NHS
Kent and Medway
NHS and Social Care Partnership Trust

Annual Report 2016-17

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

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Welcome

It has been a very busy and eventful year for the Trust. Despite the challenges of ensuring that the quality of our services and patient experience remains high in a climate of increasing financial pressures, we can feel proud of the differences we have made to people's lives.

Everyone involved with KMPT from our staff and the people who use our services to our partner organisations and commissioners, carers and families have contributed to our achievements and we would like to thank them for their support.

Our focus has remained on constantly improving the quality of our provision, continually improving our engagement and working with our partners throughout Kent and Medway to ensure the sustainability of our services. The strength of our partnerships has become increasingly important as we work together to plan how we will transform health and social care services to meet the changing needs of local people. It is the first time we have all worked together in this way and it gives us a unique opportunity to bring about positive and genuine improvement in health and social care delivery over the next five years.

Over the past year we have been building on our strengths and driving innovation. We are particularly proud of our highly successful therapeutic staffing model, which has transformed the way the Trust shapes delivery of its services within its inpatient units. This new way of working has established teams of mixed expertise from nursing, healthcare administrators, therapists, psychiatrists and psychologists – each person bringing their individuality and expertise to the team.

Another way that we are working differently is through our Peer Supported Open Dialogue model that we developed with the help of Health Foundation funding, which was awarded to KMPT last year. Open Dialogue is a mental health treatment model that originated in Finland in the 1980s and has led to results around recovery, return to employment and reduced medication. KMPT's Peer-supported Open Dialogue (POD) service is an adaptation of the original approach and involves paid support workers with lived experience becoming part of the series of meetings that are set up with patients, their families, clinicians and social workers. Anticipated outcomes include reduced hospital admissions and lengths of stay and increased wellbeing for patients and families.

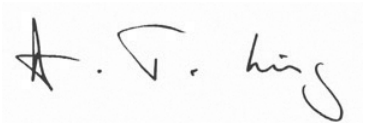
Patient wellbeing and ensuring that the strong correlation between physical and mental health is being addressed in all areas of the Trust, is a priority task. As well as ensuring that physical health is very much part of a patient's care plan and having physical health nurses on our wards, we are keen to develop psychiatric liaison throughout the county. This year we have seen our teams of mental health clinicians who are working in hospitals doing some excellent work with their acute colleagues and achieving some fantastic results.

We are also impressed with the way in which our staff and the programmes and projects we are developing are continuing to be recognised at both regional and national level. During the course of the year this has included our commitment to building on apprenticeship programmes, our research work, our facilities, Peer

Support Workers, Peer Supported Open Dialogue, the work we are doing for those with dementia, our Mother and Infant Mental Health Service (MIMHS) and being part of a national health and work pilot project through the delivery of peer to peer education training sessions. In particular, two members of staff have received national acclaim for their work: Yasmin Ishaq won a gold award for her innovative work at the prestigious Social Worker of the Year awards and Dr Ananth Puranik was awarded College Fellowship of the Royal College of Psychiatrists, which is a mark of distinction and recognition of contribution to psychiatry.

As well as being proud of what we are good at we are also delighted at the way we successfully addressed a major challenge that we had at the beginning of the year by greatly reducing the number of patients in out of area private beds. In June 2016 we had 76 patients who were being treated in private beds outside the county. We have improved our patient flow, enhanced clinical leadership, focused on delayed transfers of care and reduced lengths of stay. By November 2016 we had only four patients in private beds outside the county and we are continuing to focus on reaching and maintaining a zero target. We are, of course, all particularly proud of our new overall trust rating of Good from the Care Quality Commission (who rated eight out of ten of our services as either Good or Outstanding). We are by no means perfect, but we are determined to continue our work to become a consistently outstanding organisation in whom those we serve can place their trust.

KMPT continues to be committed to playing a significant role in working with our partners in order to safeguard resources for mental health for the benefit of those living in Kent and Medway. The huge financial challenges facing all public sector services make this a key focus for the future.



Andrew Ling

Chairman

Helen Greatorex

Chief Executive

THE PERFORMANCE REPORT

Annual report overview

Kent and Medway NHS and Social Care Partnership Trust (KMPT) specialises in caring for people with a wide range of mental health needs including substance misuse, forensic and other specialist services. The Trust was formed in April 2006 after the merger of East Kent NHS and Social Care Partnership Trust and West Kent NHS and Social Care Trust. The catchment area spans diverse communities containing areas of great affluence as well as those with much deprivation. We are constantly developing and transforming the way that we work to provide modern, dependable services to meet the needs of the people within the diverse communities that we serve.

The Trust carries out its work on behalf of eight local Clinical Commissioning Groups (CCGs), Kent County Council and NHS Specialist Commissioning. This reflects the distinct locality focus, which presents opportunities for local integration and innovation but also a challenge in terms of implementing countywide service solutions. The Trust covers a big county with a population of 1.8 million, which is spread across 1500 square miles. Our annual revenue is £183.1 million and we employ 3,502 staff who are located in 69 buildings on 36 sites.

One of the key challenges for us is our geography being spread out across a large number of sites. Having staff located in many different areas has challenged connections and engagement. We have an organisational development programme, which includes Leadership meetings and regular roadshows as well as an opportunity for staff to engage with senior leaders on a twice yearly basis in ‘The Big Conversation’. These initiatives are supporting local connections across service lines and teams and this work will continue into this financial year.

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

Our values are:

Respect – we value people as individuals; we treat others as we would like to be treated

Open – we work in a collaborative, transparent way

Accountable – we are professional and responsible for our actions

Working together – we work together to make a difference for our service users

Innovative – we find creative ways to run efficient, high quality services

Excellence – we listen and learn to continually improve our knowledge and ways of working.

Highlights and developments

‘Good’ rating and ‘Outstanding’ for caring
In January 2017 we were inspected by the CQC who rated eight out of ten of our services as either Good or Outstanding. The report we received from them identifies a number of areas of good practice including:

- Inspectors found excellent use of the dementia care mapping toolkit and implementation of ‘this is me’ life history documentation to provide person-centred care on the wards for older people with mental health problems
- The Trust had made a commitment to strengthen the Peer-Supported Open Dialogue (POD) approach and is training a second cohort of students. Open Dialogue involves regular network meetings between a patient and their family, or peer network, and mental health professionals
- In the long stay rehabilitation mental health wards staff told inspectors about the job taster programme where patients and ex-patients are given the opportunity to work in a placement on one of the units
- The Trust had a ‘Peak of the week’ quality initiative, which identified a particular area of service quality, development or improvement and shared throughout the Trust
- Inspectors saw in services across the Trust a range of support and educational groups for carers including a carer’s education programme. In the community based services for older people there were support groups such as ‘living well with dementia’. The psychology team offered behavioural family therapy for patients and carers in several wards. Wards also had carer’s champions.

Areas where the Trust has been told to improve include:

- In community-based mental health services for adults of working age the Trust must address the high caseload numbers allocated to individual staff to ensure that all patients are appropriately monitored
- The Trust must review its waiting lists for those patients waiting for initial assessment and those patients waiting for allocation to a named worker to ensure patients receive a service in a timely way
- In acute wards for adults of working age and psychiatric intensive care units, the Trust must ensure that the service is providing accommodation that adheres to guidance on same-sex accommodation
- In the forensic inpatient and secure services the Trust must protect patients and staff against the risks associated with unsuitable premises and equipment, including a review of the bed frames used in the service to reduce the risk of ligatures.

To view the full report please visit the CQC website.

Innovative research
KMPT's development, implementation, and evaluation of the Firesetting Intervention Programme for Mentally Disordered Offenders (FIP-MO) received a double accolade. This specialist intervention has been developed for individuals with history of deliberate firesetting who have a mental disorder or personality disorder. Working with staff from the Centre for Research and Education in Forensic Psychology (CORE-FP) at the University of Kent, KMPT's forensic team won an Impact through Knowledge Exchange Award as part of the University of Kent's Innovation Awards. The Impact through Knowledge Exchange award seeks to recognise collaboration between academics and an external organisation on a project which has clearly demonstrated impact in the wider community, for example, multiple services adopting the outcome of the research. Shortly following this award the joint University of Kent / KMPT team won an Outstanding Impact in Society Award, in this year's Economic and Social Research Council (ESRC) Celebrating Impact Prize, was presented by Kelvin Hopkins MP.

Dementia work
The work of some of our dementia service user envoys once again hit the national stage in the form of connecting with the Reading Well website. Keith Oliver, a former headteacher was diagnosed with dementia in 2010 following a series of viruses and unexplained falls. Since his diagnosis, Keith has campaigned tirelessly to help raise awareness of the needs of people with dementia. Last year Keith was involved in selecting the Reading Well books on prescription for dementia. The Reading Well website offers books on prescription to help people understand and manage their health and wellbeing using self-help reading. The scheme is endorsed by health professionals, NHS trusts and organisations such as Alzheimer's Society, Carers UK and Dementia UK. At the same time Reinhard Guss, a KMPT Clinical Psychologist and Chair of the Faculty of the Psychology of Older People alongside Chris Norris, Dementia Service User Envoy for KMPT, both gave a joint opening address at the Dementia 2020 Conference.

New provision
At the beginning of the year West Sussex County Council invited organisations to tender for the provision of inpatient detoxification for substance misuse services for their residents. By the summer we were told that we had been successful. The team at Bridge House (KMPT's detoxification unit) are now providing this service to people living in West Sussex as well as in Kent and Medway.

Peer Supported Open Dialogue
The Health Foundation, an independent health care charity, selected one of our teams to be part of its £1.5 million innovation programme, Innovating for Improvement. Our project, Peer-Supported Open Dialogue (POD), was one of only 20 health care projects in the UK selected by The Health Foundation. Open Dialogue pioneered by Professor Jaakko Seikkula, is already embedded in parts of Finland, Northern Europe and parts of America, and KMPT is leading the way, with three other organisations in the UK to be adapting the model for widespread use in the NHS.

Our Peer-Supported Open Dialogue project was also one of two KMPT initiatives to be shortlisted for the national Positive Practice Awards. POD was shortlisted in the

Crisis Care Pathway category. Our Mother and Infant Mental Health Service (MIMHS) was also shortlisted in the Community Perinatal Mental Health Services category. Both categories were supported by NHS England and both projects were highly commended.

System plans

We worked with other providers of health and social care in Kent and Medway to draft a Health and Social Care Sustainability and Transformation Plan (STP), which sets out how we think services need to change over the next five years to achieve the right care for people for decades to come. We published this draft plan on our website in November and our case for change was also published earlier this year.

Engaging with our service users and carers

Listen Up!

During the summer we launched our Listen Up! Campaign. The thinking behind this campaign is that the simplicity of listening can have a big impact on someone who just needs to talk and can prevent an issue escalating into a crisis. Listening leads to better understanding and it is only through truly understanding what is being heard that the right action can be taken. Through the campaign we are; reaching out and listening to those people who may need our help but who have not necessarily made contact with us already through our events, committees and forums, enlisting the help of those who we regularly engage with so that they can help us make new connections and spreading the word that everyone can help by making more time to listen to those who may be in need. We are visiting communities to listen and give more information about KMPT. We are also talking about our Kent and Medway system plans to sustain the health and social care system.

Co-Production Network

KMPT has established a Co-Production Network, which brings together service users, carers, representatives of community groups and KMPT staff to identify area of work that can be carried out and implemented jointly. One of the first pieces of work carried out by the network was to design the layout of the refurbished wards in Maidstone and the project won a North Kent CCGs Patient Experience Award – 'Providers and Patients working in Partnership'.

Celebrating Engagement event – December 2016

We held an event in December to thank all the members of our Patient Consultative Committees, Carers Consultative Committees, Expert by Experience Research Group and the Co-production Network for who help us in developing and improving our services. The event took place at St Martins Hospital, Canterbury; it was a great success and was attended by people who support our patient involvement agenda from across Kent and Medway.

Time to Talk event 2017

On the 2 of February, Time to Change held their Time to Talk Day across England, to encourage people to be open about their mental health. To support this we arranged a Time to Talk day with staff and service users taking part in Dartford, Canterbury and Maidstone via audio conferencing.

Patient and Carer Consultative Committee meetings

- West Kent Patient Consultative Committee
- North Kent Patient Consultative Committee
- East Kent Patient Consultative Committee
- East Kent Carer Consultative Committee
- West Kent Carer Consultative Committee

The PCC and CCC are bi-monthly meetings for service users and carers to meet up and share experiences of using mental health services in order to support improvement in service delivery. Meetings include KMPT staff who discuss relevant developments and other areas of work. Meetings are open to all service users and carers within their geographical area and travelling costs for service users and carers attending can be reimbursed.

Expert by Experience Research Group
The group, which is made up of people who have used or are using secondary mental health services continues to meet on a monthly basis to help the Trust learn and improve from people who have lived experience. The group get involved in many activities including: research and development, service evaluations, consultant recruitment and clinical audit and service evaluation group. In 2017 KMPT trained members to facilitate a focus groups, conduct surveys, and interviewing skills.

The group continue to engage with the staff and in 2016 group member, Nick Petrie, gave a presentation to the Board.

Annual Trustwide carers survey
In 2016-17 KMPT carried out two internal Trustwide surveys regarding carers experience of KMPT services, one in the Community Recovery Service Line and one in Older People's Services. The surveys were developed in conjunction with carers. The results have been analysed and the Trust is now taking forward the points raised through the Trustwide Patient and Carer Experience group and Triangle of Care.

Managing finances

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

It also describes how much funding we receive and where it comes from, as well as how we spend it 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 2016 -17.

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.
Taxpayer' Equity	Bottom half of the Statement of Financial Position which shows the Taxpayers investment in the Trust.
Fixed asset impairment losses	Impairment losses arise when an asset is recorded in the Trust's books at more than its current value. This difference between what the Trust can sell the asset for and the historic value in the Trust's books is an impairment loss.

Introduction

The following pages summarise the Trust's financial performance. The Operating Financial Review has been prepared in accordance with Reporting Standard 1 (RS1).

This year reflects the financial impact of the changes and developments that the Trust had put in place to respond to the needs of our stakeholders – including both patients and commissioners. The governance processes deliver changes whilst maintaining patient safety. Focus continues to be on quality impact assessment, service redesign and robust project management.

The Trust continued to earn the majority of its core business income from the local Clinical Commissioning Groups which are Ashford CCG, Canterbury and Coastal CCG, Dartford, Gravesham and Swanley CCG, Medway CCG, South Kent CCG, Swale CCG, Thanet CCG, an d West Kent CCG all under block contract. Specialist Services were commissioned via NHS England.

The partnership arrangement with Kent County Council, which enables single management of the workforce for the provision of adult services, has also continued during 2016 -17.

The Trust works closely with Medway Local Authority who is the provider of social care in the Medway locality, no formal partnership arrangement is in place.

SUMMARY OF FINANCIAL PERFORMANCE

This section summarises the financial performance for 2016 -17 and the position of the Trust as at 31 March 2017.

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.

The two most significant accounting policies, which require the exercise of judgement and which can potentially have a material impact on the Trust's accounts, are IAS 36 – Impairment of Assets and IAS 37 – Provisions, Contingent Liabilities and Contingent Assets.

The Trust's accounts for 2016 -17 have been examined by our external auditor, Grant Thornton, and their report is set out on page 63.

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

Summary of Financial Performance Targets

The Trust has one financial target and four statutory targets. Further detail of the statutory targets is given at note 32 to the accounts.

NHS Improvement Control Total – (Achieved)

At the beginning of the financial year the Trust agreed a control total with NHS Improvement of a deficit after technical adjustments of £4.1m (£4.3m before technical adjustments). As the Trust performed within the control total the Trust has been allocated £760k of incentive and bonus Sustainability and Transformation Funding. Therefore the Trust ended the year with a £3.3m (£3.6m before technical adjustments) deficit.

The planned deficit was achieved as the Trust delivered £6.9m of savings compared to the plan of £5.6m. Both the planned deficit and the actual performance included a change to the baseline contract value related to the application of the national inflator of 1.1% and the receipt of a Sustainability and Transformation Fund allocation of £1.1m.

Breakeven Duty – (Achieved)

To break even or recover any deficit over a rolling three year period. During 2016 -17 the Trust recorded a £3.3m deficit after technical adjustments. This resulted in a cumulative surplus of £0.7m. Further detail is given at note 32.1 to the accounts.

Capital Resource Limit – (Achieved)

To remain within its capital resource limit (a target on capital spending). During 2016-17 the Trust underspent by £1,025k predominately due to Capital schemes relating to Modernising Acute Inpatient facilities completing in 2017-18.

External Financing Limit – (Achieved)

To remain within its external financing limit (a target on the amount of cash resource the Trust can utilise). During 2016 -17 the Trust underspent by £1,025k due to the underspend against the capital resource limit.

Capital Cost Absorption Duty – (Achieved)

To achieve its capital cost absorption duty set at a rate of return on assets of 3.5%. The Trust achieved 3.5%.

SUMMARY OF FINANCIAL RISKS

Summaries of the financial risks are outlined within the Annual Governance Statement on page 36.

Audit

The Trust's external auditor is Grant Thornton. It conducted work during the year on audit services at a cost of £61k (excluding VAT). This work included accounts, governance and performance work.

Provision of information to Auditors

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

Going concern

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

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

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

Capital expenditure

The Trust spent net £3.4m on capital expenditure in 2016 -17, which represented an under spend against the plan revised in June 2016 of £984k. This is to be carried forward for the modernising acute inpatient facilities schemes in 2017-18.

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

1. £2m on strategic estates schemes to modernise the Trusts estate, including work on seclusion rooms which were identified in the 2016 CQC inspection.

2. £1.1m on smaller building and engineering projects to maintain the estate.

3. £0.7m on information technology projects.

Private Finance Initiative (PFI)

The use of private finance gives the Trust more access to funding for capital developments than would otherwise be available. The Trust has five PFI buildings that were built over a number of phases and were all part of the old Stone House Hospital reprovision. Details are provided in Note 27.

Payment by Results

In the acute sector the NHS operates a charging mechanism called "Payment by Results" (PbR). Under PbR, organisations that provide healthcare charge commissioners for the activities they undertake based on a national tariff price for that activity. This is part of a planned move away from the old system of commissioning on block contract agreements and will eventually apply to most NHS services.

Currently, mental health services are excluded from these arrangements and as a result most of the Trust's income is still earned from the old style block contracts, where there is neither reward for extra activity nor penalty for reduced activity. However indicative activity plans in the nationally mandated currency of clusters, are agreed and performance is monitored as part of the contracting arrangements.

The currency of clusters is the result of the north east pilot work and the clusters are based on diagnosis and care pathways within the cluster. The Trust entered into shadow local tariff arrangement in 2014-15 and has continued to work with all CCGs to develop pathways and calculate the resulting local tariff by CCG.

The results continue to produce diverse ranges of prices for each cluster so work continues to ensure service users are clustered appropriately. The pathway design work has been agreed with the CCGs, and the Trust is working with commissioners to identify the resource gaps and differences in provision and will produce plans to enable the transition and redesign of the services to deliver agreed standard cluster.

Liquidity

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

The Trust has reduced its cash holding at the end of 2016 -17 given the level of deficit. Given the low cash balance and the overall pressure on the Trust financial position cash management will remain a key focus during 17-18.

In addition to the previous capital loan the Trust took a revenue support loan from the Department of Health of £2.3m. As shown in note 21 of the accounts the amount outstanding on the two loans was £4.7m as at 31 March 2017.

Income

The Trust's income in 2016 -17 was £183.1m. Details of the sources of income are identified on page 16, note 4 and 5 of the accounts.

Expenditure

Operating expenses in 2016 -17 were £180.5m. The analysis of this expenditure is on page 6 note 17 of the accounts.

Better Payment Practice Code

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

The Trust's payment policy is consistent with this requirement however due to the reduced liquidity during the year mainly as a result of the deficit, the level of compliance in 2016 -17 was 83.8% (based on volumes) and 88.5% (based on values).

Further details of the Trust adherence to the code can be found on at note 9 of the accounts.

Review of quality

The Board has a key focus on quality and safety and this drives the Trust agenda through the quality strategy and transformation strategy and programme. Many of the initiatives mentioned in this section have already been mentioned under the 'challenges and progress' section of this report under 'safety', however, this section looks at these initiatives against the set key performance indicators.

Quality Impact Assessments – Business Cases and Service Development Initiatives

In 2016 -17 the Transformation Board had responsibility for approving and monitoring business cases and service development initiatives. Under the Trust policy all changes can only be considered if they are accompanied by an approved Quality Impact Assessment (QIA). QIAs are monitored through a QIA Group which is jointly chaired by the Executive Director of Nursing and Quality and the Executive Medical Director. This group considers and monitors all QIAs, and makes recommendations to the Quality Committee. 'Monitoring' of business cases, initiatives and CIP (Cost Improvement Schemes) schemes is undertaken at the initial design stage as part of the business case approval process and then at quarterly intervals post implementation for up to 12 months.

Quality Account

The improvement priorities agreed through the Quality Account consultation and incorporated in the benefits matrix from the Transformation Programme are:

- **Safe** - Reduce all serious incidents including absence without leave, absconding, suicide and serious self-harm during an inpatient admission or while in treatment with a working age adult community team.

- **Caring** - Further develop and implement the recovery and wellbeing approach for all our service users; Work in closer partnership with our service users to ensure access to physical health care monitoring.
- **Effective** - Work in closer partnership with service users to ensure that care is service user centre; ensuring service users are informed of changes in care coordinators.
- **Responsive** - To ensure all adults, children and young people are effectively safeguarded; Monitor the patient experience of service users' views relating to the effectiveness of their CPA.
- **Well led** - Better communication between our staff and service users and their carers; better use of benchmarking and external comparisons to improve Board quality information.

Review of performance

The performance of the Trust is monitored via its Integrated Quality and Performance Report (IQPR) which was reviewed and updated in January 2016. The report focuses on the measures outlined within the published Single Oversight Framework along with a range of other metrics designed to monitor Trust and Service line performance on a monthly basis. The report provides summary and where appropriate a more detailed breakdown of areas of under or over performance against these key agreed metrics and is available at Trust, Service line and team level to ensure that focus is applied as needed.

This report provides a high degree of assurance to the Board on performance against a balanced scorecard of regulatory, workforce, quality and finance performance targets. It provides the Trust Board with data visualisation, trend and trajectory analysis and a forecast of future performance in order that the Board understands which service areas are at risk of failing to meet targets in the future. A further review of the IQPR is planned for 2017-18 to ensure it continues to provide significant assurance to the board.

The use of an integrated approach to quality and performance is helping to ensure that a performance culture is implemented in the Trust and embedded across service lines. The Trust's performance management framework provides the overarching structure for provision of performance management information to service lines and the timeframes for performance review and action planning. It sets out the process that service lines will use to implement supportive actions for teams and individuals, and the process that will be followed where service line actions do not deliver the forecast improvement. These meetings combine review and challenge on service line progress with an opportunity to discuss issues of concern. This essentially leads to a from 'Ward to Board' oversight process where action plans are approved in advance of being reported to the Board.

More details about the IQPR can be obtained from the Trust Board papers online at www.kmpt.nhs.uk.

We have set out our performance against a number of our most significant KPIs in the following table. These KPIs are regularly reported to the Trust Board as part of the IQPR. There are other KPIs which apply to a range of Trust services. These are

regularly monitored through our internal performance management meetings to create accountability at all levels of the organisation. Externally there is also a wide ranging set of performance metrics which are monitored by CCG commissioners through our performance review arrangements.

Key Performance Indicator	2016-17 Year End	Target	Local / National
Admissions gatekept by CRHT (%)	100.0%	90%	National
CPA 7-day follow-up (%) Enhanced Only	95.3%	95%	National
Delayed transfers of Care (Monitor/CareQuality Commission)	7.4%	<7.5%	National
MHMDS completeness (Monitor definition, %)	71.5%	50%	National
CPA patients receiving formal 12 month Review	80.6%	95%	National
EIP Waiting Time Proxy (Referral to Care Coordinator in 2 Weeks)	75.0%	50%	National
% of patients with valid CPA care plan or plan of care	83.5%	95%	Local
Emergency readmissions within 28 days (younger, %)	10.6%	<5%	Local
Emergency readmissions within 28 days (older, %)	3.4%	<5%	Local
Referral to assessment within 4 weeks	82.9%	95%	Local
18 Weeks referral to treatment	91.4%	95%	Local

Carbon sustainability

KMPT continues to demonstrate its commitment to sustainability, reducing its carbon emissions and minimising its impact on the environment and climate change. Sustainability continues to form an integral part of the Trust core business. As the Trust continues to reduce its carbon footprint, it is evident that corporate social responsibilities are taken seriously as well as recognising the importance of managing the environmental impact from its operations. In promoting new and innovative projects, the Trust will maintain a commitment to NHS Carbon Reduction Strategy. The Trust's progress is monitored through the Sustainable Development Management Plan. It sets out a strategy for emissions reductions and cost savings from those carbon emitting activities that KMPT can monitor and influence. KMPT continues to make significant carbon reduction since the 2009 -10, when the Trust had an objective to achieve a minimum 34% reduction on carbon utilisation by 2020 in line with the national NHS carbon reduction target. The Trust is set to further reduce carbon thanks to the Photovoltaic Solar panel installations through the Energy Performance Contract with SKANSKA. Building on the achievements made over the last few years KMPT needs to:

- Continue to focus on the importance of total waste management
- Be innovative in the way it continues to drive down energy wastage
- Continually developing a range of tools and materials to promote our commitment to sustainability, engaging with staff and service users.

The uptake of the Green Champion network has being encouraging over the years. KMPT has a flagship Green Champion Charter in place, which empowers them to undertake their duties to further, improve KMPT's environmental performance. There is a work plan in place for the Green champions and they come up with mini projects around Sustainability to help enforce change.

Communication and awareness has been a major focus of the Carbon Management Plan. A rolling programme of campaigns; concentrating on energy, green travel and waste and sustainable development, are supported by a range of initiatives including posters, stickers, competitions and promotions. An NHS Sustainability Day provided

an opportunity for patients, visitors and service users to understand how a better environment can improve their health. KMPT staff marked the day by having various awareness raising activities:

- Cycle to work roadshow, sponsored by Evans Cycle Shop
- Week long pledges by senior members of staff
- Green Champion site based awareness raising walks

Over the next year, the Trust will also be addressing how to use its Sustainable Development plan to support the health and social care system in Kent and Medway to become more sustainable in all three dimensions of sustainability: environmental, social and financial.

This will involve highlighting the many benefits to health and wellbeing that result from taking this approach also work to support the STP process and ensure a joined up approach to the challenges we face.

ACCOUNTABILITY REPORT

Section 1 – Corporate governance

The directors' report

The Trust's Board of Director's comprises the Chairman and seven non-executive directors (NEDS), and seven directors (EDs), all of whom are collectively responsible for the success of the Trust. The Director of Operations and the Director of Workforce and organisational Development are non-voting directors.

Executive directors are full-time employees of the Trust and non-executive directors are appointed by the NHS Improvement. Executive directors manage the day-to-day running of the Trust and together with the Chairman and other non-executive directors they set the strategic direction of the Trust 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 2016 -17 there were some changes to the composition of the Board. Donna Eldridge was Acting Director of Nursing and Governance until Mary Mumvuri began in May 2016 as the permanent Director of Nursing and Quality. Richard Page and Margaret Andrews Non Executive Directors completed their terms of office in June and August 2016 respectively. Three new and replacement NEDs were appointed during the year. Jackie Craissati started in May 2016. Venu Branch in September 2016 and Catherine Walker became a full Non Executive in December 2016 after three months as an Associate NED. Angela McNab Chief Executive left the Trust in April 2016 and her permanent replacement Helen Greatorex was appointed and started in June 2016. Malcolm McFrederick Director of Operations who acted as CEO in April and May 2016, left the Trust in February 2017. Recruitment for his replacement is due to conclude in June 2017. The Director of Operations responsibilities have been shared amongst the other Executive Directors in the interim period. The Chairman's term of office will conclude in October 2017 and recruitment for a replacement will begin in June 2017.

Board membership 2016-17 – table 7

Non-executive Directors	Executive directors
Andrew Ling	Angela McNab – Chief Executive*
Margaret Andrews**	Helen Greatorex, Chief Executive Officer *********
Mark Bryant	Catherine Kinane – Executive Medical Director
Tom Phillips	Donna Eldridge, Acting Director of Nursing and Governance****
Anne-Marie Dean	Philip Cave – Executive Director of Finance
Rodney Ashurst	Malcolm McFrederick, Director of Operations*****
Richard Page***	Sandra Goatley, Director of Workforce and OD
Jackie Craissati******	Ivan McConnell – Executive Director of Transformation and Commercial Development
Venu Branch*******	Mary Mumvuri – Executive Director of Nursing and Quality
Catherine Walker********	

* Left in April 2016
** Left on 1 August 2016
*** Left June 2016
**** Acting Director until June 2016
***** Acting CEO April and May 2016, left the Trust February 2017
****** joined the Board on 13 May 2016
******* joined the Board on 1 September 2016
******** joined the Board on 1 December 2016
********* joined the Board on 6 June 2016

The Board

The Board leads the Trust by undertaking three key roles:

- The Board is responsible for setting the strategic direction for the Trust.
- Formulating strategy, such as the clinical strategy.
- Holds the organisation 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 organisation, local government authorities and others to provide safe, accessible, effective and well governed services that meet the needs of patients, carers and the Trust's local population.
- To ensure that the Trust meets its obligations to the population it serves, its stakeholders and staff in a way that is wholly consistent with public sector values, including the Nolan Principles of Public Life.

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

Table 8 shows the attendance of every member of the Trust Board at the Board meetings held during 2015 -16.

Director's attendance at Board meetings 2016-17 – table 8

Non-executive directors 2016-17	Actual / possible
Andrew Ling	6/6
Margaret Andrews	Resigned 31 August 2016
Mark Bryant	6/6
Tom Phillips	5/6
Anne-Marie Dean	6/6
Rod Ashurst	6/6
Jackie Craisatti	4/5
Venu Branch	4/4

Catherine Walker	3/3

Executive directors 2016-17	Actual / possible
Helen Greatorex	5/5
Ivan McConnell	6/6
Catherine Kinane	6/6
Philip Cave	6/6
Malcolm McFrederick	3/4
Sandra Goatley	6/6
Donna Eldridge	1/1
Mary Mumvuri	5/5

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. The Trust is required to publish in the 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 in shown below:

Register of interests – table 9

None	Job title	Interest declared
Non-executive Directors		
Andrew Ling	Chairman	None declared
Margaret Andrews	Deputy Chair / Non-Executive Director	None declared
Rodney Ashurst	Non-Executive Director	An ex-employee of BT PLC which is a current supplier of various services to KMPT, as well as many other NHS

None	Job title	Interest declared
		Bodies. His role at BT was not involved in selling to or dealing with any part of the NHS.
Mark Bryant	Non-Executive Director	Mark's daughter has joined Pembury Hospital recently as a Midwife (Band 6) This is part of Maidstone and Tunbridge Wells Trust.
Tom Phillips	Non-Executive Director	None declared
Ann-Marie Dean	Non-Executive Director	None declared
Jackie Craissati	Non-Executive Director	None declared
Venu Branch	Non-Executive Director	Not at this stage. Although Venu is in discussion with another NHS Trust about Consultancy employment.
Catherine Walker	Non-Executive Director	None declared
Executive Directors		
Angela McNab	Chief Executive – left on 30 April 2016	None declared
Helen Greatorex	Chief Executive – started 6 June 2016	None declared
Catherine Kinane	Medical Director	None declared
Philip Cave	Director of Finance	1) Phil Cave's Wife works at the South East Commissioning

None	Job title	Interest declared
		Support Unit. They support commissioning for CCGs in Kent. 2) Phil Cave is a Governor at Hythe Day School in Kent.
Ivan McConnell	Director of Transformation and Commercial Development	None declared
Malcolm McFrederick	Director of Operations	Director, M and James Ltd., Healthcare Consultancy
Sandra Goatley	Director of Workforce and OD	None declared
Donna Eldridge	Acting Director of Nursing and Governance	None declared
Mary Mumvuri	Director of Nursing and Quality	None declared

Fit and Proper Person Regulations

All Board members are subject to the fit and proper persons test. All members have confirmed that they are of good character and are competent to undertake their roles.

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. The Trust 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 here at KMPT on 1 November 2011.

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

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

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

Professor Margaret Andrews (left August 2016)

MSc, BSc, PGCE, RNT, RCT, RN,

Fellow of the Higher Education Academy

Margaret joined the Board in April 2012 and was appointed due to her interest in healthcare education and clinical experience. Margaret will help lead the Trust in its quest to modernise and improve mental health services whilst achieving Foundation Trust status. Margaret was Pro Vice-Chancellor (Partnerships) at Canterbury Christchurch University and has a long history in education. Margaret is Deputy Chair of the Trust and the appointed SID. She is also the Chair of the Quality Committee and a member of the Integrated Audit and Risk Committee. Margaret left the Trust in August 2016.

Richard Page (left June 2016)

BA, FCMA

Richard was appointed to the Board in June 2012 and is an experienced Finance Director who has over 35 years of working at Board level, with the last 20 years being spent in the NHS. In addition, Richard is the treasurer of two small local charities and a Non-Executive Director of The Malaria Consortium. Richard has been a Magistrate in central Kent (Maidstone Bench) for over 10 years and sits as a chair of both the adult and youth courts. Richard is Deputy Chair of the Integrated Audit and Risk Committee and a member of the Finance and Performance Committee. Richard left the Trust in June 2016.

Mark Bryant

BA (Hons) Engineering, Cambridge University

Mark joined the Board in October 2012. Mark 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. Mark is a non-executive director for two companies including an organic plantation in Brazil that has established a strong relationship in the local community, helping provide schooling for over 600 local children. Mark is Chair of the Finance and Performance Committee.

Tom Phillips

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

Member of the Institute for Turnaround (MIFT)

Tom was appointed to the Board in November 2012. Tom has previously held senior Board roles as Chief Executive, Chief Operating Officer and Group Finance Director in commercial multi-site retail operations within the pharmacy and leisure sectors. Most notably Tom spent 15 years as an executive board member of the Tote, a commercial organisation and also a statutory body. Tom is a non-executive director for two companies including at an international language school charity. Tom is the Chair of the Integrated Audit and Risk Committee.

Rod Ashurst

MBA Finance and Marketing, Diploma in French Studies

Rod joined the Board in November 2012. Rod has a wealth of business experience, including over ten years working at Board level, with the majority of the past 25 years having been spent at BT, with a background in leading transformational programmes, commercial development and contract management. As well as his work at BT, Rod also worked in Europe for Concert, Rod is a Trustee of the Trinity Theatre and Arts Centre in Tunbridge Wells. Rod is the Chair of the Workforce and OD Committee and a member 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. Anne-Marie 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 Council framework (CQC), is a Trustee of the charity One-in-Four and a volunteer with St. John's Ambulance. Anne Marie is Vice Chair of the Workforce and OD Committee and a member of Finance and Performance Committee.

Dr Jackie Craissati MBE

Consultant Clinical and Forensic Psychologist

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

Jackie 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 on 8 August 2016 as an Associate Director and was appointed a Non-Executive Director on 1 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 as; a Member of University College London's Museums and Heritage Committee; a Governor of Guildford Conservatoire and a Council Member of Loughborough University. She is currently a Fellow of the RSA; Co-Editor of the International Journal for Creativity and Human Development; and a Member of the European Cultural Parliament. She holds two Visiting Professorships, at Nottingham Trent University and the University of the West of Scotland. Venu is a member of both the Quality Committee and the Workforce & Organisational Development Committee. She is the Non-Executive Lead for 'Raising Concerns and Whistleblowing'.

Catherine Walker

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

Catherine Walker joined the Board in August 2016 as an Associate NED 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 ('NEST'). 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 (joined June 2016)

Chief Executive

Helen joined the Trust in June 2016. She was Executive Director of Nursing and Quality at Sussex Partnership NHS Foundation Trust from 2002. Her previous role was Executive Director of Nursing for West Sussex Health and Social Care NHS Trust. She started her career as a staff nurse at the Royal Free Hospital and has acquired significant experience of delivering high quality services over the years.

Angela McNab (left April 2016)

Chief Executive BSc, MSc

Angela was appointed on 1 April 2012. Angela joined us from NHS Luton and NHS Bedfordshire where she was Chief Executive and has an excellent career history which includes roles as Chief Executive of Human Fertilisation & Embryology Authority, Director of Public Health – Delivery and Performance at Department of Health and Director of Healthcare for Ministry of Defence. Angela began her career as a Speech and Language therapist and is keen to lead the Trust as it continues to improve patient experience. Angela left the Trust in April 2016.

Malcolm McFrederick (left February 2017)

Director of Operations MA (Cantab), MA (Cranfield), MIHM

Malcolm joined the Trust in March 2014. He has worked for the last 12 years in health both in private and public organisations at director level leading operations and transformation. His most recent experience has been with private sector based in London and acute health providers in the East of England. Malcolm took on the CEO role in an acting capacity in April 2016 until June 2016 when the new permanent CEO took over. Malcolm left the Trust in January 2017.

Professor Catherine Kinane

Executive Medical Director MB BCh BAO Dip Obs DCH MSc MRCGP MRCPsych Dip FMH. CCT GA and For Psychiatry

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

Philip Cave

Deputy Chief Executive and Executive Director of Finance, BSc, FCMA CGMA

Philip Cave joined the Trust as Finance Director on 5 January 2015, having spent the last two years in a similar role at Cambridgeshire and Peterborough NHS Foundation Trust (CPFT).

A biology graduate from the University of Sheffield, Philip joined the NHS finance training scheme in 2000. Initially working in Birmingham, he moved to London in 2003 where he worked at a PCT and various acute and community trusts. In 2007, Philip was appointed as Assistant Director of Finance at University Hospital Lewisham NHS Trust before joining

South London Healthcare NHS Trust as Associate Director of Finance in 2009. In 2011, he rejoined Lewisham as Deputy Director of Finance before taking up his post at CPFT in 2012. Philip is a Fellow of the Chartered Institute of Management Accountants.

Ivan McConnell

Executive Director of Commercial Development and Transformation, MA, CPFA

Ivan joined the Board in August 2013 with a wealth of commercial experience in assisting Trusts deliver their strategic business plans and managing high profile transformational change. Ivan has worked with Monitor the FT Regulator and the DoH and has maximised the use of technology in supporting commercial and strategic interventions for the benefit of patients.

Sandra Goatley

Director of Workforce and OD

Chartered Member CIPD

Sandra was appointed to the Trust Board as Director of Workforce and OD on 7 March 2016. Sandra has worked for a number of organisations as HR and OD Director covering both the private and public sector. These include AmicusHorizon (social housing), Legal Services Commission (public sector) and the Morleys Stores Group (private sector). Whilst Sandra has not worked in the NHS previously she brings a wealth of HR and OD experience with a specific focus on employee engagement and change management.

Mary Mumvuri (joined May 2016)

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 the Trust 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.

Donna Eldridge

Director of Nursing and Governance (temporary)

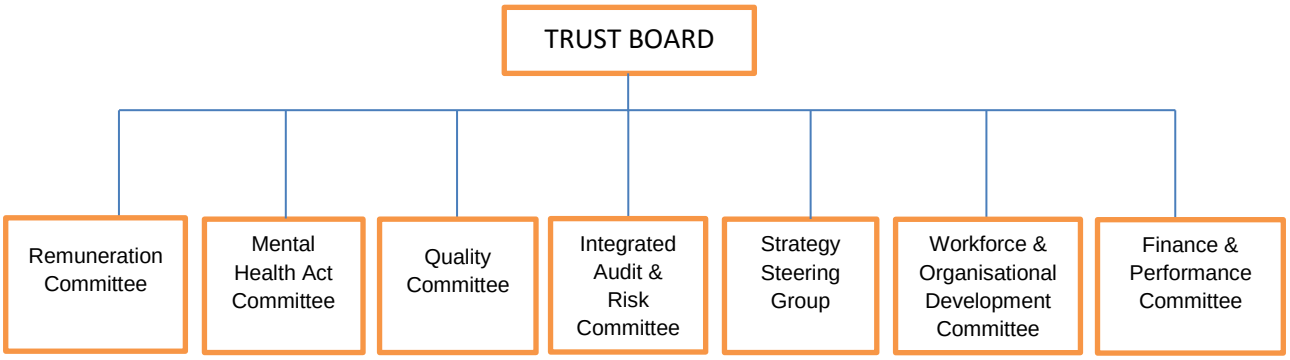
Enrolled Nurse (m), Registered Mental Health Nurse (RMN), BSc (Hons) Gerontology and Masters in Business Administration (MBA) PG Cert in Service improvement and Leadership

Donna started her career as a Health Care worker in a centre for epilepsy in Cheshire in 1983. After deciding to become a qualified nurse, Donna moved south to Brookwood hospital in Surrey and qualified in 1987 as an Enrolled Nurse in Mental Health. She worked in Kent for a short time before becoming a Registered Mental Health Nurse in 1990.
With a wide clinical experience within mental health services, Donna has knowledge of adult mental health, older people, eating disorders and mother and baby. In 1996 she specialised within older adult services in a variety of roles such as Ward Manager, Practice Development Lead and Lead Nurse.

Donna became the Assistant Director of Nursing in December 2004 and Deputy Director of Nursing in 2011. From 1 March 2016, Donna was temporarily in post as Director of Nursing and Governance until June 2016 when new Director was appointed.

Governance Structure - Board committees

The Trust Board has six permanent committees to support it in discharging its duties fully. In 2016-17 the Board established a time limited Committee, the Strategy Steering Group to oversee the development of the Trust Strategy and to ensure consistency with the Kent and Medway STP. Also in March 2017 the Trust Board agreed the establishment of a Mental Health Act Committee which will meet for the first time in May 2017. The chair of each committee presents a report at each formal board meeting. They also produce an annual report to Board once a year which details the committees' activities.



A summary of each committee is detailed below:

Integrated Audit and Risk Committee

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

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

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

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

- Provides assurance of independence for external and internal audit;

- Ensures that appropriate standards are set and compliance with them is monitored in non-financial, non-clinical areas that fall within the remit of the Trust;

- Monitors corporate governance (e.g. compliance with the code of conduct, standing orders, standing financial instructions and maintenance of register of interests).

The Integrated Audit and Risk Committee met five times during 2016-17. Attendance of two non-executive directors is required in order for the committee to be quorate. The committee was chaired by Tom Phillips for the duration of the 2016-17 periods. Margaret Andrews sat on this committee until she resigned on the 31 August 2016. Jackie Craissati and Catherine Walker also sat on this committee. Mary Mumvuri is the executive lead for this committee alongside Philip Cave.

Integrated Audit and Risk Committee – table 10

Members	Actual / possible
Tom Phillips (Chair)	5/5
Margaret Andrews	3/3
Jackie Craissati	3/4
Catherine Walker	1/1

Quality Committee

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

- Provides assurance to the Board through consultation with the Integrated Audit and Risk Committee, that the structures, systems and processes are in place and functioning to support an environment for the provision and delivery of excellent quality health and social care services. This includes agreeing and monitoring the Trust Clinical Audit programme;

- Assures the Board that where there are risks and issues that may jeopardise the Trust's ability to deliver excellent quality health and social care that these are being managed in a controlled and timely way;

- Assures the Board that the Trust is compliant with the Duty of Candour regulations.

- The Quality Committee is monitored the CQC Quality Improvement Plan following the CQC Comprehensive Inspection in March 2015 and oversaw the preparations for the January 2017 Comprehensive Inspection.

The committee meets on a monthly basis and has two non-executive directors and two executive directors' members. The committee was chaired by Margaret Andrews until August 2016 when Jackie Craissati took over. Rod Ashurst also sits on this committee, alongside Catherine Kinane and Mary Mumvuri (executive lead for quality).

Quality Committee – table 11

Members	Actual / possible
Margaret Andrews (Chair)	4/5
Jackie Craissati	7/9
Rod Ashurst	9/12
Mary Mumvuri	10/11
Catherine Kinane	7/12
Donna Eldridge	2/2

Finance and Performance Committee

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

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

- Assures the Board, through consultation with the Integrated Audit and Risk Committee that structures, systems and processes are in place and functioning to support broad and long term Financial, IM&T and Estates Strategies and that it is managing its asset base efficiently and effectively.

- Assure the Board that where there are risks and issues that may jeopardise the Trust's performance in respect of its key Financial Performance targets that these are being managed in a controlled and timely way.

The committee meets on a monthly basis and is chaired by Mark Bryant for 2016 -17. Anne-Marie Dean and Catherine Walker were also members of this

meeting. The executive lead for the committee is Philip Cave. Other members of the committee are Ivan McConnell and Malcolm McFrederick up until his date of resignation of the 5 February 2017.

Finance and Performance Committee – table 12

Members	Actual / possible
Mark Bryant (Chair)	10/10
Catherine Walker	3/3
Philip Cave	10/10
Malcolm McFrederick	3/7
Ivan McConnell	6/10

Workforce and Organisational Development Committee

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

The committee meets on a bi-monthly basis. During 2016-17 the committee was chaired by Rodney Ashurst. Venu Branch became a member of the committee when she joined in September. Sandra Goatley, Director of Workforce and OD is the lead director for this committee, and the committee also had Malcolm McFrederick as a member until he resigned in February 2017.

Workforce and Organisational Development Committee – table 13

Members	Actual / possible
Rod Ashurst (Chair)	6/6
Anne-Marie Dean (Vice-Chair until August)	1/2
Venu Branch (Vice Chair from September)	4/4

Malcolm McFrederick	4/4
Sandra Goatley	6/6

Remuneration Committee

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

The Remuneration Committee consists of all the non-executive directors of the Board and was chaired by Margaret Andrews, Deputy Trust Chair, until August 2017 when Rod Ashurst took over. It meets at least annually and on an ad hoc basis as required. During 2016-17 the committee met three times.

Remuneration Committee – table 14

Members	Actual / possible
Margaret Andrew (Chair until September)	2/3
Andrew Ling	3/3
Mark Bryant	3/3
Tom Phillips	3/3
Anne-Marie Dean	3/3
Rod Ashurst (Chair from September)	3/3
Jackie Craissati	3/3
Venu Branch	1/1
Catherine Walker	1/1

Strategy Steering Group – table 15

The Strategy Steering Group was set up in 2016 to oversee the development of the Trust Strategy and to ensure consistency with the Kent and Medway STP. The Group is chaired by Anne-Marie Dean, Trust Vice Chair. Tom Phillips is a member and the group is attended by the CEO and Director of Transformation and Commercial Development and executive lead for Strategy development.

Members	Actual / possible
Anne-Marie Dean	5/5
Tom Phillips	4/5
Helen Greatorex	5/5
Ivan McConnell	4/5
Malcolm McFrederick	1/1
Philip Cave	1/1

Mental Health Act Committee

The Trust Board agreed in March 2017 to establish a permanent committee to act as a focus for Mental Health Act activities and governance across the Trust. It is chaired by Jackie Craissati and Mary Mumvuri is the executive lead. The first meeting will take place on the 16 May 2017.

Statement of Chief Executive's responsibilities as Accountable Officer for the Trust

The Chief Executive of the NHS Trust Development Authority has designated that the Chief Executive should be the Accountable Officer to the trust. The relevant responsibilities of Accountable Officers are set out in the Accountable Officers Memorandum issued by the Chief Executive of the NHS Trust Development Authority. 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 with the approval of the Treasury 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.

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

I confirm that the annual report and accounts as a whole is fair, balanced and understandable and that I take personal responsibility for the annual report and accounts and the judgments required for determining that it is fair, balanced and understandable.

Signed: 

Name: Helen Greatorex

Position: Chief Executive

Date: 26 May 2017

KENT AND MEDWAY NHS AND SOCIAL CARE PARTNERSHIP TRUST ANNUAL GOVERNANCE STATEMENT 2016-17

1. SCOPE OF RESPONSIBILITY

1.1 In my role as Accountable Officer, and Chief Executive of this Trust since June 2016, 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 set out in the Accountable Officer Memorandum. I am also responsible for ensuring that the NHS Trust is administered prudently and economically and that resources are applied effectively and efficiently.

1.2 Kent and Medway NHS and Social Care Partnership Trust (KMPT) serves a population of over 1.6 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. This is managed within four Service Lines: Acute Services; Community Recovery Services; Older Adult Services; and Forensics and Specialist Services, all supported by a range of Corporate Teams.

1.3 In fulfilling my responsibilities to the Chief Executive of NHS Improvement (NHSI), in his capacity as Accounting Officer, I am directly accountable to the Chairman of the Trust Board and the Non-Executive members of the Trust Board for the operation of the Trust and for the implementation of the Board's decisions.

1.4 I am accountable to the Accounting Officer for the year ended 31 March 2017 through NHS Improvement (NHSI), for the performance of the Trust's functions and for meeting its statutory duties. This relationship with NHSI is transacted through regular meetings with the NHSI Chief Executive Officer (and his representatives).

1.5 As Accountable Officer I have in place processes in which I work with Partner Organisations including Clinical Commissioning Groups (CCGs), NHS Improvement (NHSI), the Local Authorities, Healthwatch, the Department of Health and other Acute and Mental Health Trusts.

1.6 Some of the main fora for the transaction of these relationships are:

- Regular South of England NHS Chief Executives' Forum
- Monthly Integrated Delivery Meetings (IDMs) with NHSI
- Performance Review Meetings with the CCG's
- Meetings with local authorities through the Kent and Medway Partnership Board, Kent County Council Health Overview and Scrutiny Committee, Medway Council Overview and Scrutiny Committee, Kent Adult Services Group and various Joint Planning Boards
- Regular meetings with the Accountable Officers at our local CCG's, Universities including KSS Deanery.
- STP Steering and Management Groups

2. THE GOVERNANCE FRAMEWORK OF THE ORGANISATION

2.1 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.

2.2 The Well Led Framework Self Assessment provides evidence and assurance of the Board's compliance with best practice guidance.

2.3 There have been seven changes to the Board composition during the year. Three new Non Executive Directors took up appointments, one Non Executive Director resigned and three current Non Executive Directors were reappointed. I took up post as permanent CEO in June 2016 and the new permanent Director of Nursing started in May 2016. Additionally the Director of Operations left the Trust in January 2017. The risk of such significant change in Board composition was noted on the Trust Risk Register and mitigation actions have included comprehensive induction programmes for new Non Executive Directors and full Board and Executive Team development programmes started and continuing.

2.4 The Board was independently evaluated by PwC during 2016 and the final report issued in January 2017. A Board Development plan including recommendations from this report has been developed. Implementation began during 2016-17 and will be completed during 2017. The implementation will be monitored directly by the Board.

2.5 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.

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

2.7 Board attendance for the 2016-17 period averaged a rate of 97%. Formal Board meetings were held bi-monthly. Where appropriate, the Board have also held additional formal meetings. Informal Board meetings and Board Seminars were also held regularly throughout the year.

2.8 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 Reference Committee
- Strategy Steering Group
- Mental Health Act Committee

2.9 Overall attendance for each committee during the 2016-17 period was as follows:

Committee name	Rate of membership attendance
Integrated Audit and Risk Committee	93%
Quality Committee	75%
Finance and Performance Committee	74%
Workforce and Organisational Development Committee	90%
Remuneration Committee	100%

2.10 There is crossover of Non Executive Director membership, to enhance their effectiveness.

2.11 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 Chair assurance reports and minutes.

2.12 The Finance and Performance Committee (FPC) review, monitor and scrutinise the Trust's key performance indicators across both finance and performance.

2.13 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.

2.14 The Integrated Audit and Risk Committee supports the Board in reviewing the effectiveness of the system of internal control, through a structured annual work plan. The main role of the Committee 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 Service Line and Corporate Directors on their risk management process.

2.15 The Integrated Audit and Risk Committee 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.

2.16 The Integrated Audit and Risk Committee's 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.

2.17 The Non-Executive members of the Integrated Audit and Risk Committee 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 4 times a year
- A rolling programme of service line risk register reviews.
- 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

2.18 During the 2016-17 period, the Committee received internal audit reports covering a broad range of the Trust's governance and risk management systems. Internal audit has given overall Reasonable Assurance. The outcomes are highlighted in the table below:

Assurance Assessments	Number of Reviews
Substantial Assurance	1
Reasonable Assurance	15
Limited Assurance	3
No Assurance	0

2.19 The three limited assurance reviews were Managerial Supervision, Chaperone and Staff Appraisal and Development. Where limited assurance is indicated on an internal audit report a comprehensive action plan is put in place, which is then subject to a follow up audit. There are no outstanding actions for any limited assurance reports.

2.20 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 workplans for internal and external auditors.

2.21 The Quality Committee meets monthly focussing alternatively on risk issues (including regular presentations from Service Line Directors on their risk registers) and then on reports from its sub-committees. This includes regular reporting on clinical audit, never events, SIs 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.

3. RISK ASSESSMENT

3.1 The Trust Board has 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 Director of Finance and the Executive Director of Nursing and Quality.

3.2 The Non-Executive Committee members of the Integrated Audit and Risk Committee play a key role in the internal control assurance processes by scrutinising the effectiveness of management actions in mitigating risks through regular reviews of the corporate functions and service line risk registers, on a rolling basis in addition to the Trust risk register.

3.3 In addition, the Board Committees all have responsibility for elements of the risk management system, with the Integrated Audit and Risk Committee providing assurance on its effectiveness.

3.4 The Trust 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.

3.5 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 2016/17 were:

<u>Financial Overspend</u>

Whilst it delivered its planned deficit as agreed with NHSI, the Trust has overspent and this puts significant pressure on the Trust financial viability. A comprehensive action plan is in place to reduce spend and create a number of efficiency savings.

<u>Inability to Recruit</u>

In line with other trusts in the country, the Trust has experienced significant difficulties in recruiting permanent nursing and medical staff. This resulted in the Trust exceeding the centrally set cap on agency spend in 16-17. There has been reliance on the use of agency staff which is now reducing and is on trajectory to stay within the target this year.

3.6 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.

3.7 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. A number of new processes and management tools were put in place including differentiating risks to quality and health and safety risk assessments so that the risk registers are easier to use and more focused, introducing a tool designed to calibrate risks and determine the overall effectiveness of controls and ensuring all high level risks are linked to performance metrics.

3.8 Training on clinical risk management is included within the mandatory induction programme which all clinical staff participate in at the start of their employment with the Trust. In 2016/17 managers and their nominated risk assessors attended further training on the principles and application of risk assessment and the tools used by the Trust to identify, record, monitor and review risk. This training was provided in response to the CQC chief inspectors visit. The Trust Board receives annual training on risk management at a Board Development Sessions.

3.9 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 delegation scheme which details who has oversight of risk via the Committee structure, Trust-wide groups and sub-groups. The increased prevention of risk is facilitated through learning from experience, embedding improvements into daily practice (via sub-groups) for this. Also, prevention of risk is achieved via the interface partnership working arrangements across the local healthcare economy, within our joint commissioning arrangements.

3.10 The Local Counter Fraud Team provided by TIAA support the Trust in the prevention, detection and investigation of alleged incidents of fraud. 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 achieved through poster distribution, fraud staffzone page, promotional material and newsletter articles. The newsletter ‘Fraudstop!’ is circulated to all staff and distributed at the Trust induction. The Trust has a Counter Fraud Policy.

3.11 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 BAF by the Integrated Audit and Risk Committee

3.12 KMPT is continuing its journey along the spectrum of risk maturity from Naïve to Enabled. The Trust has moved positively from Defined to Managed status and continues to work towards Fully Enabled by 31st March 2019. Risks are identified, assessed, mitigated and monitored at all levels of the organisation and are escalated depending on the residual rating as outlined in the KMPT Risk Management Strategy. Progress on the journey and compliance with the Strategy has been monitored by the Integrated Audit and Risk Committee.

3.13 Staff are kept up to date with the key corporate and health and safety risks for their areas with posters and via team meetings, enabling them to spot if there are any issues that have not been previously identified.

3.14 There are robust action plans and controls in place that have managed the risks and the recent staff survey has shown a marked improvement in the way the organisation is viewed by the staff and demonstrates positive change for the Trust.

3.15 There were 310 new risks (401 in 2015-16) and risk assessments added to the Datix system in 2016-17 (as at 8 March 2017) and 649 risks (470 in 2015-16) were managed to an acceptable level and closed in the same time period. This demonstrates that there is an active process around risks.

3.16 The presentation of the Board Assurance Framework has been improved to make it easier for the Board to use the document as a strategic decision making tool and there was one new risk identified in 2016/17 for the BAF relating to the new Sustainability and Transformation Plans. This risk is currently owned by the Executive Director of Commercial Development and Transformation.

4. THE RISK CONTROL FRAMEWORK

4.1 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.

4.2 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.

4.3 A good example of this has been the Trusts approach to the management of external beds. The usage has been significantly reduced resulting in substantial financial savings to the Trust and Health Economy and an improvement in quality of care for service users.

4.4 Learning through experience is a critical method for preventing risks and the Trust has a robust system by which learning from experience is identified, highlighted and embedded.

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

5. ELEMENTS OF THE BOARD ASSURANCE FRAMEWORK

5.1 The Board Assurance Framework document is refreshed annually at the beginning of each financial year by the Board and is reviewed at each of its formal meetings. 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

5.2 Based on my assessment of the Board Assurance Framework there are three key priorities to be implemented in 2017-18 in order to enhance the internal control arrangements. The implementation of these objectives will further strengthen Board visibility over the process of monitoring risk mitigation plans associated with its significant risks and as highlighted on the BAF. These priorities are to:

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

5.3 The Board will oversee the implementation of these priorities, whilst primarily taking assurance from the work of the Board Committees. In addition, the Assurance Framework was revisited to ensure that it was updated following the new guidance from the Good Governance Institute and that it serves its function as a decision making tool for the Board.

6. REVIEW OF THE EFFECTIVENESS OF RISK MANAGEMENT AND INTERNAL CONTROL

6.1 The Risk Management Framework is supported by the processes in place to identify, assess, treat and monitor risks that materialise within 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.

6.2 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 on the Effectiveness of the System of Internal Control for the Year Ended 31 March 2017

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

We note that the Trust had a year-end deficit of £3.6m, compared to the forecast of £4.3m deficit. Our opinion on the organisation's system of internal control has taken this factor into account.

My opinion is set out as follows:

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

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.

The basis for forming my opinion is as follows:

1. An assessment of the design and operation of the underpinning Assurance Framework and supporting processes; and
2. 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.

6.3 The Trust has an established Quality Governance Framework which enables the monitoring of risks to quality of services, through the Quality Committee. The Board Assurance Framework also provides a mechanism for monitoring, where these risks are significant to the delivery of the organisation's strategic objectives.

6.4 Systems and controls are in place to ensure the delivery of quality account obligations, and the associated evidence also informs my assessment of the effectiveness of the risk management and internal control framework, in relation to risks to quality.

6.5 Our performance management framework provides a structured approach to monitoring the delivery of the Trust's contractual and national obligations, and associated mitigations of risks to safety.

7. THE CARE QUALITY COMMISSION AND THE FUNDAMENTAL STANDARDS

7.1 There are systems and controls in place to ensure compliance with the Health and Social Care Act 2008 which the Care Quality Commission (CQC) monitors as part of its routine inspection process.

7.2 CQC carried out a Comprehensive Inspection in January 2017. The final report was issued in April 2017 and rated the Trust as Good overall with Outstanding for the Caring domain. Eight of the Trust's Core Services were rated Good or Outstanding.

7.3 The rating was achieved by the Trust implementing the actions set out in its quality improvement plan (QIP) during 2016 and audits were conducted on a regular basis to ensure that the quality of care was being maintained.

Additionally all service lines participated in a deep dive process between July and September 2016 as part of the Trust's inspection preparations. Recommendations were made and action plans developed to ensure that areas of concern were rectified.

7.4 The CQC conducted an unannounced focussed inspection at the Frank Lloyd Unit in January 2016 and subsequently issued the trust with a warning notice. An improvement plan was produced and implemented. The unit then received two follow-up inspections; one at 6 weeks and one at 3 months. After these inspections, the warning notice was lifted as significant improvement had been noted by the CQC.

7.5 The CQC also conducted a further focussed inspection at Littlebrook Hospital which had been made following concerns raised during an unannounced MHA monitoring visit to Amberwood Ward. The reviewer found that; patients were not sufficiently involved in their care planning and they were offered limited therapeutic activities, Mental Health Act documents were not always completed correctly, the service relied heavily on bank and agency staff to ensure safe staffing levels were maintained and patients did not have easy access to their bedrooms. The CQC had also received information through their intelligent monitoring programme that suggested; unsettled patients were not being managed effectively; a patient under the age of 18 was being cared for on an adult ward and safeguarding issues were not being reported correctly. Following this inspection an improvement plan was drafted and shared with the CQC monthly.

7.6 In January 2017, the Trust received its 2nd comprehensive inspection from the CQC. Improvement was noted at Littlestone, the Frank Lloyd Unit and the rehabilitation services since the 2015 inspection. The Trust received a letter from the CQC following the inspection which highlighted seven areas that were ongoing areas of improvement. A new quality improvement plan has been drafted for these seven areas and actions are underway. The draft inspection reports are anticipated in May 2017.

7.7 The CQC Oversight Group is responsible for ensuring that Trust Services meet the required fundamental standards and this is led by the Executive Director of Nursing and Quality. This group meets bi-monthly and reports to the Quality Committee.

7.8 The Trust has systems and procedures in place to maintain ongoing compliance with the CQC fundamental standards, for the purpose of monitoring and continually improving the quality of healthcare provided to its patients.

8. DATA SECURITY

8.1 The Director of Transformation and Commercial Development 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.

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

8.3 There have been seven Information Governance breaches which were reported to the Information Commissioner. There have been 5 instances throughout the year in which paper clinical files were unable to be located and therefore had to be reported as lost or stolen (*one in May 2016, three in July 2016 and one November 2016*). In July 2016 a member of staff inappropriately accessed records on RiO and in February 2017 information relating to 1500 patients was emailed in an unsecured manner. *(For clarification this email was sent by the Trust's Archive Company, but it was done so in a breach of Trust process as it was not sent to an NHS.net account as agreed in the Service Level Agreement).*

8.4 The Trust was audited in February 2017 by TIAA and given 'Reasonable Assurance' for Information Governance management practices in relation to the Toolkit. TIAA conducted an annual Information Governance audit which involved a detailed review of 15 of the 45 IGT initiatives and conducted a Trust-wide Staff Awareness Survey. This year TIAA examined areas which have previously been considered high risk, including:

- Information governance training
- ICD-10 audits
- Business Continuity planning
- Corporate Records management and auditing

8.5 The results of the Staff Awareness Survey will be used to review and update Information Governance Training and awareness material as part of a new Information Governance Awareness campaign.

8.6 My assessment of the information governance arrangements of the Trust is informed by evidence to support the level 2 declaration on the 2016-17 Information Governance Toolkit, as well as the information governance assurance from the internal audit review, undertaken in the financial year. The Trust has successfully achieved level 2 in all 45 elements of the Information Governance Toolkit and is therefore rated as "satisfactory".

8.7 In making this assessment I have also taken into account advice from the Trust-wide Information Governance Group, the Caldicott Guardian, internal audit and external auditors and reviewed associated evidence of compliance. During 2016-17 the role of Caldicott Guardian was transferred to the Executive Medical Director. In addition the roles of Chief Clinical Information

Officer and Clinical Safety Officer (for IT System projects) were taken by the Medical Director. Both of these roles are new both to her and the Trust.

9. THE NHS PENSION SCHEME ARRANGEMENTS

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

10. SUSTAINABILITY

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

10.2 The Trust continues to engage 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.

11. EQUALITY, DIVERSITY AND HUMAN RIGHTS

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

11.2 The Workforce and Organisational Development Committee have received compliance assurance on a bi-monthly basis through a regular review of the workforce reports. The Quality Committee monitors equality and diversity.

11.3 The Trust has arrangements in place to comply with the Equality Act 2010 and has implemented the Equality Delivery System.

12. COUNTER FRAUD AND ANTI BRIBERY ARRANGEMENTS

12.1 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 awareness sessions for staff.

12.2 The Integrated Audit and Risk Committee receives regular progress reports on the delivery of the Local Counter Fraud Service (LCFS) work plan and

investigative reports where appropriate. In addition, the Committee reviews anti-fraud and bribery Trust policies and procedures.

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

12.4 In addition during 2016-17 the recruitment procedures in relation to staff procured through agencies were reviewed to ensure third party checks on individuals are in line with KMPT policy.

13. SIGNIFICANT ISSUES

13.1 The Trust has identified the following as significant control issues for the 2016-17 period.

Data Security Breaches

During the 2016/17 period there were seven information governance serious incidents regarding the loss or misappropriation of personal information. Lessons learned from the incident have been incorporated into the risk management process.

Financial Position

The Trust's financial position was severely challenged in 2016-17 resulting in a year end deficit of £3.6 million. The plan 2017-18 is a deficit of £2.8 million which will require a reduction in run rate and Sustainability Cost Improvement Programme Planning.

EPRR

The Trust was audited by the CSU on behalf of the CCGs in September 2016 against the Emergency Planning and Resilience Response core standards as set out by NHS England and for the second year running was found to be non-compliant. The Trust has invested additional resource and has an action plan in place that seeks to achieve partial compliance by 2017 and full compliance by 2018. This will be monitored via the TWHSRG and IARC, and by the CCGs.

Never Events

There have been no never events during this period.

14. CONCLUSION

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

- The Integrated Audit and Risk Committee which considers the annual plans and reports of External and Internal Audit
- The Quality Committee which ensures that comprehensive and robust systems and processes are in place for clinical governance and quality within the Trust
- The Executive Management Team which oversees the implementation of the strategic direction of the Trust.
- The 2016-17 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

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

14.3 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.

14.4 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

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. Monitor, with the approval of the 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 of the Trust for that period. In preparing those accounts, the directors are required to:

• Apply on a consistent basis accounting policies laid down by Monitor 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 requirement outlined in the above mentioned direction of Monitor. 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 of Directors

Signed 

Name: Helen Greatorex

Position: Chief Executive

Date: 26th May 2017

Signed 

Name: Phillip Cave

Position: Director of Finance

Date: 26th May 2017

Section two – Staff and remuneration report

This section covers senior managers

1. Nominations and Remuneration Committee

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

2. Executive Remuneration policy

The main duties of the Committee are to discuss and advise the Board on appropriate remuneration and Terms of Service for the Chief Executive, other Executive Directors and other senior employees particularly covering the following:

- All aspects of salary (including any bonuses), taking independent advice where appropriate and considering current benchmarking data for Very Senior Manager (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 Executive 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 2016 -17 the Committee decided that no inflationary pay award was appropriate. This is in line with overall increases in the NHS.

The only non-cash elements of Executive remuneration packages are pension-related benefits accrued under the NHS Pensions Scheme. Contributions are made

by both the employer and employee in accordance with the rules of the national scheme, which applies to all NHS staff in the scheme.

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

Salary table - audited

	2016/17				2015/16			
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 nearest £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 commenced 06/06/2016	120-125	3	22.5-25	140-145	-	-	-	-
Malcolm McFrederick - Executive Director of Operations, Acting Chief Executive between 19/04/2016 and 05/06/2016 - Left 05/02/2017	145-150	1	17.5-20	160-165	125-130	-	7.5-10	135-140
Angela McNab - Chief Executive left 19/04/2016	5-10	-	0-5	5-10	150-155	7	7.5-10	160-165
Philip Cave - Deputy Chief Executive / Executive Director of Finance	120-125	2	30-32.5	150-155	115-120	2	65-67.5	185-190
Catherine Kinane - Executive Medical Director	175-180	-	30-32.5	205-210	175-180	2	25-27.5	205-210
Mary Mumvuri - Executive Director of Nursing and Governance commenced 09/05/2016	95-100	1	-	95-100	-	-	-	-
Donna Eldridge - Interim Executive Director of Nursing and Governance - commenced 01/03/2016 until 09/05/2016	5-10	4	2.5-5	10-15	5-10	6	7.5-10	15-20
Pippa Barber - Executive Director of Nursing and Governance - left 01/03/2016	-	-	-	-	100-105	1	7.5-10	105-110
Ivan McConnell - Executive Director of Commercial and Transformation	115-120		27.5-30	145-150	115-120	-	25-27.5	140-145
Sandra Goatley Director of Human Resources commenced 07/03/2016	115-120	1	25-27.5	140-145	5-10	-	0-2.5	5-10
Jacolyn Fergusson Interim Director of Human Resources from 27/07/2015 to 11/03/2016	-	-	-	-	210-215*	-	-	210-215*
Paul Jones - Interim Director of Human Resources from 13/04/2015 to 31/07/2015	-	-	-	-	105-110*	-	-	105-110*
Nikki Prince - Director of Human Resources left 19/04/2015	-	-	-	-	5-10	-	-	5-10
Andrew Ling - Chairman	20-25		-	20-25	20-25	5	-	20-25
Tom J Philips - Non Executive Director	5-10		-	5-10	5-10	-	-	5-10
Rod Ashurst - Non Executive Director	5-10		-	5-10	5-10	1	-	5-10
Mark Bryant - Non Executive Director	5-10		-	5-10	5-10	1	-	5-10
Anne-Marie Dean - Non Executive Director	5-10		-	5-10	5-10	-	-	5-10
Venu Branch - Non Executive Director - Commenced 13/05/2016	0-5		-	0-5	-	-	-	-
Jackie Craissati - Non Executive Director - Commenced 01/09/2016	0-5		-	0-5	-	-	-	-
Catherine Walker - Non Executive Director - Commenced 01/12/2016	0-5		-	0-5	-	-	-	-
Richard Page - Non Executive Director - Left 01/06/16	0-5		-	0-5	5-10	3	-	5-10
Margaret Andrews - Non Executive Director left 01/08/16	0-5		-	0-5	5-10	5	-	5-10
Michael Sander - Non Executive Director - Left 31/08/2015	0-5		-	0-5	0-5	1	-	0-5

*Includes agency fees

**Annual increase in pension entitlement

Fair Pay Disclosure - 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 2016-17 was £145,000- £150,000 (2015-16, £150,000 - £155,000). This was 6.8 times (2015 -16, 7.2 times) the median remuneration of the workforce, which was £20,962 (2015 -16, £20,925).

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

Pensions table 2016 – 17 - audited

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

Pensions table 2015 – 16 - 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 2016	Lump sum at age 60 related to accrued pension at 31 March 2016	Cash Equivalent Transfer Value at 1 April 2015	Real increase in Cash Equivalent Transfer Value	Cash Equivalent Transfer Value at 31 March 2016
	(bands of £2,500)	(bands of £2,500)	(bands of £5,000)	(bands of £5,000)	£000	£000	£000
Angela McNab - Chief Executive	0-2.5	-	15-20	-	235	37	276
Philip Cave - Deputy Chief Executive / Executive Director of Finance	2.5-5	2.5-5	15-20	50-55	200	39	241
Catherine Kinane - Executive Medical Direct	2-2.5	5-7.5	40-45	120-125	703	48	759
Malcolm McFrederick - Executive Director of Operations	0-2.5	2.5-5	15-20	45-50	294	26	324
Ivan McConnell - Executive Director of Transformation and Commercial Development	0-2.5	-	5-7.5	-	37	23	61
Pippa Barber - Executive Director of Nursing and Governance - left 01/03/2016	0-2.5	2.5-5	25-30	85-90	508	22	535
Donna Eldridge - Interim Director of Nursing and Governance - commenced 01/03/2016	0-2.5	0-2.5	25-30	80-85	495	3	531
Nikki Prince - Director of Human Resources - left 19/04/2015	-	-	15-20	45-50	289	1	293
Sandra Goatley - Director of Human Resources - commenced 07/03/2016	-	-	-	-	-	-	2

Staff numbers- audited

Average staff numbers

	2015 -16	2016 -17
Medical and dental	159	156
Administration and estates	671	691
Healthcare assistants and other support staff	822	824
Nursing, midwifery and health visiting staff	834	803
Scientific, therapeutic and technical staff	435	472
Other	35	50
Total	2956	2996

The tables below are all headcount for employed staff only as at 31 March 2017 therefore these numbers are not consistent with the average staff numbers above

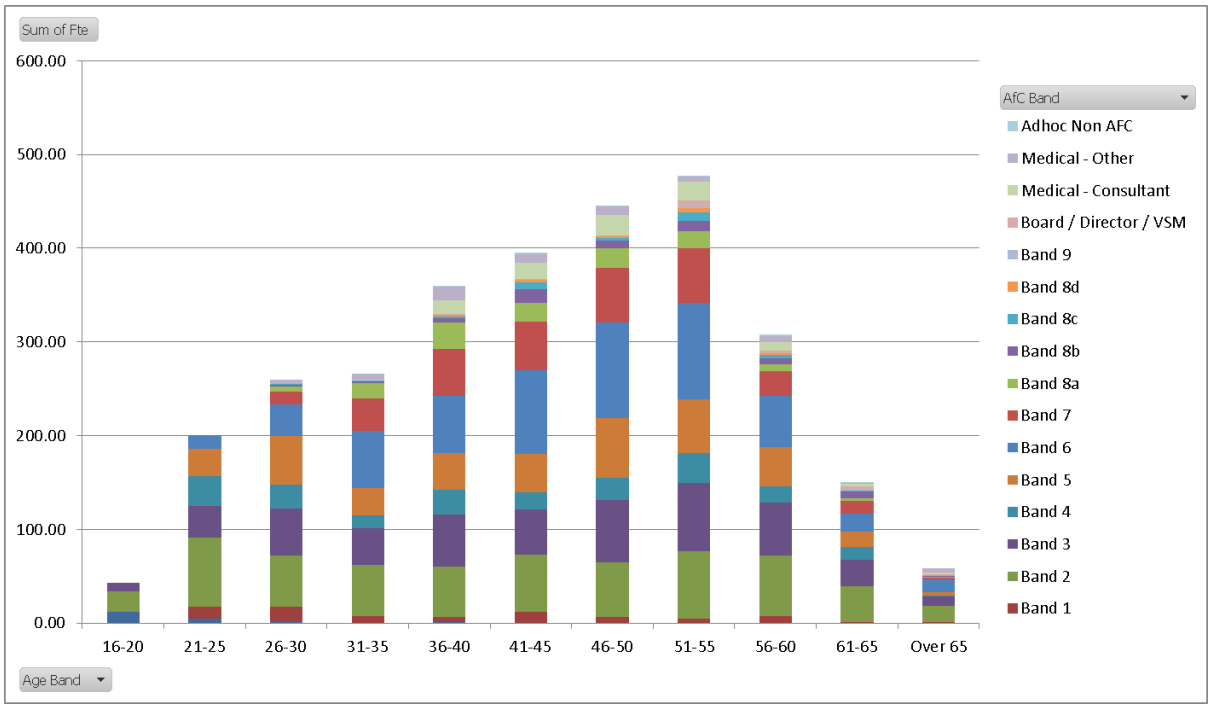
Staff numbers by band and gender

Sum of Fte	Gender		
AfC Band	Female	Male	Grand Total
Apprentice	12.00	8.00	20.00
Band 1	50.60	23.13	73.73
Band 2	402.57	167.63	570.20
Band 3	374.47	96.14	470.61
Band 4	164.36	36.71	201.07
Band 5	277.18	97.28	374.46

Band 6	398.27	153.18	551.45
Band 7	228.58	77.76	306.34
Band 8a	88.74	34.30	123.04
Band 8b	39.97	14.45	54.42
Band 8c	16.82	11.35	28.17
Band 8d	7.85	5.00	12.85
Band 9	1.90	1.00	2.90
Board / Director / VSM	8.00	9.00	17.00
Medical - Consultant	38.00	50.40	88.40
Medical - Other	34.05	28.60	62.65
Adhoc Non AFC	1.64	5.00	6.64
Grand Total	**2145.02**	**818.93**	**2963.95**

***Data is a snapshot from 31.03.2017 source ESR**

Staff by Age Band



***Data is a snapshot from 31.03.2017 source ESR**

Staff by profession

Sum of Fte	Staff Group								
AfC Band	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		5.00	14.00		1.00				20.00
Band 1					19.88			53.85	73.73
Band 2		332.09	105.96		132.15				570.20
Band 3	3.60	290.53	164.81		11.67				470.61
Band 4	9.10	75.51	106.46		10.00				201.07
Band 5	11.76	4.74	55.94	50.02	12.00		240.00		374.46
Band 6	11.24	1.80	68.45	93.38	5.00		371.58		551.45
Band 7	70.92	9.11	39.09	43.72	1.00		142.50		306.34
Band 8a	54.60		27.64	6.80			34.00		123.04
Band 8b	28.78	0.93	14.80	1.91			8.00		54.42
Band 8c	13.87		12.00	0.80			1.50		28.17
Band 8d	6.85		6.00						12.85
Band 9	2.00		0.90						2.90
Board / Director / VSM			17.00						17.00
Medical - Consultant						88.40			88.40
Medical - Other						62.65			62.65
Adhoc Non AFC	3.00	1.04		2.60					6.64
Grand Total	**215.73**	**720.76**	**633.06**	**199.22**	**192.69**	**151.05**	**797.59**	**53.85**	**2963.95**

***Data is a snapshot from 31.03.2017 source ESR**

Staff turnover for 2016 -17 was 18.09 per cent of which the majority was related to Band 2, 3, Band 5 in particular within the nursing workforce. This is an increase on the previous year of 1%.

Staff by ethnicity

	Data		
Ethnic Origin	Sum of Fte	% of Fte	BME %
A White - British	2130.45	71.88%	
B White - Irish	37.71	1.27%	
C White - Any other White background	129.38	4.37%	
D Mixed - White & Black Caribbean	6.80	0.23%	
E Mixed - White & Black African	5.07	0.17%	
F Mixed - White & Asian	21.60	0.73%	
G Mixed - Any other mixed background	20.07	0.68%	
H Asian or Asian British - Indian	98.30	3.32%	
J Asian or Asian British - Pakistani	11.29	0.38%	
K Asian or Asian British - Bangladeshi	3.00	0.10%	20.85%
L Asian or Asian British - Any other Asian background	82.17	2.77%	
M Black or Black British - Caribbean	28.93	0.98%	
N Black or Black British - African	259.25	8.75%	
P Black or Black British - Any other Black background	21.42	0.72%	
R Chinese	7.47	0.25%	
S Any Other Ethnic Group	52.47	1.77%	
Z Not Stated	48.57	1.64%	
Grand Total	2963.95	100.00%	

***Data is a Snapshot from 31.03.2017 source ESR**

Sickness Absence Data

We set a challenging target of 3.9 per cent staff absence rate for the Trust in 2016-17. We achieved a rate of 4.08 per cent, which is slightly higher than with 2015-16 (3.84 per cent).We are committed to supporting staff when they are unwell and we must do all that we can to help them return to work.

Sickness Disclosures

	Average Full Time Employees	Adjusted Full Time Employees lost to Cabinet Office definitions	Average Sick Days per Full Time Employees	Full Time Employees -Days Available	Full Time Employees -Days recorded Sickness Absence
January 2016 to December 2016	2,998	29,237	9.8	1,094,210	47,429
January 2015 to December 2015	2,932	26,209	8.9	1,069,998	42,517

Source: NHS Digital - Sickness Absence and Publication - based on data from the ESR Data Warehouse

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 the Trust ensures fair recruitment practices throughout the attraction, selection and recruitment of candidates. This is reviewed through the Trust's electronic tracking 'TRAC' recruitment system.
Policies for continuing the employment of, and for arranging training for employees who have become disabled persons during the period	The Trust adheres to the Equality Act 2010, and as such, line managers make reasonable adjustments and use referrals to the Occupational Health team to ensure the continued employment of employees who become disabled persons. In addition, the HR team provides direct support to staff affected and their managers.
Policies for the training, career development and promotion of disabled employees	There is equality of access to training for all staff.

Actions taken in the financial year to provide employees systematically with information on matters of concern to them as employees	The Trust augmented its internal communications activities during the year, including the introduction of new Intranet system (i-connect).
Actions taken during the financial year to consult employees or their representatives on a regular basis so that the views of employees can be taken into account in making decisions which are likely to affect their interests	The Trust has regular meetings of its Joint Negotiating Committee and Local Negotiating Committees for formal discussions relating to staffing issues. As stipulated within the organisational change policy, collective consultations would be enacted where there are more specific issues affecting staff i.e. restructures.
Information on health and safety performance occupational health	During the year health and safety training was delivered to 93% of staff. 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.

Expenditure on consultancy

The Trust incurred £78,000 (£229,000 2015/16) expenditure on consultancy during 2016-17.

Exit Packages 2016/17 – audited

Exit package cost band (including any special payment element)	Number of compulsory redundancies	Cost of compulsory redundancies	Number of other departures agreed	Cost of other departures agreed.	Total number of exit packages	Total cost of exit packages
		£s		£s		£s
Less than £10,000	1	5,750	0	0	1	5,750
£10,000 - £25,000	2	36,775	0	0	2	36,775
£25,001 - £50,000	3	113,938	0	0	3	113,938
£50,001 - £100,000	2	111,507	0	0	2	111,507
£100,001 - £150,000	0	0	0	0	0	0
£150,001 - £200,000	1	160,000	0	0	1	160,000
>£200,000	0	0	0	0	0	0
Total	9	427,970	0	0	9	427,970

Exit Packages 2015/16 – audited

Exit package cost band (including any special payment element)	Number of compulsory redundancies	Cost of compulsory redundancies	Number of other departures agreed	Cost of other departures agreed.	Total number of exit packages	Total cost of exit packages
		£s		£s		£s
Less than £10,000	1	7,244	0	0	1	7,244
£10,000 - £25,000	4	76,242	0	0	4	76,242
£25,001 - £50,000	2	58,123	0	0	2	58,123
£50,001 - £100,000	0	0	0	0	0	0
£100,001 - £150,000	0	0	0	0	0	0
£150,001 - £200,000	0	0	0	0	0	0
>£200,000	0	0	0	0	0	0
Total	7	141,609	0	0	7	141,609

Off Payroll engagements

The Trust had no off-payroll engagements as at 31 March 2017 and had no new off-payroll engagements between 1 April 2016 and 31 March 2017, for more than £220 per day and that last longer than six months.

ANNUAL ACCOUNTS

INDEPENDENT AUDITOR'S REPORT TO THE DIRECTORS OF KENT AND MEDWAY NHS AND SOCIAL CARE PARTNERSHIP TRUST

We have audited the financial statements of Kent and Medway NHS and Social Care Partnership Trust (the "Trust") for the year ended 31 March 2017 under the Local Audit and Accountability Act 2014 (the "Act"). The financial statements comprise the Statement of Comprehensive Income, the Statement of Financial Position, the Statement of Changes in Taxpayers' Equity, the Statement of Cash Flows and the related notes. The financial reporting framework that has been applied in their preparation is applicable law and International Financial Reporting Standards (IFRSs) as adopted by the European Union, as interpreted and adapted by the Department of Health Group Accounting Manual 2016/17 (the "2016/17 GAM") and the requirements of the National Health Service Act 2006.

This report is made solely to the Directors of Kent and Medway NHS and Social Care Partnership Trust, as a body, in accordance with Part 5 of the Act and as set out in paragraph 43 of the Statement of Responsibilities of Auditors and Audited Bodies published by Public Sector Audit Appointments Limited. 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.

Respective responsibilities of Directors, the Accountable Officer and auditor

As explained more fully in the Statement of Directors' Responsibilities, the Directors are responsible for the preparation of the financial statements and for being satisfied that they give a true and fair view. Our responsibility is to audit and express an opinion on the financial statements in accordance with applicable law, the Code of Audit Practice published by the National Audit Office on behalf of the Comptroller and Auditor General (the "Code of Audit Practice") and International Standards on Auditing (UK and Ireland). Those standards require us to comply with the Auditing Practices Board's Ethical Standards for Auditors.

As explained in the statement of the Chief Executive's responsibilities, as the Accountable Officer of the Trust, the Accountable Officer is responsible for the arrangements to secure economy, efficiency and effectiveness in the use of the Trust's resources. We are required under Section 21(3)(c) and Schedule 13 paragraph 10(a) of the Act to be satisfied that the Trust has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources and to report by exception where we are not satisfied.

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.

Scope of the audit of the financial statements

An audit involves obtaining evidence about the amounts and disclosures in the financial statements sufficient to give reasonable assurance that the financial statements are free from material misstatement, whether caused by fraud or error. This includes an assessment of whether the accounting policies are appropriate to the Trust's circumstances and have been consistently applied and adequately disclosed; the reasonableness of significant accounting estimates made by the Directors; and the overall presentation of the financial statements. In addition, we read all the financial and non-financial information in the Performance Report and the Accountability Report to identify material inconsistencies with the audited financial statements and to identify any information that is apparently materially incorrect based on, or materially inconsistent with, the knowledge acquired by us in the course of performing the audit. If we become aware of any apparent material misstatements or inconsistencies we consider the implications for our report.

Scope of the review of arrangements for securing economy, efficiency and effectiveness in the use of resources

We have undertaken our review in accordance with the Code of Audit Practice, having regard to the guidance on the specified criteria issued by the Comptroller and Auditor General in November 2016, as to whether the Trust had proper arrangements to ensure it took properly informed decisions and deployed resources to achieve planned and sustainable outcomes for taxpayers and local people. The Comptroller and Auditor General determined these criteria as that necessary for us to consider under the Code 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 2017, 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.

Opinion on financial statements

In our opinion:

- the financial statements give a true and fair view of the financial position of Kent and Medway NHS and Social Care Partnership Trust as at 31 March 2017 and of its expenditure and income for the year then ended; and
- the financial statements have been prepared properly in accordance with IFRSs as adopted by the European Union, as interpreted and adapted by the

Department of Health Group Accounting Manual 2016/17 and the requirements of the National Health Service Act 2006.

Opinion on other matters

In our opinion:

- the parts of the Accountability 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 Group Accounting Manual 2016/17 and the requirements of the National Health Service Act 2006; and
- the other information published together with the audited financial statements in the Performance Report and the Accountability Report for the financial year for which the financial statements are prepared is consistent with the audited financial statements.

Matters on which we are required to report by exception

We are required to report to you if:

- in our opinion the Annual Governance Statement does not comply with the guidance issued by NHS Improvement; or
- we have referred a matter to the Secretary of State under section 30 of the Act because we had reason to believe that the Trust, or an officer of the Trust, was about to make, or had made, a decision which involved or would involve the body incurring unlawful expenditure, or was about to take, or had begun to take a course of action which, if followed to its conclusion, would be unlawful and likely to cause a loss or deficiency; or
- we have reported a matter in the public interest under section 24 of the Act in the course of, or at the conclusion of the audit; or
- we have made a written recommendation to the Trust under section 24 of the Act in the course of, or at the conclusion of the audit; or
- we have not been able to satisfy ourselves that the Trust has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources for the year ended 31 March 2017.

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

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 Act and the Code of Audit Practice.

Elizabeth Jackson

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

Grant Thornton House

Melton Street

Euston Square

London NW1 2EP

26 May 2017

Statement of Comprehensive Income for year ended 31 March 2017

	NOTE	**2016-17 £000s**	2015-16 £000s
Gross employee benefits	8.1	**(138,797)**	(136,204)
Other operating costs	6	**(41,752)**	(46,016)
Revenue from patient care activities	4	**168,652**	164,062
Other operating revenue	5	**14,451**	17,272
Operating surplus/(deficit)		**2,554**	(886)
Investment revenue	10	**11**	20
Other gains and (losses)	11	**(380)**	929
Finance costs	12	**(1,522)**	(1,202)
Surplus/(Deficit) for the financial year		**663**	(1,139)
Public dividend capital dividends payable		**(4,238)**	(4,522)
Retained (deficit) for the year		**(3,575)**	(5,661)

Other Comprehensive Income

	2016-17 £000s	2015-16 £000s
Net (loss)/gain on revaluation of property, plant & equipment	**(1,462)**	285
Total comprehensive income for the year	**(5,037)**	(5,376)

Financial performance for the year

Retained surplus/(deficit) for the year	**(3,575)**	(5,661)
IFRIC 12 adjustment (including IFRIC 12 impairments)	**198**	460
Impairments (excluding IFRIC 12 impairments)	**0**	967
Adjustments in respect of donated gov't grant asset reserve elimination	**66**	54
Adjusted retained (deficit)	**(3,311)**	(4,180)

The reported performance of the Trust £3.6m deficit differs from the financial performance of £3.3m deficit due to allowable technical adjustments. The technical adjustments are explained in Note 32.

The notes on pages 72 to 101 form part of this account.

Statement of Financial Position as at 31 March 2017

	NOTE	31 March 2017 £000s	31 March 2016 £000s
Non-current assets:			
Property, plant and equipment	14	**149,891**	153,732
Intangible assets	15	**1,518**	2,467
Trade and other receivables	17.1	**622**	713
Total non-current assets		**152,031**	156,912
Current assets:			
Trade and other receivables	17.1	**8,038**	9,507
Cash and cash equivalents	18	**1,484**	2,065
Sub-total current assets		**9,522**	11,572
Non-current assets held for sale	19	**0**	0
Total current assets		**9,522**	11,572
Total assets		**161,553**	168,484
Current liabilities			
Trade and other payables	20	**(12,268)**	(15,692)
Provisions	24	**(696)**	(660)
Borrowings	21	**(788)**	(759)
DH capital loan	21	**(800)**	(800)
Total current liabilities		**(14,552)**	(17,911)
Net current assets/(liabilities)		**(5,030)**	(6,339)
Total assets less current liablilities		**147,001**	150,573
Non-current liabilities			
Provisions	24	**(1,814)**	(2,536)
Borrowings	21	**(13,487)**	(14,275)
DH revenue support loan	21	**(2,300)**	0
DH capital loan	21	**(1,600)**	(2,400)
Total non-current liabilities		**(19,201)**	(19,211)
Total assets employed:		**127,800**	131,362
FINANCED BY:			
Public Dividend Capital		**113,339**	111,864
Retained earnings		**275**	3,485
Revaluation reserve		**18,887**	20,714
Other reserves		**(4,701)**	(4,701)
Total Taxpayers' Equity:		**127,800**	131,362

The notes on pages 72 to 101 form part of this account.

The financial statements on pages 67 to 101 were approved by the Board on 25th May 2017 and signed on its behalf by

Helen Greatorex
Chief Executive Date: **26th May 2017**

Statement of Changes in Taxpayers' Equity
For the year ending 31 March 2017

	Public Dividend capital	Retained earnings	Revaluation reserve	Other reserves	Total reserves
	£000s	£000s	£000s	£000s	£000s
Balance at 1 April 2016	**111,864**	**3,485**	**20,714**	**(4,701)**	**131,362**
Changes in taxpayers' equity for 2016-17					
Retained surplus/(deficit) for the year	0	(3,575)	0	**0**	**(3,575)**
Net gain / (loss) on revaluation of property, plant, equipment	0		(1,462)	**0**	**(1,462)**
Transfers between reserves	0	365	(365)	0	**0**
Reclassification Adjustments					
Temporary and permanent PDC received - cash	1,475	0	0	0	**1,475**
Net recognised revenue/(expense) for the year	**1,475**	**(3,210)**	**(1,827)**	**0**	**(3,562)**
Balance at 31 March 2017	**113,339**	**275**	**18,887**	**(4,701)**	**127,800**
Balance at 1 April 2015	**114,689**	**7,933**	**21,642**	**(4,701)**	**139,563**
Changes in taxpayers' equity for 2015-16					
Retained surplus/(deficit) for the year	0	(5,661)	0	0	(5,661)
Net gain / (loss) on revaluation of property, plant, equipment	0	0	285	0	285
Transfers between reserves	0	1,213	(1,213)	0	0
Reclassification Adjustments					
PDC repaid in year	(2,825)	0	0	0	(2,825)
Net recognised revenue/(expense) for the year	**(2,825)**	**(4,448)**	**(928)**	**0**	**(8,201)**
Balance at 31 March 2016	**111,864**	**3,485**	**20,714**	**(4,701)**	**131,362**

Information on reserves

1 Public dividend capital
Public dividend capital (PDC) is a type of public sector equity finance based on the excess of assets over liabilities. Additional PDC may also be issued to NHS trusts by the Department of Health. A charge, reflecting the cost of capital utilised by the NHS foundation trust, is payable to the Department of Health as the public dividend capital dividend.

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

3 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.

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

Statement of Cash Flows for the Year ended 31 March 2017

	NOTE	2016-17 £000s	2015-16 £000s
Cash Flows from Operating Activities			
Operating surplus/(deficit)		**2,554**	(886)
Depreciation and amortisation	6	**6,701**	6,535
Impairments and reversals		**0**	967
Government Granted Assets received credited to revenue but non-cash		**0**	(97)
Decrease in Trade and Other Receivables		**1,603**	781
(Decrease) in Trade and Other Payables		**(4,049)**	(1,515)
Provisions utilised		**(328)**	(605)
(Decrease) in movement in non cash provisions		**(404)**	(86)
Net Cash Inflow from Operating Activities		**6,077**	5,094
Cash Flows from Investing Activities			
Interest Received		**11**	20
(Payments) for Property, Plant and Equipment		**(3,136)**	(9,135)
(Payments) for Intangible Assets		**0**	(708)
(Payments) for Investments with DH		**(16,000)**	(112,300)
Proceeds of disposal of assets held for sale (PPE)		**8**	5,583
Proceeds from Disposal of Investment with DH		**16,000**	112,300
Net Cash (Outflow) from Investing Activities		**(3,117)**	(4,240)
Net Cash Inflow before Financing		**2,960**	854
Cash Flows from Financing Activities			
Gross Temporary and Permanent PDC Received		**1,475**	0
Gross Temporary and Permanent PDC Repaid		**0**	(2,825)
Loans received from DH - New Revenue Support Loans		**4,600**	0
Loans repaid to DH - Capital Investment Loans Repayment of Principal		**(800)**	(2,400)
Loans repaid to DH - Working Capital Loans/Revenue Support Loans		**(2,300)**	0
Capital Element of Payments in Respect of Finance Leases and On-SoFP PFI and LIFT		**(760)**	(437)
Interest paid		**(1,475)**	(1,114)
PDC Dividend (paid)		**(4,281)**	(4,431)
Net Cash (Outflow) from Financing Activities		**(3,541)**	(11,207)
NET (DECREASE) IN CASH AND CASH EQUIVALENTS		**(581)**	(10,353)
Cash and Cash Equivalents at Beginning of the Period		**2,065**	12,418
Cash and Cash Equivalents at year end	**18**	**1,484**	2,065

NOTES TO THE ACCOUNTS

1. Accounting Policies

The Secretary of State for Health has directed that the financial statements of NHS Trusts shall meet the accounting requirements of the Department of Health Group Manual for Accounts, which shall be agreed with HM Treasury. Consequently, the following financial statements have been prepared in accordance with the DH Group Manual for Accounts 2016-17 issued by the Department of Health. The accounting policies contained in that manual 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 Manual for Accounts permits a choice of accounting policy, the accounting policy which is judged to be most appropriate to the particular circumstances of the Trust for the purpose of giving a true and fair view has been selected. The particular policies adopted by the Trust are described below. They have been applied consistently in dealing with items considered material in relation to the accounts.

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.

1.2 Going Concern

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

The Trust has incurred a deficit of £3.6m and has prepared its financial plans and cash flow forecasts for the coming 2 year financial years with forecasts to incur a £2.8m deficit in 2017/18 and a further £1.1m in 2018/19 as it moves towards financial sustainability.

These deficits have an impact on the cash position of the Trust and the Trust received £2.3m of cash support from the Department of Health in the form of a revenue support loan. The Trust is not anticipating borrowing any further cash from the Department of Health and will instead manage its cash position.

Risks do remain to the achievement of the financial forecasts, however, contracts covering the financial years 2016/17 and 2017/18 have been signed with commissioners which reduces uncertainty around the income forecasts.

Although these factors represent material uncertainties that may cast significant doubt about the Trust's ability to continue as a going concern, the directors, having made appropriate enquiries, have reasonable expectations that the Trust will have adequate resources to continue in operational existence for the foreseeable future. As directed by the Department of Health Group Accounting Manual 2016/17, 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.

1.3 Acquisitions and discontinued operations

Activities are considered to be 'acquired' only if they are taken on from outside the public sector. Activities are considered to be 'discontinued' only if they cease entirely. They are not considered to be 'discontinued' if they transfer from one public sector body to another.

Movement of assets within the DH Group

"Transfers as part of reorganisation fall to be accounted for by use of absorption accounting in line with the Treasury FReM. The FReM does not require retrospective adoption, so prior year transactions (which have been accounted for under merger accounting) have not been restated. Absorption accounting requires that entities account for their transactions in the period in which they took place, with no restatement of performance required when functions transfer within the public sector. Where assets and liabilities transfer, the gain or loss resulting is recognised in the SOCI, and is disclosed separately from operating costs.

Other transfers of assets and liabilities within the Group are accounted for in line with IAS 20 and similarly give rise to income and expenditure entries."

1.4 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.

1.4.1 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

NOTES TO THE ACCOUNTS

Notes to the Accounts - 1. Accounting Policies (Continued)

1.4.2 Key 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 2016/17 accounts are as follows:

Property Plant and Equipment see Note 1.8

PFI see Note 1.15

Accruals see Note 1.7

Provisions see Note 1.17

1.5 Revenue

Revenue in respect of services provided is recognised when, and to the extent that, performance occurs, and is measured at the fair value of the consideration receivable. The main source of revenue for the Trust is from commissioners for healthcare services.

Where income is received for a specific activity that is to be delivered in the following year, that income is deferred.

The NHS Trust receives income under the NHS Injury Cost Recovery Scheme, designed to reclaim the cost of treating injured individuals to whom personal injury compensation has subsequently been paid e.g. by an insurer. The NHS Trust recognises the income when it receives notification from the Department of Work and Pension's Compensation Recovery Unit that the individual has lodged a compensation claim. The income is measured at the agreed tariff for the treatments provided to the injured individual, less a provision for unsuccessful compensation claims and doubtful debts.

1.6 Employee Benefits

Short-term employee benefits

Salaries, wages and employment-related payments are recognised in the period in which the service is received from employees*. The cost of leave earned but not taken by employees at the end of the period is recognised in the financial statements to the extent that employees are permitted to carry forward leave into the following period.

Retirement benefit costs

Past and present employees are covered by the provisions of the NHS Pension Schemes. These schemes are unfunded, defined benefit schemes that cover NHS employers, General Practices and other bodies, allowed under the direction of the Secretary of State in England and Wales. The schemes 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, the schemes are accounted for as though they were defined contribution schemes: the cost to the NHS body of participating in a scheme is taken as equal to the contributions payable to the scheme for the accounting period.

For early retirements other than those due to ill health the additional pension liabilities are not funded by the scheme. The full amount of the liability for the additional costs is charged to expenditure at the time the NHS Trust commits itself to the retirement, regardless of the method of payment.

The schemes are subject to a full actuarial valuation every four years and an accounting valuation every year.

1.7 Other expenses

Other operating expenses are recognised when, and to the extent that, the goods or services have been received. They are measured at the fair value of the consideration payable.

NOTES TO THE ACCOUNTS

Notes to the Accounts - 1. Accounting Policies (Continued)

1.8 Property, plant and equipment

Recognition
Property, plant and equipment is capitalised if:
● 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 will be supplied to the NHS Trust;
● it is expected to be used for more than one financial year;
● the cost of the item can be measured reliably; and either
● the item cost at least £5,000; or
● Collectively, a number of items have a total cost of at least £5,000 and individually have a cost of more than £250, where the assets are functionally interdependent, they had broadly simultaneous purchase dates, are anticipated to have simultaneous disposal dates and are under single managerial control; or

● Items form part of the initial equipping and setting-up cost of a new building, ward or unit, irrespective of their individual or collective cost.

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

Valuation
All property, plant and equipment are measured initially at cost, representing the cost directly attributable to acquiring or constructing the asset and bringing it to the location and condition necessary for it to be capable of operating in the manner intended by management. All assets are measured subsequently at current value.
Land and buildings used for the Trust's services or for administrative purposes are stated in the statement of financial position at their revalued amounts, being the fair value at the date of revaluation less any impairment.

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

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

The 5 year professional valuations are carried out by local independent valuers. The valuations are carried out in accordance with the Royal Institute of Chartered Surveyors (RICS) Appraisal and Valuation Manual in so far as these terms are consistent with the agreed requirements of the Department of Health and HM Treasury. In accordance with the requirements of the Department of Health, 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 increase arising on revaluation is taken to the revaluation reserve except when it reverses an impairment for the same asset previously recognised in expenditure, in which case it is credited to expenditure to the extent of the decrease previously charged there. A revaluation decrease that does not result from a loss of economic value or service potential is recognised as an impairment charged to the revaluation reserve to the extent that there is a balance on the reserve for the asset and, thereafter, to expenditure. Impairment losses that arise from a clear consumption of economic benefit should be taken to expenditure. Gains and losses recognised in the revaluation reserve are reported as other comprehensive income in the Statement of Comprehensive Income.

Subsequent expenditure
Where subsequent expenditure enhances an asset beyond its original specification, the directly attributable cost is capitalised. Where subsequent expenditure restores the asset to its original specification, the expenditure is capitalised and any existing carrying value of the item replaced is written-out and charged to operating expenses.

NOTES TO THE ACCOUNTS

Notes to the Accounts - 1. Accounting Policies (Continued)

1.9 Intangible assets

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

Intangible assets acquired separately are initially recognised at cost. Software that is integral to the operation of hardware, for example an operating system, is capitalised as part of the relevant item of property, plant and equipment. Software that is not integral to the operation of hardware, for example application software, is capitalised as an intangible asset. Expenditure on research is not capitalised: it is recognised as an operating expense in the period in which it is incurred. Internally-generated assets are recognised if, and only if, all of the following have been demonstrated:

- the technical feasibility of completing the intangible asset so that it will be available for use;
- the intention to complete the intangible asset and use it;
- the ability to sell or use the intangible asset;
- how the intangible asset will generate probable future economic benefits or service potential;
- the availability of adequate technical, financial and other resources to complete the intangible asset and sell or use it; and
- the ability to measure reliably the expenditure attributable to the intangible asset during its development

Measurement
The amount initially recognised for internally-generated intangible assets is the sum of the expenditure incurred from the date when the criteria above are initially met. Where no internally-generated intangible asset can be recognised, the expenditure is recognised in the period in which it is incurred.

Following initial recognition, intangible assets are carried at current value in existing use by reference to an active market, or, where no active market exists, at the lower of amortised replacement cost (modern equivalent assets basis) and value in use where the asset is income generating. Internally-developed software is held at historic cost to reflect the opposing effects of increases in development costs and technological advances.

1.10 Depreciation, amortisation and impairments

Freehold land, assets under construction or development, and assets held for sale are not depreciated/amortised.

Otherwise, depreciation or amortisation is charged to write off the costs or valuation of property, plant and equipment and intangible non-current assets, less any residual value, on a straight line basis over their estimated useful lives. The estimated useful life of an asset is the period over which the NHS Trust expects to obtain economic benefits or service potential from the asset. This is specific to the NHS Trust and may be shorter than the physical life of the asset itself. Estimated useful lives and residual values are reviewed each year end, with the effect of any changes recognised on a prospective basis. Assets held under finance leases are depreciated over the shorter of the lease term and the estimated useful lives.

At each financial year-end, the NHS Trust checks whether there is any indication that its property, plant and equipment or intangible non-current assets have suffered an impairment loss. If there is indication of such an impairment, the recoverable amount of the asset is estimated to determine whether there has been a loss and, if so, its amount. Intangible assets not yet available for use are tested for impairment annually at the financial year end.

A revaluation decrease that does not result from a loss of economic value or service potential is recognised as an impairment charged to the revaluation reserve to the extent that there is a balance on the reserve for the asset and, thereafter, to expenditure. Impairment losses that arise from a clear consumption of economic benefit are taken to expenditure. Where an impairment loss subsequently reverses, the carrying amount of the asset is increased to the revised estimate of the recoverable amount but capped at the amount that would have been determined had there been no initial impairment loss. The reversal of the impairment loss is credited to expenditure to the extent of the decrease previously charged there and thereafter to the revaluation reserve.

Impairments are analysed between Departmental Expenditure Limits (DEL) and Annually Managed Expenditure (AME). This is necessary to comply with Treasury's budgeting guidance. DEL limits are set in the Spending Review and Departments may not exceed the limits that they have been set. AME budgets are set by the Treasury and may be reviewed with departments in the run-up to the Budget. Departments need to monitor AME closely and inform Treasury if they expect AME spending to rise above forecast. Whilst Treasury accepts that in some areas of AME inherent volatility may mean departments do not have the ability to manage the spending within budgets in that financial year, any expected increases in AME require Treasury approval.

NOTES TO THE ACCOUNTS

Notes to the Accounts - 1. Accounting Policies (Continued)

1.11 Donated assets

Donated non-current assets are capitalised at current value in existing use, if they will be held for their service potential, or otherwise at value on receipt, with a matching credit to income. They are valued, depreciated and impaired as described above for purchased assets. Gains and losses on revaluations, impairments and sales are treated in the same way as for purchased assets. Deferred income is recognised only where conditions attached to the donation preclude immediate recognition of the gain.

1.12 Other Reserve

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

1.13 Non-current assets held for sale

Non-current assets are classified as held for sale if their carrying amount will be recovered principally through a sale transaction rather than through continuing use. This condition is regarded as met when the sale is highly probable, the asset is available for immediate sale in its present condition and management is committed to the sale, which is expected to qualify for recognition as a completed sale within one year from the date of classification. Non-current assets held for sale are measured at the lower of their previous carrying amount and fair value less costs to sell. Fair value is open market value including alternative uses.

The profit or loss arising on disposal of an asset is the difference between the sale proceeds and the carrying amount and is recognised in the Statement of Comprehensive Income. On disposal, the balance for the asset on the revaluation reserve is transferred to retained earnings.

Property, plant and equipment that is to be scrapped or demolished does not qualify for recognition as held for sale. Instead, it is retained as an operational asset and its economic life is adjusted. The asset is de-recognised when it is scrapped or demolished.

1.14 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.

The Trust as lessee

Property, plant and equipment held under finance leases are initially recognised, at the inception of the lease, at fair value or, if lower, at the present value of the minimum lease payments, with a matching liability for the lease obligation to the lessor. Lease payments are apportioned between finance charges and reduction of the lease obligation so as to achieve a constant rate of interest on the remaining balance of the liability. Finance charges are recognised in calculating the Trust's surplus/deficit.

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.

Where a lease is for land and buildings, the land and building components are separated and individually assessed as to whether they are operating or finance leases.

The Trust as lessor

Amounts due from lessees under finance leases are recorded as receivables at the amount of the NHS Trust's net investment in the leases. Finance lease income is allocated to accounting periods so as to reflect a constant periodic rate of return on the Trust's net investment outstanding in respect of the 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 on a straight-line basis over the lease term.

NOTES TO THE ACCOUNTS

Notes to the Accounts - 1. Accounting Policies (Continued)

1.15 Private Finance Initiative (PFI) transactions

HM Treasury has determined that government bodies shall account for infrastructure PFI schemes where the government body controls the use of the infrastructure and the residual interest in the infrastructure at the end of the arrangement as service concession arrangements, following the principles of the requirements of IFRIC 12. The NHS Trust therefore recognises the PFI asset as an item of property, plant and equipment together with a liability to pay for it. The services received under the contract are recorded as operating expenses.

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

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

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

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

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

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

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

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

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

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

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

1.16 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 NHS Trust's cash management.

NOTES TO THE ACCOUNTS

Notes to the Accounts - 1. Accounting Policies (Continued)

1.17 Provisions

Provisions are recognised when the NHS Trust has a present legal or constructive obligation as a result of a past event, it is probable that the NHS Trust will be required to settle the obligation, and a reliable estimate can be made of the amount of the obligation. The amount recognised as a provision is the best estimate of the expenditure required to settle the obligation at the end of the reporting period, taking into account the risks and uncertainties. Where a provision is measured using the cash flows estimated to settle the obligation, its carrying amount is the present value of those cash flows using HM Treasury's discount rates.

Early retirement provisions are discounted using HM Treasury's pension discount rate of positive 0.24% (2015-16: positive 1.37%) in real terms. All other provisions are subject to three separate discount rates according to the expected timing of cashflows from the Statement of Financial Position date:

- A short term rate of negative 2.70% (2015-16: negative 1.55%) for expected cash flows up to and including 5 years
- A medium term rate of negative 1.95% (2015-16: negative 1.00%) for expected cash flows over 5 years up to and including 10 years
- A long term rate of negative 0.80% (2015-16: negative 0.80%) for expected cash flows over 10 years.

All percentages are in real terms.

For dilapidations, this only includes leased properties which will expire in the medium term, the costs can be estimated with reasonable certainty and there exists an obligation to return the property into its pre lease state on expiry.

Leases with a term in excess of 5 years remaining are noted as a contingent liability as no accurate estimate of cost can be determined.

When some or all of the economic benefits required to settle a provision are expected to be recovered from a third party, the receivable is recognised as an asset if it is virtually certain that reimbursements will be received and the amount of the receivable can be measured reliably.

1.18 Clinical negligence costs

The NHS Litigation Authority (NHSLA) operates a risk pooling scheme under which the Trust pays an annual contribution to the NHSLA, which in return settles all clinical negligence claims. The contribution is charged to expenditure. Although the NHSLA is administratively responsible for all clinical negligence cases the legal liability remains with the NHS Trust. The total value of clinical negligence provisions carried by the NHSLA on behalf of the Trust is disclosed at Note 25.

1.19 Non-clinical risk pooling

The NHS Trust participates in the Property Expenses Scheme and the Liabilities to Third Parties Scheme. Both are risk pooling schemes under which the NHS Trust pays an annual contribution to the NHS Litigation Authority and, in return, receives assistance with the costs of claims arising. The annual membership contributions, and any excesses payable in respect of particular claims are charged to operating expenses as and when they become due.

1.20 Contingencies

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

NOTES TO THE ACCOUNTS

Notes to the Accounts - 1. Accounting Policies (Continued)

1.21 Financial assets

Financial assets are recognised when the NHS Trust becomes party to the financial instrument contract or, in the case of trade receivables, when the goods or services have been delivered. Financial assets are derecognised when the contractual rights have expired or the asset has been transferred.

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

Loans and receivables

Loans and receivables are non-derivative financial assets with fixed or determinable payments which are not quoted in an active market. After initial recognition, they are measured at amortised cost using the effective interest method, less any impairment. Interest is recognised using the effective interest method.

At the end of the reporting period, the NHS Trust assesses whether any financial assets, other than those held at 'fair value through profit and loss' are impaired. Financial assets are impaired and impairment losses recognised if there is objective evidence of impairment as a result of one or more events that occurred after the initial recognition of the asset and that have an impact on the estimated future cash flows of the asset.

For financial assets carried at amortised cost, the amount of the impairment loss is measured as the difference between the asset's carrying amount and the present value of the revised future cash flows discounted at the asset's original effective interest rate. The loss is recognised in expenditure and the carrying amount of the asset is reduced through a provision for impairment of receivables.

1.22 Financial liabilities

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

Loans from the Department of Health are recognised at historic cost. Otherwise, financial liabilities are initially recognised at fair value.

Financial guarantee contract liabilities

Financial guarantee contract liabilities are subsequently measured at the higher of:

- The amount of the obligation under the contract, as determined in accordance with IAS 37 *Provisions, Contingent Liabilities and Contingent Assets* ; and
- The premium received (or imputed) for entering into the guarantee less cumulative amortisation.

Other financial liabilities

After initial recognition, all other financial liabilities are measured at amortised cost using the effective interest method, except for loans from Department of Health, which are carried at historic cost. The effective interest rate is the rate that exactly discounts estimated future cash payments through the life of the asset, to the net carrying amount of the financial liability. Interest is recognised using the effective interest method.

1.23 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.

1.24 Foreign currencies

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

1.25 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. Details of third party assets are given in Note 33 to the accounts.

1.26 Public Dividend Capital (PDC) and PDC dividend

Public dividend capital represents taxpayers' equity in the NHS Trust. 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. As PDC is issued under legislation rather than under contract, it is not treated as an equity financial instrument.

NOTES TO THE ACCOUNTS

Notes to the Accounts - 1. Accounting Policies (Continued)

An annual charge, reflecting the cost of capital utilised by the Trust, is payable to the Department of Health as public dividend capital dividend. The charge is calculated at the real rate set by HM Treasury (currently 3.5%) on the average carrying amount of all assets less liabilities (except for donated assets and cash balances with the Government Banking Service). The average carrying amount of assets is calculated as a simple average of opening and closing relevant net assets.

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

1.27 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 NHS Trust not been bearing its own risks (with insurance premiums then being included as normal revenue expenditure).

Subsidiaries

Material entities over which the NHS Trust has the power to exercise control are classified as subsidiaries and are consolidated. The NHS Trust has control when it is exposed to or has rights to variable returns through its power over another entity. The income and expenses; gains and losses; assets, liabilities and reserves; and cash flows of the subsidiary are consolidated in full into the appropriate financial statement lines. Appropriate adjustments are made on consolidation where the subsidiary's accounting policies are not aligned with the NHS Trust or where the subsidiary's accounting date is not co-terminus.

Subsidiaries that are classified as 'held for sale' are measured at the lower of their carrying amount or 'fair value less costs to sell'.

1.28 Research and Development

Research and development expenditure is charged against income in the year in which it is incurred, except insofar as development expenditure relates to a clearly defined project and the benefits of it can reasonably be regarded as assured. Expenditure so deferred is limited to the value of future benefits expected and is amortised through the SOCI on a systematic basis over the period expected to benefit from the project. It should be revalued on the basis of current cost. The amortisation is calculated on the same basis as depreciation, on a quarterly basis.

1.29 Accounting Standards that have been issued but have not yet been adopted

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

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

2. Operating segments

KMF - Kent and Medway Facilities provided the following services: Estates, Hotel Services Management and Environment Management. These services were provided to Kent and Medway NHS and Social Care Partnership Trust, NHS Property Services, Kent Community Healthcare NHS Foundation Trust and Medway CIC under consortium arrangements. Immaterial direct sales are also made to members, other NHS bodies and third parties.

KMPS - Kent and Medway Payroll Services - The payroll department provides services to enable payment of payroll and travel claims. It also provides pension advice services.

These services were provided to Medway NHS Foundation Trust until January 2016, Kent and Medway NHS and Social Care Partnership Trust and Medway CIC under consortium arrangements. Immaterial contracts are also in place with other parties.

	1. Shared Services		2. Healthcare		Total	
	2016-17 £000s	2015-16 £000s	**2016-17 £000s**	2015-16 £000s	**2016-17 £000s**	2015-16 £000s
Income	**5,253**	6,194	**177,850**	175,140	**183,103**	181,334
Surplus/(Deficit)						
Segment surplus/(deficit)	**(36)**	99	**(3,539)**	(5,760)	**(3,575)**	(5,661)
Common costs	**321**	502	**48,340**	45,373	**48,661**	45,876
Surplus/(deficit) before interest	**285**	**601**	**44,801**	**39,613**	**45,086**	40,215
Net Assets:						
Segment net assets	**0**	0	**751**	772	**751**	772
Depreciation	0	0	6,701	6,535	6,701	6,535
Disclosure of External Customer Income over 10%						
NHS Bodies	3,273	3,929	166,724	162,674	169,997	166,603

3. Income generation activities

The Trust undertakes income generation activities with an aim of achieving profit, which is then used in patient care.
There are no income generation activities undertaken by the Trust where full costs exceed £1m and achieve a profit or are otherwise material in relation to the accounts (2015/16 £0m).

4. Revenue from patient care activities

	2016-17 £000s	2015-16 £000s
NHS Trusts	**82**	93
NHS England	**20,187**	19,096
Clinical Commissioning Groups	**147,190**	143,852
Foundation Trusts	**167**	50
Department of Health	**44**	0
NHS Other (including Public Health England and Prop Co)	**0**	145
Additonal income for delivery of healthcare services	**0**	2,825
Non-NHS:		
Local Authorities	**556**	826
Overseas patients (non-reciprocal)	**5**	0
Other Non-NHS patient care income	**421**	0
Total Revenue from patient care activities	**168,652**	166,887

5. Other operating revenue

	2016-17 £000s	2015-16 £000s
Recoveries in respect of employee benefits	**78**	645
Education, training and research	**3,826**	3,367
Non-patient care services to other bodies	**5,723**	6,531
Sustainability & Transformation Fund Income	**1,870**	0
Income generation (Other fees and charges)	**1,162**	1,370
Rental revenue from operating leases	**1,367**	1,677
Other revenue	**425**	857
Total Other Operating Revenue	**14,451**	14,447
Total operating revenue	**183,103**	181,334

6. Operating expenses

	2016-17 £000s	2015-16 £000s
Services from other NHS Trusts	**505**	2,089
Services from CCGs/NHS England	**27**	0
Services from NHS Foundation Trusts	**1,224**	1,511
Total Services from NHS bodies*	**1,756**	3,600
Purchase of healthcare from non-NHS bodies	**7,935**	9,695
Trust Chair and Non-executive Directors	**68**	65
Supplies and services - clinical	**4,828**	4,700
Supplies and services - general	**2,290**	2,237
Consultancy services	**78**	229
Establishment	**3,972**	3,772
Transport	**849**	1,510
Service charges - ON-SOFP PFIs and other service concession arrangements	**925**	1083
Business rates paid to local authorities	**1,313**	948
Premises	**7,415**	6,438
Hospitality	**11**	18
Insurance	**291**	304
Legal Fees	**1,531**	1550
Impairments and Reversals of Receivables	**(32)**	50
Depreciation	**5,752**	5,457
Amortisation	**949**	1,078
Impairments and reversals of property, plant and equipment	**0**	512
Impairments and reversals of intangible assets	**0**	305
Impairments and reversals of non current assets held for sale	**0**	150
Internal Audit Fees	**220**	143
Audit fees	**61**	61
Other auditor's remuneration - Quality Account Review	**12**	12
Clinical negligence	**762**	553
Education and Training	**684**	718
Change in Discount Rate	**175**	(12)
Other	**(93)**	840
Total Operating expenses (excluding employee benefits)	**41,752**	46,016
Employee Benefits		
Employee benefits excluding Board members	**137,754**	135,123
Board members	**1,043**	1,081
Total Employee Benefits	**138,797**	136,204
Total Operating Expenses	**180,549**	182,220

*Services from NHS bodies does not include expenditure which falls into a category below

7. Operating Leases

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.

7.1. Kent and Medway NHS and Social Care Partnership Trust as lessee

	Buildings £000s	**Other £000s**	**2016-17 Total £000s**	2015-16 £000s
Payments recognised as an expense				
Minimum lease payments	2,132	239	**2,371**	1,953
Total	**2,132**	**239**	**2,371**	1,953
Payable:				
No later than one year	244	53	**297**	425
Between one and five years	781	186	**967**	529
After five years	1,107	0	**1,107**	999
Total	**2,132**	**239**	**2,371**	1,953

7.2. Kent and Medway NHS and Social Care Partnership Trust as 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.

	2016-17 £000s	2015-16 £000s
Recognised as revenue		
Contingent rents	1,367	1,677
Total	**1,367**	1,677
Receivable:		
No later than one year	1,367	1,677
Total	**1,367**	1,677

8. Employee benefits

8.1. Employee benefits

	2016-17 Total £000s	2015-16 Total £000s
Employee Benefits - Gross Expenditure		
Salaries and wages	**116,582**	117,144
Social security costs	**9,401**	7,366
Employer Contributions to NHS BSA - Pensions Division	**12,421**	12,095
Other pension costs	**5**	5
Termination benefits	**428**	113
Total employee benefits	**138,837**	136,723
Employee costs capitalised	**40**	519
Gross Employee Benefits excluding capitalised costs	**138,797**	136,204

8.2. Retirements due to ill-health

	2016-17 Number	2015-16 Number
Number of persons retired early on ill health grounds	**2**	4
	£000s	£000s
Total additional pensions liabilities accrued in the year	**86**	272

8.3. Pension costs

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

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

a) Accounting valuation

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

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

b) Full actuarial (funding) valuation

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

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

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

8.4 Alternative Scheme Pension costs

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

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

Scheme Provisions

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

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

9. Better Payment Practice Code

9.1. Measure of compliance

	2016-17 Number	2016-17 £000s	2015-16 Number	2015-16 £000s
Non-NHS Payables				
Total Non-NHS Trade Invoices Paid in the Year	**21,421**	**57,677**	23,435	62,569
Total Non-NHS Trade Invoices Paid Within Target	**17,951**	**51,056**	20,636	55,309
Percentage of NHS Trade Invoices Paid Within Target	**83.80%**	**88.52%**	88.06%	88.40%
NHS Payables				
Total NHS Trade Invoices Paid in the Year	**1,529**	**9,413**	1,270	**9,734**
Total NHS Trade Invoices Paid Within Target	**1,114**	**6,398**	838	**6,255**
Percentage of NHS Trade Invoices Paid Within Target	**72.86%**	**67.97%**	65.98%	64.26%

The Better Payment Practice Code requires the Trust to aim to pay all valid invoices by the due date or within 30 days of receipt of a valid invoice, whichever is later. The Trust still has a large number of small value orders which are challenging to pay within 30 days thus the percentage by number paid withen target reduced.

9.2. The Late Payment of Commercial Debts (Interest) Act 1998

	2016-17 £000s	2015-16 £000s
Amounts included in finance costs from claims made under this legislation	**14**	16
Total	**14**	16

10. Investment Revenue

	2016-17 £000s	2015-16 £000s
Interest revenue		
Bank interest	**11**	20
Total investment revenue	**11**	20

11. Other Gains and Losses

	2016-17 £000s	2015-16 £000s
Gain/(Loss) on disposal of assets other than by sale (PPE)	**(388)**	**(6)**
Gain/(Loss) on disposal of assets held for sale	**8**	**935**
Total	**(380)**	929

12. Finance Costs

	2016-17 £000s	2015-16 £000s
Interest		
Interest on loans and overdrafts	**57**	**13**
Interest on obligations under finance leases	**111**	**119**
Interest on obligations under PFI contracts:		
- main finance cost	**842**	**866**
- contingent finance cost	**452**	**100**
Interest on late payment of commercial debt	**14**	**16**
Total interest expense	**1,476**	1,114
Other finance costs	**0**	**0**
Provisions - unwinding of discount	**46**	**88**
Total	**1,522**	1,202

13. Auditor Disclosures

13.1. Other auditor remuneration

	2016-17 £000s	2015-16 £000s
Other auditor remuneration paid to the external auditor:		
Audit-related assurance services	**12**	12
Total	**12**	**12**

13.2. Limitation on auditor's liability

There is no limitation on auditor's liability for external audit work carried out for the financial years 2016/17 or 2015/16.

14.1. Property, plant and equipment

2016-17	Land	Buildings excluding dwellings	Assets under construction & payments on account	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000's	£000's	£000's	£000's	£000's	£000's	£000's	£000's
Cost or valuation:								
At 1 April 2016	31,733	114,077	4,486	1,178	393	16,329	1,808	**170,004**
Additions of Assets Under Construction	0	0	1,349	0	0	0	0	**1,349**
Additions Purchased	0	1,526	0	63	0	316	119	**2,024**
Reclassifications	0	2,359	(2,525)	34	0	0	132	**0**
Reclassifications as Held for Sale and reversals	0	0	0	0	(100)	0	0	**(100)**
Disposals other than for sale	0	0	0	0	0	(6,953)	0	**(6,953)**
Revaluation	0	(1,462)	0	0	0	0	0	**(1,462)**
At 31 March 2017	**31,733**	**116,500**	**3,310**	**1,275**	**293**	**9,692**	**2,059**	**164,862**
Depreciation								
At 1 April 2016	0	4,040	0	804	350	9,911	1,167	**16,272**
Reclassifications as Held for Sale and reversals	0	0	0	0	(100)	0	0	**(100)**
Disposals other than for sale	0	0	0	0	0	(6,953)	0	**(6,953)**
Charged During the Year	0	3,620	0	77	12	1,854	189	**5,752**
At 31 March 2017	**0**	**7,660**	**0**	**881**	**262**	**4,812**	**1,356**	**14,971**
Net Book Value at 31 March 2017	**31,733**	**108,840**	**3,310**	**394**	**31**	**4,880**	**703**	**149,891**
Asset financing:								
Owned - Purchased	31,143	81,705	3,310	309	31	4,880	459	**121,837**
Owned - Donated	590	992	0	0	0	0	0	**1,582**
Held on finance lease	0	1,186	0	5	0	0	3	**1,194**
On-SOFP PFI contracts	0	24,957	0	80	0	0	241	**25,278**
Total at 31 March 2017	**31,733**	**108,840**	**3,310**	**394**	**31**	**4,880**	**703**	**149,891**
Revaluation Reserve Balance for Property, Plant & Equipment								
At 1 April 2016	4,806	15,881	0	19	0	0	6	**20,712**
Movements - Revaluation	0	(1,823)	0	0	0	0	(3)	**(1,826)**
At 31 March 2017	**4,806**	**14,058**	**0**	**19**	**0**	**0**	**3**	**18,886**

Additions to Assets Under Construction in 2016-17

Buildings excl Dwellings	1,349
Balance as at YTD	**1,349**

The disposals other than for sale relate to the removal of fully depreciated obsolete information technology equipment from the Trust's asset register.

14.2. Property, plant and equipment prior-year

2015-16	Land	Buildings excluding dwellings	Assets under construction & payments on account	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000's	£000's	£000's	£000's	£000's	£000's	£000's	£000's
Cost or valuation:								
At 1 April 2015	34,340	107,408	9,552	1,065	437	13,804	1,688	**168,294**
Additions of Assets Under Construction	0	0	3,012	0	0	0	0	**3,012**
Additions Purchased	27	2,137	0	75	0	1,434	77	**3,750**
Reclassifications	299	6,146	(8,078)	38	0	1,099	96	**(400)**
Reclassifications as Held for Sale and Reversals	(2,857)	(1,718)	0	0	(44)	0	(53)	**(4,672)**
Disposals other than for sale	(76)	(181)	0	0	0	(8)	0	**(265)**
Revaluation	0	285	0	0	0	0	0	**285**
At 31 March 2016	**31,733**	**114,077**	**4,486**	**1,178**	**393**	**16,329**	**1,808**	**170,004**
Depreciation								
At 1 April 2015	0	0	0	737	358	8,303	1,039	**10,437**
Reclassifications as Held for Sale and Reversals	0	(35)	0	0	(38)	0	(53)	**(126)**
Disposals other than for sale	0	0	0	0	0	(8)	0	**(8)**
Impairments/reversals charged to operating expenses	0	508	0	0	0	4	0	**512**
Charged During the Year	0	3,567	0	67	30	1,612	181	**5,457**
At 31 March 2016	**0**	**4,040**	**0**	**804**	**350**	**9,911**	**1,167**	**16,272**
Net Book Value at 31 March 2016	**31,733**	**110,037**	**4,486**	**374**	**43**	**6,418**	**641**	**153,732**
Asset financing:								
Owned - Purchased	31,143	84,372	4,486	322	43	6,418	600	**127,384**
Owned - Donated	590	1,045	0	0	0	0	0	**1,635**
Held on finance lease	0	1,315	0	5	0	0	4	**1,324**
On-SOFP PFI contracts	0	23,305	0	47	0	0	37	**23,389**
Total at 31 March 2016	**31,733**	**110,037**	**4,486**	**374**	**43**	**6,418**	**641**	**153,732**

14.3. (cont). Property, plant and equipment

The Trust received no donated assets for PPE this year.

Land and property are held at revalued amounts. The current effective date of revaluation is March 31st 2015.

The full five year 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.

The remaining asset lives for each class of asset are:

	Minimum Life	Maximum Life
Buildings excluding dwellings	1	58
External Works	10	58
Engineering Works	5	39
Plant and Machinery	1	11
Transport Equipment	1	9
IT/Office equipment	1	5
Furniture and Fittings	1	8

There have been no changes to asset lives following the full 5 year revaluation.

The Trust is lessor for a number of operational leases for occupation of owned properties:

	Net Book values as at 31/3/2017 £000	**Depreciation charge in period £000**	Net book values as at 31/3/2016 £000	Depreciation charge in period £000
Building Services	**13,221**	**442**	12,559	403
Engineering Services	**5,037**	**342**	4,789	294
External Works	**1,275**	**57**	947	38
Land	**254**	**0**	254	0
	19,787	**841**	18,549	735

15. Intangible non-current assets

15.1. Intangible non-current assets

2016-17	IT - in-house & 3rd party software	Licenses and Trademarks	Total
	£000's	£000's	£000's
At 1 April 2016	**4,500**	**1,939**	**6,439**
At 31 March 2017	**4,500**	**1,939**	**6,439**
Amortisation			
At 1 April 2016	**2,679**	**1,293**	**3,972**
Charged During the Year	**664**	**285**	**949**
At 31 March 2017	**3,343**	**1,578**	**4,921**
Net Book Value at 31 March 2017	**1,157**	**361**	**1,518**
Asset Financing: Net book value at 31 March 2017 comprises:			
Purchased	1,094	361	**1,455**
Donated	63	0	**63**
Total at 31 March 2017	**1,157**	**361**	**1,518**

15.2. Intangible non-current assets prior year

2015-16	IT - in-house & 3rd party software	Licenses and Trademarks	Total
	£000's	£000's	£000's
Cost or valuation:			
At 1 April 2015	4,284	1,937	**6,221**
Additions - purchased	705	3	**708**
Additions - government granted	97	0	**97**
Reclassifications	400	0	**400**
Disposals other than by sale	(986)	(1)	**(987)**
At 31 March 2016	4,500	1,939	6,439
Amortisation			
At 1 April 2015	2,574	1,002	**3,576**
Disposals other than by sale	(986)	(1)	**(987)**
Impairments/reversals charged to operating expenses	305	0	**305**
Charged during the year	786	292	**1,078**
At 31 March 2016	2,679	1,293	3,972
Net book value at 31 March 2016	1,821	646	**2,467**
Net book value at 31 March 2016 comprises:			
Purchased	1736	646	**2,382**
Donated	85	0	**85**
Total at 31 March 2016	1,821	646	2,467

15.3. Intangible non-current assets

The assets have not been revalued so no revaluation reserve is held for these assets.

The internally generated assets comprise a bespoke Business Intelligence System which utilises data from the Trust's patient care record system, PLICS a patient information system and RIO which is a patient care record system.

The software asset for RIO has a carrying value of £1.05m depreciated costs.

16. Commitments

16.1. Capital commitments

Contracted capital commitments at 31 March not otherwise included in these financial statements:

	31 March 2017 £000s	31 March 2016 £000s
Property, plant and equipment	**0**	0
Intangible assets	**0**	0
Total	**0**	0

16.2. Other financial commitments

The trust has entered into no non-cancellable contracts.

17.1. Trade and other receivables

	Current		**Non-current**	
	31 March 2017 £000s	31 March 2016 £000s	**31 March 2017 £000s**	31 March 2016 £000s
NHS receivables - revenue	**5,016**	7,691	**0**	0
NHS prepayments and accrued income	**519**	800	**0**	0
Non-NHS receivables - revenue	**745**	718	**622**	713
Non-NHS prepayments and accrued income	**1,020**	247	**0**	0
PDC Dividend prepaid to DH	**82**	39	**0**	0
Provision for the impairment of receivables	**(172)**	(216)	**0**	0
VAT	**661**	0	**0**	0
Other receivables	**167**	228	**0**	0
Total	**8,038**	9,507	**622**	713
Total current and non current	**8,660**	10,220		
Included in NHS receivables are prepaid pension contributions:	**0**			

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.

17.2. Receivables past their due date but not impaired

	31 March 2017 £000s	31 March 2016 £000s
By up to three months	**635**	1,646
By three to six months	**202**	1,601
By more than six months	**3,329**	1,601
Total	**4,166**	4,848

17.3. Provision for impairment of receivables

	2016-17 £000s	2015-16 £000s
Balance at 1 April 2016	**(216)**	(167)
Amount written off during the year	**12**	1
Amount recovered during the year	**61**	106
(Increase)/decrease in receivables impaired	**(29)**	(156)
Balance at 31 March 2017	**(172)**	(216)

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

18. Cash and Cash Equivalents

	31 March 2017 £000s	31 March 2016 £000s
Opening balance	**2,065**	12,418
Net change in year	**(581)**	(10,353)
Closing balance	**1,484**	2,065
Made up of		
Cash with Government Banking Service	**1,350**	2,038
Commercial banks	**114**	0
Cash in hand	**20**	27
Cash and cash equivalents as in statement of financial position	**1,484**	2,065
Cash and cash equivalents as in statement of cash flows	**1,484**	2,065
Third Party Assets - Bank balance (not included above)	**254**	384

The figures relate to £254k patients monies (£354k 2015/16) and £0 project monies (£30k 2015/16) held on behalf of the TABLO project.
There are no patients monies held on deposit in 2016/17 (£0 2015/16)

19. Non-current assets held for sale

	Land	Buildings, excl. dwellings	Transport and Equipment	Total
	£000s	£000s	£000s	£000s
Balance at 1 April 2016	0	0	0	**0**
Balance at 31 March 2017	**0**	**0**	**0**	**0**
Liabilities associated with assets held for sale at 31 March 2017	0	0	0	**0**
Balance at 1 April 2015	0	0	0	**0**
Plus assets classified as held for sale in the year	2,857	1,683	6	**4,546**
Less assets sold in the year	(2,707)	(1,683)	(6)	**(4,396)**
Less impairment of assets held for sale	(150)	0	0	**(150)**
Balance at 31 March 2016	**0**	**0**	**0**	**0**
Liabilities associated with assets held for sale at 31 March 2016	0	0	0	0

20. Trade and other payables

	Current	
	31 March 2017 £000s	31 March 2016 £000s
NHS payables - revenue	**921**	2,423
NHS accruals and deferred income	**558**	493
Non-NHS payables - revenue	**3,163**	6,474
Non-NHS payables - capital	**1,339**	714
Non-NHS accruals and deferred income	**2,184**	1,795
Social security costs	**1,320**	1,106
Accrued Interest on DH Loans	**16**	14
VAT	**0**	14
Tax	**1,035**	991
Payments received on account	**0**	0
Other	**1,732**	1,668
Total	**12,268**	15,692
Total payables (current and non-current)	**12,268**	**15,692**
Included above:		
to Buy Out the Liability for Early Retirements Over 5 Years	**86**	272
number of Cases Involved (number)	**2**	4
outstanding Pension Contributions at the year end	**1,693**	1,653

21. Borrowings

	Current		Non-current	
	31 March 2017 £000s	31 March 2016 £000s	**31 March 2017 £000s**	31 March 2016 £000s
Loans from Department of Health	**800**	800	**1,600**	2,400
Revenue loans from Department of Health	**0**	0	**2,300**	0
Other borrowings;				
PFI liabilities - main liability	**647**	627	**12,177**	12,824
Finance lease liabilities	**141**	132	**1,310**	1,451
	788	759	**13,487**	**14,275**
Total	**1,588**	**1,559**	**17,387**	**16,675**
Total other liabilities (current and non-current)	**18,975**	**18,234**		

Borrowings / Loans - repayment of principal falling due in:

		31 March 2017	
	DH £000s	**Other £000s**	**Total £000s**
0-1 Years	800	788	**1,588**
1 - 2 Years	1,600	832	**2,432**
2 - 5 Years	2,300	2,769	**5,069**
Over 5 Years	0	9,886	**9,886**
TOTAL	**4,700**	**14,275**	**18,975**

22. Deferred income

	Current	
	31 March 2017 £000s	31 March 2016 £000s
Opening balance at 1 April 2016	**134**	0
Deferred revenue addition	**0**	134
Transfer of Deferred income	**(134)**	0
Current deferred Income at 31 March 2017	**0**	134
Total deferred income (current and non-current)	**0**	134

23. Finance lease obligations as 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.

Amounts payable under finance leases (Buildings)	**Minimum lease payments**		**Present value of minimum**	
	31 March 2017	31 March 2016	**31 March 2017**	31 March 2016
	£000s	£000s	**£000s**	£000s
Within one year	**243**	243	**141**	132
Between one and five years	**972**	972	**672**	628
After five years	**729**	972	**638**	823
Less future finance charges	**(493)**	(604)	**0**	0
Minimum Lease Payments / Present value of minimum lease payments	**1,451**	1,583	**1,451**	1,583
Included in:				
Current borrowings			**141**	132
Non-current borrowings			**1,310**	1,451
			1,451	1,583

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 23 above.

24. Provisions

		Comprising:			
	Total	**Early Departure Costs**	**Legal Claims**	**Other**	**Redundancy**
	£000s	**£000s**	**£000s**	**£000s**	**£000s**
Balance at 1 April 2016	**3,196**	**1,996**	**88**	**1,112**	**0**
Arising during the year	**349**	**3**	**201**	**72**	**73**
Utilised during the year	**(328)**	**(137)**	**(60)**	**(58)**	**(73)**
Reversed unused	**(928)**	**(182)**	**(78)**	**(668)**	**0**
Unwinding of discount	**46**	**46**	**0**	**0**	**0**
Change in discount rate	**175**	**175**	**0**	**0**	**0**
Balance at 31 March 2017	**2,510**	**1,901**	**151**	**458**	**0**
Expected Timing of Cash Flows:					
No Later than One Year	**696**	**137**	**151**	**408**	**0**
Later than One Year and not later than Five Years	**599**	**549**	**0**	**50**	**0**
Later than Five Years	**1,215**	**1,215**	**0**	**0**	**0**

Amount Included in the Provisions of the NHS Litigation Authority in Respect of Clinical Negligence Liabilities:

As at 31 March 2017	2,482
As at 31 March 2016	10,514

Early Departure Costs represent pension liabilities for injury benefits.
Legal claims reflect LTPS which the NHS Litigation Authority provide estimates and employment tribunal claims whose timings are based on current assumptions from the Trust Legal Department.
Other claims relate to dilapidations provision and unbilled gas charges.
Redundancies were as a result of service cessations.

25. Contingencies

	31 March 2017	31 March 2016
	£000s	£000s
Contingent liabilities		
NHS Litigation Authority legal claims	**(61)**	(44)
Other	**(1,193)**	(1,193)
Net value of contingent liabilities	**(1,254)**	(1,237)

Contingent Liabilities relate to £61k (£44k 2015/16) LTPS notified by the NHSLA and £1.1m (£1.1m 2015/16) dilapidation costs for future years onwards.
Accounting Policy Note 1.17, page 13 refers to the process for dilapidation provisions.

26. PFI and LIFT - additional information

The information below is required by the Department of Heath for inclusion in national statutory accounts

Charges to operating expenditure and future commitments in respect of ON and OFF SOFP PFI

	2016-17 £000s	2015-16 £000s
Service element of on SOFP PFI charged to operating expenses in year	**925**	1,083
Total	**925**	1,083

Payments committed to in respect of off SOFP PFI and the service element of on SOFP PFI

No Later than One Year	**959**	925
Later than One Year, No Later than Five Years	**4,119**	4,064
Later than Five Years	**13,077**	14,091
Total	**18,155**	19,080

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	**2016-17 £000s**	2015-16 £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 yea residual life (see note 23)

Scheme 2:Replacement of Stone House Hospital
The Trust replaced the old Stone House Hospital in two stages:

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

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

Phase 1 Stone House Hospital	**2016-17 £000s**	2015-16 £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**

Phase 2 Stone House Hospital	**2016-17 £000s**	2015-16 £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**

Imputed "finance lease" obligations for on SOFP PFI contracts due

	2016-17 £000s	2015-16 £000s
No Later than One Year	**1,450**	1,469
Later than One Year, No Later than Five Years	**5,728**	5,674
Later than Five Years	**13,648**	15,152
Subtotal	**20,826**	22,295
Less: Interest Element	**(8,002)**	(8,844)
Total	**12,824**	13,451

Present Value Imputed "finance lease" obligations for on SOFP PFI contracts due Analysed by when PFI payments are due	**2016-17 £000s**	2015-16 £000s
No Later than One Year	**647**	627
Later than One Year, No Later than Five Years	**2,929**	2,706
Later than Five Years	**9,248**	10,118
Total	**12,824**	13,451

Number of on SOFP PFI Contracts

Total Number of on PFI contracts	**3**

27. Impact of IFRS treatment - current year

Not relevant for trust

The information below is required by the Department of Heath for budget reconciliation purposes	2016-17 Income £000s	2016-17 Expenditure £000s	2015-16 Income £000s	2015-16 Expenditure £000s
Revenue costs of IFRS: Arrangements reported on SoFP under IFRIC12 (e.g PFI / LIFT)				
Depreciation charges	0	**466**	0	445
Interest Expense	0	**842**	0	866
Other Expenditure	0	**1,452**	0	1,539
Impact on PDC dividend payable	0	**363**	0	331
Total IFRS Expenditure (IFRIC12)	**0**	**3,123**	**0**	3,181
Revenue consequences of PFI / LIFT schemes under UK GAAP / ESA95 (net of any sublease revenue)		**2,925**		2,721
Net IFRS change (IFRIC12)		**198**		460
Capital Consequences of IFRS : LIFT/PFI and other items under IFRIC12				
Capital expenditure 2015-16		57		236
UK GAAP capital expenditure 2015-16 (Reversionary Interest)		264		255

	2016-17 Income/ Expenditure IFRIC 12 YTD £000s	2016-17 Income/ Expenditure ESA 10 YTD £000s	2015-16 Income/ Expenditure IFRIC 12 YTD £000s	2015-16 Income/ Expenditure ESA 10 YTD £000s
Revenue costs of IFRS12 compared with ESA10				
Depreciation charges	**466**	0	445	0
Interest Expense	**842**	0	866	0
Other Expenditure				
Service Charge	**925**	**2,925**	1,083	2,721
Contingent Rent	**452**	0	203	0
Lifecycle	**75**	0	253	0
Impact on PDC Dividend Payable	**363**	0	331	0
Total Revenue Cost under IFRIC12 vs ESA10	**3,123**	**2,925**	3,181	2,721
Revenue Receivable from subleasing	**0**	**0**	0	0
Net Revenue Cost/(income) under IDRIC12 vs ESA10	**3,123**	**2,925**	3,181	2,721

28. Financial Instruments

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. Trust treasury activity is subject to review by the Trust's internal auditors.

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

Interest rate risk

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

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

The Trust therefore has low exposure to interest rate fluctuations.

Credit risk

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

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

28.2. Financial Assets

	At 'fair value through profit and loss'	Loans and receivables	Available for sale	Total
	£000s	£000s	£000s	£000s
Receivables - NHS	0	5,535	0	**5,535**
Receivables - non-NHS	0	319	0	**319**
Cash at bank and in hand	0	1,484	0	**1,484**
Total at 31 March 2017	**0**	**7,338**	**0**	**7,338**
Receivables - NHS	0	7,692	0	7,692
Receivables - non-NHS	0	680	0	680
Cash at bank and in hand	0	2,065	0	2,065
Total at 31 March 2016	0	10,437	0	10,437

28.3. Financial Liabilities

	At 'fair value through profit and loss'	Other	Total
	£000s	£000s	£000s
NHS payables	0	1,479	**1,479**
Non-NHS payables	0	6,703	**6,703**
Other borrowings	0	4,700	**4,700**
PFI & finance lease obligations	0	14,275	**14,275**
Total at 31 March 2017	**0**	**27,157**	**27,157**
NHS payables	0	2,917	2,917
Non-NHS payables	0	8,878	8,878
Other borrowings	0	3,200	3,200
PFI & finance lease obligations	0	15,034	15,034
Total at 31 March 2016	0	30,029	30,029

29. Events after the end of the reporting period

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

30. Related party transactions

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 is regarded as a related party. During the year the Kent and Medway NHS and Social Care Partnership 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:

Income	**2016/2017**	2015/2016
	£000	£000
Health Education England	**3,099**	3,557
Kent Community NHS Foundation Trust	**1,157**	1,416
NHS Ashford Clinical Commissioning Group	**10,139**	9,677
NHS Canterbury and Coastal Clinical Commissioning Group	**18,931**	18,486
NHS Dartford, Gravesham & Swanley Clinical Commissioning Group	**16,072**	16,440
NHS Thanet Clinical Commissioning Group	**15,963**	16,333
NHS Swale Clinical Commissioning Group	**8,631**	8,377
NHS West Kent Clinical Commissioning Group	**33,097**	34,178
NHS South Kent Coast Clinical Commissioning Group	**21,721**	19,035
NHS Medway Clinical Commissioning Group	**21,024**	22,005
NHS England (including CSUs)	**22,582**	19,549
Department of Health	**54**	2,969

Expenditure	**2016/2017**	2015/2016
	£000	£000
East Kent University Hospitals NHS Foundation Trust	**1,216**	1,201
Maidstone & TW NHS Trust	**694**	2,881
Medway NHS Foundation Trust	**1,087**	997
NHS Pensions Agency	**12,421**	12,095

31. Losses and special payments

The total number of losses cases in 2016-17 and their total value was as follows:

	Total Value of Cases £s	**Total Number of Cases**
Losses	13,148	27
Special payments	61,859	22
Total losses and special payments and gifts	75,007	49

The total number of losses cases in 2015-16 and their total value was as follows:

	Total Value of Cases £s	**Total Number of Cases**
Losses	4,347	25
Special payments	56,844	30
Total losses and special payments	61,191	55

32. Financial performance targets

The figures given for periods prior to 2009-10 are on a UK GAAP basis as that is the basis on which the targets were set for those years.

32.1. Breakeven performance

	2006-07 £000s	2007-08 £000s	2008-09 £000s	2009-10 £000s	2010-11 £000s	2011-12 £000s	2012-13 £000s	2013-14 £000s	2014-15 £000s	2015-16 £000s	2016-17 £000s
Turnover	183,877	186,039	182,839	182,374	182,204	178,468	172,902	174,924	178,674	181,334	183,103
Retained surplus/(deficit) for the year	123	431	1,384	407	(232)	32	(1,604)	(379)	465	(5,661)	(3,575)
Adjustment for:											
Adjustments for impairments	0	0	284	1,308	245	449	2,683	1,895	301	967	0
Adjustments for impact of policy change re donated/government grants assets	0	0	0	0	0	56	56	58	41	54	66
Consolidated Budgetary Guidance - adjustment for dual accounting under IFRIC12*	0	0	0	(191)	0	1	67	33	95	460	198
Other agreed adjustments	0	0	154	0	0	0	0	0	0	0	0
Break-even in-year position	**123**	**431**	**1,822**	**1,524**	**13**	**538**	**1,202**	**1,607**	**902**	**(4,180)**	**(3,311)**
Break-even cumulative position	**123**	**554**	**2,376**	**3,900**	**3,913**	**4,451**	**5,653**	**7,260**	**8,162**	**3,982**	**671**

* Due to the introduction of International Financial Reporting Standards (IFRS) accounting in 2009-10, the Trust's financial performance measurement needs to be aligned with the guidance issued by HM Treasury measuring Departmental expenditure. Therefore, the incremental revenue expenditure resulting from the application of IFRS to IFRIC 12 schemes (which would include PFI schemes), which has no cash impact and is not chargeable for overall budgeting purposes, is excluded when measuring Breakeven performance. Other adjustments are made in respect of accounting policy changes (impairments and the removal of the donated asset and government grant reserves) to maintain comparability year to year.

	2006-07 %	2007-08 %	2008-09 %	2009-10 %	2010-11 %	2011-12 %	2012-13 %	2013-14 %	2014-15 %	2015-16 %	2016-17 %
Materiality test (I.e. is it equal to or less than 0.5%):											
Break-even in-year position as a percentage of turnover	0.07	0.23	1.00	0.84	0.01	0.30	0.70	0.92	0.50	-2.31	-1.81
Break-even cumulative position as a percentage of turnover	0.07	0.30	1.30	2.14	2.15	2.49	3.27	4.15	4.57	2.20	0.37

The amounts in the above tables in respect of financial years 2005/06 to 2008/09 inclusive have **not** been restated to IFRS and remain on a UK GAAP basis.

32.2. Capital cost absorption rate

The dividend payable on public dividend capital is based on the actual (rather than forecast) average relevant net assets based on the pre audited accounts and therefore the actual capital cost absorption rate is automatically 3.5%.

32.3. External financing

The Trust is given an external financing limit which it is permitted to undershoot.

	2016-17 £000s	2015-16 £000s
External financing limit (EFL)	3,821	4,761
Cash flow financing	2,796	4,691
External financing requirement	**2,796**	4,691
Under/(over) spend against EFL	**1,025**	70

The Trust has undershot mainly due to the undershoot in capital limit - see note 32.4 below.

32.4. Capital resource limit

The Trust is given a capital resource limit which it is not permitted to exceed.

	2016-17 £000s	2015-16 £000s
Gross capital expenditure	3,373	7,487
Less: book value of assets disposed of	0	(4,670)
Less: capital grants	0	0
Less: donations towards the acquisition of non-current assets	0	0
Charge against the capital resource limit	**3,373**	2,817
Capital resource limit	4,398	2,817
(Over)/underspend against the capital resource limit	**1,025**	0

The undershoot is due to a capital scheme that will now complete in 2017/18.

33. Third party assets

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 2017 £000s	31 March 2016 £000s
Third party assets held by the Trust	**254**	384

The figures relate to £254k patients monies (£354k 2015/16) and £0 project monies (£30k 2015/16) held on behalf of the TABLO project.