NHS
Kent and Medway
NHS and Social Care Partnership Trust

ANNUAL REPORT 2018 19

Brilliant care through brilliant people

Triangle of Care MEMBER

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Welcome

We have had an incredibly busy and productive year which resulted in our latest Care Quality Commission (CQC) report in March following our well-led inspection in late 2018. We were delighted to be rated as Good overall whilst maintaining Outstanding for caring. Across our activity ratings, we saw an improvement in nine areas which included our Forensics services achieving Outstanding once again. We are #KMPTProud to see the fabulous work of our staff, carers, service users and volunteers recognised in this way.

We know there is more work to do. Once again the inspection report flagged the importance of continuing with our estates strategy to upgrade some of our inpatient and community areas. St Martins (west) has been highlighted by CQC previously as a building which is rapidly becoming unsuitable to house an inpatient unit. The site has now been sold to Homes England who will be developing homes for our communities. The money will be reinvested into our estates strategy which includes necessary upgrades on Willow Suite intensive care unit and some of our acute inpatient wards making where we provide our services as outstanding as those caring for the people who use our services.

At the heart of everything we do is ensuring we are listening to staff, service users and carers to regularly review and improve services where needed. Numbers of staff attending Big Conversation and Leadership events have increased and we have seen an increase in the number of staff taking part in our staff survey.

Our work with the Triangle of Care has continued and will develop further as we work with the Royal College of Nursing as they lead the initiative going into 2020.

I'm also incredibly proud to be part of a trust leading the way by employing people with lived experience. As industry leaders, we hosted an Imroc peer support conference earlier this year, inviting other trusts to join us in celebrating an increasing national peer support workforce.

This year we also saw the launch of the governments NHS Long Term Plan which has reinforced our own priorities planned over the next few years. This includes preventative health care, preventing illness and tackling health inequalities, delivering community-based physical and mental health care and expanding support for perinatal mental health. Most of this work is already underway with a number of initiatives across the Kent and Medway STP, working together we will transform health and social care in Kent and Medway.

Anne-Marie Dean
Acting Chair
(on behalf of
Andrew Ling - Chairman)

Helen Greatorex
Chief Executive

THE PERFORMANCE REPORT

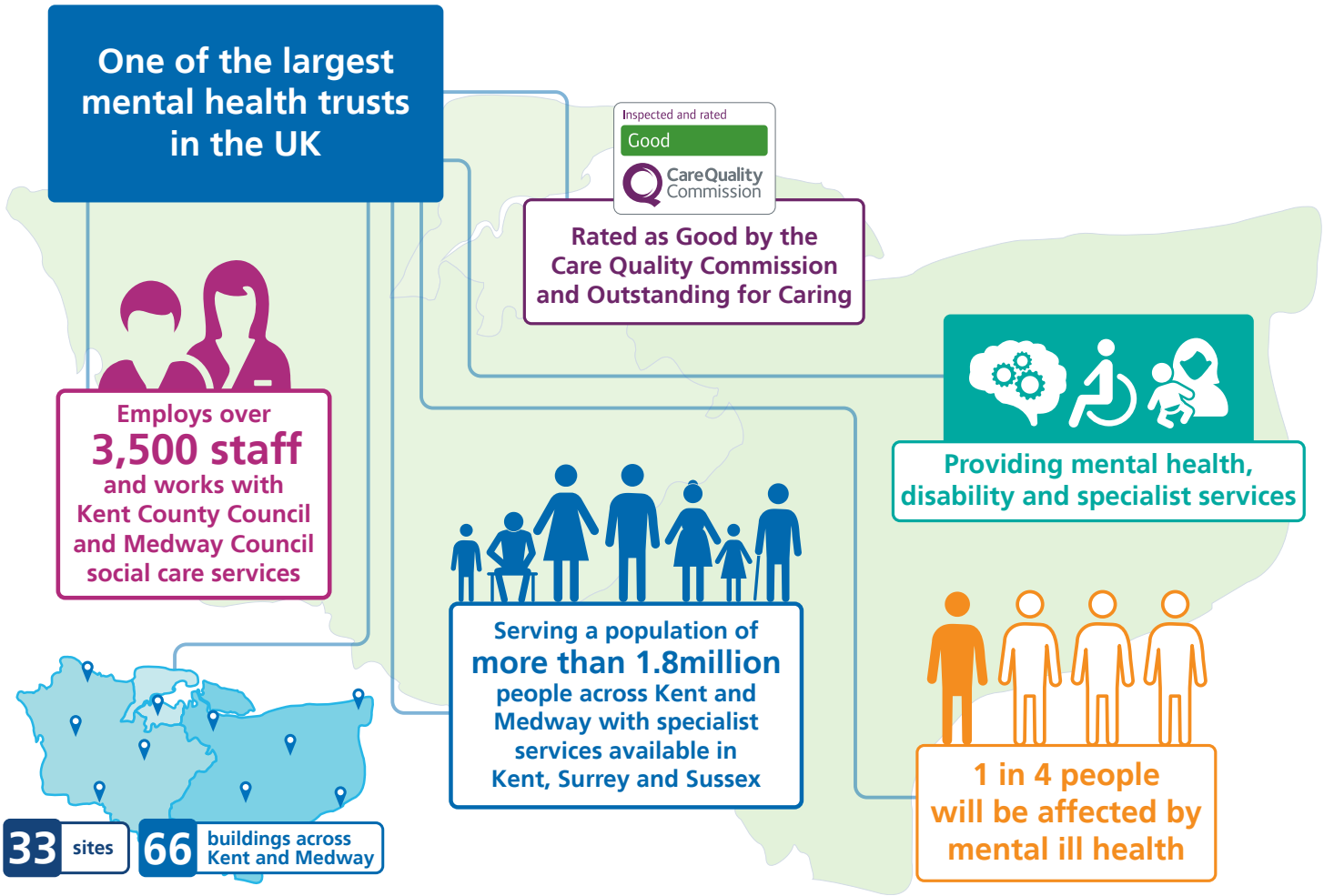
Annual overview

We are a mental health trust that provides mental health, learning disability, substance misuse and specialist services to approximately 1.8 million people across Kent and Medway.

We work in partnership with Kent County Council and the unitary authority in Medway, and are commissioned by eight regional Clinical Commissioning Groups and NHS Specialist Commissioning. We are one of the largest mental health trusts in England, covering a vast rural and urban rich area. We have annual revenue of £185 million and employ approximately 3,500 staff who work across 66 buildings on 33 sites. We are proud to be a leading mental health trust in the employment of peer support workers (those with lived experience).

Our increasingly diverse communities are spread across an area of 1,450 square miles which delivers some real challenges in reaching our mix of patients and their loved ones but also presents us with opportunities to engage with our communities to continually review and improve our services.

Having staff located in many different areas across the county has made it difficult to to embed a learning and engaged culture. In 2017-18 we developed a comprehensive organisation development programme which includes leadership events and greater access to senior managers through 'Big Conversation' events and working with days. Throughout 2018-19, we have developed this further with improved internal communications, a dedicated staff app, greater staff involvement in the development of strategies and objectives and the embedding of our vision and values as staff embrace what it means to live our trust values every day.



Our vision and values

To provide brilliant care through brilliant people.

We will do this by:

Consistently delivering outstanding quality of care

- Recruit, retain and develop the best staff making KMPT a great place to work
- Place 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 and leadership.

Vision - delivering quality through partnerships

Review of the year

NHS70

We were delighted to take part in the national and regional celebrations of the NHS70 anniversary. We engaged with our communities throughout the celebratory week by setting up a mental health awareness exhibition in Asda stores across the county. We talked about mental health and helped raise awareness of the trust in the wider NHS setting.

We developed a unique award category in our trust awards which welcomed nominations for people who had given their all within their NHS role and who had worked with partners to help improve services, while all the time ensuring patients are at the heart of everything.

The criteria stated that anyone who is involved in mental health care could be nominated - patient, carer, trust staff or volunteer. The winner of this award was Dr Bill Bamber, a retired consultant psychiatrist, who joined us at the celebratory event and recounted his working life with fond memories.

A team of healthcare professionals joined a local radio station on the day of the anniversary (5 July) to share their NHS stories with our communities.

Working with local landmarks, we arranged for buildings of interest to be lit in blue on the evening of 5 July to show recognition to all of those who work within the NHS.

It was a truly #KMPTProud series of celebrations.

Rosewood Mother and Baby Unit

Our new eight bed inpatient unit opened for referrals on 8 August. Our new Mother and Baby Unit is the first inpatient unit available within Kent, with patients previously having to travel long distances to access a unit that provides this specialist care where mums can receive the help and support they need, without having to be separated from their baby.

The unit is also available for new mothers from across Surrey and Sussex but will consider admissions from other areas of the country if beds are available.

We are proud to say that the ward and service itself was designed with the help of volunteer mums who used their lived experience to help shape the unit. Two of those volunteers now work in the unit as Peer Support Workers.

The project team was joined by trust staff, other health professionals, third sector care groups, former service users and local MP Helen Whately to officially launch the unit.

TABLO

The international three year project came to its conclusion in 2018 with a conference hosted by KMPT to launch the toolkit designed to help train people in the use of arts for the benefit of patients with long-term conditions. The project was funded by the European Union with support from the European Commission. It brought together representatives from seven other countries to develop the e-learning toolkit.

www.tablo-project.eu

Diversity conference

The trust held its first ever diversity and inclusion conference in October. The event was attended by 65 employees from KMPT who were joined by staff from other organisations including Maidstone and Tunbridge Wells NHS Trust and Kent Community Health Foundation Trust.

The day featured a range of inspirational speakers including Tara Hewitt, diversity consultant, who spoke about LGBTQ+ and issues in the workplace. Her 'talent of the rainbow and beyond' talk and workshop on transgender inclusion empowerment in the workplace were some of the key highlights. Delegates were also delighted to hear from Professor Dame Elizabeth Nneka Anionwu, Emeritus Professor of Nursing at the University of West London.

We used this platform as a springboard to revitalise some of our network groups. We now have four clearly identified groups, BAME, LGBTQ+, (dis)ABILITY and Faith networks. Each group has set objectives which align with the trust's priorities going into 2019-20.

AHP strategy

The trust's first professional strategy for Allied Health Professionals (AHP) was launched with a combined celebration of AHP practice on the first national AHP day. The event was held in October and our AHPs were joined by a range of trust colleagues to mark the day.

The strategy was developed through a review of national and local health care priorities, developed with input from AHPs and informed by service users. It sets out how the trust plans to develop the professional contribution of the Allied Health Professions over the coming years.

In summary, the aims of the strategy are to:

- Create a strategic vision for the future of AHP services provided by, or under

the leadership of, KMPT in the field of mental health and specialist services.

- Promote and ensure AHPs are used as key contributors to meeting the overarching aims of our Clinical Strategy, Quality Strategy, and the Kent and Medway Sustainability Transformation Partnership.
- Reassert AHPs core knowledge and skill in enablement and the rebuilding of meaningful lives, which are essential to health and mental and physical wellbeing.
- Outline actions for key stakeholders to achieve the delivery of high quality and clinically effective care in which the AHPs are a core component.

National award recognition

The Peer Supported Open Dialogue Service won the Royal College of Psychiatry's prestigious Psychiatric Team of the Year Award (working age adults). The team were praised by the judges for 'leading the way' in developing a new approach to the care and treatment of patients presenting for the first time with severe mental health problems.

The award is the latest national recognition for the Open Dialogue service who was Highly Commended at the Positive Practice in Mental Health Awards.

KMPT staff took home a triple win with Pam Wooding winning the Outstanding Occupational Therapist (OT) category at the Occupational Therapy Awards. Tracy Holt also won the Outstanding OT Technical Instructor/OT Assistant/service user contribution award category. In a double win for this category, Bob St Clair Baker was Highly Commended.

A team led by Edward Kanu, Head of Nursing, attended the South of England Mental Health Quality and Patient Safety Improvement Collaborative conference and were thrilled to win not one but two awards - Excellence in Co-design of Services through Improvement and the People's Choice Award as voted by delegates on the day.

Our other award finalists include:

- Andrew Dickers, Lead nurse for education and development, third place - BJN awards 2019
- Royal College of Psychiatry (RCPsych) Awards 2018, Professor Catherine Kinane, 'Psychiatrist of the Year'

- Positive Practice in Mental Health Awards, Specialist Personality Disorder Service, Specialist community services for adults with complex mental health needs, including people with a diagnosis of personality disorder category
- Positive Practice in Mental Health Awards; Peer Supported Open Dialogue Service (POD), Crisis and Acute Mental Health Care for Children and Young People, Adults, Older People category
- Nursing Times Awards; Nursing in Mental Health, Development of Nurse Independent Prescribers, Graham Caney and Grace Skinner, Clinical Nurse Specialists
- Nursing Times Awards; Nursing in Mental Health, Implementation of Triangle of Care, Lisa Medhurst, Modern Matron, Acute Care Group East
- Rcni Awards; Commitment to Carers, Lisa Medhurst, Modern Matron, Acute Care Group East, Triangle of Care
- Seven staff were voted among the top 70 Health and Care Top Stars Awards 2018
- HSJ Value Awards 2018; Patient Flow Transformation project, Mental Health category.

Restorative Service Quality Mark

The Restorative Justice Committee (RJC) announced in January 2019 that the Low Secure Forensic and Specialist Service had been awarded the Restorative Service Quality Mark (RSQM).

The RSQM is a badge of quality that guarantees that a service provides safe, high-quality restorative practice which meets six Restorative Service standards. The low secure forensic service runs a restorative justice therapy programme and focuses on preventative approaches and de-escalation with minimal use of restrictive interventions.

Chris Straker, the RJC's interim chief executive, said: "I'm thrilled that the low secure forensic and specialist service at KMPT has achieved the RSQM, the first UK forensic mental health service to do so. This award reflects the team's commitment to meet the needs of both patients and staff through the development of high-quality and innovative restorative practice. Congratulations to the whole team."

Suicide prevention

The Kent and Medway Sustainability and Transformation Partnership (STP) has awarded community group grants from government funding to support innovative programmes designed to prevent suicide and reduce self-harm as part of the Saving Lives campaign.

The trust was awarded £120,000 in 2018-19 to show primary development in five workstreams focused on high priority areas: Long-term planning, discharge and staff wellbeing. These workstreams have embraced cross-organisational working with the third sector and additional partners, to help enhance follow up for patients discharged from inpatient services and from KMPT. Additionally, resource has focused on target patients groups, working specifically with liaison psychiatry to offer an additional follow-up to patients presenting at A&E with self-harm, and more broadly across the acute care group to incorporate current suicide reduction processes into a comprehensive zero inpatient suicide plan. Finally, KMPT staff wellbeing and support has been considered through the initial development of an organisation wide, tailored, skills based suicide prevention training package.

Transforming health and social care in Kent and Medway

Other projects include Stepping Out, a walking group covering all of Kent, a film exploring why men are at high risk of suicide and identifying solutions, and an initiative called 'Bridge the Gap, a project being led by SpeakUPCIC.

STP has also funded a ground-breaking prevention app called Stay Alive. The tool contains lots of useful information to help individuals stay safe in a crisis. The app was put together by charity, Grassroots Suicide Prevention, with input from young people and adults with mental health illness and from mental health professionals.

Recovery and Wellbeing College

Working with Kent Adult Education, KMPT has piloted a Recovery and Wellbeing College in Thanet. 93 students enrolled on more than 300 course places over the 12 week autumn term. The Recovery and Wellbeing College team and the students gathered together at the Turner Contemporary in Margate to celebrate their achievements. Students beamed with pride as they accepted their graduation certificates in front of their fellow students.

The pilot has since been extended to continue for a further term and the trust is currently considering how it can be further developed across the county.

Medical training

The General Medical Council (GMC) national training surveys are a core part of the work which the GMC carry out each year, to monitor and report on the quality of postgraduate medical education and training in the UK.

Each year they run comprehensive surveys asking all doctors in training ie: (Foundation/GP/Core/Higher trainees) and their trainers for their views.

In 2018 over 70,000 trainees and trainers took part in the national training surveys, giving their views on training posts, programmes and environments in England, Northern Ireland, Scotland and Wales. This year, the GMC survey was open from 20 March to 9 May 2018 and 100 per cent of our trainees in psychiatry completed the survey.

The feedback helps the GMC make sure that doctors in training receive high-quality training in a safe and effective clinical environment and trainers are well supported in their role.

The survey looks into many variables which include: overall satisfaction, clinical supervision, reporting systems, workload, teamwork, handover, supportive environment, induction, adequate experience, curriculum coverage, access to educational resources, educational governance, educational supervision, feedback, local teaching, regional teaching and study leave.

KMPT continued to be ranked among the top three within Kent Surrey and Sussex in 2018 and were ranked fifth out of 59 mental health trusts for forensic psychiatry in the UK.

We received no red flags and an exceptional band of five green flags.

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 their experience of our services informs the changes we need to make.

Some of the activity we have conducted this year in partnership with our carers and service users includes:

Service user and carer conference - 3 May 2018

Our most recent service user and carer conference was held at Westgate Hall in Canterbury with over 100 service users, carers and third sector providers attending. The conference was well received and had a good level of engagement of service users and carers at the event which was chaired by a peer support worker. Delegates were given presentations from service users and carers on Peer Supported Open Dialogue, Recovery and Wellbeing College, Care Coordination Improvement Project and Peer Support Worker evaluation.

Co-production network

KMPT's Co-production Network brings together service users, carers, representatives of community groups and staff to help develop plans to improve and implement changes to services. Meetings enable service users and carers involvement in the trust. Some of this year's co-production activities include: Kent Recovery and Wellbeing College, Willow Suite review, Clinical Care Pathways Programme, Carers Communication Project for Older People and work on a Personality Disorder pathway.

PREM

We provide an opportunity for everyone who comes into contact with our services to complete a Friends and Family Test. In order to gather a greater understanding of patients experience we developed a Patient Reported Experience Measure (PREM) which also enables us to monitor where such experience improves, or drops.

In February 2019 we saw the highest responses for PREM yet – over 800 were received and acted upon where needed. Our service departments review the PREM responses they receive and feedback to our Trust-wide Patient and Carer Experience Group. This includes what actions have been taken and the results of those actions.

Patient and Carer Consultative Committees

We host bi-monthly Patient Consultative Committees (PCC) and Carer Consultative Committees (CCC) 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.

This year's discussions have included how the trust learns from difficulties experienced with services and a new learning bulletin has been developed for PCC and CCC members.

Experts by Experience research group

The Experts by Experience (EbyE) research group is a group of service users who are regularly involved in many aspects of trust research activity as well as contributing to other areas of trust governance. This year the EbyE group has consulted on research projects, contributed to the evaluation of the new recovery college and the clinical care pathways change programme currently being developed. One member of the group, David Cousins, picked up the Patient Contribution Award at the trust-wide KMPT awards in 2018.

Surveys of service users and carers

We participate in the national community mental health survey that seeks feedback from a random sample of our service users around key aspects of their treatment and care. The results of the national patient survey, and other patient experience surveys are considered by trust staff who develop a patient experience action plan for each care group describing the actions they will take to address issues highlighted in this feedback.

We also value the important role that carers play and we recognise they are a vital source of information about the people they care for. Our annual carers' survey was sent to over a 1,000 carers. This year we commissioned an organisation to run the survey who provided the means of engaging carers who may be less able to take part particularly because of language barriers.

The results of the patient experience surveys gives the trust a chance to understand how our services are viewed and provide valuable opportunities to identify where things can be improved.

Clinical Care Programme

In 2018, work began in earnest to improve our clinical care pathways. Led by the Chief Operating Officer, the programme includes five work streams which are:

- Personality disorder
- Initial interventions
- Enduring conditions
- Support and Signposting
- 24/7 patient flow.

These work streams have benefitted from service user and carer involvement from the outset.

Feedback from the work undertaken will be regularly reviewed as we continue to improve and implement further developments across all the pathway projects throughout 2019-20.

Engagement training – 2 November 2018

Service users and carers were invited to a free one day training workshop designed to increase their confidence and techniques in supporting KMPT engagement activities. The two main workshops were 'Interview and recruitment skills', led by Andrea Jenner, KMPT Leadership and Development Trainer and 'Presenting with Confidence', led by trainers from the Impact Factory.

Time to Talk day – 7 February 2019

This year's event was held in Canterbury and was well-supported by service users, carers, staff and partner organisations who talked about the importance of starting conversations about mental health to help break down stereotypes, improve relationships, and remove stigma. During the three hours, there was information from a number of services including Open Dialogue, the Kent and Medway Recovery and Wellbeing College, Peer Support, the chaplaincy service and SpeakUp CIC.

Insight training for carers – 21 February 2019

This training was aimed at carers to raise awareness of trusts mechanisms for safeguarding service users at risk of suicide and consider ways of working collaboratively. This included providing background information about initiatives around suicide awareness and prevention in Kent and Medway, the Kent Suicide Prevention strategy and processes for reviewing and overseeing our safeguarding practices.

Managing finances

This section describes how KMPT 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 2018-19.

Summary of Financial Performance in 2018-19

This section summarises the financial performance for 2018-19.

Within the context of a nationally challenging financial environment, KMPT performed better than its planned deficit and delivered all key financial targets detailed below.

At the beginning of the financial year we agreed a control total with NHS Improvement of a deficit after technical adjustments of £1.8m (£1.9m before technical adjustments). As we performed £1.9m better than the control total KMPT has been allocated £1.9m of incentive and bonus funding. This meant we ended the year with a £2.0m surplus (£1.0m surplus before technical adjustments). The technical adjustments excluded from the performance against the control total are £0.9m 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 2018-19 £000	Actual 2018-19 £000	Variance 2018-19 £000
Income	180,735	185,085	4,350
Expenditure	(177,238)	(180,256)	(3,018)
OPERATING SURPLUS	**3,497**	**4,829**	**1,332**
Finance cost	(1,676)	(1,525)	151
PDC dividends	(3,744)	(3,663)	81
Net gain on disposal of fixed assets	0	1,370	1,370
(DEFICIT) / SURPLUS	**(1,923)**	**1,011**	**2,934**
Impairment	0	921	921
Depreciation on donated assets	94	94	0
(DEFICIT) / SURPLUS ON A CONTROL TOTAL BASIS	**(1,829)**	**2,026**	**1,906**
Control total	(1,829)	(1,829)	
Variance against control total	**0**	**3,855**	

The key drivers for this improved performance were additional income for Forensic Community Services, support funding for agency costs within community teams and contingency not spent in year. In addition we have taken out £3.3m of savings recurrently within this position which will help long term for our sustainability.

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

Our clinical income in 2018-19 was £172.7m which was £2.1m favourable to the plan. Other operating income was £12.3m which was £2.2m favourable to the plan, predominately due to the additional £1.9m of incentive and bonus Provider Sustainability Funding.

KMPT 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 84 per cent of clinical income. Specialist services were commissioned via NHS England (14 per cent).

The partnership arrangement with Kent County Council, which previously enabled single management of the workforce for the provision of adult services, changed part way through 2018-19. The two organisations are in transition towards a new model of collaboration which will continue into 2019-20.

KMPT 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 pages 75 and 76, notes 3 and 4 of the accounts.

Expenditure

Operating expenditure in 2018-19 was £180.3m. KMPT spent £138.9m on employee expenses during 2018-19. This represented 77 per cent of total operating expenditure. Employee expenses are split between £121.0m on substantive staff, £11.4m on bank staff and £6.5m on agency staff, which was above the cap set by NHS Improvement of £6.2m.

Pay was £0.6m overspent at year end. This was due to agency staffing above cap of £0.3m and a gap in cost improvement programme (CIP) delivery, anticipated to materialise from workforce redesign.

Non pay was £2.2m adverse to plan at year end, the main driver behind this was a higher number of private placements for PICU patients than planned and external support for the transformation team.

The analysis of this expenditure can be found on page 77 note 6 of the accounts.

Cost improvement programme (CIP)

KMPT set a £6.75m CIP target for 2018-19. We delivered £6.1m of the planned savings with an adverse variance of £0.65m at year end. Of the savings delivered £3.3m recurrently and £2.8m on a non recurrent basis. There will be an increased focus in 2019-20 on recurrent savings.

The full details are shown in the table below.

Table 2

Care Groups	2018-19		
	Plan (£000)	Actual (£000)	Variance (£000)
Acute	1,331	1,293	(38)
Older People	1,214	1,032	(182)
Forensic and Specialist Services	1,160	1,159	(1)
Community Recovery	1,394	858	(535)
Support Services	1,653	1,759	106
Total	**6,752**	**6,102**	**(650)**
Recurrent	5,157	3,275	(2,003)
Non recurrent	1,595	2,827	1,354

Capital expenditure

KMPT spent £10m on capital expenditure in 2018-19, which represented an under spend against the Capital Resource Limit of £799k.

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

1. £2.7m on modernising the acute inpatient facilities
2. £1.2m on the Mother and Baby Unit on the Dartford site, a new service that launched in 2018-19
3. £2.0m on information technology projects
4. £2.7m on capital maintenance and minor schemes.

We disposed of one property with a net book value of £5m during the year, in order to part finance the capital expenditure programme. The residual proceeds are being carried into 2019-20 due to the timing of the disposal to support the 2019-20 capital refurbishment programme.

Statutory duties

As an NHS trust, KMPT 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.

As a result of the surplus delivered in 2018-19, KMPT has met its breakeven duty, reporting a cumulative position of £3.4m surplus. Further detail is given at note 36 to the accounts.

Capital resource limit – (achieved)

KMPT is expected to remain within its capital resource limit (a target on capital spending). During 2018-19 we underspent against the Capital Resource Limit by £0.8m, predominately due to a number of Capital schemes being slipped until 2019-20.

External financing limit – (achieved)

KMPT 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 we can utilise). KMPT met its target by undershooting against the limit by £9.4m. This was due to in year receipt of bonus funding relating to 2017-18 performance, profit on disposal, an increase in capital creditors due to timing of the capital programme and clearance of aged debtors during the year which was above plan.

Private finance initiative (PFI)

The use of private finance gives us access to funding for capital developments that would not otherwise be available. KMPT has five PFI buildings that were built over a number of phases between the years 2000 and 2007 as part of replacing the old Stone House Hospital. Details are provided in note 27 of the accounts.

Liquidity

KMPT operates with reasonable levels of liquidity, which is acceptable under the current financial regime. Under the present arrangements, the majority of our income is contracted to be received on the 15th of the month, which allows us to meet its main expenditure obligation (payroll) on the 24th of the month.

KMPT has increased its cash holding to £12.5m as at the end of 2018-19 due to in year receipt of bonus funding relating to 2017-18 performance, disposal of a building, an increase in capital creditors due to timing of the capital programme and clearance of aged debtors during the year above plan. Given the overall pressure

on our financial position, and the need to repay revenue and capital loans during 2019-20, cash management will remain a key focus during the coming year. As shown in note 19 of the accounts, the amount outstanding on the two loans was £3.1m as at 31 March 2019. We are confident that these will be repaid in 2019-20.

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.

Our payment policy is consistent with this requirement. The level of compliance in 2018-19 was 91.2 per cent for non NHS and 95.1 per cent for NHS (based on invoice volumes).

Further details of our adherence to the code can be found on at note 32 of the accounts.

Summary of financial risks

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

Audit

Our external auditor is Grant Thornton. They conducted work during the year on audit services at a cost of £54k. This work included accounts, governance and performance work.

Provision of information to auditors

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

KMPT's accounting policy regarding going concern (Note 1.2 to the accounts) contains further detail.

Looking forward to 2019-20

2019-20 will be another challenging year financially for us. We have set a plan to breakeven which includes receipt of £1.4m Provider Sustainability Funding and £4.5m from the Financial Recovery Fund (FRF), which is provided on a non-recurrent basis. To deliver this plan we will need to achieve an in year cost improvement programme of £6.0m (3.5 per cent). We recognise that we have an underlying deficit, and have reduced this by £3m in 2018-19. We will be taking further steps towards addressing this during 2019-20 so that we can return to a breakeven position on a recurrent basis by March 2020.

Table 3 below sets out our financial plan for the year.

	Plan 2019-20
Income	194,600
expenditure	(189,105)
OPERATING SURPLUS/(DEFICIT)	**5,495**
Finance cost	(1,622)
PDC dividends	(3,941)
SURPLUS/(DEFICIT)	**(88)**
Depreciation on donated assets	88
SURPLUS/(DEFICIT) ON A CONTROL TOTAL BASIS	**0**
Control total	0
Performance against control total	**0**

The key movements from 2018-19 to 2019-20 are as follows:

- Full year impact of 2018-19 CIP programme, net of non recurrent savings that have been reinvested £1.5m
- Aged debt received
- Addition of a one per cent contingency £1.8m
- Pay uplift for second year of Agenda for Change deal £2.9m
- 2019-20 cost pressures net of inflation funding £1.9m
- 2019-20 CIP (£6.0m)
- Financial Recovery Funding (£4.5m).

We are planning a capital expenditure programme of £9.5m for the financial year. This consists of the following:

- £1m completion of the Willow Suite refurbishment
- £1m IT
- £1m maintenance
- £1.8m completion of the Canterbury Ward reconfiguration
- £2.6m for the next stages of the Modernising Inpatient Facilities programme (Orchards and Thanet).

This assumes we will be able to spend cash carried forward from 2018-19.

Our annual accounts for 2018-19 have been examined by our external auditor, Grant Thornton, and their report is set out on page 56.

Review of performance

Our performance is monitored via its Integrated Quality and Performance Report (IQPR) which was reviewed and relaunched in 2018-19. The review and relaunch was following extensive engagement with other trusts and NHSI looking for best practice performance to the trust Board. The trust decided to set out its new look IQPR by using the five CQC domains of Safe, Effective, Well-led (Workforce and Finance), Caring and Responsive.

The trust has implemented a new Performance Framework that includes monthly Quality Performance Review (QPR) meetings that are chaired by the Executive and take place with each Care Group. The meetings focus on quality, patient safety, performance, finance and workforce matters and bring together experts in their field in order to understand performance (and data) at a granular level, test that actions are in place and that the trust strives for continuous improvement. Where an area is receiving additional attention as a result of concerns, special reporting and monitoring mechanisms are implemented and supported by trajectories for improvement.

The new IQPR report covers a broader range of indicators with the aim of providing greater assurance of all elements of the trust, business and to triangulate the trust's performance. The IQPR is designed to provide trend information across the five CQC domains. The new style report is available at trust level, with care group and team level monitoring to continue using other means of performance reporting.

2018-19 performance

The table below sets out a number of the indicators the trust has been driving to improve during 2018-19.

Table 4

Ref.	Measure	SoF	Target	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19
002.S	Care Programme Approach (CPA) patients receiving formal 12 month review		95%	93.6%	90.1%	90.5%	91.7%	93.0%	93.2%	92.9%	92.4%	93.4%	92.6%	91.3%	89.4%
001.E	CPA follow-up - proportion of discharges from hospital, followed up within seven days	✓	95%	93.9%	94.1%	93.3%	97.2%	97.2%	99.1%	94.4%	96.0%	96.3%	94.0%	92.9%	95.6%
002.E	% Clients in settled accommodation	✓		81.7%	81.6%	82.7%	83.0%	83.1%	82.8%	82.7%	82.6%	82.4%	82.2%	81.7%	81.5%
003.E	% Clients in employment	✓		14.3%	14.7%	14.9%	14.8%	14.7%	14.9%	14.9%	15.0%	15.0%	15.3%	15.2%	15.2%
004.E	Data Quality Maturity Index (DQMI) - MHSDS dataset score	✓		98.3%	98.2%	98.1%	98.1%	98.0%	98.0%	98.0%	98.0%	98.0%	98.0%	97.9%	97.9%
005.E	Inappropriate out-of-area placements for adult mental health services (bed days)	✓		98	223	226	182	236	183	237	260	275	320	410	398
006.E	Delayed transfers of care		7.5%	6.6%	7.4%	6.9%	6.8%	5.5%	7.3%	6.9%	6.5%	8.1%	10.0%	9.7%	8.7%
001.R	People with a first episode of psychosis begin treatment with a NICE recommended care package within two weeks of referral	✓	53%	93.8%	76.0%	76.2%	87.5%	75.0%	81.8%	85.0%	70.6%	76.2%	83.3%	57.1%	62.5%

In addition to the above the trust has seen improvements within its reported performance metrics in year. The number of patients receiving a physical health check within 72 hours has increased from 95.2 per cent to 98.1 per cent in the year, patients with crisis plans has increased from 91.6 per cent to 93 per cent. The trust has also improved its performance in the number of care plans distributed form 55.3 per cent to 65.6 per cent. KMPT maintained the significant improvement made in previous years of zero out of area beds, by placing no younger adult patients in beds out of its catchment areas through the whole of 2018-19. There is a small cohort of patients (equating to between 10 and 12 a month) that require female PICU treatment in out of area beds as the trust currently is not commissioned to provide these. This is one of our priorities during 2019-20, with the main aim to reduce this demand.

The trust reports against the NHS Improvement Single Oversight Framework (SOF). The trust performance for 2018-19 is set out below.

Table 5

IQPR Dashboard: Single Oversight Framework					
Ref.	**Measure**	**Target**	**Nov-18**	**Jan-19**	**Trend**
001.S	Occurence of any never event	0	0	0	
001.E	Care Programme Approach (CPA) follow-up - proportion of discharges from hospital followed up within seven days	95%	94.0%	95.6%	
002.E	% Clients in settled accommodation		82.2%	81.5%	
003.E	% Clients in employment		15.3%	15.2%	
004.E	Data Quality Management Index (DQMI) - MHSDS dataset score		98.0%	97.9%	
005.E	Inappropriate out-of-area placements for adult mental health services (bed days)		320	398	
001.W-W	Staff sickness - overall	4%	4.8%		
002.W-W	Staff sickness - short term	2%	2.4%		
003.W-W	Staff sickness - long term	2%	2.3%		
004.W-W	Staff turnover	12%	15.1%	15.4%	
011.W-W	Staff survey engagement score				Latest results Sept 2017: 3.8%
001.W-F	Capital service capacity	1.06	1.0	1.2	
002.W-F	Liquidity (days)	-11.40	-12.7	1.0	
003.W-F	Income and expenditure margin YTD (%)	-1.0%	-2.5%	-1.4%	
010.W-F	Agency spend against cap YTD (%)	0.0%	7.0%	4.5%	
001.C	Staff friends and family test % Recommended - care				
002.C	Mental health scores from friends and family test - % positive	93.0%	93.5%	94.7%	
001.R	People with a first episode of psychosis begin treatment with a NICE recommended care package within two weeks of referral	53.0%	83.3%	62.5%	

2019-20 performance

The trust will continue to monitor the indicators set out above. Following discussions regarding Mental Health Investment Standards (MHIS) the trust is negotiating investment in a number of services which should see an improvement in previous performance.

KMPT has finalised its operational and clinical plans for 2019-20 and plan to focus on several key performance areas in the coming year, these include:

- A 10 per cent reduction in acute admissions (seven days or less)
- A reduction in externally placed PICU
- An increase in CMHT referrals assessed within four weeks
- An increase in patients who commence treatment with 18 weeks.

Alongside these key metrics the trust will continue to work with all commissioners to implement those areas highlighted within the NHS ten year plan, utilising the investment the trust has received as part of the MIHS, as well as any additional funding made available in year through national initiatives designed to support the NHS plan. The impact will be jointly assessed with the commissioners of Kent and Medway so that the services required are identified and implemented in the most effective way possible.

Sustainability

We are proud of the work already undertaken to make improvements through our Board-approved Sustainable Development Management Plans (SDMP) and we continue to work towards reducing energy consumption.

Working closely with partners across Kent and Medway we have developed areas of best practice, environmental training, and seminars on new technologies in order to actively explore new initiatives in reducing the carbon footprint. We also employ the lead officer on sustainability in the STP process.

This year, the trust competed with over 300 NHS trusts and won a grant to install LED lighting across some of our hospital sites. LED lighting offers numerous benefits including using less energy, better and more uniform light distribution and require less maintenance. The project will also enhance light levels in all areas of implementation, creating a brighter and fresher environment for patients and staff – helping to improve health and wellbeing. The project will reduce the energy consumption for lighting by an average of 69 per cent in the project areas.

All our activities have a carbon footprint and this is categorised into three scopes:

1. Covers direct emissions from our activities (burning of gas to produce heat)
2. Covers indirect emissions from the generation of purchased energy
3. Covers all other indirect emissions in the value chain; including procurement, transport related activities not under our direct control and outsourced activities such as waste disposal and leased assets.

Using the Carbon Trust Sustainability reporting metrics for the healthcare sector, we have measured a 28 per cent reduction against a 2015 with a 34 per cent reduction target by 2020. We have made good progress in areas including buildings (energy), travel, behaviour change and corporate approach to contracts etc.

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.

Emergency preparedness, resilience and response (EPRR)

The trust is a category one responder under the Civil Contingencies Act (2004). Within the act the trust has specific statutory duties in relation to maintaining a resilient organisation that is able to work in partnership with other responders in response and recovery from major and business continuity incidents. In order to demonstrate compliance the trust is aligned to the NHS England national EPRR framework (2015).

NHS England nationally issue annual core standards against which each trust undertakes a self-assessment and are then audited by their commissioner. The trust was awarded substantial compliance against the 2018 NHS England EPRR core standards by the east Kent group of clinical commissioning groups. This has been reported via the local health resilience partnership executive group for Kent and Medway to NHS England.

Helen Greatorex, Chief Executive

ACCOUNTABILITY REPORT

The directors' report

Our Board includes non-executive directors (NEDs) and executive-directors (EDs), including the Chairman and Chief Executive. All of whom are collectively responsible for our success. The Director of Organisational Development and Communications is a non-voting director.

Executive directors are full-time employees and non-executive directors are appointed by 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 2018-2019 there were some changes to the board. Vincent Badu who was the Interim Director of Transformation was appointed as the Deputy Chief Executive and Executive Director of Partnerships and Strategy in September 2018.

Board membership 2018-19 – table 6

Non-executive directors	Executive directors
Andrew Ling	Helen Greatorex – Chief Executive
Anne-Marie Dean	Vincent Badu – Deputy Chief Executive and Executive Director of Partnerships and Strategy* (previously Interim Director of Transformation)
Mark Bryant	Catherine Kinane – Executive Medical Director
Tom Phillips	Mary Mumvuri – Executive Director of Nursing and Quality
Rodney Ashurst	Sheila Stenson – Executive Director of Finance
Jackie Craissati	Sandra Goatley – Director of Workforce and Communications
Venu Branch	Jacquie Mowbray-Gould – Chief Operating Officer
Catherine Walker	

*Joined the Board as a voting member September 2018.

Changes since 1 April 2019
Catherine Kinane – Executive Medical Director retired on 21 April 2019
Rosarii Harte – Interim Medical Director commenced on 22 April 2019

The Board

The Board undertakes three key roles:

1. Responsible for setting the strategic direction
2. Responsible for formulating strategy, such as the clinical strategy
3. 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 met formally in public 10 times during 2018-19. 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 7 shows the attendance of every member of the Board at Board meetings held during 2018-19.

Director's attendance at board meetings 2018-19 – table 7

Non-executive directors 2018-19	Actual/possible
Andrew Ling	9/10
Mark Bryant	10/10
Tom Phillips	9/10
Anne-Marie Dean	10/10
Rodney Ashurst	8/10
Jackie Craisatti	10/10
Venu Branch	9/10
Catherine Walker	10/10

Executive directors 2018-19	Actual/possible
Helen Greatorex	10/10
Vincent Badu	8/10
Catherine Kinane	9/10
Sheila Stenson	10/10
Mary Mumvuri	9/10
Sandra Goatley	8/10
Jacquie Mowbray-Gould	10/10

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 8

Director	Position	Interest declared
Andrew Ling	Chairman	None declared.
Anne-Marie Dean	Non-Executive Director	None declared.
Mark Bryant	Non-Executive Director	Mark's daughter, Laura, is a midwife (Band 6) at Pembury Hospital. This is part of Maidstone and Tunbridge Wells Trust. MB declared this for full transparency.
Rodney Ashurst	Non-Executive Director	None declared.
Tom Phillips	Non-Executive Director	Non-Executive Director on the Board of Barking, Havering and Redbridge University Hospital NHS Trust. He is Chair of Audit and Senior Independent Director.
Jackie Craissati	Non-Executive Director	Jackie's current company is on the NHS England framework for Independent Serious Incident Investigations. Jackie is Trustee on the Board of Samaritans and non-executive director of Parasol Homes (formerly 28a).
Venu Branch	Non-Executive Director	None declared.
Catherine Walker	Non-Executive Director	Catherine is 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). Member of an advisory and scrutiny Panel of the National Employment Savings Trust ('NEST') Corporation. NEST is the pension auto enrolment vehicle used by KMPT for workers who are not members of the NHS pension scheme.
Helen Greatorex	Chief Executive Officer	Helen's husband is Director of Talking Therapies and may compete for business in the Trust's area. From 1 April 2019 Helen's husband commenced job with Priory.
Vincent Badu	Executive Director of Partnerships & Strategy	None declared.
Jacquie Mowbray-Gould	Chief Operating Officer	None declared.
Sheila Stenson	Executive Director of Finance	Sheila is the Chair HFMA Kent, Surrey and Sussex.
Catherine Kinane	Executive Medical Director	Catherine is a Visiting Professor in the Faculty of Health and Wellbeing at Canterbury Christ Church University, Chair of the South East division of RCPsych. SOAD with CQC. Independent expert reports and visits incl. CQC executive reviewer.
Mary Mumvuri	Executive Director of Nursing and Quality	Mary is Vice chair Mental Health Nurse Director Forum.
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.

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)

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.

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 and 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, Registered Mental Health Nurse (RMN), MBA

Helen took up post as KMPT Chief Executive in June 2016, having been Executive director of nursing in Sussex for over fourteen years.

Qualifying as a Registered Mental Health Nurse (RMN) in 1987, Helen worked clinically across a wide range of settings, and specialised in mental health rehabilitation.

She went on to work in the voluntary sector as a Resettlement Officer with Mind in Waltham Forest where she helped support and resettle people, whose average length of stay in Claybury Hospital was twenty-eight years.

She was a founder member of the rehabilitation services in Brighton in the early 1990s, creating what would become a forerunner of the national Assertive Outreach model of care.

In 2018 Helen graduated as a Florence Nightingale Leadership Scholar and continues to mentor and coach others as a result.

Vincent Badu
Deputy Chief Executive, Executive Director of Strategy and Partnerships

Vincent Badu joined KMPT as Director of transformation for integrated older adults services in the autumn 2016 before being appointed as Executive director of partnerships and strategy/ Deputy chief executive in September 2018.

Since his appointment he has developed the trusts transformation and improvement team to drive necessary change and further develop mental health services across Kent and Medway. Using the building blocks of partnership working established during his period as Director of transformation for older adults, he is striving to further improve partnership working within our communities to help deliver a collaborative approach to mental health care.

Prior to joining KMPT, he was a director and member of the executive team at Sussex Partnership NHS Foundation Trust from May 2006 where he held a strategic lead for mental health social work, partnerships and people participation. Vincent is an experienced senior leader and brings a wealth of knowledge and experience from leading and developing services across a range of sectors including social care and housing. He gained more than 20 years of experience in local government across London and the south east before joining the NHS.

Vincent is passionate about leadership development, celebrating diversity and shaping and improving care and experience through participation and involvement.

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.

Sandra Goatley
Director of Workforce Development and Communications
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. Sandra added communications to her portfolio in July 2018.

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.

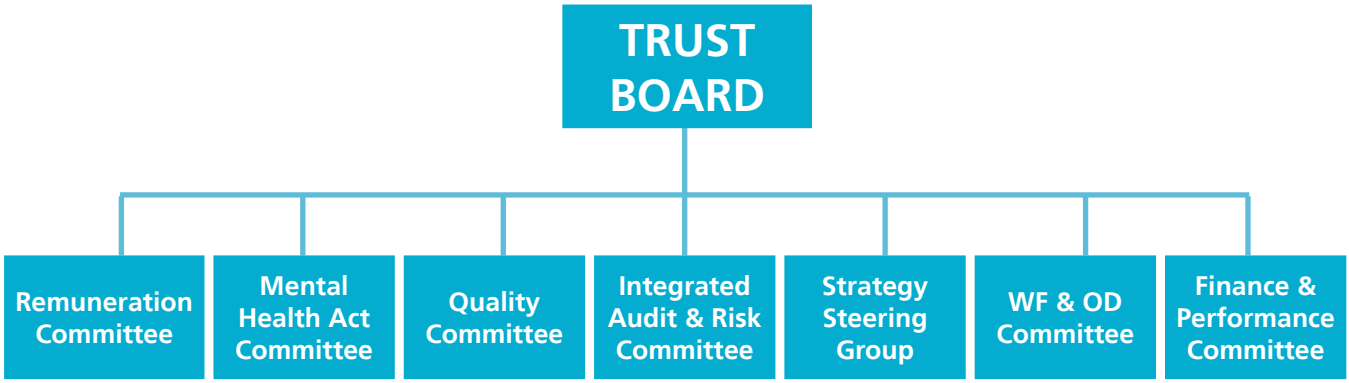
She joined KMPT from MTW where she was Deputy Director of Finance for Financial Performance and was awarded HFMA Deputy Director of Finance of the Year 2016.

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

Board committees

The Board has seven permanent committees to support it in discharging its duties fully. This includes 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.

Every NHS Board has an audit committee. The independent audit committee is a means by which the Board ensures effective internal control arrangements are in place. In addition, the committee provides a form of independent check upon the executive arm of the Board.

Members include Tom Phillips (chair), Jackie Craissati (vice chair) and Catherine Walker.

Integrated Audit and Risk Committee – table 9

Members	Actual/possible
Tom Phillips (Chair)	5/6
Jackie Craissati	5/6
Catherine Walker	5/6

Quality Committee

The purpose of this is to provide the Board with assurance concerning all aspects of quality and safety relating to the provision of care and services in support of getting the best clinical outcomes and experience for patients.

Members include Jackie Craissati (chair), Rod Ashurst (vice chair) and Venu Branch.

Quality Committee – table 10

Members	Actual/possible
Jackie Craissati	11/11
Rodney Ashurst	10/11
Venu Branch	10/11
Mary Mumvuri	10/11
Catherine Kinane	9/11

Finance and Performance Committee

The purpose of the committee is to provide the Board with assurance concerning all aspects of finance and resource relating to the provision of care and services in support of getting the best value for money and use of resources.

Members include Mark Bryant (chair), and Catherine Walker (vice chair).

Finance and Performance Committee – table 11

Members	Actual/possible
Mark Bryant (Chair)	10/10
Catherine Walker	10/10
Sheila Stenson	10/10
Jacquie Mowbray-Gould	9/10

Workforce and Organisational Development Committee

The purpose of the committee is to provide the Board with assurance concerning all aspects of workforce and organisational development relating to the provision of care and services in support of getting the best clinical outcomes and experience for patients and staff.

Members include Rod Ashurst (chair) and Venu Branch (vice chair)

Workforce and Organisational Development Committee – table 12

Members	Actual/possible
Rodney Ashurst (Chair)	6/6
Venu Branch (Vice Chair)	5/6
Sandra Goatley	4/6
Jacquie Mowbray-Gould	3/6

Remuneration Committee

The purpose of the committee is to ensure that remuneration and terms of service for the chief executive, other executive directors and other senior employees are appropriate and commensurate with their roles and responsibilities and are comparable with similar positions within the NHS.

Remuneration Committee – table 13

Members	Actual/possible
Rodney Ashurst (Chair)	4/5
Andrew Ling	5/5
Mark Bryant	5/5
Tom Phillips	4/5
Anne-Marie Dean	5/5
Jackie Craissati	4/5
Venu Branch	3/5
Catherine Walker	4/5

Strategy Steering Group – table 14

The Board is responsible for setting the strategic direction for the trust. The strategy steering group was set up in 2016 to oversee the development of the trust strategy. The need for the group reflects the major impact that the Sustainability Transformation Programme (STP) will bring and the importance of ensuring consistency between the trust's strategy and the aspirations of the Kent and Medway STP.

Strategy Steering Group - table 15

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

Mental Health Act Committee

The purpose of the committee is to ensure there are systems, structures and processes in place to support the operation of and to ensure compliance with the Mental Health Act 1983 (as amended 2007) and other related legislation within inpatient and community settings.

Members include: Venu Branch (chair)

Mental Health Act Committee - table 16

Members	Actual/possible
Jackie Craissati	0/1
Venu Branch	4/4
Anne-Marie Dean	2/2
Mary Mumvuri	4/4
Catherine Kinane	3/4

Helen Greatorex
Chief Executive

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 Kent and Medway NHS and Social Care Partnership Trust 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 Kent and Medway NHS and Social Care Partnership Trust, 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 Kent and Medway NHS and Social Care Partnership Trust for the year ended 31 March 2019 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 1.8 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.

The trust 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. The Sustainable Transformation Partnership (STP) will have a significant impact on ongoing relationships and I am ensuring that the trust is constructively engaged and considering governance aspects.

These include Clinical Commissioning Groups (CCGs), NHS Improvement (NHSI), the Local Authorities, Healthwatch, the Department of Health and Social Care, Police Authorities 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
- Quality and 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, Safeguarding Board, 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, Executive Medical Director 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. 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.

These executive directors have a key role in the development of quality standards across the trust and for maintaining effective integrated clinical governance.

The Non-Executive Committee members of the Integrated Audit and Risk Committee (IARC) play a key role in the internal control assurance processes. IARC scrutinises 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 IARC 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. The Risk Management Strategy and associated policy was comprehensively revised and updated during 2018-19 to reflect current best practice in Risk Management.

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 2018-19 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 2018-19 were:

Risk ID 5965 exiting the EU

A significant new risk to the trust is the uncertainties relating to the potential impact of the UK exiting the EU without a deal. A substantial piece of work has been undertaken in partnership with the Local Health Resilience Partnership to review the risks identified and generate plans.

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 further allocations from the Provider Support Funding (PSF) and Financial Incentive Scheme which enabled the trust to report a surplus of £1,011k at year end prior to technical adjustments and £2,026k on a control total basis. However an underlying deficit position remains. The trust's Control Total for 2019-20 has been set at breakeven which is challenging for 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.

Risk ID 4248 – community flow; high caseloads and unallocated cases

During 18-19, this was the second largest risk after finance.

This risk has been on the risk register since March 2015. Over the past 12 months a number of mitigations and improvements have been made to ensure high caseload reduced, patient flow improves and the number of people unallocated reduced. The key changes include:

- Review of caseloads – most team members have caseloads of 40 or less but during the KCC transition process this could potentially be higher – the exception is for specific interventions such as Active Review and physical health clinics. Staff now have caseload supervision and the Head of Nursing is reviewing the supervision process with the teams
- CAPA has been fully implemented, however the number of referrals outweigh the number of team assessment slots. To mitigate discussions are in place with commissioners to ensure CMHTs are adequately resourced. The teams are also beginning to roll out the initial intervention model. This CBT approach ensures all persons accepted for treatment receive a tailored clinical pathway. The PD pathway is also in delivery phase
- The number of people unallocated has been reduced to those primarily waiting for assessment.

To support all the above there is a weekly Care Group quality performance meeting with the HoS, AMDs, DCOO reporting into the monthly Quality Performance Reviews (QPR). The CliQ checks are in place and reviewed at both Quality Committee and Finance and Performance Committee. To ensure data is used effectively the DCOO leads a data quality group with the performance team.

Audits of supervision, job plans and CliQ checks evidence quality standards are improving.

Risk ID 5875 CMHTs demand and capacity (KCC/KMPT)

This risk is new and has replaced 4248 on the BAF.

The recent changes made with the KCC transition has impacted on the ability of the CMHTs to cope effectively with the high level of demand for assessment of service. A number of mitigations are in place.

1. Active recruitment of agency staff to work in the teams that have severe staffing shortages
2. Caseload reviews for all teams that have just completed the caseload re alignment work and have secured resources to provide expert social care knowledge to help this process. This should allow caseload numbers to decrease
3. East Kent AMD has just completed a review of clinical record keeping for non CPA patients and has recommended a significant decrease in the documentation required. This is awaiting approval through the trust sign off process. This will support the recording of only what is necessary and will free up time for clinical work
4. All managers are currently assessing the team's ability to respond to demands, though capacity planning, in conjunction with the Performance Directorate
5. The care group is exploring more innovative processes to reduce repetition and duplication, including the assessment process
6. The development of the clinical care pathways, such as the Initial Intervention pilot in south Kent Coast

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.

Counter fraud

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 i-connect page, promotional material and newsletter articles. The newsletter 'Fraudstop!' is circulated to all staff and distributed at the trust induction. The trust revised its Counter Fraud Policy in 2018.

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.

The risk team have developed a range of simple to use tools and guidance documents for managers based on the most up to date risk management theory. The risk management policy has been updated this year to be in alignment with HSG 65 and to use the Plan Do Check Act model for risk management.

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 2019-20 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:

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.

Review of the effectiveness of 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 2019

The purpose of my annual HoIA Opinion is to contribute to the assurances available to the Accounting 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).

My opinion is set out as follows:

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

1. My overall opinion is that **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.

The Care Quality Commission and the fundamental standards

The trust is required to register with the Care Quality Commission (CQC) under section 10 of the Health and Social Care Act 2008 and is registered without conditions for its 17 registered locations.

The trust is fully compliant with the registration requirements of the CQC.

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 conducted a well-led inspection at KMPT during October and November 2018 whereby they inspected five out of nine core services. The overall rating of the trust stayed the same as good overall however an improvement was seen in the safe domain with this moving from a requires improvement to good.

A new quality improvement plan has been developed to include all of the must do's (requirement notices) and should do's that were identified by the CQC to take forward. In total there are seven must do's and 31 should do's.

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 bi-monthly basis and reports directly to the Quality Committee. This group supported the preparations and responses for the CQC well-led inspection which took place in 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. The trust took immediate remedial action and on re-inspection by the CQC the Warning Notice was closed.

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

There have been four IG breaches which were reported to the Information Commissioner.

The trust has been audited twice within 2018-19 by TIAA. The first of these was to audit the organisation against compliance with the new General Data Protection Regulation. TIAA selected six key areas of GDPR compliance requirements, which included:

- Privacy Impact Assessments
- Data Subject Rights
- Data Classification and Asset Management
- Data Security and Breach Management
- Governance and Consent
- Data Controllers and Processors

As a result of this audit the trust were provided with "Reasonable Assurance" across all six areas.

During February 2019 TIAA also conducted an audit and received "Reasonable Assurance" for IG Management practices

in relation to the Data Security and Protection toolkit. This involved the review of five of the 10 assertions, which focused on staff awareness and understanding, cyber security and service continuity.

During the year 2019-20 there will be an awareness drive for IG across the organisation. This will include the following tasks to increase awareness and further support the staff.

IG training

In addition to the current elearning training available to all staff, there will be an introduction of face to face training sessions for those staff who would benefit more from a classroom based approach.

IG compliance lead

The organisation has introduced a compliance lead who will be working with teams and undertaking site audits to help support the improvement of information processing.

Drop-in sessions

Drop-in is sessions throughout the organisation will be introduced to enable staff / teams to meet with the IG department and discuss current concerns, receive additional support and pick up literature.

Digital communications

A full review of all internal and external website pages will be reviewed and updated along with key messages being passed to staff through the use of technology.

My assessment of the information governance arrangements of the trust is informed by evidence to support the achievement of all mandatory fields on the 2018-19 Data Security and Protection toolkit, as well as the information governance assurance from the internal audit reviews, undertaken in the financial year. The trust anticipates successfully achieving full completion of the mandatory requirements of the Toolkit and will therefore be rated as "satisfactory".

In making this assessment I have also taken into account advice from the trust-wide IG Group, the Caldicott Guardian, internal audit and external auditors and reviewed associated evidence of compliance.

Significant issues

The trust has identified the following as significant control issues for the 2018-19 period.

Financial Systems and Controls

The Year End process for 2017-18 brought to light issues which suggested potential weaknesses in the trust's financial systems and controls. The Executive Director of Finance commissioned an external review of systems and procedures to be undertaken by PriceWaterhouse Coopers (PWC). The recommendations from the review audited with final implementation taking place over the next few months.

Data Security Breaches

During the 2018-19 period there were four information governance serious incidents regarding the loss or misappropriation of personal information. Lessons learned from the incidents have been incorporated into the risk management process.

Incident 1:

A number of personnel records were removed from an office without prior knowledge or permission. Although the records were believed to have been taken off site investigations confirmed they had been transferred to an individuals desk drawers. The matter was reported to the ICO, however upon final investigation it was determined that the records were still on site and therefore no case to answer.

Incident 2:

Following a high profile news article regarding a client of the organisation, it was found that a number of staff accessed the clients record without a legitimate business need to do so. This matter was reported to the ICO and has been investigated. Internal action has been taken against the individuals 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 requirements. This matter was reported to the ICO and has been investigated. Internal action has been taken against the individual involved, and processes updated in line with the ICO's advice.

Incident 4:

A member of staff inappropriately accessed the clinical record of five individuals for personal requirements. The incident has been reported to the ICO and is currently being investigated within the organisation. Upon completion of internal investigations, a lessons learnt report will be produced and actions 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 the Trust's alternative qualifying scheme administered by the National Employment Savings Trust (NEST), 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.

Register of interests

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

Equality, diversity and human rights

Every member of KMPT should be respected and celebrated for the uniqueness they bring, and how this supports our approach to the people we look after. Ultimately translating into brilliant care through brilliant people.

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 that meets the statutory publication duties and best practice on inclusion initiatives.

The Workforce and Organisational Development Committee have received bi-monthly updates through workforce reports. The Quality Committee will monitor service user/carer impacting equality and diversity issues. The operational Equality and Diversity Steering Group (EDSG) and staff networks feed into the KMPT strategy. I as Chief Executive now chair the trust wide group. Plans are in place to meet the continuing gender reporting and new disability standards reporting requirements.

Staff Network forums are more established, supporting BAME, faith, (dis)ABILITY and LGBTQ+ staff. Each has an executive director lead and report back through the EDSG.

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.

IARC 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. IARC 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 2018-19 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 IARC who were able to benchmark local performance against other NHS providers.

Health and Safety

In October 2018, the Health and Safety Executive (HSE) inspected our management of violence and aggression against staff and musculoskeletal management. They were very impressed with how we managed the later. Late reporting of RIDDOR incidents to HSE had been an ongoing problem. In 2017-18 there were 61 incidents reported as RIDDOR's. There were 14 late RIDDOR reports made during this period. However in 2018-19 there have been 40 incidents reported as RIDDOR's, a significant reduction. Of these only three reports have been reported late, an improvement on the previous year.

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, IARC, 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.

There has been one change to Board membership during the year. A new permanent Executive Director of Partnerships and Strategy took up post in September 2018. The postholder is also the Deputy Chief Executive.

The Board had evaluated itself against the CQC well-led framework in early 2018 and has used the report from the CQC inspection in November 2018 to update and develop its Board development plan 2019. 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 which were audited during 2018. The audit concluded that the trust could take reasonable assurance from the arrangements in place. In addition to including Fit and Proper Person arrangements in recruitment procedure and in Annual Governance Declarations, a separate policy which increases the range of individuals covered has been approved by Board. All current Board members have confirmed they meet the requirements to serve on the Board of a healthcare organisation.

Board attendance for the 2018-19 period averaged a rate of 93 per cent. The Board met formally 10 times during the year.

Where appropriate, the Board has also held informal Board meetings and Board seminars regularly throughout the year. In addition, a programme of externally facilitated Board Development and Strategy days are held throughout the year.

The committees of the Board are:

- Integrated Audit and Risk Committee
- Quality Committee
- Finance and Performance Committee
- Workforce and Organisational Development Committee
- Remuneration and Terms of Service Committee
- Strategy Steering Group
- Mental Health Act Committee.

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 Board committees provide a formal report to the Board meeting after each of their meetings highlighting key issues and receive feedback from the Board, 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 Chairs' assurance reports and minutes.

The Finance and Performance Committee (FPC) review monitor and scrutinise the trust's key performance indicators across both finance and performance. There is a cross membership between the Quality Committee and IARC to ensure risks and assurance issues are clearly identified and followed through. There is also cross membership between FPC and IARC.

There is an established mechanism to maximise the effectiveness of its committees through comprehensive work plans as well as the alignment of the Board's meetings and that of its committees. This ensures timely monitoring of areas of responsibility delegated by the Board to the committees through receipt of Chair assurance reports and minutes, with a clear escalation mechanism to the Board, where deemed appropriate.

IARC supports the Board in reviewing the effectiveness of the system of internal control, through a structured annual work plan. The main role of the Ccommittee is to seek assurance that the trust's governance and risk management systems are fit for purpose, adequately resourced and effectively deployed. To aid this assurance, the coverage of the committee's work plan incorporates the review of the organisation's risk management processes, and associated risk registers, from service, directorate to corporate level. This includes an annual presentation from all Care Groups, support services and corporate directors on their risk management process.

IARC takes assurance from the Internal Audit function, by agreeing the risk based Internal Audit Plan and monitoring its delivery regularly, as well as overseeing the implementation of audit recommendations.

IARC annual self-assessment incorporated the views of the internal and external auditors, and the counter fraud function. The overall assessment results indicate that the Committee is discharging its terms of reference and meeting best practice guidelines, as set out in the NHS Audit Committee Handbook.

The Non-Executive members of IARC play a key role in governance by scrutinising the effectiveness of management actions in mitigating risks through regular reviews of the trust's risk register and Assurance

Framework. In addition, the committee's role includes:

- Monitoring of significant corporate and strategic risks on behalf of the Board , through a review of the corporate risk register at least four times a year
- A rolling programme of deep dives with each Care Group
- Scrutinising the effectiveness of the information risk management arrangements
- Formally reviewing the system of internal control on a bi-annual basis, taking assurances from the Board committees on the management of detailed risks.

TIAA carried out 20 assurance reviews, which were designed to ascertain the extent to which the internal controls in the system are adequate to ensure that activities and procedures are operating to achieve the trust's objectives. Two of these audits were originally a Limited Assurance opinion, but a revised opinion of Reasonable Assurance was issued during the audit year after a follow-up audit. For each assurance review an assessment of the combined effectiveness of the controls in mitigating the key control risks was provided. In addition, three advisory reviews have also been undertaken, which do not require any assurance level.

Of these audits the two that have a limited assurance opinion relate to data quality – key care plan performance indicators and consultant job planning. The audits have been reported to IARC and will receive follow up reviews by TIAA to ensure the key control issues which gave rise to the assessments have been addressed.

Assurance Assessments	Number of Reviews	Previous Year
Substantial Assurance	0	4
Reasonable Assurance	16	12
Limited Assurance	4	3
No Assurance	0	0

Assurance is also taken from the external auditors who audit the trust's financial statements and review its Annual Governance Statement. They also ensure that there are proper arrangements in place for securing economy, efficiency and effectiveness in its use of resources. Arrangements are in place for the discharge of statutory functions to have been checked for any irregularities and to ensure that they are legally compliant. The committee receives and agrees the annual work plans for internal and external auditors.

The Quality Committee meets monthly focussing on quality compliance and risks to quality (including regular presentations from Care Group Directors on their risk registers) and receives reports from its sub-committees; Patient Safety, Patient Experience and Clinical Effectiveness. This includes regular reporting on clinical audit, never events, serious incidents and complaints, with information about actions taken as a consequence. The Quality Committee oversees the production of the trust's Quality Account as part of its established annual schedule and monitors performance against current quality objectives through the year. The Quality Committee provides regular updates to the Board on progress against the Quality Account priorities, which are set each year with wide consultation and devised to be challenging.

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:

- IARC 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 2018-19 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 IARC 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.

The trust has identified significant control issues for the 2018-19 period relating to potential financial system and controls weaknesses and four data security breaches, which have been identified in the body of the Annual Governance Statement above.

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 2019

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: 23 May 2019

Staff and remuneration

1. Nominations and Remuneration Committee

This 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 2018-19 salaries were lifted based on NHSI guidance recommendation of a flat consolidated award of £2,075.00.

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 17 – audited

	2018-19				2017-18			
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	150 - 155	1600	245 - 247.5	400 - 405	145 - 150	1900	70 - 72.5	220 - 225
Vincent Badu - Executive Director Partnerships and Strategy / Deputy Chief Executive	110 - 115	4000	70 - 72.5	185 - 190	40 - 45	1400	10 - 12.5	55 - 60
Philip Cave - Deputy Chief Executive / Executive Director of Finance	0	0	0	0	65 - 70	1700	10 - 12.5	80 - 85
Sheila Stenson - Executive Director of Finance	115 - 120	300	57.5 - 60	175 - 180	40 - 45	400	12.5 - 15	55 - 60
Catherine Kinane - Executive Medical Director	175 - 180	1400	72.5 - 75	250 - 255	180 - 185	4300	30 - 32.5	215 - 220
Mary Mumvuri - Executive Director of Nursing and Governance	110 - 115	1200	0	115 - 120	115 -120	3300	0	115 -120
Jacquie Mowbray-Gould - Chief Operating Officer	95 - 100	7300	7.5 - 9	110 - 115	50 - 55	4400	5 - 7.5	60 - 65
Ivan McConnell - Executive Director of Transformation and Commercial Development	0	0	0	0	65 - 70	0	2.5 - 5	70 - 75
Sandra Goatley - Director of Workforce and Communications	115 -120	2300	27.5 - 30	145 - 150	115 -120	1400	25 - 27.5	145 - 150
Andrew Ling - Chairman	20 - 25	1500	0	20-25	20 - 25	100	0	20-25
Tom J Philips - Non Executive Director	5 - 10	600	0	5 - 10	5 - 10	0	0	5 - 10
Rodney Ashurst - Non Executive Director	5 - 10	700	0	5 - 10	5 - 10	500	0	5 - 10
Mark Bryant - Non Executive Director	5 - 10	700	0	5 - 10	5 - 10	1800	0	5 - 10
Anne-Marie Dean - Non Executive Director	5 - 10	2400	0	5 - 10	5 - 10	2200	0	10 - 15
Venu Branch - Non Executive Director	5 - 10	1200	0	5 - 10	5 - 10	1600	0	5 - 10
Jackie Craissati - Non Executive Director	5 - 10	1100	0	5 - 10	5 - 10	1600	0	5 - 10
Catherine Walker - Non Executive Director	5 - 10	800	0	5 - 10	5 - 10	1000	0	5 - 10

** Annual increase in pension entitlement

The figures in the above table relate to the amounts received during the financial year. For 2018-19 and 2017-18, 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 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 2019	Lump sum at age 60 related to accrued pension at 31 March 2019	Cash Equivalent Transfer Value at 1 April 2018	Real increase in Cash Equivalent Transfer Value	Cash Equivalent Transfer Value at 31 March 2019
	Bands of £2,500	Bands of £2,500	Bands of £5000	Bands of £5000	£000	£000	£000
Helen Greatorex - Chief Executive Officer	10 - 12.5	35 - 37.5	60 - 65	190 - 195	1042	352	1447
Vincent Badu - Executive Director Partnerships and Strategy / Deputy Chief Executive	2.5 - 5	5 - 7.5	15 - 20	35 - 40	227	79	329
Sheila Stenson - Executive Director of Finance	2.5 - 5	2.5 - 5	25 - 30	55 - 60	276	77	378
Catherine Kinane - Executive Medical Director	2.5 - 5	12.5 - 15	55 - 60	175 - 180	932	188	1339
Mary Mumvuri - Executive Director of Nursing and Governance	0	0	0	0	0	0	0
Jacquie Mowbray-Gould - Chief Operating Officer	5 - 7.5	15 - 17.5	35 - 40	95 - 100	541	186	756
Sandra Goatley - Director of Workforce and Communications	0 - 2.5	0	5 - 10	0	58	23	99

Pensions table 19 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
	Bands of £2,500	Bands of £2,500	Bands of £5000	Bands of £5000	£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.

c) Loss of office

There were no directors who had loss of office in 2018-19.

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 4.

e) Off payroll engagements

The trust had no off-payroll engagements as at 31 March 2019 and had no new off-payroll engagements between 1 April 2018 and 31 March 2019, for more than £245 per day and that last longer than six months.

f) Exit packages - audited

Table 20

	2018-19		2017-18	
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	0	**0**	2	**2**
£10,001 - £25,000	1	**1**	5	**5**
£25,001 - 50,000	1	**1**	2	**2**
£50,001 - £100,000	0	**0**	0	**0**
£100,001 - £150,000	0	**0**	0	**0**
£150,001 - £200,000	0	**0**	0	**0**
>£200,000	0	**0**	0	**0**
Total number of exit packages by type	**2**	**2**	**9**	**9**
Total resource cost (£)	66000	**66000**	150000	**150000**

'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 2018-19 was £175k-180k (2017-18, £180k - £185k). This was seven times (2017-18, 8 times) the median remuneration of the workforce, which was £24,915 (2017-18, £23,597).

In 2018-19, 0 (2017-18, 0) employees received remuneration in excess of the highest-paid director/member. Remuneration ranged from £6k to £180k (2017-18 £6k-£180k).

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.

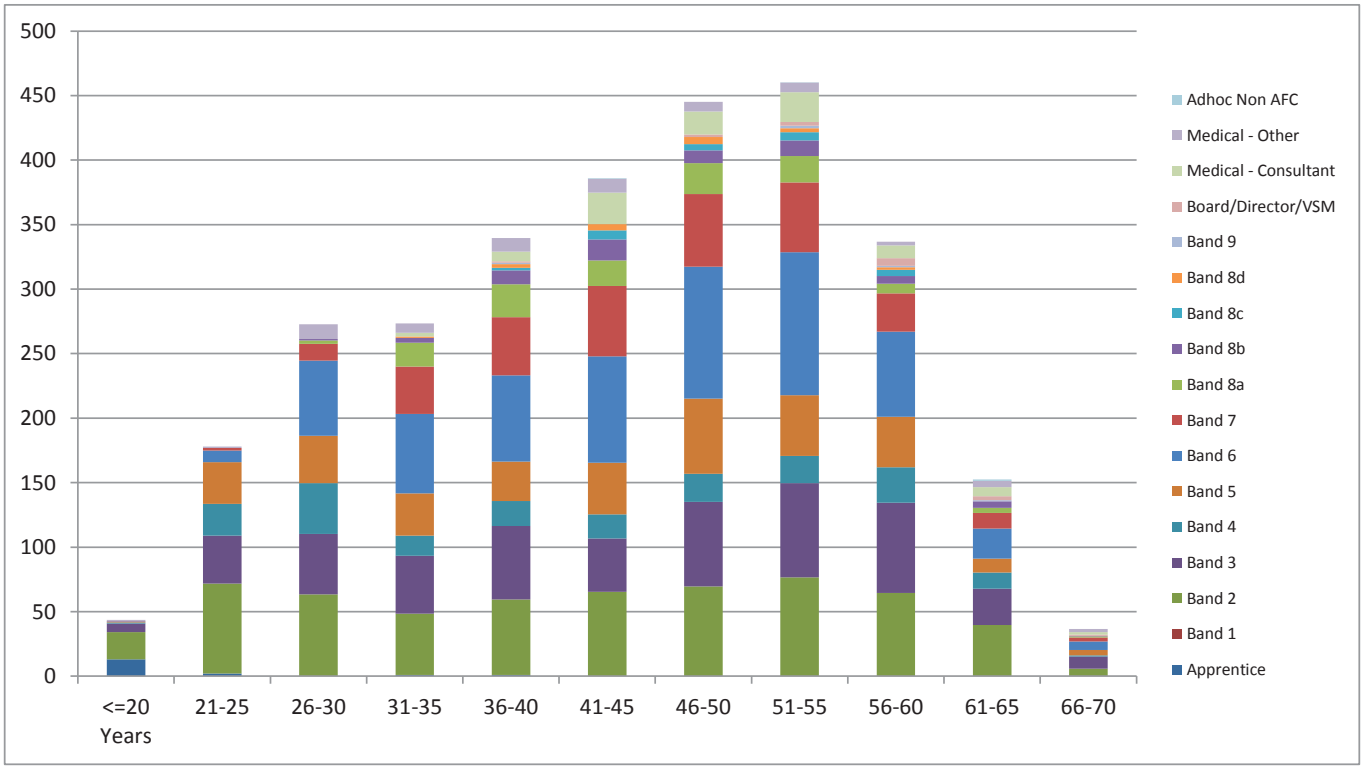
Staff report

Staff numbers by band and gender – audited - table 21

Sum of FTE			
	Female	Male	Grand Total
Apprentice	14.00	3.00	17.00
Band 1	0.00	0.00	0.00
Band 2	404.43	177.57	582.00
Band 3	374.71	104.97	479.68
Band 4	173.13	29.11	202.24
Band 5	269.76	62.50	332.26
Band 6	438.75	148.79	587.54
Band 7	221.31	85.37	306.68
Band 8a	95.11	27.68	122.79
Band 8b	44.87	20.52	65.40
Band 8c	15.80	9.45	25.25
Band 8d	12.50	7.00	19.50
Band 9	2.00	2.80	4.80
Board/Director/VSM	10.00	6.00	16.00
Medical - Consultant	37.55	56.95	94.50
Medical - Other	39.84	27.34	67.18
Adhoc Non-AFC	0.75	1.00	1.75
Grand Total	**2154.52**	**770.05**	**2924.57**

Source: Average numbers during 2018-19 from ESR

Table 22 staff by age band



Source: Average numbers during 2018-19 from ESR

Staff numbers by band and staff group – audited - table 23

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	0.00	7.00	10.00	0.00	0.00	0.00	0.00	0.00	17.00
Band 1	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
Band 2	0.00	308.35	111.38	0.00	134.81	0.00	0.00	27.47	582.00
Band 3	8.13	293.16	171.32	0.00	7.07	0.00	0.00	0.00	479.68
Band 4	4.60	85.47	108.17	0.00	4.00	0.00	0.00	0.00	202.24
Band 5	12.16	3.75	64.40	31.44	0.00	0.00	220.51	0.00	332.26
Band 6	16.70	2.50	63.85	92.40	1.00	0.00	411.08	0.00	587.54
Band 7	68.82	2.97	46.37	38.96	0.00	0.00	149.55	0.00	306.68
Band 8a	58.52	0.00	31.87	3.80	0.00	0.00	28.60	0.00	122.79
Band 8b	20.28	0.00	21.00	6.91	0.00	0.00	17.21	0.00	65.40
Band 8c	17.15	0.00	7.30	0.80	0.00	0.00	0.00	0.00	25.25
Band 8d	5.70	0.00	11.80	0.00	0.00	0.00	2.00	0.00	19.50
Band 9	2.80	0.00	2.00	0.00	0.00	0.00	0.00	0.00	4.80
Board/Director/VSM	0.00	0.00	15.00	0.00	0.00	0.00	1.00	0.00	16.00
Medical - Consultant	0.00	0.00	0.00	0.00	0.00	94.50	0.00	0.00	94.50
Medical - Other	0.00	0.00	0.00	0.00	0.00	67.18	0.00	0.00	67.18
Adhoc Non AFC	1.00	0.00	0.00	0.60	0.00	0.15	0.00	0.00	1.75
Grand Total	**215.86**	**703.20**	**664.46**	**174.91**	**146.87**	**161.83**	**829.96**	**27.47**	**2924.57**

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

Staff by ethnicity - audited - table 24

Ethnic Origin	Sum of FTE	%	BME %
A White - British	2007.37	68.64%	
B White - Irish	39.94	1.37%	
C White - Any other White background	146.74	5.02%	
D Mixed - White & Black Caribbean	7.19	0.25%	
E Mixed - White & Black African	4.47	0.15%	
F Mixed - White & Asian	15.89	0.54%	
G Mixed - Any other mixed background	21.73	0.74%	
H Asian or Asian British - Indian	105.26	3.60%	
J Asian or Asian British - Pakistani	9.77	0.33%	
K Asian or Asian British - Bangladeshi	4.00	0.14%	**24.00%**
L Asian or Asian British - Any other Asian background	74.18	2.54%	
M Black or Black British - Caribbean	31.60	1.08%	
N Black or Black British - African	274.57	9.39%	
P Black or Black British - Any other Black background	49.44	1.69%	
R Chinese	4.40	0.15%	
S Any Other Ethnic Group	99.43	3.40%	
Z Not Stated	28.59	0.98%	
Grand Total	**2924.57**		

Source: Average numbers during 2018-19 from ESR

c) Sickness absence data

We set a challenging target of 4.3 per cent staff absence rate for the trust in 2018-19. We achieved a rate of 4.44 per cent, which is an improvement from 2017-18. This percentage equates to 9.96 average sick days per full time equivalent. 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 6 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. We have been preparing for Workforce Disability Standard (WDES) reporting and have a disability forum.
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 and we have been preparing for Workforce Disability Standard (WDES) reporting.
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). We have implemented a 'Staff App; to hold and disseminate important information to staff.
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. We also run ' Big Conversation' events for staff plus leadership events.
Information on health and safety performance occupational health	During the year health and safety training was delivered to 97 per cent of staff. The trust has 70 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. We also have a dedicated freedom to speak up guardian.

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:

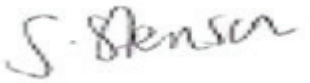
- apply on a consistent basis accounting policies laid down by the Secretary of State with the approval of the Treasury;
- make judgements and estimates which are reasonable and prudent;
- state whether applicable accounting standards have been followed, subject to any material departures disclosed and 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: 23 May 2019



Sheila Stenson, Finance Director Date: 23 May 2019

Independent auditor's report to the Directors of 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 2019, which comprise the Statement of Comprehensive Income, the Statement of Financial Position, the Statement of Changes in Taxpayers Equity, the Statement of Cash Flows and notes to the financial statements, including a summary of significant accounting policies. The financial reporting framework that has been applied in their preparation is applicable law and International Financial Reporting Standards (IFRSs) as adopted by the European Union, and as interpreted and adapted by the Department of Health and Social Care Group Accounting Manual 2018-19.

In our opinion the financial statements:

- give a true and fair view of the financial position of the trust as at 31 March 2019 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 2018-19; 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.

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 audit or otherwise appears to be materially misstated. If we identify such material inconsistencies or apparent material misstatements, we are required to determine whether there is a material misstatement in the financial statements or a material misstatement of the other information. If, based on the work we have performed, we conclude that there is a material misstatement of the 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 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 2018-19 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 issue a report 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 refer a matter to the Secretary of State under Section 30 of the Local Audit and Accountability Act 2014 because we have reason to believe that the trust, or an officer of the trust, is about to make, or has made, a decision which involves or would involve the body incurring unlawful expenditure, or is about to take, or has begun to take a course of action which, if followed to its conclusion, would be unlawful and likely to cause a loss or deficiency; or
- we make 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

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 they have been informed by the relevant national body of the intention to dissolve the trust without the transfer of its services to another public sector entity.

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

Auditor's responsibilities for the audit of the financial statements

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

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

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 2019.

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

Responsibilities of the Accountable Officer

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(1)(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 2019, 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.

Use of our report

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.

Elizabeth Jackson

Elizabeth Jackson, Key Audit Partner

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

London

23 May 2019

Annual accounts for the year ending 31 March 2019

Statement of Comprehensive Income

	Note	2018/19 £000	2017/18 £000
Operating income from patient care activities	3	172,737	168,932
Other operating income	4	12,348	12,102
Operating expenses	6, 8	(180,256)	(180,928)
Operating surplus from continuing operations		**4,829**	**106**
Finance income	11	63	14
Finance expenses	12	(1,588)	(1,583)
PDC dividends payable		(3,663)	(3,934)
Net finance costs		**(5,188)**	**(5,503)**
Other gains / (losses)	13	1,370	376
Surplus / (deficit) for the year		**1,011**	**(5,021)**
Other comprehensive income			
Will not be reclassified to income and expenditure:			
Impairments	7	(921)	(4,498)
Revaluations	15.5	-	1,308
Other reserve movements		-	1
May be reclassified to income and expenditure when certain conditions are met:			
Total comprehensive income / (expense) for the period		**90**	**(8,210)**
Adjusted financial performance (control total basis):			
Surplus / (deficit) for the period		1,011	(5,021)
Remove net impairments not scoring to the Departmental expenditure limit		921	3,731
Remove I&E impact of capital grants and donations		94	66
Adjusted financial performance surplus / (deficit)		**2,026**	**(1,224)**

The reported performance of the trust of £1m surplus differs from the financial performance of £2m surplus due to allowable technical adjustments.

The notes of pages 8 to 54 form part of these accounts.

Statement of Financial Position

	Note	31 March 2019 £000	31 March 2018 £000
Non-current assets			
Intangible assets	14	854	984
Property, plant and equipment	15	135,842	139,906
Receivables	16	443	533
Total non-current assets		**137,139**	**141,423**
Current assets			
Receivables	16	8,110	8,523
Non-current assets held for sale / assets in disposal groups	17	-	5
Cash and cash equivalents	18	12,545	5,083
Total current assets		**20,655**	**13,611**
Current liabilities			
Trade and other payables	19	(18,336)	(15,086)
Borrowings	21	(3,927)	(1,633)
Provisions	24	(588)	(672)
Other liabilities	20	(10)	(45)
Total current liabilities		**(22,861)**	**(17,436)**
Total assets less current liabilities		**134,933**	**137,598**
Non-current liabilities			
Borrowings	21	(11,837)	(15,754)
Provisions	24	(1,400)	(1,600)
Total non-current liabilities		**(13,237)**	**(17,354)**
Total assets employed		**121,696**	**120,244**
Financed by			
Public dividend capital		115,355	113,993
Revaluation reserve		13,714	14,764
Other reserves		(4,701)	(4,701)
Income and expenditure reserve		(2,672)	(3,812)
Total taxpayers' equity		**121,696**	**120,244**

The notes on pages 8 to 54 form part of these accounts.

The financial statements on pages 2 to 54 were approved on behalf of the board by the Integrated Audit and Risk Committee on 21st May 2019 and signed on its behalf by

Helen Greatorex, Chief Executive Date: 23 May 2019

Statement of Changes in Taxpayers' Equity for the year ended 31 March 2019

	Public dividend capital	Revaluation reserve	Other reserves	Income and expenditure reserve	Total
	£000	£000	£000	£000	£000
Taxpayers' equity at 1 April 2018 - brought forward	**113,993**	**14,764**	**(4,701)**	**(3,812)**	**120,244**
Surplus for the year	-	-	-	1,011	**1,011**
Other transfers between reserves	-	(129)	-	129	**-**
Impairments	-	(921)	-	-	**(921)**
Revaluations	-	-	-	-	**-**
Public dividend capital received	1,362	-	-	-	**1,362**
Taxpayers' equity at 31 March 2019	**115,355**	**13,714**	**(4,701)**	**(2,672)**	**121,696**

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

	Public dividend capital	Revaluation reserve	Other reserves	Income and expenditure reserve	Total
	£000	£000	£000	£000	£000
Taxpayers' equity at 1 April 2017 - brought forward	**113,339**	**18,887**	**(4,701)**	**275**	**127,800**
Retained (deficit) for the year	-	-	-	(5,021)	**(5,021)**
Other transfers between reserves	-	(417)	-	417	**-**
Impairments	-	(4,498)	-	-	**(4,498)**
Revaluations	-	1,308	-	-	**1,308**
Transfer to retained earnings on disposal of assets	-	(517)	-	517	**-**
Public dividend capital received	654	-	-	-	**654**
Other reserve movements	-	1	-	-	**1**
Taxpayers' equity at 31 March 2018	**113,993**	**14,764**	**(4,701)**	**(3,812)**	**120,244**

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.

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 DHSC. A charge, reflecting the cost of capital utilised by the trust, is payable to the DHSC 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 DHSC do not alter the initial PDC 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

	Note	2018/19 £000	2017/18 £000
Cash flows from operating activities			
Operating surplus		4,829	106
Non-cash income and expense:			
Depreciation and amortisation	6	5,742	6,347
Net impairments	7	2,563	3,731
(Increase) / decrease in receivables and other assets		324	(140)
Increase in payables and other liabilties		595	1,776
(Decrease) in provisions		(314)	(293)
Net cash generated from / (used in) operating activities		**13,739**	**11,526**
Cash flows from investing activities			
Interest received		63	14
Purchase of intangible assets		(222)	(18)
Purchase of property, plant, equipment and investment property		(7,210)	(4,550)
Sales of property, plant, equipment and investment property		6,408	3,280
Net cash generated from / (used in) investing activities		**(961)**	**(1,274)**
Cash flows from financing activities			
Public dividend capital received		1,362	654
Movement on loans from the Department of Health and Social Care		(800)	(800)
Capital element of finance lease rental payments		(152)	(140)
Capital element of PFI, LIFT and other service concession payments		(681)	(647)
Interest on loans		(51)	(58)
Interest paid on finance lease liabilities		(92)	(102)
Interest paid on PFI, LIFT and other service concession obligations		(1,419)	(1,370)
PDC dividend (paid)		(3,484)	(4,190)
Net cash (used in) financing activities		**(5,317)**	**(6,653)**
Increase in cash and cash equivalents		**7,462**	**3,599**
Cash and cash equivalents at 1 April - brought forward		**5,083**	**1,484**
Cash and cash equivalents at 31 March	18.1	**12,545**	**5,083**

Notes to the Accounts

Note 1 Accounting policies and other information

Note 1.1 Basis of preparation

The DHSC has directed that the financial statements of the trust shall meet the accounting requirements of the Group Accounting Manual (GAM), which shall be agreed with HM Treasury. Consequently, the following financial statements have been prepared in accordance with the GAM 2018/19 issued by the DHSC. The accounting policies contained in the GAM follow International Financial Reporting Standards to the extent that they are meaningful and appropriate to the NHS, as determined by HM Treasury, which is advised by the Financial Reporting Advisory Board. Where the GAM permits a choice of accounting policy, the accounting policy that is judged to be most appropriate to the particular circumstances of the trust for the purpose of giving a true and fair view has been selected. The particular policies adopted are described below. These have been applied consistently in dealing with items considered material in relation to the accounts.

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 1.2 Going concern

The trust's annual report and accounts have been prepared on a going concern basis. Non-trading entities in the public sector are assumed to be going concerns where the continued provision of a service in the future is anticipated, as evidenced by inclusion of financial provision for that service in published documents. 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 delivered a surplus (after technical adjustments) of £2m and has prepared its financial plans and cash flow forecasts for the coming financial year with a forecast break even position for 2019/20. The breakeven position includes £1.4m Provider Sustainability Fund and £4.5m Financial Recovery Fund, as the trust moves towards long term financial sustainability.

The trust's opening cash balance and supporting cash flow forecast for 2019/20 enable the capital programme to be financed without an external borrowing requirement.

Contracts covering the financial year 2019/20 have been signed with CCG's and a baseline agreed with NHSE, pending contract paperwork which gives certainty around the income forecasts.

As directed by the DHSC GAM 2018/19, 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 1.3 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 1.3.1 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's 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 1.3.2 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 2018/19 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 1.4 Revenue from contracts with customers

Where income is derived from contracts with customers, it is accounted for under IFRS 15. The GAM expands the definition of a contract to include legislation and regulations which enables an entity to receive cash or another financial asset that is not classified as a tax by the Office of National Statistics (ONS). As directed by the GAM, the transition to IFRS 15 in 2018/19 has been completed in accordance with paragraph C3 (b) of the Standard: applying the Standard retrospectively but recognising the cumulative effects at the date of initial application (1 April 2018).

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

Revenue from NHS contracts

The main source of income for the trust is contracts with commissioners for health care services. A performance obligation relating to delivery of a spell of health care is generally satisfied over time as healthcare is received and consumed simultaneously by the customer as the trust performs it. The customer in such a contract is the commissioner, but the customer benefits as services are provided to their patient. Even where a contract could be broken down into separate performance obligations, healthcare generally aligns with paragraph 22(b) of the Standard entailing a delivery of a series of goods or services that are substantially the same and have a similar pattern of transfer.

The trust receives income from commissioners under Commissioning for Quality and Innovation (CQUIN) schemes. The CQUIN payments are not considered distinct performance obligations in their own right; instead they form part of the transaction price for performance obligations under the contract.

Revenue from Provider Sustainability Fund

The Provider Sustainability Fund (PSF) enables NHS providers to earn income linked to the achievement of financial controls and performance targets. Access to both the general and targeted elements of PSF are unlocked as NHS providers meet their financial control totals. At each quarter, the allocated funding will be released upon achievement of the financial control total. In line with IFRS 15, PSF should be accounted for as variable consideration.

Revenue from research contracts

Where research contracts fall under IFRS 15, revenue is recognised as and when performance obligations are satisfied. For some contracts, it is assessed that the revenue project constitutes one performance obligation over the course of the multi-year contract. In these cases it is assessed that the trust's interim performance does not create an asset with alternative use for the trust, and the trust has an enforceable right to payment for the performance completed to date. It is therefore considered that the performance obligation is satisfied over time, and the trust recognises revenue each year over the course of the contract.

Note 1.4.1 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 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 1.4.2 Other income

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

Note 1.5 Expenditure on employee benefits

Short-term employee benefits
Salaries, wages and employment-related payments such as social security costs and the apprenticeship levy are recognised in the period in which the service is received from employees.

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 scheme is accounted for as though it is a defined contribution scheme.

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

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

Note 1.6 Expenditure on other goods and services

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

Note 1.7 Property, plant and equipment

Note 1.7.1 Recognition

Property, plant and equipment is capitalised where:

• it is held for use in delivering services or for administrative purposes
• it is probable that future economic benefits will flow to, or service potential be provided to, the trust
• it is expected to be used for more than one financial year
• the cost of the item can be measured reliably
• the item has cost of at least £5,000, or
• collectively, a number of items have a cost of at least £5,000 and individually have cost of more than £250, where the assets are functionally interdependent, had broadly simultaneous purchase dates, are anticipated to have similar disposal dates and are under single managerial control; 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, eg, plant and equipment, then these components are treated as separate assets and depreciated over their own useful lives.

Note 1.7.2 Measurement
Valuation
All property, plant and equipment assets are measured initially at cost, representing the costs directly attributable to acquiring or constructing the asset and bringing it to the location and condition necessary for it to be capable of operating in the manner intended by management. 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 DHSC and HM Treasury. In accordance with the requirements of the DHSC, 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 or 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 enterprise and the cost of the item can be determined reliably. Where a component of an asset is replaced, the cost of the replacement is capitalised if it meets the criteria for recognition above. The carrying amount of the part replaced is de-recognised. Other expenditure that does not generate additional future economic benefits or service potential, such as repairs and maintenance, is charged to the Statement of Comprehensive Income in the period in which it is incurred.

Depreciation
Items of property, plant and equipment are depreciated over their remaining useful 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' cease 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 1.7.3 De-recognition

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

- the asset is available for immediate sale in its present condition subject only to terms which are usual and customary for such sales;
- the sale must be highly probable ie:

  - management are committed to a plan to sell the asset
  - an active programme has begun to find a buyer and complete the sale
  - the asset is being actively marketed at a reasonable price
  - the sale is expected to be completed within 12 months of the date of classification as 'held for sale' and
  - the actions needed to complete the plan indicate it is unlikely that the plan will be abandoned or significant changes made to it.

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

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

Note 1.7.4 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.

The donated and grant funded assets are subsequently accounted for in the same manner as other items of property, plant and equipment.

Note 1.7.5 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'.

Note 1.7.6 Useful lives of property, plant and equipment

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

	Min life Years	Max life Years
Land	-	-
Buildings, excluding dwellings	30	60
Plant & machinery	5	15
Transport equipment	7	10
Information technology	4	5
Furniture & fittings	5	10

Finance-leased assets (including land) are depreciated over the shorter of the useful 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 1.8 Intangible assets

Note 1.8.1 Recognition

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

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

Software

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

Note 1.8.2 Measurement

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

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

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

Amortisation

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

Note 1.8.3 Useful economic life of intangible assets

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

	Min life Years	Max life Years
Information technology	2	5
Software licences	1	5

Note 1.9 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 the trust's cash management. Cash, bank and overdraft balances are recorded at current values.

Note 1.10 Financial assets and financial liabilities

Note 1.10.1 Recognition

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

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

Note 1.10.2 Classification and measurement

Financial assets measured at fair value through profit or loss are those that are not otherwise measured at amortised cost or fair value through other comprehensive income. This includes derivatives and financial assets acquired principally for the purpose of selling in the short term.

Financial assets and financial liabilities at amortised cost

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

After initial recognition, these financial assets and financial liabilities are measured at amortised cost using the effective interest method less any impairment (for financial assets). The effective interest rate is the rate that exactly discounts estimated future cash payments or receipts through the expected life of the financial asset or financial liability to the gross carrying amount of a financial asset or to the amortised cost of a financial liability.

Interest revenue or expense is calculated by applying the effective interest rate to the gross carrying amount of a financial asset or amortised cost of a financial liability and recognised in the Statement of Comprehensive Income as financing income or expense. In the case of loans held from the DHSC, the effective interest rate is the nominal rate of interest charged on the loan.

Financial assets and financial liabilities at fair value through income and expenditure

Financial assets measured at fair value through profit or loss are those that are not otherwise measured at amortised cost or fair value through other comprehensive income. This includes derivatives and financial assets acquired principally for the purpose of selling in the short term.

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.

Credit losses are determined and distinguished between different classes of financial asset. This has been calculated based on historical cashflows classified by relevant groups of income categories. The credit losses have been calculated using loss rates based on historical experience adjusted for forward-looking information.

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

Note 1.10.3 Derecognition
Financial assets are de-recognised when the contractual rights to receive cash flows from the assets have expired or the trust has transferred substantially all the risks and rewards of ownership.

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

Note 1.11 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 1.11.1 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 as an item of property plant and equipment.

The annual rental charge 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 1.11.2 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 1.12 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 22.1 but is not recognised in the trust's accounts.

Non-clinical risk pooling

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

Note 1.13 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 1.14 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 DHSC (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 1.15 Value added tax

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

Note 1.16 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 1.17 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 1.18 Early adoption of standards, amendments and interpretations

No new accounting standards or revisions to existing standards have been early adopted in 2018/19.

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 2018/19. These standards are still subject to HM Treasury FReM adoption and the government implementation date for IFRS 16 and IFRS 17 are still subject to HM Treasury consideration.

- IFRS 14 Regulatory Deferral Accounts – Applies to first time adopters of IFRS after 1 January 2016. Therefore is not applicable to DHSC group bodies.
- 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 23 Uncertainty over Income Tax Treatments – Application required for accounting periods beginning on or after 1 January 2019.

Note 2 Segmental Reporting

A business segment is a group of assets and operations engaged in providing products or services that are subject to risks and returns that are are different from those of other business segments.

A geographical segment is engaged in providing products or services within a particular economic environment that is subject to risks and returns that are different from those of segments operating in other economic environments. The directors consider that the Trust's activities constitute a single segment since they are provided wholly in the UK, are subject to similar risks and rewards and all assets are managed as one central pool. The Trust has also a single purpose in the provision of healthcare services.

Note 3 Operating income from patient care activities

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

Note 3.1 Income from patient care activities (by nature)	2018/19 £000	2017/18 £000
Mental health services		
Cost and volume contract income	2,512	3,874
Block contract income	167,119	163,833
Clinical partnerships providing mandatory services (including S75 agreements)	741	1,225
All services		
Agenda for Change pay award central funding	2,365	-
Total income from activities	**172,737**	**168,932**

Note 3.2 Income from patient care activities (by source)

Income from patient care activities received from:	2018/19 £000	2017/18 £000
NHS England	23,704	20,570
Clinical commissioning groups	144,748	146,840
Department of Health and Social Care	2,420	10
Other NHS providers	917	136
Local authorities	236	151
Non NHS: other	712	1,225
Total income from activities	**172,737**	**168,932**
Of which:		
Related to continuing operations	172,737	168,932

Note 4 Other operating income

	2018/19 £000	2017/18 £000
Other operating income from contracts with customers:		
Research and development (contract)	461	451
Education and training (excluding notional apprenticeship levy income)	3,385	3,593
Non-patient care services to other bodies	2,203	3,580
Provider sustainability / sustainability and transformation fund income (PSF / STF)	4,449	2,532
Income in respect of employee benefits accounted on a gross basis	274	180
Other contract income	240	586
Other non-contract operating income		
Education and training - notional income from apprenticeship fund	130	36
Rental revenue from operating leases	1,206	1,143
Total other operating income	**12,348**	**12,102**
Of which:		
Related to continuing operations	12,348	12,102

Note 5 Additional information on revenue from contracts with customers recognised in the period

	2018/19 £000
Revenue recognised in the reporting period that was included in within contract liabilities at the previous period end	45
Revenue recognised from performance obligations satisfied (or partially satisfied) in previous periods	-

Note 6 Operating expenses

	2018/19 £000	2017/18 £000
Purchase of healthcare from NHS and DHSC bodies	2,240	2,061
Purchase of healthcare from non-NHS and non-DHSC bodies	3,320	1,346
Staff and executive directors costs	138,798	136,917
Remuneration of non-executive directors	72	69
Supplies and services - clinical (excluding drugs costs)	1,891	1,792
Supplies and services - general	2,410	2,333
Drug costs (drugs inventory consumed and purchase of non-inventory drugs)	2,879	3,003
Consultancy costs	320	3
Establishment	3,831	3,729
Premises	8,145	7,879
Transport (including patient travel)	1,335	1,549
Depreciation on property, plant and equipment	5,256	5,762
Amortisation on intangible assets	486	585
Net impairments	2,563	3,731
Movement in credit loss allowance: contract receivables / contract assets	(38)	2,451
(Decrease) in other provisions	(52)	(280)
Change in provisions discount rate(s)	(24)	19
Audit fees payable to the external auditor		
audit services- statutory audit	54	54
other auditor remuneration (external auditor only)	10	10
Internal audit costs	134	144
Clinical negligence	1,009	1,084
Legal fees	1,335	1,670
Insurance	246	246
Research and development	2	3
Education and training	678	1,072
Rentals under operating leases	1,820	1,893
Redundancy	66	150
Charges to operating expenditure for on-SoFP IFRIC 12 schemes (e.g. PFI / LIFT)	986	1,039
Car parking & security	165	259
Hospitality	3	13
Losses, ex gratia & special payments	71	207
Other	245	135
Total	**180,256**	**180,928**
Of which:		
Related to continuing operations	180,256	180,928

Note 6.1 Other auditor remuneration

	2018/19 £000	2017/18 £000
Other auditor remuneration paid to the external auditor:		
2. Audit-related assurance services	10	10
Total	**10**	**10**

Note 6.2 Limitation on auditor's liability

The limitation on auditor's liability for external audit work is £2m (2017/18: £2m).

Note 7 Impairment of assets

	2018/19 £000	2017/18 £000
Net impairments charged to operating surplus / deficit resulting from:		
Abandonment of assets in course of construction	1,642	-
Changes in market price	921	3,731
Total net impairments charged to operating surplus / deficit	**2,563**	**3,731**
Impairments charged to the revaluation reserve	921	4,498
Total net impairments	**3,484**	**8,229**

Note 8 Employee benefits

	2018/19 Total £000	2017/18 Total £000
Salaries and wages	98,138	96,460
Social security costs	9,568	9,416
Apprenticeship levy	471	462
Employer's contributions to NHS pensions	12,756	12,541
Pension cost - other	16	6
Termination benefits	66	150
Temporary staff (including agency)	17,849	18,053
Total staff costs	**138,864**	**137,088**
Of which		
Costs capitalised as part of assets	-	21

Note 8.1 Retirements due to ill-health

During 2018/19 there were 4 early retirements from the trust agreed on the grounds of ill-health (5 in the year ended 31 March 2018). The estimated additional pension liabilities of these ill-health retirements is £251k (£290k in 2017/18).

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

Note 9 Pension costs

Past and present employees are covered by the provisions of the two NHS Pension Schemes. Details of the benefits payable and rules of the Schemes can be found on the NHS Pensions website at www.nhsbsa.nhs.uk/pensions. Both are unfunded defined benefit schemes that cover NHS employers, GP practices and other bodies, allowed under the direction of the Secretary of State for Health 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 2019, is based on valuation data as 31 March 2018, updated to 31 March 2019 with summary global member and accounting data. In undertaking this actuarial assessment, the methodology prescribed in IAS 19, relevant FReM interpretations, and the discount rate prescribed by HM Treasury have also been used.

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

b) Full actuarial (funding) valuation

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

The latest actuarial valuation undertaken for the NHS Pension Scheme was completed as at 31 March 2016. The results of this valuation set the employer contribution rate payable from April 2019. The Department of Health and Social Care have recently laid Scheme Regulations confirming that the employer contribution rate will increase to 20.6% of pensionable pay from this date.

The 2016 funding valuation was also expected to test the cost of the Scheme relative to the employer cost cap set following the 2012 valuation. Following a judgment from the Court of Appeal in December 2018 Government announced a pause to that part of the valuation process pending conclusion of the continuing legal process.

Note 9.1 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 0.3% 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 10 Operating leases

Note 10.1 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.

	2018/19 £000	2017/18 £000
Operating lease revenue		
Contingent rent	1,206	1,143
Total	**1,206**	**1,143**

	31 March 2019 £000	31 March 2018 £000
Future minimum lease receipts due:		
- not later than one year;	1,206	1,143
Total	**1,206**	**1,143**

Note 10.2 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.

	2018/19 £000	2017/18 £000
Operating lease expense		
Minimum lease payments	1,820	1,893
Total	**1,820**	**1,893**

	31 March 2019 £000	31 March 2018 £000
Future minimum lease payments due:		
- not later than one year;	205	311
- later than one year and not later than five years;	654	434
- later than five years.	1,132	1,300
Total	**1,991**	**2,045**

Note 11 Finance income

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

	2018/19	2017/18
	£000	£000
Interest on bank accounts	63	14
Total finance income	**63**	**14**

Note 12.1 Finance expenditure

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

	2018/19	2017/18
	£000	£000
Interest expense:		
Loans from the Department of Health and Social Care	47	55
Finance leases	92	102
Interest on late payment of commercial debt	-	1
Main finance costs on PFI and LIFT schemes obligations	763	803
Contingent finance costs on PFI and LIFT scheme obligations	656	567
Total interest expense	**1,558**	**1,528**
Unwinding of discount on provisions	30	55
Total finance costs	**1,588**	**1,583**

Note 12.2 The late payment of commercial debts (interest) Act 1998 / Public Contract Regulations 2015

	2018/19	2017/18
	£000	£000
Amounts included within interest payable arising from claims under this legislation	-	1

Note 13 Other gains / (losses)

	2018/19	2017/18
	£000	£000
Gains on disposal of assets	1,377	406
Losses on disposal of assets	(7)	(30)
Total other gains / (losses)	**1,370**	**376**

Note 14 Intangible assets - 2018/19

	Licences & trademarks £000	Internally generated information technology £000	Total £000
Valuation / gross cost at 1 April 2018 - brought forward	**1,956**	**4,055**	**6,011**
Additions	191	31	**222**
Reclassifications	58	76	**134**
Valuation / gross cost at 31 March 2019	**2,205**	**4,162**	**6,367**
Amortisation at 1 April 2018 - brought forward	**1,738**	**3,289**	**5,027**
Provided during the year	179	307	**486**
Amortisation at 31 March 2019	**1,917**	**3,596**	**5,513**
Net book value at 31 March 2019	**288**	**566**	**854**
Net book value at 1 April 2018	**218**	**766**	**984**

Note 14.1 Intangible assets - 2017/18

	Licences & trademarks £000	Internally generated information technology £000	Total £000
Valuation / gross cost at 1 April 2017 - as previously stated	**1,939**	**4,500**	**6,439**
Additions	-	18	**18**
Reclassifications	33	-	**33**
Disposals / derecognition	(16)	(463)	**(479)**
Valuation / gross cost at 31 March 2018	**1,956**	**4,055**	**6,011**
Amortisation at 1 April 2017 - as previously stated	**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 15.1 Property, plant and equipment - 2018/19

	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 2018 - brought forward	**24,126**	**115,596**	**7,120**	**1,292**	**242**	**10,018**	**1,795**	**160,189**
Additions	-	3,554	4,163	119	-	1,829	178	**9,843**
Impairments	-	(1,842)	(1,642)	-	-	-	-	**(3,484)**
Revaluations	-	-	-	-	-	-	-	**-**
Reclassifications	-	4,466	(5,430)	-	-	830	-	**(134)**
Disposals / derecognition	(840)	(4,193)	-	(47)	(46)	(1,628)	(42)	**(6,796)**
Valuation/gross cost at 31 March 2019	**23,286**	**117,581**	**4,211**	**1,364**	**196**	**11,049**	**1,931**	**159,618**
Accumulated depreciation at 1 April 2018 - brought forward	**-**	**11,265**	**-**	**880**	**223**	**6,596**	**1,319**	**20,283**
Provided during the year	-	3,361	-	118	9	1,578	190	**5,256**
Disposals / derecognition	-	-	-	(47)	(46)	(1,628)	(42)	**(1,763)**
Accumulated depreciation at 31 March 2019	**-**	**14,626**	**-**	**951**	**186**	**6,546**	**1,467**	**23,776**
Net book value at 31 March 2019	**23,286**	**102,955**	**4,211**	**413**	**10**	**4,503**	**464**	**135,842**
Net book value at 1 April 2018	**24,126**	**104,331**	**7,120**	**412**	**19**	**3,422**	**476**	**139,906**

Note 15.2 Property, plant and equipment - 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
Valuation / gross cost at 1 April 2017 - as previously stated	**31,733**	**116,500**	**3,310**	**1,275**	**293**	**9,692**	**2,059**	**164,862**
Additions	-	349	4,867	94	-	330	-	**5,640**
Impairments	(6,215)	(2,014)	-	-	-	-	-	**(8,229)**
Revaluations	5	1,303	-	-	-	-	-	**1,308**
Reclassifications	-	1,030	(1,057)	22	-	-	(28)	**(33)**
Transfers to / from assets held for sale	(5)	-	-	-	-	-	-	**(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 - as previously stated	**-**	**7,660**	**-**	**881**	**262**	**4,812**	**1,356**	**14,971**
Transfers by absorption	-	-	-	-	-	-	-	**-**
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	**-**	**11,265**	**-**	**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**

Note 15.3 Property, plant and equipment financing - 2018/19

	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 2019								
Owned - purchased	22,696	75,693	4,211	300	10	4,482	313	**107,705**
Finance leased	-	907	-	4	-	-	2	**913**
On-SoFP PFI contracts and other service concession arrangements	-	24,886	-	109	-	21	149	**25,165**
Owned - donated	590	1,469	-	-	-	-	-	**2,059**
NBV total at 31 March 2019	**23,286**	**102,955**	**4,211**	**413**	**10**	**4,503**	**464**	**135,842**

Note 15.4 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 15.5 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 16.1 Trade receivables and other receivables

	31 March 2019 £000	31 March 2018 £000
Current		
Contract receivables*	6,708	
Trade receivables*		6,773
Accrued income*		1,565
Allowance for impaired contract receivables / assets*	(1,525)	
Allowance for other impaired receivables	-	(2,611)
Deposits and advances	30	-
Prepayments (non-PFI)	1,704	1,758
PDC dividend receivable	159	338
VAT receivable	919	379
Other receivables	115	321
Total current trade and other receivables	**8,110**	**8,523**
Non-current		
Contract receivables*	443	
Trade receivables*		533
Total non-current trade and other receivables	**443**	**533**
Of which receivables from NHS and DHSC group bodies:		
Current	6,683	8,049

*Following the application of IFRS 15 from 1 April 2018, the trust's entitlements to consideration for work performed under contracts with customers are shown separately as contract receivables and contract assets. This replaces the previous analysis into trade receivables and accrued income. IFRS 15 is applied without restatement therefore the comparative analysis of receivables has not been restated under IFRS 15.

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 16.2 Allowances for credit losses - 2018/19

	Contract receivables and contract assets £000
Allowances as at 1 Apr 2018 - brought forward	
Impact of implementing IFRS 9 (and IFRS 15) on 1 April 2018	2,611
New allowances arising	1,906
Changes in existing allowances	24
Reversals of allowances	(1,968)
Utilisation of allowances (write offs)	(1,048)
Allowances as at 31 Mar 2019	**1,525**

Note 16.3 Allowances for credit losses - 2017/18

IFRS 9 and IFRS 15 are adopted without restatement therefore this analysis is prepared in line with the requirements of IFRS 7 prior to IFRS 9 adoption. As a result it differs in format to the current period disclosure.

Note 17.1 Non-current assets held for sale and assets in disposal groups

	2018/19 £000	2017/18 £000
NBV of non-current assets for sale and assets in disposal groups at 1 April	**5**	**-**
Assets classified as available for sale in the year	-	5
Assets sold in year	(5)	-
NBV of non-current assets for sale and assets in disposal groups at 31 March	**-**	**5**

Note 18.1 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.

	2018/19	2017/18
	£000	£000
At 1 April	**5,083**	**1,484**
Net change in year	7,462	3,599
At 31 March	**12,545**	**5,083**
Broken down into:		
Cash at commercial banks and in hand	94	78
Cash with the Government Banking Service	12,451	5,005
Total cash and cash equivalents as in SoFP	**12,545**	**5,083**
Total cash and cash equivalents as in SoCF	**12,545**	**5,083**

Note 18.2 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 2019	31 March 2018
	£000	£000
Total third party assets (Bank balances) not included above.	**185**	**241**

Note 19.1 Trade and other payables

	31 March 2019	31 March 2018
	£000	£000
Current		
Trade payables	4,646	4,096
Capital payables	5,062	2,429
Accruals	4,452	4,434
Social security costs	1,249	1,222
Other taxes payable	998	984
Accrued interest on loans*		14
Other payables	1,929	1,908
Total current trade and other payables	**18,336**	**15,086**
Of which payables from NHS and DHSC group bodies:		
Current	2,698	1,580

*Following adoption of IFRS 9 on 1 April 2018, loans are measured at amortised cost. Any accrued interest is now included in the carrying value of the loan within note . IFRS 9 is applied without restatement therefore comparatives have not been restated.

The payables note above includes:		
- outstanding pension contributions	1,744	1715

Note 20.1 Other liabilities

	31 March 2019 £000	31 March 2018 £000
Current		
Deferred income: contract liabilities	10	45
Total other current liabilities	**10**	**45**

Note 21 Borrowings

	31 March 2019 £000	31 March 2018 £000
Current		
Loans from the DHSC	3,110	800
Obligations under finance leases	162	152
Obligations under PFI, LIFT or other service concession contracts (excl. lifecycle)	655	681
Total current borrowings	**3,927**	**1,633**
Non-current		
Loans from the DHSC	-	3,100
Obligations under finance leases	996	1,158
Obligations under PFI, LIFT or other service concession contracts	10,841	11,496
Total non-current borrowings	**11,837**	**15,754**

Note 22 Reconciliation of liabilities arising from financing activities

	Loans from DHSC £000	Finance leases £000	PFI and LIFT schemes £000	Total £000
Carrying value at 1 April 2018	**3,900**	**1,310**	**12,177**	**17,387**
Cash movements:				
Financing cash flows - payments and receipts of principal	(800)	(152)	(681)	**(1,633)**
Financing cash flows - payments of interest	(51)	(92)	(763)	**(906)**
Non-cash movements:				
Impact of implementing IFRS 9 on 1 April 2018	14	-	-	**14**
Application of effective interest rate	47	92	763	**902**
Carrying value at 31 March 2019	**3,110**	**1,158**	**11,496**	**15,764**

Note 23 Finance leases

Note 23.1 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.

	31 March 2019 £000	31 March 2018 £000
Gross lease liabilities	**1,458**	**1,701**
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.	243	486
Finance charges allocated to future periods	(300)	(391)
Net lease liabilities	**1,158**	**1,310**
of which payable:		
- not later than one year;	162	152
- later than one year and not later than five years;	769	719
- later than five years.	227	439

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 21 above.

Note 24.1 Provisions for liabilities and charges analysis

	Pensions: early departure costs £000	Legal claims £000	Other £000	Total £000
At 1 April 2018	**1,590**	**270**	**412**	**2,272**
Change in the discount rate	(24)	-	-	**(24)**
Arising during the year	46	123	1	**170**
Utilised during the year	(121)	(74)	(43)	**(238)**
Reversed unused	-	(97)	(125)	**(222)**
Unwinding of discount	30	-	-	**30**
At 31 March 2019	**1,521**	**222**	**245**	**1,988**
Expected timing of cash flows:				
- not later than one year;	121	222	245	**588**
- later than one year and not later than five years;	1,381	-	-	**1,381**
- later than five years.	19	-	-	**19**
Total	**1,521**	**222**	**245**	**1,988**

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's Legal Department.
Other claims relate to dilapidations provisions.

Note 24.2 Clinical negligence liabilities

At 31 March 2019, £1,761k 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 2018: £1,084k).

Note 25 Contingent assets and liabilities

	31 March 2019 £000	31 March 2018 £000
Value of contingent liabilities		
NHS Resolution legal claims	(77)	(67)
Other	(1,100)	(1,134)
Net value of contingent liabilities	**(1,177)**	**(1,201)**

Contingent liabilities relate to £77k (£67k 2017/18) LTPS notified by NHS Resolution and £1.1m (£1.1m 2017/18) dilapidation costs for future years.

Note 26 Contractual capital commitments

	31 March 2019 £000	31 March 2018 £000
Property, plant and equipment	1,158	1,688
Total	**1,158**	**1,688**

Note 27 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	**2018/19**	2017/18
	£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.

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 Darent 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.

	2018/19	2017/18
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**

	2018/19	2017/18
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 27.1 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 2019 £000	31 March 2018 £000
Gross PFI, LIFT or other service concession liabilities	**17,932**	**19,376**
Of which liabilities are due		
- not later than one year;	1,376	1,444
- later than one year and not later than five years;	5,905	5,787
- later than five years.	10,651	12,145
Finance charges allocated to future periods	(6,436)	(7,199)
Net PFI, LIFT or other service concession arrangement obligation	**11,496**	**12,177**
- not later than one year;	655	681
- later than one year and not later than five years;	3,490	3,172
- later than five years.	7,351	8,324

Note 27.2 Total on-SoFP PFI, LIFT and other service concession arrangement commitments

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

	31 March 2019 £000	31 March 2018 £000
Total future payments committed in respect of the PFI, LIFT or other service concession arrangements	**49,857**	**52,913**
Of which liabilities are due:		
- not later than one year;	3,395	3,262
- later than one year and not later than five years;	13,543	13,224
- later than five years.	32,919	36,427

Note 27.3 Analysis of amounts payable to service concession operator

This note provides an analysis of the unitary payments made to the service concession operator:

	2018/19 £000	2017/18 £000
Unitary payment payable to service concession operator	**3,086**	**3,056**
Consisting of:		
- Interest charge	763	803
- Repayment of finance lease liability	681	647
- Service element and other charges to operating expenditure	986	1,039
- Contingent rent	656	567
Total amount paid to service concession operator	**3,086**	**3,056**

Note 28 Financial instruments

Note 28.1 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. The trust's 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 DHSC (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 2019 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 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 28.2 Carrying values of financial assets

IFRS 9 Financial Instruments is applied restrospectively from 1 April 2018 without restatement of comparatives. As such, comparative disclosures have been prepared under IAS 39 and the measurement categories differ to those in the current year analyses.

	Held at amortised cost	Total book value
Carrying values of financial assets as at 31 March 2019 under IFRS 9	**£000**	**£000**
Trade and other receivables excluding non financial assets	5,741	**5,741**
Cash and cash equivalents at bank and in hand	12,545	**12,545**
Total at 31 March 2019	**18,286**	**18,286**

	Loans and receivables	Total book value
Carrying values of financial assets as at 31 March 2018 under IAS 39	**£000**	**£000**
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**

Note 28.3 Carrying value of financial liabilities

IFRS 9 Financial Instruments is applied restrospectively from 1 April 2018 without restatement of comparatives. As such, comparative disclosures have been prepared under IAS 39 and the measurement categories differ to those in the current year analyses.

	Held at amortised cost £000	Total book value £000
Carrying values of financial liabilities as at 31 March 2019 under IFRS 9		
Loans from the Department of Health and Social Care	3,110	**3,110**
Obligations under finance leases	1,158	**1,158**
Obligations under PFI, LIFT and other service concession contracts	11,496	**11,496**
Trade and other payables excluding non financial liabilities	14,397	**14,397**
Total at 31 March 2019	**30,161**	**30,161**

	Other financial liabilities £000	Total book value £000
Carrying values of financial liabilities as at 31 March 2018 under IAS 39		
Loans from the Department of Health and Social Care	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**

Note 28.4 Fair values of financial assets and liabilities

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

Note 28.5 Maturity of financial liabilities

	31 March 2019 £000	31 March 2018 £000
In one year or less	18,324	12,591
In more than one year but not more than two years	896	1,617
In more than two years but not more than five years	3,363	5,374
In more than five years	7,578	8,764
Total	**30,161**	**28,346**

Note 29 Losses and special payments

	2018/19		2017/18	
	Total number of cases Number	Total value of cases £000	Total number of cases Number	Total value of cases £000
Losses				
Cash losses	24	10	32	9
Bad debts and claims abandoned	19	7	9	46
Total losses	**43**	**17**	**41**	**55**
Special payments				
Ex-gratia payments	22	54	31	111
Total special payments	**22**	**54**	**31**	**111**
Total losses and special payments	**65**	**71**	**72**	**166**

Note 30 Initial application of IFRS 9

IFRS 9 Financial Instruments as interpreted and adapted by the GAM has been applied by the trust from 1 April 2018. The standard is applied retrospectively with the cumulative effect of initial application recognised as an adjustment to reserves on 1 April 2018.

IFRS 9 replaces IAS 39 and introduces a revised approach to classification and measurement of financial assets and financial liabilities, a new forward-looking 'expected loss' impairment model and a revised approach to hedge accounting.

Under IFRS 9, borrowings from the DHSC, which were previously held at historic cost, are measured on an amortised cost basis. Consequently, on 1 April 2018 borrowings increased by £14k, and trade payables correspondingly reduced.

Reassessment of allowances for credit losses under the expected loss model resulted in no change in the carrying value of receivables.

The GAM expands the definition of a contract in the context of financial instruments to include legislation and regulations, except where this gives rise to a tax. Implementation of this adaptation on 1 April 2018 has led to the classifiction of receivables relating to Injury Cost Recovery as a financial asset measured at amortised cost. The carrying value of these receivables at 1 April 2018 was nil.

Note 30.1 Initial application of IFRS 15

IFRS 15 Revenue from Contracts with Customers as interpreted and adapted by the GAM has been applied by the trust from 1 April 2018. The standard is applied retrospectively with the cumulative effect of initial application recognised as an adjustment to the income and expenditure reserve on 1 April 2018.

IFRS 15 introduces a new model for the recognition of revenue from contracts with customers replacing the previous standards IAS 11, IAS 18 and related Interpretations. The core principle of IFRS 15 is that an entity recognises revenue when it satisfies performance obligations through the transfer of promised goods or services to customers at an amount that reflects the consideration to which the entity expects to be entitled to in exchange for those goods or services.

As directed by the GAM, the trust has applied the practical expedient offered in C7A of the standard removing the need to retrospectively restate any contract modifications that occurred before the date of implementation (1 April 2018).

Note 31 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 31.1 Related Party Income

Health Education England
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 31.2 Related Party Expenditure

NHS Pensions Scheme

Note 31.3 Events after the reporting date

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

Note 32 Better Payment Practice code

	2018/19 Number	2018/19 £000	2017/18 Number	2017/18 £000
Non-NHS Payables				
Total non-NHS trade invoices paid in the year	18,513	53,885	23,297	47,267
Total non-NHS trade invoices paid within target	16,890	52,213	21,357	46,350
Percentage of non-NHS trade invoices paid within target	91.2%	96.9%	91.7%	98.1%
NHS Payables				
Total NHS trade invoices paid in the year	1,227	6,317	1,529	9,413
Total NHS trade invoices paid within target	1,167	6,150	1,114	6,398
Percentage of NHS trade invoices paid within target	95.1%	97.4%	72.9%	68.0%

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 33 External financing

The trust is given an external financing limit against which it is permitted to underspend:

	2018/19 £000	2017/18 £000
Cash flow financing	(7,733)	(4,532)
External financing requirement	**(7,733)**	**(4,532)**
External financing limit (EFL)	1,637	(19)
Under spend against EFL	**9,370**	**4,513**

Note 34 Capital Resource Limit

	2018/19 £000	2017/18 £000
Gross capital expenditure	10,065	5,658
Less: Disposals	(5,038)	(2,904)
Charge against Capital Resource Limit	**5,027**	**2,754**
Capital Resource Limit	5,826	3,381
Under spend against CRL	**799**	**627**

Note 35 Breakeven duty financial performance

	2018/19 £000	2017/18 £000
Adjusted financial performance surplus / (deficit) (control total basis)	2,026	(1,224)
Remove impairments scoring to Departmental Expenditure Limit	1,642	-
IFRIC 12 breakeven adjustment	295	-
Breakeven duty financial performance surplus / (deficit)	**3,963**	**(1,224)**

Note 36 Breakeven duty rolling assessment

	1997/98 to 2008/09	2009/10	2010/11	2011/12	2012/13	2013/14	2014/15	2015/16	2016/17	2017/18	2018/19
		£000	£000	£000	£000	£000	£000	£000	£000	£000	£000
Breakeven duty in-year financial performance		1,524	13	538	1,202	1,607	902	(4,180)	(3,311)	(1,224)	3,963
Breakeven duty cumulative position	2,376	3,900	3,913	4,451	5,653	7,260	8,162	3,982	671	(553)	3,410
Operating income		182,374	182,204	178,468	172,902	174,924	178,674	181,334	183,103	181,034	185,085
Cumulative breakeven position as a percentage of operating income		2.1%	2.1%	2.5%	3.3%	4.2%	4.6%	2.2%	0.4%	(0.3%)	1.8%

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 cost or a greatly reduced cost.
Taxpayers' 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) and Complaints

Should you have a concern about your care and treatment, we welcome your comments and ask that you speak with the staff providing your care. If you feel unable to and would rather speak to the PALS and Complaints team direct please contact us and we will support you through the process. All complaints will be carefully listened to and thoroughly investigated.

Compliments

If you have something positive to say about our service we would love to hear from you. Please speak to staff direct or you can log your compliment at www.kmpt.nhs.uk/feedback

Contact details for PALS and Complaints

East Kent: 0800 783 9972

West Kent and Medway: 0800 587 6757

Email: kmpt.pals.kmpt@nhs.net

Or write to: KMPT
PALS and Complaints
St Martins Hospital
Littlebourne Road
Canterbury
Kent CT1 1TD

Please call **01622 724131** if you would like this leaflet in a different language or format.

Visit us at www.kmpt.nhs.uk

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