liability, is de-recognised when the liability is discharged, cancelled or expires.

Operating leases
Operating lease payments are recognised as an expense on a straight-line basis over the lease term. Lease incentives are recognised initially as a liability and subsequently as a reduction of rentals on a straight-line basis over the lease term.

Contingent rentals are recognised as an expense in the period in which they are incurred.

Leases of land and buildings
Where a lease is for land and buildings, the land component is separated from the building component and the classification for each is assessed separately.

Note 1.10.2 The trust as lessor

Finance leases
Amounts due from lessees under finance leases are recorded as receivables at the amount of the trust's net investment in the leases. Finance lease income is allocated to accounting periods to reflect a constant periodic rate of return on the trust's net investment outstanding in respect of the leases.

Operating leases
Rental income from operating leases 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 1.11 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 22.2 but is not recognised in the trust's accounts.

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

Note 1.12 Contingencies

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 1.13 Public dividend capital

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

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

A charge, reflecting the cost of capital utilised by the trust, is payable as public dividend capital dividend. The charge is calculated at the rate set by HM Treasury (currently 3.5%) on the average relevant net assets of the trust during the financial year. Relevant net assets are calculated as the value of all assets less the value of all liabilities, except for
(i) donated assets (including lottery funded assets),
(ii) average daily cash balances held with the Government Banking Services (GBS) and National Loans Fund (NLF) deposits, excluding cash balances held in GBS accounts that relate to a short-term working capital facility, and
(iii) any PDC dividend balance receivable or payable.

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

Note 1.14 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 1.15 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 1.16 Losses and special payments

Losses and special payments are items that Parliament would not have contemplated when it agreed funds for the health service or passed legislation. By their nature they are items that ideally should not arise. They are therefore subject to special control procedures compared with the generality of payments. They are divided into different categories, which govern the way that individual cases are handled. Losses and special payments are charged to the relevant functional headings in expenditure on an accruals basis, including losses which would have been made good through insurance cover had the trust not been bearing their own risks (with insurance premiums then being included as normal revenue expenditure).

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

Note 1.17 Other Reserve

Errors identified following a merger in 2006 are charged to an "Other Reserve". The Department of Health and Social Care do not alter the initial Public Dividend Capital value so this reserve is the means of identifying the over statement.

Note 1.18 Early adoption of standards, amendments and interpretations
No new accounting standards or revisions to existing standards have been early adopted in 2017/18.

Note 1.19 Standards, amendments and interpretations in issue but not yet effective or adopted

The DHSC GAM does not require the following Standards and Interpretations to be applied in 2017-18. These standards are still subject to HM Treasury FReM adoption, with IFRS 9 and IFRS 15 being for implementation in 2018-19, and the government implementation date for IFRS 16 and IFRS 17 still subject to HM Treasury consideration.

- IFRS 9 Financial Instruments – Application required for accounting periods beginning on or after 1 January 2018, but not yet adopted by the FReM: early adoption is not therefore permitted
- IFRS 15 *Revenue from Contracts with Customers* – Application required for accounting periods beginning on or after 1 January 2018, but not yet adopted by the FReM: early adoption is not therefore permitted
- IFRS 16 *Leases* – Application required for accounting periods beginning on or after 1 January 2019, but not yet adopted by the FReM: early adoption is not therefore permitted.
- FRS 17 *Insurance Contracts* – Application required for accounting periods beginning on or after 1 January 2021, but not yet adopted by the FReM: early adoption is not therefore permitted.
- IFRIC 22 *Foreign Currency Transactions and Advance Consideration* – Application required for accounting periods beginning on or after 1 January 2018.
- IFRIC 23 Uncertainty over Income Tax Treatments – Application required for accounting periods beginning on or after 1 January 2019.

Note 2 Operating income from patient care activities

Note 2.1 Income from patient care activities (by nature)	2017/18 £000	2016/17 £000
Mental health services		
Cost and volume contract income	3,874	9,438
Block contract income	163,833	158,173
Clinical partnerships providing mandatory services (including S75 agreements)	1,225	1,041
Total income from activities	**168,932**	**168,652**

Note 2.2 Income from patient care activities (by source)		
Income from patient care activities received from:	**2017/18 £000**	**2016/17 £000**
NHS England	20,570	20,187
Clinical commissioning groups	146,840	147,190
Department of Health and Social Care	10	44
Other NHS providers	136	249
Local authorities	151	556
Non-NHS: overseas patients (chargeable to patient)	0	5
Non NHS: other	1,225	421
Total income from activities	**168,932**	**168,652**
Of which:		
Related to continuing operations	168,932	168,652

Note 3 Other operating income

	2017/18 £000	2016/17 £000	
Research and development	451	88	*
Education and training	3,630	3,738	*
Non-patient care services to other bodies	3,580	5,723	
Sustainability and transformation fund income	2,532	1,870	
Rental revenue from operating leases	1,143	1,367	*
Income in respect of staff costs where accounted on gross basis	180	78	*
Other income	586	1,587	*
Total other operating income	**12,102**	**14,451**	
Of which:			
Related to continuing operations	12,102	14,451	

* The classification of 2016/17 has been restated in order to align with revised classifications in the returns to NHS Improvement.

Note 4.1 Operating expenses

	2017/18 £000	2016/17 £000	
Purchase of healthcare from NHS and DHSC bodies	2,061	1,756	
Purchase of healthcare from non-NHS and non-DHSC bodies	1,346	7,935	
Staff and executive directors costs	136,917	138,369	*
Remuneration of non-executive directors	69	68	
Supplies and services - clinical (excluding drugs costs)	1,792	2,076	
Supplies and services - general	2,333	2,290	
Drug costs (drugs inventory consumed and purchase of non-inventory drugs)	3,003	2,752	
Consultancy costs	3	78	
Establishment	3,729	3,972	
Premises	7,879	6,596	
Transport (including patient travel)	1,549	849	
Depreciation on property, plant and equipment	5,762	5,752	
Amortisation on intangible assets	585	949	
Net impairments	3,731	0	
Increase/(decrease) in provision for impairment of receivables	2,451	(32)	
(Decrease) in other provisions	(280)	(662)	*
Change in provisions discount rate(s)	19	175	
Audit fees payable to the external auditor			
audit services- statutory audit	55	61	
other auditor remuneration (external auditor only)	10	12	
Internal audit costs	144	220	
Clinical negligence	1,084	762	
Legal fees	1,670	1,531	
Insurance	246	291	
Research and development	3	0	
Education and training	1,072	684	
Rentals under operating leases	1,893	2,132	
Redundancy	150	428	*
Charges to operating expenditure for on-SoFP IFRIC 12 schemes (e.g. PFI / LIFT) on IFRS basis	1,039	925	
Car parking & security	259	246	*
Hospitality	13	11	*
Losses, ex gratia & special payments	207	194	*
Other	134	129	*
Total	**180,928**	**180,549**	
Of which:			
Related to continuing operations	180,928	180,549	

* The classification of 2016/17 has been restated in order to align with revised classifications in the returns to NHS Improvement.

The audit fees included within Note 4.1 above are reported as the gross position, the value excluding VAT for 2017/18 is £54k (2016/17 £60k)

Note 4.2 Other auditor remuneration

	2017/18 £000	2016/17 £000
Other auditor remuneration paid to the external auditor:		
Audit-related assurance services	10	12
Total	**10**	**12**

Note 4.3 Limitation on auditor's liability

The limitation on auditor's liability for external audit work is £2m (2016/17: £0m).

Note 5 Impairment of assets

	2017/18 £000	2016/17 £000
Net impairments charged to operating surplus / deficit resulting from:		
Changes in market price	3,731	-
Total net impairments charged to operating surplus / deficit	**3,731**	**0**
Impairments charged to the revaluation reserve	4,498	-
Total net impairments	**8,229**	**0**

Note 6 Employee benefits

	2017/18 Total £000	2016/17 Total £000
Salaries and wages	96,460	95,447
Social security costs	9,416	9,401
Apprenticeship levy	462	0
Employer's contributions to NHS pensions	12,541	12,421
Pension cost - other	6	5
Termination benefits	150	428
Temporary staff (including agency)	18,053	21,135
Total staff costs	**137,088**	**138,837**
Of which		
Costs capitalised as part of assets	21	40

Note 6.1 Retirements due to ill-health

During 2017/18 there were 5 early retirements from the trust agreed on the grounds of ill-health (2 in the year ended 31 March 2017). The estimated additional pension liabilities of these ill-health retirements is £290k (£86k in 2016/17).

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

Note 7 Pension costs

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

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

a) Accounting valuation

A valuation of scheme liability is carried out annually by the scheme actuary (currently the Government Actuary's Department) as at the end of the reporting period. This 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 2018, is based on valuation data as 31 March 2017, updated to 31 March 2018 with summary global member and accounting data. In undertaking this actuarial assessment, the methodology prescribed in IAS 19, relevant FReM interpretations, and the discount rate prescribed by HM Treasury have also been used.

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

b) Full actuarial (funding) valuation

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

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

The next actuarial valuation is to be carried out as at 31 March 2016 and is currently being prepared. The direction assumptions are published by HM Treasury which are used to complete the valuation calculations, from which the final valuation report can be signed off by the scheme actuary. This will set the employer contribution rate payable from April 2019 and will consider the cost of the Scheme relative to the employer cost cap. There are provisions in the Public Service Pension Act 2013 to adjust member benefits or contribution rates if the cost of the Scheme changes by more than 2% of pay. Subject to this 'employer cost cap' assessment, any required revisions to member benefits or contribution rates will be determined by the Secretary of State for Health after consultation with the relevant stakeholders.

Note 7.1 Alternative Scheme Pension costs

Employees not eligible for the NHS Pension Scheme are automatically enrolled into the National Employment Savings Trust (NEST). Employees can choose to opt out within one month of enrolment, or if they need to suspend contributing for a while they can do so without opting out.

The NEST Pension Scheme was established by the National Employment Savings Trust Order 2010. The scheme is a registered pension scheme for tax purposes under the Finance Act 2004 and was registered with HM Revenue & Customs on 21 January 2011. The Trustee of the scheme is the NEST Corporation which is a non-departmental public body established by statute, section 75 of the Pensions Act 2008. NEST is run on a not-for-profit basis and collects an annual management charge from its members of 1.3% of the employee's total fund each year. Also a charge of 1.8% is made on contributions made by the employee. At NEST, the employee keeps the same retirement pot and contributes to it even if their circumstances change.

Scheme Provisions

From April 2015 new rules mean the employee has more options for what they can do with their retirement pot. When the employee reaches 55, they will be able to take out as much as they want as cash and will have more choices in how they can get a retirement income.

Details of the benefits available under this scheme can be found on the NEST website - nestpensions.org.uk

Note 8 Operating leases

Note 8.1 Kent and Medway NHS and Social Care Partnership NHS Trust as a lessor

This note discloses income generated in operating lease agreements where Kent and Medway NHS and Social Care Partnership NHS Trust is the lessor.

The trust leases properties to a number of stakeholders primarily other NHS bodies and public sector organisations. These leases tend to be on a "full maintenance" basis.

	2017/18 £000	2016/17 £000
Operating lease revenue		
Contingent rent	1,143	1,367
Total	**1,143**	**1,367**

	31 March 2018 £000	31 March 2017 £000
Future minimum lease receipts due:		
- not later than one year;	1,143	1,367
Total	**1,143**	**1,367**

Note 8.2 Kent and Medway NHS and Social Care Partnership NHS Trust as a lessee

This note discloses costs and commitments incurred in operating lease arrangements where Kent and Medway NHS and Social Care Partnership NHS Trust is the lessee.

The majority of the leasing arrangements for the properties currently occupied by trust services are on a full repairing basis.

A number also require the trust to reinstate dilapidations on vacation of the premises. Break clauses where they exist are primarily at the 5 and 10 year point. No significant information is available on restrictions with the exception of one site where it is not to be used for any other purpose than healthcare offices or consulting rooms.

	2017/18 £000	2016/17 £000
Operating lease expense		
Minimum lease payments	1,893	2,132
Total	**1,893**	**2,132**

	31 March 2018 £000	31 March 2017 £000
Future minimum lease payments due:		
- not later than one year;	311	297
- later than one year and not later than five years;	434	967
- later than five years.	1,300	1,107
Total	**2,045**	**2,371**

Note 9 Finance income

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

	2017/18	2016/17
	£000	£000
Interest on bank accounts	14	11
Total	**14**	**11**

Note 10.1 Finance expenditure

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

	2017/18	2016/17
	£000	£000
Interest expense:		
Loans from the Department of Health and Social Care	55	57
Finance leases	102	111
Interest on late payment of commercial debt	1	14
Main finance costs on PFI and LIFT schemes obligations	803	842
Contingent finance costs on PFI and LIFT scheme obligations	567	452
Total interest expense	**1,528**	**1,476**
Unwinding of discount on provisions	55	46
Total finance costs	**1,583**	**1,522**

Note 10.2 The late payment of commercial debts (interest) Act 1998 / Public Contract Regulations 2015

	2017/18	2016/17
	£000	£000
Amounts included within interest payable arising from claims made under this legislation	1	14
Total	**1**	**14**

Note 11 Other gains / (losses)

	2017/18	2016/17
	£000	£000
Gains on disposal of assets	406	8
(Losses) on disposal of assets	(30)	(388)
Total other gains / (losses)	**376**	**(380)**

Note 12.1 Intangible assets - 2017/18

	Licences & trademarks £000	Internally generated information technology £000	Total £000
Valuation / gross cost at 1 April 2017 - brought forward	**1,939**	**4,500**	**6,439**
Additions	0	18	**18**
Reclassifications	33	0	**33**
Disposals / derecognition	(16)	(463)	**(479)**
Gross cost at 31 March 2018	**1,956**	**4,055**	**6,011**
Amortisation at 1 April 2017 - brought forward	**1,578**	**3,343**	**4,921**
Provided during the year	176	409	**585**
Disposals / derecognition	**(16)**	**(463)**	**(479)**
Amortisation at 31 March 2018	**1,738**	**3,289**	**5,027**
Net book value at 31 March 2018	**218**	**766**	**984**
Net book value at 1 April 2017	**361**	**1,157**	**1,518**

Note 12.2 Intangible assets - 2016/17

	Licences & trademarks £000	Internally generated information technology £000	Total £000
Valuation / gross cost at 1 April 2016 - as previously stated	**1,939**	**4,500**	**6,439**
Valuation / gross cost at 31 March 2017	**1,939**	**4,500**	**6,439**
Amortisation at 1 April 2016 - as previously stated	**1,293**	**2,679**	**3,972**
Provided during the year	**285**	**664**	**949**
Amortisation at 31 March 2017	**1,578**	**3,343**	**4,921**
Net book value at 31 March 2017	**361**	**1,157**	**1,518**
Net book value at 1 April 2016	**646**	**1,821**	**2,467**

Note 13.1 Property, plant and equipment - 2017/18

	Land £000	Buildings excluding dwellings £000	Assets under construction £000	Plant & machinery £000	Transport equipment £000	Information technology £000	Furniture & fittings £000	Total £000
Valuation/gross cost at 1 April 2017 - brought forward	**31,733**	**116,500**	**3,310**	**1,275**	**293**	**9,692**	**2,059**	**164,862**
Additions	0	349	4,867	94	0	330	0	**5,640**
Impairments	(6,215)	(2,014)	0	0	0	0	0	**(8,229)**
Revaluations	5	1,303	0	0	0	0	0	**1,308**
Reclassifications	0	1,030	(1,057)	22	0	0	(28)	**(33)**
Transfers to/ from assets held for sale	(5)	0	0	0	0	0	0	**(5)**
Disposals / derecognition	(1,392)	(1,572)	-	(99)	(51)	(4)	(236)	**(3,354)**
Valuation/gross cost at 31 March 2018	**24,126**	**115,596**	**7,120**	**1,292**	**242**	**10,018**	**1,795**	**160,189**
Accumulated depreciation at 1 April 2017 - brought forward	**-**	**7,660**	**-**	**881**	**262**	**4,812**	**1,356**	**14,971**
Provided during the year	-	3,665	-	98	12	1,788	199	**5,762**
Disposals / derecognition	-	(60)	-	(99)	(51)	(4)	(236)	**(450)**
Accumulated depreciation at 31 March 2018	**0**	**11,265**	**0**	**880**	**223**	**6,596**	**1,319**	**20,283**
Net book value at 31 March 2018	**24,126**	**104,331**	**7,120**	**412**	**19**	**3,422**	**476**	**139,906**
Net book value at 1 April 2017	**31,733**	**108,840**	**3,310**	**394**	**31**	**4,880**	**703**	**149,891**

The impairment relating to the land values is due to the adoption of the Modern Equivalent Asset on an alternative site basis within 2017/18, and the buildings relating to the devaluation of the St Martins Hospital site.

Note 13.2 Property, plant and equipment - 2016/17

	Land	Buildings excluding dwellings	Assets under construction	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000
Valuation / gross cost at 1 April 2016 - as previously stated	**31,733**	**114,077**	**4,486**	**1,178**	**393**	**16,329**	**1,808**	**170,004**
Transfers by absorption	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**-**
Additions	0	1,526	1,349	63	0	316	119	**3,373**
Revaluations	0	(1,462)	0	0	0	0	0	**(1,462)**
Reclassifications	0	2,359	(2,525)	34	0	0	132	**-**
Transfers to / from assets held for sale	0	0	0	0	(100)	0	0	**(100)**
Disposals / derecognition	0	0	0	0	0	(6,953)	0	**(6,953)**
Valuation/gross cost at 31 March 2017	**31,733**	**116,500**	**3,310**	**1,275**	**293**	**9,692**	**2,059**	**164,862**
Accumulated depreciation at 1 April 2016 - as previously stated	**0**	**4,040**	**0**	**804**	**350**	**9,911**	**1,167**	**16,272**
Provided during the year	**0**	**3,620**	**0**	**77**	**12**	**1,854**	**189**	**5,752**
Transfers to/ from assets held for sale	0	0	0	0	(100)	0	0	**(100)**
Disposals/ derecognition	0	0	0	0	0	(6,953)	0	**(6,953)**
Accumulated depreciation at 31 March 2017	**0**	**7,660**	**0**	**881**	**262**	**4,812**	**1,356**	**14,971**
Net book value at 31 March 2017	**31,733**	**108,840**	**3,310**	**394**	**31**	**4,880**	**703**	**149,891**
Net book value at 1 April 2016	**31,733**	**110,037**	**4,486**	**374**	**43**	**6,418**	**641**	**153,732**

Note 13.3 Property, plant and equipment financing - 2017/18

	Land	Buildings excluding dwellings	Assets under construction	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000
Net book value at 31 March 2018								
Owned - purchased	23,536	77,428	7,120	292	19	3,422	313	**112,130**
Finance leased	-	1,035	-	5	-	-	3	**1,043**
On-SoFP PFI contracts and other service concession arrangements	-	24,330	-	115	-	-	160	**24,605**
Owned - donated	590	1,538	-	-	-	-	-	**2,128**
NBV total at 31 March 2018	**24,126**	**104,331**	**7,120**	**412**	**19**	**3,422**	**476**	**139,906**

Note 13.4 Property, plant and equipment financing - 2016/17

	Land	Buildings excluding dwellings	Assets under construction	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000
Net book value at 31 March 2017								
Owned - purchased	31,143	81,705	3,310	309	31	4,880	459	**121,837**
Finance leased	0	1,186	0	5	0	0	3	**1,194**
On-SoFP PFI contracts and other service concession arrangements	0	24,957	0	80	0	0	241	**25,278**
Owned - donated	590	992	0	0	0	0	0	**1,582**
NBV total at 31 March 2017	**31,733**	**108,840**	**3,310**	**394**	**31**	**4,880**	**703**	**149,891**

Note 14 Revaluations of property, plant and equipment

All land and buildings are restated to current value using professional valuations in accordance with IAS 16 every five years and in the intervening third year by a 'desk top' review, or on the completion of a material refurbishment scheme. The current effective date of the 'desk top' revaluation is March 31st 2018, with the next full valuation to be undertaken as at 31st March 2020.

The valuation was undertaken by a Royal Institute of Chartered Surveyors accredited valuer using industry methodologies. All values are based on industry prescribed techniques.

One property has been identified as surplus to the trust's requirements and has been valued in line with IFRS13 which requires valuation at the best and highest use. The valuation was carried out by an independent valuer, Boshier & Co, MRICS.

Note 15.1 Trade receivables and other receivables

	31 March 2018 £000	31 March 2017 £000
Current		
Trade receivables	6,773	5,761
Accrued income	1,565	850
Provision for impaired receivables	(2,611)	(172)
Prepayments (non-PFI)	1,758	689
PDC dividend receivable	338	82
VAT receivable	379	661
Other receivables	321	167
Total current trade and other receivables	**8,523**	**8,038**
Non-current		
Trade receivables	533	622
Total non-current trade and other receivables	**533**	**622**
Of which receivables from NHS and DHSC group bodies:		
Current	8,049	5,617

The great majority of trade is with Clinical Commissioning Groups (CCGs) as commissioners for NHS patient care services. As CCGs are funded by Government to buy NHS patient care services, no credit scoring of them is considered necessary.

Note 15.2 Provision for impairment of receivables

	2017/18	2016/17
	£000	£000
At 1 April as previously stated	**172**	**216**
Increase in provision	2,572	(93)
Amounts utilised	(12)	(12)
Unused amounts reversed	(121)	61
At 31 March	**2,611**	**172**

The factors used to determine impairment are that the debt is greater than 90 days and other known factors such as failure to make agreed payment instalments.

Note 15.3 Credit quality of financial assets

	31 March 2018 Trade and other receivables	31 March 2017 Trade and other receivables
Ageing of impaired financial assets	**£000**	**£000**
0 - 30 days	1,960	65
30-60 Days	0	36
60-90 days	0	38
90- 180 days	23	31
Over 180 days	629	2
Total	**2,612**	**172**
Ageing of non-impaired financial assets past their due date		
0 - 30 days	943	264
30-60 Days	1,174	270
60-90 days	831	31
90- 180 days	785	112
Over 180 days	766	3,389
Total	**4,499**	**4,066**

Note 16 Non-current assets held for sale and assets in disposal groups

	2017/18	2016/17
	£000	£000
NBV of non-current assets for sale and assets in disposal groups at 1 April	0	0
Assets classified as available for sale in the year	5	0
NBV of non-current assets for sale and assets in disposal groups at 31 March	**5**	**0**

Note 17.1 Cash and cash equivalents movements

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

	2017/18	2016/17
	£000	£000
At 1 April	**1,484**	**2,065**
Net change in year	3,599	(581)
At 31 March	**5,083**	**1,484**
Broken down into:		
Cash at commercial banks and in hand	78	134
Cash with the Government Banking Service	5,005	1,350
Total cash and cash equivalents as in SoFP	**5,083**	**1,484**
Total cash and cash equivalents as in SoCF	**5,083**	**1,484**

Note 17.2 Third party assets held by the trust

The trust held cash and cash equivalents which relate to monies held by the trust on behalf of patients or other parties. This has been excluded from the cash and cash equivalents figure reported in the accounts.

	31 March 2018	31 March 2017
	£000	£000
Third party assets - Bank Balance (not included above)	**241**	**254**

Note 18.1 Trade and other payables

	31 March 2018	31 March 2017
	£000	£000
Current		
Trade payables	4,096	4,084
Capital payables	2,429	1,339
Accruals	4,433	2,742
Social security costs	1,222	1,320
Other taxes payable	984	1,035
Accrued interest on loans	14	16
Other payables	1,908	1,732
Total current trade and other payables	**15,086**	**12,268**
Of which payables from NHS and DHSC group bodies:		
Current	1,580	1,479

Note 18.2 Early retirements in NHS payables above

The payables note above includes amounts in relation to early retirements as set out below:

	2018	2018	2017	2017
	£000	Number	£000	Number
years	0		86	
- number of cases involved		0		2
- outstanding pension contributions	1,715		1,693	

Note 19 Other liabilities

	2018	2017
Obligations under finance leases	£000	£000
Current		
Deferred income	45	0
Total other current liabilities	**45**	**0**

Note 20 Borrowings

	31 March 2018	31 March 2017
	£000	£000
Current		
Loans from the Department of Health and Social Care	800	800
Obligations under finance leases	152	141
Obligations under PFI, LIFT or other service concession contracts (excl. lifecycle)	681	647
Total current borrowings	**1,633**	**1,588**
Non-current		
Loans from the Department of Health and Social Care	3,100	3,900
Obligations under finance leases	1,158	1,310
Obligations under PFI, LIFT or other service concession contracts	11,496	12,177
Total non-current borrowings	**15,754**	**17,387**

Note 21 Finance leases

Note 21.1 Kent and Medway NHS and Social Care Partnership NHS Trust as a lessee

Obligations under finance leases where Kent and Medway NHS and Social Care Partnership NHS Trust is the lessee.

There are no contingent rent obligations.
Options for renewal are as per the standard Landlord and Tenant Act 1954 and none have the option to purchase.
All properties are restricted for use as healthcare facilities.

	2018	2017
	£000	£000
Gross lease liabilities	**1,701**	**1,944**
of which liabilities are due:		
- not later than one year;	243	243
- later than one year and not later than five years;	972	972
- later than five years.	486	729
Finance charges allocated to future periods	(391)	(493)
Net lease liabilities	**1,310**	**1,451**
of which payable:		
- not later than one year;	152	141
- later than one year and not later than five years;	719	672
- later than five years.	439	638

Littlebrook Hospital PFI - Scheme 1

In 2025, after the completion of the 25 years life cycle, the Project Agreement becomes a normal Finance Lease Agreement for the 100 years remaining residual life regulated by IFRS 16 - Leases. An option appraisal is to be undertaken nearer the date of completion, therefore the future commitment relating to this agreement has not been disclosed in Note 20 above.

Note 22.1 Provisions for liabilities and charges analysis

	Pensions - early departure costs	Legal claims	Other	Total
	£000	£000	£000	£000
At 1 April 2017	**1,901**	**151**	**458**	**2,510**
Change in the discount rate	19	0	0	**19**
Arising during the year	15	295	23	**333**
Utilised during the year	(116)	(57)	(3)	**(176)**
Reversed unused	(284)	(119)	(66)	**(469)**
Unwinding of discount	55	0	0	**55**
At 31 March 2018	**1,590**	**270**	**412**	**2,272**
Expected timing of cash flows:				
- not later than one year;	118	270	284	**672**
- later than one year and not later than five years;	472	0	128	**600**
- later than five years.	1,000	0	0	1,000
Total	**1,590**	**270**	**412**	**2,272**

Early Departure Costs represent pension liabilities for injury benefits.
Legal Claims reflect LTPS which NHS Resolution provide estimates and employment tribunal claims whose timings are based on current assumptions from the trust Legal Department.
Other claims relate to dilapidations provisions.

Note 22.2 Clinical negligence liabilities

At 31 March 2018, £1,084k was included in provisions of NHS Resolution in respect of clinical negligence liabilities of Kent and Medway NHS and Social Care Partnership NHS trust (31 March 2017: £2,482k).

Note 23 Contingent liabilities

	31 March 2018	31 March 2017
	£000	£000
Value of contingent liabilities		
NHS Resolution legal claims	(67)	(61)
Other	(1,134)	(1,193)
Net value of contingent liabilities	**(1,201)**	**(1,254)**

Contingent liabilities relate to £69k (£61k 2016/17) LTPS notified by NHS Resolution and £1.1m (£1.1m 2016/17) dilapidation costs for future years onwards.
Accounting Policy Note 1.17 refers to the process for dilapidation provisions.

Note 24 Contractual capital commitments

	31 March 2018	31 March 2017
	£000	£000
Property, plant and equipment	1,688	0
Total	**1,688**	**0**

Note 25 Other financial commitments

The trust has entered into no non-cancellable contracts.

Note 26 On-SoFP PFI, LIFT or other service concession arrangements

The trust has committed to two PFI Schemes.

Scheme 1 comprises the provision of an acute psychiatric hospital at Bow Arrow Lane, Dartford. Under the agreement, some services are provided to the hospital. Certain rights and obligations are accorded to the trust under back to back arrangements with the PFI consortium.

Scheme 1 : Littlebrook Hospital	**2017/18**	2016/17
	£000s	£000s
Estimated Capital value of the PFI Scheme at the start of the contract	**7,542**	7,542
Contract start date:		**06/03/2000**
Contract end date:		**06/06/2025**

After the completion of the 25 years life-cycle, the Project Agreement becomes a normal Lease Agreement (Finance Lease) for the remaining 100 year residual life (see note 23)

Scheme 2 : Replacement of Stone House Hospital

The trust replaced the old Stone House Hospital in two stages:

Stage 1 was carried out as a variation order under Dartford and Gravesham PFI Project Agreement. It related to the construction of a mental health assessment unit and a renal dialysis unit on the Darenth Valley Hospital Site. The scheme was completed in April 2005 at a cost of £5.4m. Stage 1 was funded by public capital, rather than private finance, and was capitalised on the trust's Statement of Financial Position in 2005/06. Dartford and Gravesham NHS trust recharges the trust for all facility services and other costs provided under the PFI agreement.

Stage 2 is the PFI scheme 2 and comprises the provision of a mental health continuing care unit, a mental health rehabilitation unit, a learning disabilities forensic unit in phase 1 and an inpatient addiction unit in phase 2. The phase 2 inpatient addiction unit, which was provided as a variation under the Project Agreement, opened on 2nd July 2007. Hard FM services are provided to the units under the project agreement.

	2017/18	2016/17
Phase 1 Stone House Hospital	**£000s**	£000s
Estimated capital value of the PFI scheme at the start of the contract	**9,440**	9,440
Contract start date:		**29/09/2006**
Contract end date:		**29/09/2031**

	2017/18	2016/17
Phase 2 Stone House Hospital	**£000s**	£000s
Estimated capital value of the PFI scheme at the start of the contract	**2,787**	2,787
Contract start date:		**02/07/2007**
Contract end date:		**02/07/2037**

Note 26.1 Imputed finance lease obligations

Kent and Medway NHS and Social Care Partnership NHS Trust has the following obligations in respect of the finance lease element of on-Statement of Financial Position PFI and LIFT schemes:

	31 March 2018 £000	31 March 2017 £000
Gross PFI, LIFT or other service concession liabilities	**19,376**	**20,826**
Of which liabilities are due		
- not later than one year;	1,444	1,450
- later than one year and not later than five years;	5,787	5,728
- later than five years.	12,145	13,648
Finance charges allocated to future periods	(7,199)	(8,002)
Net PFI, LIFT or other service concession arrangement obligation	**12,177**	**12,824**
- not later than one year;	681	647
- later than one year and not later than five years;	3,172	2,929
- later than five years.	8,324	9,248

Note 26.2 Total on-SoFP PFI, LIFT and other service concession arrangement commitments

Total future obligations under these on-SoFP schemes are as follows:

	31 March 2018 £000	31 March 2017 £000
Total future payments committed in respect of the PFI, LIFT or other service concession arrangements	52,913	55,806
Of which liabilities are due:		
- not later than one year;	3,262	3,041
- later than one year and not later than five years;	13,224	12,913
- later than five years.	36,427	39,852

Note 26.3 Analysis of amounts payable to service concession operator

This note provides an analysis of the trust's payments in 2017/18:

	2017/18 £000	2016/17 £000
Unitary payment payable to service concession operator	3,056	2,846
Consisting of:		
- Interest charge	803	842
- Repayment of finance lease liability	647	627
- Service element and other charges to operating expenditure	1,039	925
- Contingent rent	567	452
Total amount paid to service concession operator	**3,056**	**2,846**

Note 27 Financial instruments

Note 27.1 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. Because of the continuing service provider relationship that the trust has with Clinical Commissioning Groups (CCGs) and the way those CCGs are financed, the trust is not exposed to the degree of financial risk faced by business entities. Also financial instruments play a much more limited role in creating or changing risk than would be typical of listed companies, to which the financial reporting standards mainly apply. The 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 trust in undertaking its activities.

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

Currency risk

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

Interest rate risk

The trust borrows from government for capital expenditure, subject to affordability as confirmed by NHS Improvement. The borrowings are for 1 – 25 years, in line with the life of the associated assets, and interest is charged at the National Loans Fund rate, fixed for the life of the loan.

The trust may also borrow from government for revenue financing subject to approval by NHS Improvement. Interest rates are confirmed by the Department of Health (the lender) at the point borrowing is undertaken.

The trust therefore has low exposure to interest rate fluctuations.

Credit risk

Because the majority of the trust's revenue comes from contracts with other public sector bodies, the trust has low exposure to credit risk. The maximum exposures as at 31 March 2017 are in receivables from customers, as disclosed in the trade and other receivables note.

Liquidity risk

The trust's operating costs are incurred under contracts with Clinical Commissioning Groups (CCGs), which are financed from resources voted annually by Parliament . The trust funds its capital expenditure from funds obtained within its prudential borrowing limit. The trust is not, therefore, exposed to significant liquidity risks.

Note 27.2 Carrying values of financial assets

	Loans and receivables	Total book value
	£000	£000
Assets as per SoFP as at 31 March 2018		
Trade and other receivables excluding non financial assets	5,958	**5,958**
Cash and cash equivalents at bank and in hand	5,083	**5,083**
Total at 31 March 2018	**11,041**	**11,041**

	Loans and receivables	Total book value
	£000	£000
Assets as per SoFP as at 31 March 2017		
Trade and other receivables excluding non financial assets	5,854	**5,854**
Cash and cash equivalents at bank and in hand	1,484	**1,484**
Total at 31 March 2017	**7,338**	**7,338**

Note 27.3 Carrying value of financial liabilities

	Other financial liabilities	Total book value
	£000	£000
Liabilities as per SoFP as at 31 March 2018		
Borrowings excluding finance lease and PFI liabilities	3,900	**3,900**
Obligations under finance leases	1,310	**1,310**
Obligations under PFI, LIFT and other service concession contracts	12,177	**12,177**
Trade and other payables excluding non financial liabilities	10,959	**10,959**
Total at 31 March 2018	**28,346**	**28,346**

	Other financial liabilities	Total book value
	£000	£000
Liabilities as per SoFP as at 31 March 2017		
Borrowings excluding finance lease and PFI liabilities	4,700	**4,700**
Obligations under finance leases	1,451	**1,451**
Obligations under PFI, LIFT and other service concession contracts	12,824	**12,824**
Trade and other payables excluding non financial liabilities	8,182	**8,182**
Total at 31 March 2017	**27,157**	**27,157**

Note 27.4 Maturity of financial liabilities

	31 March 2018	31 March 2017
	£000	£000
In one year or less	12,591	10,571
In more than one year but not more than two years	1,617	1,632
In more than two years but not more than five years	5,374	5,069
In more than five years	8,764	9,885
Total	**28,346**	**27,157**

For all financial instruments the disclosed amounts relate to book value (carrying value) as a reasonable approximation of fair value

Note 28 Losses and special payments

	2017/18		2016/17	
	Total number of cases	Total value of cases	Total number of cases	Total value of cases
	Number	£000	Number	£000
Losses				
Cash losses	32	9	20	1
Fruitless payments	0	0	1	1
Bad debts and claims abandoned	9	46	5	11
Stores losses and damage to property	0	0	1	0
Total losses	**41**	**55**	**27**	**13**
Special payments				
Compensation under court order or legally binding arbitration award	0	0	7	53
Ex-gratia payments	31	111	15	9
Total special payments	**31**	**111**	**22**	**62**
Total losses and special payments	**72**	**166**	**49**	**75**

Note 29 Related parties

The Kent and Medway NHS and Social Care Partnership trust is a body corporate established by order of the Secretary of State for Health.

During the year none of the trust board members or members of the key management staff, or parties related to any of them, has undertaken any material transactions with the Kent and Medway NHS and Social Care Partnership trust.

The Department of Health and Social Care is regarded as a related party. During the year the trust has had a significant number of material transactions with the Department, and with other entities for which the Department is regarded as the parent Department. These entities, with transactions greater than £1m, are listed below:

Note 29.1 Related Party Income

Health Education England
Kent Community Health NHS Foundation Trust
NHS Ashford Clinical Commissioning Group
NHS Canterbury and Coastal Clinical Commissioning Group
NHS Dartford, Gravesham & Swanley Clinical Commissioning Group
NHS Thanet Clinical Commissioning Group
NHS Swale Clinical Commissioning Group
NHS West Kent Clinical Commissioning Group
NHS South Kent Coast Clinical Commissioning Group
NHS Medway Clinical Commissioning Group
NHS England (including CSUs)
Department of Health and Social Care

Note 29.2 Related Party Expenditure

East Kent Hospitals University NHS Foundation Trust
Maidstone And Tunbridge Wells NHS Trust
Medway NHS Foundation Trust
NHS Pensions Scheme

Note 30 Events after the reporting date

There are no non-adjusting material events after the reporting date.

Note 31 Better Payment Practice code

	2017/18 Number	2017/18 £000	2016/17 Number	2016/17 £000
Non-NHS Payables				
Total non-NHS trade invoices paid in the year	23,297	47,267	21,421	57,677
Total non-NHS trade invoices paid within target	21,357	46,350	17,951	51,056
target	91.67%	98.06%	83.80%	88.52%
NHS Payables				
Total NHS trade invoices paid in the year	1,433	7,817	1,529	9,413
Total NHS trade invoices paid within target	1,272	7,237	1,114	6,398
Percentage of NHS trade invoices paid within target	88.76%	92.58%	72.86%	67.97%

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

Note 32 External financing

The trust is given an External Financing Limit (EFL) against which it is permitted to underspend:

	2017/18 £000	2016/17 £000
External financing limit	(19)	3,821
Cash flow financing	(4,532)	2,796
External financing requirement	**(4,532)**	**2,796**
Under spend against EFL	**4,513**	**1,025**

Note 33 Capital Resource Limit

The trust is given an Capital Resource Limit (CRL) against which it is permitted to underspend:

	2017/18 £000	2016/17 £000
Gross capital expenditure	5,658	3,373
Less: Disposals	(2,904)	0
Charge against Capital Resource Limit	2,754	3,373
Capital Resource Limit	3,381	4,398
Under / (over) spend against CRL	627	1,025

Note 34 Breakeven duty rolling assessment

	2008/09	2009/10 £000	2010/11 £000	2011/12 £000	2012/13 £000	2013/14 £000	2014/15 £000	2015/16 £000	2016/17 £000	2017/18 £000
Breakeven duty in-year financial performance		1,524	13	538	1,202	1,607	902	(4,180)	(3,311)	(1,224)
Breakeven duty cumulative position	2,376	3,900	3,913	4,451	5,653	7,260	8,162	3,982	671	(553)
Operating income		182,374	182,204	178,468	172,902	174,924	178,674	181,334	183,103	181,034
Cumulative breakeven position as a percentage of operating income		2.14%	2.15%	2.49%	3.27%	4.15%	4.57%	2.20%	0.37%	-0.31%

Glossary

This glossary explains some of the technical terms that are used within this section of the report.

Public Dividend Capital	The finance (PDC) made available to the trust to pay for its assets, including all its buildings at its start.
Fixed Assets	Assets held for use by the trust rather than for sale or conversion into cash, e.g. buildings, equipment, fixtures and fittings.
Intangible Assets	Assets that have no physical substance e.g. software licences.
Tangible Assets	Assets that have physical substance e.g. a building.
Receivables	Entities or individuals who owe the trust money.
Current Assets	Items such as, cash in the bank and in hand and monies owed to the trust.
Payables	Amounts of money that the trust owes other organisations or individuals.
Provisions	Amounts of monies that the trust has a liability to pay in the future that can be reliably estimated.
Capital Resource Limit	A limit that controls the amount of capital expenditure the trust can incur in a year. The trust must have a capital resource limit to cover all capital expenditure it incurs and should maintain expenditure within the limit.
External Financing Limit	A limit set by the Department of Health used to control and manage the cash expenditure of the trust. It covers all internal and external Sources of finance available to the trust including funding from the Department of Health.
Capital Cost Absorption Duty	This duty measures the trust's ability to ensure that the Department of Health receives a return on their investment (PDC). It measures the trust's Dividend against average relevant assets held.
Liquidity	The ability of the trust to pay all its debts when they fall due.
Benefits in kind	Goods or services provided by the trust to an employee for no costor a greatly reduced cost.
Taxpayer' Equity	Bottom half of the Statement of Financial Position which shows the Taxpayers investment in the trust.
Fixed asset impairment losses	Impairment losses arise when an asset is recorded in the trust's books at more than its current value. This difference between what the trust can sell the asset for and the historic value in the trust's books is an impairment loss.

Patient Advice and Liaison Service (PALS)

If you have a concern about your care and treatment, but feel unable to speak to the staff providing your care, or if you want some information about local health services, you can contact the confidential PALS Team by calling the numbers listed below or sending an email:

East Kent: 0800 783 9972

West Kent and Medway: 0800 587 6757

Email: PALS@kmpt.nhs.uk

Complaints and compliments

If you have something to say about our service, please talk to our staff - we welcome your feedback. If you would like to see your compliments officially recorded or want to make a formal complaint, you can write to our Chief Executive.

All complaints will be carefully listened to and thoroughly investigated.

Write to:
Chief Executive
PALS and Complaints
St Martin's Hospital
Littlebourne Road
Canterbury
Kent CT1 1TD

Please call **01622 724121** if you would like this leaflet in a different language or format.

Review May 2019 KM804