Kent and Medway NHS
NHS and Social Care Partnership Trust

Annual Report

2014 -15

Visit us at www.kmpt.nhs.uk

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Welcome from our Chairman

Here at Kent and Medway NHS and Social Care Partnership Trust, we believe in changing lives through giving excellent care that improves people's mental health. We aim to make it as easy as possible for people to get the NHS healthcare they need at the right time, in the right setting and with the right outcomes.

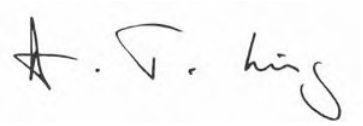
This year, we have made great progress with developing our services and also improving the quality of our buildings so that they provide a good, therapeutic environment and we have started to reduce our sites so that we develop larger, better quality community hubs and in-patient centres. Perhaps the most exciting development in this area was the opening of Upnor ward at the Priority House site in Maidstone, where it interlinks with existing acute mental health services. It was the first permanent mental health unit in the NHS to use an innovative new build process; which is a mix of modular construction methods and traditional techniques. The 18-bedded ward provides en-suite rooms for adult service users requiring mental health treatment in an acute setting. Upnor replaced Emerald Ward, A Block, which was at Medway Maritime Hospital.

Another notable development in our estate improvement programme was the full upgrade of the 136 suite at Priority House in Maidstone. The suite is available as a place of safety for people who are detained under Section 136 of the Mental Health Act 1983 (amended 2007). In 2014 the building underwent a complete refurbishment including installation of CCTV, new furniture and a new kitchen area. Most importantly; police officers now access the suite from the back of the building, which supports the dignity and privacy of the person being detained. The suite now has modern, up-to-date facilities for West Kent and Medway patients and provides a safe, fit-for-purpose environment. We are now progressing plans to upgrade similar suites throughout the county.

Patient safety is always high on our agenda and we have worked hard to reduce the number of restraints and falls with one of our improvement priorities being to continue to reduce the number. It is always a boost to be nationally recognised and in July last year we

won a prestigious national award. The HSJ Patient Safety and Care Awards recognised KMPT's Safeguarding, Managing Risk Tool (SMaRT) as being the most impressive initiative which has made patient care safer and of a better quality. SMaRT has led to general nursing staff working much more closely with mental health professionals and potentially saving lives. It was developed following an increased need to take patients' mental health into account in a general hospital setting in the same way as physical symptoms.

I am always enthused and energised by the professionalism and hard work of our staff, our executive directors and non-executive directors and would like to take this opportunity to thank them all for their continuing commitment and support. I hope that you find the information in this report useful. For future updates see our website www.kmpt.nhs.uk or follow us on Twitter @kmptnhs



Introduction from our Chief Executive

I am delighted to look back at 2014-15 and see clearly the achievements that have been made. It has been another busy year and one that has at times been very challenging but we have continued to deliver our clinical strategy of building services within the community to reduce the number of people needing acute in patient care. We have seen progress over the last year with fewer acute bed days being required overall compared with 2013-14, but of course there is much more still to be done with this.

I also hope the detailed examples in this report of progress we have made demonstrate our ongoing commitment to building high quality and safe services. As you will see we have delivered a great deal and met challenging financial demands.

Our partnership working has continued to grow and during this year we have held two conferences with carers and one with service users. We recognise that by working together with service users and carers we can achieve so much more and are already seeing the outcomes of projects that are being jointly led by carers and KMPT staff.

Making positive changes relies on the energy, commitment and professionalism of our staff. This year the clinical cabinet has continued to lead key areas of work on culture, locality leadership and recovery and has ensured that it's the clinical voice that leads KMPT. Our staff forum has also grown and focused on supporting staff in the critical and often challenging work that they do. There have been many well deserved awards for our staff and their services this year some of which you will see in the report but there are many more that do not necessarily get the recognition they deserve but without whom we could not succeed. I should like to put on record my thanks to everyone who works with Kent and Medway NHS and Social Care Partnership Trust.

About the Trust

Kent and Medway NHS and Social Care Partnership Trust 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 1.7 million, which is spread across 1500 square miles. Our annual revenue is £178 million and we employ 3,318 staff and 228 seconded staff who are located in 83 buildings on 47 sites.

Our vision

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

Our values

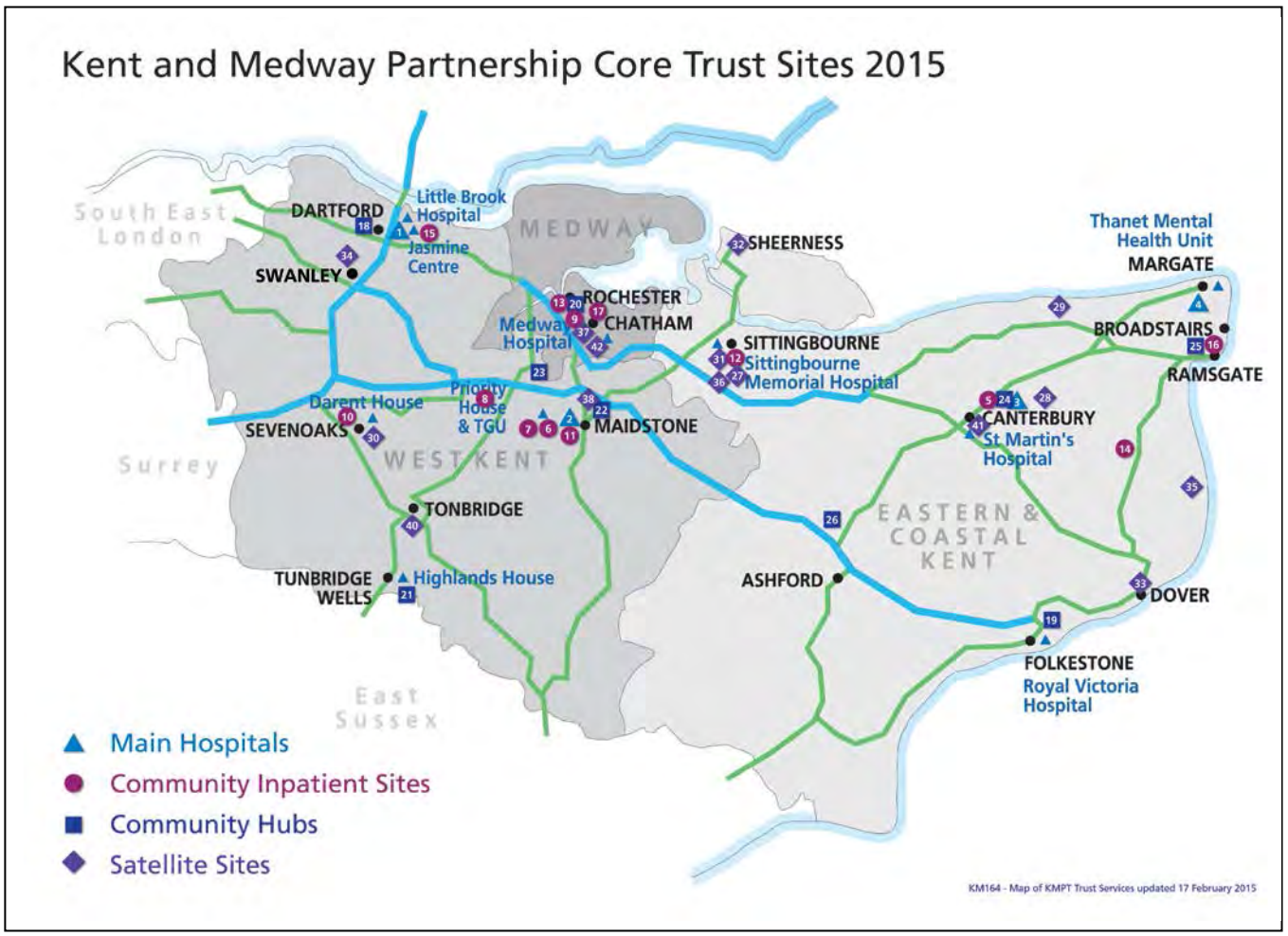
Our values are:

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.

Section one – Strategic objectives and progress

Progress and challenges

Geography



One of the key challenges for us is our geography being spread out across a large number of sites. However, we have reduced our sites over the last two years to develop larger, better quality community hubs and in-patient centres. Having staff located in many different areas has challenged connections and engagement. We have an organisational development programme and new local leadership groups, which are supporting local connections across service lines and teams and this work will continue into this financial year.

Clinical strategy

KMPT developed a clear vision and clinical strategy three years ago and have refreshed it with our new commissioners since then. The strategy has four key strands:

1. Providing services in the community to reduce the number of people who need in-patient care and support the length of stay being as short as possible. Progress in this area has included starting intermediate day treatment services - growing liaison services to provide more timely support for people and increasing home treatment.

   Establishing a recovery approach across the Trust ensuring our care planning and our interventions are focused on what matters to each service user for recovery. Keeping people safe is crucial but we want all our services to go beyond that and to have clear recovery goals.

   Improving the quality of all our services, this includes a real need to address the environments. During the past three years we have built new wards in Canterbury and a new modular ward in Maidstone. As part of the improvement plan, older people's services will be improved at the same time as our IT, which will enable better mobile working and technology to support care across our catchment area.

2. Expanding our specialist services – this includes distributing the expertise in such services into our community and acute service lines. Wider services for those with personality disorders have already been developed and opportunities in forensics and other specialist areas such as Attention Deficit Hyperactivity Disorder, (ADHD) have been identified.

Clinical Cabinet

Two years ago we set up a clinical cabinet to strengthen the clinical voice across the Trust and build a culture of clinical leadership and innovation. The Cabinet is now supporting the local leadership groups where clinical focus is on local issues and generating solutions and redesign. We used a Transformation Programme to make sure the clinical voice and evidence is delivered by project management. We have also increasingly built data driven methods; now supported by a new data system insight, which will give clinicians and managers more real time intelligence on caseloads, length of stay and outcomes to inform their change programmes and their ideas.

Governance framework

We have a very strong governance framework that supports our quality improvement and comprises of three sub-committees and a number of working groups feeding into the Quality Committee and then into the Board.

Partnership and stakeholder engagement

At the heart of our change programme is partnership and we are building stronger engagement with service users and carers who are informing the quality priorities and influencing the solutions alongside clinicians. We have held two carer conferences during the past six months of the year. These have resulted in developing more carer input; such as carer-led work streams on care plans.

During 2014-15 listening to service users and their carers has remained a high priority. In January 2015 KMPT won an award for patient engagement from the Kent, Surrey, Sussex Academic Health science network (KSS AHSN). The 'Outstanding Patient Engagement, Mental Health Providers' award', one of a number given to ground-breaking and high-achievement clinical teams and innovators in the region, recognised the success of a survey sent to people who have used the Trust's Memory Assessment Service.

We have employed peer workers across the Trust with very encouraging feedback and have a peer worker lead post. We are one of four Trusts in the country engaging in the training for Open Dialogue; an innovative approach based on engaging service users, friends and family right from the start and with peer working as a key component.

Several other initiatives to develop partnership and engagement took place during the year under the umbrella of 'Listening, Learning and Improving'. The work of the Expert by Experience group has continued with the community services feedback form and a new method of reporting back to the community mental health teams. The action plan relating to the Appreciative Inquiry into care planning has also continued to be monitored by the group, with work taking place around all 14 of the recommendations.

At the request of service users and carers, KMPT established Carer Consultative Committees in East and West Kent to complement the work of the existing Patient Consultative Committees. Each of the five committees has a representative from the Executive Board to highlight the work of the organisation at every meeting. The committees

also give service users and carers the opportunity to raise issues with the Trust and seek assurance that their voices are heard.

In June 2014 KMPT held its second customer care week with a variety of initiatives and events taking place across the organisation aimed at highlighting the relationship that staff have with service users, carers, partner organisations and each other.

A carer survey, which was designed with input from carer organisations across Kent and Medway, proved to be very successful. The survey is currently being repeated so that the organisation can assess any changes in carer views as a result of actions taken relating to the feedback received.

KMPT has been using the 'Friends and Family Question' for some time and from January 2015 the results began to be shared with the Department of Health. The feedback has been generally very positive and provided staff with a real insight into the patient's experience of their services.

Principles of Remedy

The Parliamentary and Health Service Ombudsman (PHSO) published a policy on 10 February 2009 setting out the principles for remedy for NHS complaints; the report is fully endorsed by the Department of Health and NHS England and should be used as a guide for how public bodies provide remedies for injustice or hardship resulting from maladministration or poor service raised in formal complaints.

The principles of remedy are:

1. Getting it right

2. Being customer focused

3. Being open and accountable

4. Acting fairly and proportionately

5. Putting things right

6. Seeking continuous improvement

KMPT is fully supportive of these principles and we aim to ensure that the PHSO's understanding of these remedies is reflected in our complaints handling and that these are applied to formal complaints made to us. We will also ensure that these principles are embedded within the services we provide to ensure that they apply the same principles to their complaints handling; this is achieved through regular 'learning from experience meetings'.

The PHSO's remedies also align with HM Treasury's guidelines of remedy as set out in Managing Public Money and are cited as best practice in the NHS Finance Manual.

The Trust has a complaints policy that explains how we will handle formal complaints and what complainants can expect when they make a complaint. The policy also sets out how we report, learn from and monitor complaints. The CCG is committed to ensuring that everyone who provides feedback on their experience, whether they are making a formal complaint or not, is treated with respect and compassion and provided with an open, honest and clear response. The Trust's complaints policy also ensures that the PHSO's policies of Good Administration and Good Complaint Handling are applied.

If a complainant is dissatisfied with our response to their complaint, we will always do our best to put things right, answer any further questions or provide more information. Where a complainant has approached the PHSO we are committed to working with the PHSO and co-operating with any investigation that they undertake. If the PHSO decides that there is fault in the way we have handled a complaint, we will carry out any necessary remedial action.

Complaints are an important source of feedback and for this reason we commit to always taking complaints seriously. Although the PHSO's principles of remedy apply to formal complaints, we want to apply these principles to all feedback we receive and ensure that everyone who contacts us is treated the same way. Our complaints policy is available on our website.

Community care

We have built much stronger liaison services to improve our community care and keep people out of acute services where appropriate. We now have liaison teams working seven days a week across the Trust and we are very proud of the HSJ national safety award that we won last year for the Smart tool that allows A&E teams to risk assess people much more accurately. The strengthened teams are able to respond more quickly and reduce the demand on crisis teams who can now place more focus on home treatment.

We established a new intensive day treatment service in Medway last autumn and have seen a reduction of 85% in the urgent presentations made by that cohort of people. That has made a huge impact on those with a personality disorder who have given positive feedback to the Board.

We set up a street triage pilot with the police which initially reduced 136s (Refers to those people who are detained under Section 136 of the Mental Health Act 1983, which was amended 2007) and has seen improved joint working. We are now working with the police to evaluate how to provide this in a more sustainable and appropriate way in the future.

Contact centre

A mental health contact service was set up in November 2014, enabling service users, their families and carers, professionals and the public, to access a mental health response at any time using a single telephone number. We are currently planning on improving this service over the next year to develop a mental health contact and response service. The service will be staffed by health care professionals who are ‘ready to treat’ and able to make informed decisions about the most appropriate next steps for an individual. The clinical team will be able to make decisions about eligibility and urgency of need. They will tele-triage the referral to determine the next steps, which may include onward booking of an appointment or signposting to another service that could better meet a person’s need. These changes will transform the experience of those needing a mental health response.

Safety

During the year we joined the safety collaborative to support our quality strategy and have seen significant improvements including a huge reduction in any absences without leave (AWOL).

We have also developed clear pathways with our clinical leaders and are seeing emerging case management approaches through our local leadership groups, for example; where they regularly look at the top 20 service users on the patch and have peer challenge into the case management to improve recovery and reduce representations.

Self-harm and suicide are always the top concern in safety terms. We had a rise in our suicide figures two years ago and put a great deal of focused work into suicide prevention and risk assessment. Our numbers reduced significantly and we continue to prioritise this through the safety collaborative. There have been no suicides on our wards since 2012.

We are working with commissioners and the local medical committees to support primary care in taking back service users who no longer need our support – giving them confidence as well as assurance regarding quick access if they need to re-refer or get advice. We are also creating multi-disciplinary teams in hubs to peer support discharge decision making.

We have a programme in place to improve care planning. Service users are involved in this planning and we are ensuring that the recovery plans can be entered easily and without duplication.

Exemplary employer

Staff by Age Band - table 1

Count of Employee	
Age Band (16-65)	Total
16-20	35
21-25	151
26-30	237
31-35	342
36-40	376
41-45	469
46-50	537
51-55	518
56-60	372
61-65	202
Over 65	79
Grand Total	3318

Staff by sex – table 2

Percentage	Column levels
Gender split	2014-15
Female	72.91
Male	27.09
Grand total	100

Staff by profession – table 3

Staff Group	Headcount
100 Medical and Dental	**168**
Of which are - Consultants	89
130 Managers and Senior Managers	**49**
140 Administration and Estates	**700**
150 Support Staff(Including Hcas And Other Support Staff)	**933**
160 All Qualified Nursing, Midwifery And Health Visiting Staff	**882**
180 All Qualified Scientific, Therapeutic And Technical Staff	**554**
Of which are - Allied Health Professionals	227
210 Others	**32**
Of which are - Students	24
Of Which are - Non Executives	8
Grand Total	**3318**

Staff turnover for 2014-15 was 20.29 per cent of which the majority was related to Band 2 and Band 5 along with Medical Rotations. This is an increase on last year. We set a challenging target of 3.9 per cent staff absence rate for the Trust in 2014-15. We achieved a rate of 4.3 per cent, which is consistent with 2013-14.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 absence disclosures – table 4

Sickness Absence Report

		Statistics Produced by hscic from ESR Data Warehouse		Figures Converted by DH to Best Estimates of Required Data Items		
		Quarterly Sickness Absence Publications	Monthly Workforce Publication			
OCS Code	Name	Average of 12 Months (2014 Calendar Year)	Average FTE 2014	FTE-Days Available	FTE-Days Lost to Sickness Absence	Average Sick Days per FTE
RXY	Kent and Medway NHS and Social Care Partnership Trust	4.4%	2,872	646,223	28,397	9.9

Staff by ethnicity – table 5

Count of Employee	
Ethnic Origin	Total
A White - British	2444
B White - Irish	49
C White - Any other White background	123
D Mixed - White & Black Caribbean	5
E Mixed - White & Black African	4
F Mixed - White & Asian	16
G Mixed - Any other mixed background	18
H Asian or Asian British - Indian	130
J Asian or Asian British - Pakistani	16
K Asian or Asian British - Bangladeshi	3
L Asian or Asian British - Any other Asian background	84
M Black or Black British - Caribbean	36
N Black or Black British - African	246
P Black or Black British - Any other Black background	18
R Chinese	5
S Any Other Ethnic Group	51
Z Not Stated	70
Grand Total	3318

Equal Opportunities

The majority of the Trust's workforce is white with approximately 19 per cent from black and ethnic minority communities.

In comparison, 6.94 per cent of the entire population of Kent and Medway is from a black or ethnic minority community. This shows that the Trust's workforce is diverse with excellent representation from minority ethnic groups. See page 24 for more information on equality and diversity.

During the past year KMPT has made huge strides in becoming an exemplary employer. Not only has the Trust been identified as one of three pilot sites by NHS Employers and the RCN to undertaken a critical piece of work on cultural re-alignment post Francis Report, it has taken serious steps to develop collective leadership; improve cross service line collaborations and clinical medical leadership – all of which will have a positive impact on service user experience.

The Trust is continually improving engagement with staff. During the latter half of the year, KMPT held three 'Big Organisational Development' events in each of the three localities of North, West and East Kent on how to strengthen local decision-making; improve team effectiveness and leadership.

The continued development of clinical Local Leadership Groups (LLGs) and the introduction of new cross service line solution groups are at the forefront of knowledge sharing and inter-service co-operation so that staff become even more involved in improving outcomes and driving quality for our service users.

Comprehensive Organisational Development and leadership strategies which underpin a portfolio of change management initiatives, projects and interventions designed to continuously develop staff; nurture talent; listen to reflective feedback and create a culture where staff can be ambassadors of a progressively changing work environment. KMPT is committed to developing and maintaining a 'well-led domain' as described by the King's Fund and has engaged the Pacific Institute to help embed the changes to facilitate this throughout the next year.

KMPT has a Joint Negotiating Forum, which provides a platform from which issues relating to the terms and conditions of employment for staff; changes to service provision and new

ways of working can be negotiated, and the basis for a productive and collaborative working culture can be developed and maintained in partnership.

The results of the 2014 staff survey were published in February 2015. KMPT management and Staff Side representatives have acknowledged that; whilst results are recognised as an improvement on the 2013 response, there is always room for further improvement. Three aspects worth highlighting are:

1. 72% of staff feel that they can raise a concern about unsafe clinical practice - the national average was 69%.

2. 43% of KMPT staff reported good communications with senior management - the national average for 2014 was 30%.

3. 60% of staff agreed that feedback from patients/service users is used to make informed decisions in their directorate/department - the national average for 2014 was 53%

During Spring 2015, staff-led focus groups will review those areas that could be improved so that the outcomes of the next staff survey are even better.

Cost allocation and charges for information

I can confirm that the Trust is compliant with HM Treasury guidance for cost allocations and charges for information.

Clinical models

The continual development of dynamic and innovative clinical models, to enhance the quality, safety and effectiveness of services is vital for the organisation to deliver excellent mental health and wellbeing interventions, in partnership with our clients and other stakeholders.

Clinical innovation is achieved by ensuring care is always evidence-based and delivered through an integrated, well-led and organised seamless system.

Evidence based clinical care is achieved through:

- Active communication and partnership working with our clients, their carers and our service user advisory groups - understanding the recovery journey goals of our clients is central to our work.

- Partnership working with all those contributing and supporting clinical care - the practice based evidence that they contribute to the development of individual care interventions and systems of care are crucial.
- The rigorous implementation of NICE recommended treatment interventions and our involvement in national NICE guidance development initiatives.
- Participation in national clinical research programmes, such as the Open Dialogue approach to partnership working with clients experiencing psychotic difficulties. This participation enables active learning with our service users, clinical peers and the national and international research communities.

Care delivered through integrated, well-led and organised systems is being achieved by:

- Ensuring a multi-professional team approach to care, delivered in partnership with our clients.
- The development of a single point of access to ALL our mental health services, to ensure our clients receive the most appropriate and effective treatment as quickly as possible.
- A review of the work of care co-ordinators within our teams, to enhance the support clients require to navigate their recovery journeys.
- The on-going work of our local leadership groups, tasked with overviewing the whole system of care in each of our geographical areas to ensure a seamless pathway of care for our clients, made possible by effective cross service partnership working.

Thus, through this active integration of evidence based practice, delivered through robust care systems, we look to continually develop clinical models that will deliver safe and effective clinical care of the highest quality, which remain client and care centred at all times.

Section two – quality and performance

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.

The Transformation Programme structure covers CRES (Cost Improvement Programmes) and Quality Impact Assessments undertaken through a Star Chamber review by the medical and nursing directors and a Quality Committee review of decisions. The QIAs are updated and monitored by the Transformation Board and reported to and overseen by the Quality Committee.

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 Integrated Quality and Performance Report (IQPR) has been provided in the new format since April 2014. It provides a Trust summary performance report and a breakdown of areas of under performance and over performance by service line. 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. It also provides an action orientated performance management report with a focus on the trust priorities of access, recovery and workforce management. These will be reported on a rolling programme as performance issues and risks are resolved and identified throughout the year.

Data is provided at Trust-wide, service line, corporate department and team or ward level. This enables the Board and service lines to effectively manage service line performance by drilling down to ensure that good performance is not masking under performance in another area.

The use of an integrated approach to quality and performance will help 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.

KPI's – table 6

Key Performance Indicator	2014-15 Year End	Target	Local / National
Admissions gatekept by CRHT (%)	100.0%	90.0%	National
CPA 7-day follow-up (%) Enhanced Only	96.1%	95.0%	National
Delayed transfers of Care (Monitor/CareQuality Commission)	5.6%	<7.5%	National
MHMDS completeness (Monitor definition, %)	90.3%	50.0%	National
Adults having received a 12 month CPA review (Monitor Definition, %)	95.0%	95.0%	National
Meeting commitment to serve new psychosis cases by early intervention teams	127.9%	100.0%	National
Certification against compliance with requirements regarding access to health care for people with a learning disability	Compliant	Compliant	National
Adults with CPA care plans (%)	95.5%	95.0%	Local
% of patients with valid CPA care plan or plan of care	91.5%	95.0%	
Emergency readmissions within 28 days (younger, %)	9.8%	<5%	Local
Emergency readmissions within 28 days (older, %)	5.2%	<5%	Local
Length of stay (younger, days)	30.3	<25	Local
Length of stay (older, days)	78.2	<52	Local
Referral to assessment within 4 weeks	83.9%	95.0%	Local
18 Weeks referral to treatment	90.8%	95.0%	Local
% Reviews undertaken within the maximum cluster review period	69.4%	95.0%	Local
% of service users assessed with cluster assigned	91.0%	95.0%	Local

Delivery of quality and operational performance standards

Agreement on the Trust's quality improvement priorities is made through discussion with a wide range of clinicians, service users and carers and using external feedback such as patient and staff survey results and national benchmarking of current performance against highest achievers.

Consultation and agreement of key improvements to be delivered over the next year:

- Safe - risk management of ligature and ligature points

- 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 -management of violence, restraint, control and seclusion
- Responsive - complaints handling
- Well led - caseload management

KMPT's performance strategy ensures the delivery of strategic and corporate objectives whilst instilling a culture of continuous performance improvement. The performance strategy recognises that performance management is integral to the Trust achieving its strategic aims and outcomes and needs to be embedded across the organisation.

The strategy will be delivered through the Trust's framework for performance management, which describes the arrangements and accountabilities that will translate the strategy into a workable process for driving improvement in operational performance. The Trust will ensure systems and processes are in place to comply with all aspects of external scrutiny and to achieve and exceed performance against internally and externally developed targets and standards.

The annual plan reflects changes to the profile of demand for our services:

- The impact of the implementation of our planned service developments
- The impact of changes to the health and social care economy within which we operate
- The impact of the annual commissioning intentions issued by our CCGs
- Changes to how mental health services are delivered. For example, the increased focus on more partnership delivery models of care
- Changes to how mental health services will be commissioned. For example, the introduction of care pathways and pricing contracts, which will be paid for cluster based activity and the delivered of specified outcomes.

The requirement to do more for less is an increasing feature of health and social care delivery. It is therefore essential that KMPT is able to deliver on-going improvements in all aspects of performance – finance, efficiency, clinical effectiveness, quality, safety, patient experience and workforce, all underpinned by a high level of data quality.

Financial priorities include the achievement of 4.5% CIP and the management of contracts transition to PbR but with elements of block in 2015-16. The focus in 2015-16 will be on whole system benefits as a result of investing in service developments. There are four key elements:

- personality disorder services
- A&E liaison services
- older people's services, including dementia
- acute day treatment.

The annual operating priority is to enhance access to Mental Health Care, maintaining and exceeding current quality and operational standards and meeting the new standards: 75% of people referred to primary care psychological therapies seen within six weeks and 95% within 18 weeks and 50% of people referred with psychosis seen within two weeks.

Section three – How we are organised

Trust Board - Board of Directors

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 Human Resources are non-voting directors.

Executive directors are full-time employees of the Trust and non-executive directors are appointed by the NHS Development Authority. 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 2014-15 there were some changes to the composition of the Board Malcolm McFrederick was appointed as the substantive Director of Operations in January 2015 after joining the Trust in February 2014 on an interim basis. Mick Bull, Director of Finance, left the organisation in June and Philip Cave joined the Trust in January 2015 as the new substantive Director of Finance, replacing David Meikle, who joined the Trust on an interim basis on 23 June 2014.

Board membership 2014-15 – table 7

Non-executive Directors	Executive directors
Andrew Ling	Angela McNab – Chief Executive
Margaret Andrew	Ivan McConnell – Executive Director of Transformation and Commercial Development
Mark Bryant	Catherine Kinane – Executive Medical Director

Tom Phillips	Pippa Barber – Executive Director of Nursing and Governance
Anne-Marie Dean	Mick Bull – Executive Director of Finance*
Rodney Ashurst	David Meikle – Executive Director of Finance (interim)**
Richard Page	Philip Cave – Executive Director of Finance***
Michael Sander	Nikki Prince, Director of Human Resources
	Malcolm McFrederick, Director of Operations****

* Left on 27 June 2014

****** joined on 23 June 2014 to 31 December 2014

*** joined the Trust on 5 January 2015

**** joined the Trust as an interim on 10.02.14 and was made substantive on 6 January 2015

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 2014-15 – table 8

Non-executive directors 2014-15	Actual / possible
Andrew Ling	6/6
Margaret Andrew	4/6
Mark Bryant	4/6
Tom Phillips	5/6
Anne-Marie Dean	4/6
Rod Ashurst	5/6
Richard Page	4/6
Michael Sander	6/6

Executive directors 2014-15	Actual / possible
Angela McNab	5/6
Ivan McConnell	5/6
Catherine Kinane	6/6
Pippa Barber	6/6
Mick Bull	1/1
David Meikle	3/3

Executive directors 2014-15	Actual / possible
Philip Cave	2/2
Nikki Prince	5/6
Malcolm McFrederick	6/6

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 Bodies. His role at BT was not involved in selling to or dealing with any part of the NHS.
Mark Bryant	Non-Executive Director	None declared
Richard Page	Non-Executive Director	None declared

None	Job title	Interest declared
Tom Phillips	Non-Executive Director	None declared
Michael Sander	Non-Executive Director	None declared
Ann-Marie Dean	Non-Executive Director	None declared
Executive Directors		
Angela McNab	Chief Executive	None declared
Pippa Barber	Executive Director of Nursing and Quality	None declared
Catherine Kinane	Medical Director	None declared
David Meikle *	Director of Finance	Director at Pricewater Consulting Limited
Philip Cave	Director of Finance	None declared
Ivan McConnell	Director of Transformation and Commercial Development	None declared
Malcolm McFrederick	Director of Operations	Director, M and James Ltd., Healthcare Consultancy
Nikki Prince	Director of Human Resources	None declared

* interim appointment. Please see above

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.

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
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.

Michael Sander

BSc, M.Phil, FRICS, MRTPI, MCIH (Chartered Surveyor, Town Planner, and Member of the Institute of Housing)

Michael was appointed in September 2007. He has worked in the private, voluntary and public sectors. Michael was Chief Executive of Crawley Borough Council (inc Gatwick Airport) from 1984 to 2002. He has experience in corporate management including communications, competitive tendering, finance, change management, HR and ICT; and in construction, estate and land development. He is a Trustee of the Commonwealth Housing Trust, and works as an International Election Observer. Michael is Deputy Chair of the Finance and Performance Committee.

Richard Page

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.

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 and Deputy Chairman of the Quality 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.

Executive Directors

Angela McNab

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.

Malcolm McFrederick

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.

Pippa Barber

Executive Director of Nursing and Governance R.N. Bcs (Hons) Health Service Management, BSc (Hons) Psychology, Post Graduate Diploma Health Policy

Appointed in April 2011, Pippa qualified as a Nurse in 1987 at the Middlesex Hospital London. She has held a range of clinical posts both in Acute and Community settings before taking up Management posts. Pippa has worked as a Director of Community Services, Primary Care and Commissioning. For the past few years she was working with NHS Medway as Director of Clinical Performance and Executive Nurse.

Dr 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

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.

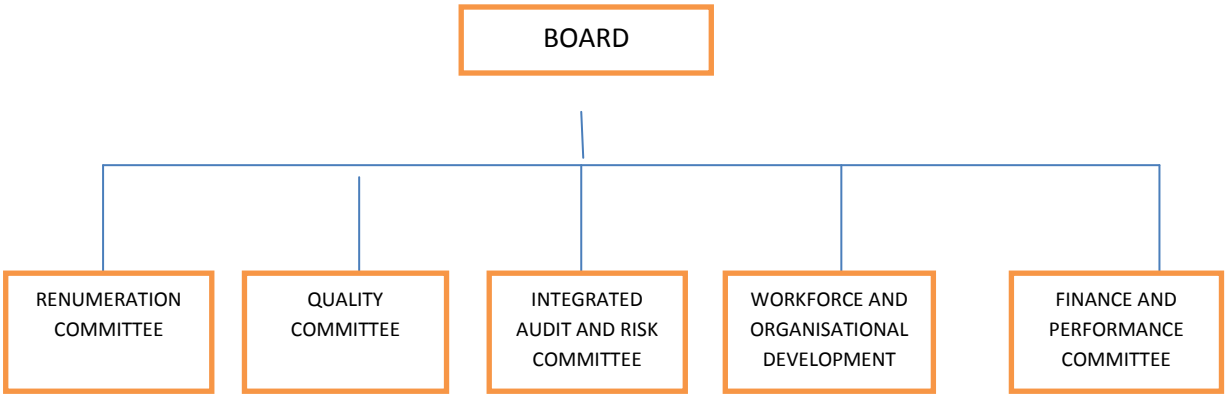
Nikki Prince

Human Resources Director Chartered Member CIPD

Nikki was appointed to the Trust Board from January 2012 having already worked for the Trust as HR Director since 2009. Nikki is no stranger to mental health having worked at the former East Kent Mental Health Trust and has also held senior HR roles at Maidstone PCT and East Kent Health Authority over a 13 year NHS career. Nikki has also been the Project Manager for ESR on behalf of several Kent and Medway Trusts and the Project Manager for Agenda for Change during her time at Maidstone.

Governance Structure - Board committees

The Trust Board has five committees to support it in discharging its duties fully. 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 seven times during 2014-15. 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 2014-15 period. Richard Page and Margaret Andrews also sit on this committee. Pippa Barber is the executive lead for this committee alongside Phillip Cave.

Audit and Risk Committee – table 10

Members	**Actual / possible**
Tom Phillips (Chair)	6/7
Richard Page (Vice Chair)	6/7
Margaret Andrews	4/7

Quality Committee

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

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

- 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 committee meets on a monthly basis and has two non-executive directors and two executive directors' members. The committee is chaired by Margaret Andrews. Mark Bryant also sits on this committee, alongside Catherine Kinane (executive lead for quality) and Pippa Barber.

Quality Committee – table 11

Members	**Actual / possible**
Margaret Andrews (Chair)	9/12
Mark Bryant (Vice Chair)	8/12
Rod Ashurst	6/12
Pippa Barber	9/12
Catherine Kinane	12/12

Finance and Performance Committee

The Finance and Performance Committee changed its name from the Finance and Resourcing Committee during the year to reflect the committee's enhanced role in monitoring 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 was chaired by Mark Bryant for 2014-15. Richard Page and Michael Sander are also members of this meeting. The executive lead for the committee is Philip Cave. Ivan McConnell and Malcolm McFrederick are also members of the committee.

Finance and Performance Committee – table 12

Members	Actual / possible
Mark Bryant (Chair)	9/10
Michael Sander (Vice Chair)	8/10
Richard Page	7/10
Mick Bull	4/4
David Miekle	3/4
Philip Cave	3/3
Malcolm McFrederick	9/10
Ivan McConnell	9/10

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 2014-15 the committee was chaired by Rodney Ashurst. Anne-Marie Dean is also a member of the committee. Nicola Prince is the lead director for this committee, which also has Malcolm McFrederick as a member.

Workforce and Organisational Development Committee – table 13

Members	Actual / possible
Rod Ashurst (Chair)	6/7
Anne-Marie Dean (Vice-Chair)	7/7
Nikki Prince	6/7
Malcolm McFrederick	7/7

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 is chaired by Margaret Andrews, Deputy Chair. It meets at least annually and on an ad hoc basis as required. During 2014-15 the committee met four times

Remuneration Committee – table 14

Members	Actual / possible
Margaret Andrew (Chair)	4/4
Andrew Ling	4/4
Mark Bryant	4/4
Tom Phillips	4/4
Anne-Marie Dean	3/4
Rod Ashurst	4/4

Members	Actual / possible
Richard Page	3/4
Michael Sander	4/4

Remuneration report

Salary Table 2014-15 table 15

Name and title	Salary (bands of £5k)	Expense payments (taxable) to nearest £100	All Pension related Benefits (bands of £2,500)	TOTAL (bands of £5k
	£000	**£00**	**£000**	**£000**
Mrs Angela McNab - Chief Executive Officer	150-155	7	2.5-5	155-60
Mr Mick Bull - Director of Finance and Resources. Resigned 16.7.2014	30-35	1	75-77.5	110-115
Mr David Meikle - Interim Director of Finance Interim from June 2014 to December 2014	100-105*	-	-	100-105*
Mr Philip Cave - Executive Director of Finance In post from 5.1.2015	25-30	-	32.5-35	60-65
Dr Catherine Kinane - Executive Medical Director	175-180	3	30-32.5	210-215
Mr Malcolm McFrederick - Interim Executive Director of Operations. Interim from April 2014 to December 2014, Permanent position from 5.1.2015	275-280*	-	60-62.5	335-340*
Mr Ivan McConnell - Executive Director of Commercial and Transformation	115-120	-	30-32.5	145-150
Mrs Pippa Barber - Executive Director of Nursing and Governance	100-105	2	-	100-105
Mrs Nikki Prince - Director of Human Resources	85-90	1	2.5-5	90-95
Mr Andrew Ling - Chairman	20-25	5	-	20-25
Mr Michael Sander - Non Executive Director	5-10	2	-	5-10
Professor Margaret Andrews - Non Executive Director	5-10	1	-	5-10
Mr Richard Page - Non Executive Director	5-10	2	-	5-10
Mr Tom J Philips - Non Executive Director	5-10	3	-	5-10
Mr Rod Ashurst - Non Executive Director	5-10	1	-	5-10
Mr Mark Bryant - Non Executive Director	5-10	1	-	5-10
Anne-Marie Dean - Non Executive Director	5-10	8	-	5-10
*Includes Agency Fees				

Expenses payments refer to the taxable element of the mileage reimbursement rate above the HMRC rate.

Salary Table 2013-14 table 16

2013-14

SALARY TABLE				
Name and title	Salary (bands of £5k)	Expense payments (taxable) to nearest £100	All Pension related Benefits (bands of £2,500)	TOTAL (bands of £5k
	£000	£00	£000	£000
Mrs Angela McNab - Chief Executive Officer	150-155	7	10-12.5	160-165
Mr Mick Bull - Director of Finance and Resources.	110-115	-	5-7.5	115-120
Dr Karen White - Executive Medical Director resigned 31st January 2014	145-150	-	30-32.5	175-180
Dr Catherine Kinane - Interim Executive Medical Director. In post from 1st Feb 2014	25-30	-	30-32.5	55-60
Ms Marie Dodd - Executive Director of Operations. Resigned 25th February 2014	95-100	-	-	95-100
Mr Malcolm McFrederick - Interim Executive Director of Operations. In post from 10th February 2014.	50-55*	-	-	50-55*
Mr Ivan McConnell - Executive Director of Commercial and Transformation. In post from 12th August 2013	70-75	-	5-7.5	75-80
Mr Michael Seitz - Interim Executive Director of Commercial and Transformation. Resigned July 2013	110-115*	-	-	110-115*
Mrs Pippa Barber - Executive Director of Nursing and Governance	100-105	-	10-12.5	110-115
Mrs Nikki Prince - Director of Human Resources	85-90	1	10-12.5	100-105
Mr Andrew Ling - Chairman	20-25	2	-	20-25
Mr Paul Godwin - Non Executive Director. Resigned 31st October 2013	0-5	-	-	0-5
Mr Michael Sander - Non Executive Director	5-10	2	-	5-10
Professor Margaret Andrews - Non Executive Director	5-10	2	-	5-10
Mr Richard Page - Non Executive Director	5-10	2	-	5-10
Mr Tom J Philips - Non Executive Director	5-10	4	-	5-10
Mr Rod Ashurst - Non Executive Director	5-10	1	-	5-10
Mr Mark Bryant - Non Executive Director	5-10	1	-	5-10
Anne-Marie Dean - Non Executive Director. In post from 1st November 2013	0-5	-	-	0-5
*Includes Agency Fees				

Pension Table 2014-15 table 17

Pension Benefits Table 2014-2015	(bands of £2,500)	(bands of £2,500)	(bands of £5,000)	(bands of £5,000)				
Name and Title	Real increase in pension at age 60	Real increase in pension lump sum at age 60	Total accrued pension at age 60 at 31 March 2015	Lump sum at age 60 related to accrued pension at 31 March 2015	Cash Equivalent Transfer Value at 1 April 2014	Real increase in cash Equivalent Transfer Value	Cash Equivalent Transfer Value at 31 March 2015	Employers Contribution to stakeholder pension
	£000	**£000**	**£000**	**£000**	**£000**	**£000**	**£000**	**£000**
Angela McNab - Chief Executive	0-2.5	-	15-20	-	193	37	235	-
Michael Bull - Executive Director of Finance and Resources - Resigned 16.7.2014	0-2.5	2.5-5.0	50-55	160-165	957	29	1,082	-
Philip Cave - Executive Director of Finance - In post from 5.1.2015	0-2.5	0-2.5	15-20	45-50	168	6	200	-
Catherine Kinane - Executive Medical Director	0-2.5	5-7.5	35-40	110-115	623	80	721	-
Malcolm McFrederick - Executive Director of Operations - Permanent post from 5.1.2015	0-2.5	0-2.5	10-15	40-45	226	15	294	-
Ivan McConnell - Executive Director of Transformation and Commercial Development	0-2.5	-	2.5-5.0	-	9	28	37	-
Pippa Barber - Executive Director of Nursing and Governance	0-2.5	0-2.5	25-30	80-85	472	23	508	-
Nikki Prince - Director of Human Resources	0-2.5	0-2.5	15-20	45-50	261	21	289	-

Pension Tables 2013-14 Table 18

Name and Title	Real increase in pension at age 60	Real increase in pension lump sum at age 60	Total accrued pension at age 60 at 31 March 2015	Lump sum at age 60 related to accrued pension at 31 March 2015	Cash Equivalent Transfer Value at 1 April 2014	Real increase in cash Equivalent Transfer Value	Cash Equivalent Transfer Value at 31 March 2015	Employers Contribution to stakeholder pension
	£000	**£000**	**£000**	**£000**	**£000**	**£000**	**£000**	**£000**
Angela McNab - Chief Executive	2.0-2.5	-	10-15	-	151	39	193	-
Michael Bull - Executive Director of Finance and Resources	0-2.5	2.5-5.0	45-50	145-150	893	44	957	-
Dr Karen White Executive Medical Director. Resigned 31st January 2014	0-2.5	5.0-7.5	55-60	175-180	1,130	-	-	
Catherine Kinane - Executive Medical Director. In post from 1st February 2014	2.0-2.5	5.0-7.5	30-35	100-105	555	57	623	-
Marie Dodd - Executive Director of Operations. Resigned 25th February 2014	-	-	20-25	60-65	419	5	434	
Ivan McConnell - Executive Director of Transformation and Commercial Development	0-2.5	-	0-5	-	-	9	9	-
Pippa Barber - Executive Director of Nursing and Governance	0-2.5	2.5-5.0	25-30	80-85	430	32	472	-
Nikki Prince - Director of Human Resources	0-2.5	2.5-5.0	10-15	40-45	231	24	261	-

Exit Packages

Agreed in 2014-15 table 19

	2014-15						2013-14					
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 by cost band**	**Total cost of exit packages by cost band**	Number of compulsory redundancies	Cost of compulsory redundancies	Number of other departures agreed	Cost of other departures agreed	Total number of exit packages by cost band	Total cost of exit packages by cost band
	Number	**£s**	**Number**	**£s**	**Number**	**£s**	Number	£s	Number	£s	Number	£s
Less than £10,000	**0**	**0**	**1**	**2,000**	**1**	**2,000**	5	15,556	0	0	5	15,556
£10,000-£25,000	**3**	**33,673**	**0**	**0**	**3**	**33,673**	11	205,300	0	0	11	205,300
£25,001-£50,000	**2**	**80,954**	**0**	**0**	**2**	**80,954**	7	242,154	1	36,000	8	278,154
£50,001-£100,000	**0**	**0**	**0**	**0**	**0**	**0**	1	51,566	0	0	1	51,566
Total number of exit packages by type and total resource cost	**5**	**114,627**	**1**	**2,000**	**6**	**116,627**	24	514,576	1	36,000	25	550,576

Redundancy and other departure costs have been paid in accordance with the provisions of the NHS Pensions Scheme. Exit costs in this note are accounted for in full in the year of departure. Where the Trust has agreed early retirements, the additional costs are met by the Trust and not by the NHS pensions scheme. Ill-health retirement costs are met by the NHS pensions scheme and are not included in the table.

This disclosure reports the number and value of exit packages agreed in the year. These were incurred as a result of the efficiency programme and also a change in contract arrangements for the Primary Care Psychological Therapy Service. Note: the expense associated with these departures may have been recognised in part or in full in a previous period

Exit Packages – Other Departures Analysis table 20

	2014-15		2013-14	
	Agreements	**Total value of agreements**	Agreements	Total value of agreements
	Number	**£000s**	Number	£000s
Exit payments following Employment Tribunals or court orders	**1**	**2**	1	36
Total	**1**	**2**	1	36

As a single exit packages can be made up of several components each of which will be counted separately in this Note, the total number above will not necessarily match the total numbers in Note 9.4 which will be the number of individuals.

Median Salary

Median Salary		April - Dec 14 (Agency)	Jan - Mar 15 (+3 months contracted salary)
Highest	Malcolm McFrederick *	£245,214.00	£277,714.00
Median Salary	Row 1659	20,925.60	20,925.60
Highest Paid person was paid * times more than median		12	13

*This payment for the Director of Operations during 2014-15 included agency fees as this was

as an interim. The Director has now taken up the permanent role from 1 January 2015 and therefore will be in line with other Directors pay from 2015-16.

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 organisation) in the financial year 2014-15 was £275k-£280k (2013-14 - £150-155k)

This was 13 times (2014-15) (2013-14 was 7 times) the median remuneration of the workforce, which was £20,925.60 (2013-14 - £21,388)

In 2014-15 0 employees received remuneration in excess of the highest paid director. (2013-14 – 0)

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

Off Payroll engagements

Table 1

For all new off-payroll engagements between 1 April 2014 and 31 March 2015, for more than £220 per day and that last longer than six months:

	Number
Number of existing engagements as of 31 March 2015	0
Of which, the number that have existed:-	
for less than one year at the time of reporting	0
for between one and two years at the time of reporting	0
for between two and three years at the time of reporting	0
for between three and four years at the time of reporting	0
for between four or more years at the time of reporting	0

Table 2

For all new off-payroll engagements between 1 April 2014 and 31 March 2015, for more than £220 per day and that last longer than six months:

	Number
Number of new engagements, or those that reached six months in duration, between April 2014 and 31 March 2015	7
Number of new engagements which include contractual clauses giving Kent & Medway NHS Trust the right to request assurance in relation to Income Tax and National Insurance obligations	7
Number for whom assurance has been requested	4
Of Which:-	
assurance has been received	4
assurance has not been received	0
engagements terminated as a result of assurance not being received	0
Number of off-payroll engagements of board members, and/or senior officers with significant financial responsibility, during the year	3
Number of individuals that have been deemed 'board members, and/or senior officers with significant financial responsibility' during the financial year. This figure includes both off-payroll and on-payroll engagements	35

An Overview of Sustainability Plans

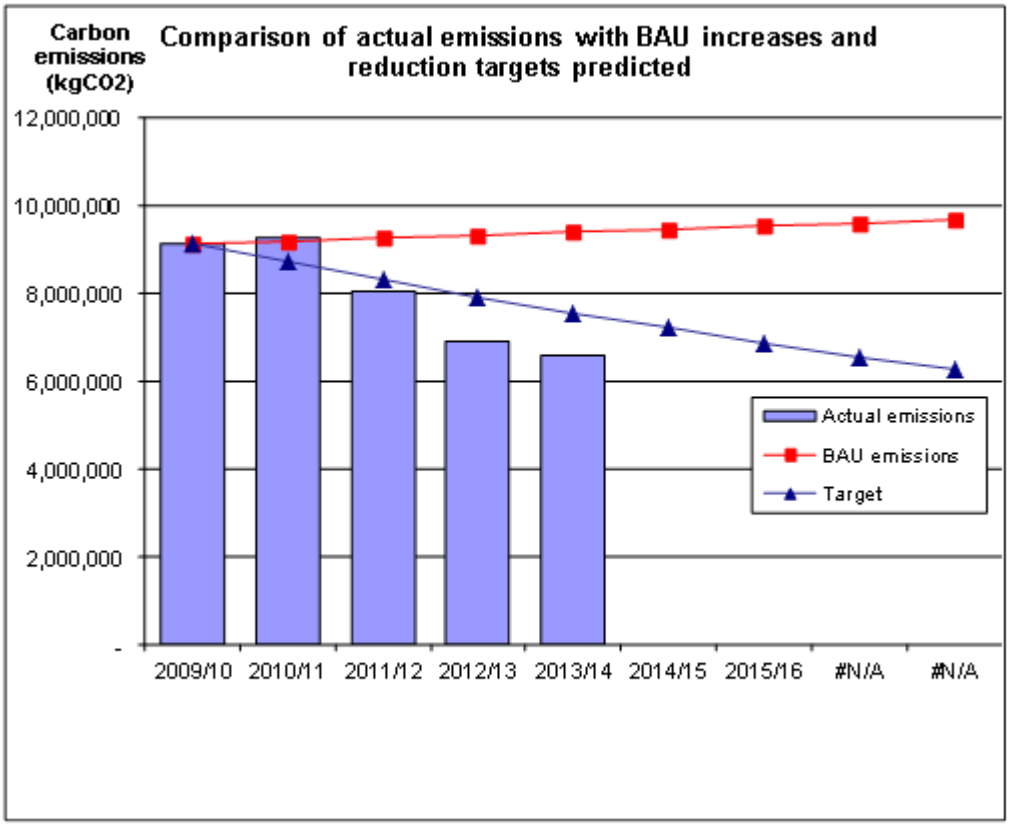
KMPT, along with all NHS Trusts is committed to tackling climate change. Reducing our carbon emissions will help tackle climate change. National drivers, such as government and NHS targets and the Carbon Reduction Commitment, as well as local drivers, encourage us to manage our carbon.

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

In 2009/10 the Trust had an objective to achieve a minimum 15% reduction on carbon utilisation by 2015-16 and we pleased to announce that, 2013-14 data shows a 27% reduction in carbon has exceeded the 15% target initially set by the Carbon Trust. This can be partly attributed to the huge efforts by staff across Trust as well as a dedicated Estates team who help in modernising the Estates through the Transformation Programme.

On another positive note, the Trust entered into a major flagship contract, the Energy Performance Contracts with SKANSKA to help drive the carbon reduction. The Trust still has a long way to go to embed sustainability into the services and processes to ensure this reduction is sustained.

Carbon Footprint



The baseline year against which performance is measured is 2009-10.
Baseline CO2e emissions 9,122 tCO2e

- 2009/10 emissions 9,122 tCO2e
- 2010/11 emissions 9,250 tCO2e
- 2011/12 emissions 8,019 tCO2e
- 2012/13 emissions 6861 tCO2e
- 2013-14 emissions 6583 tCO2e

*****According to latest data

The Green Champion initiative has been central to the carbon reduction with team members driving campaigns around Kent and Medway. There are now 80 Green Champions – twice as many as the year before.

These Champions develop small projects across the Trust which all contributed to the target. The Champions also worked with the Estates team and found that some of the older buildings were very carbon intensive.

Other initiatives that have led to the reduction include changes in the way group training is delivered so travel is minimised. Now, instead of staff travelling to a location for training, the trainers travel to them.

Recycling has been stepped up and there is 100 per cent recycling in place across the Trust. The Procurement team is also heavily involved in the sustainability efforts, making sure all paper purchased is recycled and carries the FSC accreditation. Events such as Bike Week, and Walk to Work Week offer the opportunity for staff to get involved and car sharing is being encouraged for those who live further away from work.

Priorities for the year ahead, include:

Legislation

- To ensure that legislative requirements associated with carbon reduction and sustainability are met – e.g. Climate Change Policy; NHS Carbon Reduction Strategy; Display Energy Certificates, Carbon Reduction Commitment Energy Efficiency Scheme.

Technical

- To implement technical projects identified for 2015-16 in the SKANSKA Energy Performance Contract. Projects identified include Solar Panels and Building Management Systems and these will have a clear quantification of the expected carbon reduction or reduced use of resources

Cultural change

- To work to further develop a culture across all areas of the Trust to ensure that the importance of carbon reduction is recognised, through an effective communications strategy and associated activities and campaigns.

- Skanska has partnered with Global Action Plan, the UK's leading environmental behaviour change charity to help design a bespoke behavioural change program will be designed to deliver a successful behavioural change programme to compliment the various initiatives currently happening within the Trust.

- Key campaign messages around the various strands of sustainability will be formulated to span the year and the impact of these will be measured and reported.

Monitoring

- To use the extended local monitoring mechanisms to enable more accurate assessment of resource use and the impact of projects completed at the end of 2015-16.

Other areas of sustainability - travel/transport, recycling

- To continue to develop and implement the travel plans for the major sites and hubs.

- To use the new web-based travel claim process, to develop more accurate reporting of business and lease car travel and impact on the Trust's carbon footprint;

- To reduce the amount of waste sent to landfill and increase the proportion of recycled items.

Partnership working

- To continue to develop links with the wider community in areas relating to carbon reduction and sustainable development.

Section 4: Financial overview

Glossary

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

Technical term	Plain English description
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.
Current assets	Items such as stock held by the Trust, 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.
	Amounts of monies that the Trust has a liability to pay in the future that can be reliably estimated.
Capital	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	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	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.
Management costs	The total cost of corporate administration plus the cost of management of the operational services of the Trust, including support functions.
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.
Intangible assets	Assets that have no physical substance e.g. software licences.
Tangible assets	Assets that have physical substance e.g. a building.
Investments	Money placed to generate a return over a period of time.
Receivables	Entities or individuals who owe the Trust money.
Taxpayers' Equity	Bottom half of the Statement of Financial Position which shows the taxpayers' investment in the Trust.
Fixed asset impairment losses	Impairment losses arise when an asset is recorded in the Trust's books at more than its current value. This difference between what the Trust can sell the asset for and the historic value in the Trust's books is an impairment loss.

Earlier in this report the Trust's performance against non-financial targets is set out. On page 22 details of performance against the Trust's main Key Performance Indicators are highlighted.

The following pages summarises 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.

There was £3.6m investment at the start of the year to fund £1.4m (PYE) extra beds, £0.6m A&E Liaison (West Kent & DGS), £0.6 PD Hostel (Medway), £0.6m STR workers and £0.4m other during 2014-15. The focus on contract monitoring was on performance management, PbR development and CQUIN delivery. The main change to the baseline contract value related to the application of the national deflator of 1.8%.

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 Coastal CCG, Swale CCG, Thanet CCG all under a block contract. For and West Kent CCG the contract was under a PbR basis therefore the majority of the payment was based on activity provided. Specialist Services were commissioned via the National Commissioning Board Specialist Commissioning Group.

The partnership arrangement with Kent County Council, which enables single management of the workforce for the provision of adult services, has also continued during 2014-15.

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 2014-15 and the position of the Trust as at 31st March 2015.

The accounting policies adopted follow International Financial Reporting Standards(IFRS) and the HM Treasury's Resource Accounting Manual to the extent that the Department of Health has directed it as being appropriate to NHS Trusts.

The two most significant accounting policies, which require the exercise of judgment and which can potentially have a material impact on the Trust's accounts, are FRS11 – Impairment of Fixed Assets and Goodwill, and FRS12– Provisions, Contingent Liabilities and Contingent Assets.

The Trust's summarised accounts for 2014-15 have been examined by our external auditor, Grant Thornton, and their report is set out on page 125

The Trust has four main financial targets;

- To break-even or recover any deficit over a rolling three-year period.
- To remain within its external financing limit (a target on the amount of cash resource the Trust can utilise).
- To remain within its capital resource limit (a target on capital spending).
- To achieve its capital cost absorption duty (a rate of return on assets).

During 2014-15 the Trust successfully achieved these targets, despite a number of challenges. The Trust recorded a surplus of £0.5m against its break-even duty in line with the planned surplus. This result was achieved through release of non-recurrent gains and the delivery of cash releasing efficiencies which covered cost pressures and the 1.8 per cent tariff deflator, that had reduced the Trust's income.

Summary of financial targets – table 25

Summary of Financial Targets	Achieved?
Break-even - £465k surplus	Yes
Remain within External Financing Limit - £416k Under spend	Yes
Remain within Capital Resource Limit - £41k Under spend	Yes
Achieve a 3.5 per cent Capital Cost Absorption Duty	Yes

Audit

The Trust's external auditor is Grant Thornton. It conducted work during the year on audit services at a cost of £67k (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

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

Capital expenditure

The Trust spent £14.7m on capital expenditure in 2014-15, which represented a small under-spend against the plan revised in September 2014. The Board also agreed to sell the properties that were identified as part of the estates element of the Trust's Transformation Programme which became surplus to requirements. The sale of these properties provides funding to invest in the retained infrastructure and reduces total estate running costs. Disposing of surplus properties also mitigates against reductions in market value and avoids additional security costs.

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

1. £5.7m to provide a replacement building for the Emerald Ward to move from Medway to Maidstone in 2015-16.
2. £1.3m to refurbish the DVH building in Canterbury to the same standard as the new build.
3. £0.7m for building works to phase 1 of the Canterbury service Hubs.
4. £0.9m smaller building and engineering projects to maintain the estate..

5. £3.3m on information technology to enable the workforce to have access to robust tools which will provide valuable information and free-up clinician time for patients. An element of the IT spend reflects investment in a number of systems that commenced in previous years and expanded during 2013-14:

    - Mobile working technology, e-mail upgrade £0.2m and hardware e.g. laptops £1.2m.
    - Further Development of the Cloud £0.3m.
    - Development of a patient portal £0.2m

6. PLICs - Continued investment in the project for a further £0.1m for a patient level costing system that will enable costs by patient to be calculated.

The remainder of the capital expenditure was for 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.

Phase 1 was the building of an adult inpatient unit on alternative land at Stone House. This was completed in 2000.

Phase 2 was in two stages. Stage 1 was not a PFI and was for the construction of a mental health inpatient unit and a renal dialysis unit on the Darent Valley Hospital site by the PFI contractor of the Darent Valley Hospital. This scheme was completed in April 2005 at a cost of £5.4m and was funded by public dividend capital. Stage 2 was a scheme with four units – two 20-bed units and a 12-bed unit all completed in September 2006 and a 16- bed unit completed in July 2007. These are used for the provision of medium and low secure, continuing-care and rehabilitation services.

All the PFI schemes are currently ‘on Balance sheet’ and therefore the monthly payments are treated as payments comprising interest payable, long term loan repayment and provision of facility services where applicable.

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, the Trust can incur penalties for non-achievement of Key Performance or Quality Indicators.

Mental health services are being brought into these arrangements via local implementation of a proposed tariff structure based on clusters. These clusters are 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 a local tariff arrangement in 2014-15 and has continued to work with all CCGs to develop pathways and calculate the resulting local tariff.

The results continue to produce diverse ranges of prices for each cluster so work will continue throughout 2015-16 to ensure service users are clustered appropriately.

The pathway design work has been agreed with the CCGs and the Trust will now work with commissioners to identify the resource gaps and produce plans to enable the transition and redesign of the services to deliver these agreed standard packages.

The Department of Health is expecting the Trust to be funded via cluster and indicative levels of activity. The calculation of meaningful single provider local cluster tariffs remains a priority with the plan that full PbR by tariff contracts will be in place by 2016/17. This work is ongoing and will be refined as the knowledge of all parties improves and central guidance from Monitor is provided.

Management costs table 26

Management Costs	
Management costs	10,875
Total income	178,674
Management costs as a percentage of total income	6.09%

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 two loans which have £5.6m remaining.

The Trust has reduced its cash holding at the end of 2014-15 given the level of capital investment. However, the Trust still has a good cash balance that will give it resilience going forward given the uncertain financial climate.

Local Strategic Partnership (LSP)

The government encourages local strategic partnerships as formal expressions of the more integrated service planning and delivery that has been taking place in recent years, for example across NHS, local authority and voluntary services.

The Trust has been an active partner in LSPs. It aims to co-ordinate private, public, voluntary and community organisations working together to improve the social, economic and environmental well-being of the local area and its residents.

Income – table 27

The Trust's income in 2014-15 totalled £178,674k. The sources of income were:

Management Costs	£'000	%
Clinical Commissioning Groups	141,331	79.1
NHS England	19,294	10.8

Education and Training	4,418	2.5
Non-patient care services	7,984	4.5
Other	5,025	2.8
Total	**174,924**	**100**

Expenditure – table 28

Operating expenses in 2014-15 totalled £172,750k. The analysis of this expenditure is:

Management Costs	£'000	%
Staff costs	133,729	77.4
Supplies and services	7,253	4.2
Premises	5,869	3.4
Services from other		
NHS Trusts	2,234	1.3
Services from NHS FTs	1,422	0.8
Establishment	3,859	2.2
Depreciation	6,415	3.7
Impairments	301	0.2
Other	6,688	3.9
Purchase of healthcare from non NHS Bodies	4,980	2.9
Total	**172,750**	**100**

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 and the measurement of compliance is below. A system upgrade to the Trusts ledger resulted in the system being off-line for four weeks which is the reason for the reduced level of compliance in 2014-15.

I can confirm that the Trust is signed up to the prompt payment code.

Non-NHS Payables table 29

Target	2013-14		2013-14	
	Number	£000s	Number	£000s
Total Non-NHS Trade Invoices Paid in the Year	23,569	59,647	21,033	48,089
Total Non-NHS Trade Invoices Paid Within Target	19,958	56,186	18,977	46,230
Percentage of NHS Trade Invoices Paid Within Target	85%	94%	90%	96%

NHS Payables table 30

Target	2013-14		2013-14	
	Number	£000s	Number	£000s
Total NHS Trade Invoices Paid in the Year	1,337	9,034	1,283	10,784
Total NHS Trade Invoices Paid Within Target	1,120	7,926	1,107	10,131
Percentage of NHS Trade Invoices Paid Within Target	84%	88%	86%	94%

Annual Governance Statement

1. Scope of Responsibility

1.1 In my role as Accountable Officer, and Chief Executive of this Trust, I have 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) has 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 the Trust Development Authority (TDA), 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 2015 through the Trust Development Authority (TDA) for the performance of the Trust's functions and for meeting its statutory duties. This relationship with the TDA is transacted through regular meetings with the TDA 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), the Trust Development Authority (TDA), 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
- 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 and the University of Kent

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 Board Governance Assurance Framework Self Assessment provides evidence and assurance of the Board's compliance with best practice guidance.

2.3 The Board composition has remained broadly static with the exception of two vacancies that arose in the financial year, resulting in the permanent appointment of a new Director of Finance and the Interim Director of Operations becoming the permanent post holder. A robust Board development and appraisal process has been in place for the duration of this financial period following the commissioning of an external agency.

2.4 The Board has put significant effort into evaluating and assessing its own effectiveness, including a survey of Board members, the commissioning of the Kings Fund for developmental purposes and the implementation of the actions which arose following an internal audit on board effectiveness in 2013-14. The reports and recommendations from these reviews have generated action plans (some of which relate to Board effectiveness) which are monitored 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 Board attendance for the 2014-15 period averaged a rate of 87%. Formal Board meetings are 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.

2.7 The Committees of the Board are:

- Integrated Audit and Risk Committee
- Quality Committee
- Finance and Performance Committee

- Workforce and Organisational Development Committee
- Remuneration Committee

2.8 Overall attendance for each committee during the 2014-15 period was as follows:

Committee name	**Rate of membership attendance**
Integrated Audit and Risk Committee	82%
Quality Committee	73%
Finance and Performance Committee	87%
Workforce and Organisational Development Committee	93%
Remuneration Committee	96%

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

2.10 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.

2.11 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.

2.12 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.

2.13 To aid this assurance, the coverage of the Committee's work plan incorporates the review of the organisation's risk management processes, and the corporate risk register. The Integrated Audit and Risk Committee takes assurance from the Internal Audit function, by setting the Internal Audit Plan and monitoring its delivery regularly, as well as overseeing the implementation of audit recommendations.

2.14 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.

2.15 The Non-Executive members of the Integrated Audit and Risk Committee play a key role by scrutinising the effectiveness of management actions in mitigating risks through regular reviews of the Trust's risk register. 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 every meeting
- A rolling programme of deep dives with each service line
- 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

2.16 During the 2014-15 period, the Committee received internal audit reports covering a broad range of the Trust's governance and risk management systems. The outcomes are highlighted in the table below:

Assurance Assessments	Number of Reviews
Substantial Assurance	1
Reasonable Assurance	13
Limited Assurance	2
No Assurance	0

2.17 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.

2.18 The Integrated Audit and Risk Committee takes assurance from the Internal Audit function, by monitoring its delivery regularly, as well as overseeing the implementation of audit recommendations. Assurance is also taken from the external auditors who audit the Trusts financial statement and it's Statement on Internal Control. They also ensure there are proper arrangements in place for securing economy, efficiency and effectiveness in its use of resources. Arrangements are in place for the discharge of statutory functions to have been checked for any irregularities and to ensure that they are legally compliant. The Committee receives and agrees the annual work plans for internal and external auditors.

2.19 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 am

supported in undertaking this role by the Executive Director of Nursing and Governance.

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 Trust risk register, as well as corporate functions and service line risk registers, on a rolling basis.

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. Based on the residual risk score, the top three risks of the organisation in the 2014-15 period were:

Failure to Recruit to Safe Staffing Levels

In line with other hospitals in the country, the Trust has experienced significant difficulties in recruiting permanent nursing staff across the Trust to ensure the right numbers of nursing staffing on each ward for all shifts. There has been some reliance of the use of agency staff and impacted on the Trusts ability to achieve the safe staffing requirements.

Demand for Inpatient Acute Beds – Patient Flow

The Trust experienced exceptional demand for inpatient acute beds during the year which resulted in significantly higher use of private sector out of area beds than planned. The Trust put in place a range of actions to manage the demand and used the

agreed risk share arrangement in place with Commissioners to mitigate the financial impact on the Trust. Numbers of Service Developments have been supported by Commissioners, including increasing capacity through additional beds and supporting infrastructure, to manage demand going forward.

Financial Overspend

If the Trust continues to overspend at the current rate this would put significant pressure on the Trust financial viability in the long term, and could potentially result in regulatory action. A comprehensive action plan is in place to reduce spend and create a number of efficiency savings.

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 Training on risk management is included within the mandatory induction programme which all staff participate in at the start of their employment with the Trust. Managers and their nominated risk assessors attend 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 is refreshed every three years. The Trust Board receives annual training on risk management at a Board Development Sessions.

3.8 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.

3.9 The Local Counter Fraud Team provided by TIAA support the Trust with the deterrent of risks. They have undertaken awareness training to all new starters at corporate induction; have an additional rolling programme of Fraud Awareness Training provided to Service Teams as required and run intensive 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 'Fraud Focus' is circulated to all staff and distributed at the Trust induction and other fraud awareness events. The Local Counter Fraud Specialist is also a member of the Trust's Policy Group to ensure policies and procedures are adequately fraud proofed. Trust policies include the Counter Fraud Policy and Whistle Blowing Policy.

3.10 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
- Information Risk Management Framework and Policy
- Incident Reporting Policy
- Complaints Policy
- Serious Incidents Policy
- Investigations Policy
- Learning from Experience Policy
- The bi-annual review of the BAF by the Integrated Audit and Risk Committee

3.11 KMPT is on a journey to achieve a fully risk enabled status on the risk spectrum by 31 March 2016. 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 regularly monitored by the Integrated Audit and Risk Committee.

3.12 From September 2014 the risk registers owned by and or delegated to the Committees of the Board have been reinvigorated 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.

3.13 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 454 new risks and risk assessments added to the Datix system in 2014-15 and 1028 risks were resolved and closed in the same time period. This demonstrates that there is an active process around risks.

3.16 There were several new risks identified on the Board Assurance Framework for 2014-15 which include procuring and deploying a replacement for RIO, monitoring and managing the use of ligatures, reduction of patient falls, reducing trust overspend and increasing nurse recruitment. In addition, there are some risks which have arisen through the CQC inspection which are being managed through the usual risk management process.

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 ligatures and ligature points. Where possible known ligature points are removed and where this is not possible, the risk is managed with clinical assessments and observation.

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 A control calibration tool was introduced this year to ensure that all risks were graded appropriately and that the types and effectiveness of controls were taken into account.

All high level risks were 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 2015-16 in order to enhance the internal control arrangements. The implementation of these actions 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:

- Consult on and develop an understanding of risk tolerance and risk appetite
- Enhance the description of controls and gaps in controls
- Strengthen the process of collating potential and real sources of assurance

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 Board Assurance Framework will be revisited to ensure that it is 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 In May 2014 TIAA, the Trusts internal auditors, carried out a Trust-wide review of the risk management arrangements and Assurance Framework. The outcome of the review was an audit opinion of reasonable assurance, indicating that there is a generally sound system of internal control, designed to meet the organisations objectives, and that controls are generally being applied consistently. Recommendations were made about further improvements to enhance the system of internal control, which are either being implemented, or have been completed.

6.3 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. The opinion is based on a review of the systems and processes underpinning the Board Assurance Framework and the internal audit risk–based plans reported during this period. The Trust is implementing actions arising from internal audit reviews and providing assurances on progress to the Integrated Audit and Risk Committee, which applies an integrated approach to scrutinising risk management arrangements.

6.4 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.

6.5 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.

6.6 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 Essential 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 The CQC Chief Inspector of Hospitals Team carried out a comprehensive inspection of the hospital's services between 16 and 20 March 2015. At the time of writing this report, the Trust had not received the written report from the CQC but has received two warning notices with regards to Littlestone Lodge in respect of Regulation 9 (Care and Welfare of Service Users) and Regulation 10 (Treatment of Disease, Disorder or Injury). An action plan has been put in place and it is expected that full compliance will be achieved by the target date.

7.3 The CQC Compliance Monitoring Group is responsible for ensuring that Trust services meet the required regulatory standards and this is led by the Executive Director of Nursing and Governance.

7.4 The Trust has arrangements in place to maintain ongoing compliance with the CQC registration and essential standards, for the purpose of monitoring and continually improving the quality of healthcare provided to its patients. The Trust reviews a range of metrics to identify, assess and evaluate risks pertaining to compliance with CQC standards, enabling the monthly declaration of assurance to the TDA.

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 Information Risk Management Framework and Policy.

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 Health and Social Care Information Centre requirements.

8.3 There has been one Information Governance breach which was reported to the Information Commissioner in September 2014 where a copy of a database containing patient demographic information and medical information and personal information regarding Trust staff was uploaded to an internet storage site. This matter was fully investigated at the time and all recommendations have been implemented.

8.4 There have been two other data related incidents during this year. One relates to information disclosed in error and the other to the non-secure disposal of paperwork. Both matters have been fully investigated with all recommendations implemented.

8.5 An internal audit on level 2 compliance with the information governance toolkit has been rated with reasonable assurance. A number of recommendations have been made which will be monitored by the Information Governance Group and the Integrated Audit and Risk Committee.

8.6 Evidence to support the level 2 declaration on the 2014-15 Information Governance Toolkit informs my assessment of the information governance arrangements of the Trust, as well as the information governance assurance from the internal audit review, undertaken in the financial year.

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.

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 sustainable plan and continues to work towards reducing required energy consumption.

10.2 The Trust will continue 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.

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 report.

11.3 The organisation 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 LCFS work plan and investigative reports where appropriate. In addition, the Committee reviews anti-fraud and bribery Trust policies and procedures.

12.3 The Local Counter Fraud Service (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.

13. Historical Investigation

13.1 Following a number of national investigations, the trust published its investigation into an isolated incident pertaining to an allegation of abuse by Jimmy Saville in 1969. The investigation found no evidence of Saville visiting the Trust during this period. I am confident that the Trust's safeguarding and security processes are well tested, robust and meet national guidelines. The Trust has implemented the recommendation from the report and plans to implement relevant recommendations and learn the lessons outlined in the Lampard report.

14. Significant Issues

14.1 The Trust has identified the following as significant control issues for the 2014-15 period.

Data Security Breaches

During the 2014-15 period there were three 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.

Never Events

There have been no never events during this period.

HSE Notice of Contravention

During the month of March 2015, the Trust was issued with a notice of contravention by the Health and Safety Executive (HSE); in relation to the delay in reporting six RIDDOR

(Reporting of Injuries, Diseases and Dangerous Occurrences Regulations) reportable incidents.

The action plan arising out of this matter will be reviewed regularly by the Executive Team, Health & Safety Committee and Integrated Audit and Risk Committee who will in turn provide assurance to the Board.

15. Conclusion

15.1 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 2014-15 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.

15.2 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.

15.3 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.

15.4 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

Angela McNab

Chief Executive

23 April 2015

Statement of Accounting Officer's responsibilities

The Chief Executive of the NHS has designated that the Chief Executive should be the Accountable Officer of the Trust. The relevant responsibilities of Accountable Officers are set out in the Accountable Officers Memorandum issued by the Department of Health.

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 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 flow 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 the Accountable Officer.

Statement of Comprehensive Income for year ended

31 March 2015

	NOTE	**2014-15 £000s**	2013-14 £000s
Gross employee benefits	9.1	**(133,729)**	(128,069)
Other operating costs	7	**(39,021)**	(43,536)
Revenue from patient care activities	4	**161,706**	160,487
Other operating revenue	5	**16,968**	14,437
Operating surplus		**5,924**	3,319
Investment revenue	11	**66**	56

Other gains	12	**45**	1,670
Finance costs	13	**(1,612)**	(1,595)
Surplus for the financial year		**4,423**	3,450
Public dividend capital dividends payable		**(3,958)**	(3,829)
Retained surplus for the year		**465**	(379)

Other Comprehensive Income

	2014-15	2013-14
	£000s	£000s
Impairments and reversals taken to the revaluation reserve	**0**	(267)
Net gain on revaluation of property, plant & equipment	**12,115**	1
Total comprehensive income for the year	**12,580**	(645)

Financial performance for the year

Retained surplus for the year	**465**	(379)
IFRIC 12 adjustment (including IFRIC 12 impairments)	**95**	33
Impairments (excluding IFRIC 12 impairments)	**301**	1,895
Adjustments in respect of donated gov't grant asset reserve elimination	**41**	58
Adjusted retained surplus	**902**	1,607

The reported performance of the NHS Trust £465k surplus differs from the financial performance of £902 surplus due to allowable technical adjustments.

The notes on page 5 to 36 form part of this account.

Statement of Financial Position as at 31 March 2015

	NOTE	**31 March 2015** **£000s**	31 March 2014 £000s
Non-current assets:			
Property, plant and equipment	14	**157,857**	137,671
Intangible assets	15	**2,645**	3,121
Trade and other receivables	19.1	**803**	892
Total non-current assets		**161,305**	141,684
Current assets:			
Trade and other receivables	19.1	**10,290**	4,444
Cash and cash equivalents	20	**12,418**	16,791
Sub-total current assets		**22,708**	21,235
Non-current assets held for sale	21	**0**	2,450
Total current assets		**22,708**	23,685

Total assets		**184,013**	165,369
Current liabilities			
Trade and other payables	22	**(19,580)**	(13,664)
Provisions	25	**(1,547)**	(2,928)
Borrowings	23	**(437)**	(696)
DH capital loan	23	**(2,400)**	(1,600)
Total current liabilities		**(23,964)**	(18,888)
Net current liabilities		**(1,256)**	4,797
Total assets less current liablilities		**160,049**	146,481
Non-current liabilities			
Trade and other payables	22	**0**	(169)
Provisions	25	**(2,252)**	(2,259)
Borrowings	23	**(15,034)**	(15,470)
DH capital loan	23	**(3,200)**	(1,600)
Total non-current liabilities		**(20,486)**	(19,498)
Total assets employed:		**139,563**	126,983
FINANCED BY:			
Public Dividend Capital		**114,689**	114,689
Retained earnings		**7,933**	7,156
Revaluation reserve		**21,642**	9,839
Other reserves		**(4,701)**	(4,701)
Total Taxpayers' Equity:		**139,563**	126,983

The notes on page 5 to 36 form part of this account.

The financial statements on page 1 to 36 were approved by the Board on 4th June, 2015 and signed on its behalf by

Chief Executive: Date:

Statement of Changes in Taxpayers' Equity
For the year ending 31 March 2015

	Public Dividend capital	Retained earnings	Revaluation reserve	Other reserves	Total reserves
	£000s	£000s	£000s	£000s	£000s
Balance at 1 April 2014	**114,689**	**7,156**	**9,839**	**(4,701)**	**126,983**
Changes in taxpayers' equity for 2014-15					
Retained surplus for the year	**0**	465	**0**	**0**	**465**
Net gain on revaluation of property, plant, equipment	**0**	**0**	**12,115**	**0**	**12,115**
Reclassification Adjustments					
Transfers between reserves	**0**	**312**	**(312)**	**0**	**0**
Net recognised revenue for the year	**0**	**777**	**11,803**	**0**	**12,580**
Balance at 31 March 2015	**114,689**	**7,933**	**21,642**	**(4,701)**	**139,563**
Balance at 1 April 2013	114,618	7,135	10,505	(4,700)	127,558
Changes in taxpayers' equity for the year ended 31 March 2014					
Retained deficit for the year	0	(379)	0	0	(379)
Net gain on revaluation of property, plant, equipment	0	0	1	0	1
Impairments and reversals	0	0	(267)	0	(267)
Transfers between reserves	0	400	(400)	0	0
Reclassification Adjustments					
New temporary and permanent PDC received - cash	70	0	0	0	70
Net recognised expense for the year	70	21	(666)	0	(575)
Balance at 31 March 2014	114,688	7,156	9,839	(4,700)	126,983

Statement of Cash Flows for the Year ended 31 March 2015

	NOTE	2014-15 £000s	2013-14 £000s
Cash Flows from Operating Activities			
Operating surplus		**5,924**	3,319
Depreciation and amortisation		**6,415**	6,169
Impairments and reversals		**301**	1,895
Interest paid		**(1,529)**	(1,523)
Dividend paid		**(4,108)**	(3,797)
Increase in Trade and Other Receivables		**(5,626)**	(1,329)
Increase in Trade and Other Payables		**3,121**	1,966
Provisions utilised		**(686)**	(1,105)
Decrease in movement in non cash provisions		**(785)**	481
Net Cash Inflow from Operating Activities		**3,027**	6,076
Cash Flows from Investing Activities			
Interest Received		**66**	56
Payments for Property, Plant and Equipment		**(11,752)**	(9,972)
Payments for Intangible Assets		**(333)**	(377)
Payments for Investments with DH		**(707,500)**	(501,500)
Proceeds of disposal of assets held for sale (PPE)		**2,914**	6,126
Proceeds from Disposal of Investment with DH		**707,500**	501,500
Net Cash Outflow from Investing Activities		**(9,105)**	(4,167)
Net Cash outflow before Financing		**(6,078)**	1,909
Cash Flows from Financing Activities			
Gross Temporary and Permanent PDC Received		**0**	70
Loans received from DH - New Capital Investment Loans		**4,000**	0
Loans repaid to DH - Capital Investment Loans Repayment of Principal		**(1,600)**	(1,600)
Capital Element of Payments in Respect of Finance Leases and On-SoFP PFI		**(695)**	(720)
Net Cash Inflow from Financing Activities		**1,705**	(2,250)
NET DECREASE IN CASH AND CASH EQUIVALENTS		**(4,373)**	(341)
Cash and Cash Equivalents at Beginning of the Period	**20**	**16,791**	17,132
Cash and Cash Equivalents at year end	**20**	**12,418**	16,791

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 2014-15 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 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.

1.3 Critical accounting judgements and key sources of estimation uncertainty

In the application of the Trust 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.

1.3.1 Critical judgements in applying accounting policies

Any critical judgements, apart from those involving estimations (see below) that management has made in the process o applying the Trust 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.

1.3.2 Key sources of estimation uncertainty

The Trust receives some income which is invoiced on an estimated basis which in turn is based on estimated expenditure. The expenditure estimation method used is the standard accounting practice utilising the most recent actual costs. The charge to the other party is consistent with their contractual obligation.

1.4 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.

The Trust has an "Any Qualified Provider" contract for improving access to Psychological Therapy Services. The tariff system for this work is client based and has different elements of reimbursement dependant upon outcome levels.

Payment is staged - part payment made at an initial stage of treatment and final payment at completion. Partially completed spells estimation is therefore required for the year end for clients in the middle of treatment.

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

The 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 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.

1.5 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 yet taken by employees at the end of the period is recognised to the extent that employees are permitted to carry forward leave into the following year.

Retirement benefit costs

Past and present employees are covered by the provisions of the NHS Pensions Scheme. The scheme is an unfunded, defined benefit scheme that covers NHS employers, General Practices and other bodies, allowed under the direction of the Secretary of State, in England and Wales. The scheme is 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 scheme is accounted for as if it were a defined contribution scheme: the cost to the Trust of participating in the 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 Trust commits itself to the retirement, regardless of the method of payment.

1.6 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.

1.7 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 Trust
- it is expected to be used for more than one financial year
- the cost of the item can be measured reliably; and
- the item has cost of at least £5,000; or
- collectively, a number of items have a cost of at least £5,000 and individually have 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 fair 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 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. Fair values are determined as follows:

- Land and non-specialised buildings – market value for existing use
- Specialised buildings – depreciated replacement cost

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.

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 has taken 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 but not borrowing costs, which are recognised as expenses immediately, as allowed by IAS 23 for assets held at fair value. 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.

1.8 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 fair value. Software that is integral to the operating 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

- 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 fair value by reference to an active market, or, where no active market exists, at amortised replacement cost (modern equivalent assets basis), indexed for relevant price increases, as a proxy for fair value. Internally-developed software is held at historic cost to reflect the opposing effects of increases in development costs and technological advances.

1.9 Depreciation, amortisation and impairments

Freehold land, properties under construction, and assets held for sale are not depreciated.

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

At each reporting period end, the Trust checks whether there is any indication that any of its tangible or intangible non-current assets have suffered an impairment loss. If there is indication of an impairment loss, 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.

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. 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.

1.10 Donated assets

Donated non-current assets are capitalised at their fair 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 as described above for purchased assets. Deferred income is recognised only where conditions attached to the donation preclude immediate recognition of the gain.

1.11 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.

1.12 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.

1.13 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 on 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.

1.14 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 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 in accordance with the principles of IAS 17. Subsequently, the assets are measured at fair value, which is kept up to date in accordance with the Trust's approach for each relevant class of asset in accordance with the principles of IAS 16.

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 fair 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 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 finance lease liability 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 the operating income

over the shorter of the remaining contract period or the useful economic life of the replacement component.

1.15 Cash and cash equivalents

Cash is cash in hand and deposits with any financial institution repayable without penalty on notice of not more than 24 hours. Cash equivalents are investments that mature in 3 months or less from the date of acquisition and that are readily convertible to known amounts of cash with insignificant risk of change in value.

In the Statement of Cash Flows, cash and cash equivalents are shown net of bank overdrafts that are repayable on demand and that form an integral part of the Trust's cash management.

1.16 Provisions

Provisions are recognised when the Trust has a present legal or constructive obligation as a result of a past event, it is probable that the 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 rate of -1.5% short term rate, -1.05% medium term rate, 2.20% for long term in real terms and 1.30% for employee early departure obligations.

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.

Present obligations arising under onerous contracts are recognised and measured as a provision. An onerous contract is considered to exist where the Trust has a contract under which unavoidable costs of meeting the obligations under the contract exceed the economic benefits expected to be received under it.

1.17 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 Trust. The total value of clinical negligence provisions carried by the NHSLA on behalf of the Trust is disclosed at note 25.

1.18 Non-clinical risk pooling

The Trust participates in the Property Expenses Scheme and the Liabilities to Third Parties Scheme. Both are risk pooling schemes under which the Trust pays an annual contribution to 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.

1.19 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 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.

1.20 Financial assets

Financial assets are recognised when the Trust becomes party to the financial instrument contract or, in the case of trade receivables, when the goods or services have been delivered. Financial assets are 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 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 which occurred after the initial recognition of the asset and which has an impact on the estimated future cash flows of the asset.

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

1.21 Financial liabilities

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

Loans from the Department of Health are recognised at historical 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 premium received (or imputed) for entering into the guarantee less cumulative amortisation.

The amount of the obligation under the contract, as determined in accordance with IAS 37 Provisions, Contingent Liabilities and Contingent Assets.

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.

1.22 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.

1.23 Foreign currencies

The Trust's functional currency and presentational currency is sterling. Transactions denominated in a foreign currency are translated into sterling at the exchange rate ruling on the dates of the transactions. At the end of the reporting period, monetary items denominated in foreign currencies are 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.

1.24 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 34 to the accounts.

1.25 Public Dividend Capital (PDC) and PDC dividend

Public dividend capital represents taxpayers' equity in the 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.

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.

1.26 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 Trusts not been bearing their own risks (with insurance premiums then being included as normal revenue expenditure).

1.27 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 SOCNE/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.

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

The Treasury FReM does not require the following Standards and Interpretations to be applied in 2014-15. The application of the Standards as revised would not have a material impact on the accounts for 2014-15, were they applied in that year.

IFRS 9 Financial Instruments - subject to consultation
IFRS 13 Fair Value Measurement - subject to consultation
IFRS 15 Revenue from Contracts with Customers

2. Operating segments

2.1 Shared Services

KMF - Kent and Medway Facilities provided the following services: Estates, Hotel Services Management and Environment

These services were provided to Kent and Medway NHS 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 Service - The Payroll department provides services to enable payment of payroll and travel claims. It also provides pension advice services.

These services were provided to East Kent Hospitals University NHS Foundation Trust until October 2014, Medway NHS Foundation Trust, Kent and Medway NHS 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**	
	2014-15 £000s	2013-14 £000s	**2014-15 £000s**	2013-14 £000s	**2014-15 £000s**	2013-14 £000s
Income	**6,930**	7,036	**171,744**	167,888	**178,674**	174,924
Surplus/(Deficit)						
Segment surplus/(deficit)	**20**	(153)	**445**	(226)	**465**	(379)
Common costs	**517**	545	**24,413**	27,781	**24,930**	28,326
Surplus before interest	**537**	392	**24,858**	27,556	**25,395**	27,948
Net Assets:						
Segment net assets	**0**	257	**139,563**	126,726	**139,563**	126,983
Depreciation	**7**	24	**6,097**	6,143	**6,104**	6,167
Disclosure of External Customer Income over 10%						
NHS Bodies	**4,088**	4,021	**160,625**	159,417	**164,713**	163,438

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 was otherwise material in relation to the accounts (2013-14 £0m).

4. Revenue from patient care activities

	2014-15 £000s	2013-14 £000s
NHS Trusts	***110***	***247***
NHS England	**19,294**	20,141
Clinical Commissioning Groups	***141,331***	***139,276***
NHS Other (including Public Health England and Prop Co)	***49***	***0***
Non-NHS:		
Local Authorities	***622***	***823***
Overseas patients (non-reciprocal)	**263**	0
Injury costs recovery	**20**	0
Other	**17**	0
Total Revenue from patient care activities	**161,706**	160,487

5. Other operating revenue

	2014-15 £000s	2013-14 £000s
Recoveries in respect of employee benefits	**1,016**	1,000
Education, training and research	**4,418**	3,238
Charitable and other contributions to revenue expenditure -non- NHS	**0**	1
Non-patient care services to other bodies	**7,984**	5,956
Income generation	**1,338**	1,596
Rental revenue from operating leases	**1,607**	1,855
Other revenue	**605**	791
Total Other Operating Revenue	**16,968**	14,437
Total operating revenue	**178,674**	174,924

6. Overseas Visitors Disclosure

	2014-15 £000	2013-14 £000s
Income recognised during 2014-15 (invoiced amounts and accruals)	**263**	0
Cash payments received in-year (invoices issued 2014-15)	**153**	0

7. Operating expenses

	2014-15	2013-14
	£000s	£000s
Services from other NHS Trusts	**2,234**	1,957
Services from NHS Foundation Trusts	**1,422**	2,658
Total Services from NHS bodies*	**3,656**	4,615
Purchase of healthcare from non-NHS bodies	**4,980**	5,926
Trust Chair and Non-executive Directors	**69**	71
Supplies and services - clinical	**4,940**	5,008
Supplies and services - general	**2,273**	2,217
Consultancy services	**4**	63
Establishment	**3,859**	3,937
Transport	**1,484**	1,521
Service charges - ON-SOFP PFIs and other service concession arrangements	**891**	839
Business rates paid to local authorities	**1,093**	1,292
Premises	**5,869**	6,038
Hospitality	**16**	6
Insurance	**36**	28
Legal Fees	**1,779**	1444
Impairments and Reversals of Receivables	**(85)**	191
Depreciation	**5,403**	5,211
Amortisation	**1,012**	958
Impairments and reversals of property, plant and equipment	**701**	1,895
Impairments and reversals of non current assets held for sale	**(400)**	0
Audit fees	**73**	75
Other auditor's remuneration Internal Audit Fees, clinical coding audit and Quality accounts	**97**	269
Clinical negligence	**357**	325
Education and Training	**712**	624
Change in Discount Rate	**88**	90
Other	**114**	893
Total Operating expenses (excluding employee benefits)	**39,021**	43,536
Employee Benefits		
Employee benefits excluding Board members	**132,909**	127,248
Board members	**820**	821
Total Employee Benefits	**133,729**	128,069
Total Operating Expenses	**172,750**	171,605

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

8. Operating Leases

The majority of the leasing arrangments 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.

8.1 Trust as lessee

	Buildings £000s	Other £000s	2014-15 Total £000s	2013-14 £000s
Payments recognised as an expense				
Minimum lease payments			**1,417**	2,277
Sub-lease payments			**0**	26
Total			**1,417**	2,303
Payable:				
No later than one year	**295**	**396**	**691**	488
Between one and five years	**178**	**496**	**674**	972
After five years	**943**	**0**	**943**	843
Total	**1,416**	**892**	**2,308**	2,303
Total future sublease payments expected to be received:			**0**	0

8.2 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.

	2014-15 £000	2013-14 £000s
Recognised as revenue		
Contingent rents	**1,607**	1,855
Total	**1,607**	1,855
Receivable:		
No later than one year	**1,607**	1,855
Total	**1,607**	1,855

9. Employee benefits and staff numbers

9.1 Employee benefits

	2014-15 Total £000s	Permanently employed £000s	Other £000s
Employee Benefits - Gross Expenditure			
Salaries and wages	**116,007**	92,873	23,134
Social security costs	**7,307**	7,307	0
Employer Contributions to NHS BSA - Pensions Division	**11,527**	11,527	0
Other pension costs	**5**	5	0
Termination benefits	**25**	25	0
Total employee benefits	**134,871**	**111,737**	**23,134**
Employee costs capitalised	**1,142**	345	797
Gross Employee Benefits excluding capitalised costs	**133,729**	**111,392**	**22,337**

Employee Benefits - Gross Expenditure 2013-14	**Total £000s**	**Permanently employed £000s**	**Other £000s**
Salaries and wages	109,962	91,532	18,430
Social security costs	7,436	7,436	0
Employer Contributions to NHS BSA - Pensions Division	11,504	11,504	0
Other pension costs	4	4	0
Termination benefits	85	85	0
TOTAL - including capitalised costs	128,991	110,561	18,430
Employee costs capitalised	922	379	543
Gross Employee Benefits excluding capitalised costs	128,069	110,182	17,887

9.2 Staff Numbers

	2014-15 Total Number	Permanently employed Number	Other Number	2013-14 Total Number
Average Staff Numbers				
Medical and dental	**175**	**163**	**12**	212
Administration and estates	**719**	**646**	**73**	629
Healthcare assistants and other support staff	**1,218**	**799**	**419**	977
Nursing, midwifery and health visiting staff	**1,084**	**830**	**254**	912
Nursing, midwifery and health visiting learners	**0**	**0**	**0**	0
Scientific, therapeutic and technical staff	**451**	**432**	**19**	464
Social Care Staff	**10**	**7**	**3**	11
Other	**24**	**22**	**2**	25
TOTAL	**3,681**	**2,899**	**782**	3,229
Of the above - staff engaged on capital projects	**20**	**9**	**11**	17

9.3 Staff Sickness absence and ill health retirements

	2014-15 Number	2013-14 Number
Total Days Lost	**28,397**	27,473
Total Staff Years	**2,872**	2,777
Average working Days Lost	**9.89**	9.89

	2014-15 Number	2013-14 Number
Number of persons retired early on ill health grounds	**7**	11
	£000s	£000s
Total additional pensions liabilities accrued in the year	**607**	362

9.4 Exit Packages agreed in 2014-15

	2014-15			2013-14		
Exit package cost band (including any special payment element)	**Number of compulsory redundancies**	**Number of other departures agreed**	**Total number of exit packages by cost band**	Number of compulsory redundancies	Number of other departures agreed	Total number of exit packages by cost band
	Number	**Number**	**Number**	Number	Number	Number
Less than £10,000	**0**	**1**	**1**	5	0	5
£10,000-£25,000	**3**	**0**	**3**	11	0	11
£25,001-£50,000	**2**	**0**	**2**	7	1	8
£50,001-£100,000	**0**	**0**	**0**	1	0	1
Total number of exit packages by type (total cost	**5**	**1**	**6**	24	1	25
Total resource cost (£s)	**114,627**	**2,000**	**116,627**	514,576	36,000	550,576

Redundancy and other departure costs have been paid in accordance with the provisions of the NHS Pensions Scheme. Exit costs in this note are accounted for in full in the year of departure. Where the Trust has agreed early retirements, the additional costs are met by the Trust and not by the NHS pensions scheme. Ill-health retirement costs are met by the NHS pensions scheme and are not included in the table.

This disclosure reports the number and value of exit packages agreed in the year. These were incurred as a result of the efficiency programme and also a change in contract arrangements for the Primary Care Psychological Therapy Service. Note: the expense associated with these departures may have been recognised in part or in full in a previous period

9.5 Exit packages - Other Departures analysis

	2014-15		2013-14	
	Agreements	**Total value of agreements**	Agreements	Total value of agreements
	Number	**£000s**	Number	£000s
Exit payments following Employment Tribunals or court orders	**1**	**2**	1	36
Total	**1**	**2**	1	36

As a single exit packages can be made up of several components each of which will be counted separately in this Note, the total number above will not necessarily match the total numbers in Note 9.4 which will be the number of individuals.

9.6 Pension costs

Past and present employees are covered by the provisions of the NHS Pensions Scheme. Details of the benefits payable under these provisions can be found on the NHS Pensions website at www.nhsbsa.nhs.uk/pensions. The scheme is an unfunded, defined benefit scheme that covers NHS employers, GP practices and other bodies, allowed under the direction of the Secretary of State, in England and Wales. The scheme is 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 scheme is accounted for as if it were a defined contribution scheme: the cost to the NHS Body of participating in the scheme is taken as equal to the contributions payable to the scheme for the accounting period.

The scheme is subject to a full actuarial valuation every four years (until 2004, every five years) and an accounting valuation every year. An outline of these follows:

a) Full actuarial (funding) valuation

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

The last such valuation, which determined current contribution rates was undertaken as at 31 March 2004 and covered the period from 1 April 1999 to that date. The conclusion from the 2004 valuation was that the scheme had accumulated a notional deficit of £3.3 billion against the notional assets as at 31 March 2004.

In order to defray the costs of benefits, employers pay contributions at 14% of pensionable pay and most employees had up to April 2008 paid 6%, with manual staff paying 5%.

Following the full actuarial review by the Government Actuary undertaken as at 31 March 2004, and after consideration of changes to the NHS Pension Scheme taking effect from 1 April 2008, his Valuation report recommended that employer contributions could continue at the existing rate of 14% of pensionable pay, from 1 April 2008, following the introduction of employee contributions on a tiered scale from 5% up to 8.5% of their pensionable pay depending on total earnings.

On advice from the scheme actuary, scheme contributions may be varied from time to time to reflect changes in the scheme's liabilities.

b) Accounting valuation

A valuation of the scheme liability is carried out annually by the scheme actuary as at the end of the reporting period by updating the results of the full actuarial valuation.

Between the full actuarial valuations at a two-year midpoint, a full and detailed member data-set is provided to the scheme actuary. At this point the assumptions regarding the composition of the scheme membership are updated to allow the scheme liability to be valued.

The valuation of the scheme liability as at 31 March 2011, is based on detailed membership data as at 31 March 2008 (the latest midpoint) updated to 31 March 2011 with summary global member and accounting data.

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) Resource Account, published annually. These accounts can be viewed on the NHS Pensions website. Copies can also be obtained from The Stationery Office.

c) Scheme provisions

The NHS Pension Scheme provided defined benefits, which are summarised below. This list is an illustrative guide only, and is not intended to detail all the benefits provided by the Scheme or the specific conditions that must be met before these benefits can be obtained:

The Scheme is a "final salary" scheme. Annual pensions are normally based on 1/80th for the 1995 section and of the best of the last three years pensionable pay for each year of service, and 1/60th for the 2008 section of reckonable pay per year of membership. Members who are practitioners as defined by the Scheme Regulations have their annual pensions based upon total pensionable earnings over the relevant pensionable service.

With effect from 1 April 2008 members can choose to give up some of their annual pension for an additional tax free lump sum, up to a maximum amount permitted under HMRC rules. This new provision is known as “pension commutation”.

Annual increases are applied to pension payments at rates defined by the Pensions (Increase) Act 1971, and are based on changes in retail prices in the twelve months ending 30 September in the previous calendar year.

Early payment of a pension, with enhancement, is available to members of the scheme who are permanently incapable of fulfilling their duties effectively through illness or infirmity. A death gratuity of twice final year’s pensionable pay for death in service, and five times their annual pension for death after retirement is payable

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 the statement of comprehensive income at the time the Trust commits itself to the retirement, regardless of the method of payment.

Members can purchase additional service in the NHS Scheme and contribute to money purchase AVC’s run by the Scheme’s approved providers or by other Free Standing Additional Voluntary Contributions (FSAVC) providers.

[Where the Trust has employees who are members of other schemes, disclosures will be required in respect of them too.]

9.7 Pensions 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 payable under this scheme can be found on the NEST website - nestpensions.org.uk

10 Better Payment Practice Code

10.1 Measure of compliance

	2014-15 Number	2014-15 £000s	2013-14 Number	2013-14 £000s
Non-NHS Payables				
Total Non-NHS Trade Invoices Paid in the Year	**23,569**	**59,647**	21,033	48,089
Total Non-NHS Trade Invoices Paid Within Target	**19,958**	**56,186**	18,977	46,230
Percentage of NHS Trade Invoices Paid Within Target	**84.68%**	**94.20%**	90.22%	96.14%
NHS Payables				
Total NHS Trade Invoices Paid in the Year	**1,337**	**9,036**	1,283	10,784
Total NHS Trade Invoices Paid Within Target	**1,120**	**7,926**	1,147	10,131
Percentage of NHS Trade Invoices Paid Within Target	**83.77%**	**87.72%**	89.40%	93.95%

The Better Payment Practice Code requires the NHS body to aim to pay all valid invoices by the due date or within 30 days of receipt of a valid invoice, whichever is later. The reduction in performance this year was mainly as a result of a system upgrade which resulted in the system being unavailable for payments for four weeks.

10.2 The Late Payment of Commercial Debts (Interest) Act 199

	2014-15 £000s	2013-14 £000s
Amounts included in finance costs from claims made under this legislation	**1**	0
Compensation paid to cover debt recovery costs under this legislation	**2**	0
Total	**3**	0

11 Investment Revenue

	2014-15 £000s	2013-14 £000s
Interest revenue		
Bank interest	**66**	56
Total investment revenue	**66**	56

12 Other Gains

	2014-15 £000s	2013-14 £000s
Loss on disposal of assets other than by sale (PPE)	**(37)**	62
Gain on disposal of assets held for sale	**82**	1,608
Total	**45**	1,670

13 Finance Costs

	2014-15 £000s	2013-14 £000s
Interest		
Interest on loans and overdrafts	**53**	59
Interest on obligations under finance leases	**130**	169
Interest on obligations under PFI contracts:		
- main finance cost	**895**	931
- contingent finance cost	**449**	364
Interest on late payment of commercial debt	**2**	0
Total interest expense	**1,529**	1,523
Provisions - unwinding of discount	**83**	72
Total	**1,612**	1,595

2014-15	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 2014	**30,943**	**121,130**	**1,631**	**1,386**	**480**	**11,480**	**2,217**	**169,267**
Additions of Assets Under Construction	**0**	**0**	**8,882**	**0**	**0**	**0**	**0**	**8,882**
Additions Purchased	0	3,401	**0**	21	0	1,896	198	**5,516**
Reclassifications	0	322	(961)	0	0	428	8	**(203)**
Reclassifications as Held for Sale and reversals	480	318	0	(5)	(30)	0	0	**763**
Disposals other than forsale	0	(81)	0	(338)	(13)	0	(735)	**(1,167)**
Upward revaluation/positive indexation	3,334	8,780	0	1	0	0	0	**12,115**
At 31 March 2015	**34,757**	**133,870**	**9,552**	**1,065**	**437**	**13,804**	**1,688**	**195,173**
Depreciation								
At 1 April 2014	**417**	**21,500**	**0**	**996**	**355**	**6,714**	**1,614**	**31,596**
Reclassifications as Held for Sale and reversals	0	775	**0**	(2)	(25)	0	0	**748**
Disposals other than forsale	0	(81)	**0**	(323)	(13)	0	(715)	**(1,132)**
Impairments	0	701	0	0	0	0	0	**701**
Charged During the Year	0	3,567	**0**	66	41	1,589	140	**5,403**
At 31 March 2015	**417**	**26,462**	**0**	**737**	**358**	**8,303**	**1,039**	**37,316**
Net Book Value at 31 March 2015	**34,340**	**107,408**	**9,552**	**328**	**79**	**5,501**	**649**	**157,857**
Asset financing:								
Owned - Purchased	33,750	81,880	9,552	300	79	5,501	592	**131,654**
Owned - Donated	590	1,089	0	0	0	0	0	**1,679**
Held on finance lease	0	1,312	0	0	0	0	5	**1,317**
On-SOFP PFI contracts	0	23,127	0	28	0	0	52	**23,207**
Total at 31 March 2015	**34,340**	**107,408**	**9,552**	**328**	**79**	**5,501**	**649**	**157,857**

14.1 Property, plant and equipment

2014-15	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 2014	**30,943**	**121,130**	**1,631**	**1,386**	**480**	**11,480**	**2,217**	**169,267**
Additions of Assets Under Construction	**0**	**0**	**8,882**	**0**	**0**	**0**	**0**	**8,882**
Additions Purchased	0	3,401	**0**	21	0	1,896	198	**5,516**
Reclassifications	0	322	(961)	0	0	428	8	**(203)**
Reclassifications as Held for Sale and reversals	480	318	0	(5)	(30)	0	0	**763**
Disposals other than for sale	0	(81)	0	(338)	(13)	0	(735)	**(1,167)**
Upward revaluation/positive indexation	3,334	8,780	0	1	0	0	0	**12,115**
At 31 March 2015	**34,757**	**133,870**	**9,552**	**1,065**	**437**	**13,804**	**1,688**	**195,173**
Depreciation								
At 1 April 2014	**417**	**21,500**	**0**	**996**	**355**	**6,714**	**1,614**	**31,596**
Reclassifications as Held for Sale and reversals	0	775	**0**	(2)	(25)	0	0	**748**
Disposals other than for sale	0	(81)	**0**	(323)	(13)	0	(715)	**(1,132)**
Impairments	0	701	0	0	0	0	0	**701**
Charged During the Year	0	3,567	**0**	66	41	1,589	140	**5,403**
At 31 March 2015	**417**	**26,462**	**0**	**737**	**358**	**8,303**	**1,039**	**37,316**
Net Book Value at 31 March 2015	**34,340**	**107,408**	**9,552**	**328**	**79**	**5,501**	**649**	**157,857**
Asset financing:								
Owned - Purchased	33,750	81,880	9,552	300	79	5,501	592	**131,654**
Owned - Donated	590	1,089	0	0	0	0	0	**1,679**
Held on finance lease	0	1,312	0	0	0	0	5	**1,317**
On-SOFP PFI contracts	0	23,127	0	28	0	0	52	**23,207**
Total at 31 March 2015	**34,340**	**107,408**	**9,552**	**328**	**79**	**5,501**	**649**	**157,857**

Revaluation Reserve Balance for Property, Plant & Equipment

	Land	Buildings	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
At 1 April 2014	2,005	7,805	0	17	5	0	7	**9,839**
Movements: 5 year full revaluation, disposals and transfer of historic cost depreciation	3,267	8,534	0	3	0	0	(2)	**11,802**
At 31 March 2015	**5,272**	**16,339**	**0**	**20**	**5**	**0**	**5**	**21,641**

Additions to Assets Under Construction in 2014-15

	£000's
Buildings excl Dwellings	8,882
Balance as at 31 March 2015	**8,882**

14.2 Property, plant and equipment prior-year

2013-14	Land	Buildings excluding dwellings	Dwellings	Assets under construction & payments on account	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000s	£000s	£000s	£000s	£000s	£000s	£000s	£000s	£000s
Cost or valuation:									
At 1 April 2013	32,313	118,024	64	1,802	1,341	644	9,210	1,942	**165,340**
Additions of Assets Under Construction	0	0	0	1,219	0	0	0	0	**1,219**
Additions Purchased	0	5,585	0		29	8	2,015	275	**7,912**
Reclassifications	0	528	0	(1,390)	16	0	347	0	**(499)**
Reclassifications as Held for Sale and Reversals	(1,370)	(2,358)	0	0	0	0	0	0	**(3,728)**
Disposals other than for sale	0	(383)	(64)	0	0	(172)	(92)	0	**(711)**
Revaluation	0	1	0	0	0	0	0	0	**1**
Impairments/negative indexation charged to reserves	0	(267)	0	0	0	0	0	0	**(267)**
At 31 March 2014	**30,943**	**121,130**	**0**	**1,631**	**1,386**	**480**	**11,480**	**2,217**	**169,267**
Depreciation									
At 1 April 2013	417	17,331	64	0	918	459	5,471	1,494	**26,154**
Reclassifications	0	0	0	0	7	0	(7)	0	**0**
Reclassifications as Held for Sale and Reversals	0	(1,358)	0	0	0	0	0	0	**(1,358)**
Disposals other than for sale	0	0	(64)	0	0	(150)	(92)	0	**(306)**
Impairments/negative indexation charged to operating expenses	0	1,895	0	0	0	0	0	0	**1,895**
Charged During the Year	0	3,632	0	0	71	46	1,342	120	**5,211**
At 31 March 2014	**417**	**21,500**	**0**	**0**	**996**	**355**	**6,714**	**1,614**	**31,596**
Net Book Value at 31 March 2014	30,526	99,630	0	1,631	390	125	4,766	603	**137,671**
Asset financing:									
Owned - Purchased	29,936	75,752	0	1,631	351	125	4,766	530	**113,091**
Owned - Donated	590	1,085	0	0	0	0	0	0	**1,675**
Held on finance lease	0	1,451	0	0	0	0	0	7	**1,458**
On-SOFP PFI contracts	0	21,342	0	0	39	0	0	66	**21,447**
Total at 31 March 2014	**30,526**	**99,630**	**0**	**1,631**	**390**	**125**	**4,766**	**603**	**137,671**

14.3 (cont). Property, plant and equipment

The Trust received no donated assets in the year.

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

The full 5 year valuation was undertaken by a Royal Institute of Chartered Surveyors accredited valuer using industry methodologies. All values are based on industry prescribed techniques.

The remaining asset lives for each class of asset are:	Minimum Life	Maximum Life
Buildings excluding dwellings	2	59
External Works	11	59
Engineering Works	6	40
Plant and machinery	1	12
Transport Equipment	1	10
IT/Office equipment	1	5
Furniture and Fittings	2	9

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

There are 2 assets held at market value in non operational use for a value of £1.9m. All other assets are held at existing use.

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

	Net Book values as at 31/3/2015 £000	Depreciation charge in period £000
Building Services	**10,649**	**475**
Engineering Services	**3,780**	**218**
External Works	**985**	**38**
Land	**254**	**0**
	15,668	**731**

15.1 Intangible non-current assets

2014-15	IT - in-house & 3rd party software	Computer Licenses	Licenses and Trademarks	Total
	£000's	£000's	£000's	£000's
At 1 April 2014	**4,045**	**0**	**1,640**	**5,685**
Additions Purchased	53	0	280	**333**
Reclassifications	186	0	17	**203**
At 31 March 2015	**4,284**	**0**	**1,937**	**6,221**
Amortisation				
At 1 April 2014	**1,830**	**0**	**734**	**2,564**
Charged during the year	744	0	268	**1,012**
At 31 March 2015	**2,574**	**0**	**1,002**	**3,576**
Net Book Value at 31 March 2015	**1,710**	**0**	**935**	**2,645**
Asset Financing: Net book value at 31 March 2015 comprises:				
Purchased	1,710	0	935	**2,645**
Total at 31 March 2015	**1,710**	**0**	**935**	**2,645**

15.2 Intangible non-current assets prior year

2013-14	IT - in-house & 3rd party software	Computer Licenses	Licenses and Trademarks	Total
	£000s	£000s	£000s	£000s
Cost or valuation:				
At 1 April 2013	1,029	2,671	1,126	4,826
Additions - purchased	17	0	360	377
Reclassifications	3,016	(2,671)	154	499
Disposals other than by sale	(17)	0	0	(17)
At 31 March 2014	4,045	0	1,640	5,685
Amortisation				
At 1 April 2013	184	904	532	1,620
Reclassifications	904	(904)	0	0
Disposals other than by sale	(14)	0	0	(14)
Charged during the year	756	0	202	958
At 31 March 2014	1,830	0	734	2,564
Net book value at 31 March 2014	2,215	0	906	3,121
Net book value at 31 March 2014 comprises:				
Purchased	2,215	0	906	3,121
Total at 31 March 2014	2,215	0	906	3,121

15.3 Intangible non-current assets

Intangible assets have not been revalued.

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.

There is one internally generated asset (RIO) which has a carrying value of £453k depreciated costs.

16 Analysis of impairments and reversals recognised in 2014-15

	2014-15 Total £000s
Property, Plant and Equipment impairments and reversals taken to SoCI	
Total charged to Annually Managed Expenditure	701
Total Impairments of Property, Plant and Equipment changed to SoCI	**701**
Non-current assets held for sale - reversals charged to SoCI.	
Other	(400)
Total charged to Annually Managed Expenditure	**(400)**
Total impairments of non-current assets held for sale charged to SoCI	**(400)**
Total Impairments charged to SoCI - AME	**(400)**
Overall Total Impairments	**301**

The £400k reversal of impairment relates to the £354k impairment of a building and £46k land damaged through arson. The land has then been revalued to £650k market value with planning permission.

16.1 Analysis of impairments and reversals recognised in 2014-15

	Total £000s	Property Plant and Equipment £000s	Current Assets Held for £000s
Impairments and reversals taken to SoCI			
Unforeseen obsolescence	**0**	0	0
Loss as a result of catastrophe	**0**	0	0
Other	**301**	701	(400)
Changes in market price	**0**	0	0
Total charged to Annually Managed Expenditure	**301**	**701**	(400)
Total Impairments of Property, Plant and Equipment changed to SoCI	**301**	**701**	**(400)**

17 Commitments

17.1 Capital commitments

Contracted capital commitments at 31 March 2015 not otherwise included in these financial statements which relate to Energy Infrastructure, New Emerald Ward and OASIS capital schemes:

	31 March 2015 £000s	31 March 2014 £000s
Property, plant and equipment	**1,121**	1,948
Total	**1,121**	1,948

18 Intra-Government and other balances

	Current receivables £000s	Non-current receivables £000s	Current payables £000s	Non-current payables £000s
Balances with Other Central Government Bodies	471	0	3,725	0
Balances with Local Authorities	254	0	274	0
Balances with NHS bodies outside the Departmental Group	0	0	0	0
Balances with NHS bodies inside the Departmental Group	8,115	0	6,517	3,200
Balances with Public Corporations and Trading Funds	0	0	1,663	0
Balances with Bodies External to Government	1,450	803	10,238	15,034
At 31 March 2015	**10,290**	**803**	**22,417**	**18,234**
prior period:				
Balances with Other Central Government Bodies	1,979	0	4,034	0
Balances with Local Authorities	186	0	423	0
Balances with NHS bodies outside the Departmental Group	0	0	0	0
Balances with NHS Trusts and FTs	688	0	2,343	0
Balances with Public Corporations and Trading Funds	0	0	872	0
Balances with Bodies External to Government	1,591	892	5,992	169
At 31 March 2014	**4,444**	**892**	**13,664**	**169**

19.1 Trade and other receivables

	Current		Non-current	
	31 March 2015	31 March 2014	**31 March 2015**	31 March 2014
	£000s	£000s	**£000s**	£000s
NHS receivables - revenue	**6,645**	2,370	**0**	0
NHS prepayments and accrued income	**1,210**	0	**0**	0
Non-NHS receivables - revenue	**773**	1,083	**803**	892
Non-NHS receivables - capital	**1**	0	**0**	0
Non-NHS prepayments and accrued income	**1,097**	847	**0**	0
PDC Dividend prepaid to DH	**130**	0	**0**	0
Provision for the impairment of receivables	**(167)**	(255)	**0**	0
VAT	**471**	296	**0**	0
Other receivables	**130**	103	**0**	0
Total	**10,290**	4,444	**803**	892
Total current and non current	**11,093**	5,336		

NHS accrued income includes a provision for credit notes.

The great majority of trade is with Clincial 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.

19.2 Receivables past their due date but not impaired

	31 March 2015	31 March 2014
	£000s	£000s
By up to three months	**1,939**	851
By three to six months	**1,125**	488
By more than six months	**1,548**	1,112
Total	**4,612**	2,451

Of the £3m receivables past their due date by less than 6 months, £117k relates to non NHS debt and £2.9m relates to NHS debt.

Of the £1.5m receivables past their due date by more than 6 months, £58k have payment plans in place and £1.4m relate to outstanding NHS debt which is disputed. NHS debt is not impaired as any dispute settlement is via revised billing.

19.3 Provision for impairment of receivables

	2014-15	2013-14
	£000s	£000s
Balance at 1 April 2014	**(255)**	(68)
Amount written off during the year	**3**	4
Amount recovered during the year	**748**	34
Increase in receivables impaired	**(663)**	(225)
Balance at 31 March 2015	**(167)**	(255)

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.

20 Cash and Cash Equivalents

	31 March 2015	31 March 2014
	£000s	£000s
Opening balance	**16,791**	17,132
Net change in year	**(4,373)**	(341)
Closing balance	**12,418**	16,791
Made up of		
Cash with Government Banking Service	**12,392**	16,760
Cash in hand	**26**	31
Cash and cash equivalents as in statement of financial position	**12,418**	16,791
Cash and cash equivalents as in statement of cash flows	**12,418**	16,791
Patients' money held by the Trust, not included above	**183**	181

21 Non-current assets held for sale

	Land	Buildings, excl. dwellings	Dwellings	Plant and Machinery	Transport and Equipment	Total
	£000s	£000s	£000s	£000s	£000s	£000s
Balance at 1 April 2014	1,536	914	0	0	0	**2,450**
Plus assets classified as held for sale in the year	572	1,305	0	3	5	**1,885**
Less assets sold in the year	(1,102)	(1,725)	0	(3)	(5)	**(2,835)**
Plus reversal of impairment of assets held for sale	46	354	0	0	0	**400**
Less assets no longer classified as held for sale, for reasons other than disposal by sale	(1,052)	(848)	0	0	0	**(1,900)**
Balance at 31 March 2015	**0**	**0**	**0**	**0**	**0**	**0**
Balance at 1 April 2013	2,485	1,835	257	0	0	4,577
Plus assets classified as held for sale in the year	1,370	1,000	0	0	0	2,370
Less assets sold in the year	(2,319)	(1,921)	(257)	0	0	(4,497)
Balance at 31 March 2014	1,536	914	0	0	0	2,450
Liabilities associated with assets held for sale at 31 March 2014	0	(100)	0	0	0	(100)

All "Assets Held for Sale" were buildings which became vacant as a result of improved use of buildings facilitated by the Estate Rationalisation Programme which is supporting the Transformation Programme.

In 2014-15, the buildings were valued at their expected market value and reclassified as "Held for Sale" and an impairment of £208k was realised at that time. The reversal of the impairment related to a building which was revalued to market value with planning permission as a result of damage by arson.

Assets are transferred to Held for Sale when they are available for sale in their present condition and are being actively marketed.

22 Trade and other payables

	Current		Non-current	
	31 March 2015 £000s	31 March 2014 £000s	**31 March 2015 £000s**	31 March 2014 £000s
NHS payables - revenue	**2,875**	1,232	**0**	0
NHS accruals and deferred income	**1,242**	1,419	**0**	0
Non-NHS payables - revenue	**5,305**	4,620	**0**	0
Non-NHS payables - capital	**3,087**	441	**0**	0
Non-NHS accruals and deferred income	**3,288**	2,140	**0**	0
Social security costs	**1,070**	1,062	**0**	0
PDC Dividend payable to DH	**0**	20	**0**	0
Tax	**1,058**	1,085	**0**	0
Payments received on account	**51**	51	**0**	169
Other	**1,604**	1,594	**0**	0
Total	**19,580**	13,664	**0**	169
Total payables (current and non-current)	**19,580**	13,833		
Included above:				
outstanding Pension Contributions at the year end	**1,590**	1,579		

23 Borrowings

	Current		Non-current	
	31 March 2015 £000s	31 March 2014 £000s	**31 March 2015 £000s**	31 March 2014 £000s
Loans from Department of Health	**2,400**	1,600	**3,200**	1,600
PFI liabilities:				
Main liability	**313**	559	**13,451**	13,763
Finance lease liabilities	**124**	137	**1,583**	1,707
Total	**2,837**	2,296	**18,234**	17,070
Total other liabilities (current and non-current)	**21,071**	19,366		

Borrowings / Loans - repayment of principal falling due in:

	31 March 2015		
	DH £000s	**Other £000s**	**Total £000s**
0-1 Years	2,400	437	**2,837**
1 - 2 Years	800	759	**1,559**
2 - 5 Years	2,400	2,438	**4,838**
over 5 years	0	11,837	**11,837**
TOTAL	**5,600**	**15,471**	**21,071**

24 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 lease payments**	
	31 March 2015 £000s	31 March 2014 £000s	**31 March 2015 £000s**	31 March 2014 £000s
Within one year	**243**	267	**124**	137
Between one and five years	**972**	972	**587**	548
After five years	**1,215**	1,458	**996**	1,159
Less future finance charges	**(723)**	(853)	**0**	0
Minimum Lease Payments / Present value of minimum lease payments	**1,707**	1,844	**1,707**	1,844
Included in:				
Current borrowings			**124**	137
Non-current borrowings			**1,583**	1,707
			1,707	1,844

25 Provisions

Comprising:

	Total	Early Departure Costs	Legal Claims	Other	Redundancy
	£000s	£000s	£000s	£000s	£000s
Balance at 1 April 2014	5,187	1,902	146	2,981	158
Arising during the year	**850**	112	179	367	192
Utilised during the year	**(686)**	(145)	(74)	(364)	(103)
Reversed unused	**(1,723)**	0	(148)	(1,408)	(167)
Unwinding of discount	**83**	83	0	0	0
Change in discount rate	**88**	88	0	0	0
Balance at 31 March 2015	**3,799**	**2,040**	**103**	**1,576**	**80**
Expected Timing of Cash Flows:					
No Later than One Year	**1,547**	**142**	**103**	**1,222**	**80**
Later than One Year and not later than Five Years	**922**	**568**	**0**	**354**	**0**
Later than Five Years	**1,330**	**1,330**	**0**	**0**	**0**

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

As at 31 March 2015	**6,756**
As at 31 March 2014	5,379

Early departure costs represent pension liabilities for injury benefits.
Legal claims reflect LTPS which the NHS Litigation Authority provide probable estimates and employment tribunal claims whose timings are based on current assumptions from the Trust Legal Department.
Other claims relate to dilapidations provision, unbilled gas charges for a Trust site and a Health and Safety Executive fine.
Redundancies were as a result of service cessations and efficiency programme.

26 Contingencies

	31 March 2015 £000s	31 March 2014 £000s
Contingent liabilities		
NHS Litigation Authority legal claims	**(93)**	(62)
Other	**(785)**	(911)
Net value of contingent liabilities	**(878)**	(973)

Contingent Liabilities relate to £93k LTPS notified by the NHSLA and £785k dilapidations costs for years 2015/16 onwards

There is also potential liability due to an historic arrangement which appears to underwrite the valuation of a property. The liability is contingent on the 3rd party proving the agreement was entered into and also a valuation being agreed.

There may be fines due for late notification of RIDDOR however the Trust has not yet been advised of the amount.

Contingent assets

There is a current insurance claim awaiting completion for a Trust property which was burnt to the ground relating to an act of arson, the value of the settlement is not yet known.

27 PFI - 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	**2014-15 £000s**	2013-14 £000s
Service element of on SOFP PFI charged to operating expenses in year	**891**	839
Total	**891**	839
Payments committed to in respect of off SOFP PFI and the service element of on SOFP PFI		
No Later than One Year	**1,083**	891
Later than One Year, No Later than Five Years	**3,927**	3,953
Later than Five Years	**15,153**	16,210
Total	**20,163**	21,054

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	**2014/2015**	2013/2014
Estimated capital value of the PFI Scheme	**7,542**	7,542
Contract start date:		**06/03/2000**
Contract end date:		**06/06/2025**

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 fundec 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	**2014/2015**	2013/2014
Estimated capital value of the PFI Scheme	**9,440**	9,440
Contract start date:		**29/09/2006**
Contract end date:		**29/09/2031**
Phase 2 Stone House Hospital	**2014/2015**	2013/2014
Estimated capital value of the PFI Scheme	**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	**2014-15 £000s**	2013-14 £000s
No Later than One Year	**1,179**	1,454
Later than One Year, No Later than Five Years	**5,739**	5,542
Later than Five Years	**16,556**	17,932
Subtotal	**23,474**	24,928
Less: Interest Element	**(9,710)**	(10,605)
Total	**13,764**	14,323

Present Value Imputed "finance lease" obligations for on SOFP PFI contracts due	**2014-15**	2013-14
Analysed by when PFI payments are due	**£000s**	£000s
No Later than One Year	**313**	559
Later than One Year, No Later than Five Years	**2,610**	2,268
Later than Five Years	**10,841**	11,496
Total	**13,764**	14,323
Number of on SOFP PFI Contracts		
Total Number of on PFI contracts	**2**	

28 Impact of IFRS treatment - current year

	2014-15 £000s	2013-14 £000s
The information below is required by the Department of Heath for budget reconciliation purposes		
Revenue costs of IFRS: Arrangements reported on SoFP under IFRIC12 (e.g PFI)		
Depreciation charges	**403**	384
Interest Expense	**895**	931
Other Expenditure	**1,420**	1,249
Impact on PDC dividend payable	**255**	230
Total IFRS Expenditure (IFRIC12)	**2,973**	**2,794**
Revenue consequences of PFI / LIFT schemes under UK GAAP / ESA95 (net of any sublease revenue)	**(2,878)**	(2,761)
Net IFRS change (IFRIC12)	**95**	**33**
Capital Consequences of IFRS : PFI and other items under IFRIC12		
Capital expenditure 2014-15	**63**	457

29 Financial Instruments

29.1 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 NHS Trust has with Clincial Commissioning Groups (CCGs) and the way those CCGs are financed, the NHS 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 NHS 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 NHS 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 the strategic health authority. 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 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 2015 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, 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.

29.2 Financial Assets

	Loans and receivables	Total
	£000s	£000s
Receivables - NHS	**7,262**	**7,262**
Receivables - non-NHS	**1,117**	**1,117**
Cash at bank and in hand	**12,418**	**12,418**
Total at 31 March 2015	**20,797**	**20,797**
Receivables - NHS	4,790	4,790
Receivables - non-NHS	1,150	1,150
Cash at bank and in hand	16,791	16,791
Total at 31 March 2014	22,731	22,731

29.3 Financial Liabilities

	Other	Total
	£000s	£000s
NHS payables	**4,116**	**4,116**
Non-NHS payables	**11,695**	**11,695**
Other borrowings	**5,600**	**5,600**
PFI & finance lease obligations	**15,471**	**15,471**
Total at 31 March 2015	**36,882**	**36,882**
NHS payables	2,651	2,651
Non-NHS payables	7,237	7,237
Other borrowings	3,200	3,200
PFI & finance lease obligations	16,167	16,167
Total at 31 March 2014	29,255	29,255

30 Events after the end of the reporting period

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

31 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 any material transactions with the Kent and Medway NHS 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 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 are listed below:

Income	**2014/2015**	2013/2014
	£000	£000
East Kent University Hospitals NHS Foundation Trust	**367**	530
Brighton & Sussex University Hospitals NHS Trust	**0**	962
Health Education England	**4,075**	2,128
Kent Community NHS Trust	**1,174**	1,556
Kent Community NHS Foundation Trust	**77**	0
Sussex Partnership NHS Foundation Trust	**217**	670
NHS Ashford Clinical Commissioning Group	**8,976**	9,127
NHS Canterbury and Coastal Clinical Commissioning Group	**17,708**	16,434
NHS Dartford, Gravesham & Swanley Clincial Commissioning Group	**17,851**	18,222
NHS Thanet Clinical Commissioning Group	**14,385**	13,357
NHS Swale Clinical Commissioning Group	**9,131**	9,386
NHS West Kent Clinical Commissioning Group	**33,666**	32,913
NHS South Kent Coast Clincial Commissioning Group	**18,556**	18,023
NHS Medway Clinical Commissioning Group	**21,771**	20,637
NHS England	**19,772**	19,951

Expenditure	**2014/2015**	2013/2014
	£000	£000
East Kent University Hospitals NHS Foundation Trust	1,393	1,837
Maidstone & TW NHS Trust	2,362	2,082
Medway NHS Foundation Trust	1,246	1,690
NHS Litigation Authority	510	495

	2014/2015	2013/2014
New PDC	**£000**	£000
Department of Health	**0**	70

	2014/2015	2013/2014
New Loan	**£000**	£000
Department of Health	**4,000**	0

32 Losses and special payments

The total number of losses cases in 2014-15 and their total value was as follows:

	Total Value of Cases £s	**Total Number of Cases**
Losses	67,783	21
Special payments	77,848	36
Total losses and special payments	145,631	57

The total number of losses cases in 2013-14 and their total value was as follows:

	Total Value of Cases £s	Total Number of Cases
Losses	3,504	15
Special payments	111,736	42
Total losses and special payments	115,240	57

33. 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.

33.1 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**
Turnover	183,877	186,039	182,839	182,374	182,204	178,468	172,902	174,924	**178,674**
Retained surplus/(deficit) for the year	123	431	1,384	407	(232)	32	(1,604)	(379)	**465**
Adjustment for:									
Adjustments for impairments	0	0	284	1,308	245	449	2,683	1,895	**301**
Adjustments for impact of policy change re donated/government grants assets	0	0	0	0	0	56	56	58	**41**
Consolidated Budgetary Guidance - adjustment for dual accounting under IFRIC12*	0	0	0	(191)	(47)	1	67	33	**95**
Other agreed adjustments	0	0	154	0	0	0	0	0	**0**
Break-even in-year position	123	431	1,822	1,524	(34)	538	1,202	1,607	**902**
Break-even cumulative position	123	554	2,376	3,900	3,866	4,404	5,606	7,213	**8,115**

* Due to the introduction of International Financial Reporting Standards (IFRS) accounting in 2009-10, NHS 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 %**
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**
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**

The amounts in the above tables in respect of financial years 2006/07 to 2008/09 inclusive have **not** been restated to IFRS and remain on a UK GAAP basis.

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33.2 Capital cost absorption rate

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

33.3 External financing

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

	2014-15	2013-14
	£000s	£000s
External financing limit (EFL)	**6,494**	(674)
Cash flow financing	**6,078**	(1,909)
Unwinding of Discount Adjustment	**0**	72
External financing requirement	**6,078**	(1,837)
Under spend against EFL	**416**	1,163

The £416k underspend of cash relates mainly to a late disposal receipt received of £295k and small movements in working capital.

33.4 Capital resource limit

The Trust is given a capital resource limit which it is not permitted to exceed, underspends are allowed.

	2014-15	2013-14
	£000s	£000s
Gross capital expenditure	**14,732**	9,511
Less: book value of assets disposed of	**(2,871)**	(4,522)
Charge against the capital resource limit	**11,861**	4,989
Capital resource limit	**11,902**	5,488
Underspend against the capital resource limit	**41**	499

34 Third party assets

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

	31 March	31 March
	2015	2014
	£000s	£000s
Third party assets held by the Trust	**183**	181

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 for the year ended 31 March 2015 under the Audit Commission Act 1998. 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 the accounting policies directed by the Secretary of State with the consent of the Treasury as relevant to the National Health Service in England.

We have also audited the information in the Remuneration Report that is subject to audit, being:

- the table of salaries and allowances of senior managers on page 40;
- the table of pension benefits of senior managers on page 42; and
- the details of pay multiples on page 43.

This report is made solely to the Board of Directors of Kent and Medway NHS and Social Care Partnership Trust in accordance with Part II of the Audit Commission Act 1998 and for no other purpose, as set out in paragraph 44 of the Statement of Responsibilities of Auditors and Audited Bodies published by the Audit Commission in March 2014. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the Trust's directors and the Trust as a body, for our audit work, for this report, or for the opinions we have formed.

Respective responsibilities of Directors and auditor

As explained more fully in the Statement of Directors' Responsibilities in respect of the accounts, 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 and International Standards on Auditing (UK and Ireland). Those standards also require us to comply with the Auditing Practices Board's Ethical Standards for Auditors.

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 annual report, which comprises strategic objectives and progress, quality and performance, how we are organised and financial overview, 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.

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 2015 and of its expenditure and income for the year then ended; and
- have been prepared properly in accordance with the accounting policies directed by the Secretary of State with the consent of the Treasury as relevant to the National Health Service in England.

Opinion on other matters

In our opinion:

- the part of the Remuneration Report subject to audit has been prepared properly in accordance with the requirements directed by the Secretary of State with the consent of the Treasury as relevant to the National Health Service in England; and
- the information given in the annual report for the financial year for which the financial statements are prepared is consistent with the financial statements.

Matters on which we report by exception

We report to you if:

- in our opinion the governance statement does not reflect compliance with the NHS Trust Development Authority's Guidance
- we refer the matter to the Secretary of State under section 19 of the Audit Commission Act 1998 because we have reason to believe that the Trust, or an officer of the Trust, is about to make, or has made, a decision involving unlawful expenditure, or is about to take, or has taken, unlawful action likely to cause a loss or deficiency; or
- we issue a report in the public interest under section 8 of the Audit Commission Act 1998.

Conclusion on the Trust's arrangements for securing economy, efficiency and effectiveness in the use of resources

Respective responsibilities of the Trust and auditor

The Trust is responsible for putting in place proper arrangements to secure economy, efficiency and effectiveness in its use of resources, to ensure proper stewardship and governance, and to review regularly the adequacy and effectiveness of these arrangements.

We are required under Section 5 of the Audit Commission Act 1998 to satisfy ourselves that the Trust has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources. The Code of Audit Practice issued by the Audit Commission requires us to report to you our conclusion relating to proper arrangements, having regard to relevant criteria specified by the Audit Commission in October 2014.

We report if significant matters have come to our attention which prevent us from concluding that the Trust has put in place proper arrangements for securing economy, efficiency and effectiveness in its use of resources. We are not required to consider, nor have we considered, whether all aspects of the Trust's arrangements for securing economy, efficiency and effectiveness in its use of resources are operating effectively.

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, published by the Audit Commission in October 2014, as to whether the Trust has proper arrangements for:

- securing financial resilience
- challenging how it secures economy, efficiency and effectiveness.

The Audit Commission has determined these two criteria as those 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 2015.

We planned our work in accordance with the Code of Audit Practice. Based on our risk assessment, we undertook such work as we considered necessary to form a view on whether, in all significant respects, the Trust had put in place proper arrangements to secure economy, efficiency and effectiveness in its use of resources.

Conclusion

On the basis of our work, having regard to the guidance on the specified criteria published by the Audit Commission in October 2014, we are satisfied that in all significant respects Kent and Medway NHS and Social Care Partnership Trust put in place proper arrangements to secure economy, efficiency and effectiveness in its use of resources for the year ending 31 March 2015.

Certificate

We certify that we have completed the audit of the accounts of Kent and Medway NHS and Social Care Partnership Trust in accordance with the requirements of the Audit Commission Act 1998 and the Code of Audit Practice issued by the Audit Commission.

Paul Hughes

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

Grant Thornton House, Melton Street

Euston Square,

London NW1 2EP

4 June 2015

Your Views

We want to know what you think. Therefore, if you have any comments to make about this Annual Report, or you would like further copies, please contact:

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This report can be downloaded as a PDF from www.kmpt.nhs.uk

You can also request a full copy of the Trust Accounts from the address above.

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

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