NHS
Kent and Medway
NHS and Social Care Partnership Trust

Annual Report / 23–24

2023–2024 at a glance

Opened, new
£12.6m
dementia friendly Ruby Ward

981
referrals received in Thanet Mental Health Together service since its launch in January 2024

1
new recovery house in Medway and 2 safe havens in Medway and Thanet providing quicker access to skilled mental health professionals

KMPT given responsibility for leading Mental Health Together service

Established SUN Network February 2024

SUN is a network of peer support groups offering easily accessible, regular, community-based support to empower its members to manage challenges they may be facing

60
nurse degree apprentices welcomed with 100% retention rate

Minimum or no use of out of area beds in acute wards

10
GPs trained to diagnose dementia in the community

343
clinical staff attended CRAM sessions as of April 2024

Increase BAME staff in roles at band **7** and above

Over **700+**
hours spent listening to our people, patients and partners to help inform our culture and identity programme

52 international nurses hired from 2 countries

207 staff trained in DIALOG+

DIALOG+ is a model that uses a personalised care planning tool, designed and implemented with patients. It helps a person use their own words to plan and plot the route to their own recovery and help measure patient outcomes

Research community membership grown from
25 to **196** people

Contents

CEO's statement

I have been part of the NHS for 22 years. I have a deep respect for the outstanding work it does but it is no secret that it continues to face tough challenges and increased pressures. As the health and societal needs of those we care for continue to change, we also need to make sure we are moving forward to have an NHS that is fit for the future. And whilst the pandemic has shone a light on the importance of mental health, we are still not yet at a position of parity with physical health.

We are the largest provider of mental health care in Kent and Medway. Not only do we have a responsibility to the people we care for and the people who work for us, we also have a responsibility to go further and tackle broader issues that will make a difference to everyone in Kent and Medway.

It is a privilege to build on the sterling work of my predecessor Helen Greatorex, who retired this year. She leaves us in a strong, balanced financial position and, most notably, took Kent and Medway from being one of the worst-affected areas for patients being sent for care outside of our area, to one of the best at keeping people close to home for their care.

> We can only create a healthier society if we do it together, whether that be with our partners, our patients or our people."

We know there is more to be done to be an outstanding organisation, and one that truly supports the communities we serve.

In my first six months leading KMPT, I committed to making every day a better day for our patients by setting-out six priorities:

- Patient flow
- Access to dementia care
- Mental Health Together, a transformation of community mental health services
- Reducing violence and aggression against our staff
- Recruitment, retention and introducing new ways of working to address staffing gaps
- Reshaping KMPT's identity and culture

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I am thrilled to report that work is well underway in all areas, and I am proud to share just some of our 2024 highlights so far, many of which have been captured in this report. From opening Ruby Ward, a £12.6 million standalone ward, designed specifically to meet the needs of older adults with complex mental ill-health, such as dementia, to starting the roll out of the new Mental Health Together service - a multi-agency community care programme, designed to ensure that people with severe mental illness are supported mentally, physically and socially within one care plan.

I am always mindful that the small things can make a difference to staff in addition to ensuring we are successfully delivering transformation of our services and large projects. During my first 100 days in post, I have spent a lot of time listening to our people, the people we care for and the partners we work with to understand the challenges they face first-hand and opportunities for us to improve. This time has been invaluable and I would like to thank everyone who has, and continues to, take time to talk to me and engage with our priorities so that we can deliver them together. It is so important to me as CEO that I prioritise this engagement, and I will continue to do so.

Our vision to provide outstanding care in the right place, for every service user, every time, can only be wholly achieved by working in partnership with likeminded organisations and over the last year we have strengthened our relationships with existing and new partners. We can only create a healthier society if we do it together, whether that be with our partners, our patients or our people.

As part of our commitment to tackling inequalities across the region, and creating social value for our people, patients and communities, we launched an impact report in collaboration with the Purpose Coalition on the purpose-led changes we have, and continue to, deliver. Whilst we are just at the start of our journey, I am confident this partnership will put us in a strong position to help address key issues impacting our communities, and build on the significant insight and knowledge our research team is gathering about the people who need our support, so that we can shape mental health services that are fit for the future.

While our patients are at the heart of everything we do, and drive every decision I make as CEO, I am also absolutely committed to making sure KMPT is a great place to work, where our people feel valued and recognised for the work they do. This report is just a snapshot of the great work our people have done and continue to do, day in day out, and I would like to thank them all for their unrelenting dedication to caring for some of the most vulnerable people in our society.

S. Stenson.

Sheila Stenson
Chief Executive

Chair's statement

As I look back on a year of transformation at KMPT, on behalf of the Board I want to express our deep gratitude for the hard work and dedication of our people. Their commitment to providing high-quality care whilst adapting to significant changes to how we work and how we deliver our services is never taken for granted.

They have helped us transform the way we offer care in the community – with the first phase of the new Mental Health Together service already operational in Thanet, and expected to be in place across all of Kent and Medway before the summer. This is a really important step forward in our journey to truly transform how community mental health care is delivered across the county, side by side with our partners, and with individual patients' needs at the heart.

I am pleased to report that KMPT ended the year in a good financial position, having generated a small surplus, and we will continue to focus on maintaining that financial stability going forwards.

> One particular highlight of my year was joining partners, patients and staff to open our new Ruby Ward.

At a time when the NHS remains under immense pressure to respond to growing demand for services, this is an achievement.

One particular highlight of my year was joining partners, patients and staff to open our new Ruby Ward. This state-of-the-art new facility, specifically designed with the needs of older adults in mind, means that people across the county will no longer be forced to stay in old dormitory style wards, and supports the trust to deliver high quality care, in the best environment for our patients.

Last year was also the first of our new three-year strategy, which set out our vision to deliver outstanding care, and work in partnership to deliver this in the right place, for every service user, every time.

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> We commissioned our three yearly independent review of the trust's leadership, governance and management, which found many things to be proud of.

The Board is pleased to see progress against the strategy: we have embarked on work to improve the flow of people through our inpatient services; initiated much needed work to understand, confront and reduce violence, aggression and racism experienced by staff; and we have met the target set to reduce staff vacancies. We acknowledge it will take time to see significant progress against every area set out in the strategy. It is therefore important this momentum built on, and the pace quickened to deliver the results we all want to see.

We commissioned our three yearly independent review of the trust's leadership, governance and management, which found many things to be proud of. It also highlighted helpful areas for improvement, such as our digital maturity and governance arrangements, which I am pleased to say we have begun to address quickly and effectively.

Finally, I cannot sign off this foreword without acknowledging the outstanding contribution made by our former CEO, Helen Greatorex, who sadly left the trust last year, having strengthened the trust's leadership and guided us through challenging times. I would also like to thank Venu Branch, who also left last year, for her valued contribution to the Board.

I want to welcome and thank our new CEO Sheila Stenson who, over the last six months, has provided a fresh perspective and unrelenting focus on where KMPT's efforts need to be targeted to make the biggest difference for our patients.

As I look forward to next year I am excited to continue to work closely with Sheila and the Board on achieving our ambitions.

Dr Jackie Craissati
Chair

About KMPT

We are Kent and Medway NHS and Social Care Partnership Trust (KMPT).

We provide a wide range of adult mental health and learning disability services to our local population of 1.8 million people in Kent and Medway, as well as specialist services for adults in Sussex and Surrey.

Each year we care for over 2,000 people in our hospitals and 54,000 people in the community. We are proud to have a workforce of over 3,700 people from 66 nationalities, and to serve an increasingly diverse range of communities across rural and urban areas.

We are part of the Kent and Medway Integrated Care System, a partnership of organisations that come together to plan and deliver joined up health and care services to improve the lives of people across Kent and Medway.

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

Our strategic focus for 2023 to 2024

In April 2023, we launched our new three-year strategy which sets out our vision for the future. We want to provide outstanding care and to work in partnership to deliver this in the right place, for every service user, every time.

To achieve this, we have built our strategy around three pillars – or as we like to call them, the three Ps – the people we care for, the people who work for us and the partners we work with. It's shaped by the voices of all of these people, their changing needs and our own strengths.

Our 2023–2026 Strategy

Our mission

Our mission is what we set out to do every day - we deliver brilliant care through brilliant people.

Our vision

To provide outstanding care and to work in partnership to deliver this in the right place, for every service user, every time.

We will achieve this vision through our strategic ambitions (also known as the three ps)

People we care for

We deliver outstanding, person-centred care that is safe, high quality and easy to access.

People who work for us

We are a great place to work and have engaged and capable staff living our values.

Partners we work with

We lead in partnership to deliver the right care and to reduce health inequalities in our communities.

Which are supported by our strategic enablers

We use technology, data and knowledge to transform patient care and our productivity.

We are efficient, sustainable, transformational and make the most of every resource.

We create environments that benefit our service users and people.

All of this is underpinned by our core values

Respect	Open	Accountable
Working Together	Innovative	Excellence

Performance report

People we care for

Introduction

We are always striving to deliver outstanding, person-centred care that is safe, high quality and easy to access. While some areas of our care are rated outstanding, we know we need to bring all our services in line with the highest standards and create a culture where we continually improve what we do and involve the people we care for in making those improvements.

This past year we have focused on improving access to mental health care for people across Kent and Medway, and creating safer and better experiences in the community and on our wards.

Here are some examples of our work that is helping us achieve this ambition.

CASE STUDY 1

A new partnership: The development of Safe Haven and partner services

Emergency Departments can often be a point of contact for our service users. However, they can frequently be overwhelming or not the most appropriate place for those in distress. Individuals in need may face long waits or uncomfortable environments.

We worked in partnership with The Safe Haven to create improvements for those in crisis and provide a better solution to this recurring problem. The Safe Haven (which is run by Mental Health Matters and based at Medway Maritime Hospital) provides a much-needed alternative resource for those seeking support for their mental health in times of difficulty, particularly out of hours. By joining up the providers in one place we were able to have a "one team" approach that offers patients a better, more seamless experience.

> We worked in partnership with The Safe Haven to create improvements for those in crisis and provide a better solution to this recurring problem.

A more supportive experience

One example of how this approach has helped is the case of a 31-year-old female, four months pregnant, with a diagnosis of schizoaffective disorder. She was brought into the Medway Maritime Hospital Emergency Department after being removed from her temporary hotel accommodation by police for disinhibited behaviour in the hotel restaurant. Consequently, this lady presented with symptoms of stress and therefore relapse, as she was without accommodation. She was vulnerable and in distress.

The mental health liaison service – based in the hospital Emergency Department - provided an assessment of her mental health and swiftly transferred her to a community team for onward care. Although she had attended emergency services largely due to a lack of accommodation, it was felt that given her history- one involving distress, trauma and vulnerability- further support would be needed.

The Safe Haven offers support on all of these things, but in a more calm and appropriate setting than an Emergency Department. They worked to help her finding further accommodation and to discuss the matter with Medway Council, including booking a taxi to the new accommodation upon finding it.

The introduction of the Safe Haven has enabled KMPT to support our flow of service users and minimise their time spent in busy and difficult Emergency Departments. People's needs are still met, but in a much more manageable and effective environment.

Reduction in urgent referrals

Data shows a significant change in urgent referrals. Medway Liaison Psychiatry Service has diverted 18% of urgent referrals from requiring full assessment at initial triage. This included a reduction in Emergency Department attendance and mental health admission after Safe Haven attendance.

Moving forward

The Liaison Psychiatry Service and Safe Haven teams have sought to strengthen relationships since the Safe Haven opened. The liaison team members routinely check in with Haven staff at the start of shifts in order to create seamless transitions that improve patient safety and experience. The open communication between services is of great significance in delivering effective, joined up care.

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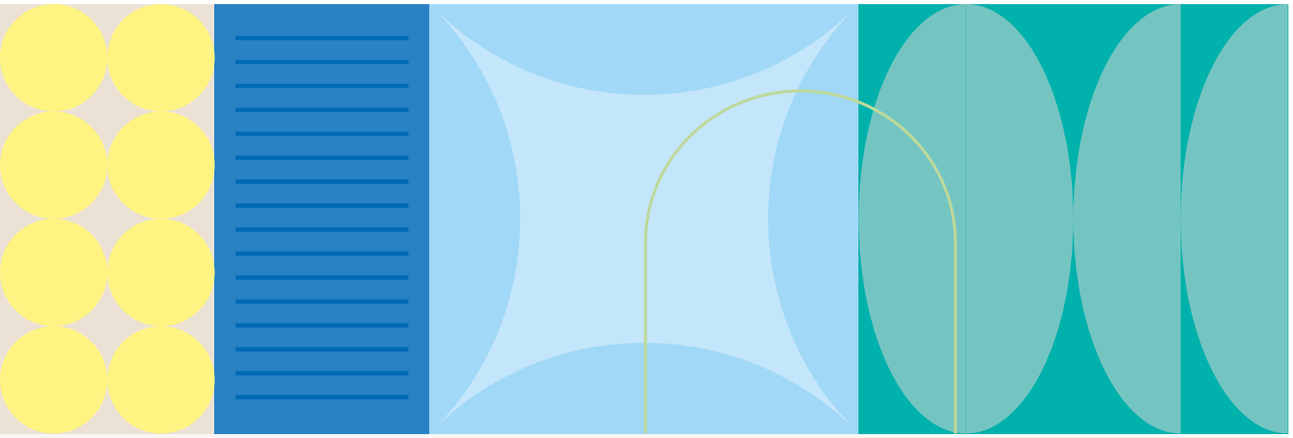

When recommissioning the Safe Havens, the ICB was careful to ensure that revision to the existing Safe Haven model was done via wide reaching engagement with system partners and lived experience experts, and extensive horizon scanning of models elsewhere in the country and learning from these. The Kent and Medway Safe Haven model is an excellent example of true integrated system care working with a number of positive outcomes and a sense of shared system ownership of Safe Haven success and sustainability."

Louise Clack
Deputy Director Mental Health
NHS Kent & Medway

CASE STUDY 2

Redesigning our suicide prevention approach from the perspective of those who have experienced it

Suicide is a country and system wide challenge that we are working closely with our partners in Kent and Medway on reducing, as we have some of the highest rates of suicide in the country. Building on this, last year we also looked at what more we can do within KMPT to redesign our suicide prevention approach for our current and future patients.

We have modernised our clinical risk assessment and management training (CRAM) to align with NICE guidance on risk assessment. Additionally, we initiated training on the collaborative assessment and management of suicidality (CAMS) with an external provider, significantly enhancing patient care, safety, and experience.

A move away from risk categorisation

In the last financial year, the Trust adjusted its clinical risk assessments to be in line with NICE guidelines. We shifted towards a more inclusive model involving clinicians, patients' families, and carers to co-produce a more effective approach.

In the latter months of 2023, we prepared to launch new training in January 2024. Multi-disciplinary teams, including clinical and non-clinical staff, service users, and others with lived experience, participated in workshops aimed at reforming risk assessment practices. This initiative not only modernised our training but made it more experiential and simplified the process of assessing and managing risks related to suicidal behaviours and other concerns. All staff members now also receive mandatory CRAM training, with select staff attending CAMS training focused on suicide prevention.

We anticipate these initiatives will greatly improve both staff working conditions and patient experiences. Integrating diverse perspectives has enhanced our risk assessment process, with 343 clinical staff having attended CRAM sessions as at April 2024. Our goal is for all clinical staff to undergo this training within three years, with effectiveness measured through monitoring, patient satisfaction, and clinician feedback.

Embedding collaborative assessment and management of suicidality (CAMS)

We're also embedding the CAMS model into our therapeutic framework. To date, 23 clinical staff within our Trust have been trained, aiming to champion this approach throughout the organisation. From February to March 2024, CAMS sessions were offered to 800 staff members, and the first 334 have taken up the offer. Feedback has been overwhelmingly positive.

In particular our redesign of CRAM training has attracted a lot of positive attention:

> This new risk assessment process will make the service user's voice more prominent"

> Great training – I have been reflecting on my past engagements with patients and how I could have done things differently"

> This is the best training and approach to clinical risk assessment and management KMPT has provided for some time. Well done"

A successful first step working side by side with patients to develop a longer-term approach

This marks a successful start on our journey working with patients to develop the best approach for them and aligned with national changes. We plan to continue embedding the training model and offer further, specialised training to support diverse patient groups, including those with autism, older adults, and individuals with personality disorders.

Lived experience film

One of our aims has been to integrate the views of those with lived experience into our work in this area. We brought together eight individuals with lived experience for a whole day to record a video reflecting on their experiences with the services within KMPT. The 32-minute length piece featured their thoughts on the difficult experience of their loss of loved ones to suicide and their hopes for future interactions or interventions in the Trust's work going forward.

We are planning to produce further videos to be used in bespoke training sessions. Such as one on working with autistic persons and persons with an emotionally unstable personality disorder (EUPD) diagnosis. Additionally, we plan to create one which focuses on working with the family members of service users that are at risk of harming themselves.

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> The training is in its early stages. The process to get to a viable training programme was difficult for me at times. I feel that the Trust has started this process but still needs to push forwards. As to whether this training leads to a positive change in outcomes will depend on individual clinicians and practitioners championing the change. It will require a change in relationships with clients and their carers to ensure that the widest base is used to gain information so that a complete history as possible is used."

The work we have done with those with lived experience has helped inform how we have developed our training programmes, and shows that it is still evolving.

People who work for us

Introduction

We cannot do what we do without our people. It's their contribution that makes a difference in the lives of our patients and their loves ones. Which is why we are always striving to create a culture and organisation that allows them to thrive. And we're constantly looking to improve their working lives.

This past year we have worked hard to build a sustainable workforce for the future. We have undertaken initiatives that bring in new members of staff, from the UK and internationally, and bolster our workforce overall. We have taken time to consider how best to attract and retain talented staff. We have also carried out a deep dive into our culture and identity to truly understand what it feels like to work for KMPT, so that we can do more of what our people appreciate and focus on those things that will make the biggest difference to them.

> This past year we have worked hard to build a sustainable workforce for the future.

CASE STUDY 1

Offering a warm welcome to our internationally recruited staff

Our internationally recruited staff are a hugely important part of our work at KMPT and we are proud to have them. We understand how challenging relocating to a new country can be, and how it is not always easy to feel at home right away in a new workplace or country. This is why we have 'gone the extra mile' in offering them pastoral care offer and making sure that existing staff understood the help we can offer.

Award-winning work

We wanted to offer the best support possible so we based our programme around NHS England's requirements for the Pastoral Care Quality Award. It was vital to us that all newly appointed internationally recruited staff received support throughout every part of their recruitment and relocation journey, including practical, emotional and professional support.

Our upgraded programme has gone on to be awarded NHS England's Pastoral Care Quality Award.

We also rolled out cultural awareness training for managers, which will be extended to all staff across the Trust. This included presentations by representatives from international nursing associations and internationally-recruited staff.

Together with the support of advocates, who accompany the new recruits in their first few weeks, and the pre-arrival information provided in regular newsletters, we are proud of the improvements made to our international colleagues' experience.

Benefits for both staff and patients alike

So far, the response has been incredibly positive. We have seen benefits in terms of additional and improved care for patients and increased staff morale.

By offering support right from the start we are confident that our international staff will settle into their new roles more quickly. In turn this benefits staffing levels across the Trust and brings a reduction in need for bank and agency staff. Greater support will lead to greater staff retention, which brings benefits for patients and staff alike.

We are planning to undertake an evidence-based study of the results of the programme next year.

> This has been awarded to recognise your Trust's work in international recruitment and your commitment to providing high-quality pastoral care to internationally educated nurses and midwives during recruitment processes and their employment."

Feedback we received from Tania Topp, Regional Preceptorship Lead, NHS England South East

So, what does our new pastoral care programme look like?

Here are just a few of the things we are offering our recruits:

- A welcome letter from the pastoral care team and management team.
- Events to meet managers before starting work.
- Providing managers preparation events before meeting new international team members.
- Eight weeks accommodation provided for each new member of staff.
- After this we then aid the nurses in finding longer term accommodation.
- A personal welcome and welcome grocery pack upon arrival at their accommodation.
- Two weeks of on-call support after arriving.
- A welcome event, welcoming them to the team and the Trust.
- A walking tour of the area where they are living and working, to get to know their new home.
- We have clarified the follow up process for monitoring OSCE pass and fail outcomes.

Feedback from internationally recruited nurses:

> Thank you for the enormous support and guidance that was provided by you during each and every tough situation that I faced as a new person here."

> I am in love with the accommodation and surroundings! Thanks for your support!"

CASE STUDY 2

Launch of the culture review

The last year has seen a profound shift in how KMPT talks about workplace culture.

In March 2023 two members of staff made a five-minute video of their experiences working on our acute wards for our Trust Board. They spoke openly about the violence, aggression and racism they experience daily at work from patients. The Trust took a proactive approach in response.

We brought in Sylvia Stevenson, an experienced professional, as a partner to support facilitating long-term change and achieving inclusivity. The review initially gathered data via a survey from staff across all services and every level of employment. We set the bold ambition of hearing from 1000 staff. We heard from 1006 staff in total the highest response rate for a local survey in many years. One area the survey focused on was violence and aggression in the workplace and the insight this gathered is now being taken forward as part of our work on reducing violence and aggression on our wards.

We also began a series of listening into action sessions, which totalled hundreds of hours of listening time. Initially they were online but ward staff were unable to attend so our Equality and Diversity Manager, Yasmin Damree-Ralph, visited staff on wards with Sylvia Stevenson. This was a huge undertaking and the first of its kind in the Trust. They listened to staff experiences, suggestions and recommendations for improvement both on a practical daily level and regarding a longer term, cultural shift.

Staff are currently engaging with feedback, and in time we will start to find ways to measure the changes this has brought. These suggestions of improvements - from the people who understand the demands of their jobs the best - were shared with senior leadership at the Trust to ensure they understand the culture they need to be establishing and leading.

Our top 100 leaders carried out a cultural competence assessment, and then did this with their senior teams, to understand what more they need to do, individually and within their leadership teams, to build their cultural confidence and ultimately become diversity allies.

Sylvia and Yasmin have joined senior management team meetings and supported leaders and teams. They also presented to the board and at Leaders' events. Consequently, information has been shared at every level of the Trust.

Many suggestions made by staff are being worked on and will be implemented imminently. The insights from this research are being analysed and will form a 12-month EDI plan.

This project has been an invaluable way to gain an understanding of our staff's lives and marks a new direction in equality, diversity and inclusion.

This, alongside the insight we have gained from our engagement with patients and partners to understand their perceptions of us, will give us clear, measurable actions we can take forward in order to be a great place to work, be cared for and partner with.

CASE STUDY 3

Recruitment drive to fill inpatient consultant psychiatrist vacancies

Across KMPT we had a number of inpatient wards without substantive consultants. Consequently, we relied on short term agency locum doctors to cover these wards. This was having a negative impact on the wards, due to a lack of consistent medical leadership at ward level. Additionally, it added to an increased financial burden for the Trust.

A combined recruitment approach

We realised that we needed to take a focused and systematic approach to addressing these vacancies - by proactively looking to recruit externally as well as retain trainees within KMPT.

Within the last year we have successfully increased our numbers of higher trainee doctors after a successful bid to Health Education England (HEE). We have also retained a high number of trainees completing their training within KMPT, as well as improving the numbers of external appointments. As at April 2024, we have recruited substantive consultants to all our inpatient wards across KMPT.

For the first time, it brings stability to the clinical leadership on all our wards by substantive consultant psychiatrists. In fact, this makes KMPT one of the few mental health trusts where all adult and older adult inpatient wards have substantive consultants.

This success has significantly improved the morale of all ward staff. Moving forward it will result in improved continuity and quality of care to patients on these wards. It will also have a positive impact on patient flow going forward.

> Within the last year we have successfully increased our numbers of higher trainee doctors after a successful bid to the Health Education England (HEE).

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Partners who work with us

Introduction

We know the importance of leading in partnership with others to deliver the right care and to reduce health inequalities in our communities. Kent and Medway has some of the most deprived communities in the country, with the highest rates of suicide and self-harm.

Over the past year we have worked in partnership with others to help the UK reach its levelling up goals. We have built new partnerships with demographics we may not have previously worked with. We understand that mental health and wellbeing incorporates many aspects of a person's life - such as their physical health, financial wellbeing or personal relationships - so we have taken a holistic approach which encompasses the many aspects of our patients and community's lives.

CASE STUDY 1

Radically changing the approach to community mental health care

NHS England identified that community mental health care was outdated and in need of improvement. The system of referral meant that service users would get caught in a loop of struggling to access the help that they needed.

GPs would refer patients to the community mental health team where they would be faced with long waiting lists and, after finally being seen, sometimes their needs would not be deemed sufficiently severe for treatment. So they would be referred back to their GP again. Patients were slipping through these gaps, often resulting in worsening health or pushing them to crisis.

The NHS therefore needed to work with other service providers in the community to bring faster access, before they reached crisis point.

Consequently, NHS England created a new community mental health framework (CMHF) which outlined a way for mental health trusts across the country to create a new approach to deliver better, more patient-centred and supportive care.

One of the key aspects of this framework was to consider how other parts of a patient's life might be impacting their feelings and condition, this meant working with partner services and the voluntary sector to deliver a new model for community mental health.

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Forming Mental Health Together

KMPT worked in partnership with a range of physical health services, social care providers, voluntary, community and social enterprise partners (VCSE), and those with lived experience to develop the new service.

Mental Health Together understands that a person's mental health is impacted by any number of factors in their life. Such as their relationships, problems with employment or debt and their physical wellbeing. So rather than focusing on a diagnosis it looks at their needs in a wider context and then refers them to other services and providers for specialist support. It also stops people needing to wait for diagnosis to try to offer care on the distinction of severe and non-severe, as the old framework did. Instead, it is truly joined up care based on a patient's need.

One critical change is that Mental Health Together will only ask for one assessment (called DIALOG+). All required experts will then work together with the patient to create one, personalised treatment plan. This means that patients will no longer have to navigate a complex web to get help beyond clinical services and repeatedly tell their story when trying to find support.

Peer Supported Open Dialogue

Peer Supported Open Dialogue (POD) is a key part of the Mental Health Together approach. This ground-breaking, research-led method focuses on trauma-informed care and supporting individuals in the context of their distress, rather than merely their clinical diagnosis. In fact, due to its success and KMPT's involvement in this research, it is now expected to become a national recommended approach to supporting people in crisis. This marks a major shift in mental health services in this country.

The POD team is made up of clinical and research staff from within KMPT and is part of the ODDESSI* research programme, led by UCL (University College London). Its outcomes have been so significant it is expected to be rolled out across the country.

Key facts on POD:

- POD is about working with people and supporting them in a mental health crisis by including everyone (family and peers) in the conversations when making treatment decisions.
- It signals the start of a move away from the medical model, instead using a trauma-informed approach to care and treatment and supporting people in the context of their distress
- It will be a core part of the new way of delivering community mental health services in Kent and Medway as part of Mental Health Together

An evening of reflection

In February, members of the Peer Supported Open Dialogue (POD) team – past and present - were joined by some of the people they have worked with at Canterbury Cathedral Lodge for an evening of reflection and discussion on the project and its successes.

Both the team and service users reported positive experiences.

Views from service users:

> I had tried every type of therapy, and open dialogue was probably the only point where I felt; this is what I need!"

Views from staff

> I remember seeing a service user and they'd been a long-term service user as they were scared of doctors. After the meeting with Vicky (clinician in POD) they said how different that felt, how she was human. And because of that, they were willing to engage."

60.1%

of staff from all partners working as part of MHT have received DIALOG+ training. This has standardised assessments across all organisations involved.

CASE STUDY 2

Forging community relationships to diversify research

The KMPT Research and Innovation Team is now in the second year of implementing an ambitious five-year plan to reach new communities and increase the number and diversity of people directly involved in research. We successfully bid for funding from the Clinical Research Network, Kent Surrey and Sussex (CRN KSS). In August 2023, the team, led by Holly Till, was awarded £26,328 to run the project for seven months. This has been hugely beneficial for meeting the Trust's aims.

Relationships before research

It has been well documented that those who take part in research, or are looked after by research active organisations, have better health outcomes. We have long struggled to take research to the people, and make it more accessible and relevant to the communities we serve. Previously we have only been able to offer research opportunities to a small audience.

But the funding has meant that we have been able to develop meaningful, trusting relationships with local people and proactively reach diverse groups to understand their specific needs or vulnerabilities.

Not only has this allowed us to learn more about particular barriers to accessing mental health care, it has also built a much-trusted bridge between ourselves and the communities themselves. We have now established a diverse group of community partners including Dad Space, Porchlight, Folkestone Nepalese Community Centre, The Beaney, House of Art and Knowledge to name a few.

Working with organisations like these have helped us understand how to broaden mental health research access and learn how mental health services need to change to better serve these communities overall.

As Nat Farley, Research Community Involvement Facilitator, explains:

"Our team's motto is "relationship first, research after". We go to communities and suspend what we think we may know about a group of individuals and take the time to learn from their skills, knowledge and expertise - they tell us what they want us to know. Therefore, enabling KMPT and communities to co-produce research that empowers both mis-represented and underrepresented groups to increase positive health outcomes.

"There are no exact stats for the amount of people living with a mental health condition and that may be due to individual preference for non-disclosure, social, cultural or economic influences. However, KMPT recognises that there are many silent voices that should be heard within research and that researchers cannot keep doing the same thing and expect different outcomes.

"The thing I love most about KMPT is that we recognise the need for diverse community voices to be heard and we realise that research inclusivity takes time."

Events and engagements

Community engagement events are an important part of this. We worked with the organisations we had built relationships with to ensure we created events that were engaging to their communities.

For example, we worked with community leaders in the Gurkha community in Folkestone and identified that their community members have a keen interest in art. So, we developed a community event where attendees created an image that represents what mental health means to them. We collaborated with Dad Space to put on an event at a local gym. People frequently use exercise as a way of supporting their mental health so this was a key audience to address, in a fitting setting. We were able to talk about research with a new audience that was predominantly men (who are grossly in underrepresented in research participants).

Numerous other events have been planned using this model of understanding a community's interests prior to raising the subject of becoming involved in research. Not only does it make it more likely that we can engage these communities in research, but also that we are able to learn about any barriers specific to a community in mental healthcare more broadly.

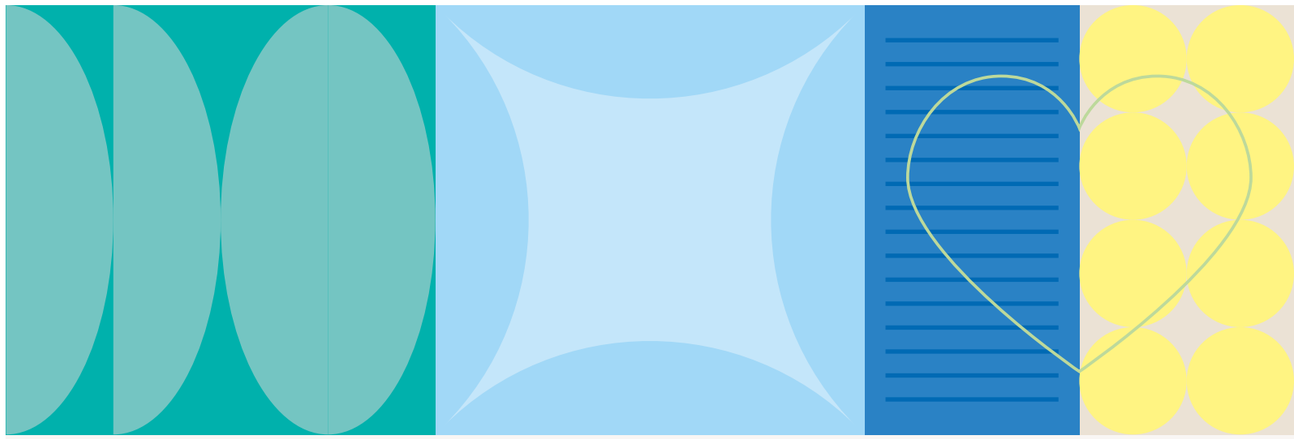
Additional projects have also been run by a collaboration of colleagues across the University of Kent and KMPT. These projects led by Professor Lisa Dikomitis and Dr Jo Rodda focused specifically on engaging young people from ethnic minority groups, older adults in coastal communities as well as people with serious mental illness.

In our initial bid we aimed to increase the number of research community members from

25 to 75

We are very proud to have more than doubled this with

196 members



> For the Gurkha, Nepalese and male communities, particularly men in a paternal caregiving role, mental health is a relatively new concept. This is not to say these communities are not aware of mental ill health. For instance, dementia is a great concern within Gurkha and Nepalese populations whilst men can experience paternal perinatal depression (PPND).
>
> Within these societal groups there is an awareness of the various effects of mental ill health but the ability to access appropriate mental health support is the biggest challenge. This may be attributed to the belief that these groups are hard to reach which is not the case - they are hardly reached and as such research about these communities is frequently based on the assumptions of the researcher and not the needs of the community."
>
> Nat Farley

CASE STUDY 3

Our commitment to the Purpose Coalition's purpose goals

As an NHS Trust we recognise that we play a significant role in our community's health and wellbeing. Not only in terms of looking after the mental health of our patients but in the way our role doing so connects and impacts on wider concerns or issues. Be that physical health of patients and other health providers, social and equality issues in the community or as an employer.

Over the last year we committed to working with our partners and the Purpose Coalition to address this.

What is the Purpose Coalition?

Chaired by Rt Hon Justine Greening, the UK's former Secretary of State for Education, Transport and International Development, the Purpose Coalition is a group of organisations and leaders from the public and private sectors and cross-party parliamentarians who are working together to share the best ways for organisations to play a positive role in their communities and break down barriers to opportunity.

What are the 14 purpose goals?

- Strong foundations in Early Years
- Successful school years
- Positive destinations past 16+
- Right advice and experience
- Open recruitment
- Fair career progression
- Widening access to savings and credits
- Good health and well-being
- Extending enterprise
- Closing the digital divide
- Infrastructure for opportunity
- Building homes and sustainable communities
- Homes and energy transition
- Achieve equality through diversity and inclusion

> As an NHS Trust we recognise that we play a significant role in our community's health and wellbeing.

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The 14 purpose goals

Last year we set out to benchmark our social impact activities and best practice against the framework of the Purpose Coalition's purpose goals and to come up with a plan to improve them.

The goals identify the 14 core barriers to opportunity that exist in the UK and provide a framework for organisations such as KMPT to adopt in order to play our part in overcoming these and levelling up within the community.

In March 2024, KMPT launched its levelling up impact report. The report assesses where we have delivered a positive social impact and identifies where we can go even further through a series of recommendations.

We have already made good progress in delivering and planning activity against the Purpose Coalition's recommendations which cover diversity, increasing our community outreach and leading the supply chain through social-value based procurement.

We look forward to forging a strategic partnership with fellow Purpose Coalition members in 2024-25 to consolidate our position as a regional leader in mental health and to pioneer innovative approaches to mental health provision and community engagement.

Some highlights of our work in these areas

- We are working collaboratively with our supply chain to reduce health inequalities. One way is through our procurement process where suppliers must demonstrate how they support these goals too, for instance how they support healthier and more resilient communities; are a fair and responsible employer and pay the minimum national living wage. Some highlights of the commitments made by our supply chain include providing workplace apprenticeships and work experience placements, recruitment of long-term unemployed people, career support to local job centres, volunteering in the community, meaningful activity and therapeutic input for patients (for example, baking, gardening skills), and the creation of local jobs with fair wages.

- We have a number of work experience opportunities, including our Bright Futures cohort where we have invited individuals of a 16+ leavers demographic to explore their interest in working in healthcare.

- We are working with Step Into Health to support army veterans and their families gaining access to roles within KMPT. This will offer new opportunities in the NHS, acknowledge transferable skills and recognise the barriers into employment that the community may face.

- We've been working hard to make sure we're focusing on important initiatives and working with our staff to ensure that KMPT is a happy and healthy and inclusive place to work. We've introduced initiatives such as Virgin Pulse Go, Trust-wide wellbeing events, wellbeing boxes, and other useful resources for staff such as the Active 10 app.

- We established the Green Spaces improvement project to enhance outdoor areas on and around sites. This will enhance staff wellness and engage service users.

In December 2023, KMPT was delighted to have been selected as the winner of the Good Health and Wellbeing Award at the annual Purpose Coalition Awards. This prestigious award highlights our commitment to meeting the goals outlined in Goal 8: Good health and wellbeing, with a strong emphasis on addressing health and wellbeing inequalities.

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Strategic enablers

Introduction

We cannot achieve our objectives without our strategic enablers, which support everything we do. These include using technology and data to transform patient care and increase productivity; being efficient, sustainable and making the best use of our resources; and creating spaces and environments that meet the needs of our climate, our people and patients.

This past year we have undertaken a number of initiatives that help us push forward our ambitions to continuously improve our enablers.

> We cannot achieve our objectives without our strategic enablers, which support everything we do.

CASE STUDY 1

New state of the art Ruby Ward opens to deliver the very best care for dementia patients

This year we opened a new, standalone hospital ward for older people with mental health conditions.

The new Ruby Ward is situated on our Hermitage Lane site in Maidstone and is the result of £12.6 million investment. It brings an exciting new replacement to our older inpatient services. The investment was awarded to us as part of a national NHS England drive to remove "dormitory" style wards which were not best serving our patients' care or safety needs.

Ruby Ward has increased inpatient bed capacity for the county from 10 beds to 16 beds. There are a number of features which bring better conditions to our inpatients. This includes 16 single ensuite rooms, as well as a dementia friendly and focused layout. This has been designed in line with The King's Fund guidance, in order to support the independence and dignity of inpatients experiencing dementia. As such it is themed by colour with pictures and signage, which enable patients to move freely and easily around the ward. There is also a dedicated space for us to offer the range of therapies that we will be providing to our older patients. This includes counselling, group therapy and creative activities. There is also a space dedicated to help patients relearn essential skills such as cooking or cleaning.

> Ruby Ward has increased inpatient bed capacity for the county from 10 beds to 16 beds.

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Better environment for both staff and patients

The new ward creates more space for patients and staff to receive and deliver care. It improves working conditions for staff, such as offering more space to change, shower or take breaks, and for them to deliver high quality care.

The ward marks another step in our green intentions. It is an energy efficient property, which uses solar power as well as thermally efficient fabric which reduces heat losses and energy efficient LED lighting. The ward was also designed with outdoors facilities in mind for both patients and staff. This includes four new gardens to benefit the mental wellbeing of our patients.

> I am delighted to see our new, state-of-the-art Ruby Ward open its doors to our patients and bring an end to the last of our old, outdated dormitory wards. I am committed to ensuring our buildings are fit for purpose and enable us to provide the very best care to our patients and that is exactly what we have created here. Not only will Ruby create a better day every day for our patients, it will also increase our capacity to support older people with mental health needs."

Sheila Stenson, KMPT chief executive

> KMPT's new Ruby Ward is very impressive. It really sets the gold standard for care provision and it is clear that a lot of thought and careful planning has gone into the design of the ward. It has a very open feel, and a huge amount of outside space that will undoubtedly benefit the wellbeing of patients, visitors and staff. The individual ensuite bedrooms ensure privacy and dignity for patients, and the light and airy communal spaces, quiet rooms and activity rooms, including a piano, all help create an environment that supports healing."

Carol Ann-Thornett, KMPT engagement council chair

> This outstanding development will have a profound impact on the local community by providing state-of-the-art facilities for patients, staff and visitors alike in a welcoming space that aids recovery."

Helen Whately, MP for Faversham and Mid Kent

CASE STUDY 2

Strengthening our use of data and reporting

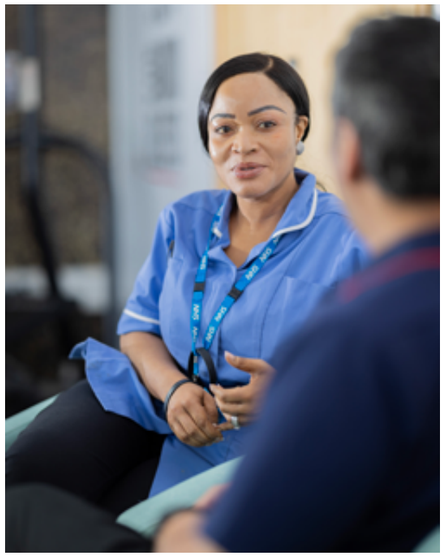
As part of our plans to transform our digital capabilities we successfully introduced a new system for our staff to use and interact with data. Power BI enhances our staff's ownership, experience and confidence in using data by turning complex data into easy-to-understand visuals.

Over 500 staff have used Power BI's 'live' reports so far and there is an ongoing programme developing new reports, improving existing reports, and training and supporting staff to use it confidently to support their work and our strategic objectives.

Reporting to support strategic and operational delivery

We prioritised key reports, such as the Trust's integrated quality and performance report (IQPR), when we first migrated to the new system which guaranteed continuity in reporting. We have also used it to run key reports to support strategic and operational delivery, covering topics such as waiting list management, management of inpatient flow and oversight of equality, diversity and inclusion.

We expect to see an improved focus on many of the key performance issues and data quality issues across the Trust's systems. It has improved our capabilities to integrate datasets, triangulate data and has the speed and quality of report development.



End user focused

The system is designed with end users, our staff, in mind and security is embedded to allow patient identification in a safe and secure way. It has brought a "self-service" approach for staff who can, for the first time, access data and reports themselves. This has improved response times, reduced the need for manual interventions; and given greater ease and autonomy for staff to own, understand and use data across the Trust. The software also improves analysis of data and brings more confidence in the results.

The integration of Trust-wide data sources means that users are able to access multiple sets of data in a single location. We recognise there is a lot to do and we will be continuing to develop this work over the next financial year. We are committed to improving our digital and data capability and will be hosting our first data conference in early 24/25.

> Power BI enhances our staff's ownership, experience and confidence in using data.

CASE STUDY 3

Removing paper-based prescriptions

This year saw us complete a three-year programme to enhance patient safety and medicine management.

eMeds is a digital prescribing platform that brings together patient data and prescription history from a single record. It allows clinicians to prescribe and request medicines digitally, at the click of a button, and to view a patient's previous prescribing history. Admission, transfer and discharge information is automatically sent from our patient record system to eMeds. Medication orders are then sent to our dispensing partner Lloyds Pharmacy electronically.

From May 2023 it is now being used by all of our clinical staff to prescribe medicine for our patients on inpatient wards.

Safer, faster, more effective and green

eMeds has brought major benefits for patients and clinicians, including patient safety. Having one, clear record of a patient's prescribing history makes it much easier for clinical and ward staff to understand drug contradictions, allergies or the need for review. It also removes the risk of human error in mis-prescribing or misinterpreting handwritten notes.

It also reduces admin time, meaning ward staff can focus on delivering patient care. Remote prescribing has sped up the delivery of orders, and streamlined nurses' working days as they no longer need to check in with doctors to access drug charts. This is particularly significant when operating in an emergency or out of hours situation.

The new system has positively impacted on the percentage of blank boxes on the electronic prescription charts, with the average now reduced to 1%. Having one clear record of a patient's history has improved decision support, especially when decisions must be made quickly.

eMeds helps bring us closer to our sustainability aims by reducing paper use.

We will be upgrading to a new version of eMeds on inpatient wards and continue its rollout into our community, crisis and home treatment teams over the course of the next year.

Staff feedback

The response has been overwhelmingly positive. 85% of staff consider eMeds to be preferable to paper charts.

> Due to dyslexia, I find eMeds easier to use for medication review, medication ordering and also reduces the risk of medication error. Introducing eMeds has made my life easier. Electronic prescriptions are delivered directly to the pharmacy's computer systems, compared to previous manual data entry and then calling or faxing to clarify orders. Overall, I believe this will improve patient safety and pharmacists are less likely to interpret electronic orders incorrectly. Overall it has improved both patient and staff communication during drug round."

CASE STUDY 4

Moving closer to net zero

Our green plan demonstrates our commitment to tackling climate change. It brings together projects and activities that contribute to sustainable development across the Trust, which is in line with community and government guidelines.

The plan includes projects to address concerns such as carbon emissions, direct energy consumption, procurement, transport (including business, commuting and patient travel), green spaces and waste. In addition, it seeks to improve staff wellbeing, patient care and our sustainability obligations (such as waste reduction and carbon emissions).

Our initiatives have had a number of significant impacts on our people, patients and community in the last year, including greener environments and improved health and wellbeing.

One of the key successes this year has been a 67% (3352 tonnes) reduction in carbon against our 2009-2010 baseline (10,219 tonnes). We are developing our heat decarbonisation plans as we move KMPT's heating systems away from fossil fuels towards self-generated electricity.

We have also installed six EV charge points with 11 sockets in total across many of our major sites. This will help us meet greener NHS targets of having entirely electric fleets for Trust owned transportation and rapid response ambulances. We are on track to achieving this by 2028. The second phase of this initiative will see EV charge points becoming accessible to our staff.

Green and outdoor spaces are vital for staff and patient mental wellbeing. So, we have developed our outdoor spaces by collaborating with the Human Nature Partnership. We will continue working with them and our staff to improve our courtyards and gardens, which is also beneficial for local wildlife as well as protecting buildings from issues such as temperature control, or localised flooding.

> I really enjoyed the session. It was very interactive and enthusiastically presented. I learnt new things and benefited from everyone's comments and experience."

Johnathan Dennis, Apprentice Garden Co-ordinator commenting on his experiences of participating in the Human Nature Partnership project

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Summary of financial performance in 2023-24

During 2023-24, we have continued to experience significant pressure and changing demands on our services which has reflected in some of the ways we utilised our funding in year.

We have continued our collaborative working with our main commissioner, Kent and Medway ICB to take forward new programmes of care such as the Community Mental Health Framework (CMHF) which is a complex and large-scale transformation programme for our Community Services.

A key component of our capital programme was the completion of Ruby Ward build, a new older adults ward on our Maidstone site, which completed and was fully operational in March 2024; this was part of the national initiative to eradicate dormitories.

The table below sets out the final financial position against KMPT's plan.

Statement of Comprehensive Income

	Plan	Actual	Variance
	£000s	£000s	£000s
Income	255,268	272,032	16,764
Expenditure	(249,719)	(275,643)	(25,924)
Operating Surplus/(Deficit)	**5,549**	**(3,611)**	**(9,160)**
Finance Costs	(5,549)	(6,148)	(599)
Other gains/(losses) including disposal of assets		(158)	(158)
Surplus/deficit	**-**	**(9,917)**	**(9,917)**
Impairments and impact of technical adjustments	0	10,960	10,960
Surplus/(Deficit) for Control Total Purpose	**0**	**1,043**	**1,043**

Income - £272.03m

The Trust received £272.03m of income in 2023/24. This covers its clinical services funding but also funding from NHS England to cover the increase in NHS pension funding (increased from 14.3% to 20.6% in April 2019); and the impact of the consultants pay reform deal.

KMPT received the majority of its income from Kent and Medway ICB under a block contract, with ICB income accounting for 75.7% of total income.

Specialist Services were commissioned through NHS England and make up 6.1% of our total income. The trust received income for our Forensic inpatient and community services from Sussex Partnership Trust as the host of the provider collaborative.

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

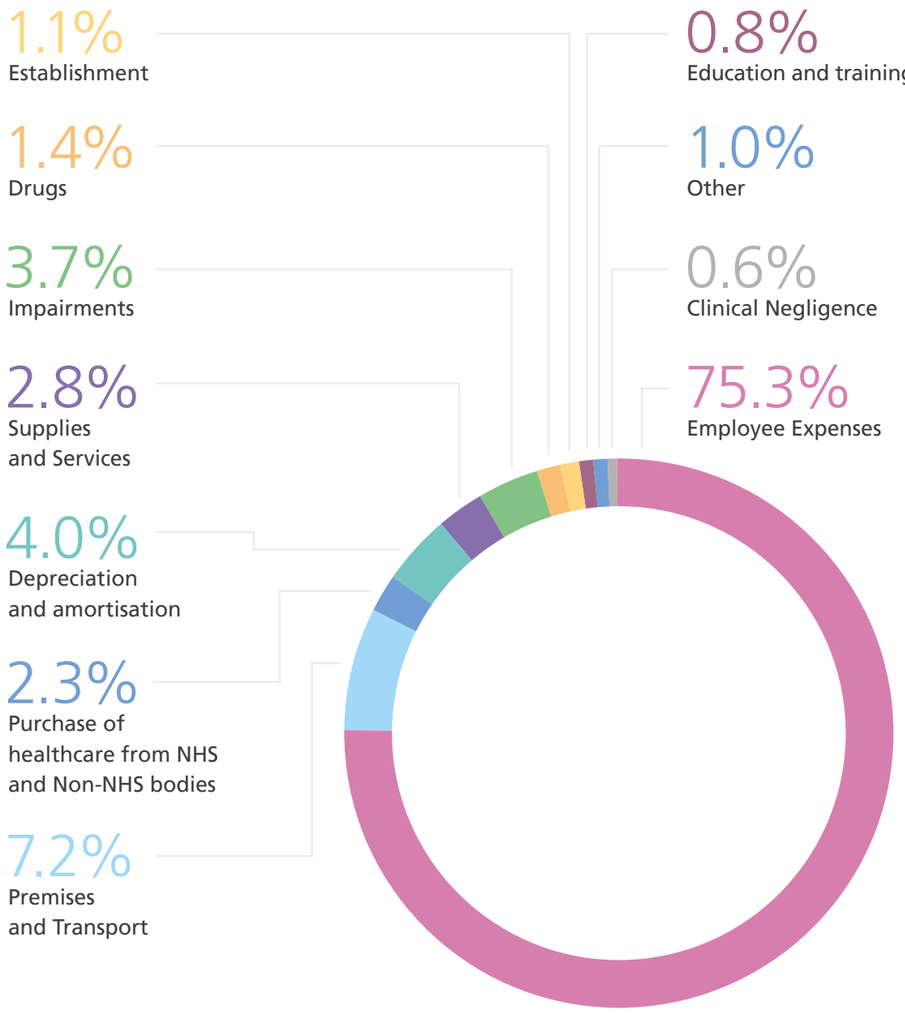
In additional, the Trust received funding for NHS pensions and the Implementation of the consultants pay reform deal.

The employer contribution rate for NHS pensions increased from 14.3% to 20.6% from 1 April 2019. For 23-24, the additional amount was paid over by NHS England on providers behalf but is reflected in KMPT's annual accounts in both income and employee expenses.

Expenditure - £275.6m

Operating expenditure in 2023-24 was £275.6m, £17.8m higher than the previous year. The largest area of spend for KMPT is employee expenses which accounted for 75.3% of total operating expenditure. Employee expenses has increased £11.6m in year, due to pay award £8.2m and investment in service delivery in particular the Crisis and Home Treatment Service and the Community Mental Health Framework.

The graph below provides a summary of how we spent our money in 2023-24, with further details in Notes 1 and 6 of the accounts pages 106 and 119.



Cost Improvement Programme

The Trust had a cost improvement programme of £4.76m for the financial year 2023/24. This programme sought to ensure that the trust was able to offer sustainable services that reflected the operational needs of the Trust. The plan was delivered in full and the table below sets out the final financial position.

Details are shown below.

Pillar	Plan	Actual	Variance
	£000	£000	£000
Back Office	1,567	1,310	(257)
Service Line Reporting	1,804	2,721	917
Procurement and Purchasing	400	183	(217)
Workforce	437	-	(437)
Commerical development	550	550	0
Unidentified	6	-	(6)
Total	4,764	4,764	0

Capital Expenditure

KMPT spent £12.8m on capital expenditure in 2023-24, this included significant investment into the following:

1. £7.8m on improving mental health services, the eradicating dormitories project – this has been a key programme of work across several financial years and has now completed with Ruby Ward opening in March 24.
2. £1.8m on IT infrastructure to support delivery of KMPT's clinical technology strategy and IT devices replacement.
3. £3.1m on backlog maintenance.

Looking forward to 2024-25

In April 2024, the Trust submitted a breakeven operational plan for 2024-25. This has been done in conjunction with the Kent and Medway Integrated Care System and is not without risk due to the impact of the inflation still been felt alongside operational pressures. The competing demands on budgets will need to be monitored and costs managed accordingly in order to deliver to the planned position.

Our financial focus remains on long term financial sustainability. The continued demand for healthcare efficiency means that the trust is seeking delivery of a £10.74m cost improvement programme in year.

In line with the mental health long term plan and working in conjunction with our commissioners, we will continue to invest in front line services. This funding is expected to deliver improvements across the trust with investments being made into the Urgent and Emergency services, and on the inpatient wards through investment in therapeutic intervention. We will continue to invest in digital solutions to enable out front-line staff to access the right systems and equipment to undertake their role.

Our capital programme is significant in the coming year, and has been 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.

Audit

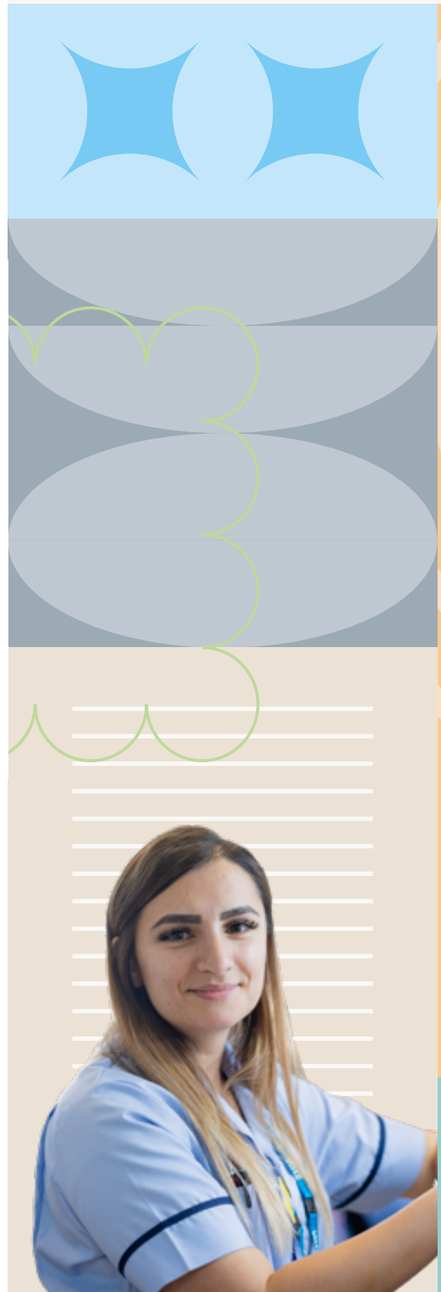
Our external auditor is Grant Thornton. They conducted work during the year on audit services at a cost of £95k + VAT. This work included annual accounts, governance and performance work.

Our annual accounts for 2023-24 have been examined by our external auditor, and their report is set out on pages 90 - 98.

S. Stenson.

Sheila Stenson
Chief Executive
Date: 19th June 2024

Accountability report



The Directors' Report

The Trust is led by the Board of Directors which has overall responsibility for the performance and management of the Trust. This responsibility includes setting the overall strategy for the organisation and monitoring progress, while ensuring resources are efficiently and economically used to meet the needs of its service users and the public. The Board of Directors 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 also works in partnership with patients, carers, the Integrated Care Board, local health organisations, local government authorities and others to provide safe, accessible, effective and well-governed services that meet the needs of patients, carers and KMPT's local population.
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.

In order to carry out their duties and responsibilities, Board members convene at Board meetings. The Trust Board of Directors comprises Executive Directors (EDs) and Non-Executive Directors (NEDs), including the Chair. They are, as a Unitary Board, a collectively responsible for our success. The Associate NED, Chief People Officer and the Director of Transformation and Partnerships are non-voting directors. The Director of Communications and Engagement also attends all Board meetings.

The EDs are paid 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 EDs 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 EDs in their decision-making, as well as assisting them with the formation of the Trust's strategy. While EDs are employees of the Trust under a permanent contract of employment, NEDs are appointed for a set term. The Board of Directors also approves the Annual Report and Accounts prior to its submission to Parliament. The Annual Report and Accounts is prepared

> The Board ensures that KMPT meets the obligations of the population it serves.

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> During 2023-24 there have been a number of changes to the Board.

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.

During 2023-24 there have been a number of changes to the Board. Venu Branch's tenure as a NED and Deputy Chair ended at the end of February 2024, at which point Dr MaryAnn Ferreux was appointed a NED of the Trust having previously gone through a competitive recruitment exercise. Catherine Walker was appointed as Deputy Chair, in addition to her roles as NED and Senior Independent Director. Changes to EDs included Helen Greatorex, stepping down as Chief Executive in October 2023, and Sheila Stenson then being appointed as the new Chief Executive. Other changes include Donna Hayward-Sussex becoming Deputy Chief Executive in addition to her role as Chief Operating Officer and becoming a voting member of the Board. Nicholas Brown also joined the Board in October 2023 as the Chief Finance and Resources Officer, which is also a voting Board member role.

The Board met formally in public seven times and seven times in private during 2023-24. Public board meetings have been broadcast live during 2023-24 and two public Board meetings were held in-person. People who have experienced our services presented to the Board, enabling members to hear first-hand how services work for users and carers, and areas of improvement. The Board also receives updates at every meeting on quality improvement.

Board Membership 2023-24 & Board Attendance

Board Member	Role	Board Meeting Attendance
Jackie Craissati	Trust Chair	7/7
Catherine Walker	Non-Executive Director, Senior Independent Director & Deputy Chair	7/7
Venu Branch – until February 2024	Non-Executive Director & Deputy Chair	6/6
Peter Conway	Non-Executive Director	7/7
Kim Lowe	Non-Executive Director	6/7
Sean Bone-Knell	Non-Executive Director	6/7
Mickola Wilson	Non-Executive Director	7/7
Dr Asif Bachlani	Associate Non-Executive Director	7/7
Dr MaryAnn Ferreux	Non-Executive Director	7/7
Stephen Waring	Non-Executive Director	7/7
Sheila Stenson	Chief Finance and Resources Officer and Deputy Chief Executive until September 2023, then Chief Executive from November 2023	7/7
Helen Greatorex – until 31st October 2023	Chief Executive	3/4
Dr Afifa Qazi	Chief Medical Officer	6/7
Andy Cruickshank	Chief Nurse	6/7
Nicholas Brown – from November 2023	Chief Finance and Resources Officer	4/4
Donna Hayward-Sussex	Chief Operating Officer and then Deputy Chief Executive from November 2023	7/7
Dr Adrian Richardson	Director of Partnerships and Transformation	7/7
Sandra Goatley	Chief People Officer	7/7

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 2000 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.

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

Trust Chair

Dr Jackie Craissati MBE
Trust Chair

Jackie joined the Board in May 2016 and became Trust Chair in July 2020. Prior to this she was Chair of the Quality Committee and Deputy 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 - Psychological Approaches CIC - offering consultancy and training to those working with complex mental health and offending behaviour, as well as leading independent investigations into serious incidents as commissioned by NHS England.

Jackie has been appointed Chair of Dartford & Gravesham NHS Trust. She is also Chair of Crohn's & Colitis UK and an Independent Governor of the University of East London.

Executive directors

Sheila Stenson
Deputy Chief Executive and Chief Finance and Resources Officer until September 2023, and then Chief Executive from November 2023

Sheila has a proven track record of leading teams within challenged trusts across acute, foundation and mental health services. She has led and been part of significant change in her career, including service redesign, transformation, restructuring, implementing new systems, technology and governance, and developing robust financial processes and controls.

Sheila joined KMPT in 2017 as its Chief Finance and Resources Officer, and then also became its deputy Chief Executive in October 2022. During this time under her direction the trust delivered break even for the first time and eradicated its underlying financial deficit.

She is a chartered management accountant and has been awarded a number of Healthcare Financial Management Awards (HFMA) including an honorary fellowship award in recognition of her dedication to the NHS and HFMA. Sheila graduated from the University of Sussex with a BA Honours Degree in Business Studies.

Helen Greatorex
Chief Executive, Registered Mental Health Nurse (RMN), MBA – left the Trust in October 2023

Helen joined KMPT as chief executive in 2016, following 14 years on the board at Sussex Partnership where she was Chief Nurse.

This year marks forty years since Helen started her training in mental health nursing at Friern Hospital, London. Her experience in mental health has spanned a wide range of settings including the voluntary sector, where she worked for Mind on resettling patients in the community following decade long hospital stays.

In July 2022, Helen joined Kent and Medway's Integrated Care Board as the partner member for community and mental health, representing both KMPT and Kent Community Health Foundation Trust.

Helen retired from KMPT in October 2023.

Dr Adrian Richardson

Director of Partnerships and Transformation

Adrian has over 20 years' experience working within the NHS. He qualified as a doctor in 2001 and transitioned from clinical work as a Geriatrician into leadership roles in successful organisations across the South of England. He has extensive experience in transformation, partnership working, strategy, improvement and engagement.

He trained with Virginia Mason in improvement and transformation and lead the Patient First improvement transformation programmes at Western Sussex Hospitals and Brighton and Sussex Hospitals.

He moved to Frimley Health where he established an improvement programme and worked on several large-scale transformation programmes including implementation of their Electronic Patient Record system.

Since joining KMPT last year he has led a redesign of the transformation function within the organisation and the implementation of a new methodology to deliver the KMPT Strategy.

Dr Afifa Qazi

Chief Medical Officer

Afifa is a consultant for older adults with special interest in care for people with dementia. She won the prestigious HSJ award in 2016 for Community Services Redesign. She is also the winner of the EAHSN Health Innovation award in 2014, which she received for transforming crisis care for dementia in Essex. In 2022 she received the highly competitive Psychiatrist of the Year award from the Royal College of Psychiatrists and was commended by the judges on her person-centred approach.

She been instrumental in partnership working with the Kent and Medway Medical School (KMMS and holds a Clinical lecturer post at KMMS.

She has ensured that KMPT offers robust training to all trainees in psychiatry, with the majority of them now remaining in Kent on completion of their training. She has had significant successes in medical recruitment and retention with huge reduction in agency doctor usage by the trust.

Andy Cruickshank

Chief Nurse

Andy is an experienced mental health nurse who has held several senior nurse leadership and management positions within East London NHS Foundation Trust, including the Director of Nursing for the London Mental Health Services for ELFT, prior to coming to KMPT in March 2022.

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.

He led projects to reduce violence within inpatient units and developed frameworks to use Quality Improvement to tackle some of the most difficult issues within services.

He trained as an Improvement Advisor at the Institute for Healthcare Improvement and is a Fellow at the Health Foundation. he has a Masters in Leadership for Improvement.

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Donna Hayward-Sussex

Chief Operating Officer and then from October 2023, Deputy Chief Executive

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 development of the Mental Health Alliance in Lewisham and the trust wide redesign of crisis services. Donna became deputy Chief Executive in November 2023.

Donna 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 across Kent and Medway. She is particularly keen to develop integrated services that blur the boundary between the voluntary and statutory sector.

Sandra Goatley

Chief People Officer, 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.

Nicholas (Nick) Brown

Chief Finance and Resources Officer

Nick is an experienced senior finance professional who has fulfilled a variety of roles during his career in the NHS. He has a proven track record of working within financially challenged systems.

Having begun his career as a National Finance Trainee he worked across a number of mental health providers before moving into commissioning roles within South East London. He is a Chartered Management Accountant and has over twenty years' experience in the NHS.

He has led and been part of significant change in his NHS career, which has included service redesign, transformation, implementation of new financial systems and governance and developing robust financial processes and controls.

He joined KMPT from South East London ICB where he was Director of Financial Management.

Nick graduated from the De Montfort University with a BA Honours Degree in Business Studies.

Non-executive directors

Venu Branch

Non-Executive Director and Deputy Chair – left February 2024

Venu joined the Board in August 2016 and in February 2021 she became the Deputy Trust Chair.

Venu is the CEO of the Westway Trust with a background 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, Creative Scotland, and the British Council. She has also worked at executive director level in the charitable sector, including at Stonewall and Community Links. In 2022 she was named as one of the UKs Top 20 CEOs by the CEO Publication and was previously awarded the National Asian Woman of Achievement award.

Venu was the Chair of the Workforce and Organisational Development Committee and Co-Chair of the BAME NEDs Forum for the Kent and Medway system.

Catherine Walker

Non-Executive Director, Senior Independent Director (SID) and from March 2024, Deputy Chair

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. She holds two specialist Tribunal judicial appointments related to the NHS, health and disability.

She chairs the Appointments committee of a London acute NHS Foundation Trust and is a former lay advisor for Health Education England. She is the Chair of the Members' Panel of the National Employment Savings Trust (NEST).

She is the former Practice Director of a firm of pensions solicitors.

She is currently a member of the Finance and Performance Committee and Chair of the Remuneration and Terms of Service Committee. She is KMPT's Senior Independent Director and Deputy Trust Chair.

Peter Conway

Non-Executive Director

Peter has a background in banking and finance spanning 28 years, latterly as a Finance Director with Barclays Bank PLC. He has been a Non-Executive Director with the NHS since 2006, and was the Non-Executive Vice-Chair and Audit Committee Chair of Kent Community Health Foundation Trust until 31.3.2024

He has held a portfolio of public sector roles in the past including:

- Non-Executive Director and Audit Committee Chair, Rural Payments Agency
- Non-Executive Director and Audit Committee Chair, NHS West Kent
- Independent Member of the Audit Committees of the Home Office, Ministry of Justice, DEFRA, Health and Safety Executive and Child Maintenance and Enforcement Commission
- Trustee Director, Citizens Advice North and West Kent

Peter chairs the Trust's Audit and Risk Committee and is a member of the Finance and Performance Committee and Remuneration Committee.

Kim Lowe

Non-Executive Director

Kim joined the Board in August 2020 as an associate non-executive director (NED) before being appointed as a NED in November 2020. She has spent most of her career at John Lewis Partnership and for over 36 years she has worked across people, customer service, employee engagement, HR and business. She 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 John Lewis in 2020 to continue to build her portfolio NED career in the public and private sector, including John Lewis Partnership, Central Surrey Health and Council Lay Member at University of Kent.

Kim has become the Chair of the People Committee.

Mickola Wilson

Non-Executive Director

Mickola joined the Board in August 2020 and is a non-executive director (NED).

She is an Executive Director at Seven Dials Fund Management, a real estate investment Consultancy and has a number of non-executive roles. She is a NED the Mailbox Investment Holdings PLC and an advisor to the Mercers Livery Company.

She is also a very active member of the Chartered Surveyors Livery leading a programme to support students from disadvantaged backgrounds through university.

Mickola is Chair of the Finance and Performance Committee and a member of the Remunerations Committee.

Sean Bone-Knell

Non-Executive Director

Sean joined the Board in August 2020 as an associate non-executive director (NED) before being appointed as a non-executive director 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 progressed through the ranks developing operational and strategic experience and in 2019 he was awarded the Kent Medal for Outstanding Service.

In the Queen's Birthday Honours list 2020 he was awarded the Queen's Fire Service Medal.

Sean previously held a National Portfolio with the National Fire Chiefs Council for the areas of Road Safety, Marine Firefighting and Dementia. Whilst holding the Dementia portfolio, he worked as part of the Prime Minister's Challenge Group on Dementia with the Alzheimer's Society.

Sean is the Chair of the Mental Health Act Committee and the Charity Committee, and a member of the Quality Committee.

Stephen Waring
Non-Executive Director

Stephen joined the Board in January 2023 and he has had a long and varied public sector career. At the Department of Health his roles included private secretary to the Secretary of State for Health, Head of the National Cancer Programme and chief of staff for a former Chief Executive of the NHS. He ran a whole health economy NHS reconfiguration programme in south west London, and led the production of the cross-Government Mental Health Strategy, 'No Health without Mental Health'.

Stephen currently works for the Greater London Authority on health and care policy and partnership working.

Stephen is vice chair of trustees for a leading national charity that works alongside people with an acquired brain injury and physical disabilities offering specialist community-based and residential support to help them live as independently as possible.

Dr MaryAnn Ferreux
Associate Non-Executive Director until February 2024, and a Non-Executive Director from March 2024

MaryAnn joined the Board in February 2023 as an Associate Non-Executive Director.

MaryAnn has international experience working across both the Australian and UK health system, with specialist qualifications in health system leadership, management, and public health. She has held Board level roles as a medical leader in both primary and secondary care and is passionate about improving the patient experience and delivering better integrated care. She is currently the Chief Medical Officer at Health Innovation Kent Surrey Sussex.

She is a Fellow of the Royal Australasian College of Medical Administrators, Australasian College of Health Service Management and Faculty of Clinical Informatics, as well as being a Certified Health Executive and leadership coach. She has a special interest in researching health equity and the impact of the social determinants of health; her current doctoral studies will explore health inequalities within the Kent and Medway region.

Dr Asif Bachlani,
Associate Non-Executive Director

Asif joined the Trust in November 2022 as an Associate Non-Executive Director with his portfolio being the Data Strategy, Digital Transformation and Improved Patient Outcomes.

He works clinically as a Consultant Psychiatrist and Clinical Lead for the ASD pathway at Priory Woking Hospital.

Asif has held various managerial and digital positions in NHS and independent sector including Clinical Director, Clinical Lead for Mental Health Outcomes and Chief Clinical Information Officer. Asif has also been the NHS London Clinical Lead for Mental Health Outcomes for 2 years (2017-19).

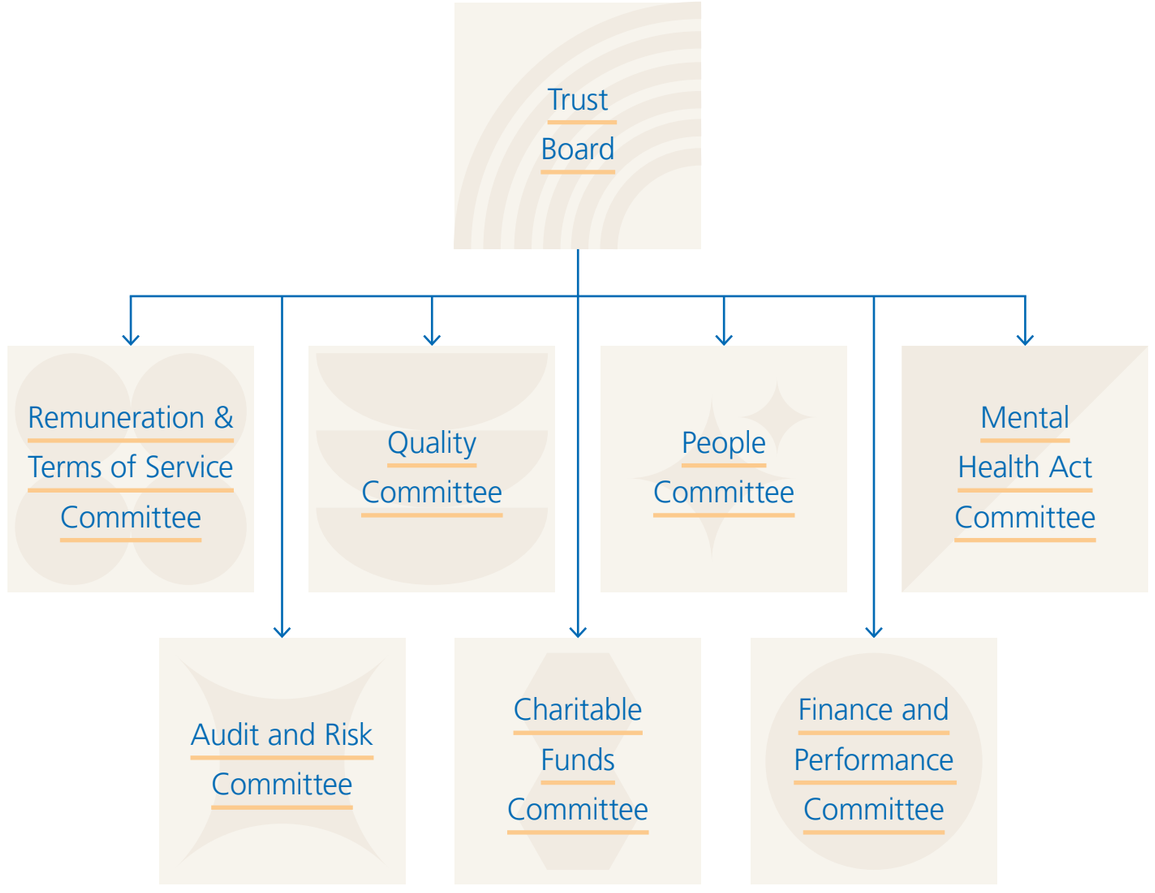
Asif has subsequently become a Fellow of Royal College of Psychiatrists in 2019 and has recently become the Vice-Chair of the NHS Benchmarking Mental Health, Autism and Learning Disability Reference Group.

Asif is also a committee member of the RCPsych Digital Special Interest Group and is Co-lead for the Digital Module of the RCPsych Leadership and Management Fellowship scheme. Asif is the Data and Digital literacy Lead for the RCPsych.

Board committees

The Board has seven 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)

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

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

During 2023-24 members included Peter Conway (Chair), Kim Lowe and Stephen Waring. Other members in 2023-24 included Sean Bone-Knell.

Quality Committee (QC)

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

Members include Stephen Waring (Chair), Sean Bone-Knell and Dr Asif Bachlani. Other members in 2023-34 included Catherine Walker.

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.

Members include Mickola Wilson (Chair), Peter Conway and Catherine Walker. Other members in 2023-24 included Dr MaryAnn Ferreux.

People Committee (PC)

In 2023-24, it was agreed that the Workforce and Organisation Development Committee, should be renamed the People Committee. The purpose of the committee is to provide the Board with assurance concerning all aspects of workforce and organisational development relating to the provision of care and services in support of getting the best clinical outcomes and experience for patients and staff.

Members include Kim Lowe (Chair), Peter Conway and Dr MaryAnn Ferreux. Other members in 2023-24 included Venu Branch.

Mental Health Act Committee

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

Members include Sean Bone-Knell (Chair) and Dr Asif Bahclani. Other members in 2023-24 included Kim Lowe.

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Remuneration and Terms of Service Committee

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

Catherine Walker is the Chair of the Remuneration and Terms of Service Committee. All non-executive directors are members of this committee.

Charitable Funds Committee

The purpose of the Committee is to act on behalf of the Corporate Trustee, with delegated responsibility for overseeing, monitoring and evaluating all charitable activities to ensure they are in accordance with the charity's objectives.

Members include Sean Bone-Knell (Chair) and Kim Lowe. Previous members in 2023-24 included Peter Conway and Dr Asif Bachlani.

Board Committee Attendance

Board Member	Audit and Risk Committee	Quality Committee	Finance and Performance Committee	People Committee	Mental Health Act Committee	Remuneration and Terms of Service Committee	Charitable Funds Committee
Jackie Craissati						2/2	
Venu Branch				5/5		1/2	
Catherine Walker		5/5	1/1			2/2	
Peter Conway	5/5		6/7	1/1		2/2	4/4
Mickola Wilson			6/7			1/2	
Sean Bone-Knell	4/4	1/1			2/4	2/2	
Kim Lowe	1/1			6/6	4/4	2/2	
Dr Asif Bachlani		6/6				1/2	4/4
Stephen Waring	5/5	5/6				1/2	
Dr MaryAnn Ferreux			1/2	1/1		1/2	
Helen Greatorex							
Sheila Stenson	3/3		3/4				0/2
Afifa Qazi		5/6	5/7		3/4		
Andy Cruickshank	5/5	6/6			3/4		
Donna Hayward-Sussex		6/6	7/7	6/6			
Nicholas Brown	2/2		3/3				2/2
Sandra Goatley				6/6			
Dr Adrian Richardson							4/4

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 2024 and up to the date of approval of the annual report and accounts.

The Trust has entered into a settlement agreement during 2023-24. An additional step in the approval process has been advised, the trust has therefore already taken action to rectify the situation but is awaiting final approval at the time of drafting this report.

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 Chief Finance and Resources Officer, 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 Chief Finance and Resources Officer 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. He 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 Audit and Risk Committee (ARC) plays 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 ARC 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 Policy 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 relevant staff are required to attend in addition to specific training appropriate to individual responsibilities, such as Prevention and Management of Violence and Aggression. Throughout 2023-24 managers and their nominated risk assessors have been offered tailored 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.

Staff attendance at training is regularly monitored by the Trust, with training reports being provided to committees for oversight.

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 Board Assurance Framework, the Risk Register, the requirements of the Care Quality Commission and national priorities.

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 2023-24.

- Financial risk has remained a constant throughout the year although the relative potential impacts have changed proportionately as a result of delivering financial breakeven at the end of March 2023, 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.
- Workforce Risks, particularly turnover, vacancy and sickness have fallen within the assurance framework throughout 2023/24.

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. During 2023/24 the Trust moved to a new risk system called InPhase, which was a major change for the Trust.

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

The National Security Risk Assessment and Local Resilience Fora Risk registers are regularly reviewed by the Risk Team alongside the Trust Risk Register to ensure that the correct types and levels of risks are scrutinised. ARC reviews the Board Assurance Framework and the Trust Risk Register, with the Board receiving the Board Assurance Framework at every public meeting. 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. Management of risk is achieved through the partnership working across the local health economy, local health resilience partnership and in our joint commissioning arrangements.

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

Staff are kept up to date with the national, regional and corporate risks for their areas through a range of media including team meetings and briefings, enabling them to identify and manage any new actions. The Corporate Quality and Safety Team work closely with Directorates to improve the quality and maintenance

of their risk registers. The Emergency Preparedness, Resilience and Response function compliance is assured externally by NHS England; within 2023 achieving Substantial compliance.

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. In 2023/24, the Trust continued to use an independent company to run its Freedom to Speak up Service and this reports directly into the Chief Executive. The confidential service is available 24 hours a day 365 days a year. The purpose of this is to ensure that staff know how to raise any concerns they might have about their workplace, and have an accessible and effective mechanism through which to do this. The Freedom to Speak Up Guardian is an independent and impartial point of contact, who has the authority to speak to anyone within or outside of the trust, is expert in all aspects of raising and handling concerns, and has dedicated time to perform this role. In 2023/24, the service received 101 referrals, compared to 81 referrals in 2022/23.

The Board Assurance Framework was refreshed to align with the new Trust Strategy in 2023 and is kept under constant review by the Executive Management Team and Board Assurance Framework Oversight Group. The Trust has an overarching People plan in place covering the next two years. This focusses on short and medium-term workforce strategies and staffing systems. This includes workforce planning, inclusivity and addressing violence and aggression. Progress against the People Strategy is reported to the People 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 Chief People Officer. 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.

The CQC Oversight Group, chaired by the Chief Nurse, is responsible for ensuring that Trust services meet the required fundamental standards as set out in the Health and Social Care Act. This group meets on a monthly basis and reports directly to the Quality Committee. There have been a number of unannounced inspections conducted by the CQC throughout the 2023-24 period focusing on areas of concern in inpatient settings. Services inspected in 2023 included Brookfield Centre, Tarentfort Centre, the acute wards at the three main hospital sites of Littlebrook, Priority House and St Martins. In March 2024, a focussed inspection was conducted on two wards at Littlebrook Hospital which specifically

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reviewed the safe and well-led domains in response to a number of deaths that had occurred relating to patients that had been granted section 17 leave. There are quality improvement plans in place to ensure that improvements are made following the 2023 inspections and these are monitored via the group. Areas for concern are then escalated to the Quality Committee.

Further to the above, the Chief Nurse requested that the Health Services Safety Investigation Body (HSSIB) conduct a review. HSSIB are commissioned by NHSE to independently review safety within healthcare. They visited in April and although we have not received the formal report, the initial feedback indicated that they did not have concerns related to engagement and practice on the wards – they were complementary around the interactions, attitude and care of the staff across the services they visited. We will wait their report and action as outlined above.

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. In In 2023/24, the Trust implemented the updated Fit and Proper Persons Guidance and the updated Code of Governance. The Trust also carried out its external Well Led review, in line with best practice.

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. The trust has undertaken risk assessments on the effects of climate change and severe weather and has developed a Green Plan following the guidance of the Greener NHS programme.

Clinical Risk and Patient Safety

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, within an Integrated Quality and Performance Report, encompassing the quality and patient safety aspects for the trust. The Quality Committee focusses on quality compliance and risks to quality and receives reports from its sub-committees, Patient Safety, Patient Experience and Clinical Effectiveness. This includes regular reporting on clinical audit, Never Events, Serious Incidents and complaints, with information about actions taken as a consequence. The Quality Committee 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.

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.

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.

ARC receives regular reports from the Anti-Crime 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 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 Security and Governance Update for 2023-24:

The Trust has continued to develop and adopt a number of increasingly secure digital platforms to enable communication, remote working and increased efficiency, enabling all services to continue to interact with, and support our patients, partners and the public through the constantly evolving ways of working.

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 Data Security Protection Toolkit (DSPT) and also in their respective annual reports.

The Trust had 14 Data Security and Protection incidents as defined by 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, ten related to information disclosed in error, one related to inappropriate access to information, one related to a cyber security breach and two related to a loss of data. All incidents were thoroughly investigated internally, and all required actions taken and lessons learnt by the Trust have been completed.

These incidents have informed improvements to the organisation's information risk management process and enabled process changes surrounding storage of, and access to personal data.

The Chief Finance and Resources Officer 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 (Chief Medical Officer (CMO)) 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 and Records Management 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 Information Governance 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 DSPT.

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 via the system of meeting structures. 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, ARC 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 maintain the effectiveness of 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. In 2024/25, adjustments will be made to the process so as to implement recommendations from the recent independent Well-Led review.

The 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 13 reviews in 2023-24, 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 were two areas reviewed by internal audit, Job Plans Report and the 8x8 Cloud Telephony Service, where it was assessed that the effectiveness of some of the internal control arrangements provided 'limited assurance'. Recommendations were made to further strengthen the controls 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 Anti-Crime Service 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 2023-24 Quality Account disclosure and associated internal assurances in place to validate its accuracy, which include data quality verification, and associated Quality Committee assurance.

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

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

S. Stenson.

Sheila Stenson
Chief Executive
Date: 19th June 2024

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

The Chief Executive of NHS England, 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.

S. Stenson.

Sheila Stenson
Chief Executive
Date: 19th June 2024

Remuneration Report

1 Remuneration and Terms of Service Committee

The Remuneration and Terms of Service Committee sets the policy and decision-making framework relating to the remuneration, terms of service and other benefits of Very Senior Managers of the Trust. Remuneration for all other staff follows national NHS Agenda for Change or Medical and Dental terms and conditions.

The Committee is also responsible for ensuring that a robust and effective process is in place to discharge the requirements of the Fit and Proper Person Test for all existing and future senior appointments, whether temporary or substantive, and for monitoring and evaluating the performance of Very Senior Managers.

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

2 Remuneration policy

Remuneration, terms of service and benefits for Very Senior Managers are determined considering:

- The combined benefits afforded to the Very Senior Manager, including basic salary, any other monetary benefit including bonuses, allowances, premiums or relocation packages, and any non-monetary benefits such as lease cars and leave;
- The job description and responsibilities of the Very Senior Manager;
- Benchmarking for Very Senior Manager roles of similar size and complexity to ensure the remuneration is justified on the basis of attracting suitable candidates;
- Performance of the Very Senior Manager;
- National guidance on Very Senior Manager remuneration.

In 2023-24, all Very Senior Managers were paid through the Trust's payroll.

Each Very Senior Manager has annual objectives, which are agreed with the Chief Executive, except for the Chief Executive's annual objectives, which are agreed with the Trust Chair.

The Trust's normal capability and disciplinary policies apply to Very Senior Managers, including the sanction of summary dismissal for gross misconduct.

All Very Senior Managers are appointed with notice periods of six months, and no contracts contain any provision for compensation over and above legal entitlement for early termination. Very Senior Managers are subject to redundancy clawback arrangements in line with NHS provisions.

3 Decisions relating to remuneration in 2022-23

There were no payments for loss of office for Very Senior Managers during 2022-23 or 2023-24.

4 Fair Pay Disclosures

Reporting bodies are required to disclose the relationship between the total remuneration of the highest-paid director / member in their organisation against the 25th percentile, median and 75th percentile of remuneration of the organisation's workforce. Total remuneration of the employee at the 25th percentile, median and 75th percentile is further broken down to disclose the salary component.

The banded annualised remuneration of the highest paid director in the financial year 2023-24 was £205k-£210k (compared with £200k - £205k in 2022-23). This was 5.51 times more (compared with 6.15 times more in 2021-22) than the median remuneration of the workforce, which was £37,639 (compared with £32,934 in 2022-23). The highest paid director's salary is denoted by a number of variable components, inclusive of clinical excellence awards. Remuneration ranged from £10k to £345k (2022-23 £5k to £290k). There were 13 individuals whose full-time equivalent remuneration were above that of the highest paid director within the organisation, with 11 of these individuals being temporary medical staff, deriving a higher average hourly rate than an equivalent substantive worker. The remaining 2 individuals were substantive employees who did not meet the criteria to be defined as a Very Senior Manager, as defined by NHS England. The 2 substantive employee's whose remuneration was higher than the Highest Paid Director both work within the Medical directorate, holding senior positions within the organisation, whilst undertaking clinical duties. The relationship to the remuneration of the organisation's workforce is disclosed in the below table.

Total remuneration includes salary, non-consolidated performance-related pay, clinical excellence awards, benefits-in-kind, but not severance payments. It does not include employer pension contributions or the Cash Equivalent Transfer Value of pensions. Total remuneration is excluding the pay award for 2024-25 for Agenda for Change Employees, as this is yet to be formally announced.

As audited

Salary and allowances

	2022-23	2023-24	Percentage change
Highest paid director (£)	202,500	207,500	2.00%
Employees as a whole (£)	37,902	42,701	12.66%

1

Pay ratio information

	25th percentile		Median		75th percentile	
	2022-23	2023-24	2022-23	2023-24	2022-23	2023-24
Total remuneration (£)	25,309	28,719	32,934	37,622	44,175	48,955
Salary component of total remuneration (£)	23,723	25,928	32,934	36,265	43,516	46,352
Remuneration ratio	8.00:1	7.23:1	6.15:1	5.52:1	4.58:1	4.24:1

1 Highest paid director remuneration is inclusive of all payments, disregarding salary sacrifices.

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5 Senior Manager Remuneration and Benefits

a) Remuneration – as audited

Salary table

	Name and Title	2023-24 Salary (Bands of £5K)	2023-24 Expense payments (taxable) to nearest £100	2023-24 Performance pay and bonuses (bands of £5K)	2023-24 Long term performance pay and bonuses (bands of £5K)	2023-24 All pension related benefits (band of £2.5K)	2023-24 TOTAL (bands of £5K)	2022-23 Salary (Bands of £5K)	2022-23 Expense payments (taxable) to nearest £100	2022-23 Performance pay and bonuses (bands of £5K)	2022-23 Long term performance pay and bonuses (bands of £5K)	2022-23 All pension related benefits (band of £2.5K)	2022-23 TOTAL (bands of £5K)
Executive Directors	**Sheila Stenson** - Chief Executive (since November 2023), Deputy Chief Executive/Chief Finance (from November 2022 until October 2023), Executive Director of Finance (until October 2022)	160-165	0	0	0	40-42.5	205-210	130-135	0	0	0	52.5-55	185-190
	Donna Hayward-Sussex - Deputy Chief Executive (from November 2023), Chief Operating Officer (from March 2022)	135-140	0	0	0	82.5-85	220-225	125-130	0	0	0	67.5-70	195-200
	Helen Greatorex - Chief Executive (until November 2023)	125-130	0	0	0	72.5-75	195-200	175-180	0	0	0	245-247.5	420-425
	Vincent Badu - Deputy Chief Executive, Executive Director of Strategy and Partnerships (until October 2022)							70-75	0	0	0	0	70-75
	Dr Afifa Qazi - Chief Medical Officer	205-210	0	0	0	0	205-210	200-205	0	0	0	0	200-205
	Sandra Goatley - Chief People Officer	130-135	0	0	0	35-37.5	165-170	125-130	0	0	0	32.5-35	155-160
	Andy Cruickshank - Chief Nurse	130-135	0	0	0	0	130-135	120-125	0	0	0	40-42.5	160-165
	Dr Adrian Richardson - Director of Partnerships and Transformation (from January 2023)	125-130	0	0	0	42.5-45	170-175	20-25	0	0	0	35-37.5	55-60
	Nicholas Brown - Chief Finance and Resources Officer (since November 2023)	55-60	0	0	0	5-7.5	60-65						
Non-executive Directors	**Dr Jackie Craissati** - Chair	45-50	0	0	0	0	45-50	45-50	0	0	0	0	45-50
	Venu Branch - Non-Executive Director (until February 2024)	10-15	0	0	0	0	10-15	15-20	0	0	0	0	15-20
	Catherine Walker - Non-Executive Director	15-20	0	0	0	0	15-20	15-20	0	0	0	0	15-20
	Fiona Carragher - Non-Executive Director (until September 2022)							0-5	0	0	0	0	0-5
	Peter Conway - Non-Executive Director	10-15	0	0	0	0	10-15	10-15	0	0	0	0	10-15
	Kim Lowe - Non-Executive Director	10-15	0	0	0	0	10-15	10-15	0	0	0	0	10-15
	Sean Bone-Knell - Non-Executive Director	10-15	0	0	0	0	10-15	10-15	0	0	0	0	10-15
	Mickola Wilson - Non-Executive Director	10-15	0	0	0	0	10-15	10-15	0	0	0	0	10-15
	Dr Asif Bachlani - Non-Executive Director (from October 2022)	10-15	0	0	0	0	10-15	05-10	0	0	0	0	05-10
	Dr MaryAnn Ferreux - Non-Executive Director (from February 2023)	10-15	0	0	0	0	10-15	0-5	0	0	0	0	0-5
	Stephen Waring - Non-Executive Director (from January 2023)	10-15	0	0	0	0	10-15	0-5	0	0	0	0	0-5

2,3,4,5,6,7,8,9,10,11,12,13

2 Sheila Stenson was appointed as Chief Executive in November 2023, Deputy Chief Executive in November 2022 until October 2023, and was Chief Finance and Resources Officer until October 2023.
3 Donna Hayward-Sussex was appointed as Chief Operating Officer in March 2022 and Deputy Chief Executive in November 2023.
4 Helen Greatorex was Chief Executive until November 2023.
5 Vincent Badu left the trust in October 2022.
6 Andy Cruickshank was appointed Chief Nurse in March 2022.
7 Dr Adrian Richardson was appointed Director of Partnerships and Transformation in January 2023.
8 Nicholas Brown was appointed Chief Finance and Resources Officer in November 2023.
9 Venu Branch left the trust in February 2024.
10 Fiona Carragher left the trust in September 2022.
11 Dr Asif Bachlani was appointed as a Non-Executive Director in October 2022.
12 Dr MaryAnn Ferreux was appointed as a Non-Executive Director in February 2023.
13 Stephen Waring was appointed as a Non-Executive Director in January 2023.

b) Pension Benefits – as audited

2023-24

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 2024	Lump sum at age 60 related to accrued pension at 31 March 2024	Cash Equivalent Transfer Value at 1 April 2023	Real increase in Cash Equivalent Transfer Value	Cash Equivalent Transfer Value at 31 March 2024	Employer's contribution to stakeholder pension
	(Bands of £2,500)	(Bands of £2,500)	(Bands of £5,000)	(Bands of £5,000)				
	£000	£000	£000	£000	£000	£000	£000	£000
Sheila Stenson – Chief Executive (since November 2023), Deputy Chief Executive (from November 2022 until October 2023), Chief Finance and Resources Officer (until October 2023)	0-2.5	47.5-50	45-50	120-125	575	255	911	-
Donna Hayward-Sussex – Chief Operating Officer (from March 2022) and Deputy Chief Executive (from November 2023)	5-7.5	0	35-40	0	428	151	642	-
Helen Greatorex – Chief Executive (until November 2023)	2.5-5	0	5-10	0	50	63	135	-
Dr Afifa Qazi – Chief Medical Officer	0	0	60-65	40-45	844	134	1,087	
Sandra Goatley – Chief People Officer	2.5-5	0	20-25	0	277	54	377	-
Andrew Cruickshank – Chief Nurse (from March 2022)	0	27.5-30	50-55	140-145	923	157	1,190	-
Dr Adrian Richardson – Director of Partnerships and Transformation (from January 2023)	2.5-5	0	15-20	0	162	60	255	-
Nicholas Brown – Chief Finance and Resources Officer (since November 2023)	0-2.5	0-2.5	15-20	45-50	292	0	334	-

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2022-23

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 2023	Lump sum at age 60 related to accrued pension at 31 March 2023	Cash Equivalent Transfer Value at 1 April 2022	Real increase in Cash Equivalent Transfer Value	Cash Equivalent Transfer Value at 31 March 2023	Employer's contribution to stakeholder pension
	(Bands of £2,500)	(Bands of £2,500)	(Bands of £5,000)	(Bands of £5,000)				
	£000	£000	£000	£000	£000	£000	£000	£000
Helen Greatorex – Chief Executive	10-12.5	25-27.5	85-90	255-260	1,800	287	2,167	-
Vincent Badu – Deputy Chief Executive, Executive Director of Strategy and Partnerships (until October 2022)	0-2.5	0	30-35	40-45	493	0	519	-
Sheila Stenson – Chief Executive (since November 2023), Deputy Chief Executive (from November 2022 until October 2023), Chief Finance and Resources Officer (until October 2023)	2.5-5	0-2.5	40-45	65-70	507	34	575	-
Dr Afifa Qazi – Chief Medical Officer	0-2.5	0	55-60	35-40	801	0	844	-
Sandra Goatley – Chief People Officer	0-2.5	0	15-20	0	223	30	277	-
Andrew Cruickshank – Chief Nurse (from March 2022)	2.5-5	0-2.5	50-55	100-105	838	42	923	-
Donna Hayward-Sussex – Chief Operating Officer (from March 2022) and Deputy Chief Executive (from November 2023)	2.5-5	0	25-30	0	346	53	428	-
Dr Adrian Richardson – Director of Partnerships and Transformation (from January 2023)	0-2.5	0	10-15	0	132	2	162	-

The value of pension benefits accrued during the year is calculated as the real increase in pension multiplied by 20, less, the contributions made by the individual. The real increase excludes increases due to inflation or any increase or decrease due to a transfer of pension rights.

This value does not represent an amount that will be received by the individual. It is a calculation that is intended to convey to the reader of the accounts an estimation of the benefit that being a member of the pension scheme could provide.

The pension benefit table provides further information on the pension benefits accruing to the individual.

Cash Equivalent Transfer Values

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 SI 2008 No.1050 Occupational Pension Schemes (Transfer Values) Regulations 2008.

Real Increase in CETV

This reflects the increase in CETV that is funded by the employer. It does not include the increase in accrued pension due to inflation or contributions paid by the employee (including the value of any benefits transferred from another pension scheme or arrangement).

Payments to past members

There were no payments to past members in 2023/24.

Staff Report

1 Average staff numbers – as audited

Average number of employees (WTE basis)

	Permanent Number	Other Number	2023-2024 Total Number	2022-2023 Total Number
Administration and estates staff	858	25	883	896
Health care assistants and other support staff	720	316	1,035	1,069
Medical and dental staff	220	15	234	223
Nursing, midwifery and health visiting staff	859	204	1,062	1,070
Nursing, midwifery and health visiting learners	26	-	26	16
Scientific, therapeutic and technical staff	549	8	557	426
Healthcare Scientists	-	-	-	-
Social Care	-	-	-	-
Other (students)	76	5	81	13
Total Average Numbers	**3,307**	**572**	**3,879**	**3,713**
Of which **Number of employees (WTE) engaged on capital projects**	**19**	**1**	**20**	**20**

2 Workforce demographic – as audited

Workforce Demographic: Gender

	FTE		
	Female	Male	Grand Total
Apprentice	5.40	4.80	**10.20**
Band 2	312.13	154.63	**466.76**
Band 3	480.69	145.99	**626.67**
Band 4	304.23	63.81	**368.04**
Band 5	272.74	82.66	**355.39**
Band 6	527.77	161.50	**689.27**
Band 7	315.66	99.56	**415.22**
Band 8a	128.35	44.76	**173.11**
Band 8b	52.74	20.16	**72.90**
Band 8c	34.15	22.45	**56.61**
Band 8d	17.60	8.76	**26.36**
Band 9	6.90	4.00	**10.90**
Director	3.00	3.00	**6.00**
Medical	104.98	92.65	**197.63**
NED	5.00	4.60	**9.60**
Grand Total	**2571.34**	**913.33**	**3484.66**

Workforce Demographic: Age

Age Band	FTE
<=20 Years	18.27
>=71 Years	14.02
21-25	233.13
26-30	339.92
31-35	389.62
36-40	354.10
41-45	448.11
46-50	477.55
51-55	492.23
56-60	429.20
61-65	235.22
66-70	53.29
Grand Total	**3484.66**

14, 15

14 Workforce Demographic Data is not inclusive of agency workers as this data is not held by the trust.

15 The total numbers displayed in the workforce demographic tables are based on data from the end of March 2024. This displays a discrepancy in the staff numbers shown in the demographic tables in comparison with the average staff numbers table. This is due to the average staff number table alluding to average weekly staffing numbers from April 2023 to March 2024, as opposed to the demographic tables which display staff numbers at a single point in time.

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Workforce Demographic: Ethnicity

Ethnic Origin	FTE	% of Staff
A White - British	2,100.89	60.29%
B White - Irish	24.85	0.71%
C White - Any other White background	132.77	3.81%
CA White English	14.53	0.42%
CM White Traveller	1.00	0.03%
CP White Polish	5.00	0.14%
CX White Mixed	1.80	0.05%
CY White Other European	5.13	0.15%
D Mixed - White & Black Caribbean	14.35	0.41%
E Mixed - White & Black African	12.68	0.36%
F Mixed - White & Asian	19.47	0.56%
G Mixed - Any other mixed background	34.00	0.98%
GA Mixed - Black & Asian	1.00	0.03%
H Asian or Asian British - Indian	157.46	4.52%
J Asian or Asian British - Pakistani	20.60	0.59%
K Asian or Asian British - Bangladeshi	8.76	0.25%
L Asian or Asian British - Any other Asian background	66.69	1.91%
LA Asian Mixed	1.00	0.03%
LB Asian Punjabi	1.00	0.03%
LE Asian Sri Lankan	1.00	0.03%
LF Asian Tamil	1.00	0.03%
LH Asian British	2.00	0.06%
M Black or Black British - Caribbean	42.90	1.23%
N Black or Black British - African	518.45	14.88%
P Black or Black British - Any other Black background	27.39	0.79%
PC Black Nigerian	8.16	0.23%
PD Black British	5.50	0.16%
R Chinese	8.20	0.24%
S Any Other Ethnic Group	64.53	1.85%
SB Japanese	1.00	0.03%
SC Filipino	4.00	0.11%
SE Other Specified	1.00	0.03%
Z Not Stated	176.54	5.07%
Grand Total	**3484.66**	**100%**

3 Staff costs – as audited

Staff Costs

	Permanent £000	Other £000	2023-24 Total £000	2022-23 Total £000
Salaries and wages	135,700	1,046	136,746	131,400
Social security costs	14,435	-	14,435	13,767
Apprenticeship levy	704	-	704	642
Employer's contributions to NHS pension scheme	25,363	-	25,363	23,064
Pension cost - other	69	-	69	61
Termination benefits	267	-	267	56
Agency/contract staff	-	31,440	31,440	28,131
Total gross staff costs	176,538	32,486	209,024	197,121
Recoveries in respect of seconded staff	-	-	-	-
Total staff costs	176,538	32,486	209,024	197,121
Of which: Costs capitalised as part of assets	1,136	124	1,260	1,175

4 Exit packages – as audited

Exit Packages

Exit package cost band (including any special payment element)	Number of compulsory redundancies	Cost of compulsory redundancies	Number of other departures agreed	Cost of other departures agreed	Total number of exit packages	Total cost of exit packages	Number of departures where special payments have been made	Cost of special payment element included in exit packages
Less than £10,000	-	-	11	-	11	£22,000	-	-
£10,000 - £25,000	-	-	1	-	-	£18,000	-	-
£25,001 - £50,000	-	-	1	-	1	£29,000	-	-
£50,001 - £100,000	2	£126,000	1	-	3	£183,000	-	-
£100,001 - £150,000	1	£141,000	-	-	1	£141,000	-	-
£150,001 - £200,000	-	-	-	-	-	-	-	-
>£200,000	-	-	-	-	-	-	-	-
Totals	3	£267,000	14	-	17	£393,000	-	-

Exit packages: other (non-compulsory) departure payments

	2023/24 Payments agreed Number	2023/24 Total value of agreements £000	2022/23 Payments agreed Number	2022/23 Total value of agreements £000
Voluntary redundancies including early retirement contractual costs	-	-	-	-
Mutually agreed resignations (MARS) contractual costs	-	-	-	-
Early retirements in the efficiency of the service contractual costs	-	-	-	-
Contractual payments in lieu of notice	14	127	-	-
Exit payments following Employment Tribunals or court orders	-	-	-	-
Non-contractual payments requiring HMT approval	-	-	-	-
Total	14	127	-	-
Of which: Non-contractual payments requiring HMT approval made to individuals where the payment value was more than 12 months' of their annual salary	-	-	-	-

5 Off-payroll engagements

The Trust had no off-payroll engagements as at 31 March 2023 and had no new off-payroll engagements between 1 April 2022 and 31 March 2023, for more than £245 per day and that last longer than six months.

6 Expenditure on consultancy

Please refer to note [x] in the Annual Accounts.

7 Sickness absence rates

NHS sickness absence rates are published by NHS Digital at the following link: https://digital.nhs.uk/data-and-information/publications/statistical/nhs-sickness-absence-rates. This source is an official statistics publication complying with the UK Statistics Authority's Code of Practice.

8 Staff turnover rates

Staff turnover rates are published by NHS Digital at the following link: https://digital.nhs.uk/data-and-information/publications/statistical/nhs-workforce-statistics. This source is an official statistics publication complying with the UK Statistics Authority's Code of Practice.

9 Staff engagement levels

Each year, the Trust participates in the National NHS Staff Survey and this year, 52% of staff participated. Around 100 questions are asked in the survey, including a select number of questions designed to present a view on the organisations overall engagement. These questions relate to job satisfaction, involvement, and advocacy for the organisation as a place to work or be treated. This year, the survey returned an engagement score for the Trust of 6.9 out of 10.

10 Staff policies applied during the year

The Trust has a range of staff policies which are reviewed on a regular basis to ensure that they are up to date and compliant with legislation and current best practice.

These policies are available to all staff on the internal i-Connect pages.

All of our policies are subject to an Equality Impact Assessment process. This is a practical tool which enables us to identify potential discrimination and to take appropriate steps to remove any potential disadvantage for a particular group.

Recruitment and Selection

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 includes giving full and fair consideration to applications for employment made by disabled persons.

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KMPT also reports the data as part of the Workforce Disability Equality Standard and Workforce Race Equality Standard.

Training and development

KMPT offers a wealth of internal training for its staff. Where external training is required at cost, KMPT's Training Policy sets out a fair and transparent process for applying to its Training Panel for support. The diversity of staff making applications to the Panel and of staff whose applications are successful is regularly reviewed.

Policies regarding raising concerns

We continue with our commitment to advancing a culture where all staff are positively encouraged to raise issues about safety, quality, and effectiveness of the service, and supported when they do so.

In 2022-23, the Trust began working with the National Guardian Service to provide its Freedom to Speak Up Guardian. This role is recognised as an independent and impartial source of advice and support to staff who want to raise a concern.

11 Staff Health, Safety and Wellbeing

During the year, health and safety training was delivered to 96 per cent of staff.

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.

12 Staff Partnership and Joint Negotiation

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.

S. Stenson.

Sheila Stenson
Chief Executive
Date: 19th June 2024

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,

Sheila Stenson
Chief Executive
Date: 19th June 2024

Nicholas Brown
Chief Finance and Resources Officer
Date: 19th June 2024

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

Report on the audit of the financial statements

Opinion on financial statements

We have audited the financial statements of Kent and Medway NHS and Social Partnership Trust (the 'Trust') for the year ended 31 March 2024, 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 2023-24.

In our opinion, the financial statements:

- give a true and fair view of the financial position of the Trust as at 31 March 2024 and of its expenditure and income for the year then ended; and
- 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 2023-24; 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 2023-24 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 2022) 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.

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.

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.

Our responsibilities and the responsibilities of the directors with respect to going concern are described in the relevant sections of this report.

Other information

The other information comprises the information included in the annual report, other than the financial statements and our auditor's report thereon. The directors are responsible for the other information contained within the annual report. 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.

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 themselves. 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 requirements of the Department of Health and Social Care Group Accounting Manual 2023-24 or is misleading or inconsistent with the information of which we are aware from our audit. We are not required to consider whether the Annual Governance Statement addresses all risks and controls or that risks are satisfactorily addressed by internal controls.

We have nothing to report in this regard.

Opinion on other matters required by the Code of Audit Practice

In our opinion:

- the parts of the Remuneration and Staff Report to be audited have been properly prepared in accordance with the requirements of the Department of Health and Social Care Group Accounting Manual 2023-24; and
- based on the work undertaken in the course of the audit of the financial statements, 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.

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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 directors

As explained more fully in the Statement of directors' responsibilities in respect of the accounts the directors are responsible for the preparation of the financial statements in the form and on the basis set out in the Accounts Directions and 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.

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. Irregularities, including fraud, are instances of non-compliance with laws and regulations. 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 2023-24).

- 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, the risk of fraudulent revenue recognition and the risk of fraudulent land and buildings valuations. We determined that the principal risks were in relation to:
  - management override of controls;
  - revenue recognition in relation to variable and other income;
  - the valuation of land and building.
- 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 building valuations;
  - 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.
- We communicated relevant laws and regulations and potential fraud risks to all engagement team members. We remained alert to any indications of non-compliance with laws and regulations, including fraud, throughout the audit.

- 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
    - 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.

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

Report on other legal and regulatory requirements – 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 2024.

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

Responsibilities of the Accountable Officer

As explained in the Statement of the chief executive's responsibilities as the accountable officer of the Trust the 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(2A)(c) 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 January 2023. 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 – certification of completion of the audit

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

Use of our report

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

John Paul Cuttle

John Paul Cuttle,
Key Audit Partner
for and on behalf of Grant Thornton UK LLP, Local Auditor

30 Finsbury Square
London
EC2A 1AG

Date: 20th June 2024

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Annual accounts for the year ended 31st March 2024

Statement of Comprehensive Income

	Note	2023/24 £000	2022/23 £000
Operating income from patient care activities	3	252,360	241,303
Other operating income	4	19,672	17,613
Operating expenses	6, 8	(275,643)	(257,880)
Operating (deficit) / surplus from continuing operations		**(3,611)**	**1,036**
Finance income	10	1,081	571
Finance expenses	11	(3,796)	(2,395)
PDC dividends payable		(3,433)	(3,413)
Net finance costs		**(6,148)**	**(5,237)**
Other losses	12	(158)	(91)
Deficit for the year		**(9,917)**	**(4,292)**
Other comprehensive income			
Will not be reclassified to income and expenditure:			
Impairments	7	(2,686)	(613)
Revaluations	16	792	3,600
Total comprehensive expense for the period		**(11,811)**	**(1,305)**

Adjusted financial performance (control total basis) - Note

The Trust's deficit for 2023/24 was £9,917k. NHS England 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 £1,043k surplus.

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):		
Deficit for the year	(9,917)	(4,292)
Remove net impairments not scoring to the Departmental expenditure limit	10,165	4,334
Remove I&E impact of capital grants and donations	(182)	3
Remove impact of IFRS 16 on IFRIC 12 schemes	977	-
Adjusted financial performance surplus	**1,043**	**45**

Statement of Financial Position

	Note	31 March 2024 £000	31 March 2023 £000
Non-current assets			
Intangible assets	13	3,917	3,780
Property, plant and equipment	14	127,346	135,203
Right of use assets	16	35,502	30,472
Investment property	17	2,201	2,201
Receivables	19	289	396
Total non-current assets		**169,255**	**172,052**
Current assets			
Receivables	19	5,670	11,447
Cash and cash equivalents	20	17,399	19,685
Total current assets		**23,069**	**31,132**
Current liabilities			
Trade and other payables	21	(23,544)	(31,959)
Borrowings	23	(2,781)	(2,500)
Provisions	24	(2,260)	(2,440)
Other liabilities	22	(981)	(828)
Total current liabilities		**(29,566)**	**(37,727)**
Total assets less current liabilities		**162,758**	**165,457**
Non-current liabilities			
Borrowings	23	(44,970)	(33,514)
Provisions	24	(2,320)	(2,431)
Total non-current liabilities		**(47,290)**	**(35,945)**
Total assets employed		**115,468**	**129,512**
Financed by			
Public dividend capital		137,738	134,656
Revaluation reserve		22,408	24,302
Income and expenditure reserve		(44,678)	(29,446)
Total taxpayers' equity		**115,468**	**129,512**

The notes on pages 104 to 138 form part of these accounts.

The financial statements on pages 100 to 103 were approved by the board on the 19th June 2024 and signed on its behalf by

S. Stenson.

Sheila Stenson
Chief Executive
Date: 19th June 2024

Statement of Changes in Equity for the year ended 31 March 2024

	Public dividend capital	Revaluation reserve	Other reserves	Income and expenditure reserve	Total
	£000	£000	£000	£000	£000
Taxpayers' and others' equity at 1 April 2023 - brought forward	**134,656**	**24,302**	**-**	**(29,446)**	**129,512**
Application of IFRS 16 measurement principles to PFI liability on 1 April 2023	-	-	-	(5,315)	**(5,315)**
Deficit for the year	-	-	-	(9,917)	**(9,917)**
Impairments	-	(2,686)	-	-	**(2,686)**
Revaluations	-	792	-	-	**792**
Public dividend capital received	3,082	-	-	-	**3,082**
Taxpayers' and others' equity at 31 March 2024	**137,738**	**22,408**	**-**	**(44,678)**	**115,468**

Statement of Changes in Equity for the year ended 31 March 2023

	Public dividend capital	Revaluation reserve	Other reserves	Income and expenditure reserve	Total
	£000	£000	£000	£000	£000
Taxpayers' and others' equity at 1 April 2022 - brought forward	**126,785**	**21,315**	**(5,280)**	**(19,929)**	**122,891**
Implementation of IFRS 16 on 1 April 2022	-	-	-	55	**55**
Deficit for the year	-	-	-	(4,292)	**(4,292)**
Other transfers between reserves	-	-	5,280	(5,280)	**-**
Impairments	-	(613)	-	-	**(613)**
Revaluations	-	3,600	-	-	**3,600**
Public dividend capital received	7,871	-	-	-	**7,871**
Taxpayers' and others' equity at 31 March 2023	**134,656**	**24,302**	**-**	**(29,446)**	**129,512**

Information on reserves

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

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

Other Reserves
Errors identified following a merger in 2006 were charged to other reserves. In 2022/23 the Trust obtained agreement from NHS England that the balance in this reserve could be transferred to the Income and expenditure reserve.

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

Statement of Cash Flows

	Note	2023/24 £000	2022/23 £000
Cash flows from operating activities			
Operating (deficit) / surplus		(3,611)	1,036
Non-cash income and expense:			
Depreciation and amortisation	6.1	10,892	10,064
Net impairments	7	10,229	4,347
Income recognised in respect of capital donations	4	(186)	-
Decrease / (Increase) in receivables and other assets		5,877	(4,518)
(Decrease) / Increase in payables and other liabilities		(4,992)	8,370
Decrease in provisions		(328)	(499)
Other movements in operating cash flows		(2)	-
Net cash flows from operating activities		**17,879**	**18,800**
Cash flows from investing activities			
Interest received		1,081	571
Purchase of intangible assets		(1,458)	(1,005)
Purchase of PPE and investment property		(14,611)	(18,106)
Receipt of cash donations to purchase assets		186	-
Net cash flows used in investing activities		**(14,802)**	**(18,540)**
Cash flows from financing activities			
Public dividend capital received		3,082	7,871
Capital element of finance lease rental payments		(2,025)	(1,983)
Capital element of PFI, LIFT and other service concession payments		(1,011)	(492)
Interest paid on finance lease liabilities		(1,054)	(1,050)
Interest paid on PFI, LIFT and other service concession obligations		(929)	(1,320)
PDC dividend paid		(3,426)	(3,678)
Net cash flows used in financing activities		**(5,363)**	**(652)**
Decrease in cash and cash equivalents		**(2,286)**	**(392)**
Cash and cash equivalents at 1 April - brought forward		**19,685**	**20,077**
Cash and cash equivalents at 31 March	20	**17,399**	**19,685**

Notes to the Accounts

Note 1 Accounting policies and other information

Note 1.1 Basis of preparation

The Department of Health and Social Care has directed that the financial statements of the Trust shall meet the accounting requirements of the Department of Health and Social Care Group Accounting Manual (GAM), which shall be agreed with HM Treasury. Consequently, the following financial statements have been prepared in accordance with the GAM 2023/24 issued by the Department of Health and Social Care. The accounting policies contained in the GAM follow International Financial Reporting Standards to the extent that they are meaningful and appropriate to the NHS, as determined by HM Treasury, which is advised by the Financial Reporting Advisory Board. Where the GAM permits a choice of accounting policy, the accounting policy that is judged to be most appropriate to the particular circumstances of the Trust for the purpose of giving a true and fair view has been selected. The particular policies adopted are described below. These have been applied consistently in dealing with items considered material in relation to 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 2024/25 do not indicate a going concern risk.

Note 1.3 Critical accounting judgments and key sources of estimation uncertainty

In the application of NHS trust accounting policies, management is required to make judgments, 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 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 judgments in applying accounting policies

Any critical judgments, 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 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 considering historical experience, current trends, and other related factors. However, because balances cannot be determined with certainty, actual results could be materially different depending 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 1.8%.

Land is currently valued at £20,546k, a 5% reduction in the valuation would decrease asset values by £1,027k. Buildings are valued at £99,841k, a 5% decrease in values would result in a £4,992k reduction in asset values. Together these would contribute to a change in PDC dividend of £105k.

Note 1.4 Revenue from contracts with customers

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

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.

Note 1.4.1 Revenue from NHS contracts

The main source of income for the Trust is contracts with commissioners for health care services. In 2023/24, the majority of the trust's income from NHS commissioners was in the form of block contract arrangements.

The main source of income for the Trust is contracts with commissioners for health care services. Funding envelopes are set at an Integrated Care System (ICS) level. The majority of the Trust's income is earned from NHS commissioners in the form of fixed payments to fund an agreed level of activity.

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.

Note 1.4.2 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 1.4.3 Other forms of income

Grants and donations

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. Where the grant is used to fund capital expenditure, it is credited to the Statement of Comprehensive Income once conditions attached to the grant have been met. Donations are treated in the same way as government grants.

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 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 the 1995/2008 and 2015 schemes are accounted for, and the scheme liability valued, as a single combined scheme. 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. 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, e.g. plant and equipment, then these components are treated as separate assets and depreciated over their own useful lives.

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.

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 2023/24 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 the assets 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.

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 the following criteria in IFRS 5 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 and the assets are not revalued, except where the 'fair value less costs to sell' falls below the carrying amount. 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 2023/24 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.

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. Annual contract payments to the operator (the unitary charge) are apportioned between the repayment of the liability including the finance cost, the charges for services and lifecycle replacement of components of the asset.

Initial recognition

In accordance with HM Treasury's FReM, the underlying assets are recognised as property, plant and equipment, together with an equivalent finance lease liability. Initial measurement of the asset and liability are in accordance with the initial measurement principles of IFRS 16 (see leases accounting policy).

Subsequent measurement

Assets are subsequently accounted for as property, plant and equipment and/or intangible assets as appropriate.

The liability is subsequently reduced by the portion of the unitary charge allocated as payment for the asset and increased by the annual finance cost. The finance cost is calculated by applying the implicit interest rate to the opening liability and is charged to finance costs in the Statement of Comprehensive Income. The element of the unitary charge allocated as payment for the asset is split between payment of the finance cost and repayment of the net liability.

Where there are changes in future payments for the asset resulting from indexation of the unitary charge, the Trust remeasures the PFI liability by determining the revised payments for the remainder of the contract once the change in cash flows takes effect. The remeasurement adjustment is charged to finance costs in the Statement of Comprehensive Income.

The service charge is recognised in operating expenses in the Statement of Comprehensive Income.

Initial application of IFRS 16 liability measurement principles to PFI and LIFT liabilities

IFRS 16 liability measurement principles have been applied to PFI, LIFT and other service concession arrangement liabilities in these financial statements from 1 April 2023. The change in measurement basis has been applied using a modified retrospective approach with the cumulative impact of remeasuring the liability on 1 April 2023 recognised in the income and expenditure reserve.

Comparatives for PFI, LIFT and other service concession arrangement liabilities have not been restated on an IFRS 16 basis, as required by the DHSC Group Accounting Manual. Under IAS 17 measurement principles which applied in 2022/23 and earlier, movements in the liability were limited to repayments of the liability and the annual finance cost arising from application of the implicit interest rate. The cumulative impact of indexation on payments for the asset was charged to finance costs as contingent rent as incurred.

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	1	10

Note 1.8 Intangible assets

Note 1.8.1 Recognition

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

Internally generated intangible assets

Internally generated goodwill, brands, mastheads, publishing titles, customer lists and similar items are not capitalised as intangible assets.

Expenditure on research is not capitalised.

Expenditure on development is capitalised 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. Revaluation 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	7

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 2022/23 and 2023/24, 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 the 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, i.e. 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 a 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

A lease is a contract or part of a contract that conveys the right to use an asset for a period of time in exchange for consideration. An adaptation of the relevant accounting standard by HM Treasury for the public sector means that for NHS bodies, this includes lease-like arrangements with other public sector entities that do not take the legal form of a contract. It also includes peppercorn leases where consideration paid is nil or nominal (significantly below market value) but in all other respects meet the definition of a lease. The trust does not apply lease accounting to new contracts for the use of intangible assets.

The Trust determines the term of the lease term with reference to the non-cancellable period and any options to extend or terminate the lease which the Trust is reasonably certain to exercise.

Note 1.13.1 The Trust as a lessee

Recognition and initial measurement

At the commencement date of the lease, being when the asset is made available for use, the Trust recognises a right of use asset and a lease liability.

The right of use asset is recognised at cost comprising the lease liability, any lease payments made before or at commencement, any direct costs incurred by the lessee, less any cash lease incentives received. It also includes any estimate of costs to be incurred restoring the site or underlying asset on completion of the lease term.

The lease liability is initially measured at the present value of future lease payments discounted at the interest rate implicit in the lease. Lease payments includes fixed lease payments, variable lease payments dependent on an index or rate and amounts payable under residual value guarantees. It also includes amounts payable for purchase options and termination penalties where these options are reasonably certain to be exercised.

Where an implicit rate cannot be readily determined, the Trust's incremental borrowing rate is applied. This rate is determined by HM Treasury annually for each calendar year. A nominal rate of 3.51% applied to new leases commencing in 2023 and 4.72% to new leases commencing in 2024.

The Trust does not apply the above recognition requirements to leases with a term of 12 months or less or to leases where the value of the underlying asset is below £5,000, excluding any irrecoverable VAT.

Lease payments associated with these leases are expensed on a straight-line basis over the lease term or other systematic basis. Irrecoverable VAT on lease payments is expensed as it falls due.

Subsequent measurement

As required by a HM Treasury interpretation of the accounting standard for the public sector, the Trust employs a revaluation model for subsequent measurement of right of use assets, unless the cost model is considered to be an appropriate proxy for current value in existing use or fair value, in line with the accounting policy for owned assets. Where consideration exchanged is identified as significantly below market value, the cost model is not considered to be an appropriate proxy for the value of the right of use asset.

The Trust subsequently measures the lease liability by increasing the carrying amount for interest arising which is also charged to expenditure as a finance cost and reducing the carrying amount for lease payments made. The liability is also remeasured for changes in assessments impacting the lease term, lease modifications or to reflect actual changes in lease payments. Such remeasurements are also reflected in the cost of the right of use asset. Where there is a change in the lease term or option to purchase the underlying asset, an updated discount rate is applied to the remaining lease payments.

Note 1.13.2 The Trust as a lessor

The Trust assesses each of its leases and classifies them as either a finance lease or an operating lease. 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.

Where the Trust is an intermediate lessor, classification of the sublease is determined with reference to the right of use asset arising from the headlease.

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

Income from operating leases is recognised on a straight-line basis or another systematic 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.

Initial application of IFRS 16 in 2022/23

IFRS 16 Leases as adapted and interpreted for the public sector by HM Treasury was applied to these financial statements with an initial application date of 1 April 2022. IFRS 16 replaced IAS 17 Leases, IFRIC 4 Determining whether an arrangement contains a lease and other interpretations.

The standard was applied using a modified retrospective approach with the cumulative impact recognised in the income and expenditure reserve on 1 April 2022. Upon initial application, the provisions of IFRS 16 were only applied to existing contracts where they were previously deemed to be a lease or contain a lease under IAS 17 and IFRIC 4. Where existing contracts were previously assessed not to be or contain a lease, these assessments were not revisited.

The Trust as lessee

For continuing leases previously classified as operating leases, a lease liability was established on 1 April 2022 equal to the present value of future lease payments discounted at the Trust's incremental borrowing rate of 0.95%. A right of use asset was created equal to the lease liability and adjusted for prepaid and accrued lease payments and deferred lease incentives recognised in the Statement of Financial Position immediately prior to initial application. Hindsight was used in determining the lease term where lease arrangements contained options for extension or earlier termination.

No adjustments were made on initial application in respect of leases with a remaining term of 12 months or less from 1 April 2022 or for leases where the underlying assets had a value below £5,000. No adjustments were made in respect of leases previously classified as finance leases.

The Trust as lessor

Leases of owned assets where the Trust was lessor were unaffected by initial application of IFRS 16. For existing arrangements where the Trust was an intermediate lessor, classification of all continuing sublease arrangements was been reassessed with reference to the right of use asset.

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 HM Treasury's discount rates effective from 31 March 2024:

		Nominal rate	Prior year rate
Short-term	Up to 5 years	4.26%	3.27%
Medium-term	After 5 years up to 10 years	4.03%	3.20%
Long-term	After 10 years up to 40 years	4.72%	3.51%
Very long-term	Exceeding 40 years	4.40%	3.00%

HM Treasury provides discount rates for general provisions on a nominal rate basis. Expected future cash flows are therefore adjusted for the impact of inflation before discounting using nominal rates. The following inflation rates are set by HM Treasury, effective from 31 March 2024:

	Inflation rate	Prior year rate
Year 1	3.60%	7.40%
Year 2	1.80%	0.60%
Into perpetuity	2.00%	2.00%

Early retirement provisions and injury benefit provisions both use the HM Treasury's post-employment benefits discount rate of 2.45% in real terms (prior year: 1.70%).

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 24.2 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 25 where an inflow of economic benefits is probable.

Contingent liabilities are not recognised, but are disclosed in Note 25, 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 during the financial year. Relevant net assets are calculated as the value of all assets less the value of all liabilities, except for:
(i) donated 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.

This policy is available at https://www.gov.uk/government/publications/guidance-on-financing-available-to-nhs-trusts-and-foundation-trusts.

In accordance with the requirements laid down by the Department of Health and Social Care (as the issuer of PDC), the dividend for the year is calculated on the actual average relevant net assets as set out in the "pre-audit" version of the annual accounts. The dividend 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 Climate change levy

Expenditure on the climate change levy is recognised in the Statement of Comprehensive Income as incurred, based on the prevailing chargeable rates for energy consumption.

Note 1.19 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 1.20 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 1.21 Early adoption of standards, amendments and interpretations

No new accounting standards or revisions to existing standards have been early adopted in 2023/24.

Note 1.22 Standards, amendments and interpretations in issue but not yet effective or adopted

IFRS 16 Leases – application of liability measurement principles to PFI and other service concession arrangements.

From 1 April 2023, the measurement principles of IFRS 16 will also be applied to the Trust's PFI liabilities where future payments are linked to RPI. 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. Such remeasurements will be recognised as a financing cost.

Under existing accounting practices, amounts relating to changes in the price index are expensed as incurred. Initial application of these principles will be on 1 April 2023 using a modified retrospective approach with the cumulative impact taken to reserves. This is expected to result in an increased PFI liability on the statement of financial position. The effect of this has not yet been quantified.

Other standards, amendments and interpretations

IFRS 17 Insurance Contracts is applied for accounting periods beginning on or after 1 January 2023. However, this has not yet been adopted by the FReM: early adoption is not therefore permitted.

Note 2 Operating Segments

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)	**2023/24 £000**	**2022/23 £000**
Mental health services		
Income from commissioners under API contracts*	222,551	208,056
Services delivered under a mental health collaborative	19,523	16,641
Clinical partnerships providing mandatory services (including S75 agreements)	1,815	1,889
All services		
Private patient income	148	115
National pay award central funding***	85	6,860
Additional pension contribution central funding**	7,715	7,009
Other clinical income	523	733
Total income from activities	**252,360**	**241,303**

*Aligned payment and incentive contracts are the main form of contracting between NHS providers and their commissioners. More information can be found in the 2023/25 NHS Payment Scheme documentation.

https://www.england.nhs.uk/pay-syst/nhs-payment-scheme/

**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.

*** Additional funding was made available by NHS England in 2023/24 and 2022/23 for implementing the backdated element of pay awards where government offers were made at the end of the financial year. 2023/24: In March 2024, the government announced a revised pay offer for consultants, reforming consultant pay scales with an effective date of 1 March 2024. Trade Unions representing consultant doctors accepted the offer in April 2024. 2022/23: In March 2023, the government made a pay offer for staff on agenda for change terms and conditions which was later confirmed in May 2023. The additional pay for 2022/23 was based on individuals in employment at 31 March 2023.

Note 3.2 Income from patient care activities (by source)

	2023/24	**2022/23**
Income from patient care activities received from:	**£000**	**£000**
NHS England	24,301	29,050
Clinical commissioning groups	-	45,655
Integrated care boards	206,049	147,220
Other NHS providers	20,768	18,147
Local authorities	571	383
Non-NHS: private patients	148	115
Non NHS: other	523	733
Total income from activities	**252,360**	**241,303**
Of which:		
Related to continuing operations	252,360	241,303
Related to discontinued operations	-	-

On 1st July 2022 Integrated Care Systems (ICSs) were legally established through the Health and Care Act 2022, and Clinical Commissioning Groups were closed down. Following the dissolution of Kent and Medway Clinical Commissioning Group the Trust's main commissioner is Kent and Medway Integrated Care Board.

Note 4 Other operating income

	2023/24			2022/23		
	Contract income	Non-contract income	Total	Contract income	Non-contract income	Total
	£000	£000	£000	£000	£000	£000
Research and development	686	-	**686**	696	-	**696**
Education and training	6,960	795	**7,755**	5,878	879	**6,757**
Non-patient care services to other bodies	8,591	-	**8,591**	7,816	-	**7,816**
Income in respect of employee benefits accounted on a gross basis	487	-	**487**	553	-	**553**
Receipt of capital grants and donations and peppercorn leases	-	186	**186**	-	-	**-**
Charitable and other contributions to expenditure	-	33	**33**	-	75	**75**
Revenue from operating leases	-	1,389	**1,389**	-	988	**988**
Other income	545	-	**545**	728	-	**728**
Total other operating income	**17,269**	**2,403**	**19,672**	**15,671**	**1,942**	**17,613**
Of which:						
Related to continuing operations			19,672			17,613
Related to discontinued operations			-			-

* In 2022/23 and 2023/24, 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 leases - Kent and Medway NHS and Social Care Partnership Trust as 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.

Note 5.1 Operating lease income

	2023/24	2022/23
	£000	£000
Lease receipts recognised as income in year:		
Minimum lease receipts	1,389	988
Total in-year operating lease income	**1,389**	**988**

Note 5.2 Future lease receipts

	31 March 2024	31 March 2023
	£000	£000
Future minimum lease receipts due in:		
- not later than one year	1,389	988
Total	**1,389**	**988**

Note 6.1 Operating expenses

	2023/24	2022/23
	£000	£000
Purchase of healthcare from NHS and DHSC bodies	1,611	7,382
Purchase of healthcare from non-NHS and non-DHSC bodies	4,669	5,087
Staff and executive directors costs	207,497	195,890
Remuneration of non-executive directors	178	146
Supplies and services - clinical (excluding drugs costs)	3,035	3,312
Supplies and services - general	4,585	4,401
Drug costs (drugs inventory consumed and purchase of non-inventory drugs)	3,768	3,337
Consultancy costs	113	219
Establishment	2,957	2,437
Premises	15,734	12,967
Transport (including patient travel)	4,154	3,186
Depreciation on property, plant and equipment	9,574	8,912
Amortisation on intangible assets	1,318	1,152
Net impairments	10,229	4,347
Movement in credit loss allowance: contract receivables / contract assets	(17)	(1)
(Decrease) / Increase in other provisions	(30)	38
Change in provisions discount rate(s)	(60)	(306)
Fees payable to the external auditor		
audit services- statutory audit	114	89
Internal audit costs	152	130
Clinical negligence	1,591	1,434
Legal fees	164	75
Insurance	183	202
Research and development	2	4
Education and training	2,123	2,073
Expenditure on short term leases	515	-
Expenditure on low value leases	23	119
Variable lease payments not included in the liability	-	200
Redundancy	267	56
Charges to operating expenditure for on-SoFP IFRIC 12 schemes (e.g. PFI / LIFT)	732	549
Car parking & security	172	224
Hospitality	4	12
Losses, ex gratia & special payments	45	7
Other	241	200
Total	**275,643**	**257,880**
Of which:		
Related to continuing operations	275,643	257,880
Related to discontinued operations	-	-

*Supplies and services - clinical includes £33k (2022/23: £75k) for utilisation of personal protective equipment consumables donated from DHSC for COVID response.

** The audit fees included within Note 6 above are reported as the gross position, the value excluding VAT for 2023/24 is £95k (2022/23 £74k).

Note 6.2 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 6.3 Limitation on auditor's liability

The limitation on auditor's liability for external audit work is £2 million (2022/23: £2 million).

Note 7 Impairment of assets

	2023/24	2022/23
	£000	£000
Net impairments charged to operating surplus / deficit resulting from:		
Abandonment of assets in course of construction	64	13
Changes in market price	10,165	4,334
Total net impairments charged to operating surplus / deficit	**10,229**	**4,347**
Impairments charged to the revaluation reserve	2,686	613
Total net impairments	**12,915**	**4,960**

The Trust completed a large multi year capital project in 2023/24, Ruby Ward, the valuation of this project resulted in a total impairment to operating expenditure of £8,301k.

Note 8 Employee benefits

	2023/24	2022/23
	Total	Total
	£000	£000
Salaries and wages	136,746	131,400
Social security costs	14,435	13,767
Apprenticeship levy	704	642
Employer's contributions to NHS pensions	25,363	23,064
Pension cost - other	69	61
Termination benefits	267	56
Temporary staff (including agency)	31,440	28,131
Total gross staff costs	**209,024**	**197,121**
Of which		
Costs capitalised as part of assets	1,260	1,175

Note 8.1 Retirements due to ill-health

During 2023/24 the trust agreed to 5 early retirements on the grounds of ill-health (4 in the year ended 31 March 2023). The estimated additional pension liabilities of these ill-health retirements is £265k (£113k in 2022/23).

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

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Note 9 Pension costs

Past and present employees are covered by the provisions of the 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 the 1995/2008 and 2015 schemes are accounted for, and the scheme liability valued, as a single combined scheme. 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 2024, is based on valuation data as 31 March 2023, updated to 31 March 2024 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 2020. The results of this valuation set the employer contribution rate payable from April 2024. The Department of Health and Social Care has recently laid Scheme Regulations confirming the employer contribution rate will increase to 23.7% of pensionable pay from 1 April 2024 (previously 20.6%). The core cost cap cost of the scheme was calculated to be outside of the 3% cost cap corridor as at 31 March 2020. However, when the wider economic situation was taken into account through the economic cost cap cost of the scheme, the cost cap corridor was not similarly breached. As a result, there was no impact on the member benefit structure or contribution rates.

Note 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:
https://www.nestpensions.org.uk/

Note 10 Finance income

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

	2023/24	2022/23
	£000	£000
Interest on bank accounts	1,081	571
Total finance income	**1,081**	**571**

Note 11 Finance expenditure

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

	2023/24	2022/23
	£000	£000
Interest expense:		
Interest on lease obligations	1,050	1,050
Finance costs on PFI, LIFT and other service concession arrangements:		
Main finance costs	929	507
Contingent finance costs*	-	813
Remeasurement of the liability resulting from change in index or rate*	1,757	-
Total interest expense	**3,736**	**2,370**
Unwinding of discount on provisions	37	25
Other finance costs	23	-
Total finance costs	**3,796**	**2,395**

* From 1 April 2023, IFRS 16 liability measurement principles are applied to PFI, LIFT and other service concession liabilities. Increases to imputed lease payments arising from inflationary uplifts are now included in the liability, and contingent rent no longer arises. More information is provided in Note 28.

Note 12 Other gains / (losses)

	2023/24	2022/23
	£000	£000
Gains on disposal of assets	21	-
Losses on disposal of assets	(179)	(1)
Total losses on disposal of assets	**(158)**	**(1)**
Fair value losses on investment properties	-	(90)
Total other losses	**(158)**	**(91)**

Note 13.1 Intangible assets - 2023/24

	Software licences	Internally generated information technology	Intangible assets under construction	Total
	£000	£000	£000	£000
Valuation / gross cost at 1 April 2023 - brought forward	**3,624**	**1,367**	**1,476**	**6,467**
Additions	441	176	841	**1,458**
Reclassifications	-	1,354	(1,354)	**-**
Disposals / derecognition	(652)	(76)	-	**(728)**
Valuation / gross cost at 31 March 2024	**3,413**	**2,821**	**963**	**7,197**
Amortisation at 1 April 2023 - brought forward	**1,974**	**713**	**-**	**2,687**
Provided during the year	860	458	-	**1,318**
Disposals / derecognition	(649)	(76)	-	**(725)**
Amortisation at 31 March 2024	**2,185**	**1,095**	**-**	**3,280**
Net book value at 31 March 2024	**1,228**	**1,726**	**963**	**3,917**
Net book value at 1 April 2023	**1,650**	**654**	**1,476**	**3,780**

Note 13.2 Intangible assets - 2022/23

	Software licences	Internally generated information technology	Intangible assets under construction	Total
	£000	£000	£000	£000
Valuation / gross cost at 1 April 2022 - as previously stated	**2,379**	**1,272**	**1,102**	**4,753**
Additions	308	95	602	**1,005**
Reclassifications	970	-	(228)	**742**
Disposals / derecognition	(33)	-	-	**(33)**
Valuation / gross cost at 31 March 2023	**3,624**	**1,367**	**1,476**	**6,467**
Amortisation at 1 April 2022 - as previously stated	**1,139**	**429**	**-**	**1,568**
Provided during the year	868	284	-	**1,152**
Disposals / derecognition	(33)	-	-	**(33)**
Amortisation at 31 March 2023	**1,974**	**713**	**-**	**2,687**
Net book value at 31 March 2023	**1,650**	**654**	**1,476**	**3,780**
Net book value at 1 April 2022	**1,240**	**843**	**1,102**	**3,185**

Note 14.1 Property, plant and equipment - 2023/24

	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 2023 - brought forward	**20,452**	**99,138**	**11,559**	**768**	**130**	**10,163**	**20**	**142,230**
Additions	-	9,743	1,012	180	-	297	109	**11,341**
Impairments	(165)	(12,501)	(64)	-	-	-	-	**(12,730)**
Reversals of impairments	257	209	-	-	-	-	-	**466**
Revaluations	2	(4,372)	-	-	-	-	-	**(4,370)**
Reclassifications	-	9,904	(10,799)	-	-	895	-	**-**
Disposals / derecognition	-	-	-	(43)	(61)	(1,637)	(7)	**(1,748)**
Valuation/gross cost at 31 March 2024	**20,546**	**102,121**	**1,708**	**905**	**69**	**9,718**	**122**	**135,189**
Accumulated depreciation at 1 April 2023 - brought forward	**-**	**1,952**	**-**	**627**	**130**	**4,307**	**11**	**7,027**
Provided during the year	-	5,309	-	63	-	1,995	2	**7,369**
Revaluations	-	(4,981)	-	-	-	-	-	**(4,981)**
Disposals / derecognition	-	-	-	(43)	(61)	(1,461)	(7)	**(1,572)**
Accumulated depreciation at 31 March 2024	**-**	**2,280**	**-**	**647**	**69**	**4,841**	**6**	**7,843**
Net book value at 31 March 2024	**20,546**	**99,841**	**1,708**	**258**	**-**	**4,877**	**116**	**127,346**
Net book value at 1 April 2023	**20,452**	**97,186**	**11,559**	**141**	**-**	**5,856**	**9**	**135,203**

Note 14.2 Property, plant and equipment - 2022/23

	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 2022 - as previously stated	**20,519**	**104,895**	**8,103**	**787**	**130**	**7,478**	**11**	**141,923**
IFRS 16 implementation - reclassification of existing finance leased assets to right of use assets	-	(14,376)	-	-	-	-	-	**(14,376)**
Additions	-	8,252	8,625	29	-	2,221	9	**19,136**
Impairments	(141)	(3,023)	(13)	-	-	-	-	**(3,177)**
Reversals of impairments	52	992	-	-	-	-	-	**1,044**
Revaluations	22	(1,009)	-	-	-	-	-	**(987)**
Reclassifications	-	3,407	(5,156)	-	-	1,007	-	**(742)**
Disposals / derecognition	-	-	-	(48)	-	(543)	-	**(591)**
Valuation/gross cost at 31 March 2023	**20,452**	**99,138**	**11,559**	**768**	**130**	**10,163**	**20**	**142,230**
Accumulated depreciation at 1 April 2022 - as previously stated	**-**	**4,027**	**-**	**603**	**130**	**3,442**	**11**	**8,213**
Prior period adjustments	-	-	-	-	-	-	-	**-**
Accumulated depreciation at 1 April 2022 - restated	**-**	**4,027**	**-**	**603**	**130**	**3,442**	**11**	**8,213**
IFRS 16 implementation - reclassification of existing finance leased assets to right of use assets	-	(2,558)	-	-	-	-	-	**(2,558)**
Provided during the year	-	5,070	-	72	-	1,407	-	**6,549**
Revaluations	-	(4,587)	-	-	-	-	-	**(4,587)**
Disposals / derecognition	-	-	-	(48)	-	(542)	-	**(590)**
Accumulated depreciation at 31 March 2023	**-**	**1,952**	**-**	**627**	**130**	**4,307**	**11**	**7,027**
Net book value at 31 March 2023	**20,452**	**97,186**	**11,559**	**141**	**-**	**5,856**	**9**	**135,203**
Net book value at 1 April 2022	**20,519**	**100,868**	**8,103**	**184**	**-**	**4,036**	**-**	**133,710**

Note 14.3 Property, plant and equipment financing - 31 March 2024

	Land	Buildings excluding dwellings	Assets under construction	Plant & machinery	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000
Owned - purchased	20,546	84,570	1,708	258	4,877	116	**112,075**
On-SoFP PFI contracts and other service concession arrangements	-	15,271	-	-	-	-	**15,271**
Total net book value at 31 March 2024	**20,546**	**99,841**	**1,708**	**258**	**4,877**	**116**	**127,346**

Note 14.4 Property, plant and equipment financing - 31 March 2023

	Land	Buildings excluding dwellings	Assets under construction	Plant & machinery	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000
Owned - purchased	20,452	81,123	11,559	141	5,856	9	**119,140**
On-SoFP PFI contracts and other service concession arrangements	-	16,063	-	-	-	-	**16,063**
Total net book value at 31 March 2023	**20,452**	**97,186**	**11,559**	**141**	**5,856**	**9**	**135,203**

Note 15 Revaluation of property, plant and equipment

Montagu Evans LLP is a member of the Royal Institution of Chartered Surveyors (RICS) and is independent of the Trust.

Montagu Evans LLP completed a desktop valuation of the Trust's land and buildings as at 31st March 2024. The last full valuation was undertaken by Montagu Evans LLP as at 31st March 2020.

The valuations were prepared in accordance with International Financial Reporting Standards (IFRS) as adopted in HM Treasury's Financial Reporting Manual (FReM), together with the Department of Health and Social Care's Group Accounting Manual (GAM) which provides guidance for those DHSC group bodies that have a statutory requirement to produce an annual report and accounts following the end of the financial year.

FReM and GAM require the statement of assets at Fair Value and should be valued using the appropriate valuation methodology. In determining the relevant methodology, Montagu Evans LLP have relied on the RICS Valuation - Global Standards 2021 (effective January 2022) and the RICS Valuation – Global Standards 2017 – UK National Supplement (effective January 2019) which are collectively referred to as the "RICS Red Book" and form the basis for the valuation methodology in respect of the Trust's assets being valued. 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 capital expenditure undertaken between valuations, the age and condition of the properties, changes to the RICS Build Cost Information Service (BCIS) construction data, build costs and location factors when assessing value attributable to each asset. The valuation exercise was carried out in March 2024 with a valuation date of 31st March 2024.

Overall the valuation has contributed to net downward movement of £12,123k of which £10,229k was taken to the Statement of Comprehensive Income and £1,894k taken to the revaluation reserve.

The Trust completed The Ruby Ward in 2023/24 which contributed to £8,141k of the total downward movement.

Note 16 Leases - Kent and Medway NHS and Social Care Partnership Trust as a lessee

This note details information about leases for which the Trust is a 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.

Note 16.1 Right of use assets - 2023/24

	Property (land and buildings) £000	Plant & machinery £000	Transport equipment £000	Total £000	Of which: leased from DHSC group bodies £000
Valuation / gross cost at 1 April 2023 - brought forward	**35,289**	**14**	**90**	**35,393**	**10,484**
Additions	4,345	-	60	**4,405**	-
Remeasurements of the lease liability	3,588	-	(1)	**3,587**	3,121
Impairments	(651)	-	-	**(651)**	-
Revaluations	181	-	-	**181**	-
Disposals / derecognition	(577)	-	-	**(577)**	(536)
Valuation/gross cost at 31 March 2024	**42,175**	**14**	**149**	**42,338**	**13,069**
Accumulated depreciation at 1 April 2023 - brought forward	**4,883**	**13**	**25**	**4,921**	**839**
Provided during the year	2,156	1	48	**2,205**	573
Disposals / derecognition	(290)	-	-	**(290)**	(266)
Accumulated depreciation at 31 March 2024	**6,749**	**14**	**73**	**6,836**	**1,146**
Net book value at 31 March 2024	**35,426**	**-**	**76**	**35,502**	**11,923**
Net book value at 1 April 2023	**30,406**	**1**	**65**	**30,472**	**9,645**

Net book value of right of use assets leased from other NHS providers	9,465
Net book value of right of use assets leased from other DHSC group bodies	2,458

Note 16.2 Right of use assets - 2022/23

	Property (land and buildings) £000	Plant & machinery £000	Transport equipment £000	Total £000	Of which: leased from DHSC group bodies £000
Valuation / gross cost at 1 April 2022 - brought forward	**-**	**-**	**-**	**-**	**-**
IFRS 16 implementation - reclassification of existing finance leased assets from PPE or intangible assets	14,376	-	-	**14,376**	-
IFRS 16 implementation - adjustments for existing operating leases / subleases	19,100	14	45	**19,159**	10,484
Additions	-	-	45	**45**	-
Remeasurements of the lease liability	4,640	-	-	**4,640**	-
Impairments	(4,640)	-	-	**(4,640)**	-
Reversal of impairments	1,813	-	-	**1,813**	-
Valuation/gross cost at 31 March 2023	**35,289**	**14**	**90**	**35,393**	**10,484**
Accumulated depreciation at 1 April 2022 - brought forward	-	-	-	**-**	-
IFRS 16 implementation - reclassification of existing finance leased assets from PPE or intangible assets	2,558	-	-	**2,558**	-
Provided during the year	2,325	13	25	**2,363**	839
Accumulated depreciation at 31 March 2023	**4,883**	**13**	**25**	**4,921**	**839**
Net book value at 31 March 2023	**30,406**	**1**	**65**	**30,472**	**9,645**
Net book value at 1 April 2022	**-**	**-**	**-**	**-**	**-**

Net book value of right of use assets leased from other NHS providers	7,182
Net book value of right of use assets leased from other DHSC group bodies	2,463

Note 16.3 Reconciliation of the carrying value of lease liabilities

Lease liabilities are included within borrowings in the statement of financial position. A breakdown of borrowings is disclosed in note 23.1.

	2023/24 £000	2022/23 £000
Carrying value at 31 March	**28,632**	**6,826**
IFRS 16 implementation - adjustments for existing operating leases	-	19,104
Lease additions	4,405	45
Lease liability remeasurements	3,587	4,640
Interest charge arising in year	1,050	1,050
Early terminations	(289)	-
Lease payments (cash outflows)	(3,079)	(3,033)
Carrying value at 31 March	**34,306**	**28,632**

Lease payments for short term leases, leases of low value underlying assets and variable lease payments not dependent on an index or rate are recognised in operating expenditure.

These payments are disclosed in Note 6.1. Cash outflows in respect of leases recognised on-SoFP are disclosed in the reconciliation above.

Note 16.4 Maturity analysis of future lease payments

	Total 31 March 2024 £000	Of which leased from DHSC group bodies: 31 March 2024 £000	Total 31 March 2023 £000	Of which leased from DHSC group bodies: 31 March 2023 £000
Undiscounted future lease payments payable in:				
- not later than one year;	2,788	702	3,045	891
- later than one year and not later than five years;	16,868	1,729	17,894	2,161
- later than five years.	19,610	11,358	11,037	7,774
Total gross future lease payments	**39,266**	**13,789**	**31,976**	**10,826**
Finance charges allocated to future periods	(4,960)	(1,891)	(3,344)	(1,136)
Net lease liabilities at 31 March 2024	**34,306**	**11,898**	**28,632**	**9,690**
Of which:				
Leased from other NHS providers		9,447		7,216
Leased from other DHSC group bodies		2,451		2,474

Note 17 Investment Property

	2023/24 £000	2022/23 £000
Carrying value at 1 April - brought forward	**2,201**	**2,268**
Acquisitions in year	-	23
Movement in fair value	-	(90)
Carrying value at 31 March	**2,201**	**2,201**

Note 18 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 2023/24 the Trust received £33k of items purchased by DHSC (2022/23: £75k).

These inventories were recognised as additions to inventory at deemed cost with the corresponding benefit recognised in income. The utilisation of these items is included in the expenses disclosed above.

Note 19.1 Receivables

	31 March 2024	31 March 2023
	£000	£000
Current		
Contract receivables	1,910	7,863
Allowance for impaired contract receivables / assets	(95)	(120)
Prepayments (non-PFI)	1,650	1,624
PDC dividend receivable	387	394
VAT receivable	1,697	1,567
Other receivables	121	119
Total current receivables	**5,670**	**11,447**
Non-current		
Prepayments (non-PFI)	53	42
Other receivables	236	354
Total non-current receivables	**289**	**396**
Of which receivable from NHS and DHSC group bodies:		
Current	1,509	7,958
Non-current	224	271

The majority of the Trust's contract receivables are with NHS England or Integrated Commissioning Boards (ICBs) as commissioners for NHS patient care services. As they are funded by Government to buy NHS patient care services, no credit scoring of them is considered necessary.

Note 19.2 Allowances for credit losses

	2023/24	2022/23
	Contract receivables and contract assets	Contract receivables and contract assets
	£000	£000
Allowances as at 1 April - brought forward	**120**	**128**
New allowances arising	31	44
Reversals of allowances	(48)	(45)
Utilisation of allowances (write offs)	(8)	(7)
Allowances as at 31 Mar 2024	**95**	**120**

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.

	2023/24	2022/23
	£000	£000
At 1 April	**19,685**	**20,077**
Net change in year	(2,286)	(392)
At 31 March	**17,399**	**19,685**
Broken down into:		
Cash at commercial banks and in hand	31	29
Cash with the Government Banking Service	17,368	19,656
Total cash and cash equivalents as in SoFP	**17,399**	**19,685**
Total cash and cash equivalents as in SoCF	**17,399**	**19,685**

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 2024	31 March 2023
	£000	£000
Bank balances	112	143
Total third party assets	**112**	**143**

Note 21 Trade and other payables

	31 March 2024	31 March 2023
	£000	£000
Current		
Trade payables	6,767	5,710
Capital payables	919	4,189
Accruals	9,747	16,409
Social security costs	1,803	1,730
Other taxes payable	1,788	1,620
Pension contributions payable	2,499	2,284
Other payables	21	17
Total current trade and other payables	**23,544**	**31,959**
Of which payables from NHS and DHSC group bodies:		
Current	3,829	2,916

Note 22 Other liabilities

	31 March 2024	31 March 2023
	£000	£000
Current		
Deferred income: contract liabilities	981	828
Total other current liabilities	**981**	**828**

Note 23.1 Borrowings

	31 March 2024	31 March 2023
	£000	£000
Current		
Lease liabilities	1,802	1,984
Obligations under PFI, LIFT or other service concession contracts	979	516
Total current borrowings	**2,781**	**2,500**
Non-current		
Lease liabilities	32,504	26,648
Obligations under PFI, LIFT or other service concession contracts	12,466	6,866
Total non-current borrowings	**44,970**	**33,514**

Note 23.2 Reconciliation of liabilities arising from financing activities

	Lease Liabilities	PFI and LIFT schemes	Total
	£000	£000	£000
Carrying value at 1 April 2023	**28,632**	**7,382**	**36,014**
Cash movements:			
Financing cash flows - payments and receipts of principal	(2,025)	(1,011)	**(3,036)**
Financing cash flows - payments of interest	(1,054)	(927)	**(1,981)**
Non-cash movements:			
Application of IFRS 16 measurement principles to PFI liability on 1 April 2023	-	5,315	**5,315**
Additions	4,405	-	**4,405**
Lease liability remeasurements	3,587	-	**3,587**
Remeasurement of PFI / other service concession liability resulting from change in index or rate	-	1,757	**1,757**
Application of effective interest rate	1,050	929	**1,979**
Early terminations	(289)	-	**(289)**
Carrying value at 31 March 2024	**34,306**	**13,445**	**47,751**

	Lease Liabilities	PFI and LIFT schemes	Total
	£000	£000	£000
Carrying value at 1 April 2022	**6,826**	**7,874**	**14,700**
Cash movements:			
Financing cash flows - payments and receipts of principal	(1,983)	(492)	**(2,475)**
Financing cash flows - payments of interest	(1,050)	(507)	**(1,557)**
Non-cash movements:			
Impact of implementing IFRS 16 on 1 April 2022	19,104	-	**19,104**
Additions	45	-	**45**
Lease liability remeasurements	4,640	-	**4,640**
Application of effective interest rate	1,050	507	**1,557**
Carrying value at 31 March 2023	**28,632**	**7,382**	**36,014**

Note 24.1 Provisions for liabilities and charges analysis

	Pensions: early departure costs	Pensions: injury benefits	Legal claims	Other	Total
	£000	£000	£000	£000	£000
At 1 April 2023	**-**	**1,223**	**281**	**3,367**	**4,871**
Change in the discount rate	-	(60)	-	(51)	**(111)**
Arising during the year	-	109	257	-	**366**
Utilised during the year	-	(132)	(23)	(5)	**(160)**
Reversed unused	-	(6)	(235)	(197)	**(438)**
Unwinding of discount	-	37	-	15	**52**
At 31 March 2024	**-**	**1,171**	**280**	**3,129**	**4,580**
Expected timing of cash flows:					
- not later than one year;	-	133	280	1,847	**2,260**
- later than one year and not later than five years;	-	530	-	1,083	**1,613**
- later than five years.	-	508	-	199	**707**
Total	**-**	**1,171**	**280**	**3,129**	**4,580**

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 £2,983k (2022/23 £3,085k) and the clinicians pension provision.

Note 24.2 Clinical negligence liabilities

At 31 March 2024, £5,388k 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 2023: £11,353k).

Note 25 Contingent assets and liabilities

	31 March 2024	31 March 2023
	£000	£000
Value of contingent liabilities		
Other	(413)	(413)
Gross value of contingent liabilities	**(413)**	**(413)**
Amounts recoverable against liabilities	-	-
Net value of contingent liabilities	**(413)**	**(413)**
Net value of contingent assets	**-**	**-**

Contingent liabilities relate to dilapidation costs for future years.

Note 26 Contractual capital commitments

	31 March 2024	31 March 2023
	£000	£000
Property, plant and equipment	3,882	5,910
Total	**3,882**	**5,910**

Note 27 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.

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

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

Note 27.1 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:

	31 March 2024	31 March 2023
	£000	£000
Gross PFI, LIFT or other service concession liabilities	**19,872**	**11,136**
Of which liabilities are due		
- not later than one year;	1,842	990
- later than one year and not later than five years;	6,294	3,282
- later than five years.	11,736	6,864
Finance charges allocated to future periods	(6,427)	(3,754)
Net PFI, LIFT or other service concession arrangement obligation	**13,445**	**7,382**
- not later than one year;	979	516
- later than one year and not later than five years;	3,346	1,668
- later than five years.	9,120	5,198

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

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

	31 March 2024	31 March 2023
	£000	£000
Total future payments committed in respect of the PFI, LIFT or other service concession arrangements	**34,178**	**34,027**
Of which payments are due:		
- not later than one year;	2,734	2,522
- later than one year and not later than five years;	10,937	9,043
- later than five years.	20,507	22,462

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Note 27.3 Analysis of amounts payable to service concession operator

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

	2023/24	2022/23
	£000	£000
Unitary payment payable to service concession operator	**2,672**	**2,361**
Consisting of:		
- Interest charge	929	507
- Repayment of balance sheet obligation	1,011	492
- Service element and other charges to operating expenditure	732	549
- Contingent rent	-	813
Total amount paid to service concession operator	**2,672**	**2,361**

Note 28 Impact of change in accounting policy for on-SoFP PFI, LIFT and other service concession liabilities

IFRS 16 liability measurement principles have been applied to PFI, LIFT and other service concession arrangement liabilities from 1 April 2023. When payments for the asset are uplifted for inflation, the imputed lease liability recognised on the SoFP is remeasured to reflect the increase in future payments. Such increases were previously recognised as contingent rent as incurred.

The change in measurement basis has been applied retrospectively without restatement of comparatives and with the cumulative impact on 1 April 2023 recognised in the income and expenditure reserve. The incremental impact of applying the new accounting policy on (a) the allocation of the unitary charge in 2023/24 and (b) the primary statements in 2023/24 is set out in the disclosures below.

Note 28.1 Impact of change in accounting policy on the allocation of unitary payment

	IFRS 16 basis (new basis) 2023/24	IAS 17 basis (old basis) 2023/24	Impact of change 2023/24
	£000	£000	£000
Unitary payment payable to service concession operator	**2,672**	**2,672**	**-**
Consisting of:			
- Interest charge	929	453	**476**
- Repayment of balance sheet obligation	1,011	967	**44**
- Service element	732	732	**-**
- Contingent rent	-	520	**(520)**

Note 28.2 Impact of change in accounting policy on primary statements

Impact of change in PFI accounting policy on 31 March 2024 Statement of Financial Position:	**£000**
Increase in PFI / LIFT and other service concession liabilities	(7,028)
Decrease in PDC dividend payable / increase in PDC dividend receivable	116
Impact on net assets as at 31 March 2024	**(6,912)**

Impact of change in PFI accounting policy on 2023/24 Statement of Comprehensive Income:	**£000**
PFI liability remeasurement charged to finance costs	(1,757)
Increase in interest arising on PFI liability	(476)
Reduction in contingent rent	520
Reduction in PDC dividend charge	116
Net impact on deficit	**(1,597)**

Impact of change in PFI accounting policy on 2023/24 Statement of Changes in Equity:	**£000**
Adjustment to reserves for the cumulative retrospective impact on 1 April 2023	(5,315)
Net impact on 2023/24 deficit	(1,597)
Impact on equity as at 31 March 2024	**(6,912)**

Impact of change in PFI accounting policy on 2023/24 Statement of Cash Flows:	**£000**
Increase in cash outflows for capital element of PFI / LIFT	(44)
Decrease in cash outflows for financing element of PFI / LIFT	44
Net impact on cash flows from financing activities	**-**

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 ICBs and the way those ICBs 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. 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 2023 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 Integrated Commissioning Boards (ICBs), 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 2024	Held at amortised cost	Total book value
	£000	£000
Trade and other receivables excluding non financial assets	2,172	**2,172**
Cash and cash equivalents	17,399	**17,399**
Total at 31 March 2024	**19,571**	**19,571**

Carrying values of financial assets as at 31 March 2023	Held at amortised cost	Total book value
	£000	£000
Trade and other receivables excluding non financial assets	8,216	**8,216**
Cash and cash equivalents	19,685	**19,685**
Total at 31 March 2023	**27,901**	**27,901**

Note 29.3 Carrying values of financial liabilities

Carrying values of financial liabilities as at 31 March 2024	Held at amortised cost	Total book value
	£000	£000
Obligations under leases	34,306	**34,306**
Obligations under PFI, LIFT and other service concession contracts	13,445	**13,445**
Trade and other payables excluding non financial liabilities	18,808	**18,808**
Clinical pension provision	199	**199**
Total at 31 March 2024	**66,758**	**66,758**

The above figure for Trade and other payables excludes liabilities for Social security costs, Other taxes payable and Other payables (£6,111k) as these are defined as non financial liabilities.

Carrying values of financial liabilities as at 31 March 2023	Held at amortised cost	Total book value
	£000	£000
Obligations under leases	28,632	**28,632**
Obligations under PFI, LIFT and other service concession contracts	7,382	**7,382**
Trade and other payables excluding non financial liabilities	25,166	**25,166**
Clinical pension provision	282	**282**
Total at 31 March 2023	**61,462**	**61,462**

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 2024	31 March 2023
	£000	£000
In one year or less	23,637	29,483
In more than one year but not more than five years	23,162	21,176
In more than five years	31,346	17,901
Total	**78,145**	**68,560**

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.
This is because all of the trust's financial assets and 30% of the financial liabilities are due within one year or less.
The remaining 70% of financial liabilities relate to leases for right of use assets and the trust's PFI which are subject to regular rent reviews.

Note 30 Losses and special payments

	2023/24		2022/23	
	Total number of cases	Total value of cases	Total number of cases	Total value of cases
	Number	£000	Number	£000
Losses				
Cash losses	35	26	26	7
Bad debts and claims abandoned	14	4	1	2
Total losses	**49**	**30**	**27**	**9**
Special payments				
Ex-gratia payments	17	45	20	7
Total special payments	**17**	**45**	**20**	**7**
Total losses and special payments	**66**	**75**	**47**	**16**

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:

Related Party Income	Related Party Expenditure
Kent Community Health NHS Foundation Trust	NHS Pensions Scheme
Sussex Partnership NHS Foundation Trust	NHS Resolution
NHS Kent and Medway ICB	
NHS England (including CSUs)	
Department of Health and Social Care	

Note 32 Events after the reporting date

There have been no material events after the reporting date

Note 33 Better Payment Practice code

	2023/24 Number	2023/24 £000	2022/23 Number	2022/23 £000
Non-NHS Payables				
Total non-NHS trade invoices paid in the year	13,347	91,262	13,958	84,678
Total non-NHS trade invoices paid within target	12,312	88,938	12,748	78,928
Percentage of non-NHS trade invoices paid within target	92.2%	97.5%	91.3%	93.2%
NHS Payables				
Total NHS trade invoices paid in the year	1,276	7,489	1,183	13,180
Total NHS trade invoices paid within target	1,223	7,121	1,109	12,620
Percentage of NHS trade invoices paid within target	95.8%	95.1%	93.7%	95.8%

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 34 External financing limit

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

	2023/24	2022/23
	£000	£000
Cash flow financing	2,332	5,788
Leases taken out in year	-	-
Other capital receipts	-	-
External financing requirement	**2,332**	**5,788**
External financing limit (EFL)	2,397	5,788
Under / (over) spend against EFL	**65**	**-**

Note 35 Capital Resource Limit

	2023/24	2022/23
	£000	£000
Gross capital expenditure	20,791	24,849
Less: Disposals	(466)	(1)
Less: Donated and granted capital additions	(186)	-
Charge against Capital Resource Limit	**20,139**	**24,848**
Capital Resource Limit	20,204	24,848
Under / (over) spend against CRL	**65**	**-**

Note 36 Breakeven duty financial performance

	2023/24
	£000
Adjusted financial performance surplus (control total basis)	1,043
Remove impairments scoring to Departmental Expenditure Limit	64
Add back incremental impact of IFRS 16 on PFI revenue costs in 2023/24	(977)
IFRIC 12 breakeven adjustment	1,455
Breakeven duty financial performance surplus	**1,585**

Note 37 Breakeven duty rolling assessment

	2008/09	2009/10	2010/11	2011/12	2012/13	2013/14	2014/15	2015/16
	£000	£000	£000	£000	£000	£000	£000	£000
Breakeven duty in-year financial performance		1,524	13	538	1,202	1,607	902	(4,180)
Breakeven duty cumulative position	2,376	3,900	3,913	4,451	5,653	7,260	8,162	3,982
Operating income		182,374	182,204	178,468	172,902	174,924	178,674	181,334
Cumulative breakeven position as a percentage of operating income		2.1%	2.1%	2.5%	3.3%	4.2%	4.6%	2.2%

	2016/17	2017/18	2018/19	2019/20	2020/21	2021/22	2022/23	2023/24
	£000	£000	£000	£000	£000	£000	£000	£000
Breakeven duty in-year financial performance	(3,311)	(1,224)	3,963	4,627	668	(4,388)	280	1,585
Breakeven duty cumulative position	671	(553)	3,410	8,037	8,705	4,317	4,597	6,182
Operating income	183,103	181,034	185,085	202,403	220,039	231,746	258,916	272,032
Cumulative breakeven position as a percentage of operating income	0.4%	(0.3%)	1.8%	4.0%	4.0%	1.9%	1.8%	2.3%