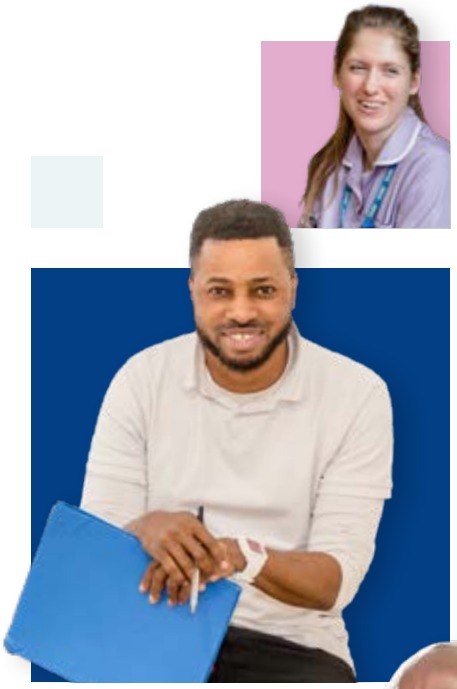
NHS
Kent and Medway
NHS and Social Care Partnership Trust

Annual Report
2021-22




Brilliant care through brilliant people

2021-22 at a glance

7 Qi projects completed

115 staff trained in bitesize Qi modules

Listened to 5,000 local people about ways to improve mental health across the county

Supported 35 neighbourhood level projects

Decreased the number of ethnic minority staff experiencing abuse from patients

Reduced out of area placements from 166 to 50 in the last two years

Trained 44 staff as mental health first aiders

Recruited 1,222 participants in our 27 research studies across a range of mental health subjects including dementia, depression, psychosis, open dialogue and bipolar

Increased the number of people on the dementia registers in Kent and Medway by 9%

Recruited 22 new mental health practitioners

Retained our overall Good rating by CQC and rated Outstanding for caring and effective

Achieved our highest ever staff survey response rate 68%

Driven nearly 50,000 visits to our new PATH online hub that supports women with perinatal mental illnesses

Ranked 13/49 in mental health trusts for our research participation numbers

Contents

Welcome

Performance report

Accountability report

Annual accounts

CEO's statement

I have had the privilege of working in the NHS and in mental health for almost forty years and in that time I've seen first-hand, as a nurse and as a chief executive, the continuous commitment of its people to deliver high quality care. The last two years of living in a pandemic has tested KMPT, as it has the whole of the NHS, but our people have continued to work extremely hard to deliver brilliant care and I am hugely proud of my colleagues' commitment and what they have achieved.

While the rest of the country eased its restrictions, the NHS has continued to work in extraordinary circumstances to protect the most vulnerable in society. In mental health, the picture is similar nationally as it is locally in Kent and Medway. There has been a sustained increase in people needing our support and services, and the impact of the pandemic is still being felt in some areas like dementia, for instance, where diagnosis rates across the UK fell to an historic low.

I'm also very aware of the impact all of this has had on our people. This is why we have stepped up our own health and wellbeing offer to staff and why improving employee recruitment, retention and wellbeing is one of our three strategic priorities for the next year. I'm also delighted that KMPT has led on delivering mental health and wellbeing support to NHS and social care staff across the whole of the county through the talking wellness hub. The team has taken an innovative approach by taking the service directly to frontline staff using a fully converted double decker bus. This has been hugely popular and while only a few weeks in, has already supported over 500 Kent and Medway NHS staff.

As this annual report shows, we have made significant progress on our priorities for 2021-22 despite the impact of COVID-19 on our people and our services. Firstly, we have improved the quality of what we do through our dedicated approach to quality improvement. Our Qi projects have both improved staff wellbeing and productivity, and made improvements to the care we offer our patients like the introduction of safety pods. We are committed to accelerating our work on QI this year and will be empowering our people to create and find ways to improve the quality of our services.

Secondly, we have used our expertise to lead and work with our partners to improve care and services. We launched an engagement council made up of service users and their loved ones who provide input at a strategic level. Our commitment to play a full role in our integrated system has been welcomed by our partners. Our establishment and leadership of the Mental Health Learning Disability and Autism Board in 2019 enabled providers of those services to work together to drive up our performance across the county. Over the last twelve months the work of the board has strengthened further and been positively commented on by our regulators. Through our vital role within the newly created Integrated Care Board, one of our joint priorities has been to improve dementia diagnosis in Kent and Medway where we are ahead both regionally and nationally in diagnosis rates. We have worked with local and regional partners to significantly reduce the number of local residents who are placed in care outside of the county. And we have led on a European project to prevent, diagnose and successfully manage mild to moderate perinatal mental illness.

Over 47,000 people have visited our online hub already to seek help and resources, we have trained healthcare professionals and run support sessions for parenting groups to help raise awareness and understanding of perinatal mental health.

Thirdly, we have been supporting new ways to integrate mental and physical health services to people across Kent and Medway with our partners. We have embedded mental health specialists in council outreach teams to help rough sleepers, and have created new mental health practitioner roles to sit within primary care networks so that people in Kent and Medway can gain access to mental health care through their GPs.

As this annual report shows, we have made significant progress on our priorities for 2021-22 despite the impact of COVID-19 on our people and our services

In addition to this, we have had much to celebrate over the year. Our Rosewood Mother and Baby Unit was the winner of the Royal Horticultural Society Chelsea Flower show competition, the prize being a beautiful new 'garden of hope' created especially for our patients, families and staff to benefit from. We won first prize at the Cambridge QI online conference for our work on minimising violence and restrictive practice on our acute wards and also won multiple awards at the local Healthwatch awards recognising the brilliant care we deliver across the county. We were awarded £12.65 million to build a new state-of-the art mental health ward for which work is already underway. We also registered our new mental health charity which will be launched later this year. Then, in February, we retained our CQC Good overall rating and our long held Outstanding rating for Caring. We also added a new overall rating of Outstanding for Effective. This is a significant achievement and one that reflects the extremely hard work that all of my KMPT colleagues have been doing over recent months and years.

Finally, underpinning all of this has been the positive progress we have made to enable our people to be the best that they can be. We have taken steps to make our systems more efficient and easier to use, we have reduced our underlying deficit and we have created more ways for our people to speak up and be heard. We have also continued having vital conversations, events and training about diversity and inclusion so that we can meet our aspirations to become a fully inclusive, diverse and anti-racist organisation. We achieved the highest ever response rate to our staff survey, which was also one of the highest among mental health trusts in the country, and retained our engagement score.

We are an organisation focused on delivering brilliant care through brilliant people and I am immensely proud of my colleagues for maintaining the service we deliver while improving the organisation in what has been another challenging year. I am equally grateful for the strong support and engagement of our Board and partners throughout the year. There is of course always more to be done, but there is also much to be celebrated in this report. I offer my formal and sincere thanks to staff, our partners and our service users and their loved ones for their continued support.

Helen Greatorex
Chief Executive

Chair's statement

As we gradually emerge from two years of a pandemic, this is a time for reflection. The Board is immensely proud of all our staff who have worked ceaselessly in difficult circumstances to provide the very best possible care for our services users and their loved ones.

Demand for our services has continued to increase and the distress of people who need our support is always at the forefront of our thoughts. Staff have shown immense resilience, but the Board recognises the toll that the pandemic has taken. Our strategy for 2022/23 reflects this understanding and the Board and executive team have deliberately taken the view that we should focus on three key priorities that we believe will make a demonstrable difference to the ability of our workforce to provide brilliant care for all.

Demand for our services has continued to increase and the distress of people who need our support is always at the forefront of our thoughts

There are many things to celebrate as we look back at the past year. The non-executive team visits to frontline services – albeit constrained by the pandemic – have noted the warm welcome and compassionate care provided by our staff. Our well-led CQC inspection in 2022 rated us as outstanding for effectiveness as well as for care, reflecting the great strides we have made in implementing new roles and ways of working, and an increased emphasis on quality improvement. We still have work to do and there is no room for complacency.

We are very focused on our estates and are working hard to improve the environment for staff and services users alike; we want to escalate the work on quality improvement; and we are determined to focus on our people's wellbeing, as well as equality and diversity as we move towards becoming an anti-racist organisation.

The Board is committed to working across the Integrated Care System in Kent and Medway. Last year we invested time and effort in working with our partners to establish the Mental Health, Learning Disability and Autism Improvement Board as a really effective collaboration coming together to improve pathways of care for the people of Kent. Our shared vision is that anyone living in Kent and Medway can receive support for their mental health difficulties in a timely, accessible and effective way. We will continue to focus our energies on this partnership working in the forthcoming year.

We start every Board meeting with a personal story from service users or carers, and this really sets the tone and focus of our meetings. I would like to conclude this introduction to the Annual Report by thanking all those with lived experience of mental ill health who have contributed in their diverse ways over the past year to our development as an organisation. Your vital contribution allows us to continually improve what we do for those in our care now and in the future.

Dr Jackie Craissati
Chair

About Kent and Medway NHS and Social Care Partnership Trust

KMPT provides mental health, learning disability, substance misuse and specialist services to approximately 1.8 million people across Kent and Medway.

We work in partnership with NHS providers, councils, charities, primary care and other health and social care organisations to deliver quality services and key pathways of care to people living in Kent and Medway. We are commissioned by Kent and Medway Clinical Commissioning Group and NHS Specialist Commissioning.

We are proud to be an employer that supports diversity and currently employ around 3,600 staff from 57 nationalities.

We provide a range of inpatient, community and crisis mental health services for working age and older adults including:

- Younger adult wards and older adult wards for those acutely unwell
- Health-based places of safety for people subject to Section 136 of the Mental Health Act
- Early intervention for psychosis service for people between 14 and 65 who are experiencing their first episode of psychosis and symptoms for less than three years
- Rehabilitation units to support people with mental health difficulties transition back into the community
- Specialist services including forensic, personality disorder, mental health of learning disability, substance misuse detoxification centre, perinatal psychiatry and veterans' mental health high intensity service
- Hospital liaison services based in Maidstone Hospital, Dartford, QEQM and Willian Harvey Hospital Ashford
- Community mental health support for younger and older adults
- Primary care mental health services, working alongside GPs to support and diagnose
- Mental health crisis services and home treatment teams

We are one of the largest mental health trusts in the country spread across 1,450 square miles, 33 sites and 66 buildings. We are proud to serve an ever-increasing diverse range of communities across rural and urban areas.

In February 2022 we retained our good overall rating from the Care Quality Commission and were rated as outstanding for effective and caring.

One of the largest mental health trusts in the UK

Employs over

3,600 staff

and works with Kent County Council and Medway Council social care services

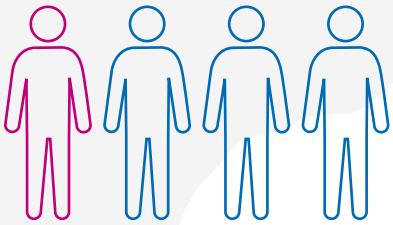
Rated as **Good** by the Care Quality Commission and **Outstanding** for Caring and Effective

Providing mental health, disability and specialist services

Serving a population of more than

1.8 million people

across Kent and Medway with specialist services available in Kent, Surrey and Sussex



1 in 4 people

will be affected by mental ill health

66 buildings

across Kent and Medway

33 sites

We are proud to be an employer that supports diversity

Our strategy

We have one simple mission, to deliver brilliant care through brilliant people.

In 2021-22, our strategy focused on the following three objectives:

Quality

To consistently deliver outcomes that matter to people through outstanding quality of care that is underpinned by a mature approach to quality improvement.

Using our expertise to lead and partner

To partner effectively with other organisations in Kent and Medway to design and improvement innovative primary and community care models for mental health, learning disability and substance misuse.

Integration

To support the integration of mental and physical health service across Kent and Medway to deliver seamless care for our service users and carers and support delivery of the NHS Long Term Plan.

Towards the end of the year we reviewed how we can best deliver our mission, while responding to the challenges and opportunities ahead and continually meeting the needs of our people and service users. From 1 May 2022, we have three new strategic priorities which will ensure we make KMPT even better for our people to work for and even better for our service users to receive high quality care.

For 2022-23 our focus will be on:

People

by improving employee recruitment, retention and wellbeing

Quality

by accelerating an empowered culture to improve the quality of services

Partnerships

by building partnerships with a purpose to improve key pathways of care

Our strategic priorities

Our mission:

Brilliant care through brilliant people

Our values

Our values reflect who we are and how we work together with each other, with our service users and with our partners to achieve our mission and priorities.

We believe our values help us to create a culture for patients, their loved ones and our staff to feel empowered, to share their views and to use their professional skills and lived experience to improve our services through co-production, openness, respect and innovation.

We are dedicated to looking after our people's health, wellbeing and psychological safety and are proud to encourage a diverse and inclusive environment where people can be themselves.

#KMPTProud

Performance report

Quality Improvement

We are committed to providing the highest quality of care and embracing feedback and engagement from our service users and their loved ones to help us continuously improve.

Our aspiration is that everyone across KMPT is empowered to improve the quality of our services by looking at what's currently working well and what could be done differently. To achieve this, we use a method called Quality Improvement (Qi).

What is Qi

Qi is about problem solving, continual learning and adaptation. The starting point is to identify a problem where we would like to see improvement, and this becomes a Qi project.

Our people work collaboratively with patients, carers and family members to develop a plan that everyone can play a part in and own to bring about the changes we want to see.

Using a variety of appropriate Qi methods allows us to measure the difference those changes are making each day to patient care, while taking a consistent and open approach to problem solving. If we're not seeing the results we want or expect, we can adapt what we're doing to try and get the desired outcome.

We learn from our results, grow and continually improve. We share our successes and failures with colleagues so that we can change the way we work and provide brilliant care through brilliant people.

Over the last year we have been growing our Qi capabilities and building a culture of continuous improvement by encouraging our people to create and find ways to improve what we do. This includes encouraging people at all levels in the organisation and across all roles to think differently and be innovative.

We share our successes and failures with colleagues so that we can change the way we work and provide brilliant care through brilliant people

Our key achievements include:

- We have completed 7 Qi projects and shared this learning across the organisation, as well as at our public board
- We have developed and delivered bitesize training modules to over 350 staff
- We have launched and run a series of Qi awareness events which have been attended by 800 staff to date
- We delivered a 'Leading the way' training programme for our 100 senior leaders
- We won the Best Presentation on Wellbeing at the Cambridge Health Leaders Awards 2022 for our Qi project on reducing violence in acute wards

Read more about three of the quality improvement projects that are making a difference to patient care.

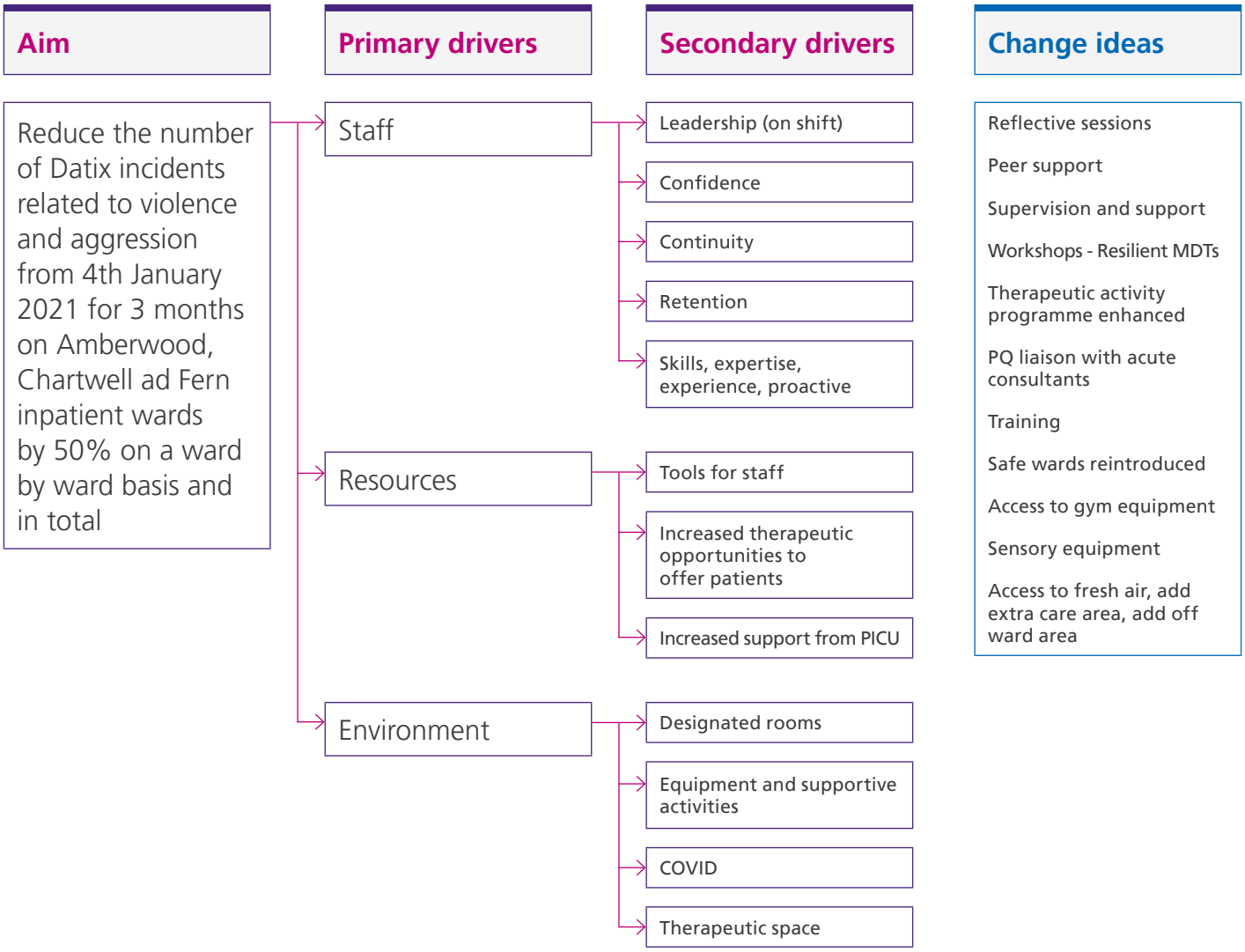
Case study: Reducing violence and restrictive practices within acute inpatient units

The aim of this quality improvement project was to reduce the number of violence and restrictive practices within KMPT's acute inpatient units by 50 per cent after three-months.

Three acute wards were identified to take part in the improvement plan: Amberwood in Dartford, Chartwell in Maidstone and Fern in Canterbury.

To give us a benchmark we looked at the period between October 2020 and January 2021 where an average of 28 incidents of restraints were recorded as taking place.

We brought together a project group which included service users from the three wards to work collaboratively and look at the various ways in which changes could be put in place.



The potential change ideas were co-produced by the project team and service users to ensure that everyone's ideas were captured and to make sure the project was as collaborative as it could be.

Service users were asked to complete a survey to decide which of the ideas put forward were the most popular and, in their opinion, have the most impact. The ideas were ranked using a method called the Qi Pareto Principle.

The idea of the sensory equipment was chosen to be taken forward. This included: light projectors to play music, soothing DVDs to assist with relaxation and ear defenders specifically identified by our service users.

Additional ideas were also gathered from the wider acute care group to help support the aims of the project: enhanced recruitment of substantive staff, safety pods, introducing safety huddles, revising therapeutic planner, developing safe care champions and inclusion of professionals from various disciplines such as drama therapist, sports technicians and the introduction of peer support workers that not usually included as part of a multi-disciplinary team.

Funds for the project were secured through charitable contributions. We would like to thank the generosity and support of Chelsey Dartford Lions Club who donated £500 for the rollout of these improvements on Amberwood ward.

The new equipment was installed in August 2021.

Due to the huge success of the pilot we are now looking to implement these changes across all of our acute care units

The outcome

The impact of this project was monitored between October 2021 to January 2022, a year after the initial data was collected. The aim of the project was to reduce violence and restrictive practices by 50 per cent after a 3-month period. The final result was a reduction of 56 per cent reduction with only 12.3 incidents being reported.

Good practice across KMPT and national award recognition

Due to the huge success of the pilot we are now looking to implement these changes across all of our acute care units. We also received recognition at the Cambridge Health Leaders Awards 2022 for this project, winning Best Presentation on Wellbeing.

Albert Kemp, quality improvement facilitator said: “I am delighted that the project has been recognised for this award. The hard work and dedication to the project has worked to ensure its success.”

Case study: Safety pods

In 2021 KMPT introduced the use of safety pods across 6 of its inpatient wards to help improve the health and wellbeing of patients whilst reducing any risk of injury and trauma during any physical intervention.

The safety pods are perfectly shaped to provide the right neck and head support for people. Plus, their ergonomic design responds to a person's natural body shape to allow the best seating position for them, thereby reducing the risk of harm.

The response has been fantastic and both staff and patients have expressed how much they have improved the therapeutic environment and care.

"Patients have already commented they like the safety pods in the lounge and calming room. It's good to chill whilst watching TV. I believe the safety pods will support a reduction in injuries for all during a restraint." Cheryl Lee, matron.

"At the core of what we do is to support services in reducing the use of restrictive practices by offering safer alternatives. Safety pods will increase safety to those we support, and our staff: as well as improving dignity to all." Dale Tinkler, promoting safe services tutor.

"We know there is a lot of evidential research that shows the safety and therapeutic benefits of using safety pods. We are continuously working on improving our patient experience and enhancing safety, therefore, we are delighted to have this new addition to in the acute care group to help us achieve this." Sharon Walcott, interim head of service.

"We are excited to use the Safety pods on Bluebell ward as we see it as a less restrictive option for delivering innovative patient centred care. We are sure that these pods will be able to support vulnerable patients and can be used as a more therapeutic way of helping them in times of distress. We are sure that staff will also find these pods useful in helping to maintain those therapeutic relationships with patients and broaden our de-escalation options." Ollie Webb, inpatient senior practitioner on Bluebell ward.

Above: A safety pod at Cherrywood

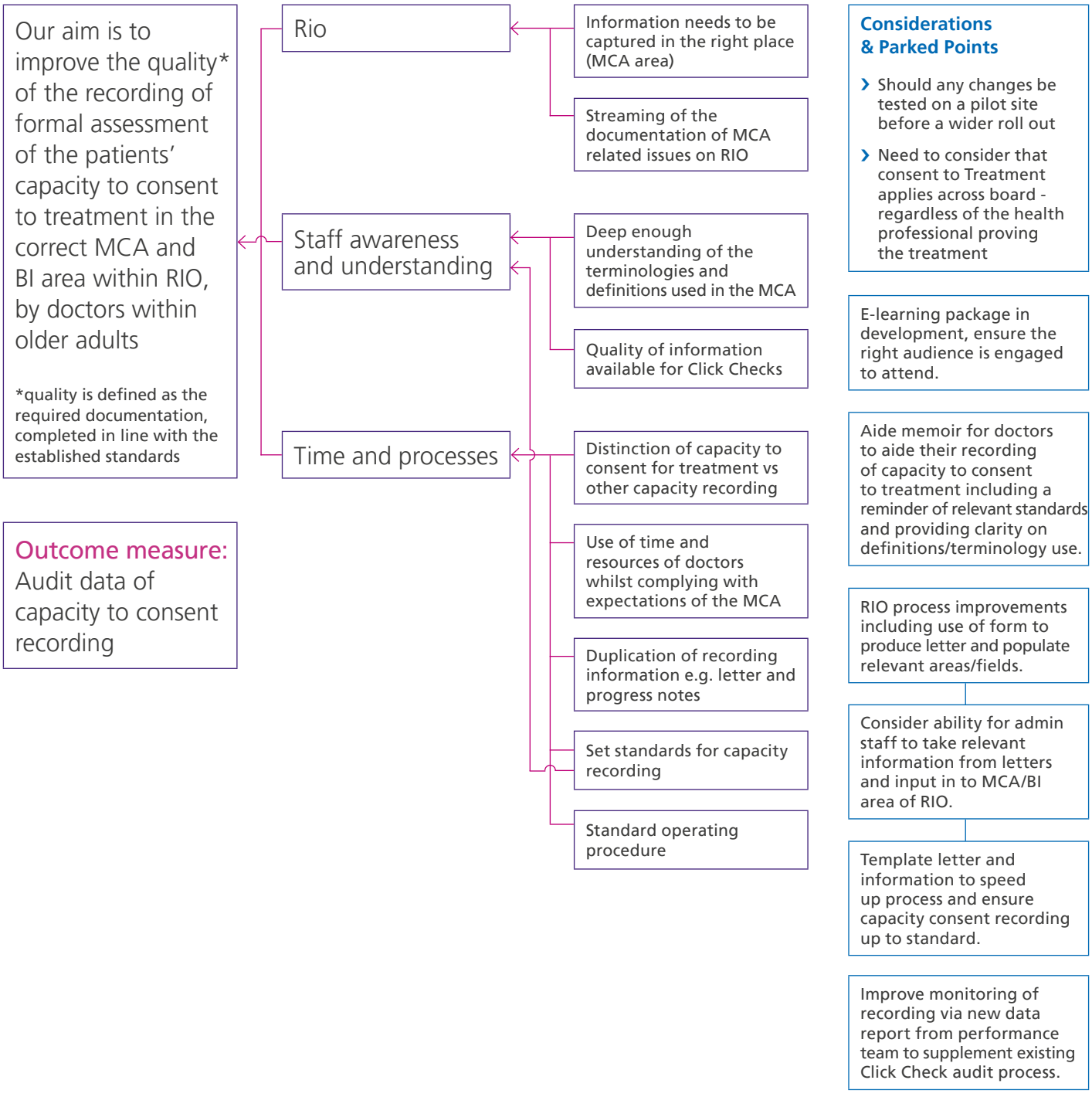
The response has been fantastic and both staff and patients have expressed how much they have improved the therapeutic environment and care

Case study: Capacity to consent

The Mental Capacity Act (MCA) is **designed to protect and empower people who may lack the mental capacity to make their own decisions about their care and treatment**. It applies to people aged 16 and over.

NHS mental health trusts are required by law to report on compliance with recording of MCA. We noted through our system of checks that recording was not always happening due to workload pressures among doctors. In response, we engaged in a Qi project to support staff and ensure we are complaint with our requirements.

The project team was made up of staff from our older adults care group who came together to explore the current processes, barriers, issues and successes. A driver diagram was used to capture this information (see below) and ideas for change were explored and prioritised.



Four ideas were chosen to take forward, which included:

- Launching new e-learning essential training for 'Mental Capacity Assessment Recording: Consent to Treatment' package on our learning and development microsite i-learn
- Supporting the e-learning with practical workshops
- Engaging with the consultant body
- Amending the process to involve our administration team, and to submit a data request to produce an auto-populating form for our electronic patient records system

Due to the interdependency of these ideas and their ability to be owned by different members of the group they were all progressed simultaneously using the Plan, Do, Study, Act (PDSA) cycles model.

What are Plan, Do, Study, Act cycles?

The PDSA model for improvement provides a framework for developing, testing and implementing changes leading to improvement. It is based in scientific method and moderates the impulse to take immediate action with the wisdom of careful study.

Using PDSA cycles enables you to test out changes on a small scale, building on the learning from these test cycles in a structured way before wholesale implementation. This gives stakeholders the opportunity to see if the proposed change will succeed and is a powerful tool for learning from ideas that do and don't work. This way, the process of change is safer and less disruptive for patients and staff.

The outcome

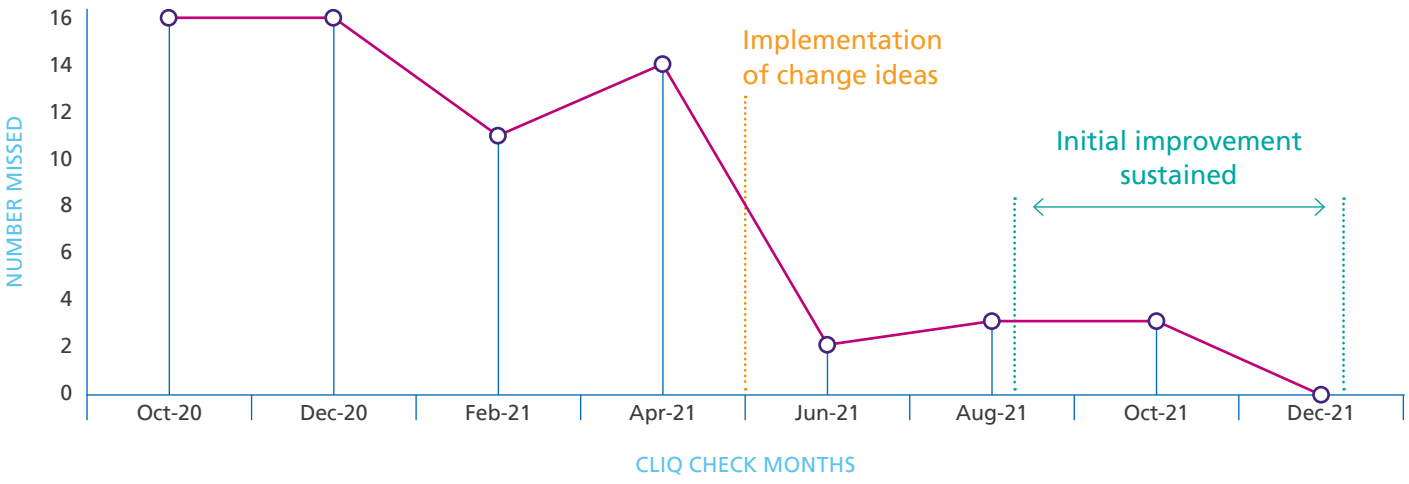
A significant improvement has been seen in the reported data and six months after the changes were implemented this improvement has been sustained.

Highlight

PRE-IMPROVEMENT AVERAGE MISSED RECORDINGS: 14

POST-IMPROVEMENT AVERAGE MISSED RECORDINGS: 2

High impact areas for lack of MCA/BI recording



We will be introducing a new data review process to monitor improvement and gather richer data. We also plan to roll out a second stage of the project which will involve looking at the forms we use to record compliance in our electronic patient record system.

Research and innovation

NHS organisations that carry out research routinely and regularly offer better care, and greater choice, to patients and service users. Research activity means patients and service users have access to the latest, innovative treatments. Staff benefit too, as they learn new skills that give them better career opportunities and promotion prospects, and they can apply for funding to test their own ideas for new methods of care and new ways of organising services.

In the last year we have been investing in our research and innovation capabilities and have ambitious plans for the year ahead. Our new director of research and innovation is also jointly positioned within the Kent and Medway Medical School which bolsters our collaborative academia relationships.

We recruited a total of 1222 participants to 27 portfolio studies covering areas such as perinatal mental health, dementia, depression and anxiety, psychosis, open dialogue, bipolar, intellectual disability and COVID-19. We are now ranked 13 out of 49 mental health trusts for our recruitment numbers which is our highest position to date.

In support of our partnership project to improve perinatal mental illnesses (PATH) we launched our first sponsored study to explore the stigma of perinatal mental health and to inform our approach, with 669 people taking part. Further information on the project we led is later in this report under Partnerships.

We supported eight research publications in peer reviewed journals. This included:

- **Ethics and Management of cannabis use in pregnancy**
  by Towobola, Towobola, Nair & Makwana, in *BJPsych Bulletin*
- **Developing trauma-informed care: using psychodynamic concepts to help staff respond to the attachment needs of survivors of trauma**
  by Rye, Anderson & Pickard, in *Advances in Mental Health and Intellectual Disabilities*
- **Peer supported Open Dialogue in the National Health Service: implementing and evaluating a new approach to Mental Health Care**
  by Kinane, Osborne, Ishaq, Coleman & MacInnes, in *BMC Psychiatry*
- **New project to support parents experiencing perinatal mental illnesses**
  by Nair, in *General Practice Nursing*
- **Epilepsy related multimorbidity, polypharmacy and risks in adults with intellectual disabilities: a national study**
  by Sun et al (Mogbeyiteren Eyeoyibo), in *Journal of Neurology*
- **Innovative Staffing Solutions to Nursing Shortages in Acute Mental Health Inpatient Wards**
  by Ma, Kritsimali, Olby-Clements, Boyd & Demirbasa, in Issues in *Mental Health Nursing*
- **Lost voices part 1: A narrative case study of two young men with learning disabilities disclosing experiences of sexual, emotional and physical abuse**
  by Digman, in *British Journal of Learning Disabilities*
- **Lost voices part 2: Modifying psychological therapies for two young men with complex learning disabilities following alleged sexual and physical abuse: A case study in trauma recovery**
  by Digman, in *British Journal of Learning Disabilities*

Our research and innovation team has been involved in a new and exciting collaboration with the Royal Literary Fund (RLF) to offer writing support to our clinical staff through a series of free online workshops. The RLF funds professional writers to work in universities, with businesses and charities, and more recently with NHS trusts like ours to develop people's approach and types of writing. This has supported the development of our people and also improved the quality of publications we have had published in peer review journals. We plan to continue this collaboration over the coming year.

Our Clinical Research Practitioners led a national Twitter takeover of the National Institute for Health and Care Research (NIHR) twitter handle to showcase their newly accredited role, which was a first for both KMPT and NIHR. We achieved 24,000 impressions and there were 149 mentions of **#CRPractitioner on the day.**

Our work of the coming year will support our ambitions to: increase the number of research studies we carry out; boost our research grant income; bolster collaborative relationships with our neighbouring universities, and with Kent and Medway Medical School; encourage more people who work in, and more people who use, our services, to get involved in research projects; increase the number of service users from ethnic minority backgrounds to take part in research projects; increase partnerships; and ensure our research is used to improve patient care.

Our Clinical Research Practitioners led a national Twitter takeover of the National Institute for Health and Care Research (NIHR) twitter handle to showcase their newly accredited role, which was a first for both KMPT and NIHR

Innovation fund

Our innovation fund was launched in November 2021 to encourage staff to look at innovative small-scale projects that can help improve patient care, health and wellbeing or productivity. Approved projects can receive up to £5,000 to support their innovation.

Since launching, we have received 46 bids from teams across the organisation and 10 projects have been awarded funding. As well as leading to positive benefits for our service users and people, the fund has also helped empower our people to think differently about how a small change in their service area can make a huge difference and take ownership for quality improvement.

The total fund is £50,000 per year.

Above: Amy, peer support worker with a copy of the book she wrote and illustrated

Below is a summary of three of our successful projects from the last year.

› Sensory room

A sensory room at Littlebrook Hospital in Dartford is being developed to help reduce the number of incidents of violence and aggression on Pinewood (a male acute inpatient ward) by introducing a space where patients can interact with therapeutic and sensory stimulus. The room is being equipped with a variety of equipment including a laser sky projector, floor and wall mats and ROMPA rainbow-coloured bumpas.

› Self-option box

Similar to calm down boxes, patients on Walmer ward can create self-option boxes where they pick a number of sensory items that are meaningful to them. Options include a range of sensory items to help them throughout stay, particularly in moments of heightened stress or challenging times. The boxes are entirely personal to the them and may include items that help with distraction and focus on wellbeing.

› My mum's poorly brain

Amy, a peer support worker, at Rosewood Mother and Baby Unit (MBU) in Dartford authored and illustrated a short picture book, My mum's poorly brain, to help mothers being cared for talk to their older children about how they are feeling. The book explains in simple language how mum's brain might be feeling, what help she might need and the type of health care professionals that could help mum feel better. The overarching message is that no matter how poorly mum's brain might be, she still loves her children. 250 copies have been produced and are being used to support families in our care. We also plan to share this with other trusts who provide an MBU service.

Approved projects can receive up to £5,000 to support their innovation

We listen and learn from the feedback shared with us by patients, carers and staff to improve our services

Partnerships

Over the last year we have continued to use our expertise to lead and partner with our patients and their loved ones, carers, private and voluntary organisations as well as other health providers to improve our care and services.

Engagement with our service users and their loved ones

In 2021-22 we encouraged a more diverse range of people with lived experience of mental health to come forward and be involved in not only improving but actively developing our services. To date, we have secured the support of over 120 people who make up our engagement pool and have helped us improve 380 trust-wide activities in 2021 and 2022.

We are delighted that this work was recognised at the Healthwatch Recognition awards, for committing to a new way of working that sees people with personal experience of mental health working to transform services.

Above: Catriona Toms at the Healthwatch Recognition awards

Engagement Council

At the end of 2021 we created an engagement council. 13 people from our engagement pool, with lived experience of using our services were appointed to the council. They are representative of both our geographical makeup and of the people we support across Kent and Medway. Their role is work with the trust's board, engagement pool and our care group services to suggest ways we can improve and develop our services.

Above: Cinzia, a member of the Engagement Council

Case study: Engagement Council and Engagement pool members

Cinzia started her career as a humanities teacher. She became involved in championing the work of KMPT following her own experience of living with ill mental health. Cinzia said: "I developed a mental health condition which took me out of the workplace for a number of years. As I began to recover, I became interested in helping others and felt like I could make a difference. I knew what it was like to suffer with a mental health problem and I wanted to use my skills in the field of healthcare to help others.

"I wanted to work with KMPT because I'd received great care from the trust when I'd been ill and I wanted to give something back. I noticed that the Engagement team was advertising for people to get involved and I decided to respond, which turned out to be an excellent decision! I quickly realised that their approach matched my own strong beliefs about working as equal partners in order to improve services.

"As part of the council we work in a co-produced way, which means that people with lived experience and staff work as equals to improve outcomes for all."

Engagement pool member, Liz shared: "My husband was admitted to St Martins Hospital and that experience led me to want to provide feedback. Working in a collaborative, co-produced way, I feel that our experiences are heard and recognised by the team. I see changes happening and I feel happy that services are improving as a result of my involvement.

"I think I am able to express my views on how things can be improved and how they are received by service users and their partners. I am able to represent other service users and carers who perhaps don't feel that comfortable in expressing their views."

Above: Dr Afifa Qazi, Chief Medical Officer, speaking at a national Alzheimer's Society conference

Partnering to improve dementia diagnosis

Through our vital role within the newly created Integrated Care Board, one of our joint priorities has been to improve dementia diagnosis in Kent and Medway where rates fell significantly due to the impact of the pandemic.

We are ahead both regionally and nationally in diagnosis rates. The number of people on the dementia register in Kent and Medway has increased by 9% in the last year, compared to 0.14% across the whole of England.

Our work has included raising awareness of dementia and pre and post-diagnostic support to enable people with dementia to live well. We also started a programme with GPs to train them to become dementia experts, which will see more people diagnosed in primary care settings in the future.

Work is also underway to introduce a new Enhanced Memory Assessment and Intervention Service. This has been developed by Kent and Medway clinicians, with the valuable input of our engagement pool and dementia envoys, and will be available to people with concerns about their memory who are referred by their GP or other healthcare professionals. People will be assessed and then diagnosed by clinicians on the same day and within six weeks of their GP referral. Currently there are two separate stages to diagnosis, the first is an assessment and the second is a follow up appointment with a clinician which can take on average 18 weeks from a referral.

Partnering to reduce out of area care

The ambitions of the NHS Long Term Plan and the Five Year Forward View is to support local health systems to reduce the number of people who access psychiatric inpatient care outside of their communities and borough, otherwise known as 'out of area' placements. Research tells us that people's recovery in mental health is usually better when close to their own home, community or loved ones. Out of area placements can often make it difficult for families to support their loves ones due to geographic distance.

KMPT agreed to work in partnership with the Kent and Medway Clinical Commission Group (CCG) to review all out of area placement and specialist placements the CCG were responsible for to review how they may be reduced.

In April 2020, KMPT agreed to lead on this national initiative and identified 166 people who were being support by out of area placements at a cost to the care system in Kent and Medway system of approximately £20 million per year.

In response, we carried out a clinical review to look at the quality and cost of the services being delivered by all care providers and in April 2021 we created a dedicated Review and Resettlement team to strengthen the ability of review panels to clinically assess patients who are privately placed. Our aim was to ensure that:

- the right care was being delivered in the right place at the right time;
- every person receiving the most appropriate care as close to home as possible; and
- no one person be placed outside of the county longer than absolutely necessary.

Total number of patients identified, length of stay and cost:

Number of patients: 80

Average length of stay: 2 years 7 months

Forecast Annual Cost: £11.2 million

Targets set for the review and resettlement team for the financial year 2021/2022:

Reduce the cohort of Out of Area specialist placements to 50

Reduce the annual spend on out of area specialist placements by £1.5 million

Outcome:

Out of area placements reduce to: 50

Reduction in annual spend by £1.87 million

Total admissions: 13 admissions

Discharges: 27

Financial savings reinvested in front line patient care

In 2022-23 we will continue to work alongside the CCG to further reduce the number of out of area specialist placements to 40 and reduce the financial spend by a further 16.5%

Physical health checks for people with severe mental illness

Under the NHS long-term plan, more people with severe mental illness (SMI) will receive a physical health check by 2023-24. This is part of the NHS plan to develop new and integrated models of primary and community mental health care which includes access to psychological therapies, improved physical health care, employment support, personalised and trauma informed care, medicines management and support for self-harm and coexisting substance use.

In the last year we have worked with partners in primary care to improve the uptake of physical health checks and annual health checks. In the coming year we will continue to improve engagement with our service users and their loved ones to encourage more people to have a health check as early identification and intervention can be lifesaving.

NHS Provider Collaborative

NHS Led Provider Collaboratives involve providers of specialist health and care services in the same geographical area working together to continuously improve patient experience. KMPT is part of the Kent, Surrey and Sussex Provider Collaborative for adult secure services. In the last year, we have worked together with our partners and lead provider to successfully move people out of inpatient hospital settings into the community to better support and aide the quality of care they receive. We have done this while also reporting a surplus of £1.6 million for KMPT and Kent, Surrey and Sussex, which will be reinvested into services over the coming year. The transfer of learning, disability and autism services from NHS England to the collaborative will also take place later in 2022-23.

In the last year, we have worked together with our partners and lead provider to successfully move people out of in-patient hospital settings into the community to better support and aide the quality of care they receive

Improving perinatal mental illnesses

Approximately 1 in 5 women will suffer from perinatal mental illnesses (PMI) during their pregnancy or in the year after the birth of their child. Mental health conditions such as postnatal depression and anxiety are not always recognised and treated.

This is why pathways to improving perinatal mental illnesses (PATH) was created to enable women, families and healthcare professionals to prevent, diagnose and successfully manage mild and moderate perinatal mental health issues. Funded by the European Union, this cross-border initiative involves thirteen partners from France, Belgium, the Netherlands and the UK, which has been led by us.

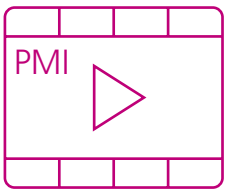
As part of the project, we launched our first sponsored study to explore the stigma of perinatal mental health and inform our approach, with 669 people taking part.

In May 2021, we launched a campaign to raise awareness of PMI, destigmatise it and provide support to prevent and overcome it. We created a host of online resources for health professionals, employers, new and expectant families to access through a new dedicated online hub. To date the hub has been visited 47,096 times. Beyond the hub we are developing training and support sessions for healthcare professionals, families and support workers, including those who run mother and baby groups. These will be rolled out in the summer of 2022.

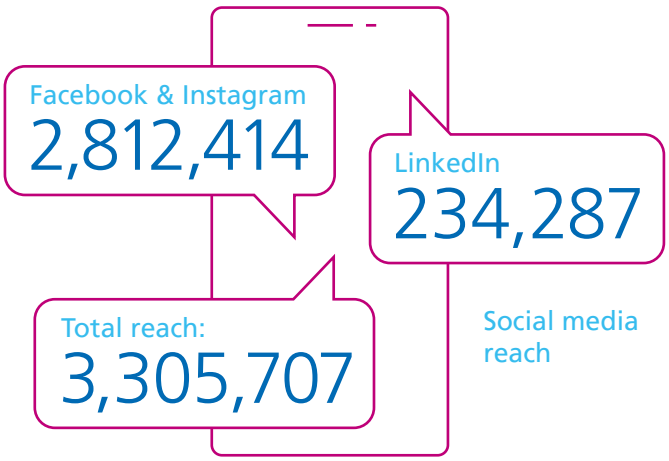
parents were surveyed on their experiences to develop our work

Engaged with healthcare professionals and employers

30
maternity centres and
170
pharmacies were provided with PATH bags to hand out to new and expectant parents



We collaborated with Sandra Igwe, best-selling children's author and founder of The Motherhood Group, and Mark Williams, mental health campaigner and founder of Fathers Reaching Out, to tell their stories of PMI through animation videos



Social media reach

Path Hub unique visits

34,229

Media coverage across

Sky News – GB News – BBC Radio Devon – KMFM – KMTV – Unity 101 – Daily Express – Women's Health – Journal of General Practise Nursing

Above: The PATH hub

PATH
PERINATAL MENTAL HEALTH

This is taken from a Dad who joined charity, Dad Matters, after reading about them on the online hub:

"I found the first couple of weeks after the birth particularly hard. First COVID-19 stopped me from meeting Eris for a few days and then not living with her and not seeing a lot of her was really hard to get used to. I joined the group when I was finding things difficult and then a few days later put a post on the page explaining my situation and how hard I was finding it. It was really helpful to have support and advice from people who had been in similar situations, but also people that didn't know me or the situation directly. One of the administrators then reached out to me privately to offer the group's direct support which was really nice too. The group is just a really nice way to ask advice and to know you have something to fall back on and people that understand first-hand how you are feeling."

"The birth didn't go as I had planned and I found myself worrying for the first time about the future and things not going as I was hoping. The information on the PATH website is so easy to read and understand that it has really helped to calm my nerves and start to enjoy the start of motherhood!" Mum accessing the hub

The group is just a really nice way to ask advice and to know you have something to fall back on and people that understand first-hand how you are feeling

Integration

The NHS Long Term Plan sets out how the NHS will move to a new service model in which patients get more options, better support and properly joined-up care at the right time in the optimal care setting. Local organisations are increasingly focused on population health, moving to Integrated Care Systems (ICS).

Our commitment to play a full role in our integrated system in Kent and Medway has been welcomed by our partners and builds on the work we have already been doing with our partners in recent years and shared in this report. Our establishment and leadership of the Mental Health Learning Disability and Autism Board in 2019 enabled providers of those services to work together to drive up our performance across the county. Over the last twelve months the work of the board has strengthened further and been positively commented on by our regulators.

What is integration?

Integration involves joining up primary, secondary and social care, taking into account both physical and mental health. Crucially, this means care for patients and their families is delivered holistically and in a more person-centred, co-ordinated way, to deliver outcomes and services that best meet their needs.

We have delivered a number of projects within the ICS. Highlights include:

- **Improving outcomes for people most vulnerable with co-occurring conditions,** which is when a mental health disorder and a substance disorder coexist. We developed a new shared way of working between mental health providers, Kent Country Council and substance misuse services to improve the consistency of quality care delivered.
- **Listening to the views of our local people on how we can improve mental health.** Through the Kent and Medway Listens for better Mental Health initiative we joined forces with our partners to listen to the voices of nearly 5,000 local people about what is putting pressure on their mental wellbeing and what can be done to support them. In response we will be developing detailed, shared action plans with our partners at system and place level over the next year.
- **Improving student wellbeing.** We have been part of a forum with local providers to improve practice and knowledge of wellbeing among Kent and Medway students through collaboration. This has improved the interface between student wellbeing services and secondary mental health services enabling a clearer pathway of joint support when required.

We joined forces with our partners to listen to the voices of nearly 5,000 local people

Embedding mental health services into physical health services

Another focus for us in 2021-22 has been finding ways to embed and offer mental health services and care at the right time and in the right setting. We created new mental health practitioner roles to sit within each primary care network across Kent and Medway to extend the range of convenient mental health care for local people, through their local GP. To date, we have recruited 24 mental health practitioners, and patients receiving care in these sessions are sharing positive outcomes and ease of access.

We have also embedded mental health specialist services in council outreach teams to help homelessness and rough sleepers. This work was successfully delivered in West Kent and will inform the wider development within the ICS for supporting rough sleepers in Kent and Medway. We have also supported improved joint working, collaboration and awareness raising to staff working in housing, mental health and substance misuse. Our work will inform commissioning for mental health and homelessness moving forward.

Taking an integrated approach to planning and delivering care

We have advised on the planning and design of Ebbsfleet's garden city health and wellbeing hub which aims to be a world-class community building that will deliver a flexible model of physical and mental health and care services. It will also have a focus on the prevention of ill health and the promotion of wellbeing to improve local resident's health and reduce the future demand on services.

We have been part of a joint task force in Maidstone to support the development of multi-agency action plans that shape effective responses to tackle crime, anti-social behaviour and health/social inequalities impacting on local communities.

We have continued to work with the East Kent Wellbeing Health Improvement Partnership (EKWHIP) to improve the interface between mental health, the police and housing in East Kent to enable all service to work in a more integrated way to benefit the most vulnerable.

Community mental health

Under new national standards, new expanded community health teams will be required to provide fast support to people in their own homes as an alternative to hospitalisation, and to ramp up NHS support for people living in care homes. This includes community mental health services for adults and older adults, which will be completely transformed to improve patients' experiences and outcomes through an integrated model of primary and community mental health care.

Local systems are working to create their own model to achieve these outcomes for the people in their area. In the last year, we established our community mental health transformation programme and agreed an implementation plan securing the support of our partners.

Our people

Our people continue to report being highly engaged. We have diversity of talent at all levels in the organisation and our workforce is made up of people from a culturally rich and ethnically diverse background between the ages of 20 - 70 years old.







We achieved our highest participation rate to date in the 2021 national NHS staff survey, with a response rate of 68%. This is an increase of 7% on last year and one of the highest rates compared to 50 other NHS mental health, learning disability and community trusts across the country. Our overall results place us above average in many areas.

Our people continue to report being highly engaged, with an overall engagement score of 7.0

Our annual staff survey shows:

- Our people continue to report being highly engaged, with an overall engagement score of 7.0
- Our line managers are outstanding. Particularly when encouraging colleagues and providing clear and helpful feedback
- Our levels of engagement are increasing year-on-year, with our black and minority ethnic staff in particular engaging at a higher level than other comparable trusts
- Our learning and development service is brilliant. People highly value our approach to supporting them with career, skills and knowledge development and appraisals, and our approach to flexible working
- We've made year-on-year improvements in staff morale and we're now rated as above average in comparison to other comparable trusts

Achievements

68%

of people took part in our annual survey

Our overall staff engagement score is

7.0

(on a scale of 0-10)

Colleagues who identify as non-white have a very high engagement score of

7.6

compared to our overall average of

7.0

82%

of staff said their immediate line manager encourages them at work

78%

of staff said their immediate manager gives them clear feedback on their work (best score nationally)

6.1

We're rated as above average for staff morale in comparison to other comparable trusts (average 6.0)

75%

of people said they have opportunities to improve their knowledge and skills

91%

of staff had an annual appraisal

79%

of staff said they could approach their manager to talk openly about flexible working

0

staff with a disability went through the disciplinary service

Trained

44

new mental health first aiders

Established a menopause café programme

Won gold award for Kent and Medway healthy workplace

KMPT

Introduced 'wellbeing' conversations into our line manager and employee staff 6 weekly supervision meetings

Equality, diversity and inclusion

We are committed to making KMPT a fully inclusive, diverse and anti-racist organisation in which individuals' differences are respected, and everyone is encouraged to bring their whole self to work to make a full contribution to the brilliant care we deliver to our service users.

In the last year we have implemeted a number of successful ininitatives to promote equality, diversity and inclusion. This has included holding race and diversity training and awareness events across the organisation and continuing to support our people to have conversations. We alsoproduced our first annual report to Board on Equality, Diversity and Inclusion, bringing together work on all protected characteristics into one document. In March 2022, our equality diversity and inclusion team received a Kent and Medway Healthwatch award for their work to protect staff through risk assessments during the pandemic.

As an NHS organisation we are required to report against the NHS Workforce Race Equality Standard (WRES) and NHS Workforce Disability Standards (WDES). In 2021, we implemented a WRES action plan which includes positive initiatives to encourage Black, Asian and minority ethnic employees to pursue developmental and leadership programmes. Our first cohort of reverse mentoring began in 2021 with 16 members of staff mentoring KMPT's executive team and senior leaders. Nine staff have since completed the programme and gained their mentoring qualification. KMPT has also reported on the experiences of disabled people in the workplace on a yearly basis. The report and associated action plan are published on KMPT's website and are monitored through the Equality and Diversity Steering Group.

We do not tolerate bullying and harassment of any kind and emphasise the importance of respecting others in a range of policies. We are working hard to ensure people feel confident they can raise issues in a safe, supportive and confidential environment and that we will investigate allegations quickly, sensitively and fairly. We have a team of 25 freedom to speak up guardians across the organisation who offer informal, confidential support to those who have experienced or witnessed inappropriate behaviour. In June 2022 we are introducing a new, independent freedom to

speak up service, available 24/7 365 days a year for our staff to discuss their concerns.

In the last year we also set up an anti-bullying and harassment task and finish group, chaired by the executive director of finance and performance. The number of ethnic minority staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months has gone down from 44.3% to 35.4% against a target of 34.4%.

We aim to ensure all staff receive equal treatment that is free of discrimination and we follow all employment-related procedures impartially and objectively.

Our equality, diversity and inclusion work is supported by our four active diversity networks who play a vital role in developing our approach to a range of issues, enacting and supporting positive change and in raising awareness among staff.

Staff Networks

Black Asian Minority Ethnic Group Network

Executive sponsor

Vincent Badu, Deputy Chief Executive

Membership numbers

150 STAFF MEMBERS

Key achievements in 2021

- Ran drop-in sessions for Black, Asian and Minority Ethnic staff who were apprehensive about raising concerns in larger network meetings
- Joined with colleagues across Kent and Medway to celebrate Black History month
- Successfully contributed to two very successful online conferences (The Power of Me and Black History Month the NHS at 75)

DAWN Disability and Wellness Network

Executive sponsor

Donna Hayward-Sussex, Chief Operating Officer

Membership numbers

33 STAFF MEMBERS

Key achievements in 2021

- KMPT is in the top 5% of Trusts for employees declaring a disability
- The review of the Staff Wellness Passport
- Pilot training programme to help managers support their staff. Run by Disability Rights UK
- Deaf awareness training available to all staff on iLearn

Faith Network

Executive sponsor

Afifa Qazi, Chief Medical Officer

Membership numbers

27 STAFF MEMBERS

Key achievements in 2021

- A focus on End of Life Care took place later in 2021
- The Chaplaincy team held its first death cafe during dying matters week
- Continue to promote the Faith Network to encourage wider awareness and understanding of faith related issues

Lesbian, Gay, and Bisexual, Transgender, Questioning, Plus (LGBTQ++) Network

Executive sponsor

Sandra Goatley, Director of Workforce and OD

Membership numbers

63 STAFF MEMBERS

Key achievements in 2021

- Attended the only Pride parade to take place in Kent and Medway (Canterbury)
- Held successful LGBTQ History month conference (February 2022) with over 50 people attending
- Supported the rollout of raising staff awareness about Trans patients with training delivered by the METRO charity

Looking after our people

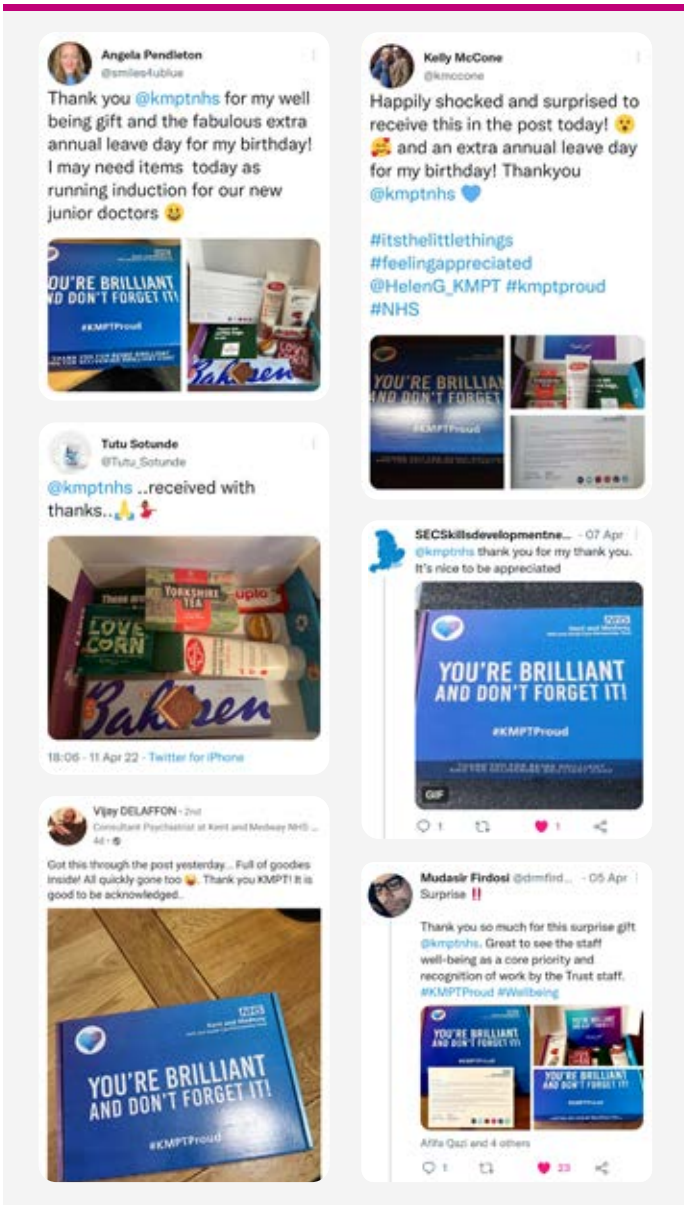
In response to the ongoing challenges of the pandemic on our people, we increased our health and wellbeing offer to staff. We created a new health and wellbeing strategy, took part in the NHS trailblazer scheme for healthy workplaces complete with health workplace allies, and embedded the role of wellbeing guardian. We introduced regular wellbeing discussions between line managers and their reports as part of our 6-weekly supervision meetings to identify if and when further support is needed to individuals.

We gave everyone an additional day of annual leave for a second year running, trained more staff to be mental health first aiders and shared benefits, discounts, support and advice to help our people. As the year came to an end, we sent all of our staff a hamper of sustainable goodies as a token of appreciation and thanks.

We are committed to supporting our staff when they are unwell and have continued to do all that we can to help them return to work. We finalised a health and wellbeing strategy which will see us further supporting our people over the coming year.

At an organisational level, we have made people one of our three strategic priorities for the next year, as we focus on recruitment, retention and wellbeing. This will involve a renewed focus on reducing our vacancy gap through improved recruitment and retention, opening new staff restorative spaces at our three main sites in Dartford, Canterbury and Maidstone, and developing a strategy for psychological safety in the workplace. Our aim is that KMPT staff are confident, skilled and deliver consistently brilliant care.

> As the year came to an end, we sent all of our staff a hamper of sustainable goodies as a token of appreciation and thanks



Above: Responses from staff following receipt of their wellbeing hampers

As well as supporting our own staff, KMPT has led on delivering mental health and wellbeing support to NHS and social care staff across the whole of the county through the talking wellness hub. The team has taken an innovative approach by taking the service directly to frontline staff using a fully converted double decker bus. This has been hugely popular and while only a few weeks in, has already supported over 500 Kent and Medway NHS staff.

Case study: talking wellness

COVID-19 pressures on the wider NHS brought national recognition that the mental health and wellbeing of health and social care staff was at risk of deteriorating, to the point where some staff were in real danger of developing symptoms of trauma, such as anxiety, depression, Post Traumatic Stress Disorder (PTSD) and other mental health disorders.

NHS England recognised that help was needed and funded 40 resilience hubs across the country to deliver mental health and wellbeing support to NHS and social care staff.

Kent and Medway's staff mental health and wellbeing service, talking wellness, is one of those hubs, and KMPT is proud to be the lead organisation delivering the service.

Support for staff is provided by a team of professionally trained people offering rapid access to assessment and local evidence-based mental health services and support where it is needed.

In January 2022, the team successfully secured additional funding to improve access to the service. Entering into a partnership with the Project Wingman charity, talking wellness has taken an innovative approach to service delivery - by using a fully converted double decker bus. Over a 14-week period the bus has visited each of the county's seven acute hospital sites, together with three of its community hospitals, staying a week at each location.

During the first two months of the tour over 1000 NHS staff had visited the bus. A welcome outcome of those visits has been that some staff felt the space was so safe they were able to open up about how they were feeling, leading to them directly referring into the service, something they openly stated they may not have done using the more traditional routes.

Above: the talking wellness bus ready to visit NHS staff across Kent and Medway

> During the first two months of the tour over 1000 NHS staff had visited the bus

Whilst the offer of a cup of team and a piece of cake can seem quite a small thing to offer staff there is no doubt that it is a pleasant and natural way for people to find out about the service and explore what's on offer; and to do so in a relaxed atmosphere within an environment that focuses on destigmatising mental health issues whilst offering help and support to staff.

Our culture

In addition to the wellbeing support, we started a large piece of work to improve our culture and staff engagement. We focused on three areas: a just and learning culture, living our values and empowering team of teams.

Just and learning culture

- Piloted a team development session around building psychological safety
- Developed a co-created and consistent approach to early and respectful resolution for staff and secured investment for an increased number of trained mediators

Living our values

- Delivered a Reverse Mentoring programme in partnership with Maidstone and Tunbridge Wells NHS Trust with a focus on Black, Asian and minority ethnic staff and executive directors and deputy directors
- Improved managers' induction and appraisal process focusing on embedding trust values
- Review of trust values and ensuring they are evident throughout our recruitment process

Empowered team of teams

- Rolled out a newly designed internal leadership programme
- Hybrid working training for all managers focused on embedding the principles of effective hybrid working
- Working group brought together to improve the reporting and response to staff who are experience violence and aggression following the staff survey results in 2020

We want KMPT staff to be confident, skilled and able to deliver consistently brilliant care

Strategic enablers

Our strategic enablers are essential supports that help us achieve our priorities and ultimately support our mission to deliver brilliant care through brilliant people.

Left: Our award-winning mother and baby unit in Dartford offers specialist inpatient support for new mothers with serious mental ill health from Kent, Surrey and Sussex.

Estates and facilities management

The environment we live and work in has a significant impact on our mood, wellbeing and on the people in our care. In the last year we have made progress to improve our green spaces across our sites, to introduce wellbeing programmes, and to work differently.

Hybrid working

During the pandemic we learned a lot about working differently and in modern ways. We applied this learning to our working arrangements and in early 2022 we introduced our new hybrid way of working. Our aim is to be greener, utilise our spaces more effectively, be more efficient, save money and continue to support our people's development and wellbeing.

The launch of our new hybrid working principles was supported with the decision to close our trust headquarters at Farm Villa on Hermitage Lane in Maidstone on the 1 April 2022. This will save us around £160,000 per year in running costs.

Over the next year we will continue to support the further rollout of our hybrid ways of working, including focusing on how we can best utilise our spaces and buildings' occupancy.

Above: Garden of Hope

Delivering wellbeing spaces for our staff and patients

Garden of Hope

We have been improving our green and wellbeing spaces for our staff and patients over the last year. Most notably, in 2021, our Rosewood Mother and Baby Unit (MBU) in Dartford became the final home to the Royal Horticultural Society's (RHS) Garden of Hope.

Our journey began in 2019 when we applied to the RHS's Chelsea Flower Show competition. In 2020, our MBU was announced as the successful winner but due to the pandemic, installation was postponed. Fast forward to October 2021 and we were delighted to officially reveal the stunning garden designed by RHS' designer and BBC Two's presenter of Gardener's World, Arit Anderson.

Arit's vision reflects the journey women make back to recovery. It embraces the idea of growth, reflection and transitioning back to health with bridges, water and raw and imposing wooden structures representing fractured physical forms coming together as they heal. Central to the design is a beautiful steam-bent wooden sculpture by Charlie Whinney, which twists and flows through the garden, incorporating seating areas a child's swing and creating the feeling of a big hug. The planting has a natural fee, with a number of tress, some turning with autumnal colours, and areas of dense rich green planting at the front of the garden, becoming more colourful further back. As a symbol of how a garden both feeds the soul of our bodies, selections of edible plants are also included.

The Garden of Hope provides a therapeutic space for mums and their babies to enjoy and provides a space to reflect and has been an extraordinary addition to the MBU.

Above: Preview for VIP guests of the Garden of Hope at the Royal Chelsea Flower Show

Webb's garden

Webb's garden is a stunning two-acre walled garden set in the grounds of our Canterbury site. It provides a tranquil and relaxing, therapeutic space for patients and staff to experience the outdoors which helps to support their health and wellbeing. The garden is managed by our voluntary services team with a group of volunteers who grow a wide-range of homegrown vegetables, fresh fruit and cut flowers for sale. All proceeds are reinvested into our programme of ongoing service improvement for our patients.

Wi-Fi was introduced in December 2021 to the garden and this now allows both patients and staff to utilise the space to conduct open space meetings and training as well as running group therapeutic activities. The impact for staff, including students, and patients has been clear.

Andrea Baldwin, student, shared: "The benefits of having internet at Webb's garden means that as a student I can come and use the internet to do some work, or even have meetings as it is hard to find a spare empty room sometimes. Having access to the internet in the garden is very good to do research on all the plants that I am learning about and to quickly complete tasks that are needed for my learning in the hub.

"It also makes learning much easier especially after doing some work at Webb's garden and coming down to write down what we've learnt with fresh thoughts, plus it helps to be able to look at and use the books provided."

The garden is managed by our voluntary services team with a group of volunteers who grow a wide-range of homegrown vegetables, fresh fruit and cut flowers for sale

Above: Webb's garden

The introduction of this new technology will help people to utilise the garden fully and support the plans for the garden both now and in the future as we look to make improvements to the garden.

Staff rest places

Preparations have been underway to deliver our first of three rest rooms for staff in Dartford. This will be ready in the summer of 2022 and the following two rest rooms based in Canterbury and Maidstone will be delivered in the autumn. The subsequent rooms at the two other sites are planned for delivery in the autumn.

Above: Ruby ward dining room garden

Above: Ruby ward family visiting garden

Above: Ruby ward lounge

Investing in new and existing buildings

In December 2021 we secured full planning permission by Maidstone Borough Council to build a new, purpose-built, inpatient facility for older adults with functional mental health needs. The new Ruby ward building will be situated on our Hermitage Lane site in Maidstone, relocating from its current home at Medway Maritime Hospital.

The £12.65 million investment was awarded to the local NHS as part of a national drive to eradicate 'dormitory' style wards in inpatient mental health facilities. It will ensure that Kent and Medway residents have access to the highest standards of inpatient mental health care, should they need it.

It will include single ensuite rooms, space for providing counselling, group therapy, creative activities and access to specially designed garden areas. Dedicated areas indoors and outside for

Above: Ruby ward bedroom

patients and visitors feature in the new design as well as facilities to help people relearn essential skills such as cooking and cleaning. It will also be carbon neutral. Building work has begun and the facility will open in July 2023.

Over the next year we plan to refurbish a number of wards including Woodchurch and Sevenscore.

Green plan

In January 2022, our board approved KMPT's first ever Green Plan to achieve net zero. The plan sets out our ambitious targets over the next 10 years and how we will achieve our long-term net zero emissions.

The plan also captures what we have achieved so far against our green commitments. We have made great strides to reduce our carbon emissions through projects including renewable installations, LED light installations and various behaviour change initiatives. Another key contributor to our carbon reduction is the closing buildings that are no longer needed or sustainable, for example our old headquarters. The decommissioning of buildings has followed sustainability principles ensuring that where possible furniture and equipment is re-used within the trust through our furniture re-use scheme.

In February we switched to purchasing 100% renewable energy, which means we are offsetting over 1300 TONNES of CO2 per year.

Our staff, volunteers and patients recently planted over 80 trees across three of our hospital sites as part of the NHS Forest scheme. Once mature, the trees have the potential to absorb approximately 2000kgCO2 of carbon from the atmosphere every year. They will also provide a habitat for wildlife, and offer staff, patients, and local people more space to enjoy nature – something which is proven to boost mental wellbeing.

Above: Staff helping to plant 80 trees across KMPT as part of the NHS Forest scheme

Above: Sirina Blankson, Sustainability and Environment manager

As we look to the future, we will challenge ourselves to tackle the difficult aspects of carbon reduction and reaching our Net Zero target. This includes ensuring everyone within KMPT can make environmentally beneficial and sustainable choices, reducing our reliance on fossil fuels and disposable items, actively reducing energy and water usage, using resources more efficiently and supporting our people and our local communities to lead more sustainable lifestyles.

Above: Green Plan

Right: The Green Plan focuses on 10 main areas split across four themes which have been identified as being key to embedding sustainability into the operations of the Trust

Improving our accommodation and estates management

We started a joint initiative with Kent Community Health NHS Foundation Trust (KCHFT) to secure a joint estates maintenance contract to deliver better value for money and have a market engagement event planned for summer 2022 to take this forward in 2023.

Over the next year we also plan to work with partners to find colocation (hubs) so that we can all work more efficiently and effectively.

Technology

In the last year we have continued to use technology to improve the way we access and share information efficiently, effectively and securely to support and enable our people to do their jobs and to best support our service users.

Highlights include going live with our programme to replace paper-based prescriptions with electronic prescribing. This will improve patient safety and efficiency in the medicine management process by reducing the risk of medication errors, ensuring fast access to potentially lifesaving information and reduce duplication of information gathering. We have started this at our Rivendell rehabilitation unit in East Kent and plan to roll this out more widely across the trust this year. We also started work to improve how we record patient information.

Over the next year we will be investing in a number of projects and assets that will transform how we work

Over the next year we will be investing in a number of projects and assets that will transform how we work. Our three main areas of focus will be:

- **Streamlining clinical work by making our systems more efficient.** We will transform our core digital patient record and find ways to integrate solutions directly into Rio to improve more accurate and real-time recording of information bringing benefits to our staff and patients alike.
- **Improving how our workforce systems serve our people.** This includes reducing duplication and ensuring accuracy in our systems, introducing a new telephony service called 8x8, and electronic document management systems. Underpinning this we will also be supporting our people to build their digital confidence and skills.
- **Coordinating and improving systems to make it easy to connect, share and hold one version of data.** We will use digital technology to better share information across multiple systems to ensure all care providers in Kent and Medway share the most up to date information about our service users. Some of the projects this involves includes eMeds and eRefferals.

Finance

In 2021-22 we broke even on our financial position which is a positive achievement against the backdrop of recovering and living with the pandemic. Our managing finances section, which follows, shares further detail on our position over the last year.

Our focus for the coming year is to tackle our underlying deficit of £7.6 million. This will include managing every single penny to ensure whatever we spend is value for money; making sure we are being paid fairly for our services and that our suppliers charge us fairly for their services; and investing in improving quality and efficiency so that we can make savings this year and into the future.

Managing finances

KMPT has operated within an interim financial regime due to the pandemic for the financial year ending 31 March 2022. For the second year all trusts have been supported to deliver a breakeven financial position through a combination of reimbursement for COVID-19 related costs and support funding. Before accounting for prior period adjustments, of which there was one this year, we have met the requirement to report a financial position of breakeven, reporting a small surplus.

An additional investment of £7.9m has been made into mental health services provided by KMPT, aligned with the national long-term mental health implementation plan. This has been monitored both in terms of spend against investment, and benefits realised, with government targets for investment realised.

This year we have approved a total of 12 business cases including:

- Increased resource in safeguarding
- Criminal Justice and Liaison Diversion Service "Reconnect" service
- International recruitment of nurses
- Trainee Nursing Associate roles
- Dementia Crisis service
- Digital Devices replacement programme
- Development of KMPT charity
- Personal safety devices for clinical staff

These investments allow us to continue enhancing the services we provide for our population, and support the recruitment, retention and development of our workforce.

KMPT and its partners work together to reduce mental health inequalities and improve services and outcomes for our users and their loved ones

Summary of financial performance in 2021-22

The finance regime for 2021-22 continued in line with the previous year. Normal contracting was paused and additional funds were made available to support all trusts to deliver a breakeven position and cover additional costs relating to COVID-19.

The table below shows the final financial performance against KMPT's plan:

Statement of Comprehensive Income

	Plan 2021-22	Actual 2021-22	Variance 2021-22
	£000	£000	£000
Income	224,714	231,746	7,032
Expenditure	(222,224)	(226,533)	(4,309)
OPERATING SURPLUS	**2,490**	**5,213**	**2,724**
Finance Costs	(2,490)	(4,112)	(1,622)
SURPLUS / (DEFICIT)	**0**	**1,101**	**1,101**
Impairment	0	(1,081)	(1,081)
SURPLUS/(DEFICIT) PRE-PRIOR PERIOD ADJUSTMENT	**0**	**20**	**20**
Prior Period Adjustment	0	(4,599)	(4,599)
SURPLUS/(DEFICIT) FOR CONTROL TOTAL PURPOSE	**0**	**(4,578)**	**(4,578)**

Helen Greatorex
Chief Executive
Date: 15 June 2022

Income

KMPT received the majority of its income from Kent and Medway Clinical Commissioning Group under a block contract, accounting for 77% of total income.

Specialist Services were commissioned through NHS England and make up 6% of our total income. Provider Collaborative income for our forensic inpatient and community services is accounted for within other NHS below, this income is received from Sussex Partnership Trust as the host of the collaborative.

The employer contribution rate for NHS pensions increased from 14.3% to 20.6% from 1 April 2019. For 2021-22, the additional amount is paid over by NHS England on providers' behalf but is reflected in KMPT's annual accounts in both income and employee expenses. This totals £6.6m and is shown in the table below.

Income Categories

Income Category	£000	%
Clinical commissioning groups	177,652	77%
NHS England	14,831	6%
Other NHS	16,424	7%
Pensions top up	6,640	3%
Local authorities	1,784	1%
Education and training	5,541	2%
Non-patient care services to other bodies	5,235	2%
Research & Development income	837	0%
Contributions to expenditure - consumables (inventory)	111	0%
Rental revenue from operating leases	1,315	1%
Other	1,376	1%
Total	**231,746**	**100%**

Further details regarding income are identified on pages 104, 105, 117 and 118, notes 1, 3 and 4 of the accounts.

Expenditure

Operating expenditure in 2021-22 was £227m, £10m higher than the previous year. The largest area of spend for KMPT is employee expenses which accounted for 78% of operating expenditure. There was a £8.6m increase from last year, including:

- £4m: pay inflation relating to national pay award
- 3.3m: investment in new services, including perinatal community teams, psychiatric liaison, early intervention in psychosis, and a 24/7 crisis access line
- £0.08m: an increase in provision for unused annual leave owed to staff at the end of the year, carried forward to be used in 2022/23

To support staff during the pandemic, KMPT the Trust received personal protective equipment from the Department of Health and Social Care at nil cost. The deemed cost of these has been included within supplies and services (£0.1m), with the same amount being reflected as notional income.

Analysis of operating expenditure is provided in the table below.

Annual Expenditure

	2021-22		2020-21	
	£000	%	£000	%
Employee Expenses	177,801	78%	169,177	78%
Purchase of healthcare from NHS and non-NHS bodies	5,868	3%	5,955	3%
Establishment	2,486	1%	2,533	1%
Supplies and Services	7,550	3%	8,658	4%
Drugs	3,358	1%	3,177	1%
Premises and Transport	14,023	6%	13,202	6%
Impairments	(1,071)	0%	247	0%
Depreciation and amortisation	6,769	3%	6,798	3%
Other	9,749	4%	6,581	3%
Total	226,533		216,328	

Further details regarding this expenditure can be found on page 120 note 5 of the accounts.

Cost improvement programme

KMPT set a £7m cost improvement programme target for 2021-22. We delivered £6.6m of the planned savings with a gap of £0.4m at year end. Of the savings delivered £3.7m (56%) recurrently and £2.9m (44%) on a non-recurrent basis.

The full details are shown in the table below.

Cost improvement programme overview

Care Group	2021-22		
	Plan (£000)	Actual (£000)	Variance (£000)
Acute	607	327	(280)
Older people	330	230	(100)
Forensic and specialist services	2793	2977	184
Community recovery	771	712	(59)
Support services	2300	2316	16
Trust-wide	198	20	(178)
Total	**6,999**	**6,581**	**(418)**
Recurrent	6,999	3682	(3,317)
Non-Recurrent	0	2,899	2,899

Capital expenditure

KMPT spent £9.1m on capital expenditure in 2021-22, £6.4m lower than the original annual plan. Any capital allocation unutilised was returned in year either to the Kent and Medway system or nationally to support other organisations with capital programmes.
The most significant capital expenditure in the year includes the following items:

1. £3.1m on backlog maintenance
2. £3.4m in IT infrastructure to support delivery of KMPT's clinical technology strategy and IT devices replacement
3. £1.9m on improving mental health services – the eradicating dormitories project
4. £0.7m on refurbishing Orchards ward, which was reopened during the year

Summary of financial risks

Summaries of the financial risks are outlined within the annual governance statement.

Audit

Our external auditor is Grant Thornton. They conducted work during the year on audit services at a cost of £60k + VAT. This work included annual accounts, governance and performance work.

Provision of information to auditors

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 auditor is aware of that information.

Going concern

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

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

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

Looking forward to 2022-23

The coming financial year will see the NHS resume elements of contracting, in the context of a changed financial and commissioning landscape. Integrated Care Boards will come into legal form from July 2022, which will change the interactions KMPT has with its main commissioner, currently Kent and Medway CCG.

Annual planning has been submitted in April, which for KMPT is a breakeven position for 2022-23. This has been done in conjunction with the Kent and Medway healthcare system and is not without risk. Rising inflation, uncertainty around pay awards and volatility in the energy market is putting pressure on costs that will have to be managed both internally through contingency and as a healthcare system.

Our strategic objectives this year include a focus on eradicating our underlying deficit, which at the end of 2021-22 is £7.6m. We will do this by continuing to focus on productivity and efficiency initiatives, by improving controls within the organisation around our temporary staffing and contractual spend, and by working with our commissioners to continue ensuring we are appropriately reimbursed for the services we provide.

We will continue to invest in priority front line services, in line with the mental health long term plan, with a further £5m from commissioners to support this. We will also continue to invest in digital, enabling our front-line staff access to the right systems and equipment to do their roles, and quality improvement, working with our newly launched Quality Improvement team to drive the QI method throughout the Trust and realise benefits both financially and for our workforce and patients.

Our capital programme is significant for the coming year and is having to be carefully planned due to the current constraints regarding the national funding allocations. The Trust Capital Group has prioritised the schemes to be completed and the plan will address high risk backlog maintenance, ward refurbishments and digital investment. KMPT is continuing with the capital scheme to build a new older adults ward on our Maidstone site to replace Ruby ward, following a national funding award of £12.6m as part of the national initiative to eradicate dormitories. £7.8m will be received during 2022-23 for this scheme.

Our annual accounts for 2021-22 have been examined by our external auditor, Grant Thornton, and their report is set out on page 91.

Helen Greatorex
Chief Executive
Date: 15 June 2022

Accountability report

The Directors' Report

The Board of Directors (the Board) includes the Executive Directors and Non-Executive Directors (NEDs).

The Board has overall responsibility for the performance and management of the Trust and, as a unitary board, shares collective responsibility for the Trust's success. This includes setting the overall strategy, monitoring progress and ensuring resources are managed efficiently, effectively and economically. It does this by holding the Trust to account for the delivery of the strategy through seeking assurance that the systems of control are robust and reliable.

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

The Executive Directors are paid, permanent employees of the Trust. They are responsible for managing the organisation on a day-to-day basis and in their capacity as members of the Board they are also responsible for the leadership of the Trust. This managerial role distinguishes the Executive Directors from the NEDs, who do not have a managerial role. The Trust has a Scheme of Delegation which sets out the delegated authority to the Executive Team.

The NEDs are responsible for supporting and constructively challenging the Executive Directors in their decision-making, as well as assisting them with the formation of the Trust's strategy. NEDs are appointed by NHSE/I for a set term.

During 2021-22 there have been a number of changes to the Board. Anne-Marie Dean, left at the end of October 2021. Mickola Wilson and Sean Bone-Knell became voting NEDs in September 2021. Mary Mumvuri, Executive Director of Nursing, Allied Health Professionals and Quality left the Trust in December 2021 and was replaced by Andy Cruickshank who became Chief Nurse in March 2022. Jacquie Mowbray-Gould, Chief Operating Officer left the Trust in February 2022 and was replaced by Donna Hawyard-Sussex in March 2022. Martin Carpenter regularly attended the Board as part of the NExT Director's Scheme.

The Board convenes at Board meetings to carry out its duties and responsibilities. It met in public 8 times during 2021-22. Board meetings have been broadcast live during 2021-22 and the technology has been embraced to enable the public and staff to join these meetings. People with experience of using our services have been invited to these meetings, enabling members to hear first-hand how services work for users and carers, and how we can improve.

The Board of Directors approves the Annual Report and Accounts prior to its submission to Parliament. The Annual Report and Accounts are prepared by the Directors of the Trust, who confirm that this Annual Report and Accounts, taken as a whole, is fair, balanced and understandable, and provides the information necessary for patients, regulators and other stakeholders to assess the Trust's performance, business model and strategy.

Board Membership 2021-22 & Board Attendance

Board Member	Role	Board Meeting Attendance
Jackie Craissati	Trust Chair	8/8
Catherine Walker	Non-Executive Director & Senior Independent Director	6/8
Venu Branch	Non-Executive Director & Deputy Chair	6/8
Fiona Carragher	Non-Executive Director	8/8
Peter Conway	Non-Executive Director	6/8
Kim Lowe	Non-Executive Director	6/8
Sean Bone-Knell	Non-Executive Director	7/8
Mickola Wilson	Non-Executive Director	6/8
Anne-Marie Dean – until October 2021	Non-Executive Director	3/4
Martin Carpenter	NExT Director's Scheme	4/4
Helen Greatorex	Chief Executive	8/8
Dr Afifa Qazi	Chief Medical Officer	8/8
Mary Mumvuri – left December 2021	Executive Director of Nursing, Allied Health Professionals and Quality	6/6
Andy Cruickshank – started March 2022	Chief Nurse	0/1
Vincent Badu	Executive Director of Partnerships and Strategy and Deputy Chief Executive	8/8
Sheila Stenson	Executive Director of Finance and Performance	8/8
Sandra Goatley	Director of Workforce*	8/8
Jaquie Mowbray-Gould – left February 2022	Chief Operating Officer*	6/7
Donna Hayward-Sussex – started March 2022	Chief Operating Officer*	1/1

*Non-voting directors.

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 and is also published twice a year within the Board's meeting packs. We are required to publish in this Annual Report the directorships of any member of the Board in companies that are likely to, or seek to, conduct business with the NHS. Our register of interests is shown below:

Register of Board members interests

A copy of the Register of Board Members' interests is publicly available on the Trust's website.

Performance appraisal

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

Executive Directors

Helen Greatorex

Chief Executive, Registered Mental Health Nurse (RMN), MBA

Helen became Chief Executive in June 2016, having been Executive Director of Nursing in Sussex for over fourteen years. Qualifying as a Registered Mental Health Nurse (RMN) in 1987, Helen worked clinically across a wide-range of settings, and specialised in mental health rehabilitation. She went on to work in the voluntary sector as a Resettlement Officer with Mind in Waltham Forest where she helped support and resettle people, whose average length of stay in Claybury Hospital was twenty-eight years. She was a founder member of the rehabilitation services in Brighton in the early 1990s, creating what would become a forerunner of the national Assertive Outreach model of care. In 2018, Helen graduated as a Florence Nightingale Leadership Scholar and continues to mentor and coach others as a result.

Vincent Badu

Deputy Chief Executive, Executive Director of Strategy and Partnerships

Vincent was appointed to his current role in 2018, after joining KMPT in 2016 as Director of Transformation. He has executive responsibility for strategy development and improvement programmes. Alongside this he leads our partnership working with key stakeholders across the Kent & Medway integrated care systems and local place based partnerships. Prior to joining KMPT, he was a director and member of the executive team at Sussex Partnership NHS Foundation Trust from May 2006. He gained more than 20 years of experience in local government across London and the south east before joining the NHS. Vincent is passionate about leadership development, celebrating diversity, shaping and improving care quality, patient and staff experience through co-production, participation and involvement.

Sheila Stenson

Executive Director of Finance and Performance
BA ACMA CGMA

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

Dr Afifa Qazi

Chief Medical Officer

Afifa is well regarded domestically and internationally for developing the 'Community care model for Dementia', a model of innovative practice that has reduced hospital admissions and length of stays for people with dementia. She won the prestigious HSJ award in 2016 and the EAHSN Health Innovation award in 2014 for developing services for people with dementia. She is actively involved in research and has numerous publications in peer reviewed academic journals. She is an invited speaker at national and international conferences. She has a keen interest in QI and has led on numerous projects. She continues to take part in teaching and training and is passionate about empowering staff. In her previous role, she worked for North East London Foundation Trust as a Consultant Psychiatrist and as an Associate Medical Director for Essex and Kent Children and adolescent mental health services.

Andy Cruickshank

Chief Nurse – from March 2022

Andy is an experienced mental health nurse who has held several senior nurse leadership and management positions within East London NHS Foundation Trust (ELFT), and was the Director of Nursing for the London Mental Health Services for ELFT, prior to joining KMPT. For many years Andy worked in CAMHS, developing acute admission and intensive care services for adolescents at Guy's Hospital and then in East London. At ELFT Andy led on innovations and Quality Improvement (QI) projects. He trained as an Improvement Advisor at the Institute for Healthcare Improvement (IHI) in the US and is a Fellow at the Health Foundation – as part of this he has achieved a Masters in Leadership for Improvement from Ashridge Business School. Andy is interested in how improvement work can be used to engage not only individual staff teams, but organisations and communities and how this might help to transform outcomes for those in need but also to help people to live and work well.

Donna Hayward-Sussex

Chief Operating Officer – from March 2022

Donna joined the Trust in March 2022 from her previous role as Service Director at South London and Maudsley Foundation Trust. In this role, Donna led several transformation programmes including the redesign of crisis services. She is a psychotherapist by background and combines a strong management background with extensive experience in operationally leading and developing mental health services in the NHS and voluntary sector. Her previous role in Buckinghamshire Mind led to a partnership with Oxford Health NHS Foundation Trust delivering CAMHS and adult services across the county. Donna is passionate about service provision and is committed to working in partnership to provide excellent care.

Sandra Goatley

Director of Workforce and Organisational Development, Chartered Fellow CIPD

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

Mary Mumvuri

Executive Director of Nursing, Allied Health Professionals and Quality, RMN, MSc Mental Health Studies, MSc Health Management, Nye Bevan NHS Executive Leadership award – left December 2021

Mary started her career as a staff nurse in Lewisham and Guys Mental Health Trust.

She has worked in senior nursing leadership roles, clinical governance and quality improvement across community and inpatient settings. Mary has extensive knowledge of mental health services having worked in a number of mental health and learning disability provider Trusts in London and East of England.

She joined KMPT from Cambridge and Peterborough Foundation Trust where she was the Deputy Director of Nursing and Quality.

Mary has a keen interest in quality improvement that is led by frontline staff.

Her strong values of fairness, transparency and equality have shaped her leadership style and she is passionate about ensuring that staff are developed, trained and supported to provide the best care possible.

Jacquie Mowbray-Gould

Chief Operating Officer, Registered Mental Health Nurse (RMN) – left February 2022

Jacquie trained as a mental health nurse in Newcastle, qualifying in 1991. Her first role was in rehabilitation services at a time when the Trust forged an interesting partnership with a housing association where the association provided the buildings and the Trust the staff.

Jacquie moved to London in 1994 to work for an older persons' day hospital. She was appointed as staff nurse and became manager within the year. After two further years at the day hospital, she accepted an interesting position at Barnet Council. From this role, Jacquie gained a good understanding of the workings of a local authority and the responsibility of the 'public purse'.

Jacquie's next role was director of operations at North East London NHS Foundation Trust, where she worked across health and social care. She said her focus was on constantly improving the patient pathway by joining up services where possible, working in partnership and building relationships.

Her last position was with Devon Partnership NHS Trust, which provides a wide range of services to people with mental health and learning disability needs. Jacquie's first role there in 2011 was managing partner for the older people's service, however, she was promoted to deputy chief operating officer after only 18 months and worked hard on developing relationships with CCGs and improving system care pathways.

Non-Executive Directors

Dr Jackie Craissati

Trust Chair

Jackie joined the Board in May 2016. She took over the role of Trust Chair in July 2020. Prior to this she was Chair of the Quality Committee and Vice-Chair of the Board. She is a Consultant Clinical and Forensic Psychologist and was previously Clinical Director of the Forensic and Prisons Directorate at Oxleas NHS Foundation Trust. After 26 years in the NHS, she left in January 2016 to set up her own not for profit community interest company offering consultancy and training to those working with complex mental health and offending behaviour. Jackie retains a role as consultant advisor to the national offender personality disorder pathway, and leads independent investigations into serious incidents as commissioned by NHS England. Jackie has held a number of Board roles and is currently an Independent Governor of the University of East London and external Non-Executive Director on the Office of the Public Guardian's Audit Committee.

Venu Branch

Deputy Trust Chair

Venu joined the Board in August 2016. In February 2021 she became the Deputy Trust Chair. Venu is CEO of the Westway Trust and her background is in director-level posts in non-departmental public bodies within the creative and public sector. These include the National Endowment for Science Technology and the Arts (NESTA), Creative Scotland and the British Council. She has worked at executive director level in the charitable sector, including at Stonewall and Community Links. She has extensive board-level experience, which has included a member of University College London's museums and heritage committee, a governor of Guildford School of Acting Conservatoire and a Council Member of Loughborough University.

Venu is Chair of the Workforce and Organisational Development Committee and Co-Chair of the Black Asian and Minority Ethnic NEDs Forum for the Kent and Medway system.

Catherine Walker

Senior Independent Director (SID)

Catherine joined the Board in August 2016. She qualified as a barrister and the majority of her early career was spent as an investment banker at NatWest and Schroders. She currently holds a specialist judicial appointment with the Ministry of Justice, hearing appeals on health and disability cases in Tribunal. Catherine is also a member of the Health Service Products Appeals Tribunal. She chairs the Appointments committee of a large London acute NHS Foundation Trust and is the Chair-elect of the Members' Panel of the National Employment Savings Trust (NEST). She was a lay advisor for Health Education England, the former Practice Director of a firm of pensions solicitors, and held a long-term role as governor and director of an Academy Trust in Kent.

She is currently Vice Chair of the Quality Committee and Chair of the Remuneration and Terms of Service Committee. She is KMPT's Senior Independent Director.

Peter Conway

Peter joined the Trust in August 2020 as an Associate NED before being appointed as a NED in October 2020. He has a professional background in banking and finance spanning 27 years, latterly as a Finance Director with Barclays Bank PLC. Between 2006 and 2011 he was NED and Audit Chair of NHS West Kent and since 2011 he has been NED, Vice-Chair and Audit/Risk Committee Chair for Kent Community Health NHS Foundation Trust (KCHFT). He has held a portfolio of public sector roles including, NED and Audit Chair of Rural Payments Agency, Independent Member of the Audit Committees of the Home Office, Ministry of Justice, DEFRA, Health and Safety Executive and Child Maintenance and Enforcement Commission, and he was also Trustee Director of Citizens Advice North and West Kent.

Peter's aspirations are to help the Trust become excellent in the eyes of patients, staff and regulators, encourage closer working with KCHFT and influence transformation across the wider Kent healthcare system.

Peter took over as Chair of the Audit and Risk Committee in October 2020 and is a member of the Finance and Performance Committee.

Kim Lowe

Kim joined the Trust in August 2020 as an Associate NED before being appointed as a NED in November 2020. She has spent most of her career at John Lewis Partnership. For over 36 years she has worked across people, customer service, employee engagement, HR and business, and was appointed Managing Director of John Lewis Bluewater in 2014. In 2007 she was appointed Partnership Board Director, and also as a member of the audit and risk and remuneration committees. Her final role was to lead the pension review at John Lewis before leaving in 2020 to continue to build her NED career in the public and private sector, including John Lewis Partnership, Central Surrey Health and Council Lay Member at University of Kent.

Kim is passionate about employee engagement which she believes lies at the heart of a successful enterprise. She joined KMPT because of its strong values and understanding of the importance of an inclusive culture.

Kim has become the Chair of the Mental Health Act Committee and a member of the Workforce and OD Committee.

Mickola Wilson

Mickola joined the Trust in August 2020 as a non-executive director (NED). She has an Executive Director role at Seven Dials Fund Management, a real estate investment Consultancy and has a number of non-executive roles. She is a NED at Palace Capital PLC and the Mailbox REIT both listed companies specialising in property investment. She is an active member of the Chartered Surveyors Livery, leading a programme to support students from disadvantaged backgrounds through university.

Spurred on by the sheer enthusiasm of the KMPT team, she hopes to make her contribution to the ambitious programme to ensure that health care in the community is treated equally with the outstanding work of hospitals and GPs in Kent.

Mikola is the Chair of the Finance and Performance Committee.

Sean Bone-Knell, QFSM, MBA, MiFireE

Sean joined the Trust in August 2020 as an Associate NED before being appointed as a NED in September 2021. He retired from his role as the Kent Fire and Rescue Service Assistant Chief Fire Officer and Director of Operations in March 2020. During his 33 years of service he was awarded the Kent Medal for Outstanding Service. He was a Corporate Management Board Member for 11 years. From 2012-2022 he held a portfolio with the National Fire Chiefs Council covering road safety, marine firefighting and dementia. On the latter he was part of the Prime Minister's challenge group with the Alzheimer's Society to introduce national policies, and a commitment for emergency services working with those living with dementia. Sean completed his MBA with the University of Kent at Canterbury and has also studied at Cranfield and Warwick Universities.

He has had personal experiences of mental health issues and knows how effective and life-changing the right intervention can be. He wants to help KMPT move to the next level and continue to build, develop and learn.

Sean is a member of the Audit and Risk Committee and the Mental Health Act Committee.

Fiona Carragher

Fiona joined the Trust in August 2020 and was appointed as a NED in November 2020. She is currently Executive Director of Research and Influencing at Alzheimer's Society. Previously she was Deputy Chief Scientific Officer for NHS England where she established the first ever Knowledge Transfer Programme for NHS scientists, developed the CSO Women in Science and Engineering Fellowship to support young women to network and share learning with partners from outside health, led the UK Antimicrobial Resistance Diagnostics Collaborative programme to tackle the inappropriate use of antibiotics, and led the cross sector National Action Plan on Hearing Loss. She is a Health and Care Professions Council registered Clinical Scientist and Fellow of the Royal College of Pathologists.

Fiona is passionate about collaboration and partnership and hopes her cross-sector experience will support the teams at KMPT reach their ambition to provide brilliant care for the people they serve.

Fiona has been the Chair of the Quality Committee since November 2020 and is a member of the Audit and Risk Committee.

Anne-Marie Dean

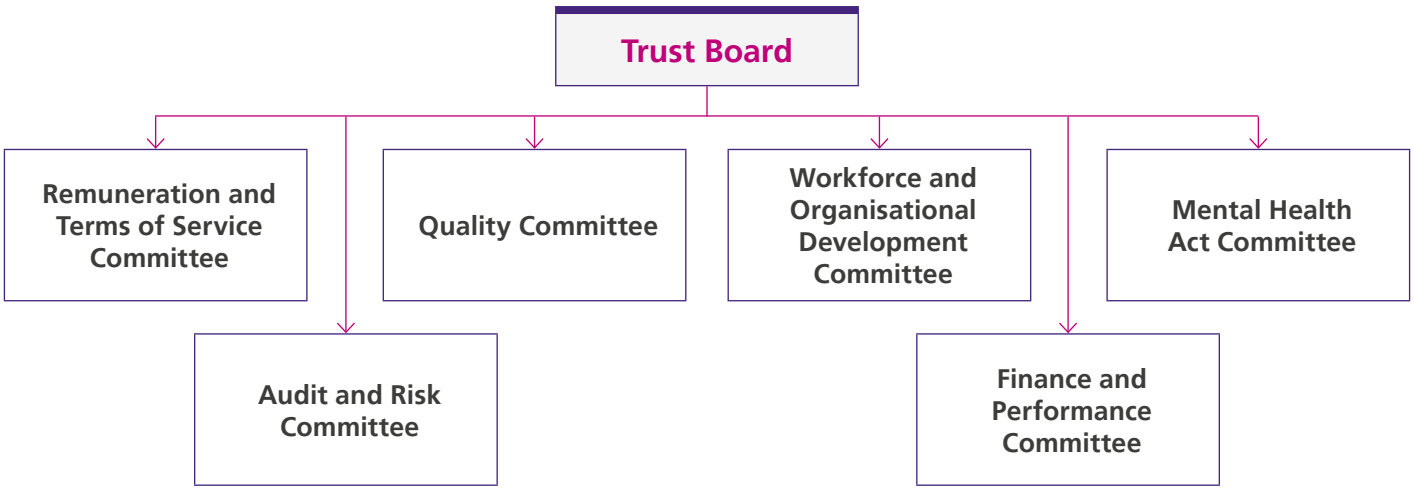
NHS Accelerated Management Development Programme, Kings Fund College Strategic – left KMPT in November 2021

Anne-Marie has performed a number of roles, including 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 Chair of Healthwatch Havering, which is part of the Care Quality Commissions framework (CQC), is a Trustee of the charity One-in-Four and a volunteer with St. John's Ambulance.

Anne Marie was the Vice-Chair of the Mental Health Act Committee and was a member of Quality Committee.

Board committees

The Board has six permanent committees to support it in discharging its duties fully. The chair of each committee presents a report at each formal Board meeting.



A summary of each committee is detailed below:

Audit and Risk Committee (ARC)

Every NHS Board has an audit committee. The independent audit committee ensures effective internal control arrangements are in place. In addition, the committee provides a form of independent check upon the executive arm of the Board. All Members are non-executive directors. During 2021-22 members included Peter Conway Fiona Carragher and Sean Bone-Knell.

Quality Committee (QC)

The quality committee provides the Board with assurance concerning all aspects of quality and safety relating to the provision of care and services in support of getting the best clinical outcomes and experience for patients. Members include Fiona Carragher Anne-Marie Dean (left in November 2021) and Catherine Walker. Within the year the Terms of Reference for QC were amended to state only 2 Non-Executive Directors will now sit on the Committee.

Finance and Performance Committee (FPC)

The purpose of the committee is to provide the Board with assurance concerning all aspects of finance and resource relating to the provision of care and services in support of getting the best value for money and use of resources. Board members who sit in FPC are Mickola Wilson (Chair), Peter Conway (NED), Sheila Stenson (Executive Director of Finance and Performance) and Donna Hayward-Sussex (Chief Operating Officer).

Workforce and Organisational Development Committee (WFODC)

The purpose of the committee is to provide the Board with assurance concerning all aspects of workforce and organisational development relating to the provision of care and services in support of getting the best clinical outcomes and experience for patients and staff. Board members who sit in WFODC are Venu Branch (Chair), Kim Lowe (NED), Sandra Goatley (Director of Workforce and Organisational Development) and Donna Hayward-Sussex (Chief Operating Officer).

Mental Health Act Committee (MHAC)

The purpose of the committee is to ensure there are systems, structures and processes in place to support the operation of and to ensure compliance with the Mental Health Act 1983 (as amended 2007) and other related legislation within inpatient and community settings. Board members who sit in MHAC are Kim Lowe (Chair), Sean Bone-Knell (NED), Dr Afifa Qazi (Chief Medical Officer) and Andy Cruickshank (Chief Nurse).

Remuneration and Terms of Service Committee (Rem Com)

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

Board Committee Attendance

Board Member	Audit and Risk Committee	Quality Committee	Finance and Performance Committee	Workforce and Organisational Development Committee	Mental Health Act Committee	Remuneration and Terms of Service Committee
Jackie Craissati						5/5
Venu Branch				5/6		5/5
Catherine Walker		6/6				5/5
Peter Conway	5/5		6/6			4/5
Mickola Wilson			6/6			3/5
Sean Bone-Knell	5/5				3/4	4/5
Fiona Carragher	5/5	6/6				4/5
Kim Lowe				6/6	4/4	3/5
Martin Carpenter						2/2
Anne Marie-Dean		3/3				1/2
Helen Greatorex						
Vincent Badu						
Sheila Stenson	4/5		6/6			
Afifa Qazi		6/6			4/4	
Mary Mumvuri		4/5			3/3	
Andy Cruickshank		1/1				
Jacquie Mowbray-Gould		4/5		4/5		
Donna Hayward-Sussex		1/1	5/5	1/1		
Sandra Goatley			1/1	6/6		

Helen Greatorex
Chief Executive
Date: 15 June 2022

Annual governance statement

Scope of responsibility

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

I am also responsible for ensuring that the NHS Trust is administered prudently and economically and that resources are applied efficiently and effectively. I also acknowledge my responsibilities as set out in the NHS Trust Accountable Officer Memorandum.

The purpose of the system of internal control

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

An on-going review in the estates' directorate is focused predominantly on contractual and financial management of a number of contracts awarded through a procurement process. As a result of this review the Trust made a number of improvements to their procurement and financial management processes. Strengthened governance arrangements are in place and have been for a number of months during this financial year.

Capacity to handle risk

The Trust Board holds 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 Finance and Performance, Chief Medical Officer and the Chief Nurse.

The Chief Nurse is the executive lead for clinical governance and the implementation of risk management ensuring that the Trust has robust systems in place to comply with the objectives set out in its approved policies and procedures.

The Chief Medical Officer is the Responsible Officer for medical revalidation for the Trust. The Executive Director of Finance and Performance holds a specific role for leading strategic development and implementation of financial risk management (including anti-fraud and bribery), which includes oversight of the Standing Financial Instructions. She is also the Senior Information Risk Officer and, as Chair of the Information Governance Group, is responsible for developing and implementing information risk management. These executive directors have a key role in the leadership of the risk management process.

The Non-Executive Committee members of the Audit and Risk Committee (ARC) play a key role in the internal control assurance processes. ARC scrutinises the effectiveness of management actions in mitigating risks through the Trust risk register and a process of deep dives. Board Committees also have a responsibility for elements of the risk management system, with the Audit and Risk Committee providing assurance on its effectiveness.

The Trust recognises the important role all leaders across the Trust have in developing a robust approach to risk management. They must ensure it forms an integral part of good management practice and is embedded as part of the Trust's culture. The provision of appropriate training is central to the achievement of this aim.

The Trust's Risk Management Strategy encompasses our risk management process and sets out how staff are supported and trained to enable them to identify, evaluate and manage risk.

The Trust provides mandatory and statutory training that all staff are required to attend in addition to specific training appropriate to individual responsibilities, such as Prevention and Management of Violence and Aggression. Throughout 2021-22 managers and their nominated risk assessors have been offered tailored further training on the principles and application of risk assessment and the tools used by the Trust to identify, record, monitor and review risk.

Training on clinical risk management is included in the mandatory induction programme which all clinical staff participate in at the start of their employment with the Trust.

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

The risk and control framework

The Trust's Risk Management Strategy provides the framework for the 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.

COVID-19 has continued to be the biggest event to impact both strategically and operationally upon the Governance, Risk and Internal Control arrangements. The Trust leadership has had to be agile and swift in its response to changing conditions and the Trust's risk and control framework has continued to be robust in identifying and managing risks in order to maintain a safe and effective environment.

Risk management across the Trust is a dynamic activity and the risks identified as having the potential to have the greatest impact on the strategic objectives have changed accordingly during the year 2021-22.

- Financial risk has remained a constant throughout the year although the relative potential impacts have changed proportionately as a result of controls, mitigations and external changes. The three key elements have been Long Term Financial Sustainability; Maintenance Services Funding availability and Capital Projects and the Availability of Capital.
- Operational Risks to Quality of Care have been Memory Assessment Demand and Demand and Capacity for Adult and Older Adult Community Mental Health Teams.
- Organisational Risk has focussed on Covid Risks both ensuring Covid secure workplaces and agile working in response to the Easing of Lockdown National Roadmap, with the Trust responding through appropriate revisions of its Standard Operating Procedures.

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

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. The Trust is committed to the proactive management of risk and we recognise that high quality systems of healthcare for patients contain inherent risks. Nonetheless, it is our intention to manage and minimise risks wherever possible to service users, staff, and members of the public and other stakeholders. The Trust's Risk Analysis process considers the likelihood of the risk event arising, the range and scale of consequences, and the controls that are or could be put in place to reduce or eliminate the risk and/ or mitigate the consequences. The use of a control calibration tool to ensure that all risks are graded appropriately and that the types and effectiveness of controls taken into account has had a positive impact in improving risk management and awareness. All risks are given a performance metric with measurable outcomes that show whether the controls are working.

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

The Local Counter Fraud Team provided by TIAA support the Trust in the prevention, detection and investigation of alleged incidents of fraud, bribery and corruption. They have undertaken awareness training to all new starters at corporate induction and run publicity campaigns to highlight fraud in the NHS. The newsletter 'Fraudstop!' is circulated to all staff and distributed at the Trust induction. The Trust Board also received a presentation from TIAA on fraud and bribery board awareness in February 2022.

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. The risk team have developed a range of simple to use tools and guidance documents for managers based on the most up to date risk management theory.

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

At the heart of the trust's risk management framework is the desire to learn from events and situations in order to continuously improve quality of care. Incident reporting is a factor in the continuing assessment of risk and results in the instigation of changes in practice. Any themes or trends in incidents identified are investigated and subject to deep dives to ascertain cause and instigate corrective action if required. The Trust encourages proactive identification of risk. Identifying sources of potential risk and proactively assessing risk situations forms part of everyday working practise throughout the trust.

Staff reporting is a key element of risk identification. Freedom to Speak is an important part of the control framework within the Trust. A Freedom to Speak Up Guardian is in place with a network of diverse Ambassadors to encourage open and honest relationships as part of the Trust's Just and Learning Culture. There were 101 contacts during the year (this includes all contacts including the green button) and as a result of contacts, changes were made to support staff following Serious Incidents, lessons learned in relation to the value of communications and managers supporting one another to enable them to have difficult conversations with patients and their families.

The Board Assurance Framework document is formally refreshed annually at the beginning of each financial year and is reviewed at regular intervals. The format of the Board Assurance Framework was adjusted in 2021-22 to make it easier to monitor risks that could affect the Trust Strategy.

The Trust has in place an overarching People Strategy which ensures that short, medium- and long-term workforce strategies and staffing systems are in place and effective. Progress against the People Strategy is reported to the Workforce and OD Committee, with that Committee reporting on progress through its Committee Chair report. The Board is assured directly that staffing processes are safe, sustainable and effective by the Director of Workforce and Organisational Development. In developing the People Strategy, the Trust has ensured that it aligns with the national strategies including the NHS People Plan and Developing Workforce Safeguards. Recommendations in relation to workforce planning and establishment reviews have been reviewed to ensure best practice is maintained.

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

Subsequent to the CQC's well-led inspection undertaken during November and December 2021, the Trust maintained its overall 'good' rating. A quality improvement plan (QIP) was developed for those areas identified as requiring some improvement. These have been submitted to the CQC.

The CQC Oversight Group, chaired by the Chief Nurse, is responsible for ensuring that Trust services meet the required fundamental standards. This group meets on a bi-monthly basis and reports directly to the Quality Committee. The main area identified for improvement is the Trust's estates and facilities and ensuring this is an effective response to repairs and maintenance concerns in patient areas and ensuring these are dealt with in a timely way.

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

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.

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

The Trust has undertaken risk assessments and has plans in place which take account of the 'Delivering a Net Zero Health Service' report under the Greener NHS programme. The Trust ensures that its obligations under the Climate Change Act 2008 and the Adaptation Reporting requirements are complied with.

Subsequent to the CQC's well-led inspection undertaken during November and December 2021, the Trust maintained its overall 'good' rating

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

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

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

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

Clinical risk and patient safety are overseen by the Quality Committee, the Chief Nurse, the Chief Medical Officer and the Chief Operating Officer. The Board receives monthly quality reports encompassing the quality and patient safety aspects for the trust. The Quality Committee focusses on quality compliance and risks to quality (including regular presentations from Care Group Directors on their risk registers) and receives reports from its sub-committees, Patient Safety, Patient Experience and Clinical Effectiveness. This includes regular reporting on clinical audit, Never Events, SIs and complaints, with information about actions taken as a consequence. The Quality Committee review the Quality Digest which analyses incidents and serious incidents by severity, theme, Care Group and location. Numbers and types of incidents are reported over time to establish any trends and benchmarked against national indicators to identify outliers. Resulting actions initiated by Care Groups, the Central Incident Investigation Team or the Quality Committee are reported and monitored to ensure effectiveness. 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.

Specialised risk management activities including emergency planning and business continuity, health and safety, fire and security, are carried out by the qualified specialists within the Corporate Risk Management Team which reports to the Executive Team and is accountable to the Audit and Risk Committee.

The Audit and Risk Committee receives regular reports from the Local Counter Fraud Specialist which identifies specific fraud risks and investigates whether or not there was evidence of those being exploited. No significant risks, classes of transactions or account balances were identified.

Arrangements are in place for the discharge of statutory functions to have been checked for any irregularities and to ensure that they are legally compliant. The Committee receives and agrees the annual work plans for internal and external auditors.

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

Assurance is also taken from the external auditors who audit the Trust's financial statements and review its Annual Governance Statement. They also ensure that there are proper arrangements in place for securing economy, efficiency and effectiveness in its use of resources.

Information governance Update for 2021-22:

The Trust has adopted a number of increasingly more secure electronic methods of communication and remote working, enabling all services to continue to interact and support our patients, partners and the public during these unprecedented times. The Trust has worked alongside its partners to implement shared care records, ensuing that the correct

information is in the correct place at the correct time. In line with NHS Digital guidance on Data Security and Protection Incidents, it is necessary for all NHS Trusts to report any incidents of Data Security and Data Protection breaches on the DSPT and also in their respective annual reports. The Trust had 16 Data Security and Protection incidents as defined the NHS Digital guidance. These incidents were reported to NHS Digital on the DSPT and automatically reported via the DSPT to the Information Commissioners' Office (ICO). Of these incidents, five related to the unavailability of information, seven were incidents of information disclosed in error, and four related to inappropriate access to information. All incidents were thoroughly investigated internally, and by the ICO, and all required actions taken and lessons learnt by the Trust have been completed. These incidents have informed risk improvements to the organisation's information risk management process and enabled process changes surrounding storage of, and access to personal data.

Information Security and Governance

The Executive Director of Finance and Performance is the Senior Information Risk Owner (SIRO) of the organisation, providing information risk management expertise at Board level. The SIRO oversees the consistent implementation of the information risk assessment process by Information Asset Owners, as described in the relevant organisation policies and procedures. Additionally, the SIRO acts as chair to the Trust-Wide Information Governance Group which is attended by the Caldicott Guardian and Data Protection Officer, as well as clinical and operational representatives.

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

The Trust continuously reviews its systems and procedures for the confidentiality, integrity and security of personal and confidential data, and always works towards reducing data security incidents. As a result of investigations into incidents and reviews of IG, Data Security & Records Management by the Information Governance Group, measures are taken to ensure the procedures and policies on Information Governance and Data Security are updated to enable compliance.

Additionally, the Trust has systems and processes in place to govern access to confidential data and to ensure guidance and standards are followed when staff are using or accessing confidential data. The Trust monitors its IG and Data Security risks through the Information Governance Group.

The Trust commissions internal auditors TIAA to undertake annual audits of the evidence collated for its yearly on-line submission of evidence for the Data Security and Protection Toolkit (DSPT).

The Trust achieved an overall "high" confidence level and substantial assurance from TIAA for this year's audit of the 2021/21 DSPT evidence.

The Trust continuously reviews its systems and procedures for the confidentiality, integrity and security of personal and confidential data, and always works towards reducing data security incidents

Review of effectiveness

As Accountable Officer, I have responsibility for reviewing the effectiveness of the system of internal control. My review of the effectiveness of the system of internal control is informed by the work of the internal auditors, clinical audit and the executive directors and managers and clinical leads within the NHS Trust who have responsibility for the development and maintenance of the internal control framework. I have drawn on the information provided in this annual report and other performance information available to me.

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

My review is also informed by comments made by the external auditors in their management letter and other reports. I have been advised on the implications of the result of my review of the effectiveness of the system of internal control by the board, the audit and risk committee and the quality committee and a plan to address weaknesses and ensure continuous improvement of the system is in place.

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

There 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.

The Audit and Risk Committee (ARC) 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.

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

Internal Audit carried out 15 reviews in 2021-22, which were designed to ascertain the extent to which the internal controls in the system are adequate to ensure that activities and procedures are operating to achieve Kent and Medway NHS and Social Care Partnership Trust's objectives. For each assurance review an assessment of the combined effectiveness of the controls in mitigating the key control risks was provided.

There was one area reviewed by internal audit, Facilities Management Reactive Maintenance Report, where it was assessed that the effectiveness of some of the internal control arrangements provided 'limited assurance'. Recommendations were made to further strengthen the control and these were accepted and implemented.

Head of Internal Audit overall opinion is that [Reasonable] assurance can be given that there is a generally sound system of internal control, designed to meet the organisation's objectives, and that controls are generally being applied consistently.

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 Audit and Risk Committee at each meeting.

The LCFS concluded that KMPT has sound arrangements in place to ensure compliance with counter fraud and anti-bribery requirements, as set out in the Government Functional Standards and the NHS Standard Contract.

The Quality Committee provided assurance in relation to Serious Incident Reporting. The Serious Incident reporting policy ensures the identifying potential risk issues through incidents, claims, near misses, patient advice and liaison enquiries and complaints through the triangulation of data; investigating and analysing root cause analysis; discussing risk and incident management through local governance agendas and learning from near misses, risk events, legal claims and complaints and sharing the lessons learned across the trust. Assurance on the effectiveness of serious incident controls is achieved through understanding of themes and trends both qualitative and quantitative analysis by severity, number, type and location over time.

Assurance is also taken from the external auditors who audit the Trust's financial statements and review its Annual Governance Statement. They also ensure that there are proper arrangements in place for securing economy, efficiency and effectiveness in its use of resources.

Conclusion

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

- The 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 2021-22 Quality Account disclosure and associated internal assurances in place to validate its accuracy, which include data quality verification, and associated Quality Committee assurance.
- Board assurance that each director knows of no information which would be relevant to the auditors for the purposes of their audit report, and of which the auditors are not aware, and; have taken all the steps that he or she ought to have taken to make himself/ herself aware of any such information and to establish that the auditors are aware of it.

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

The impact of the COVID-19 pandemic has touched every area of Trust's work and operation and for the purposes of this statement, is included as a significant control issue. This is on the basis that the annual plan, goals and finances were significantly impacted. The Board remained sighted on these issues, with strategic guidance provided to staff as appropriate.

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.

Helen Greatorex
Chief Executive
Date: 15 June 2022

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

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

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

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

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

Helen Greatorex
Chief Executive
Date: 15 June 2022

Looking after the health and wellbeing of our patients and staff is one of our priorities

Staff and remuneration

1 Remuneration and Terms of Service Committee

The Remuneration and Terms of Service Committee is responsible for ensuring there is a formal and transparent procedure for developing the policy and decision making framework for setting the remuneration, terms of service and other benefits for Very Senior Managers (VSM's). In undertaking this role the committee will recommend and monitor the level and structure of remuneration for VSM's not covered by Agenda for Change terms and conditions using the NHSE/I guidance for Very Senior Managers pay.

Further details of the committee can be found within the Directors' report section of this document.

2 Executive Remuneration policy

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

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

The Committee reviews salaries each year. For 2021-22 there were no consolidated or non-consolidated pay increases applied.

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

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

3 Salary and pension entitlements of senior managers

a) Remuneration

Salary table – audited

Name and Title		2021-22				2020-21			
		Salary (bands of £5k)	Expense payments (taxable) to nearest £100	All Pension related Benefits (bands of £2.5k)*	TOTAL (bands of £5k)	Salary (bands of £5k)	Expense payments (taxable) to nearest £100	All Pension related Benefits (bands of £2.5k)*	TOTAL (bands of £5k)
		£000	£	£000	£000	£000	£	£000	£000
Helen Greatorex - Chief Executive		155-160	0	30-32.5	185-190	155-160	0	15-17.5	170-175
Vincent Badu - Deputy Chief Executive, Executive Director of Strategy and Partnerships		130-135	0	35-37.5	165-170	130-135	0	35-37.5	165-170
Sheila Stenson - Executive Director of Finance and Performance		125-130	0	35-37.5	160-165	125-130	0	27.5-30	155-160
Afifa Qazi - Chief Medical Officer		180-185	0	55-57.5	240-245	180-185	0	142.5-145	320-325
Mary Mumvuri - Executive Director of Nursing and Governance		95-100	0	0	95-100	115-120	0	0.00	115-120
Jacquie Mowbray-Gould - Chief Operating Officer		100-105	0	42.5-45	145-150	110-115	0	62.5-65	175-180
Sandra Goatley - Director of Workforce and Organisational Development		120-125	0	30-32.5	150-155	120-125	0	30-32.5	150-155
Andy Cruickshank - Chief Nurse		5-10	0	10-12.5	20-25	0	0	0	0
Donna Hayward-Sussex - Chief Operating Officer		5-10	0	2.5-5	10-15	0	0	0	0
Julie Nerney - Trust Chair		0	0	0	0	5-10	0	0.00	5-10
Jackie Craissati - Trust Chair		40-45	0	0	40-45	35-40	0	0.00	35-40
Non Executive Directors	**Tom J Philips**	0	0	0	0	5-10	0	0.00	5-10
	Rod Ashurst	0	0	0	0	5-10	0	0.00	5-10
	Mark Bryant	0	0	0	0	5-10	0	0.00	5-10
	Anne-Marie Dean	5-10	0	0	5-10	10-15	0	0.00	10-15
	Venu Branch	15-20	0	0	15-20	10-15	0	0.00	10-15
	Catherine Walker	15-20	300	0	15-20	10-15	0	0.00	10-15
	Fiona Carragher	15-20	0	0	15-20	5-10	0	0.00	5-10
	Peter Conway	10-15	0	0	10-15	5-10	0	0.00	5-10
	Kim Lowe	15-20	0	0	15-20	5-10	0	0.00	5-10
	Sean Bone-Knell	15-20	0	0	15-20	5-10	0	0.00	5-10
	Mickola Wilson	15-20	0	0	15-20	5-10	0	0.00	5-10

* Annual increase in pension entitlement

1. Julie Nerney resigned on 14 July 2020
2. Jackie Craissati was appointed Acting Chair from 1 April 2020 and was appointed Substantive Chair in January 2021.
3. Tom J Philips, Rod Ashurst and Mark Bryant completed tenures as Non-Executive Directors on 30 November 2020.
4. Fiona Carragher, Peter Conway, Kim Lowe, Sean Bone-Knell and Mickola Wilson joined as Non-Executive Directors on 1 August 2020.
5. Anne-Marie Dean completed tenure as Non-Exexcutive Director on 31st October 2021.
6. Jacquie Mowbray-Gould resigned as Chief Operating Office in March 2022.
7. Mary Mumvari resigned as Executive Director of Nursing and Governance in December 2022.
8. Andy Cruickshank was appointed Chief Nurse in March 2022.
9. Donna Hayward-Sussex was appointed Chief Operating Officer in March 2022.

The figures in the above table relate to the amounts received during the financial year. For 2021-22 and 2020-21, there were no annual or long-term performance-related bonuses.

b) Pension benefits

Pensions table 2021-22 – audited

Name and Title	Real increase in pension at pension age	Real increase in pension lump sum at pension age	Total accrued pension at pension age at 31 March 2022	Lump sum at age 60 related to accrued pension at 31 March 2022	Cash Equivalent Transfer Value at 1 April 2021	Real increase in Cash Equivalent Transfer Value	Cash Equivalent Transfer Value at 31 March 2022
	(bands of £2,500)	(bands of £2,500)	(bands of £5,000)	(bands of £5,000)			
	£000	£000	£000	£000	£000	£000	£000
Helen Greatorex - Chief Executive	0-2.5	5-7.5	70-75	220-225	1694	75	1800
Vincent Badu - Deputy Chief Executive, Executive Director of Strategy and Partnerships	2.5-5	0-2.5	25-30	40-45	446	26	493
Sheila Stenson - Executive Director of Finance and Performance	2.5-5	0-2.5	35-40	60-65	467	19	507
Afifa Qazi - Chief Medical Officer	2.5-5	0-2.5	55-60	40-45	728	45	801
Mary Mumvuri - Executive Director of Nursing and Governance	0	0	0	0	0	0	0
Jacquie Mowbray-Gould - Chief Operating Officer	2.5-5	0-2.5	45-50	105-110	928	49	995
Sandra Goatley - Director of Workforce and Organisational Development	0-2.5	0	10-15	0	180	24	224
Andy Cruickshank - Chief Nurse	0-2.5	0-2.5	45-50	95-100	700	10	838
Donna Hayward-Sussex - Chief Operating Officer	0-2.5	0	20-25	0	292	2	346

1. As Non-Executive Directors do not receive pensionable remuneration; there are no entries in respect of pensions for Non-Executive Directors.
2. A Cash Equivalent Transfer Value (CETV) is the actuarially assessed capital value of the pension scheme benefits accrued by a member at a particular point in time. The benefits valued are the member's accrued benefits and any contingent spouse's (or other allowable beneficiary's) pension payable from the scheme. CETVs are calculated in accordance with the Occupational Pension Schemes (Transfer Values) Regulations 2008.
3. Real Increase in CETV reflects the increase in CETV effectively funded by the employer. It takes account of the increase in accrued pension due to inflation, contributions paid by the employee (including the value of any benefits transferred from another scheme or arrangement) and uses common market valuation factors for the start and end of the period.
4. Mary Mumvuri did not make any contributions into the NHS Pension Scheme in 2021-22.
5. No contributions were made to stakeholder pensions.

Pensions table 2020-21 – audited

Name and Title	Real increase in pension at pension age	Real increase in pension lump sum at pension age	Total accrued pension at pension age at 31 March 2022	Lump sum at age 60 related to accrued pension at 31 March 2022	Cash Equivalent Transfer Value at 1 April 2021	Real increase in Cash Equivalent Transfer Value	Cash Equivalent Transfer Value at 31 March 2022
	(bands of £2,500)	(bands of £2,500)	(bands of £5,000)	(bands of £5,000)			
	£000	£000	£000	£000	£000	£000	£000
Helen Greatorex - Chief Executive	0-2.5	2.5-5	70-75	215-220	1590	54	1694
Vincent Badu - Deputy Chief Executive, Executive Director of Strategy and Partnerships	2.5-5	0-2.5	20-25	40-45	395	26	446
Sheila Stenson - Executive Director of Finance and Performance	0-2.5	0-2.5	30-35	60-65	428	14	467
Afifa Qazi - Chief Medical Officer	7.5-10	5-7.5	50-55	35-40	589	103	728
Mary Mumvuri - Executive Director of Nursing and Governance	0	0	0	0	0	0	0
Jacquie Mowbray-Gould - Chief Operating Officer	2.5-5	2.5-5	45-50	105-110	831	68	928
Sandra Goatley - Director of Workforce and Organisational Development	2-2.5	0	10-15	0	138	22	180

1. As Non-Executive Directors do not receive pensionable remuneration; there are no entries in respect of pensions for Non-Executive Directors.
2. A Cash Equivalent Transfer Value (CETV) is the actuarially assessed capital value of the pension scheme benefits accrued by a member at a particular point in time. The benefits valued are the member's accrued benefits and any contingent spouse's (or other allowable beneficiary's) pension payable from the scheme. CETVs are calculated in accordance with the Occupational Pension Schemes (Transfer Values) Regulations 2008.
3. Real Increase in CETV reflects the increase in CETV effectively funded by the employer. It takes account of the increase in accrued pension due to inflation, contributions paid by the employee (including the value of any benefits transferred from another scheme or arrangement) and uses common market valuation factors for the start and end of the period.
4. Mary Mumvuri did not make any contributions into the NHS Pension Scheme in 2021-22.
5. No contributions were made to stakeholder pensions.

a) Loss of office
There were no directors who had loss of office in 2021-22.

b) Expenses of directors
The directors receive reimbursement of travel and incidental expenses incurred as a result of their duties. The values are shown on the page above.

c) Off payroll engagements
The Trust had no off-payroll engagements as at 31 March 2022 and had no new off-payroll engagements between 1 April 2021 and 31 March 2022, for more than £245 per day and that last longer than six months.

d) Exit packages

Exit packages

Exit package cost band (including any special payment element)	2021-22			2020-21		
	Number of compulsory redundancies	Cost of compulsory redundancies £	Total number of exit packages	Number of compulsory redundancies	Cost of compulsory redundancies £	Total number of exit packages
<£10,000	1	5,750	1	0	0	0
£10,001 - £25,000	0	0	0	0	0	0
£25,001 - 50,000	4	146,296	4	1	30,412	1
£50,001 - £100,000	0	0	0	1	66,755	1
£100,001 - £150,000	0	0	0	0	0	0
£150,001 - £200,000	0	0	0	0	0	0
>£200,000	0	0	0	0	0	0
Total number of exit packages by type	**5**	**-**	**5**	**2**	**-**	**2**
Total resource cost (£)	-	152,046	-	-	97,167	-

In 2021-22 there have been no departures where special payments have been made.
There have been no non-compulsory departures in year.

'Fair pay' (pay multiples) disclosures - audited

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

The banded annualised remuneration of the highest paid director in the financial year 2021-22 was £185k-190k (2020-21, £180k - £185k). This was 7 times (2020-21, 7 times) than the median remuneration of the workforce, which was £24,882 (2020-21, £24,157).

In 2021-22, 0 (2020-21, 0) employees received remuneration in excess of the highest-paid director/ member. Remuneration ranged from £7k to £115k (2019-20 £5k to £110k).

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.

Percentage change in remuneration of highest paid director

	Salary & Allowances			Performance Pay & Bonuses		
	2020-21	2021-22	Percentage change	2020-21	2021-22	Percentage change
Highest paid director	182.5	187.5	2.74%	36,192	24,128	-33%
Employees as a whole	29,507	30,625	10.97%	8,514	9,207	8%

Pay ratio information

	25th percentile		Median		75th percentile	
	2020-21	2021-22	2020-21	2021-22	2020-21	2021-22
Total remuneration (£)	18,393	18,336	24,583	25,186	37,890	39,098
Salary component of total remuneration (£)	18,005	18,336	19,737	19,918	31,209	31,534
Pay ratio information	10:1	10:1	7:1	7:1	5:1	5:1

Staff costs

	Permanent £000	Other £000	2021-22 Total £000	2020/21 Total £000
Salaries and wages	118,768	1,066	**119,834**	111,365
Social security costs	11,335	-	**11,335**	11,385
Apprenticeship levy	572	-	**572**	532
Employer's contributions to NHS pension scheme	21,821	-	**21,821**	20,484
Pension cost - other	46	-	**46**	39
Termination benefits	152	-	**152**	97
Temporary staff	-	25,062	**25,062**	25,708
Total gross staff costs	**152,694**	**26,128**	**178,822**	**169,610**
Recoveries in respect of seconded staff	-	-	**-**	-
Total staff costs	**152,694**	**26,128**	**178,822**	**169,610**
Of which Costs capitalised as part of assets	869	-	**869**	**336**

Average number of employees (WTE basis)

	Permanent Number	Other Number	2021-22 Total Number	2020/21 Total Number
Medical and dental	211	16	**227**	225
Administration and estates	868	28	**896**	901
Healthcare assistants and other support staff	765	297	**1,062**	1,086
Nursing, midwifery and health visiting staff	877	177	**1,054**	1,008
Nursing, midwifery and health visiting learners	15	-	**15**	13
Scientific, therapeutic and technical staff	390	15	**405**	370
Healthcare science staff	-	-	**-**	-
Social care staff	-	-	**-**	-
Other	12	-	**12**	12
Total average numbers	**3,138**	**533**	**3,671**	**3,615**
Of which Number of employees (WTE) engaged on capital projects	14	-	**14**	6

Staff numbers by band and gender

	Female	Male	Grand Total
Unspecified	1		1
Director Salary	1	2	3
Band 8a	120	37	157
Band 8b	63	26	89
Band 6	558	148	706
Band 8c	28	15	43
Expense only	9	3	12
Band 7	311	105	416
Band 8d	20	10	30
Band 9	4	8	12
Medical	96	95	191
Band 2	413	164	577
Band 5	286	83	369
Band 3	532	152	684
Band 4	260	51	311
Apprentice	11	4	15
Grand Total	2713	903	3616

Source: Average Full Time Equivalent (FTE) numbers during 2021-22 from the Electronic Staff Record (ESR).

Staff numbers by age band

	Count of FTE
<=20 Years	33
>=71 Years	30
21-25	211
26-30	338
31-35	358
36-40	399
41-45	452
46-50	526
51-55	541
56-60	421
61-65	247
66-70	59
Unspecified	1
Grand Total	3616

Source: Average Full Time Equivalent (FTE) numbers during 2021-22 from the Electronic Staff Record (ESR).

Staff numbers by ethnicity

	Count of FTE	% Of Staff
A White - British	2425	67.06%
B White - Irish	35	0.97%
C White - Any other White background	128	3.54%
CA White English	29	0.80%
CB White Scottish	1	0.03%
CM White Traveller	1	0.03%
CP White Polish	7	0.19%
CX White Mixed	4	0.11%
CY White Other European	12	0.33%
D Mixed - White & Black Caribbean	10	0.28%
E Mixed - White & Black African	11	0.30%
F Mixed - White & Asian	18	0.50%
G Mixed - Any other mixed background	33	0.91%
GA Mixed - Black & Asian	1	0.03%
GE Mixed - Asian & Chinese	1	0.03%
GF Mixed - Other/Unspecified	1	0.03%
H Asian or Asian British - Indian	123	3.40%
J Asian or Asian British - Pakistani	10	0.28%
K Asian or Asian British - Bangladeshi	8	0.22%
L Asian or Asian British - Any other Asian background	67	1.85%
LA Asian Mixed	1	0.03%
LB Asian Punjabi	1	0.03%
LF Asian Tamil	1	0.03%
LH Asian British	4	0.11%
M Black or Black British - Caribbean	32	0.88%
N Black or Black British - African	394	10.90%
P Black or Black British - Any other Black background	22	0.61%
PC Black Nigerian	18	0.50%
PD Black British	11	0.30%
R Chinese	6	0.17%
S Any Other Ethnic Group	49	1.36%
SB Japanese	1	0.03%
SC Filipino	7	0.19%
SE Other Specified	1	0.03%
Z Not Stated	43	1.19%
(blank)	100	2.77%
Grand Total	**3616**	**100.00%**

Source: Average headcount numbers during 2021-22 from the Electronic Staff Record (ESR).

Sickness absence data

We set a challenging target of 4 per cent staff absence rate in 2021-22. We achieved a rate of 4.4 per cent, which is a slight decrease on 2020-21. Last year we introduced a 'Health and Wellbeing' pillar to the People Plan and have just finalised our Health and Wellbeing Strategy. We are also committed to supporting staff when they are unwell and do all that we can to help them return to work.

Staff engagement

We had a 68% response rate in the 2021 NHS National Staff Survey. This is an increase from the previous year (61% the previous year), staff engagement is high.

Staff turnover

Turnover for 20-21 was at 10.1%. This increased in 21-22 to 12.7%, against a target of 9%.

c) Expenditure on consultancy
Please refer to note 5 in the Annual Accounts.

We had a 68% response rate in the 2021 NHS National Staff Survey. This is an increase from the previous year (61% the previous year), staff engagement is high

Staff policies applied during the year

Policies applied for giving full and fair consideration for employment made by disabled persons

KMPT has a recruitment and selection policy, which sets out how we ensure fair recruitment practices through the attraction, selection and recruitment of candidates. This is reviewed through the electronic tracking 'TRAC' recruitment system. KMPT also reports the data as part of the Workforce Disability Equality Standard and Workforce Race Equality Standard.

Policies for continuing the employment of and for arranging training for employees who have become disabled persons during the period

KMPT adheres to the Equality Act 2010, and as such, line managers make reasonable adjustments and use referrals to the Occupational Health team to ensure the continued employment of employees who become disabled persons. In addition, the Workforce team provides direct support to staff affected and their managers.

Policies for the training, career development and promotion of disabled employees

There is equality of access to training for all staff.

Actions taken in the financial year to provide employees systematically with information on matters of concern to them as employees

Regular messaging was put in place to ensure teams continued to receive updates during the pandemic. This included all staff emails, managers briefings and messages from the Chief Executive and others from our executive management team.

Actions taken during the financial year to consult employees or their representatives on a regular basis so that the views of employees can be taken into account in making decisions which are likely to affect their interests

KMPT has regular meetings of its Joint Negotiating Forum (JNF) and Local Negotiating Committees (LNC) for formal discussions relating to staffing issues.

As stipulated within the organisational change policy, collective consultations would be enacted where there are more specific issues affecting staff i.e. restructures.

Information on health and safety performance occupational health

During the year, health and safety training was delivered to 97 per cent of staff. The Trust has 138 keyworkers trained in moving and handling. The health and safety department undertakes audits on the whole hospital in conjunction with the staff side chair.

There are contract review meetings with the external occupational health provider, reviewing all elements of service; for pre-employment and in employment activity.

Information on policies and procedures with respect to countering fraud and corruption

The trust has a whistleblowing policy in place. TiAA provide support services to KMPT.

Helen Greatorex
Chief Executive
Date: 15 June 2022

Annual accounts

Statement of directors' responsibilities in respect of the accounts

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

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

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

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

The directors confirm that the annual report and accounts, taken as a whole, is fair, balanced and understandable and provides the information necessary for patients, regulators and stakeholders to assess the NHS Trust's performance, business model and strategy.

By order of the board

Helen Greatorex
Chief Executive
Date: 15 June 2022

Sheila Stenson
Finance Director
Date: 15 June 2022

Independent auditors report to the directors of Kent and Medway NHS and Social Care Partnership Trust

Report on the Audit of the Financial Statements

Opinion on financial statements

We have audited the financial statements of Kent and Medway NHS and Social Care Partnership Trust (the 'Trust') for the year ended 31 March 2022, which comprise the Statement of Comprehensive Income, the Statement of Financial Position, the Statement of Changes in Equity, the Statement of Cash Flows and notes to the financial statements, including a summary of significant accounting policies. The financial reporting framework that has been applied in their preparation is applicable law and international accounting standards in conformity with the requirements of the Accounts Directions issued under Schedule 15 of the National Health Service Act 2006, as interpreted and adapted by the Department of Health and Social Care Group accounting manual 2021 to 2022.

In our opinion, the financial statements:

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

Basis for opinion

We conducted our audit in accordance with International Standards on Auditing (UK) (ISAs (UK)) and applicable law, as required by the Code of Audit Practice (2020) ("the Code of Audit Practice") approved by the Comptroller and Auditor General. Our responsibilities under those standards are further described in the 'Auditor's responsibilities for the audit of the financial statements' section of our report. We are independent of the Trust in accordance with the ethical requirements that are relevant to our audit of the financial statements in the UK, including the FRC's Ethical Standard, and we have fulfilled our other ethical responsibilities in accordance with these requirements. We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our opinion.

Conclusions relating to going concern

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

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

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

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

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

Other information

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

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

We have nothing to report in this regard.

Other information we are required to report on by exception under the Code of Audit Practice

Under the Code of Audit Practice published by the National Audit Office in April 2020 on behalf of the Comptroller and Auditor General (the Code of Audit Practice) we are required to consider whether the Annual Governance Statement does not comply with the guidance issued by NHS England or is misleading or inconsistent with the information of which we are aware from our audit. We are not required to consider whether the Annual Governance Statement addresses all risks and controls or that risks are satisfactorily addressed by internal controls.

We have nothing to report in this regard.

Opinion on other matters required by the Code of Audit Practice

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

- the parts of the Remuneration and Staff Report to be audited have been properly prepared in accordance with international accounting standards in conformity with the requirements of the Accounts Directions issued under Schedule 15 of the National Health Service Act 2006, as interpreted and adapted by the Department of Health and Social Care Group accounting manual 2021 to 2022; and
- based on the work undertaken in the course of the audit of the financial statements and our knowledge of the Trust, the other information published together with the financial statements in the annual report for the financial year for which the financial statements are prepared is consistent with the financial statements.

Matters on which we are required to report by exception

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

- we issue a report in the public interest under Section 24 of the Local Audit and Accountability Act 2014 in the course of, or at the conclusion of the audit; or
- we refer a matter to the Secretary of State under Section 30 of the Local Audit and Accountability Act 2014 because we have reason to believe that the Trust, or an officer of the Trust, is about to make, or has made, a decision which involves or would involve the body incurring unlawful expenditure, or is about to take, or has begun to take a course of action which, if followed to its conclusion, would be unlawful and likely to cause a loss or deficiency; or
- we make a written recommendation to the Trust under Section 24 of the Local Audit and Accountability Act 2014 in the course of, or at the conclusion of the audit.

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

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

As explained in the Statement of directors' responsibilities in respect of the accounts, the Directors are responsible for the preparation of the financial statements in the form and on the basis set out in the Accounts Directions, for being satisfied that they give a true and fair view, and for such internal control as the Directors determine is necessary to enable the preparation of financial statements that are free from material misstatement, whether due to fraud or error.

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

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

Auditor's responsibilities for the audit of the financial statements

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

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

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

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

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

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

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

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

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

Under the Code of Audit Practice, we are required to report to you if, in our opinion, we have not been able to satisfy ourselves that the Trust has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources for the year ended 31 March 2022.

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

Responsibilities of the Accountable Officer

As explained in the Statement of the chief executive's responsibilities as the accountable officer of the Trust,the Chief Executive, as Accountable Officer, is responsible for putting in place proper arrangements for securing economy,efficiency and effectiveness in the use of the Trust's resources.

Auditor's responsibilities for the review of the Trust's arrangements for securing economy, efficiency and effectiveness in its use of resources

We are required under Section 21(3)(c) and Schedule 13 paragraph 10(a) of the Local Audit and Accountability Act 2014 to be satisfied that the Trust has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources. We are not required to consider, nor have we considered, whether all aspects of the Trust's arrangements for securing economy, efficiency and effectiveness in its use of resources are operating effectively.

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

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

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

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

We cannot formally conclude the audit and issue an audit certificate for Kent and Medway NHS and Social Care Partnership Trust for the year ended 31 March 2022 in accordance with the requirements of the Local Audit and Accountability Act 2014 and the Code of Audit Practice until we have completed our work on the Trust's arrangements for securing economy, efficiency and effectiveness in its use of resources.

Use of our report

This report is made solely to the Directors of the Trust, as a body, in accordance with Part 5 of the Local Audit and Accountability Act 2014. Our audit work has been undertaken so that we might state to the Trust's Directors those matters we are required to state to them in an auditor's report and for no other purpose. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the Trust and the Trust's Directors as a body, for our audit work, for this report, or for the opinions we have formed.

John Paul Cuttle

John Paul Cuttle, Key Audit Partner
for and on behalf of Grant Thornton UK LLP,
Local Auditor
London
Date: 15 June 2022

Annual accounts for the year ended 31 March 2022

Statement of Comprehensive Income

	Note	2021/22 £000	Restated 2020/21 £000
Operating income from patient care activities	3	**218,074**	202,580
Other operating income	4	**13,672**	17,459
Operating expenses	5, 7	**(226,533)**	(216,328)
Operating surplus/(deficit) from continuing operations		**5,213**	3,711
Finance income	10	**11**	3
Finance expenses	11	**(1,769)**	(1,714)
PDC dividends payable		**(3,378)**	(2,796)
Net finance costs		**(5,136)**	(4,507)
Other gains / (losses)	12	**1,024**	454
Surplus / (deficit) for the year		**1,101**	(342)
Other comprehensive income			
Will not be reclassified to income and expenditure:			
Impairments	6	**271**	(2,343)
Revaluations	15	**5,223**	434
Total comprehensive income / (expense) for the period		**6,595**	(2,251)

Adjusted financial performance - note

The Trust's surplus for 2021-22 was £1,101k. NHS England and Improvement excludes the impact of certain transactions - impairments, revaluations and capital grants for the purposes of measuring NHS Trusts' financial performance. After removing these transactions the Trust's adjusted financial performance for the financial year would have been a £21k surplus.

As outlined in Note 32 a prior period adjustment has been transacted in year to correct the previous treatment whereby a finance lease had been classified as an on-SOFP PFI. This has resulted in a final adjusted deficit of £4,578k.

The below table does not form part of the Statement of Comprehensive Income and represents a note to the accounts.

Adjusted financial performance (control total basis):		
Surplus / (deficit) for the period	1,101	(124)
Remove net impairments not scoring to the Departmental expenditure limit	(1,080)	127
Prior period adjustments	(4,599)	-
Adjusted financial performance surplus / (deficit)	**(4,578)**	**3**

The prior year deficit reported in the adjusted financial performance note is as per the prior year audited accounts. In accordance with the Government Accounting Manual (GAM) it has not been updated for the prior period adjustment, which has been recorded against current year performance. This is different to the deficit in the Statement of Comprehensive Income above, which has also been produced in accordance with the GAM

Statement of Financial Position

	Note	31 March 2022 £000	Restated 31 March 2021 £000	Restated 31 March 2020 £000
Non-current assets				
Intangible assets	13	**3,185**	2,221	461
Property, plant and equipment	14	**133,710**	125,965	122,971
Investment property	16	**2,268**	1,091	1,091
Receivables	18	**538**	725	403
Total non-current assets		**139,701**	130,002	124,926
Current assets				
Inventories	17	**-**	-	-
Receivables	18	**6,522**	5,416	8,510
Cash and cash equivalents	20	**20,077**	17,266	15,678
Total current assets		**26,599**	22,682	24,188
Current liabilities				
Trade and other payables	21	**(21,547)**	(20,935)	(17,233)
Borrowings	23	**(914)**	(840)	(2,984)
Provisions	25	**(1,629)**	(855)	(1,208)
Other liabilities	22	**(1,817)**	(1,932)	(2,576)
Total current liabilities		**(25,907)**	(24,562)	(24,001)
Total assets less current liabilities		**140,393**	128,122	125,113
Non-current liabilities				
Borrowings	23	**(13,786)**	(14,700)	(15,541)
Provisions	25	**(3,716)**	(2,090)	(1,492)
Total non-current liabilities		**(17,502)**	(16,790)	(17,033)
Total assets employed		**122,891**	111,332	108,080
Financed by				
Public dividend capital		**126,785**	121,821	116,318
Revaluation reserve		**21,315**	15,821	18,622
Other reserves		**(5,280)**	(5,280)	(5,280)
Income and expenditure reserve		**(19,929)**	(21,030)	(21,580)
Total taxpayers' equity		**122,891**	111,332	108,080

The notes on pages 103 to 149 form part of these accounts.

Helen Greatorex
Chief Executive
Date: 15 June 2022

Statement of Changes in Equity for the year ended 31 March 2022

	Note	Public dividend capital	Revaluation reserve	Other reserves*	Income and expenditure reserve	Total
		£000	£000	£000	£000	£000
Taxpayers' and others' equity at 1 April 2021 - brought forward		**121,821**	**15,821**	**(5,280)**	**(21,030)**	**111,332**
Surplus/(deficit) for the year		**-**	**-**	**-**	**1,101**	**1,101**
Impairments		**-**	**271**	**-**	**-**	**271**
Revaluations		**-**	**5,223**	**-**	**-**	**5,223**
Public dividend capital received		**4,964**	**-**	**-**	**-**	**4,964**
Taxpayers' and others' equity at 31 March 2022		**126,785**	**21,315**	**(5,280)**	**(19,929)**	**122,891**

Statement of Changes in Equity for the year ended 31 March 2021 - Restated

	Public dividend capital	Revaluation reserve	Other reserves*	Income and expenditure reserve	Total
	£000	£000	£000	£000	£000
Taxpayers' and others' equity at 1 April 2020 - brought forward	116,318	18,622	(5,280)	(17,199)	112,461
Prior period adjustment	-	-	-	(4,381)	(4,381)
Taxpayers' and others' equity at 1 April 2020 - restated	116,318	18,622	(5,280)	(21,580)	108,080
Surplus/(deficit) for the year	-	-	-	(342)	(342)
Other transfers between reserves	-	(283)	-	283	-
Impairments	-	(2,343)	-	-	(2,343)
Revaluations	-	434	-	-	434
Transfer to retained earnings on disposal of assets	-	(609)	-	609	-
Public dividend capital received	5,503	-	-	-	5,503
Taxpayers' and others' equity at 31 March 2021	121,821	15,821	(5,280)	(21,030)	111,332

* Errors identified following a merger in 2006 were charged to an 'Other reserves'. Discussions are ongoing with the Department of Health and Social Care (DHSC) to adjust for this via Public Dividend Capital in 2022/23.

Information on reserves

Public dividend capital
Public dividend capital (PDC) is a type of public sector equity finance based on the excess of assets over liabilities at the time of establishment of the predecessor NHS organisation. Additional PDC may also be issued to trusts by the Department of Health and Social Care (DHSC). A charge, reflecting the cost of capital utilised by the Trust, is payable to the DHSC as the PDC.

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

Other reserves
Errors identified following a merger in 2006 were charged to an 'Other reserves'. Discussions are ongoing with the DHSC to adjust for this via Public Dividend Capital in 2022/23.

Merger reserve
This reserve reflects balances formed on merger of NHS bodies.

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

Statement of Cash Flows

	Note	2021/22 £000	Restated 2020/21 £000
Cash flows from operating activities			
Operating surplus / (deficit)		**5,213**	3,711
Non-cash income and expense:			
Depreciation and amortisation	5	**6,769**	6,798
Net impairments	6	**(1,071)**	247
(Increase) / decrease in receivables and other assets		**(1,093)**	2,636
Increase / (decrease) in payables and other liabilities		**2,172**	431
Increase / (decrease) in provisions		**2,376**	238
Net cash flows from / (used in) operating activities		**14,366**	14,061
Cash flows from investing activities			
Interest received		**11**	3
Purchase of intangible assets		**(913)**	(2,067)
Purchase of PPE and investment property		**(9,828)**	(10,055)
Sales of PPE and investment property		**-**	1,495
Net cash flows from / (used in) investing activities		**(10,730)**	(10,624)
Cash flows from financing activities			
Public dividend capital received		**4,964**	5,503
Movement on loans from DHSC		**-**	(2,300)
Capital element of finance lease rental payments		**(378)**	(339)
Capital element of PFI, LIFT and other service concession payments		**(462)**	(338)
Interest on loans		**-**	(7)
Other interest		**(4)**	(1)
Interest paid on finance lease liabilities		**(555)**	(580)
Interest paid on PFI, LIFT and other service concession obligations		**(1,186)**	(1,127)
PDC dividend (paid) / refunded		**(3,204)**	(2,660)
Net cash flows from / (used in) financing activities		**(825)**	(1,849)
Increase / (decrease) in cash and cash equivalents		**2,811**	1,588
Cash and cash equivalents at 1 April - brought forward		**17,266**	15,678
Cash and cash equivalents at 31 March	20	**20,077**	17,266

Notes to the Accounts

Note 1 Accounting policies and other information

Note 1.1 Basis of preparation

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

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

Note 1.2 Going concern
These accounts have been prepared on a going concern basis. The financial reporting framework applicable to NHS bodies, derived from the HM Treasury Financial Reporting Manual, defines that the anticipated continued provision of the entity's services in the public sector is normally sufficient evidence of going concern. The directors have a reasonable expectation that this will continue to be the case. Budgets and cashflow forecasts for 2022/23 do not indicate a going concern risk.

Note 1.3 Critical accounting judgements and key sources of estimation uncertainty
In the application of NHS 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.

Note 1.3.1 Critical judgements in applying accounting policies
Any critical judgements, apart from those involving estimations (see below) that management has made in the process of applying the NHS trust accounting policies and that have the most significant effect on the amounts recognised in the financial statements, are annotated where applicable in the notes to these accounts.

The main areas of critical judgement are:
- The valuation under a Modern Equivalent Asset on an Alternative Site basis
- The valuation of non specialised property assets on a Market Value for Existing Use basis
- The valuation of the investment property at fair value
- The valuation of the Private Finance Initiative assets on a net of VAT basis.

Note 1.3.2 Sources of estimation uncertainty
The Trust Accounts contain estimated figures that are based on assumptions made by the Trust about the future, or that are otherwise uncertain. Estimates are made taking into account historical experience, current trends and other related factors. However, because balances cannot be determined with certainty, actual results could be materially different dependent upon the assumptions made and resulting estimates.
There is one item in the Statement of Financial Position where actual results could be materially different from assumptions and estimates:

Property Valuations

Valuations of land and buildings (included in Note 14) were carried out by external valuers. These were carried out in accordance with the methodologies and bases for estimation set out in the professional standards of the Royal Institution of Chartered Surveyors.

The value of land and buildings could materially differ for two main reasons:
1. If assumptions around future use of the assets was to change e.g. from specialised use to non-specialised use this would alter the basis of valuation from Depreciated Replacement Cost (DRC) to Equivalent Use Value (EUV).
2. If the indices used by the valuers materially changed, this would alter the total valuation. Over the past 12 months, BCIS indices have fluctuated by a maximum of 9.3%.

Land is currently valued at £20,519k, a 5% reduction in the valuation would decrease asset values by £1m. Buildings are valued at £100,868k, a 5% decrease in values would result in a £5.0m reduction in asset values.

Note 1.4.1 Revenue from contracts with customers
Where income is derived from contracts with customers, it is accounted for under IFRS 15. The GAM expands the definition of a contract to include legislation and regulations which enables an entity to receive cash or another financial asset that is not classified as a tax by the Office of National Statistics (ONS).

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

Revenue from NHS contracts

The main source of income for the Trust is contracts with commissioners for health care services. In 2021/22 and 2020/21, the majority of the trust's income from NHS commissioners was in the form of block contract arrangements.

2021/22

As a result of COVID-19 the financial regime for NHS organisations was amended. Block contract arrangements were agreed based on national guidance with our lead commissioners. The related performance obligation is the delivery of healthcare and related services, with the Trust's entitlement to consideration not varying based on the levels of activity performed.

Comparative period (2020/21)

In the comparative period (2020/21) in the first half of the year the Trust received block funding from its commissioners. For the second half of the year, block contract arrangements were agreed at a Sustainability and Transformation Partnership level. The related performance obligation was the delivery of healthcare and related services, with the Trust's entitlement to consideration not varying based on the levels of activity performed. The Trust received additional income outside of the block and system envelopes to reimburse specific costs incurred and other income top-ups to support the delivery of services. Reimbursement and top-up income was accounted for as variable consideration.

Revenue from research contracts
Where research contracts fall under IFRS 15, revenue is recognised as and when performance obligations are satisfied. For some contracts, it is assessed that the revenue project constitutes one performance obligation over the course of the multi-year contract. In these cases it is assessed that the Trust's interim performance does not create an asset with alternative use for the Trust, and the Trust has an enforceable right to payment for the performance completed to date. It is therefore considered that the performance obligation is satisfied over time, and the Trust recognises revenue each year over the course of the contract. Some research income alternatively falls within the provisions of IAS 20 for government grants.

Note 1.4.2 Revenue grants and other contributions to expenditure
Government grants are grants from government bodies other than income from commissioners or trusts for the provision of services. Where a grant is used to fund revenue expenditure it is taken to the Statement of Comprehensive Income to match that expenditure.

Note 1.4.3 Apprenticeship service income
The value of the benefit received when accessing funds from the Government's apprenticeship service is recognised as income at the point of receipt of the training service. Where these funds are paid directly to an accredited training provider from the Trust's Digital Apprenticeship Service (DAS) account held by the Department for Education, the corresponding notional expense is also recognised at the point of recognition for the benefit.

Note 1.5 Expenditure on employee benefits
Short-term employee benefits
Salaries, wages and employment-related payments such as social security costs and the apprenticeship levy are recognised in the period in which the service is received from employees. The cost of annual leave entitlement earned but not taken by employees at the end of the period is recognised in the financial statements to the extent that employees are permitted to carry-forward leave into the following period.

Pension costs

NHS Pension Scheme

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

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

Note 1.6 Expenditure on other goods and services
Expenditure on goods and services is recognised when, and to the extent that they have been received, and is measured at the fair value of those goods and services. Expenditure is recognised in operating expenses except where it results in the creation of a non-current asset such as property, plant and equipment.

Note 1.7 Property, plant and equipment

Note 1.7.1 Recognition
Property, plant and equipment is capitalised where:

• it is held for use in delivering services or for administrative purposes
• it is probable that future economic benefits will flow to, or service potential be provided to, the Trust
• it is expected to be used for more than one financial year
• the cost of the item can be measured reliably
• the item has cost of at least £5,000, or
• collectively, a number of items have a cost of at least £5,000 and individually have cost of more than £250, where the assets are functionally interdependent, had broadly simultaneous purchase dates, are anticipated to have similar disposal dates and are under single managerial control.

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

Note 1.7.2 Measurement
Valuation
All property, plant and equipment assets are measured initially at cost, representing the costs directly attributable to acquiring or constructing the asset and bringing it to the location and condition necessary for it to be capable of operating in the manner intended by management. All assets are measured subsequently at current value.

Land and buildings used for the Trust's services or for administrative purposes are stated in the Statement of Financial Position at their revalued amounts, being the fair value at the date of revaluation less any impairment.

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

• Land and non-specialised buildings – market value for existing use
• Specialised buildings – depreciated replacement cost on a modern equivalent asset basis.

HM Treasury has adopted a standard approach to depreciated replacement cost valuations based on modern equivalent assets and, where it would meet the location requirements of the service being provided, an alternative site can be valued. All land and buildings are restated to current value using professional valuations in accordance with IAS 16 every five years and in the intervening third year by a 'desk top' review, or on the completion of a material refurbishment scheme. In light of the material impairment previously recognised, the Trust has taken the decision to undertake a valuation more frequently, and has decided to undertake this annually. In 2021/22 this was carried out as a desktop revaluation of the estate.

The professional valuations are carried out by local independent valuers. The valuations are carried out in accordance with the Royal Institute of Chartered Surveyors (RICS) Appraisal and Valuation Manual in so far as these terms are consistent with the agreed requirements of the DHSC and HM Treasury. In accordance with the requirements of the DHSC, a full asset valuation took place in March 2020.

Properties in the course of construction for service or administration purposes are carried at cost, less any impairment loss. Cost includes professional fees and, where capitalised in accordance with IAS 23, borrowing costs. Assets are revalued and depreciation commences when they are brought into use.

The carrying value of existing assets at that date will be written off over their useful remaining lives and new fixtures and equipment are carried at depreciated historic cost as this is not considered to be materially different from fair value.

An item of property, plant and equipment which is surplus with no plan to bring it back into use is valued at fair value under IFRS 13, if it does not meet the requirements of IAS 40 or IFRS 5.

Valuation guidance issued by the Royal Institute of Chartered Surveyors states that valuations are performed net of VAT where the VAT is recoverable by the entity, and the replacement option would be via a similar approach that would equally allow VAT recovery. In 2019/20 this basis was applied to the Trust's Private Finance Initiative (PFI) scheme at the Greenacres site, where the construction was completed by a special purpose vehicle and the costs had recoverable VAT for the Trust. Although PFI schemes are not a future option in the NHS, it is management's view that, were it to be required to rebuild this asset, it would replace under a similar special purpose vehicle that would enable VAT recovery. In 2019/20 the Trust opted to change practice following a full review by the Trust's valuer, Montagu Evans, and is adopting this judgement going forward.

Modern Equivalent Asset on an Alternative Site Basis
In 2017/18 the Trust adopted the alternative site for its land valuations. The valuation assumption within note 15, relating to the land values, is to adopt the methodology appropriate for a Modern Equivalent Asset (MEA) on an Alternative Site Basis whereby the Trust would not hold more land than is necessary for the delivery of services. This follows the economic principle of substitution. Without affecting services some land at each of the four sites can be identified as non functional, and therefore excluded from an MEA valuation.

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

Depreciation
Items of property, plant and equipment are depreciated over their remaining useful lives in a manner consistent with the consumption of economic or service delivery benefits. Freehold land is considered to have an infinite life and is not depreciated.

Property, plant and equipment which has been reclassified as ‘held for sale’ cease to be depreciated upon the reclassification. Assets in the course of construction and residual interests in off-Statement of Financial Position PFI contract assets are not depreciated until the asset is brought into use or reverts to the Trust, respectively.

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

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

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

Impairments

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

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

Other impairments are treated as revaluation losses. Reversals of 'other impairments' are treated as revaluation gains.

Note 1.7.3 De-recognition

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

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

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

Note 1.7.4 Donated and grant funded assets

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

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

In 2020/21 this includes assets donated to the Trust by the DHSC as part of the response to the coronavirus pandemic. As defined in the GAM, the Trust applies the principle of donated asset accounting to assets that the trust controls and is obtaining economic benefits from at the year end.

Note 1.7.5 Private Finance Initiative (PFI) and Local Improvement Finance Trust (LIFT) transactions

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

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

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

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

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

Note 1.7.6 Useful lives of property, plant and equipment
Useful lives reflect the total life of an asset and not the remaining life of an asset. The range of useful lives are shown in the table below:

	Min life Years	Max life Years
Land	-	-
Buildings, excluding dwellings	3	90
Plant & machinery	5	15
Transport equipment	7	10
Information technology	4	5
Furniture & fittings	5	10

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

Note 1.8.1 Recognition
Intangible assets are non-monetary assets without physical substance which are capable of being sold separately from the rest of the Trust's business or which arise from contractual or other legal rights. They are recognised only where it is probable that future economic benefits will flow to, or service potential be provided to, the Trust and where the cost of the asset can be measured reliably.

Internally generated intangible assets
Internally generated goodwill, brands, mastheads, publishing titles, customer lists and similar items are not capitalised as intangible assets. Expenditure on research is not capitalised. Expenditure on development is capitalised where it meets the requirements set out in IAS 38, where all of the following can be demonstrated:

• the project is technically feasible to the point of completion and will result in an intangible asset for sale or use
• the Trust intends to complete the asset and sell or use it
• the Trust has the ability to sell or use the asset
• how the intangible asset will generate probable future economic or service delivery benefits, e.g. the presence of a market for it or its output, or where it is to be used for internal use, the usefulness of the asset;
• adequate financial, technical and other resources are available to the Trust to complete the development and sell or use the asset and
• the Trust can measure reliably the expenses attributable to the asset during development.

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

Note 1.8.2 Measurement
Intangible assets are recognised initially at cost, comprising all directly attributable costs needed to create, produce and prepare the asset to the point that it is capable of operating in the manner intended by management.

Subsequently intangible assets are measured at current value in existing use. Where no active market exists, intangible assets are valued at the lower of depreciated replacement cost and the value in use where the asset is income generating. Revaluations gains and losses and impairments are treated in the same manner as for property, plant and equipment. An intangible asset which is surplus with no plan to bring it back into use is valued at fair value where there are no restrictions on sale at the reporting date and where they do not meet the definitions of investment properties or assets held for sale.

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

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

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

	Min life Years	Max life Years
Information technology	3	7
Software licences	3	5

Note 1.9 Inventories
Inventories are valued at the lower of cost and net realisable value. The cost of inventories is measured using the weighted average cost method.

In 2020/21 and 2021/22, the Trust received inventories including personal protective equipment from the DHSC at nil cost. In line with the GAM and applying the principles of the IFRS Conceptual Framework, the Trust has accounted for the receipt of these inventories at a deemed cost, reflecting the best available approximation of an imputed market value for the transaction based on the cost of acquisition by the DHSC.

Note 1.10 Investment properties
Investment property, which is property held to earn rentals and/or for capital appreciation (including property under construction for such purposes), is stated at its fair value at the balance sheet date. Gains or losses arising from changes in the fair value of investment property are included in profit or loss for the period in which they arise.

Note 1.11 Cash and cash equivalents
Cash is cash in hand and deposits with any financial institution repayable without penalty on notice of not more than 24 hours. Cash equivalents are investments that mature in 3 months or less from the date of acquisition and that are readily convertible to known amounts of cash with insignificant risk of change in value.

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

Note 1.12 Financial assets and financial liabilities

Note 1.12.1 Recognition
Financial assets and financial liabilities arise where the Trust is party to the contractual provisions of a financial instrument, and as a result has a legal right to receive or a legal obligation to pay cash or another financial instrument. The GAM expands the definition of a contract to include legislation and regulations which give rise to arrangements that in all other respects would be a financial instrument and do not give rise to transactions classified as a tax by Office for National Statistics (ONS).

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

Note 1.12.2 Classification and measurement
Financial assets and financial liabilities are initially measured at fair value plus or minus directly attributable transaction costs except where the asset or liability is not measured at fair value through income and expenditure. Fair value is taken as the transaction price, or otherwise determined by reference to quoted market prices or valuation techniques.

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

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

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

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

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

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

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

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

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

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

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

Note 1.12.3 Derecognition
Financial assets are de-recognised when the contractual rights to receive cash flows from the assets have expired or the Trust has transferred substantially all the risks and rewards of ownership.

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

Note 1.13 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.

Note 1.13.1 The Trust as a lessee

Finance leases

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

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

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

Operating leases

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

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

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

Note 1.13.2 The Trust as a lessor
Finance leases

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

Operating leases

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

Note 1.14 Provisions
The Trust recognises a provision where it has a present legal or constructive obligation of uncertain timing or amount; for which it is probable that there will be a future outflow of cash or other resources; and a reliable estimate can be made of the amount. The amount recognised in the Statement of Financial Position is the best estimate of the resources required to settle the obligation. Where the effect of the time value of money is significant, the estimated risk-adjusted cash flows are discounted using the discount rates published and mandated by HM Treasury.

Clinical negligence costs
NHS Resolution operates a risk pooling scheme under which the Trust pays an annual contribution to NHS Resolution, which, in return, settles all clinical negligence claims. Although NHS Resolution is administratively responsible for all clinical negligence cases, the legal liability remains with the Trust. The total value of clinical negligence provisions carried by NHS Resolution on behalf of the Trust is disclosed at note 25.2 but is not recognised in the Trust's accounts.

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

Note 1.15 Contingencies
Contingent assets (that is, assets arising from past events whose existence will only be confirmed by one or more future events not wholly within the entity's control) are not recognised as assets, but are disclosed in note 26 where an inflow of economic benefits is probable.

Contingent liabilities are not recognised, but are disclosed in note 26, unless the probability of a transfer of economic benefits is remote.

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

Note 1.16 Public dividend capital
Public dividend capital (PDC) is a type of public sector equity finance based on the excess of assets over liabilities at the time of establishment of the predecessor NHS organisation. HM Treasury has determined that PDC is not a financial instrument within the meaning of IAS 32.

The Secretary of State can issue new PDC to, and require repayments of PDC from, the Trust. PDC is recorded at the value received.
An annual charge, reflecting the cost of capital utilised by the Trust, is payable as PDC dividend. The charge is calculated at the rate set by the Secretary of State with the consent of HM Treasury (currently 3.5%) on the average relevant net assets of the Trust. Relevant net assets are calculated as the value of all assets less the value of all liabilities, except for
(i) donated and grant funded assets,
(ii) average daily cash balances held with the Government Banking Services (GBS) and National Loans Fund (NLF) deposits, excluding cash balances held in GBS accounts that relate to a short-term working capital facility,
(iii) approved expenditure on COVID-19 capital assets
(iv) assets under construction for nationally directed schemes,
(v) any PDC dividend balance receivable or payable.

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

Note 1.17 Value added tax
Most of the activities of the Trust are outside the scope of VAT and, in general, output tax does not apply and input tax on purchases is not recoverable. Irrecoverable VAT is charged to the relevant expenditure category or included in the capitalised purchase cost of fixed assets. Where output tax is charged or input VAT is recoverable, the amounts are stated net of VAT.

Note 1.18 Third party assets
Assets belonging to third parties in which the Trust has no beneficial interest (such as money held on behalf of patients) are not recognised in the accounts. However, they are disclosed in a separate note to the accounts in accordance with the requirements of HM Treasury's FReM.

Note 1.19 Losses and special payments
Losses and special payments are items that Parliament would not have contemplated when it agreed funds for the health service or passed legislation. By their nature they are items that ideally should not arise. They are therefore subject to special control procedures compared with the generality of payments. They are divided into different categories, which govern the way that individual cases are handled. Losses and special payments are charged to the relevant functional headings in expenditure on an accruals basis.

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

Note 1.20 Early adoption of standards, amendments and interpretations
No new accounting standards or revisions to existing standards have been early adopted in 2021/22.

Note 1.21 Standards, amendments and interpretations in issue but not yet effective or adopted

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

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

On transition to IFRS 16 on 1 April 2022, the Trust will apply the standard retrospectively without restatement and with the cumulative effect of initially applying the standard recognised in the income and expenditure reserve at that date. For existing operating leases with a remaining lease term of more than 12 months and an underlying asset value of at least £5,000, a lease liability will be recognised equal to the value of remaining lease payments discounted on transition at the Trust's incremental borrowing rate. The Trust's incremental borrowing rate will be defined by HM Treasury. For 2022, this rate is 0.95%. The related right of use asset will be measured equal to the lease liability adjusted for any prepaid or accrued lease payments. For existing peppercorn leases not classified as finance leases, a right of use asset will be measured at current value in existing use or fair value. The difference between the asset value and the calculated lease liability will be recognised in the income and expenditure reserve on transition. No adjustments will be made on 1 April 2022 for existing finance leases.

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

The Trust has prepared for IFRS16 by engaging all stakeholders in identifying finance leases as per the accounting standard. The Trust expects this standard to have a material impact on non-current assets, liabilities and depreciation. The estimated impact of applying the standard in 2022/23 is: -

	£000
Estimated impact on 1 April 2022 statement of financial position	
Additional right of use assets recognised for existing operating leases	18,381
Additional lease obligations recognised for existing operating leases	(18,326)
Net impact on net assets on 1 April 2022	**55**
Estimated in-year impact in 2022/23	
Additional depreciation on right of use assets	(1,758)
Additional finance costs on lease liabilities	(155)
Lease rentals no longer charged to operating expenditure	1,838
Estimated impact on surplus / deficit in 2022/23	**(75)**
Estimated increase in capital additions for new leases commencing in 2022/23.	**527**

From 1 April 2022, the principles of IFRS 16 will also be applied to the Trust's PFI liabilities where future payments are linked to a price index representing the rate of inflation. The PFI liability will be remeasured when a change in the index causes a change in future repayments and that change has taken effect in the cash flow. Under existing accounting practices, amounts relating to changes in the price index are expensed as incurred. This is expected to increase the PFI liability on the statement of financial position upon transition to IFRS 16. The effect of this has not yet been quantified.

Other standards, amendments and interpretations
IFRS 17 Insurance Contracts – Application required for accounting periods beginning on or after 1 January 2023, but not yet adopted by the FReM: early adoption is not therefore permitted.

Note 2 Segmental Reporting

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

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

Note 3 Operating income from patient care activities

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

Note 3.1 Income from patient care activities (by nature)	**2021/22**	2020/21
	£000	£000
Mental health services		
Block contract / system envelope income	**192,482**	191,996
Services delivered as part of a mental health collaborative	**14,808**	-
Clinical partnerships providing mandatory services (including S75 agreements)	**3,274**	2,539
All services		
Private patient income	**71**	52
Additional pension contribution central funding*	**6,640**	6,219
Other clinical income	**799**	1,774
Total income from activities	**218,074**	202,580

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

Note 3.2 Income from patient care activities (by source)

	2021/22	2020/21
Income from patient care activities received from:	**£000**	£000
NHS England	**21,471**	34,826
Clinical commissioning groups	**177,652**	164,222
Department of Health and Social Care	**-**	5
Other NHS providers	**16,424**	1,258
Local authorities	**1,784**	1,515
Non-NHS: private patients	**71**	52
Non NHS: other	**672**	702
Total income from activities	**218,074**	202,580
Of which:		
Related to continuing operations	**218,074**	202,580

Note 4 Other operating income

	2021/22			2020/21		
	Contract income	**Non-contract income**	**Total**	Contract income	Non-contract income	Total
	£000	**£000**	**£000**	£000	£000	£000
Research and development	**837**	**-**	**837**	778	-	778
Education and training	**4,976**	**565**	**5,541**	4,203	459	4,662
Non-patient care services to other bodies	**5,235**	**-**	**5,235**	2,292	-	2,292
Reimbursement and top up funding*	**-**	**-**	**-**	5,884	-	5,884
Income in respect of employee benefits accounted on a gross basis	**244**	**-**	**244**	194	-	194
Contributions to expenditure - consumables donated from DHSC for COVID response**	**-**	**111**	**111**	-	1,991	1,991
Rental revenue from operating leases	**-**	**1,315**	**1,315**	-	1,297	1,297
Other income	**389**	**-**	**389**	361	-	361
Total other operating income	**11,681**	**1,991**	**13,672**	13,712	3,747	17,459
Of which:						
Related to continuing operations			**13,672**			17,459

* Reimbursement and top up funding was incorporated within the block contract in 2021/22.

** In 2020/21 and 2021/22, the Trust received inventories including personal protective equipment from the DHSC at nil cost. In line with the GAM and applying the principles of the IFRS Conceptual Framework, the Trust has accounted for the receipt of these inventories at a deemed cost.

Note 5 Operating expenses

	2021/22	Restated 2020/21
	£000	£000
Purchase of healthcare from NHS and DHSC bodies	**1,923**	1,718
Purchase of healthcare from non-NHS and non-DHSC bodies	**3,945**	4,237
Staff and executive directors costs	**177,801**	169,177
Remuneration of non-executive directors	**161**	161
Supplies and services - clinical (excluding drugs costs)*	**3,494**	4,972
Supplies and services - general	**4,056**	3,686
Drug costs (drugs inventory consumed and purchase of non-inventory drugs)	**3,358**	3,177
Consultancy costs	**16**	91
Establishment	**2,486**	2,533
Premises	**10,836**	10,413
Transport (including patient travel)	**3,187**	2,789
Depreciation on property, plant and equipment	**6,172**	6,495
Amortisation on intangible assets	**597**	303
Net impairments	**(1,071)**	247
Movement in credit loss allowance: contract receivables / contract assets	**(23)**	(344)
Increase/(decrease) in other provisions	**2,588**	98
Change in provisions discount rate(s)	**46**	62
Audit fees payable to the external auditor		
audit services- statutory audit	**72**	64
Internal audit costs	**159**	129
Clinical negligence	**1,181**	1,070
Legal fees	**315**	109
Insurance	**245**	271
Research and development	**25**	-
Education and training	**1,766**	1,266
Rentals under operating leases	**2,001**	2,063
Redundancy	**152**	97
Charges to operating expenditure for on-SoFP IFRIC 12 schemes (e.g. PFI / LIFT)	**534**	592
Car parking & security	**162**	233
Hospitality	**10**	-
Losses, ex gratia & special payments	**6**	78
Other	**333**	541
Total	**226,533**	216,328
Of which:		
Related to continuing operations	**226,533**	216,328

*Supplies and services - clinical includes £111k (2020/21: £1,991k) for uilisation of personal protective equipment consumables donated from DHSC for COVID response.

The audit fees included within Note 5 above are reported as the gross position, the value excluding VAT for 2021/22 is £60k (2020/21 £54k).

Note 5.1 Other auditor remuneration

No additional sums outside of the statutory audit fee have been paid to the external auditor in the current or prior year.

Note 5.2 Limitation on auditor's liability

The limitation on auditor's liability for external audit work is £2 million (2020/21: £2 million).

Note 6 Impairment of assets

	2021/22	2020/21
	£000	£000
Net impairments charged to operating surplus / deficit resulting from:		
Abandonment of assets in course of construction	**9**	120
Changes in market price	**(1,080)**	127
Total net impairments charged to operating surplus / deficit	**(1,071)**	247
Impairments charged to the revaluation reserve	**(271)**	2,343
Total net impairments	**(1,342)**	2,590

Note 7 Employee benefits

	2021/22 Total £000	2020/21 Total £000
Salaries and wages	**119,834**	111,365
Social security costs	**11,335**	11,385
Apprenticeship levy	**572**	532
Employer's contributions to NHS pensions	**21,821**	20,484
Pension cost - other	**46**	39
Termination benefits	**152**	97
Temporary staff (including agency)	**25,062**	25,708
Total staff costs	**178,822**	169,610
Of which		
Costs capitalised as part of assets	**869**	336

Note 7.1 Retirements due to ill-health

During 2021/22 there were 3 early retirements from the trust agreed on the grounds of ill-health (6 in the year ended 31 March 2021). The estimated additional pension liabilities of these ill-health retirements is £51k (£264k in 2020/21).

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

Note 8 Pension costs

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

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

a) Accounting valuation

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

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

b) Full actuarial (funding) valuation

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

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

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

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

Note 9.1 Alternative Scheme Pension costs

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

The NEST Pension Scheme was established by the National Employment Savings Trust Order 2010. The scheme is a registered pension scheme for tax purposes under the Finance Act 2004 and was registered with HM Revenue & Customs on 21 January 2011. The Trustee of the scheme is the NEST Corporation which is a non-departmental public body established by statute, section 75 of the Pensions Act 2008. NEST is run on a not-for-profit basis and collects an annual management charge from its members of 0.3% of the employee's total fund each year. Also a charge of 1.8% is made on contributions made by the employee. At NEST, the employee keeps the same retirement pot and contributes to it even if their circumstances change.

Scheme Provisions

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

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

Note 9 Operating leases

Note 9.1 Kent and Medway NHS and Social Care Partnership Trust as a lessor

This note discloses income generated in operating lease agreements where Kent and Medway NHS and Social Care Partnership Trust is the lessor.
The Trust leases properties to a number of stakeholders primarily other NHS bodies and public sector organisations. These leases tend to be on a "full maintenance" basis.

	2021/22	2020/21
	£000	£000
Operating lease revenue		
Other	**1,315**	1,297
Total	**1,315**	1,297

	31 March 2022	31 March 2021
	£000	£000
Future minimum lease receipts due:		
On building leases:		
- not later than one year;	**1,315**	1,297
- later than one year and not later than five years;	**-**	-
- later than five years.	**-**	-
Total	**1,315**	1,297

Note 9.2 Kent and Medway NHS and Social Care Partnership Trust as a lessee

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

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

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

	2021/22	2020/21
	£000	£000
Operating lease expense		
Minimum lease payments	**2,001**	2,063
Total	**2,001**	2,063

	31 March 2022	31 March 2021
	£000	£000
Future minimum lease payments due:		
On building leases:		
- not later than one year;	**1,611**	1,889
- later than one year and not later than five years;	**5,761**	4,787
- later than five years.	**11,261**	17,003
On other leases:		
- not later than one year;	**135**	146
- later than one year and not later than five years;	**147**	81
- later than five years.	**-**	-
On all leases		
- not later than one year;	**1,746**	2,035
- later than one year and not later than five years;	**5,908**	4,868
- later than five years.	**11,261**	17,003
Total	**18,915**	23,906

Note 10 Finance income

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

	2021/22	2020/21
	£000	£000
Interest on bank accounts	11	3
Total finance income	11	3

Note 11.1 Finance expenditure

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

		Restated
	2021/22	2020/21
	£000	£000
Interest expense:		
Finance leases	555	580
Interest on late payment of commercial debt	4	1
Main finance costs on PFI and LIFT schemes obligations	538	562
Contingent finance costs on PFI and LIFT scheme obligations	648	564
Total interest expense	1,745	1,707
Unwinding of discount on provisions	24	7
Total finance costs	1,769	1,714

Note 11.2 The late payment of commercial debts (interest) Act 1998 / Public Contract Regulations 2015

	2021/22	2020/21
	£000	£000
Amounts included within interest payable arising from claims made under this legislation	4	1

Note 12 Other gains / (losses)

	2021/22	2020/21
	£000	£000
Gains on disposal of assets	2	619
Losses on disposal of assets	(155)	(165)
Total gains / (losses) on disposal of assets	(153)	454
Fair value gains/(losses) on investment properties	1,177	-
Total gains / (losses)	1,024	454

Note 13 Intangible assets - 2021/22

	Software licences £000	Internally generated information technology £000	Intangible assets under construction £000	Total £000
Valuation / gross cost at 1 April 2021 - brought forward	**2,317**	**1,665**	**-**	**3,982**
Additions	**325**	**34**	**554**	**913**
Reclassifications	**-**	**100**	**548**	**648**
Disposals / derecognition	**(263)**	**(527)**	**-**	**(790)**
Valuation / gross cost at 31 March 2022	**2,379**	**1,272**	**1,102**	**4,753**
Amortisation at 1 April 2021 - brought forward	**1,062**	**699**	**-**	**1,761**
Provided during the year	**340**	**257**	**-**	**597**
Reclassifications	**-**	**-**	**-**	**-**
Disposals / derecognition	**(263)**	**(527)**	**-**	**(790)**
Amortisation at 31 March 2022	**1,139**	**429**	**-**	**1,568**
Net book value at 31 March 2022	**1,240**	**843**	**1,102**	**3,185**
Net book value at 1 April 2021	**1,255**	**966**	**-**	**2,221**

Note 13.1 Intangible assets - 2020/21

	Software licences £000	Internally generated information technology £000	Total £000
Valuation / gross cost at 1 April 2020	1,366	3,205	4,571
Additions	1,159	908	2,067
Reclassifications	1	-	1
Disposals / derecognition	(209)	(2,448)	(2,657)
Valuation / gross cost at 31 March 2021	2,317	1,665	3,982
Amortisation at 1 April 2020	1,158	2,952	4,110
Provided during the year	113	190	303
Disposals / derecognition	(209)	(2,443)	(2,652)
Amortisation at 31 March 2021	1,062	699	1,761
Net book value at 31 March 2021	1,255	966	2,221
Net book value at 1 April 2020	208	253	461

Note 14.1 Property, plant and equipment - 2021/22

	Land	Buildings excluding dwellings	Assets under construction	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000
Valuation/gross cost at 1 April 2021 - brought forward	18,957	96,738	9,093	1,012	138	6,640	872	133,450
Additions	-	1,605	5,311	13	-	1,226	-	8,155
Impairments charged to operating expenses	-	(3,315)	(9)	-	-	-	-	(3,324)
Impairments charged to the revaluation reserve	-	(497)	-	-	-	-	-	(497)
Reversals of impairments	1,325	3,838	-	-	-	-	-	5,163
Revaluations	237	882	-	-	-	-	-	1,119
Reclassifications	-	5,644	(6,292)	8	(8)	-	-	(648)
Disposals / derecognition	-	-	-	(246)	-	(388)	(861)	(1,495)
Valuation/gross cost at 31 March 2022	20,519	104,895	8,103	787	130	7,478	11	141,923
Accumulated depreciation at 1 April 2021 - brought forward	-	3,301	-	707	135	2,667	675	7,485
Provided during the year	-	4,830	-	110	-	1,154	78	6,172
Revaluations	-	(4,104)	-	-	-	-	-	(4,104)
Reclassifications	-	-	-	5	(5)	-	-	-
Transfers to / from assets held for sale	-	-	-	-	-	-	-	-
Disposals / derecognition	-	-	-	(219)	-	(379)	(742)	(1,340)
Accumulated depreciation at 31 March 2022	-	4,027	-	603	130	3,442	11	8,213
Net book value at 31 March 2022	20,519	100,868	8,103	184	-	4,036	-	133,710
Net book value at 1 April 2021	18,957	93,437	9,093	305	3	3,973	197	125,965

Note 14.2 Property, plant and equipment - 2020/21

	Land	Buildings excluding dwellings	Assets under construction	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000
Valuation / gross cost at 1 April 2020	19,464	101,278	1,944	1,424	176	11,802	1,941	138,029
Additions	-	3,262	7,779	82	-	1,550	7	12,680
Impairments charged to operating expenses	(159)	(1,082)	(120)	-	-	-	-	(1,361)
Impairments charged to the revaluation reserve	(35)	(2,308)	-	-	-	-	-	(2,343)
Reversals of impairments	290	824	-	-	-	-	-	1,114
Revaluations	6	(5,150)	-	-	-	-	-	(5,144)
Reclassifications	-	323	(510)	27	-	170	(11)	(1)
Transfers to / from assets held for sale	(609)	(261)	-	-	-	-	-	(870)
Disposals / derecognition	-	(148)	-	(521)	(38)	(6,882)	(1,065)	(8,654)
Valuation/gross cost at 31 March 2021	18,957	96,738	9,093	1,012	138	6,640	872	133,450
Accumulated depreciation at 1 April 2020	-	4,116	-	1,059	172	8,113	1,598	15,058
Provided during the year	-	4,906	-	123	1	1,341	124	6,495
Revaluations	-	(5,578)	-	-	-	-	-	(5,578)
Reclassifications	-	-	-	20	-	-	(20)	-
Transfers to / from assets held for sale	-	-	-	-	-	-	-	-
Disposals / derecognition	-	(143)	-	(495)	(38)	(6,787)	(1,027)	(8,490)
Accumulated depreciation at 31 March 2021	-	3,301	-	707	135	2,667	675	7,485
Net book value at 31 March 2021	18,957	93,437	9,093	305	3	3,973	197	125,965
Net book value at 1 April 2020	19,464	97,162	1,944	365	4	3,689	343	122,971

Note 14.3 Property, plant and equipment financing - 2021/22

	Land	Buildings excluding dwellings	Assets under construction	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000
Net book value at 31 March 2022								
Owned - purchased	**20,519**	**74,335**	**8,103**	**184**	**-**	**4,036**	**-**	**107,177**
Finance leased	**-**	**11,819**	**-**	**-**	**-**	**-**	**-**	**11,819**
On-SoFP PFI contracts and other service concession arrangements	**-**	**14,714**	**-**	**-**	**-**	**-**	**-**	**14,714**
NBV total at 31 March 2022	**20,519**	**100,868**	**8,103**	**184**	**-**	**4,036**	**-**	**133,710**

Note 14.4 Property, plant and equipment financing - 2020/21 - Restated

	Land	Buildings excluding dwellings	Assets under construction	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000
Net book value at 31 March 2021								
Owned - purchased	18,957	69,011	9,093	305	3	3,973	197	101,539
Finance leased	-	10,769	-	-	-	-	-	10,769
On-SoFP PFI contracts and other service concession arrangements	-	13,657	-	-	-	-	-	13,657
NBV total at 31 March 2021	18,957	93,437	9,093	305	3	3,973	197	125,965

Note 15 Revaluations of property, plant and equipment

Montagu Evans LLP, who is a member of the Royal Institute of Chartered Surveyors (RCIS) and is independent of the Trust, undertook a desk top valuation of the Trust's land and buildings as at 31st March 2022. The last full valuation was undertaken by the Montagu Evans LLP as at 31st March 2020. The valuations were carried out in accordance with the RICS Appraisal and Valuation Manual in so far as these terms are consistent with the agreed requirements of the DHSC and HM Treasury. The valuations were undertaken in accordance with the Trust's accounting policy (see note 1).

The valuers considered the remaining useful economic lives of the property assets, taking into account work undertaken between valuations, the age and condition of the properties, location factors and changes to the BCIS (all price) tender price index when assessing value attributable to each asset.

Overall the valuation has contributed to net upward movement of £6.6m of which £1.1m was a credit to the Statement of Comprehensive Income for reversals of previous impairments.

The valuation exercise was carried out in March 2022 with a valuation date of 31st March 2022. In applying the Royal Institute of Chartered Surveyors (RICS) Valuation Global Standards 2020 ('Red Book'), the valuer has confirmed that whilst COVID-19 continues to affect economies and real estate markets , as at the valuation date property markets are functioning and transaction volumes and other relevant evidence are at levels where an adequate quantum of market evidence exists upon which to base opinions of value. Accordingly, the valuation is not reported as being subject to 'material valuation uncertainty' as defined by VPS 3 and VPGA 10 of the RICS Valuation – Global Standards.

Note 16.1 Investment Property

	2021/22	2020/21
	£000	£000
Carrying value at 1 April - brought forward	**1,091**	1,091
Fair value gains	**1,177**	-
Carrying value at 31 March	**2,268**	1,091

Note 17 Inventories

In response to the COVID 19 pandemic, the Department of Health and Social Care centrally procured personal protective equipment and passed these to NHS providers free of charge. During 2021/22 the Trust received £111k of items purchased by DHSC (2020/21, £1,991k).

The deemed cost of these inventories was charged directly to expenditure on receipt with the corresponding benefit recognised in income.

Note 18.1 Receivables

	31 March 2022 £000	31 March 2021 £000
Current		
Contract receivables	**3,450**	2,290
Allowance for impaired contract receivables / assets	**(128)**	(159)
Prepayments (non-PFI)	**1,572**	1,545
PDC dividend receivable	**129**	303
VAT receivable	**1,384**	1,304
Other receivables	**115**	133
Total current receivables	**6,522**	5,416
Non-current		
Prepayments (non-PFI)	**76**	65
Other receivables	**462**	660
Total non-current receivables	**538**	725
Of which receivable from NHS and DHSC group bodies:		
Current	**3,332**	2,392
Non-current	**289**	397

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

Note 18.2 Allowances for credit losses

	2021/22	2020/21
	Contract receivables and contract assets	Contract receivables and contract assets
	£000	£000
Allowances as at 1 April - brought forward	**159**	546
New allowances arising	**36**	65
Reversals of allowances	**(59)**	(409)
Utilisation of allowances (write offs)	**(8)**	(43)
Allowances as at 31 Mar 2022	**128**	159

Note 19 Non-current assets held for sale and assets in disposal groups

	2021/22	2020/21
	£000	£000
NBV of non-current assets for sale and assets in disposal groups at 1 April	**-**	-
Assets classified as available for sale in the year	**-**	870
Assets sold in year	**-**	(870)
NBV of non-current assets for sale and assets in disposal groups at 31 March	**-**	-

During 2020/21 Canada House was transferred from Property, Plant and Equipment and sold at auction, realising a profit of £0.6m.

Note 20 Cash and cash equivalents movements

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

	2021/22	2020/21
	£000	£000
At 1 April	**17,266**	15,678
Net change in year	**2,811**	1,588
At 31 March	**20,077**	17,266
Broken down into:		
Cash at commercial banks and in hand	**32**	32
Cash with the Government Banking Service	**20,045**	17,234
Total cash and cash equivalents as in SoFP	**20,077**	17,266
Total cash and cash equivalents as in SoCF	**20,077**	17,266

Note 20.1 Third party assets held by the trust

Kent and Medway NHS and Social Care Partnership Trust held cash and cash equivalents which relate to monies held by the Trust on behalf of patients or other parties and in which the trust has no beneficial interest. This has been excluded from the cash and cash equivalents figure reported in the accounts.

	31 March 2022	31 March 2021
	£000	£000
Total third party assets	**157**	131

Note 21.1 Trade and other payables

	31 March 2022 £000	31 March 2021 £000
Current		
Trade payables	**4,874**	4,386
Capital payables	**3,136**	4,809
Accruals	**8,088**	6,696
Social security costs	**1,736**	1,593
Other taxes payable	**1,602**	1,441
Other payables	**2,111**	2,010
Total current trade and other payables	**21,547**	20,935
Of which payables from NHS and DHSC group bodies:		
Current	**2,213**	1,967

Note 21.2 Ill health Retirements

During 2021/22 there were 3 early retirements from the Trust agreed on the grounds of ill-health (6 in the year ended 31 March 2021). The estimated additional pension liabilities of these ill-health retirements is £51k (£264k in 2020/21).

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

Note 22 Other liabilities

	31 March 2022 £000	31 March 2021 £000
Current		
Deferred income: contract liabilities	**1,817**	1,932
Total other current liabilities	**1,817**	1,932

Note 23.1 Borrowings

	31 March 2022 £000	Restated 31 March 2021 £000
Current		
Obligations under finance leases	**422**	378
Obligations under PFI, LIFT or other service concession contracts	**492**	462
Total current borrowings	**914**	840
Non-current		
Obligations under finance leases	**6,404**	6,826
Obligations under PFI, LIFT or other service concession contracts	**7,382**	7,874
Total non-current borrowings	**13,786**	14,700

Note 23.2 Reconciliation of liabilities arising from financing activities - 2021/22

	Finance leases	PFI and LIFT schemes	Total
	£000	£000	£000
Carrying value at 1 April 2021	**7,204**	**8,336**	**15,540**
Cash movements:			
Financing cash flows - payments and receipts of principal	**(378)**	**(462)**	**(840)**
Financing cash flows - payments of interest	**(555)**	**(538)**	**(1,093)**
Non-cash movements:			
Application of effective interest rate	**555**	**538**	**1,093**
Carrying value at 31 March 2022	**6,826**	**7,874**	**14,700**

Note 23.3 Reconciliation of liabilities arising from financing activities - 2020/21 - Restated

	Loans from DHSC	Finance leases	PFI and LIFT schemes	Total
	£000	£000	£000	£000
Carrying value at 1 April 2020	2,307	996	10,841	14,144
Prior period adjustment	-	6,547	(2,167)	4,380
Carrying value at 1 April 2020 - restated	2,307	7,543	8,674	18,524
Cash movements:				
Financing cash flows - payments and receipts of principal	(2,300)	(339)	(338)	(2,977)
Financing cash flows - payments of interest	(7)	(580)	(562)	(1,149)
Non-cash movements:				
Application of effective interest rate	-	580	562	1,142
Carrying value at 31 March 2021	-	7,204	8,336	15,540

Note 24 Finance leases

Note 24.1 Kent and Medway NHS and Social Care Partnership Trust as a lessee

The Trust has finance leases for two buildings, the Beacon and Littlebrook. The assets acquired under these leases are carried as property, plant and equipment on the Statement of Financial Position. The Trust is committed to making minimum payments under these leases comprising settlement of the long-term liability and finance costs. The minimum lease payments do not include rents that are contingent on events taking place after the lease was entered into, such as adjustments following rent reviews.

In 2025 there are renewal and purchase options for the Littlebrook building. The lease for the Beacon expires in 2025, options for future use of the building will be considered over the coming year.

Obligations under finance leases where the Trust is the lessee.

	31 March 2022	Restated 31 March 2021
	£000	£000
Gross lease liabilities	**8,309**	9,243
of which liabilities are due:		
- not later than one year;	949	934
- later than one year and not later than five years;	7,360	8,309
- later than five years.	-	-
Finance charges allocated to future periods	(1,483)	(2,039)
Net lease liabilities	**6,826**	7,204
of which payable:		
- not later than one year;	422	378
- later than one year and not later than five years;	6,404	6,826
- later than five years.	-	-

All of the above lease liabilities relate to buildings.

Note 25.1 Provisions for liabilities and charges analysis

	Pensions: injury benefits	Legal claims	Other	Total
	£000	£000	£000	£000
At 1 April 2021	**1,686**	**430**	**829**	**2,945**
Change in the discount rate	**46**	**-**	**-**	**46**
Arising during the year	**10**	**195**	**2,653**	**2,858**
Utilised during the year	**(127)**	**(19)**	**-**	**(146)**
Reversed unused	**-**	**(274)**	**(108)**	**(382)**
Unwinding of discount	**24**	**-**	**-**	**24**
At 31 March 2022	**1,639**	**332**	**3,374**	**5,345**
Expected timing of cash flows:				
- not later than one year;	**127**	**332**	**1,170**	**1,629**
- later than one year and not later than five years;	**508**	**-**	**1,937**	**2,445**
- later than five years.	**1,004**	**-**	**267**	**1,271**
Total	**1,639**	**332**	**3,374**	**5,345**

Legal Claims reflect cases covered by the Liabilities to Third Party Scheme (LTPS) for which NHS Resolution provide estimates and employment tribunal claims whose timings are based on current assumptions from the Trust's Legal Department.
Other claims relate to dilapidations provisions and the clinicians pension provision.

Note 25.2 Clinical negligence liabilities

At 31 March 2022, £13,761k was included in provisions of NHS Resolution in respect of clinical negligence liabilities of Kent and Medway NHS and Social Care Partnership Trust (31 March 2021: £3,409k).

Note 26 Contingent assets and liabilities

	31 March 2022	31 March 2021
	£000	£000
Value of contingent liabilities		
NHS Resolution legal claims	**-**	-
Other	**(413)**	(815)
Net value of contingent liabilities	**(413)**	(815)

Contingent liabilities relate to dilapidation costs for future years.

Note 27 Contractual capital commitments

	31 March 2022	31 March 2021
	£000	£000
Property, plant and equipment	**13,292**	4,222
Total	**13,292**	4,222

Note 28 On-SoFP PFI, LIFT or other service concession arrangements

The Trust has a PFI arrangement covering four of its properties - Allington Centre, Littlestone, Tarenfort Centre and Rosebud Lodge, these buildings are all used as inpatient facilities.

There were two phases to the PFI. The first started in 2006 and the second in 2007. Both arrangements end in 2037. The contractor took on the obligation to construct the centres and maintain them in a minimum acceptable condition. The contracts specify the minimum standards for the services to be provided by the contractor. The buildings and any plant and equipment installed in them at the end of the contract will be transferred to the authority for nil consideration.

	2021/22	2020/21
Phase 1 Stone House Hospital	**£000s**	£000s
Estimated capital value of the PFI scheme at the start of the contract	**9,440**	9,440
Contract start date:		**29/09/2006**
Contract end date:		**02/07/2037**

	2021/22	2020/21
Phase 2 Stone House Hospital	**£000s**	£000s
Estimated capital value of the PFI scheme at the start of the contract	**2,787**	2,787
Contract start date:		**02/07/2007**
Contract end date:		**02/07/2037**

Note 28.1 On-SoFP PFI, LIFT or other service concession arrangement obligations

The following obligations in respect of the PFI, LIFT or other service concession arrangements are recognised in the statement of financial position:

		Restated
	31 March 2022	31 March 2021
	£000	£000
Gross PFI, LIFT or other service concession liabilities	**12,135**	13,135
Of which liabilities are due		
- not later than one year;	999	1,000
- later than one year and not later than five years;	3,387	3,547
- later than five years.	7,749	8,588
Finance charges allocated to future periods	(4,261)	(4,799)
Net PFI, LIFT or other service concession arrangement obligation	**7,874**	8,336
- not later than one year;	492	462
- later than one year and not later than five years;	1,664	1,713
- later than five years.	5,718	6,161

Note 28.2 Total on-SoFP PFI, LIFT and other service concession arrangement commitments

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

	31 March 2022	**31 March 2021**
	£000	**£000**
Total future payments committed in respect of the PFI, LIFT or other service concession arrangements	**35,963**	46,274
Of which payments are due:		
- not later than one year;	2,333	2,273
- later than one year and not later than five years;	8,823	16,906
- later than five years.	24,807	27,095

Note 28.3 Analysis of amounts payable to service concession operator

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

	2021/22	2020/21
	£000	£000
Unitary payment payable to service concession operator	**2,182**	**2,056**
Consisting of:		
- Interest charge	538	562
- Repayment of balance sheet obligation	462	338
- Service element and other charges to operating expenditure	534	592
- Contingent rent	648	564
Total amount paid to service concession operator	**2,182**	**2,056**

Note 29 Financial instruments

Note 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 Trust has with CCGs and the way those CCGs are financed, the Trust is not exposed to the degree of financial risk faced by business entities. Also financial instruments play a much more limited role in creating or changing risk than would be typical of listed companies, to which the financial reporting standards mainly apply. The Trust has limited powers to borrow or invest surplus funds and financial assets and liabilities are generated by day-to-day operational activities rather than being held to change the risks facing the Trust in undertaking its activities.

The Trust's treasury management operations are carried out by the Finance department, within parameters defined formally within the Trust's Standing Financial Instructions and policies agreed by the board of directors. The Trust's treasury activity is subject to review by the Trust's internal auditors.

Currency risk

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

Interest rate risk

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

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

The Trust therefore has low exposure to interest rate fluctuations.

Credit risk

Because the majority of the Trust's revenue comes from contracts with other public sector bodies, the Trust has low exposure to credit risk. The maximum exposures as at 31 March 2022 are in receivables from customers, as disclosed in the trade and other receivables note.

Liquidity risk

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

Note 29.2 Carrying values of financial assets

Carrying values of financial assets as at 31 March 2022	Held at amortised cost	Total book value
	£000	£000
Trade and other receivables excluding non financial assets	3,899	3,899
Cash and cash equivalents	20,077	20,077
Total at 31 March 2022	23,976	23,976

The above figure for Trade and other receivables excludes the following which are classed as non financial assets - Prepayments, 1,648k, PDC dividend receivable, £129k and VAT receivable, £1,384k.

Carrying values of financial assets as at 31 March 2021	Held at amortised cost	Total book value
	£000	£000
Trade and other receivables excluding non financial assets	2,924	2,924
Cash and cash equivalents	17,266	17,266
Total at 31 March 2021	20,190	20,190

Note 29.3 Carrying values of financial liabilities

Carrying values of financial liabilities as at 31 March 2022	Held at amortised cost	Total book value
	£000	£000
Obligations under finance leases	6,826	6,826
Obligations under PFI, LIFT and other service concession contracts	7,874	7,874
Trade and other payables excluding non financial liabilities	16,098	16,098
Clinical pension provision	289	289
Total at 31 March 2022	31,087	31,087

The above figure for Trade and other payables excludes liabilities for Social security costs, Other taxes payable and Other payables (£5,449k) as these are defined as non financial liabilities.

Carrying values of financial liabilities as at 31 March 2021	Held at amortised cost	Total book value
	£000	£000
Obligations under finance leases	7,204	7,204
Obligations under PFI, LIFT and other service concession contracts	8,336	8,336
Trade and other payables excluding non financial liabilities	15,891	15,891
Clinical pension provision	397	397
Total at 31 March 2021	31,828	31,828

Note 29.4 Maturity of financial liabilities

The following maturity profile of financial liabilities is based on the contractual undiscounted cash flows. This differs to the amounts recognised in the statement of financial position which are discounted to present value.

	31 March 2022	31 March 2021
	£000	£000
In one year or less	**18,046**	17,825
In more than one year but not more than five years	**10,769**	11,856
In more than five years	**8,016**	8,985
Total	**36,831**	38,666

Note 29.5 Fair values of financial assets and liabilities

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

Note 30 Losses and special payments

	2021/22		Restated 2020/21	
	Total number of cases	**Total value of cases**	Total number of cases	Total value of cases
	Number	**£000**	Number	£000
Losses				
Cash losses	**19**	**8**	29	20
Fruitless payments and constructive losses	**-**	**-**	1	1
Bad debts and claims abandoned	**-**	**-**	23	28
Stores losses and damage to property	**-**	**-**	1	1
Total losses	**19**	**8**	54	50
Special payments				
Ex-gratia payments	**13**	**3**	23	156
Total special payments	**13**	**3**	23	156
Total losses and special payments	**32**	**11**	77	206

Note 31 Related parties

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

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

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

Note 31.1 Related Party Income

Health Education England
NHS Kent and Medway Clinical Commissioning Group
NHS England (including CSUs)
Department of Health and Social Care
Sussex Partnership NHS Foundation Trust

Note 31.2 Related Party Expenditure

NHS Pensions Scheme
NHS Resolution
Medway NHS Foundation Trust

Note 32 Prior period adjustments

A prior period adjustment has been transacted in year to correct the previous treatment whereby a finance lease had been classified as an on-SOFP PFI.

Impact of the Prior Period Adjustment on the Statement of Financial Position

		As previously stated £000	As stated in 2021/22 Accounts £000	Impact of Prior Period Adjustment £000
Current liabilities				
Borrowings	31-Mar-20	(3,203)	(2,984)	219
Borrowings	31-Mar-21	(1,055)	(840)	215
Non-current liabilities				
Borrowings	31-Mar-20	(10,941)	(15,541)	(4,600)
Borrowings	31-Mar-21	(9,886)	(14,700)	(4,814)
Taxpayers' equity				
Income and expenditure reserve	1 Apr 2020	(17,199)	(21,580)	4,381
Income and expenditure reserve	31 Mar 2021	(16,431)	(21,030)	4,599

Impact of the Prior Period Adjustment on the Statement of Comprehensive Income

Operating income	2020/21	220,039	220,039	-
Operating expenditure	2020/21	(216,315)	(216,328)	(13)
Finance cost	2020/21	(1,509)	(1,714)	(205)
Surplus/(deficit) for the year	2020/21	(124)	(342)	(218)

Note 33 Events after the reporting date

There have been no material events after the reporting date.

Note 34 Better Payment Practice code

	2021/22	2021/22	2020/21	2020/21
Non-NHS Payables	**Number**	**£000**	Number	£000
Total non-NHS trade invoices paid in the year	13,009	71,849	13,936	71,966
Total non-NHS trade invoices paid within target	11,677	65,127	12,935	69,161
Percentage of non-NHS trade invoices paid within target	89.8%	90.6%	92.8%	96.1%
NHS Payables				
Total NHS trade invoices paid in the year	1,007	7,695	1,160	7,650
Total NHS trade invoices paid within target	961	7,194	1,121	7,471
Percentage of NHS trade invoices paid within target	95.4%	93.5%	96.6%	97.7%

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

Note 35 External financing limit

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

	2021/22	2020/21
	£000	£000
Cash flow financing	**1,313**	719
Finance leases taken out in year	**-**	-
Other capital receipts	**-**	-
External financing requirement	**1,313**	719
External financing limit (EFL)	**1,313**	8,672
Under / (over) spend against EFL	**-**	7,953

Note 36 Capital Resource Limit

	2021/22	2020/21
	£000	£000
Gross capital expenditure	**9,068**	14,747
Less: Disposals	**(155)**	(1,039)
Charge against Capital Resource Limit	**8,913**	13,708
Capital Resource Limit	**10,955**	13,767
Under / (over) spend against CRL	**2,042**	59

Note 37 Breakeven duty financial performance

	2021/22	2020/21
	£000	£000
Adjusted financial performance surplus / (deficit) (control total basis)	**(4,578)**	3
Remove impairments scoring to Departmental Expenditure Limit	**9**	120
IFRIC 12 breakeven adjustment	**181**	545
Breakeven duty financial performance surplus / (deficit)	**(4,388)**	**668**

Note 38 Breakeven duty rolling assessment

	2008/09	2009/10	2010/11	2011/12	2012/13	2013/14	2014/15
	£000	£000	£000	£000	£000	£000	£000
Breakeven duty in-year financial performance		1,524	13	538	1,202	1,607	902
Breakeven duty cumulative position	2,376	3,900	3,913	4,451	5,653	7,260	8,162
Operating income		182,374	182,204	178,468	172,902	174,924	178,674
Cumulative breakeven position as a percentage of operating income		2.1%	2.1%	2.5%	3.3%	4.2%	4.6%

	2015/16	2016/17	2017/18	2018/19	2019/20	2020/21	2021/22
	£000	£000	£000	£000	£000	£000	£000
Breakeven duty in-year financial performance	(4,180)	(3,311)	(1,224)	3,963	4,627	668	(4,388)
Breakeven duty cumulative position	3,982	671	(553)	3,410	8,037	8,705	4,317
Operating income	181,334	183,103	181,034	185,085	202,403	220,039	231,746
Cumulative breakeven position as a percentage of operating income	2.2%	0.4%	(0.3%)	1.8%	4.0%	4.0%	1.9%

Brilliant care through brilliant people