NHS
Kent and Medway
NHS and Social Care Partnership Trust

Annual Report 24–25

2024–2025 at a glance

33.5% of dementia patients diagnosed within 6 weeks (up from just under 8%)

90% of staff using new app-based intranet within first 6 months

90% of mental health patients in acute hospitals triaged within 1 hour by liaison psychiatry (up from 30%)

Mental Health Together & Mental Health Together Plus rolled out across Kent & Medway. Nearly **24,000** people supported

RCPsych perinatal accreditation

(only 50% of mother and baby units in England accredited); leading South East perinatal provider collaborative

18 permanent consultants appointed so patients get quicker access to support

5 Innovation Den winners with projects to improve patient and staff well-being

Electric vehicle charging at **3** main sites; **75%** carbon reduction in Hydrotreated Vegetable Oil generator trial; & **430** trees planted

10,000 research participants reached; research community nearly doubled to 374

2 new safe havens opened; **10** available across county; **200+** people supported by first Recovery House

Increased engagement with NHS staff survey, **55%** of staff responded (above national average for mental health trusts using same company as us) particularly from black and minority ethnic staff where engagement score rose

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CEO's statement

I am continually inspired by the dedication of our people, who work tirelessly to care for our patients. Thank you for everything you have done this year.

On the day I became CEO, I said that our patients would be at the heart of every decision I made. I have spent significant time with them, our people and our partners to understand what we are doing well and where we can improve, as part of this. Investing in our staff, and relationships with our partners, as well as strengthening the involvement of patients, their loved ones and carers in how we develop both the trust, and its services, is absolutely key to doing that.

This year, we've built a solid foundation for future growth, even as we've faced unprecedented demand. I want to acknowledge the way our teams have risen to this challenge and I'm excited about the year ahead and the opportunity to put our new improvement model 'Doing Well Together' into action. It will empower more staff to help deliver board to ward improvements.

Thanks to new and innovative ways of working, we've made our wards safer, reducing violence and aggression. We've also made significant strides in creating a welcoming and inclusive environment for everyone. I spend a lot of time with our staff and I'm proud of our diverse workforce. I've heard first-hand about the challenges they face, and how distressing that can be. I'm pleased our work to promote inclusivity has grown significantly. Our monthly meetings with staff on Equality, Diversity, and Inclusivity (EDI) are well-attended, fostering open conversations and positive change. Our award-winning EDI action plan is also making a real difference. However, we know we have more to do.

We've made progress with our partners on transforming community care through the Mental Health Together service. Within a short time of taking on the lead provider role we'd enacted key phases of its introduction; a vital step towards people getting the full range of support needed, without navigating multiple organisations. This has been a huge change for our staff and to fully implement transition of this magnitude we must make sure we learn and improve for the future. I have made a commitment to our staff that we will take learning from the implementation of Mental Health Together forward into the coming year.

I'm also proud to see the Kent and Medway Provider Collaborative deliver important improvements, particularly in supporting autistic people to be discharged from mental health hospitals into more independent settings, and developing a better dementia model for neurodivergent people.

We've worked hard to strengthen our culture, creating a new identity that reflects our commitment to improving the lives of our communities, which we will launch next financial year. In doing so, we listened to what matters to people, and our new identity reflects those conversations. While we plan to change our name next year, pending approval, this work is about so much more than that; it's about transforming how we work together, how it feels for patients and their loved ones to receive our support and the experience other organisations have partnering with us. To help with this we have also adopted four new trust values: Caring, Inclusive, Curious and Confident.

I also want to celebrate the fantastic achievements of many of our staff and teams. They've won prestigious awards and been finalists for many others, and I am proud to say there are too many to list here! Our monthly Values in Practice awards (which have received 783 nominations since they launched in May) and our first NHS Long Service Awards have highlighted incredible work that might otherwise not have be recognised, and given us an opportunity to celebrate. I knew so many people at the Long Service Awards, and it was a joy to honour that dedication with them.

Finally, I want to address the upcoming changes to the NHS. I know there are colleagues across the NHS who are personally affected and I empathise with how hard it must feel for them. But, at the same time, I also strongly believe it offers positive opportunities, which we must embrace with our patients at the forefront of our minds. We have managed our finances well again this year, and this puts us in a strong position to respond. As part of this we will be looking at the growth in our 'back office' costs since the pandemic, as requested, and will do so in an open and transparent way with our staff.

I am pleased that this annual report allows us to reflect on our collective achievements, and delighted to share them with the communities we serve. I look forward to leading the trust's important work next year.

Sheila Stenson
Chief Executive

> Thanks to new and innovative ways of working, we've made our wards safer, reducing violence and aggression.

Caring | Inclusive | Curious | Confident

Chair's statement

As I reflect on the past year, particularly the pressures currently facing the whole of the NHS, I am so grateful for the dedication of our staff. On behalf of the entire Board, I extend our sincere thanks for their efforts in supporting our patients and each other.

It was a delight to spend time with our longest-serving staff members at our first celebration recognising full NHS service. I could not believe that in one room we were celebrating over 2,800 years of care. What an achievement!

I am pleased to report that KMPT has concluded another year in a sound financial position, generating a surplus. This achievement, amidst the ever-growing demand for our services, is a testament to our collective commitment to responsible financial management. We will continue to prioritise maintaining this financial stability, ensuring we can invest in the services our community needs.

This year marked Sheila's first full year as our Chief Executive, and I want to recognise her leadership which has been instrumental in driving significant improvements. These include the reduction in violence and aggression on our wards and the implementation of zonal observations. Both these initiatives have been warmly received by our staff and also provide a much better experience for our service users.

We have seen encouraging developments in other key areas, with particular success reducing wait time for dementia diagnoses, and in developing a new trust identity that will help deliver a true step change in the trust's culture and patient care. The Board also commends the progress made on our inclusivity agenda. We recognise that cultural change is an ongoing journey, and we remain committed to fostering an inclusive and equitable environment for all.

There have been challenges, not least the exceptional demand for our beds and other services. While we have not made the progress we wanted against the three-year target for bed occupancy, substantial effort has been invested in making sure every day a patient spends with us is valuable, by which I mean we were able to offer meaningful clinical or therapeutic interventions to help them.

> I am pleased to report that KMPT has concluded another year in a sound financial position, generating a surplus.

The Board is focused on the work already underway to develop a longer-term, sustainable approach to patient flow, including innovating in how we collaborate with the wider health and social care system to help people who are clinically ready for discharge, but still in our psychiatric beds. Indeed, as we enter the final year of our three year strategy, the Board and I will be keen to see further momentum against all strategic priorities to meet our final targets.

Partnership is extremely important to us, and we have actively engaged with a range of core partners to influence and improve mental health care in our region. This includes the strengthening of our partnership with Kent Police, following the effective implementation of the "Right Care, Right Person" initiative. I would also like to thank our voluntary sector partners who have been crucial in the development of exciting new services for people who are in crisis.

Finally, I would also like to acknowledge Dr Asif Bachlani, our former Non-Executive Director, who departed in September, being awarded Psychiatrist of the Year by the Royal College of Psychiatrists. This is a prestigious achievement and the second time, in four years, that a member of KMPT has received this honour.

I would like to extend a final word of thanks to all those who work to make the trust a thriving and caring organisation. I am greatly looking forward to next year.

Dr Jackie Craissati
Chair

> Partnership is extremely important to us, and we have actively engaged with a range of core partners to influence and improve mental health care in our region.

Overview

Overall, the annual report is designed to give a balanced view of the trust, share our achievements and report against the required key benchmarks.

This section called the Performance Report, provides key information and outlines the progress made against our strategy in 2024-25. It will help you understand the organisation, our purpose, and how we have performed during the year.

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 more than 59,000 people in the community. We are proud to have a workforce of over 3,900 people from 76 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 2024 to 2025

This was the second year of a new three-year strategy established to help us provide outstanding care and work in partnership to deliver this in the right place, for every service user, every time.

To achieve this, we 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.

To guide our work in 2024/25, our newly appointed CEO set 6 organisational priorities. These were:

- Improving patient flow
- Reducing violence and aggression on our wards
- Transforming community mental health care
- Reducing wait times for dementia assessments
- Improving our culture, identity and staff experience
- Getting the basics right

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 | Working Together | Open | Innovative | Accountable | 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 want to bring all our services in line with the highest standards, create a culture where we continually improve, and better 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, responding to increased demand for our services, cutting the time people spend on dementia waiting lists, and providing more holistic care that focuses on the full spectrum of each person's needs.

One of our priorities was to address demands for our beds, called patient flow, and this year we have got to the heart of key issues and begun new work to address them. We are working even more closely with partners on the high number of people who are clinically ready for discharge, but still in our beds as they have nowhere suitable to go, and are taking a fresh look at how we reduce avoidable readmissions as well as making sure every day a patient spends in one of our beds is purposeful. We have started exploring new ways to solve these challenges with our social care colleagues as we recognise that we cannot do this alone, and will continue this into the next financial year.

There are more details later about how we have transformed community services to wrap around our patients and give them better joined up care for all aspects of life affecting their mental health. Another important innovation in our community work has been embedding pharmacy staff in every community team. They now work with them, hand in hand, providing stronger support for safe and effective prescriptions and reducing wait times for medication reviews.

> I am pleased to report that KMPT has concluded another year in a sound financial position, generating a surplus.

The 2 case studies below give greater detail about core work to improve our care.

CASE STUDY 1

Cutting dementia wait lists

Lengthy waits for dementia assessments have been a serious issue country-wide, which we have been seeing here in Kent and Medway too. Although we overcame the backlog caused by the pandemic, the number of people referred for assessment since then has been unprecedented, meaning people are still waiting too long to get help.

While system-wide improvements, like GP training and accreditation to carry out dementia assessments, are underway, we needed further action to have the positive impact we wanted to see. We launched the Standalone Memory Assessment Service (MAS) last summer. It standardises our triage and assessment processes, protects staff time to carry them out, and increases the number of people available to do this work.

We have seen encouraging results since, with 1 in 3 patients across the trust now being diagnosed within 6 weeks (the Government standard), compared to just under 8% before. And we know it has the potential to make even bigger improvements. Colleagues in our North Kent directorate have been trialling new ways of working with our MAS model, resulting in an impressive 77% of their patients now being diagnosed within 6 weeks, and in some weeks have been achieving 100%, inspiring wider adoption of their methods across our services. We are determined this will significantly reduce dementia waiting lists county-wide.

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Many of my patients have shared that the swiftness in being provided an appointment for them or their loved one has revived their hope in the NHS. This has also helped me to move them on in their journey of care, as they are reassured that if they need to be referred back to the service the wait would not be long.”

Dr Sheeba Hakeem, Consultant Psychiatrist and Head of Psychiatry (North Directorate)

Beyond frontline service improvements, our research teams are pioneering ground-breaking work into new ways of diagnosing dementia and potentially helping people take advantage of new treatments that require early diagnosis to be effective. KMPT is the only NHS trust in England to own a portable, lowfield MRI scanner after securing funding from the National Institute of Research. This technology, when compared to traditional MRI machines, is smaller, less expensive and easier to use. Collaborating with Kent and Medway Medical School and Canterbury Christ Church University, we will soon start to explore its potential to increase scanner availability significantly, speed up results, and improve patient experience.

Furthermore, we are collaborating with University College London on the ADAPT study, a cutting-edge UK-wide clinical trial to find out whether a new blood test to diagnose Alzheimer’s disease can help people with memory symptoms. This could provide faster and more accurate diagnosis, with the potential to change the way that dementia is diagnosed across the UK. We are also developing new projects to improve support for people after diagnosis, such as a study of psychological support for carers.

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Research has the power to transform lives. Here in Kent and Medway, we’re combining world-leading science with the voices of those affected by dementia and mental illness to drive real change. From innovative brain imaging to pioneering clinical trials, our work is shaping the future of mental health and dementia care.”

Dr Sukhi Shergill, Director of Research and Innovation

CASE STUDY 2

Bridging the gap to give our patients holistic care

Consultant CONNECT

Mental and physical health are closely connected, and we know that issues in one area often lead to problems in another. To improve patient outcomes, we wanted to go beyond our role as mental health practitioners and look after the full range of our patients’ needs, where we could.

When we talked with our prescribers and physical health nurses about improving patient outcomes, they stressed the need for better access to general practitioners (GPs) and specialists to help people with their physical health. When access is limited, staff spend time trying to get guidance and support and delays in treatment can harm patients’ mental health further.

We spoke with our staff and together chose Consultant Connect, an integrated app that enables real-time communication between our teams and specialist physical health clinicians. We started with a successful pilot in the Medway community mental health team (CMHT), where we received positive feedback and strong results. This success enabled us to expand the programme to all seven CMHTs, training 150 clinicians to achieve this.

Previously, staff spent considerable time seeking physical health help for their patients, or had to refer non-emergency patients to emergency departments. Now, specialists respond to messages within 24 hours and calls within 30 seconds. This speeds up treatment and reduces clinical risk. Previously, acute hospital referrals could take up to three months.

In twelve months, Consultant Connect has helped 361 people, 91% with cardiology. And 99% of those interventions resulted in immediate treatment plans, with only 1% needing further referral. We’ve also seen a positive impact on primary and acute care, saving over £94,000 by treating people within our services, without referring them to an acute trust, and so freeing up their time to help others in need.

The pharmacy team were also finalists for the Medicines, Pharmacy and Prescribing Initiative of the Year at the Health Service Journal Awards — a testament to the collaborative work with the Consultant Connect team to ensure patients at KMPT receive more timely physical health reviews.

People who work for us

Introduction

Our people's hard work and dedication make a difference to our patients and their families. That's why we're so committed to creating a supportive and positive environment for our staff where everyone can flourish, and we're always looking for ways to improve their working lives. We were pleased that 55% of colleagues responded to the NHS staff survey this year, which is both higher than last year and above the national average for mental health trusts using the the same company as us. We also saw our engagement score hold steady at 6.8. Our focus next year is improving this. We were also encouraged to see fewer colleagues working unpaid overtime and reporting work-related stress.

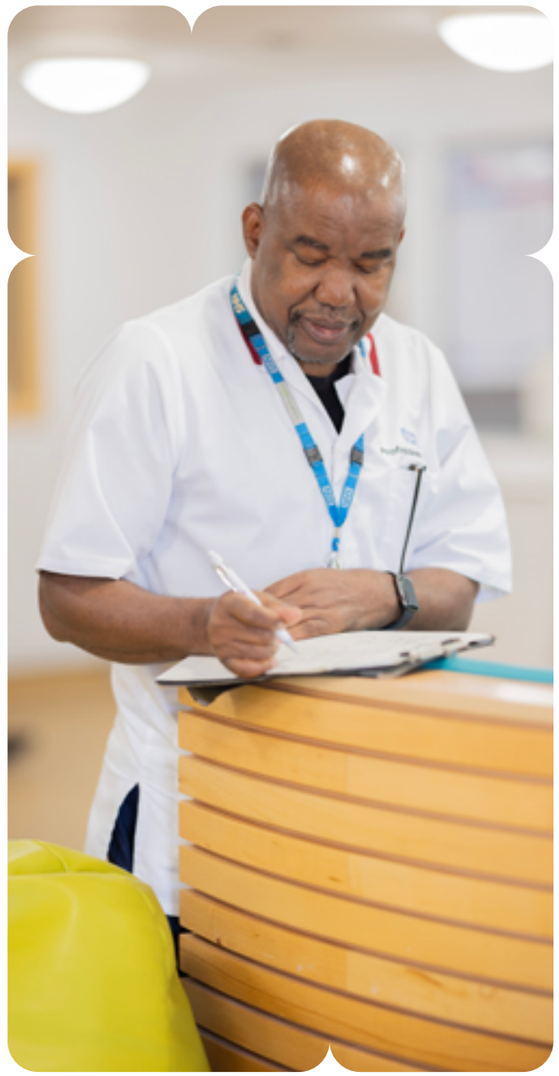
Vacancies in certain NHS specialisms can be challenging, and we've been working hard to ensure we have the people and skills needed. After the fantastic progress of last financial year, when we met our recruitment goals much earlier than expected, this year we have provided tailored support to teams with specific needs. We were especially pleased to welcome 18 new permanent consultants over the year.

> After intensive listening in 2023-24, we have used what everyone told us to develop a new identity that will evolve the culture of the trust and improve both the staff and patient experience of being here.

After intensive listening in 2023-24, we have used what everyone told us to develop a new identity that will evolve the culture of the trust and improve both the staff and patient experience of being here. This informed the introduction of an innovative app-based intranet that can be used on any device, including phones. Our staff work in many different professions, and settings, across a large county, so it's vital we make it easy for them to access the information and systems they need to do their jobs, as well as stay in contact with their colleagues. It will be a vital enabler in the establishment of our new identity. As part of our new identity, we have also developed four new values to help everyone understand what our trust stands for – Caring, Inclusive, Curious and Confident. These will launch next year and will guide every decision we make, big or small.

We were pleased to be re-accredited with the Medway Workplace Wellbeing Award at Platinum level, which recognises how supportive and productive our workplace is, and to receive menopause-friendly accreditation for the first time. Once again, our staff networks have made an invaluable contribution to the trust's culture and people's experiences of working here, celebrating our differences and giving staff safe spaces to engage with like-minded colleagues.

Staff also won and were finalists for prestigious awards that attract high levels of applications from across the country.



Dr Rachel Daly

Psychiatric Educator of the Year
Royal College of Psychiatrists

Dr Asif Bachlani

(former Non-Executive Director)
Psychiatrist of the Year
Royal College of Psychiatrists

North Kent MHLD team

Psychiatric Team of the Year: Intellectual Disability
Royal College of Psychiatrists

Moving and Handling team

Winner
HSJ Patient Safety Collaboration of the Year award

EDI team

Winner
Purpose Coalition Breaking Down Barriers award

Dr Afifa Qazi

Finalist
HSJ Clinical Leader of the Year

Pharmacy team

Finalist
HSJ Medicines, Pharmacy and Prescribing Initiative of the Year

Nic Jones

Finalist
Social Worker of the Year

Rough Sleepers team

Finalist
Purpose Coalition Good Health and Wellbeing award

Tarentfort centre

Finalist
HSJ Mental Health Safety Improvement Award

Below we take a more detailed look at 2 key achievements over the year.

CASE STUDY 1

Innovative work to create calmer, safer, wards

Our staff have the fundamental right to feel safe at work, but sadly, we know that isn't always the case. So, we made it one of our priorities to focus on making this happen. We know our patients are often very unwell, and we wanted to make our wards calmer and safer for everyone.

We started a major project, one of the biggest of its kind in the country for a mental health trust, to minimise the number of times violence or aggression occur. To help staff better understand the potential for these behaviours when patients felt distressed or frustrated, spot where this might be starting to build and put therapeutic interventions in place that prevent it, we gave all our wards safety culture bundles. These are a combination of tools to enable the easy capturing of incidences, as well as promoting preventative mechanisms for high risk patients.

We also introduced new ways of working, such as safety huddles that prompt all staff involved in these patients' care (known as a multi-disciplinary teams) to talk regularly about how to best look after them and respond to issues proactively before they occur. We also started a new way of observing patients at risk, called 'zoning observations', to keep them safe in the least restrictive way possible, help them feel more at ease on our wards, and more able to engage with and talk to staff. We've been highly proactive in asking staff to properly report every problem, not view it as "just part of the job", so we know what is happening on the frontline and can help and learn from it.

> "We used to wait for an incident to happen but now we plan how to prevent them..."

> "We come up with a pian that is clear and agreed with staff, everyone knows what to do now."

> "Although I am not sure the SCB prevents incidents, especially when we have a mixture of patients, but it does help staff come up with a proactive action plan, staff notice the triggers and signs much earlier..."

> "I do a daily activity planner with patients and we all enjoy it, we do yoga together now! The teamwork is brilliant now"

There are now fewer problems on our wards, and some wards have seen months without any incidents, which is a vast improvement from experiences before this work started. They have also been able to reduce the use of restrictive practices, which is much better for our patients and our staff.

We will keep working to ensure our wards are safe and supportive for everyone, and look at what we can do to help our community teams next.

> "While I was sceptical at first, the introduction of safety culture bundles and zonal observations to the ward has proven to be an asset. It is not only helping to maintain patient and staff safety, but has also has significantly reduced the use of physical interventions and the additional distress this puts on patients and staff."
>
> **Tom Turbefield, Sevenscore ward manager, shared his experiences**

CASE STUDY 2

Award winning work to make our trust more inclusive

We're proud to have a diverse workforce and recognise the importance of creating a culture where they feel supported, empowered and safe to be themselves. Staff had told us systemic inequalities and discriminatory behaviours, especially racism, were impacting them and patient experience. We were determined to act and embarked on a cultural transformation programme to build a truly inclusive environment where everyone feels valued.

We heard from more than 1,000 colleagues and spent over 500 hours talking in detail with our people. We are now implementing the Equality, Diversity and Inclusivity (EDI) action plan, focused on 6 key areas, built in response to their experiences:

- Reducing incidents related to racism, violence and aggression on our wards
- Improving leadership accountability and cultural competence
- Developing people policies to reflect our people's needs and improve staff health equities and wellbeing
- Better connecting with our people through effective communication and engagement
- Enhancing our EDI Strategy through workforce engagement and improving our data
- Improving the end-to-end incident logging system and process

In March, our EDI team won the Fair Career Progression category at the Purpose Coalition awards. The team was recognised for their commitment to advancing Black, Asian and Minority Ethnic (BAME) talent, empowering nurses to elevate their careers and making a profound and lasting impact on our workforce. We were also pleased to see higher levels of engagement from BAME staff with this year's staff survey, and we want to keep building on this into next year.

Key achievements this year

Empowering our leaders:

We are empowering leaders to be better equipped to recognise and address issues related to EDI, both within their teams and across the organisation. 50 senior leaders have been given specialist training to help them understand how actions, language, and leadership approaches have evolved and identify their personal strengths, gaps, and developmental needs, which have informed our new leadership development programme, rolling out in 2025.

Improving our reasonable adjustment process:

To enhance the experience of disabled colleagues, we created a new way of supporting requests for reasonable adjustments, which has supported 90 colleagues so far. An improved policy and clearer application process were introduced alongside a ring-fenced centralised budget to support the implementation of adjustments. We are the first trust to do this and have been working with several other NHS organisations to support them in replicating how we work. We have seen improved communication between staff, their managers, and colleagues - supporting a greater understanding of disabilities, long-term health conditions, and neurodiversity.

> 66 We are empowering leaders to be better equipped to recognise and address issues related to EDI, both within their teams and across the organisation.

People policies:

A review of our policies has developed a 'caring for you' policy that is more relevant and responsive to the needs of our diverse workforce. This offers flexible bank holidays, allowing staff to choose the holidays they prefer, rather than forcing them to observe traditional holidays, unpaid pet bereavement leave, and medical donation leave. The policy was created in consultation with our staff and internal networks. We took a fresh approach, moving away from the standard NHS model, and our new values have been central to every step of its development.

Partners who work with us

Introduction

We believe that working with partners is key to providing good care and helping our communities live well. Good health – be that mental or physical - is about more than medicine or treatment. It's about everything that contributes to how we live our lives – our homes, jobs, backgrounds, and access to education. They all profoundly shape our wellbeing.

Kent and Medway has a mix of very different communities - from very affluent to very deprived – beliefs and cultures. It also, sadly, sees some of the highest rates of suicide and self-harm. By working alongside people and organisations that deeply understand these communities, and who can provide a range of specialist expertise, we have the opportunity make the most difference. We can create joined-up, holistic, care that meets the needs of every individual person.

As one of the few public sector organisations to have people working across the whole region, and being a large regional employer, we also have the opportunity to do more than just treat symptoms. We have the chance to tackle some of the root causes of inequality, building a healthier, more equitable future for everyone. But we can only do that alongside others who believe the same.

Over the last year, we have built new partnerships with communities and organisations we may not have previously worked with, and continued our work with the Purpose Coalition to go beyond our 'day job' and create social value in our region. If you visit our website you will see the recently published report highlighting what we have achieved and recommendations for going further.

Below we share how two key achievements, delivered hand in hand with partners that have helped our communities, this past year.

CASE STUDY 1

Strengthening partnerships and transforming community mental health care

Building on the work that started last financial year, when we were appointed lead provider for Mental Health Together (MHT), we have seen encouraging progress in transforming community mental health care.

By uniting NHS teams, social care, and voluntary sector partners to create one team using one model of care, we've made it easier for people to access the support they need, reducing duplication and delays. We know that mental health is connected to many different things, including housing, employment, and relationships. That's why we're partnering with groups that provide support for all of those areas, not just mental health. This joined-up way of working ensures that people receive the right help, at the right time, without the burden of navigating multiple services during a vulnerable time in their lives.

We hit a key milestone in June when MHT became available across Kent and Medway. Then, since October, we've expanded on this with the introduction of Mental Health Together Plus (MHT+), which combines the expertise of the Community Mental Health Teams (CMHT) and the Community Mental Health Service for Older People (CMHSOP) to provide faster, more integrated, support for people with complex needs.

Collaboration is absolutely central to MHT's success and our integrated approach is already making a difference:

- Patients now receive support through a more accessible system.
- More people are accessing voluntary sector services, helping with employment, housing, and financial difficulties.
- Patient satisfaction is improving, with DIALOG+ tracking real progress in outcomes.

> "Bringing our skills from Live Well Kent & Medway into MHT has enhanced what we can offer to patients. Using DIALOG+, we've shared knowledge of community support services more widely, improving patient experience and access to the right care. The multi-agency approach has transformed how we work with local populations."
>
> **Pam Burniston, Area Manager for Mental Health Services at Porchlight**

As expected with a new model, we soon identified areas where positive refinements could be made, including working with partners to find ways of reducing waiting times and streamlining referrals. In Medway, we trialled a new approach using Mental Health Navigators from Shaw Trust as the 'front door' instead of trust staff. These navigators assist KMPT Clinical Pathway Leads with reviewing referrals and help with directing people to the most appropriate support - whether that's MHT, Talking Therapies, or other support organisations.

Since the pilot began, over 1,065 routine referrals have been triaged, and early feedback suggests the approach is successful in reducing waiting times. We are evaluating the pilot to see whether it would be beneficial to replicate this approach elsewhere in our work.

> "The front door test and learn work over the last eight weeks has really demonstrated the benefit of a multi-agency approach to ensuring clients get the right support at the right time. We've seen great collaboration between the Shaw Trust Navigators and KMPT teams, working as one team - a true reflection of the 'Together' in Mental Health Together."
>
> **Matt Jackson, Programme Manager, Shaw Trust**

Looking ahead to 2025, we are just beginning what is one of the biggest changes to community-based care in a generation. We have supported more than 24,000 people through MHT, so far, and are committed to strengthening partnerships and continually innovating how we provide care. As part of this we are being proactive in learning from what worked, and what may have felt more challenging, to continue to offer a better experience for patients and partners.

> "Since introducing our blended model, where all partners come together to provide a multi-agency and holistic response, I've been so impressed with the commitment, expertise, and collaboration of our partners. This new way of working is improving access, quality of care, and meaningful engagement with those who need it most. I'm excited to see how we continue developing these relationships, all to the benefit of our patients."
>
> **Vicky Stevens, Deputy Chief Operating Officer at KMPT**

While we are pleased with this progress we also acknowledge that change of this magnitude can feel challenging for the staff involved. We are committed to learning from their experiences so, going forwards, we improvement work feels as smooth and easy as possible for all involved.

CASE STUDY 2

Improving how we help neurodivergent people

Driven by a commitment to improving patient care, our pharmacy team has undertaken important work to stop the over-prescription of psychotropic medications for autistic people and people with learning disabilities over the past year.

Before work started it was crucial to understand the specific challenges faced by people living in in Kent and Medway, and not rely purely on national data. Previous data collection showed that people with learning disabilities in our region were 2.5 times more likely to be prescribed antidepressants and 20 times more likely to receive antipsychotics without a proper diagnosis.

From this, they set two important goals for implementing the STOMP-STAMP models, developed centrally in the NHS, successfully here:

1 To educate health and social care professionals, people with learning disabilities and autism, and the general public

2 To learn more about how psychotropic medication is prescribed to people in the learning disabilities and autism community in our county, through structured medication reviews (SMRs)

To date they have conducted 36 SMRs, which painstakingly and comprehensively evaluate a patient's medications, while considering their overall health. In these reviews, clinicians and patients work together to assess the benefits, risks, and alternatives to medications, focusing on each patient's unique needs and preferences.

By taking all clinicians involved in each person's care through this review process, we have seen a positive reduction in medication usage, decreased risks of side effects, and improved patient care. Our team made 17 psychotropic medication recommendations during the review, including lowering dosages and discontinuing some medications altogether, as well as similar interventions related to physical health medicines.

This work has also established a strong foundation for better, more effective prescribing to manage challenging behaviours going forwards.

Today, our team of prescribers, pharmacists, and primary care providers confidently employ new prescribing guidelines. We have also incorporated training sessions on STOMP-STAMP principles for our resident doctors and pharmacy teams.

Medication interventions from structured medication reviews

12 Drug stopped / not started

3 Drug switched

2 Dose amended

> We are seeing clear improvements in patients' health. They feel more alert and energetic, and report fewer side effects from their medicines. This change comes mainly from our new person-centred approach, which helps them feel heard and valued. Many of the patients reviewed have additional physical health conditions that can be impacted by psychotropic medicines, so stopping or reducing these medicines will benefit their long-term health. Consultants have also given us very positive feedback. They see that we can offer important insights into treatment. We help explain why specific medications are prescribed and whether they are necessary, and identify other possible causes for behaviours."
>
> **Michael Trent, STOMP-STAMP pharmacist**

Looking ahead, we are committed to increasing the number of healthcare professionals trained to conduct these SMRs in our local healthcare system. This step is essential to ensure that every person with learning disabilities and autism receives these assessments, ultimately improving their health and quality of life.

Strategic enablers

Introduction

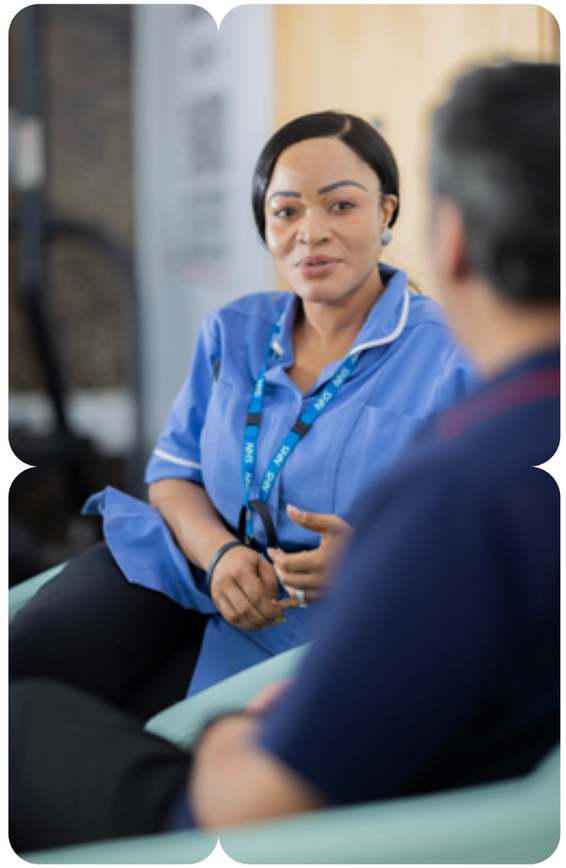
We cannot achieve our objectives without our strategic enablers, which support everything we do. These include using technology and data to transform patient care and increase productivity, being efficient, sustainable and making the best use of our resources, and creating spaces and environments that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

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

Using technology and data to deliver better care

We have continued to invest in our digital tools and systems so our people spend less time on paperwork and admin and have more time caring for their patients instead.

One example of this is **transforming how we measure the success of community mental health care**. In 2024, our community services (called Mental Health Together) began using DIALOG+, a patient led outcome measure and plan of care enabling the person and their clinician to identify and track their wellbeing and satisfaction.



Since many aspects of life impact mental health, DIALOG+ provides a simple but important way for patients to rate their satisfaction across 11 key areas of their life - such as mental health, physical health, job situation, relationships etc - on a scale of 1 to 7, from 'completely dissatisfied' to 'completely satisfied.'

By collecting this real-time feedback, clinicians can see what's improving, what needs more attention, and how care can be adjusted to better meet patient needs.

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

Transforming how we measure patients' progress

Before the introduction of DIALOG+, only 5-10% of patients had recorded outcome measures, making it difficult to track their progress over time and evidence the impact of care.

Now, that picture is changing. Since launching DIALOG+:

33% of patients currently open to community services have had at least one DIALOG+ outcome recorded.

5.9% already have paired scores, meaning two or more scores, allowing clinicians to compare and assess real change over time.

Although paired scores are still emerging, particularly for newer patients, this still marks a significant improvement in our ability to understand and evidence patient progress. Instead of assuming care is making a difference, DIALOG+ provides clear evidence of what is working and what needs adjustment or a different approach. This patient-led approach helps ensure their mental health support is tailored and responsive.

Early results: meaningful improvements across Kent and Medway

Despite the implementation being in its early stages, the impact of DIALOG+ is already visible across MHT.

Here's a quick look at how patient satisfaction has improved in several areas across all 3 of our localities:

How satisfied are you with your consultations with your mental health professional?

East Kent	North Kent	West Kent
5.0 → 5.5	5.3 → 5.4	4.8 → 5.3
(from 'satisfied' towards 'highly satisfied')	(from 'satisfied' towards 'highly satisfied')	(from 'in the middle' to above 'satisfied')

How satisfied are you with your mental health?

East Kent	North Kent	West Kent
3.4 → 4.1	3.8 → 4.2	2.8 → 3.6
(from 'dissatisfied' to 'in the middle')	(from 'dissatisfied' to 'in the middle')	(from 'dissatisfied' towards 'in the middle')

How satisfied are you with your medication?

East Kent	North Kent	West Kent
4.3 → 4.7	4.5 → 4.9	4.0 → 4.6
(from 'in the middle' to 'satisfied')	(from 'in the middle' to 'satisfied')	(from 'in the middle' towards 'satisfied')

Looking ahead: data-driven care in 2025 and beyond

Our number of paired scores will continue to grow in 2025, allowing us to refine and improve our services like never before. With this data, DIALOG+ helps us understand the overall service impact and the broader needs of our patients. It also shifts the focus from simply providing services to making sure those services lead to real improvements in people's lives.

Beyond the data

While Mental Health Together is focused on delivering data-driven, outcome-based care, DIALOG+ takes this a step further by giving people control over their own wellbeing. As the core assessment tool and personalised care plan, it will evolve in 2025 into a personally owned digital care plan, ensuring care is shaped by what matters most to each person.

Creating a more sustainable, greener trust

Over the last year, our Net Zero Green Plan has made good progress towards achieving net zero by 2024. We cut our carbon emissions by around two thirds (compared to our 2009/10 baseline) thanks to energy saving upgrades and other green initiatives. We piloted a new scheme to reduce the 2000 litres of diesel we use each year to power our generators by trialling a cleaner, greener alternative (Hydrotreated Vegetable Oil) at our Oakwood site in Maidstone. Whilst not widely used in the healthcare sector yet, it is fast becoming the preferred alternative to diesel for many industries, and we saw a 75% carbon reduction during our trial.

We also made significant savings by improving how we deal with waste, for example our furniture reuse project. We also increased our green spaces by 10%, and planted 430 trees, which allows us to offer more care in outdoor settings and provide therapeutic spaces for family members and our staff when they have breaks. You can find more information in our sustainability report on page 80.

A full review of the trust's performance can be found later in the Annual Report.

Making the most of our sites for patients and staff

This year, we've invested £4.5 million in our estate to help create environments that support recovery and healing, as well as support the safety and wellbeing of our people, the people we care for and their families. Some examples of how we have done this are below.

We've improved some buildings' energy performance, for example installing solar protection prior cooling (using materials to block the sun's heat from getting into a building, so less energy is required to keep it cool) in all bedrooms at the Rosewood Mother and Baby Unit to protect infants from heat-related cot deaths. Extensive work has also been delivered at the Thanet Mental Health Unit, incuding improving Sevenscore ward's courtyard so patients can enjoy fresh air in a more inviting space, and laying new flooring throughout the indoor communal areas to create a more welcoming atmosphere. We also refurbished four 'Rooms of Safety,' introducing reduced ligature enhancements and door top alarms.

As part of our anti-ligature focus, we've upgraded eighty-four bedroom doors across our sites with new, safer, anti-barricade doors. We constructed a new perimeter fence at the Brookfield Centre, printed with engaging features such as a beach landscape and goal post, to provide greater privacy and more enjoyable outdoor space for patients, as well as improving security.

These infrastructure upgrades, collectively, contribute to safer, more therapeutic environments for our patients and enable our staff to provide high-quality care with greater confidence and reduced need for heightened monitoring.

66

As part of our anti-ligature focus, we've upgraded eighty-four bedroom doors across our sites with new, safer, anti-barricade doors.

Performance Overview

Summary of progress against our six priorities

Below is an overview of our six priority programmes and the performance against set metrics for 2024/25. Full details of the Integrated Quality Performance Report are contained within the Trust Board papers, which are held on our website.

Dementia

Implementing the Memory Assessment Service (MAS) this year has significantly reduced wait times, with 33.5% of patients now diagnosed within 6 weeks (the national standard), a substantial rise from last year's 7.7%. A successful North Kent pilot refining the MAS model has achieved 77% diagnoses within 6 weeks, and in some weeks have been achieving 100%. Encouragingly, our average wait time has fallen to 146.3 days, which is lower than the national average of 151 days.

Violence & Aggression (V&A)

We're confident work over the past year is significantly improving the V&A staff experience. We've successfully encouraged greater reporting, and wards' safety culture bundles show some are achieving up to a 90% reduction, with incident-free months in certain locations. Staff feedback highlights better awareness of high-risk patients, improved action plans and communication, and enhanced wellbeing. We've identified the underlying causes of racially motivated V&A in three pilot areas and are collaborating with staff on solutions.

Patient Flow

Our 3-year aim is to reduce bed occupancy to 85% but we're not yet seeing the reduction we want, which is reflective of the national demand for mental health beds, and challenges around discharges for those who are clinically ready. We're actively reviewing frequent admissions and avoidable readmissions, and ensuring every admission is purposeful. While a reduction in bed occupancy hasn't yet been achieved, this work has clarified the underlying issues and key drivers. In addition to work happening within the organisation we are also developing a sustainable, long-term strategy with a focus on new clinical pathways with our partners.

Community Mental Health Framework

Mental Health Together (MHT) and Mental Health Together Plus (MHT+) have been launched across Kent & Medway, driving significant advancements in community mental health care. Both services are experiencing high demand, with an average of 3,631 referrals a month since July 2024.

At February 2025, 6,226 patients were waiting for an 'outcome' (for example treatment or care plan), with over half (3,395) already actively engaged in their care pathway and in contact with MHT staff. Of those not yet on a care pathway, half had been waiting fewer than 4 weeks (the new national standard) for their first contact. To further reduce waiting times, we are refining our triage function, the pilot of which has received positive feedback from both staff and patients.

Culture, Identity & Staff Engagement

We're making good progress improving our cultural competency and introducing a new organisational identity. We've also improved how we manage conduct and capability issues to ensure fair treatment for all staff. Furthermore, we're refining our recruitment to attract a more diverse workforce. Overall, we're on track to achieve our ambitious goals in this area.

Getting the Basics Right

Our initial work has defined the scope and objectives, leading to a first project targeting missed appointments (DNAs) in community teams. This resulted in a 20% reduction through text reminders and better admin support. We're looking at replicating this trust-wide, which we anticipate will help manage demand for MHT. This is going to be a key programme of work next financial year to improve processes and free up staff time to spend on caring for patients.

> Our initial work has defined the scope and objectives, leading to a first project targeting missed appointments (DNAs) in community teams.

Strategic Theme	Priority Programme	Metric	2024/25 Trust Target	Baseline Performance	Current Performance (February 2025)	In year target Achieved?
Patients We Care For	Dementia	% of patients diagnosed within 6 weeks	95%	7.7%	33.5%	On track for 3-year target
	Patient Flow	Bed Occupancy	85%	94.8%	95.7%	In year target not met
People Who Work For Us	Violence & Aggression	Decrease incidences of violence & aggression on our wards by 15%	7.5%	-	28.3%	In year target not met
		Number of BAME staff who have **not** experienced racial acts of violence and aggression	-	74%	69.2%	On track for 3-year target
	Culture, Identity & Staff Engagement	The number of minority ethic staff involved in conduct & capability cases; variation in line with white staff	1.0%	0.42%	0.21%	In year target achieved 3-year target also achieved
		Increase the percentage of global majority staff in roles at Band 7 and above	18.5%	13.6%	28.4%	In year target achieved
Partners We Work With	Community Mental Health Framework (CMHF)	Referrals to MHT commence treatment in 4 weeks *	85%	40.0%	6.2%*	Performance data under review*
	Getting the Basics Right	MHT patients who do not attend their appointments (DNAs) per week	-	25 (Jan 25)	20	

* This year a new, national, 4-week wait measure was adopted, tracking time spent on multiple aspects of the patient journey within this timeframe (patient seen, meaningful assessment, baseline outcome, treatment/care plan). This makes comparison with historical data, tracking referral to assessment and referral to treatment within 18 weeks, unreliable.

Summary of financial performance in 2024-25

We ended the 2024-25 financial year delivering a surplus of £3.5m.

In year we have continued to work in collaboration with with our system colleagues and working with our main commissioners we have become the Lead Provider for the Community Mental Health Framework (CMHF) and Perinatal services. This is one of the main reasons for our increase in income. In addition, we continue to see changing demands on our services, particularly for our beds, which has reflected in some of the ways we utilised our funding in year.

We delivered an extensive capital programme totalling £14.34m in 2024-25. A key component of our capital programme was the ongoing anti-ligature works to ensure patient safety on our wards. In addition to this IT and Digital spend was also a prominent feature of the total capital spend during the year.

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

Statement of Comprehensive Income

	Plan	Actual	Variance
	£000s	£000s	£000s
Income	290,109	300,474	10,365
Expenditure	(284,979)	(292,799)	(7,820)
Operating Surplus/(Deficit)	**5,130**	**7,675**	**2,545**
Finance Costs	(5,051)	(4,843)	(208)
Surplus/deficit	**79**	**2,832**	**2,753**
Impairments and impact of technical adjustments	645	693	48
Surplus/(Deficit) for Control Total Purpose	**724**	**3,525**	**2,801**

Income - £300.47m

The Trust received £300.47m of income in 2024/25, £28.4m higher than the previous financial year. This includes its clinical services funding but also funding from NHS England to cover the increase in NHS pension contribution central funding (increased from 20.6% to 23.7% in April 2024); and the impact of the 2024/25 NHS pay settlements.

KMPT received the majority of its income from Kent and Medway ICB under a block contract, with ICB income accounting for 74.8% of total income.

Specialist Services were commissioned through NHS England and make up 4.0% 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 100, 101, 114 and 115, notes 1, 3 and 4 of the accounts.

Expenditure - £292.80m

Operating expenditure in 2024/25 was £292.8m, which is £17.2m higher than the previous year. The largest area of spend for KMPT is employee expenses which totalled £229.09m and accounted for 78.2% of total operating expenditure. Employee expenses has increased by £21.6m in year, which is due to annual pay awards and the pension contributions increase. Other factors include investment in service delivery for programmes such as the CMHF. Non-pay related costs totalled £63.71m and the graphs below provides a summary of how we spent our money in 2024-25. Further details can be found in Notes 1 and 6 of the annual accounts, pages 101 and 116.

16% Medical

30% Nursing

16% Scientific, Therapeutic & Technical

17% Healthcare Assistants

20% Admin, Clerical & Management

1% Other Non Clinical

29% Premises & Transport

15% Purchase of healthcare from NHS & Non-NHS bodies

16% Depreciation & amortisation

18% Supplies & Services

2% Impairments

5% Drugs

4% Establishment

4% Education & training

3% Other

3% Clinical Negligence

Cost Improvement Programme

The Trust had a planned cost improvement programme of £11.5m for the financial year 2024/25 with £10.7m delivered. This programme sought to ensure that the trust was able to offer sustainable services that reflected the operational needs of the Trust.

Capital Expenditure

KMPT spent £14.4m on capital expenditure in 2024/25, this included significant investment into the following:

→ 4.9m on backlog maintenance, investing in our estate to support the delivery of patient care. This includes £1.2m of expenditure on anti-ligature work on our wards.

→ 3.7m on IT infrastructure to support delivery of KMPT's clinical technology strategy and IT devices replacement.

→ 3.2m on lease expenditure.

Looking forward to 2025-26

In April 2025, the Trust submitted revenue and capital plans for 2025/26. Our financial focus remains on long term financial sustainability. The continued demand for healthcare efficiency has resulted in an extensive efficiency programme with planned savings of £17.6m.

Our capital programme is significant in the coming year, and has been carefully planned due to the current challenges regarding the national funding allocations. The Trust has prioritised schemes to be completed and the plan will address high risk backlog maintenance, ward refurbishments and digital investment. We have also secured funding to deliver a new Female Psychiatric Intensive Care Unit (PICU) which proposes to eliminate Female PICU Out of Area and Independent Sector placements for women from Kent and Medway.

Audit

Our external auditor is Grant Thornton. They conducted work during the year on audit services at a cost of £110k + VAT. This work included annual accounts, governance and performance work.

Our annual accounts for 2024/25 have been examined by our external auditor, and their report is set out on page 89.

Accountability report

The Directors' Report

We are led by the Board of Directors (the 'Board') who hold the overarching responsibility for how well our Trust is performing and how it's managed. This responsibility includes setting the overall strategy for the organisation and monitoring progress, while ensuring resources are efficiently and effectively used to meet the needs of its service users and the public. The Board does this by holding the Trust to account for the delivery of the strategy through seeking assurance that the systems of control are robust and reliable. The Board works in partnership with patients, carers, the Integrated Care Board (ICB), 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 receives assurance that KMPT meets the needs 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.

> 66 The Board met formally in public seven times and six times in private during 2024-25. Public board meetings have been broadcast live during 2024-25 and two public Board meetings were held in-person.

In order to carry out their duties and responsibilities, Board members convene at Board meetings. The Board comprises Executive Directors (EDs) and Non-Executive Directors (NEDs), including the Chair, supported by the Trust Secretary. As a Unitary Board, they share collective responsibility for our success. Our Associate NEDs, Chief People Officer, and Director of Transformation and Partnerships also contribute to these discussions as non-voting directors. Additionally, 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 approves the Annual Report and Accounts prior to its submission to Parliament. The Annual Report and Accounts is prepared by the Board, 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 2024-25 there have been a number of changes to Board membership. Dr Asif Bachlani's tenure as an Associate NED ended at the end of October 2024 and Catherine Walker's tenure as a NED, Deputy Chair and Senior Independent Director ended at the end of November 2024, at which point Julius Christmas was appointed a NED of the Trust having gone through a competitive recruitment exercise. Dr Julie Hammond and Pamela Creaven were appointed as Associate NEDs at the beginning of February 2025. Peter Conway was appointed as Deputy Chair and Stephen Waring was appointed as Senior Independent Director. There were no changes to the EDs within 2024-25.

The Board met formally in public seven times and six times in private during 2024-25. Public board meetings have been broadcast live during 2024-25 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 2024-25 & Board Attendance

Board Member	Role	Board Meeting Attendance
Jackie Craissati	Trust Chair	7/7
Catherine Walker – until November 2024	Non-Executive Director, Senior Independent Director & Deputy Chair	4/5
Peter Conway	Non-Executive Director, and then Deputy Chair from November 2024	5/7
Julius Christmas – from December 2024	Non-Executive Director	2/2
Kim Lowe	Non-Executive Director	5/7
Sean Bone-Knell	Non-Executive Director	6/7
Mickola Wilson	Non-Executive Director	4/7
Dr Asif Bachlani – until October 2024	Associate Non-Executive Director	2/4
Dr MaryAnn Ferreux	Non-Executive Director	6/7
Stephen Waring	Non-Executive Director, and then Senior Independent Director from November 2024	7/7
Pamela Creaven – from February 2025	Associate Non-Executive Director	1/1
Dr Julie Hammond – from February 2025	Associate Non-Executive Director	1/1
Sheila Stenson	Chief Executive from	7/7
Dr Afifa Qazi	Chief Medical Officer	6/7
Andy Cruickshank	Chief Nurse	7/7
Nick Brown	Chief Finance and Resources Officer	7/7
Donna Hayward-Sussex	Chief Operating Officer and Deputy Chief Executive	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 NHS Code of Governance for NHS provider trusts 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 receives assurance that executive appraisals have been conducted in accordance with NHS England guidance and agrees 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
Chief Executive

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

Joining KMPT in 2017 as Chief Finance and Resources Officer, becoming deputy Chief Executive in October 2022, under her leadership, KMPT eradicated its underlying financial deficit and began ambitious programmes to make estates sustainable and transform digital services.

In November 2023, Sheila joined Kent and Medway's Integrated Care Board as partner member for community and mental health, representing KMPT and Kent Community Health Foundation Trust.

A chartered management accountant, Sheila has been awarded a number of Healthcare Financial Management Awards (HFMA) including an honorary fellowship for her dedication to the NHS and HFMA.

Dr Adrian Richardson
Director of Partnerships and Transformation

Adrian qualified as a doctor in 2001 transitioning from a Geriatrician into leadership roles in successful organisations across the South. He has extensive experience in transformation, partnership working, strategy, improvement and engagement.

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

He moved to Frimley Health establishing their improvement programme and was part of the team implementing their Electronic Patient Record system. He delivered a portfolio management system and designed initiatives to support change as well as recovery from Covid-19.

Since joining KMPT he has redesigned the trust transformation function and is leading the implementation of our Doing Well Together programme.

He strongly believes in a collaborative approach to transformation and improvement, empowering everyone to deliver change.

Dr Afifa Qazi
Chief Medical Officer

Dr Qazi is a consultant psychiatrist and CMO at KMPT. She won the prestigious HSJ award in 2016 and the EAHSN Health Innovation award in 2014, for transforming crisis services for people with dementia. In 2022 she won the Psychiatrist of the Year award from the Royal College of Psychiatrists (MRCPsych) and was commended by the judges on her person-centred approach. In 2024 she was the Finalist for the HSJ Clinical leader of the year.

She has been instrumental in partnership working with the Kent and Medway Medical School where she takes an active part in teaching and holds a Clinical lecturer post.

She has ensured that KMPT offers robust training, with the majority of resident doctors staying in the county. She has had significant successes in medical recruitment and retention with huge reduction in agency doctor usage in KMPT.

She is the executive lead for the BME network.

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.

Donna Hayward-Sussex
Chief Operating Officer and 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.

Nick Brown
Chief Finance Officer 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

Catherine Walker

Non-Executive Director, Senior Independent Director (SID) and Deputy Chair – left November 2024

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

Peter Conway

Non-Executive Director, and from November 2024, Deputy Chair

Peter has a background in banking and finance spanning 29 years, latterly as a Finance Director with Barclays Bank PLC. He has been a Non-Executive Director with the NHS since 2006, is a Non-Executive Director of the West Kent Housing Association, and was the Vice-Chair and Audit Committee Chair of Kent Community Health Foundation Trust. 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 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 NED before being appointed as a NED in September 2021. He retired from his role as the Kent Fire and Rescue Service, Assistant Chief Fire Officer and Director of Operations in March 2020. During his 33 years of service he 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, and from November 2024, Senior Independent 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 on an interim, part-time basis for the Greater London Authority on health and care policy and partnership working.

Stephen recently stepped down from the role of 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 after a six-year term of office.

Dr MaryAnn Ferreux
Non-Executive Director

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.

Julius Christmas
Non-Executive Director

Julius Christmas was appointed to the Board in December 2024 and brings Board-level expertise and experience in digital transformation, innovation, technology and cyber risk management. He is the Non-Executive lead for Digital transformation.

Julius has had a long career in technology and change working across multiple commercial sectors. This experience has involved leading large-scale technology, change and transformation functions, as well as having accountability for the delivery of major technology-enabled change and transformation programmes.

Julius was Group Chief Information Officer at Saga PLC, where he was a member of the Executive Leadership team and led the technology and cyber functions. Additionally, he has been an active "30% club" mentor and an industry board member and computer science curriculum adviser at the University of Kent. Julius is also the digital lead NED for Dartford and Gravesham NHS Trust.

Dr Asif Bachlani
Associate Non-Executive Director – left October 2024

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.

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 was also the NHS London Clinical Lead for Mental Health Outcomes for 2017-19.

Asif subsequently became a Fellow of Royal College of Psychiatrists in 2019 is 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.

Trust Board

- Remuneration & Terms of Service Committee
- Charitable Funds Committee
- Finance and Performance Committee
- Mental Health Act Committee
- Audit and Risk Committee
- Quality Committee
- People Committee

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 2024-25 members included Peter Conway (Chair), Julius Christmas, Kim Lowe and Stephen Waring.

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.

During 2024-25 members include Stephen Waring (Chair), Sean Bone-Knell and Dr MaryAnn Ferreux. Other members in 2024-25 included Dr Asif Bachlani.

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 Julius Christmas. Other members in 2024-25 included Catherine Walker.

People Committee (PC)

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, Dr MaryAnn Ferreux and Pam Creaven.

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 Julie Hammond. Other members in 2024-25 included Dr Asif Bachlani.

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.

Dr MaryAnn Ferreux is the Chair of the Remuneration and Terms of Service Committee, having taken over from Catherine Walker in November 2024. 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), Kim Lowe and Dr MaryAnn Ferreux.

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	
Catherine Walker			2/4			1/2	
Peter Conway	4/4		5/6	5/6		2/2	
Mickola Wilson			4/6			1/2	
Sean Bone-Knell		2/6			4/4	2/2	4/4
Kim Lowe	4/4			6/6		2/2	3/4
Dr Asif Bachlani		3/4			2/3		
Stephen Waring	4/4	5/6				2/2	
Dr MaryAnn Ferreux		1/4		5/6		2/2	2/4
Julius Christmas	1/1		2/2				
Pamela Creaven							
Dr Julie Hammond							
Sheila Stenson							
Afifa Qazi		6/6	3/6		4/4		
Andy Cruickshank	4/4	6/6			4/4		
Donna Hayward-Sussex		6/6	6/6				
Nick Brown	4/4		6/6				4/4
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 2025 and up to the date of approval of the annual report and accounts.

Following the Trust entering into a settlement agreement during 2023-24 the trust has reviewed its processes, in 2024-25, and whilst held to be correct has implemented a more formal sign off process as part of the decision-making arrangements.

Capacity to handle risk

The Board, which comprises of executive and non-executive directors, is responsible for defining the strategy and annual strategic priorities, against strategic objectives to ensure the effective running of the organisation. The Board has a proactive approach to risk management and receives a Board Assurance Framework document at its meetings. The BAF is also reviewed by the Audit and Risk Committee (ARC) – in accordance within the ARC workplan - which it discusses in terms of the effectiveness of assurance and controls effecting the strategic objectives.

The Trust has an integrated approach to the management of risk supported by ARC and the other sub-committees of the Board, all of which have their associated terms of reference reviewed on an annual basis. Risks are also considered at performance meetings and subject matter sub-committees and groups.

ARC is responsible for reviewing the establishment and ongoing maintenance of an effective system of governance, risk management and internal controls. This includes counter fraud, internal financial control, both internal and external audit, health and safety, fire safety and emergency preparedness and response.

The internal audit team adheres to a planned programme of reports to ARC inclusive of an annual evaluation of the effectiveness of the Risk Management and the Board Assurance Framework.

The Chief Executive and her executive team provide leadership and articulate their focus on risk management through (previously) the Risk Management and Board Assurance Framework Oversight Group and replacing that from September 2024 the Trust Leadership Team Meeting.

The Trust Leadership Team, which comprises of the executive team and senior leaders, considers the corporate risks and ensure that risk owners and responsible action owners and oversight committees are named. The Trust Leadership Team is the foundation for the monitoring and management of trust risks with oversight by the executive team of escalation/de-escalation of risks to and from the Board Assurance Framework (as the Executive Management Team Board Assurance Framework and Risk Oversight Group), with oversight by the Chief Nurse; as the accountable executive who ensures regular reporting, oversight and scrutiny of the application of the Risk Management Framework.

The Trust is committed to developing staff with technical capability to effectively manage risk and staff are trained to manage risk clinically and non-clinically. All non-clinical risk is managed via a digital system, risk application. Risk owners maintain each risk to allow for a single point of truth. The data within the risk application allows for point in time reports which can be manipulated for committees and groups.

Staff have access via the trust intranet, or on request via their line management access to the Non-Clinical Risk Management Framework, Non-Clinical Risk Management Policy, Non-Clinical Risk Management Standard Operating Procedure, Digital Risk Application User Guide and Clinical Risk Management documentation. The Trust Risk Manager maintains the training needs analysis and training objectives. In addition to planned training and planned governance meeting attendance by the Trust Risk Manager for operational and service risks, with ad hoc support being actively encouraged.

The Risk and Control Framework

As accountable officer, I have overall responsibility for effective risk management and integrated governance systems in place in the trust to comply with NHS Provider Licence section 4 (governance) and actions to identify and mitigate these risks in relation to:

- effectiveness of governance structures
- responsibilities of directors and sub-committees
- reporting lines and accountabilities between the Board, its sub-committees and the Executive Team
- the submission of timely and accurate information to assess risks to compliance with the trust's licence and,
- the degree and rigour of oversight the Board has over the trust's performance.

The Board is responsible for delivery of the Trust's objectives and robust risk management and internal control is a key aspect of this. This includes risk management, counter-fraud and bribery, external audit, internal audit and internal financial control.

The Non-Clinical Risk Management Framework was implemented in September 2024 replacing the Risk Management Strategy. The Trust continues to embed this framework to ensure that staff follow a clearly defined process via the associated Policy and Standard Operating Procedure for managing the identification, evaluation, transfer and control of non-clinical risk. This occurs through a process that identifies the likelihood versus impact score of each individual risk; which is tracked against the target risk value and date for completion of that target; with agreed action/s to be applied by the defined risk action owners.

The current risk score denotes the escalation and de-escalation of risks to the trust risk register from service risk registers at 15 (Extreme) and all those that effect the strategic objectives are considered for inclusion on the Board Assurance Framework, by the relevant Executive Director, notwithstanding their current score.

The Board establishes a risk appetite for high level risks on a risk-by-risk basis, oversees the risks and encourages proactive identification and mitigation of such risks. At the beginning of the financial year

2024/25, the Board assessed the potential risks which may prevent the achievement of its six strategic objectives and evaluated this throughout the year as new risks were presented. The six strategic objectives are:

- We deliver outstanding, person centred care that is safe, high quality and easy to access.
- We are a great place to work and have engaged and capable staff living our values
- We lead in partnership to deliver the right care and to reduce health inequalities in our communities
- 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

In addition to this at the close of 2024/25 the trust has commissioned NHS Providers to refresh board members training, in order to enhance board risk competencies, as well as a review of the trust risk appetite ready for 2025/26.

As of 31 March 2025, there are twelve major and high potential risks to achieving the trust's strategic objectives held on the Board Assurance Framework. The key risks have remained relatively constant and are published through the Board Assurance Framework and include:

- Organisational inability to meet Memory Assessment Service Demand
- Community Psychological Services Therapy Waiting Times
- Inpatient Flow
- Community Mental Health Framework Achieving outcomes to evidence success
- Management of Environmental Ligatures
- Organisational Management of violence and aggression
- Organisational Culture impact on Change Programmes
- Trust agency usage
- Delivery of Financial Targets
- Delivery of Underlying Financial Sustainability
- Delivery of a fit for purpose estate
- Maintenance of a sustainable estate

Incident Reporting

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. The Trust actively encourages incident reporting via a digital incident reporting application. Alongside the corporate patient safety function, governance leads in clinical directorates continue to support incident analysis and governance improvements, including playing a key role for risk management governance.

The incident reporting system is used to capture incidents and near misses (failings in processes or systems that could have resulted in harm), enabling information relating to the incident to be captured, investigated, and actions taken to address any failings and identify any ongoing issues or risks.

The Trust strives to learn through clinical supervision and reflective practice, individual and peer reviews, performance management, feedback from patients, carers and staff, continuing professional development, audit and from incident and complaint investigations.

The dissemination of good practice and lessons learnt is achieved through a variety of mechanisms including Patient Safety and Incident Response Framework (PSIRF) governance arrangements and the discussion of incidents and risk assessments at relevant clinical and non-clinical groups, such as clinical services' Integrated Quality Performance Report meetings.

Complaints and compliments provide a good indication of the quality-of-service delivery across the Trust. As an organisation, the Trust recognises complaints as a means of improving performance. Learning from complaints is ongoing and is often linked with outcomes following clinical incident investigations.

Clinical Risk and Patient Safety

Clinical risk and patient safety are overseen by the Quality Committee (QC) on an assurance basis, and the Chief Nurse, the Chief Medical Officer and the Chief Operating Officer on an operational basis. The Board receives monthly quality reports, within an Integrated Quality and Performance Report, encompassing the quality and patient safety aspects for the Trust. The QC 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 QC reviews the Quality Digest which analyses incidents and serious incidents by severity, theme, directorate 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 PSIRF Team or the QC are reported and monitored to ensure effectiveness.

The QC 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 QC 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.

NHS England Well-Led Framework

NHS England's well-led framework identifies the characteristics required of good provider organisations that ensure quality services are provided:

- leadership capacity and capability
- clear vision and credible strategy
- culture of high-quality care
- clear responsibilities, roles and systems of accountability
- clear and effective processes for managing risks
- robust and appropriate information effectively processed and challenged
- people using services, the public, staff and partners engaged and involved
- robust systems and processes for learning, continuous improvement and innovation.

The trust has robust quality and corporate governance arrangements to ensure the quality of services it provides, and reviews these on an ongoing and annual basis via the Board.

Care Quality Commission (CQC)

The Trust is fully compliant with the registration requirements of the Care Quality Commission.

The Regulation, Compliance and Quality Group (RCQG), 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 QC. This group regularly reviews the quality statements and each agenda includes items that cover these and is based on internal risk intelligence and concerns raised with the regulator. During 2024-25, the group has identified the need to have a self-assessment and peer review tool as a way of both educating/supporting staff with their understanding of the quality statements and how they are part of everyday practice alongside being able to monitor compliance and acting on areas that are identified for improvement.

The CQC conducted an unannounced onsite inspection, on 4th to 6th March 2025, of the trust's mental health crisis services and health-based places of safety, and community based mental health services for adults. A section 29A warning notice was subsequently issued on 8th April 2025 in relation to two specific areas. The CQC found the trust was routinely detaining service users in section 136 suites (health-based places of safety) beyond the expiry of their section 136 detention under the Mental Health Act 1983, without any legal framework. They also found that risk assessment and management of service users in the community mental health services was variable and the trust was not always mitigating against avoidable harm. Immediate action has been taken, including the development and implementation of robust quality improvement plans

which are monitored via the RCQG and with onward reporting and escalation to the Quality Committee and Board.

In addition to the above, each directorate monitors improvement plan actions and provides assurance to the RCQG. There are monthly quality performance reviews (QPRs) held in each directorate whereby key performance data is discussed and further actions agreed.

Efficiency and effectiveness of compliance with NHS provider licence section 4

The Trust has identified no principal risks with compliance to section 4 (governance) of the NHS provider licence. This conclusion is supported by the effectiveness of the Trust's governance structures, which were reviewed as part of an independent Well-Led review in 2023/24, with the majority of recommendations implemented in 2024/25. The Board and its sub-committees have clear governance arrangements, as detailed within the terms of reference for each forum, which are reviewed on an annual basis, or sooner if there are significant internal or external changes which need to be reflected, and the last annual review was conducted in quarter 2 of 2024/25, with changes approved at the July 2024 and September 2024 Board meetings. The reporting lines and accountabilities are detailed within the Terms of Reference for the Board and its sub-committees, as well as in the Trust's Standing Orders, Standing Financial Instructions and Scheme of Delegation which are reviewed at regular intervals to ensure continued compliance with any legislative and regulatory changes, and to reflect any internal changes in relation to approval limits, authorities and accountabilities.

The Trust ensures submission of timely and accurate information through an agreed standard operating picture whereby reports are submitted to the Trust Secretary's Office ten days prior to the meeting, to enable review of the content by the Trust Secretariat and for any inaccuracies or ambiguities to be addressed with the report author, prior to circulation to the Board or its sub-committees.

The Board has a high degree of oversight of the Trust's performance through the Integrated Quality and Performance Report (IQPR), which utilises Statistical Process Control to assist in the identification of significant change and enable appropriate escalation of any areas of concern. The Trust's performance is also monitored via the Quality Accounts, which provide assurance regarding the delivery of care and progress against the Quality Priorities, and a bi-annual strategy performance update, which details the performance against each of the Trust's strategic objectives.

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.

Workforce

The Trust ensures that short, medium and long-term workforce strategies are in place to give assurance via the People Committee that processes are safe, sustainable and effective.

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.

Sustainability

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. A copy of the Green Plan can be found on the Trust's website. The trust ensures through its Green Plan that it focuses on sustainability and tracking to Net Zero across all our operations and services. Compliance is monitored by a dedicated Head of Sustainability, Environment and EFM Compliance Assurance.

Emergency Preparedness, Resilience and Response (EPRR)

The Trust is a Category One responder under the Civil Contingencies Act (2004). Within the Act the Trust has specific statutory duties in relation to maintaining a resilient organisation that is able to work in partnership with other responders in response and recovery from major, critical and business continuity incidents.

In order to demonstrate compliance, the Trust is aligned to the National Emergency preparedness, Resilience and Response Framework (2022). NHS England nationally issues core standards against which each Trust undertakes a self-assessment and is then audited by its commissioner. The Trust have been assessed as (99%) substantially compliant for 2024 against the NHS England EPRR core standards.

NHS England define substantially compliant as: The organisation if fully compliant against 89% - 99% of the relevant NHS EPRR Core Standards. This has been reported via Kent and Medway ICB, the Local Health Resilience Partnership Executive Group for Kent and Medway and to NHS England region and NHS England nationally.

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 ARC.

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) reviews, monitors and scrutinises the Trust's key performance indicators across both finance and performance. There is a cross membership between the QC and ARC to ensure risks and assurance issues are clearly identified and followed through. There is also cross membership between FPC and ARC; and ARC and the People Committee. There is a robust process in place to enable the referral of any assurance issues between Committees, to ensure such issues are viewed with appropriate lens and expertise.

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.

A number of policies have lapsed in year, with the Trust taking active steps to remedy the situation with senior managers reviewing the relevance of policies and their durations. There has been no material effect on the Trust's operations.

Information Security and Governance Update for 2024-25

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, and will be introducing a patient portal system early in 2025/26 to increase collaboration with our patients.

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 two 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, one related to information disclosed in error and one related to inappropriate access to information. 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 DSPT 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 Information Governance, 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.

Data quality and governance

The Trust's Data Quality Group aims to promote high data quality in order to deliver the best possible care and services to patients. The Data Quality Group provides a forum through which data quality queries can be raised, discussed and solutions found to issues identified. These solutions should be implemented by the appropriate team driven by a focus on partnership across operational and support services. The group reports into the Information Governance Group and ARC.

Input into trust systems is assured through the use of performance management tools and exception reporting, in the last year significant progress has been made in enhanced availability of reports across different trust systems to improve visibility of data quality. There is continuous monitoring and support for queries arising from staff and patient level reports within operational teams to ensure all expected data is accurately captured. Additionally, monitoring of activity levels allows early identification of variances to allow investigation and assess if any potential issues with data completeness exist. This process is strengthened by the monthly Care Group Quality Performance Reviews (QPRs) which allow the Executive Team the opportunity to review exceptions and agree required actions.

Whilst there is no mandatory Referral to Treatment (RTT) targets within Mental Health services there remains a large focus on the management of waiting lists to effectively manage demand on teams, with a particular focus with Mental Health Together, Dementia services and Early Intervention in Psychosis. To aid services to monitor their waiting times and ensure their data and waiting lists are accurate, reports cover all variables and highlights areas of potential data quality. This process gives assurance that we are reporting an accurate picture of waiting times and waiting lists for our clinical services.

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 QC 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, a number of adjustments were made to the process to implement recommendations from the independent Well-Led review conducted in 2023/24, which included a focus on best practice in relation to challenge, style, scrutiny and tone to support the Board and its Committees; and review and amendment of terms of reference and workplans to ensure alignment with the Trust's strategic objectives whilst achieving a balance between operational matters and strategic oversight.

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 across service, directorate and corporate levels.

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

Internal Audit carried out 15 reviews in 2024-25, 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, e-Meds Post Implementation Review and Recruitment Processes, 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 ARC at each meeting.

As part of its counter fraud assurance the trust has an ongoing case that has been referred on to the NHS Counter Fraud Authority. As a result of this the Trust is commissioning an additional review of its processes to ensure the appropriate governance remains in place.

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 QC provided assurance in relation to PSIRF. The PSIRF policy supports the development and maintenance of an effective patient safety event/ incident response system that integrates the four key aims of the PSIRF:

- Compassionate engagement and involvement of those affected by patient safety events/incidents.
- Application of a range of system-based approaches to learning from patient safety events/incidents.
- Considered and proportionate responses to patient safety events/incidents and safety issues.
- Supportive oversight focused on strengthening response system functioning and improvement.

The policy is specific to patient safety event/incident learning responses conducted solely for the purpose of learning and improvement across all clinical services within the trust. Responses under the policy follow a systems-based approach. This recognises that patient safety events/incidents result from multiple interactions between systems and do not take a 'person-focused' approach.

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

In conclusion, in my capacity as Accountable Officer, I have reviewed the internal control measures in place at Kent and Medway NHS and Social Care Partnership Trust and believe that the Trust has maintained a sound system of internal control designed to meet the Trust's objectives and that controls are generally applied consistently. The Annual Governance Statement discloses the significant risks all of which are known to our regulators, commissioners and population, through Board papers and / or meetings with the relevant parties.

The Trust has identified only one significant internal control issue during 2024/25 which relates to a "Section 29A Warning Notice" issued by the Care Quality Commission (CQC) on the 8th April 2025. An in-depth action plan has been developed by the Chief Nurse in response to the findings from the CQC inspection, which will be monitored by the QC, and assurance provided to the Board via existing governance processes.

Sheila Stenson
Chief Executive
Date: 12th June 2025

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

The Chief Executive of NHS England 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.

Sheila Stenson
Chief Executive
Date: 12th June 2025

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 2024-25, 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 since 2023-24

There were no payments for loss of office for Very Senior Managers during 2023-24 or 2024-25.

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 2024-25 was £225k-£230k (compared with £205k - £210k in 2023-24). This was 5.98 times more (compared with 5.51 times more in 2023-24) than the median remuneration of the workforce, which was £38,029 (compared with £37,622 in 2023-24). The highest paid director's salary is denoted by a number of variable components, inclusive of clinical excellence awards. Annualised remuneration ranged from £12.5k to £260k (2023-24 £10k to £345k). There were 2 individuals whose full-time equivalent remuneration were above that of the highest paid director within the organisation, with both individuals being substantive employees who did not meet the criteria to be defined as a Very Senior Manager, as defined by NHS England. The 2 substantive employees 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. [1,2]

Taxable benefits include expense allowances that are subject to UK income tax and benefits received by the individual in respect of qualifying services. Any amounts stated are the gross value before tax is deducted.

As audited

Salary and allowances

	2023-24	2024-25	Percentage change
Highest paid director (£)	£207,500	£227,500	9.63%
Employees as a whole (£)	£41,938	£49,803	18.75%

1 Total annualised remuneration excludes pension value and is calculated based on annualised figures, presenting a disparity with the Senior Manager Remuneration & Benefits Tables, which present actual salary earned for the year 2024-2025, based on actual hours worked.
2 Salaries presented exclude salary sacrifices and the purchasing and selling of annual leave.
3 The average percentage change in employee remuneration from the previous financial year reflects the combined impact of nationally agreed NHS pay awards, incremental progression within pay bands where applicable, and changes in workforce composition, including recruitment, retirements and leavers. Additionally, variations in overtime, shift enhancements, and other allowances contributed to the overall change. These figures are consistent with national NHS pay frameworks and reflect the organisation's commitment to fair, transparent, and contractual remuneration practices across all staff groups.
4 The calculation for the Percentage change was to calculate the difference between current and previous year, divide by the previous year and multiply by 100.

Pay ratio information

	25th percentile		Median		75th percentile	
	2023-24	2024-25	2023-24	2024-25	2023-24	2024-25
Total remuneration (£)	£28,719	£29,140	£37,622	£38,029	£48,955	£50,021
Salary component of total remuneration (£)	£25,928	£26,530	£36,265	£37,338	£46,352	£48,526
Remuneration ratio	7.23:1	7.81:1	5.51:1	5.98:1	4.24:1	4.55:1

5 Employees a whole calculated based on FTE, so excludes temporary staff and is based on total annualised remuneration, minus highest paid director remuneration, divided by FTE.
6 Locum salary and remuneration calculated using an assumed £60 per hour pay rate and annualised to 1 FTE, equalling 40 hours per week, and totalling £125,143.20.
7 The changes in the pay ratios between the current and prior years reflect a combined impact of nationally agreed NHS pay awards, incremental progression within pay bands where applicable, and changes in workforce composition, including recruitment, retirements and leavers. Additionally, variations in overtime, shift enhancements, and other allowances contributed to the overall change. These figures are consistent with national NHS pay frameworks and reflect the organisation's commitment to fair, transparent, and contractual remuneration practices across all staff groups.

5 Senior Manager Remuneration and Benefits

a) Remuneration – as audited

Salary table

	Name and Title	2024-25 Salary (Bands of £5K)	2024-25 Expense payments (taxable) to nearest £100	2024-25 Performance pay and bonuses (bands of £5K)	2024-25 Long term performance pay and bonuses (bands of £5K)	2024-25 All pension related benefits (band of £2.5K)	2024-25 TOTAL (bands of £5K)	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)
Executive Directors	**Helen Greatorex** – Chief Executive (until November 2023)	-	-	-	-	-	-	160-165	0	0	0	40-42.5	205-210
	Sheila Stenson – Chief Executive (since November 2023)	185-190	0	0	0	152.5-155	340-345	160-165	0	0	0	40-42.5	205-210
	Afifa Qazi – Chief Medical Officer	225-230	0	0	0	130-132.5	355-360	205-210	0	0	0	0	205-210
	Sandra Goatley – Chief People Officer	140-145	0	0	0	40-42.5	180-185	130-135	0	0	0	35-37.5	165-170
	Andy Cruickshank – Chief Nurse	135-140	0	0	0	15-17.5	150-155	130-135	0	0	0	0	130-135
	Donna Hayward-Sussex – Chief Operating Officer and Deputy Chief Executive (since November 2023)	150-155	0	0	0	55-57.5	205-210	135-140	0	0	0	82.5-85	220-225
	Adrian Richardson – Director of Partnerships and Transformation	130-135	0	0	0	32.5-35	165-170	125-130	0	0	0	42.5-45	170-175
	Nick Brown – Chief Finance and Resources Officer (since November 2023)	135-140	0	0	0	32.5-35	170-175	55-60	0	0	0	5-7.5	60-65
Non-executive Directors	**Jackie Craissati** – Trust 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
	Catherine Walker – Non-Executive Director (until November 2024)	10-15	0	0	0	0	10-15	15-20	0	0	0	0	15-20
	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
	Asif Bachlani – Associate Non-Executive Director (until October 2024)	5-10	0	0	0	0	5-10	10-15	0	0	0	0	10-15
	Dr Mary Ann Ferreux – Non-Executive Director	10-15	0	0	0	0	10-15	10-15	0	0	0	0	10-15
	Stephen Waring – Non-Executive Director	10-15	0	0	0	0	10-15	10-15	0	0	0	0	10-15
	Julius Christmas – Non-Executive Director (since December 2024)	0-5	0	0	0	0	0-5	-	-	-	-	-	-
	Pam Creaven – Associate Non-Executive Director (since February 2025)	0-5	0	0	0	0	0-5	-	-	-	-	-	-
	Dr Julie Hammond – Associate Non-Executive Director (since February 2025)	0-5	0	0	0	0	0-5	-	-	-	-	-	-

8 Helen Greatorex was Chief Executive until November 2023.
9 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.
10 Donna Hayward-Sussex was appointed as Deputy Chief Executive in November 2023
11 Nick Brown was appointed Chief Finance and Resources Officer in November 2023.
12 Venu Branch left the trust in February 2024.
13 Catherine Walker left the trust in November 2024.
14 Asif Bachlani left the trust in October 2024.
15 Julius Christmas was appointed as a Non-Executive Director in December 2024.
16 Pam Creaven was appointed as an Associate Non-Executive Director in February 2025.
17 Dr Julie Hammond was appointed as an Associate Non-Executive Director in February 2025.

b) Pension Benefits – as audited

2024-25

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 2025	Lump sum at age 60 related to accrued pension at 31 March 2025	Cash Equivalent Transfer Value at 1 April 2024	Real increase in Cash Equivalent Transfer Value	Cash Equivalent Transfer Value at 31 March 2025
	(Bands of £2,500)	(Bands of £2,500)	(Bands of £5,000)	(Bands of £5,000)			
	£000	£000	£000	£000	£000	£000	£000
Helen Greatorex – Chief Executive (to 31/10/2023)	0	0	0	0	0	0	0
Sheila Stenson – Executive Director of Finance and Performance and Deputy Chief Executive (to 31/10/2023), Chief Executive (since 01/11/2023)	7.5-10	12.5-15	55-60	140-145	911	133	1,128
Afifa Qazi – Chief Medical Officer	7.5-10	2.5-5	70-75	45-50	1,087	121	1,305
Sandra Goatley – Chief People Officer	2.5-5	0	25-30	0	377	40	461
Andy Cruickshank – Chief Nurse	0-2.5	0	55-60	145-150	1,190	23	1,310
Donna Hayward-Sussex – Chief Operating Officer Deputy Chief Executive (since 01/11/2023)	2.5-5	0	40-45	0	642	53	757
Adrian Richardson – Director of Partnerships and Transformation	2.5-5	0	20-25	0	255	23	312
Nick Brown – Chief Finance and Resources Officer (since 01/11/2023)	2.5-5	0	15-20	45-50	334	21	395

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
	(Bands of £2,500)	(Bands of £2,500)	(Bands of £5,000)	(Bands of £5,000)			
	£000	£000	£000	£000	£000	£000	£000
Helen Greatorex – Chief Executive (to 31/10/2023)	2.5-5	0	5-10	0	50	63	135
Sheila Stenson – Executive Director of Finance and Performance and Deputy Chief Executive (to 31/10/2023), Chief Executive (since 01/11/2023)	0-2.5	47.5-50	45-50	120-125	575	255	911
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
Andy Cruickshank – Chief Nurse	0	27.5-30	50-55	140-145	923	157	1,190
Donna Hayward-Sussex – Chief Operating Officer Deputy Chief Executive (since 01/11/2023)	5-7.5	0	36-40	0	428	151	642
Adrian Richardson – Director of Partnerships and Transformation	2.5-5	0	15-20	0	162	60	255
Nick Brown – Chief Finance and Resources Officer (since 01/11/2023)	0-2.5	0-2.5	15-20	45-50	292	0	334

18 As Non-Executive Directors do not receive pensionable remuneration; there are no entries in respect of pensions for Non-Executive Directors.

19 A Cash Equivalent Transfer Value (CETV) is the actuarially assessed capital value of the pension scheme benefits accrued by a member at a particular point in time. The benefits valued are the member's accrued benefits and any contingent spouse's (or other allowable beneficiary's) pension payable from the scheme. CETVs are calculated in accordance with the Occupational Pension Schemes (Transfer Values) Regulations 2008.

20 Real Increase in CETV reflects the increase in CETV effectively funded by the employer. It takes account of the increase in accrued pension due to inflation, contributions paid by the employee (including the value of any benefits transferred from another scheme or arrangement) and uses common market valuation factors for the start and end of the period.

21 No contributions were made to stakeholder pensions.

22 No additional benefits would become receivable by individual directors or senior managers upon early retirement beyond those already accrued through their contractual entitlements under the NHS Pension Scheme or other applicable pension arrangements. Any early retirement benefits would be determined in accordance with the standard pension scheme rules and subject to the approval processes set out in NHS terms and conditions. There are no individual agreements or enhanced early retirement provisions in place for directors or senior managers beyond those generally available under national NHS policies.

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 2024/25.

Staff Report

1 Average staff numbers – as audited

Average number of employees (WTE basis)

	Permanent Number	Other Number	24-25 Total Number	23-24 Total Number
Administration and estates staff	975	20	995	883
Health care assistants and other support staff	869	285	1,154	1,035
Medical and dental staff	211	10	221	234
Nursing, midwifery and health visiting staff	941	202	1,143	1,062
Nursing, midwifery and health visiting learners	17	-	17	26
Scientific, therapeutic and technical staff	519	9	528	557
Healthcare Scientists	-	-	-	-
Social Care	-	-	--	-
Other (students)	68	3	71	81
Total Average Numbers	**3,600**	**529**	**4,129**	**3,879**
Of which: Number of employees (WTE) engaged on capital projects	**26**	**1**	**27**	**20**

23 Substantive, bank and agency staff, as well as those on external secondment into the Trust are included in these staff numbers.
24 For the 2024/25 financial year, the source data used for calculating the average number of staff employed by the Trust has changed. While this has resulted in some variances compared to the previous year, the impact is not considered material and therefore no adjustments have been made to the prior year numbers.

2 Workforce demographic – as audited

Workforce Demographic: Gender

	FTE		
	Female	Male	Grand Total
Apprentice	2.00	2.00	**4.00**
Band 2	299.08	146.47	**445.55**
Band 3	455.87	166.80	**622.67**
Band 4	295.26	56.41	**351.67**
Band 5	328.20	99.54	**427.73**
Band 6	536.53	161.12	**697.65**
Band 7	338.14	108.77	**446.91**
Band 8a	136.60	45.53	**182.13**
Band 8b	56.70	22.02	**78.72**
Band 8c	35.66	24.05	**59.71**
Band 8d	13.50	7.76	**21.26**
Band 9	10.31	4.00	**14.31**
Director	4.00	3.00	**7.00**
Medical	114.93	105.36	**220.29**
NED	6.60	4.60	**11.20**
Grand Total	**2,633.37**	**957.43**	**3,590.80**

Workforce Demographic: Age

Age Band	FTE
<=20 Years	10.80
>=71 Years	16.29
21-25	217.63
26-30	363.39
31-35	407.89
36-40	360.26
41-45	469.55
46-50	489.73
51-55	495.78
56-60	436.34
61-65	265.75
66-70	57.40
Grand Total	**3,590.80**

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

26 The total numbers displayed in the workforce demographic tables are based on data from the end of March 2025. 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 2024 to March 2025, as opposed to the demographic tables which display staff numbers at a single point in time.

Workforce Demographic: Ethnicity

Ethnic Origin	FTE	% of Staff
A White - British	2,027.77	57.77%
B White - Irish	27.32	0.82%
C White - Any other White background	145.15	4.00%
CA White English	12.53	0.32%
CM White Traveller	1.00	0.02%
CP White Polish	5.20	0.15%
CX White Mixed	1.80	0.05%
CY White Other European	5.13	0.20%
D Mixed - White & Black Caribbean	11.35	0.30%
E Mixed - White & Black African	15.68	0.42%
F Mixed - White & Asian	17.37	0.50%
G Mixed - Any other mixed background	36.95	0.97%
GA Mixed - Black & Asian	1.00	0.02%
H Asian or Asian British - Indian	180.57	4.89%
J Asian or Asian British - Pakistani	23.15	0.60%
K Asian or Asian British - Bangladeshi	11.00	0.27%
L Asian or Asian British - Any other Asian background	63.15	1.71%
LA Asian Mixed	0.61	0.02%
LB Asian Punjabi	1.00	0.02%
LH Asian British	2.00	0.05%
M Black or Black British - Caribbean	43.20	1.09%
N Black or Black British - African	583.47	15.34%
P Black or Black British - Any other Black background	24.84	0.70%
PC Black Nigerian	8.21	0.22%
PD Black British	5.50	0.17%
R Chinese	10.20	0.30%
S Any Other Ethnic Group	66.50	1.74%
SB Japanese	1.00	0.02%
SC Filipino	5.00	0.12%
SE Other Specified	1.00	0.02%
Z Not Stated	252.14	7.02%
Grand Total	**3,590.80**	**100%**

3 Staff costs – as audited

Staff Costs

	Permanent £000	Other £000	2024-25 Total £000	2023-24 Total £000
Salaries and wages	152,646	360	**153,006**	136,746
Social security costs	15,248	-	**15,248**	14,435
Apprenticeship levy	745	-	**745**	704
Employer's contributions to NHS pension scheme	32,135	-	**32,135**	25,363
Pension cost - other	53	-	**53**	69
Other post employment benefits	-	-	**-**	-
Other employment benefits	-	-	**-**	-
Termination benefits	252	-	**252**	267
Temporary staff	-	28,721	**28,721**	31,440
Total gross staff costs	**201,079**	**29,081**	**230,160**	**209,024**
Recoveries in respect of seconded staff	-	-	**-**	-
Total staff costs	**201,079**	**29,081**	**230,160**	**209,024**
Of which: Costs capitalised as part of assets	**819**	-	**819**	**1,260**

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	1	£2,733	8	£27,893	**9**	**30,626**	0	0
£10,000 - £25,000	4	£58,686	1	£12,371	**5**	**71,057**	0	0
£25,001 - £50,000	0	0	0	0	**0**	**0**	0	0
£50,001 - £100,000	1	£76,647	0	0	**1**	**76,647**	0	0
£100,001 - £150,000	1	£114,160	0	0	**1**	**114,160**	0	0
£150,001 - £200,000	0	0	0	0	**0**	**0**	0	0
>£200,000	0	0	0	0	**0**	**0**	0	0
Totals	**7**	**252,226**	**9**	**40,264**	**16**	**292,490**	**0**	**0**

Exit packages: other (non-compulsory) departure payments

	2024/25 Payments agreed	2024/25 Total value of agreements	2023/24 Payments agreed	2023/24 Total value of agreements
	Number	£000	Number	£000
Voluntary redundancies including early retirement contractual costs	0	0	0	0
Mutually agreed resignations (MARS) contractual costs	0	0	0	0
Early retirements in the efficiency of the service contractual costs	0	0	0	0
Contractual payments in lieu of notice	9	40	14	127
Exit payments following Employment Tribunals or court orders	0	0	0	0
Non-contractual payments requiring HMT approval	0	0	0	0
Total	**9**	**40**	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	0	0	0	0

5 Off-payroll engagements

The Trust had no off-payroll engagements as at 31 March 2024 and had no new off-payroll engagements between 1 April 2024 and 31 March 2025, for more than £245 per day.

6 Expenditure on consultancy

The Trust's expenditure on consultancy in 2024/25 was £82k, (2023/24 £113k).

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, 55% of staff participated. Around 100 questions are asked in the survey, including a select number of questions designed to present a view on the organisation's 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 6.8 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 Staffroom intranet 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.

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 97 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: 12th June 2025

Progress Report on the Trust Green Plan 2024/25

Foreword

In 2021, KMPT developed a board approved Green Plan with a target to achieving Net Zero carbon emissions by 2040. This plan is used to address our efforts towards improving our sustainability credentials in response to Climate Change Statutory requirement to achieve Net Zero by 2040 and the NHS Long Term Plan.

This report provides an update on how the Trust is performing against the Board approved Green Plan over the year 2024/25 showcasing key achievements, challenges, and future strategies to enhance sustainability across our operations.

Executive Summary

This year, KMPT has taken significant strides in reducing carbon emissions, improving energy efficiency, and embedding sustainable practices across sites and services. Key milestones include:

A **66%** in overall carbon emissions reduction compared to the 2009 baseline

Over **126,154kw** in Solar generation so far for 24/25

Over **800 staff** completed Building Net Zero training

18 EV chargers sockets installed at 3 main sites to service KMPT Rapid Response Ambulances

Application submitted to Salix to decarbonise **6** KMPT buildings at a total value ~ £3m

Exceeded National targets Offensive Waste

The launch of Green Spaces for improvement of patient care at Tarentfort and Oakwood

Partnered up with Kent County Council on Active Travel initiatives and are part of the Kent Connected Journey Planner

Kent and Medway System Collaboration

As a Trust and with our NHS partners in Kent & Medway, we continue to lead the way with our collaborative approach to delivering a cleaner, greener healthcare system through sharing best practice and forming joint working groups. By learning from each other we can go further by reducing carbon for healthier lives across our communities in Kent and Medway.

Despite progress, challenges include funding constraints and the need for broader stakeholder engagement.

Our Green Plan Framework

Our Green Plan framework captures the strategic approach through our Trusts strategic ambitions.

Themes:	1	2	3	4
People we care for		✓		✓
People we work with	✓	✓		
Partners we work with			✓	

Figure 1: The Green plan includes 10 action areas across 4 themes

We are pleased to see the progress achieved and how well the Trust is performing against its targets especially with the range of improvements made over the past year showing the Trusts commitment to improving sustainability.

Progress towards Targets

In 2024/25 we produced 25,076 tonnes of CO2 from sources we directly control (our NHS Carbon Footprint). This includes pollution from energy, staff travel for work, water and waste. We also produced a significant amount of pollution from indirect sources (our NHS Carbon Footprint Plus).

Progress against our Net Zero target is shown in figure 2, with a breakdown of key emissions sources in figures 3 and 4. Although we are recording a reduction in overall carbon emissions, we are no longer on track with our target trajectory, with a slight increase seen from 2023/24.

Emissions Reductions & Targets (tCO2)

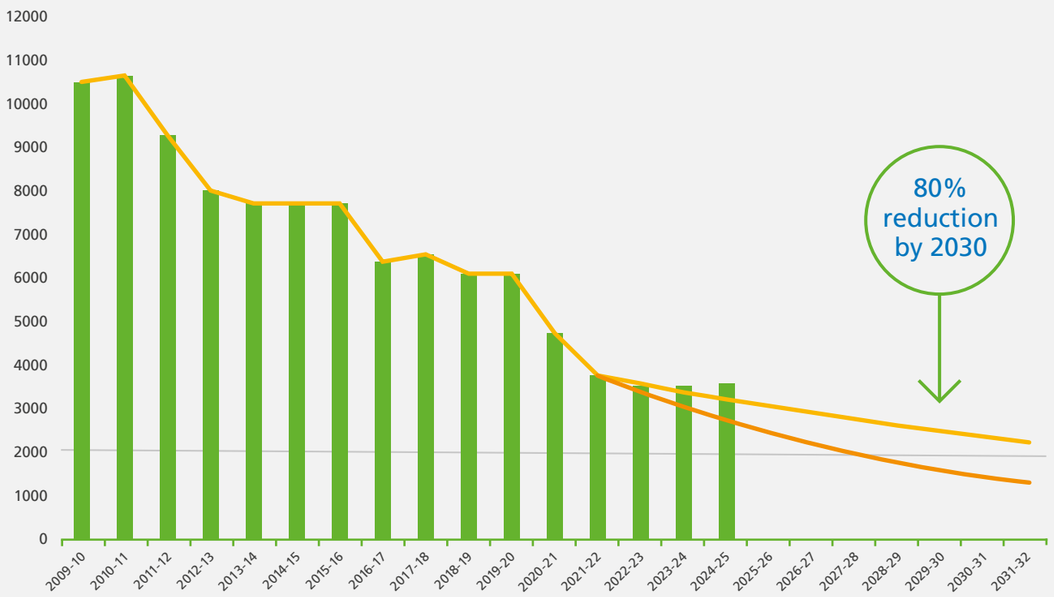


Figure 2: Emissions Reduction & Targets

Total Carbon Emissions from 2019/2020

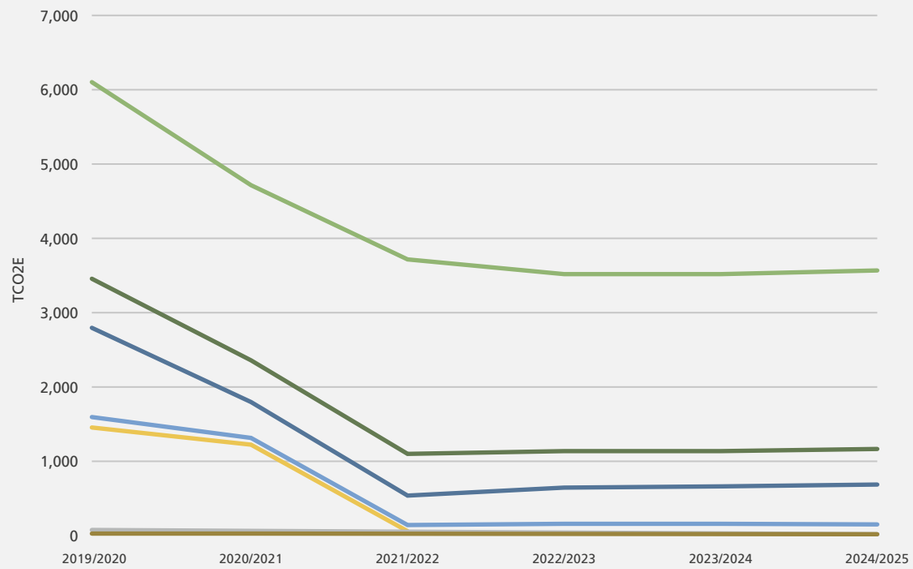


Figure 3: Total Carbon Emission from 2019

Total Emissions from 2009/2010

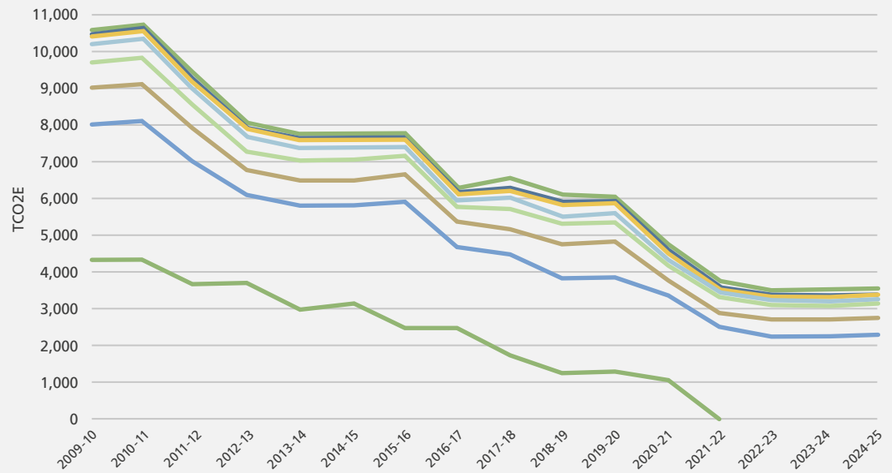


Figure 4: Key Emission sources

Key

- Fossil Fuels
- Energy (Well-to-tank)
- Business Travel
- NHS Fleet & Leased Vehicles
- Electricity
- Metered Dose Inhalers
- Water & Sewage
- Waste

Key achievements

What have we delivered this year 2024/25

We have made significant progress this year in delivery of the carbon reduction projects set out within our Green Plan in particular:

Decarbonisation:

- 20 Heat Decarbonisation Plans have been produced funded by £95k grant
- Application submitted to Salix to decarbonise 6 KMPT buildings at a total value £3m
- Over 700 staff completed Building Net Zero training

Energy Efficiency

- Over 2500 lamps upgraded to LED lighting, reducing energy consumption

Renewable Energy

- Total Solar generation so far for 24/25 was 126,154 kWh
- BI reporting for Utilities now live for Trust visibility
- 100% of our Electricity sourced is from our supplier is from renewable generation

Sustainable Transport

- 20 sockets EV chargers installed at 3 main sites to service KMPT Rapid Response Ambulances and Trust Fleet
- Partnered up with Kent County Council on Active Travel initiatives and the introduction of Kent Connected Journey Planner on our webpages
- Improved on site bike storage facilities to promote cycle to work
- 18 free to use pedal bikes located at 3 main sites for staff and patients, complete with helmets and lights
- Season Bus Travel discount for staff

Waste Management & Circular Economy

- Over 15 tonnes of carbon savings from WARPIT furniture reuse scheme
- Exceeded National targets Offensive Waste by 12%
- Food waste disposal implementation across main sites ahead of legislation
- Optimisation of Clinical Waste Collections to reduce cost, maximise capacity and CO2.

Green Prescribing & Sustainable Healthcare

- Successful Grant for Green Spaces improvement at Tarentfort and Oakwood
- Total number of trees planted 500
- Significant increase in Low carbon Inhalers use phasing out high carbon intensive alternatives

Social Value

We are pleased to see the progress on embedding social value within our supplier contracts through encouraging alignment various engagements activities such as tree planting, community engagements and workforce diversity programs.

Challenges & Lessons Learned

The challenges to the delivery of the Green Plan remain the lack of capital funding for Net Zero projects and the external influences of rising energy cost and the current economic crisis.

While awareness of environmental sustainability is growing, further training is needed to embed sustainability in daily operations.

Lastly, ensuring all suppliers align with Sustainability standards remains a challenge. There has been a huge improvement across this area with Social Value workstream implementation.

What are we focusing on in 2025/2026

Over the next 12 months, it is important we strive to track closely to Net Zero targets by focusing on what we can achieve based on our capabilities and available funding. We also aim to utilise opportunities for external funding wherever possible (e.g. PSDS, NEEF and also through research and innovation)

These will include:

1. **Sustainable Use of Resources:**
   Respond to the changes in Waste legislation 2025 by focusing on increasing recycling and reducing clinical waste.
2. **Adaptation:**
   Focus on adapting the highest impact areas across the Trust estate to the threats of Climate Change through expansion of renewables, implementation of the Heat Decarbonisation Plans, KMPT Climate Change Adaptation Plan and associated policy documents.
3. **Sustainable Care Models:**
   Expand the Green social prescribing knowledge and Green Spaces implementation through carbon literacy training.

Conclusion

The Green Plan continues to drive progress toward our Net Zero target with each area delivering progress. To ensure we stay on track for our Net Zero target by 2040, it is essential that this agenda becomes everyone's responsibility across the Trust, including our patients, suppliers and executives

NHS England are tasking all Trusts with reviewing and refreshing their Green Plans in 2025. The refreshed Green Plan will give us the opportunity to take a comprehensive look at our performance so far and data prioritisation processes to ensure we're using our resources in the most efficient way.

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: 12th June 2025

Nick Brown
Chief Finance and Resources Officer
Date: 12th June 2025

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 Care Partnership Trust (the 'Trust') for the year ended 31 March 2025, which comprise the statement of comprehensive income, the statement of financial position, the statement of changes in taxpayers equity, the statement of cash flows and notes to the financial statements, including material accounting policy information. 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 2024-25.

In our opinion, the financial statements:

- give a true and fair view of the financial position of the Trust as at 31 March 2025 and its expenditure and income for the year then ended;
- have been properly prepared in accordance with international accounting standards as interpreted and adapted by the Department of Health and Social Care Group Accounting Manual 2024-25; 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 (2024) ("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 2024-25 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 2024) 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 November 2024 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 2024-25 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 2024-25; 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.

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 2024-25).
- We enquired of management and the audit and risk committee, concerning the Trust's policies and procedures relating to:
  - the identification, evaluation and compliance with laws and regulations;
  - the detection and response to the risks of fraud; and
  - the establishment of internal controls to mitigate risks related to fraud or non-compliance with laws and regulations.
- We enquired of management, internal audit and the audit and risk committee, whether they were aware of any instances of non-compliance with laws and regulations or whether they had any knowledge of actual, suspected or alleged fraud.
- We assessed the susceptibility of the Trust's financial statements to material misstatement, including how fraud might occur, evaluating management's incentives and opportunities for manipulation of the financial statements. This included the evaluation of the risk of management override of controls and the valuation of land and buildings. We determined that the principal risks were in relation to:
  - Year end, manual journals
  - Judgements made in relation to assumptions and market conditions
- 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 high risk journals;
  - 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.
- The engagement partner's 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 2025.

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 have undertaken our review in accordance with the Code of Audit Practice, having regard to the guidance issued by the Comptroller and Auditor General in November 2024. 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 have documented 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 have considered whether there is evidence to suggest that there are significant weaknesses in arrangements.

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

We cannot formally conclude the audit and issue an audit certificate for Kent And Medway NHS And Social Care Partnership Trust NHS Trust for the year ended 31 March 2025 in accordance with the requirements of the Local Audit and Accountability Act 2014 and the Code of Audit Practice until we have received confirmation from the National Audit Office that the audit of the NHS group consolidation is complete for the year ended 31 March 2025. We are satisfied that this work does not have a material effect on the financial statements for the year ended 31 March 2025.

Use of our report

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

John Paul Cuttle

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

London
Date: 12 June 2025

Annual accounts for the year ended 31st March 2025

Statement of Comprehensive Income

	Note	2024/25 £000	2023/24 £000
Operating income from patient care activities	3	278,657	252,360
Other operating income	4	21,817	19,672
Operating expenses	6,8	(292,799)	(275,643)
Operating surplus / (deficit) from continuing operations		**7,675**	**(3,611)**
Finance income	10	1,027	1,081
Finance expenses	11	(2,374)	(3,796)
PDC dividends payable		(3,496)	(3,433)
Net finance costs		**(4,843)**	**(6,148)**
Other gains / (losses)	12	-	(158)
Surplus / (deficit) for the year		**2,832**	**(9,917)**
Other comprehensive income			
Will not be reclassified to income and expenditure:			
Impairments	7	(1,524)	(2,686)
Revaluations	15	3,804	792
Total comprehensive income / (expense) for the period		**5,112**	**(11,811)**

Adjusted financial performance (control total basis) - Note
The Trust's surplus for 2024/25 was £2,832k. 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 £3,525k 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):		
Surplus / (deficit) for the year	2,832	(9,917)
Remove net impairments not scoring to the Departmental expenditure limit	619	10,165
Remove I&E impact of capital grants and donations	5	(182)
Remove I&E impact of IFRIC 12 schemes on an IFRS 16 basis	2,840	2,686
Add back I&E impact of IFRIC 12 schemes on former UK GAAP basis	(2,771)	-
Add back I&E impact of IFRIC 12 schemes on an IAS 17 basis	-	(1,709)
Adjusted financial performance surplus	**3,525**	**1,043**

Statement of Financial Position

	Note	31 March 2025 £000	31 March 2024 £000
Non-current assets			
Intangible assets	13	4,260	3,917
Property, plant and equipment	14	142,816	127,346
Right of use assets	16	25,163	35,502
Investment property	17	2,201	2,201
Receivables	19	476	289
Total non-current assets		**174,916**	**169,255**
Current assets			
Receivables	19	8,888	5,670
Cash and cash equivalents	20	12,015	17,399
Total current assets		**20,903**	**23,069**
Current liabilities			
Trade and other payables	21	(28,730)	(23,544)
Borrowings	23	(1,197)	(2,781)
Provisions	24	(577)	(2,260)
Other liabilities	22	(808)	(981)
Total current liabilities		**(31,312)**	**(29,566)**
Total assets less current liabilities		**164,507**	**162,758**
Non-current liabilities			
Borrowings	23	(36,215)	(44,970)
Provisions	24	(2,932)	(2,320)
Total non-current liabilities		**(39,147)**	**(47,290)**
Total assets employed		**125,360**	**115,468**
Financed by			
Public dividend capital		142,518	137,738
Revaluation reserve		24,688	22,408
Income and expenditure reserve		(41,846)	(44,678)
Total taxpayers' equity		**125,360**	**115,468**

The notes on pages 100 to 134 form part of these accounts.

The financial statements on pages 96 to 99 were approved by the board on the 12th June 2025 and signed on its behalf by

S. Stenson.

Sheila Stenson
Chief Executive
Date: 12th June 2025

Statement of Changes in Taxpayers Equity for the year ended 31 March 2025

	Public dividend capital	Revaluation reserve	Income and expenditure reserve	Total
	£000	£000	£000	£000
Taxpayers' and others' equity at 1 April 2024 - brought forward	**137,738**	**22,408**	**(44,678)**	**115,468**
Surplus for the year	-	-	2,832	**2,832**
Impairments	-	(1,524)	-	**(1,524)**
Revaluations	-	3,804	-	**3,804**
Public dividend capital received	4,780	-	-	**4,780**
Taxpayers' and others' equity at 31 March 2025	**142,518**	**24,688**	**(41,846)**	**125,360**

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

	Public dividend capital	Revaluation reserve	Income and expenditure reserve	Total
	£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**

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.

Financial assets reserve
This reserve comprises changes in the fair value of financial assets measured at fair value through other comprehensive income. When these instruments are derecognised, cumulative gains or losses previously recognised as other comprehensive income or expenditure are recycled to income or expenditure, unless the assets are equity instruments measured at fair value through other comprehensive income as a result of irrevocable election at recognition.

Statement of Cash Flows

	Note	2024/25 £000	2023/24 £000
Cash flows from operating activities			
Operating surplus / (deficit)		7,675	(3,611)
Non-cash income and expense:			
Depreciation and amortisation	6.1	10,366	10,892
Net impairments	7	1,021	10,229
Income recognised in respect of capital donations	4	(13)	(186)
(Increase) / decrease in receivables and other assets		(3,792)	5,877
Increase / (decrease) in payables and other liabilities		3,576	(4,992)
Decrease in provisions		(1,371)	(328)
Other movements in operating cash flows		-	(2)
Net cash flows from operating activities		**17,462**	**17,879**
Cash flows from investing activities			
Interest received		1,027	1,081
Purchase of intangible assets		(1,945)	(1,458)
Purchase of PPE and investment property		(7,851)	(14,611)
Receipt of cash donations to purchase assets		13	186
Net cash flows used in investing activities		**(8,756)**	**(14,802)**
Cash flows from financing activities			
Public dividend capital received		4,780	3,082
Capital element of lease rental payments		(13,058)	(2,025)
Capital element of PFI, LIFT and other service concession payments		(1,020)	(1,011)
Interest paid on lease liability repayments		(833)	(1,054)
Interest paid on PFI, LIFT and other service concession obligations		(899)	(929)
PDC dividend paid		(3,060)	(3,426)
Net cash flows used in financing activities		**(14,090)**	**(5,363)**
Decrease in cash and cash equivalents		**(5,384)**	**(2,286)**
Cash and cash equivalents at 1 April - brought forward		**17,399**	**19,685**
Cash and cash equivalents at 31 March	20	**12,015**	**17,399**

Note 1 Accounting policies and other information

Note 1.1 Basis of preparation

The Department of Health and Social Care (DHSC) has directed that the financial statements of the Trust shall meet the accounting requirements of the DHSC Group Accounting Manual (GAM), which shall be agreed with HM Treasury. Consequently, the following financial statements have been prepared in accordance with the GAM 2024/25 issued by the DHSC. The accounting policies contained in the GAM follow International Financial Reporting Standards to the extent that they are meaningful and appropriate to the NHS, as determined by HM Treasury, which is advised by the Financial Reporting Advisory Board. Where the GAM permits a choice of accounting policy, the accounting policy that is judged to be most appropriate to the particular circumstances of the Trust for the purpose of giving a true and fair view has been selected. The particular policies adopted are described below. These have been applied consistently in dealing with items considered material in relation to the accounts.

Accounting convention

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

Note 1.2 Going concern

These accounts have been prepared on a going concern basis. The financial reporting framework applicable to NHS bodies, derived from the HM Treasury Financial Reporting Manual, defines that the anticipated continued provision of the entity's services in the public sector is normally sufficient evidence of going concern. The directors have a reasonable expectation that this will continue to be the case. Budgets and cashflow forecasts for 2025/26 do not indicate a going concern risk.

Note 1.3 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 1.3.1 Revenue from NHS contracts

The main source of income for the Trust is contracts with commissioners for health care services. In 2024/25 the majority of the trust's income from NHS commissioners was in the form of block contract arrangements.

Funding envelopes are set at an Integrated Care System (ICS) level. The majority of the Trust's income is earned from NHS commissioners under the NHS Payment Scheme (NHSPS) and is 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.

Where the relationship with a particular Integrated Care Board is expected to be a low volume of activity (annual value below £0.5m), an annual fixed payment is received by the provider as determined in the NHSPS documentation. Such income is classified as 'other clinical income' in these accounts.

Note 1.3.2 Mental health provider collaboratives

NHS led provider collaboratives for specialised mental health, learning disability and autism services involve a lead NHS provider taking responsibility for managing services, care pathways and specialised commissioning budgets for a population. As lead provider for the Perinatal Provider Collaborative, commencing in October 2024, the Trust is accountable to NHS England and as such recognises the income and expenditure associated with the commissioning of services from other providers in these accounts. Where the Trust is the provider of commissioned services, this element of income is recognised in respect of the provision of services, after eliminating internal transactions.

Note 1.3.3 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 1.3.4 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 apprenticeship service account held by the Department for Education, the corresponding notional expense is also recognised at the point of recognition for the benefit.

Note 1.4 Expenditure on employee benefits

Short-term employee benefits

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

Pension costs

NHS Pension Scheme

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

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

Note 1.5 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 1.6 Property, plant and equipment

Note 1.6.1 Recognition

Property, plant and equipment is capitalised where:

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

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

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 1.6.2 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.

Assets are measured subsequently at valuation. Assets which are held for their service potential and are in use (ie operational assets used to deliver either front line services or back office functions) are measured at their current value in existing use, being the fair value at the date of revaluation less any impairment. Assets that were most recently held for their service potential but are surplus with no plan to bring them back into use are measured at fair value under IFRS 13 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 under IAS 40 or IFRS 5.

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.

For specialised assets, current value in existing use is interpreted as the present value of the asset's remaining service potential, which is assumed to be at least equal to the cost of replacing that service potential. Specialised assets are therefore valued at their depreciated replacement cost (DRC) on a modern equivalent asset (MEA) basis. An MEA basis assumes that the asset will be replaced with a modern asset of equivalent capacity and meeting the location requirements of the services being provided.

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 2024/25 this was carried out as a full quinquennial revaluation of the estate.

The professional valuations are carried out by local independent valuers. The valuations are carried out by 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. By the requirements of the DHSC, a full asset valuation took place in March 2025.

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.

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, borrowings costs. Assets are revalued and depreciation commences when the assets are brought into use.

IT equipment, transport equipment, furniture and fittings, and plant and machinery that are held for operational use are valued at depreciated historic cost where these assets have short useful lives or low values or both, as this is not considered to be materially different from current value in existing use.

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 1.6.3 De-recognition

Assets intended for disposal are reclassified as 'held for sale' once all of 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 1.6.4 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.

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

PFI and LIFT transactions that 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 IAS17, 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 in 2023/24

IFRS 16 liability measurement principles were applied to PFI, LIFT and other service concession arrangement liabilities in these financial statements from 1 April 2023. The change in measurement basis was 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.

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 1.7 Intangible assets

Note 1.7.1 Recognition

Intangible assets are non-monetary assets without physical substance controlled by the Trust. They are capable of being sold separately from the rest of the trust's business or arise from contractual or other legal rights. Intangible assets 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 where it meets recognition criteria.

Note 1.7.2 Measurement

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

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

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

Amortisation

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

Useful lives of intangible assets

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

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

Note 1.8 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.

Between 2020/21 and 2023/24 the Trust received inventories including personal protective equipment from the Department of Health and Social Care (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. Distribution of inventories by the Department ceased in March 2024.

Note 1.9 Investment properties

Investment properties, which are properties held to earn rentals and/or for capital appreciation (including property under construction for such purposes), are measured at fair value at the balance sheet date. Changes in fair value are recognised as gains or losses in income/expenditure during the period in which they arise.

Only those assets which are held solely to generate a commercial return are considered to be investment properties. Where an asset is held, in part, for support service delivery objectives, then it is considered to be an item of property, plant and equipment. Properties occupied by employees, whether or not they pay rent at market rates, are not classified as investment properties.

Note 1.10 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 1.11 Financial assets and financial liabilities

Note 1.11.1 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, ie, when receipt or delivery of the goods or services is made.

Note 1.11.2 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 or financial liabilities in respect of assets acquired or disposed of through leasing arrangements are recognised and measured in accordance with the accounting policy for leases described below.

Financial assets are classified as subsequently measured at amortised cost.

Financial liabilities classified as subsequently measured at amortised cost.

Financial assets and financial liabilities at amortised cost

Financial assets and financial liabilities at amortised cost are those held to collect 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 Department of Health and Social Care, 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 at fair value through other comprehensive income. This includes derivatives and financial assets acquired principally to sell in the short term. Movements in the fair value of financial assets and liabilities in this category are recognised as gains or losses in the Statement of Comprehensive income.

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.

Impairment of financial assets

For all financial assets measured at amortised cost including lease receivables, contract receivables and contract assets or assets measured at fair value through other comprehensive income, the Trust recognises an allowance for expected credit losses.

The Trust adopts the simplified approach to impairment for contract and other receivables, contract assets and lease receivables, measuring expected losses as at an amount equal to lifetime expected losses. For other financial assets, the loss allowance is initially measured at an amount equal to 12-month expected credit losses (stage 1) and subsequently at an amount equal to lifetime expected credit losses if the credit risk assessed for the financial asset significantly increases (stage 2).

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.

For financial assets that have become credit impaired since initial recognition (stage 3), expected credit losses at the reporting date are measured as the difference between the asset's gross carrying amount and the present value of estimated future cash flows discounted at the financial asset's original effective interest rate.

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 1.11.3 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 1.12 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 1.12.1 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 4.72% applied to new leases commencing in 2024 and 4.81% to new leases commencing in 2025.

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 1.12.2 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.

Note 1.13 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 2025:

		Nominal rate	Prior year rate
Short-term	Up to 5 years	4.03%	4.26%
Medium-term	After 5 years up to 10 years	4.07%	4.03%
Long-term	After 10 years up to 40 years	4.81%	4.72%
Very long-term	Exceeding 40 years	4.55%	4.40%

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 2025:

	Inflation rate	Prior year rate
Year 1	2.60%	3.60%
Year 2	2.30%	1.80%
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 2.40% in real terms (prior year: 2.45%).

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 1.14 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 1.15 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 public dividend capital dividend. The charge is calculated at the rate set by HM Treasury (currently 3.5%) on the average relevant net assets of the Trust during the financial year. Relevant net assets are calculated as the value of all assets less the value of all liabilities, with certain additions and deductions as defined by the Department of Health and Social Care.
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 1.16 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 1.17 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 1.18 Third party assets

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

Note 1.19 Losses and special payments

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

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

Note 1.20 Early adoption of standards, amendments and interpretations

No new accounting standards or revisions to existing standards have been early adopted in 2024/25.

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

The DHSC GAM does not require the following IFRS Standards and Interpretations to be applied in 2024/25. These Standards are still subject to HM Treasury FReM adoption:

IFRS 17 Insurance Contracts – The Standard is effective for accounting periods beginning on or after 1 January 2023. IFRS 17 has been adopted by the FReM from 1 April 2025. Adoption of the Standard for NHS bodies will therefore be in 2025/26. The Standard revises the accounting for insurance contracts for the issuers of insurance. Application of this standard from 2025/26 is not expected to have a material impact on the financial statements.

IFRS 18 Presentation and Disclosure in Financial Statements - The Standard is effective for accounting periods beginning on or after 1 January 2027. The Standard is not yet UK endorsed and not yet adopted by the FReM. Early adoption is not permitted. The expected impact of applying the standard in future periods has not yet been assessed.

IFRS 19 Subsidiaries without Public Accountability: Disclosures - The Standard is effective for accounting periods beginning on or after 1 January 2027. The Standard is not yet UK endorsed and not yet adopted by the FReM. Early adoption is not permitted. The expected impact of applying the standard in future periods has not yet been assessed.

Changes to non-investment asset valuation – Following a thematic review of non-current asset valuations for financial reporting in the public sector, HM Treasury has made a number of changes to valuation frequency, valuation methodology and classification which are effective in the public sector from 1 April 2025 with a 5 year transition period. NHS bodies are adopting these changes to an alternative timeline.

Changes to subsequent measurement of intangible assets and PPE classification / terminology to be implemented for NHS bodies from 1 April 2025:

• Withdrawal of the revaluation model for intangible assets. Carrying values of existing intangible assets measured under a previous revaluation will be taken forward as deemed historic cost.

• Removal of the distinction between specialised and non-specialised assets held for their service potential. Assets will be classified according to whether they are held for their operational capacity.
These changes are not expected to have a material impact on these financial statements.

Changes to valuation cycles and methodology to be implemented for NHS bodies in later periods:

• A mandated quinquennial revaluation frequency (or rolling programme) supplemented by annual indexation in the intervening years.

• Removal of the alternative site assumption for buildings valued at depreciated replacement cost on a modern equivalent asset basis. The approach for land has not yet been finalised by HM Treasury.

Note 1.22 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 1.22.1 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 1.23 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 2.3%.

Land is currently valued at £19,314k, a 5% change in the valuation would alter land asset values by £966k. Buildings are valued at £110,850k, a 5% change in the valuation would alter building asset values by £5,543k.

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 1.3

Note 3.1 Income from patient care activities (by nature)

	2024/25 £000	2023/24 £000
Mental health services		
Income from commissioners under API contracts*	234,713	222,551
Services delivered under a mental health collaborative	26,826	19,523
Income for commissioning services in a mental health collaborative ****	2,098	-
Clinical partnerships providing mandatory services (including S75 agreements)	1,248	1,815
All services		
Private patient income	134	148
National pay award central funding***	235	85
Additional pension contribution central funding**	12,678	7,715
Other clinical income	725	523
Total income from activities	**278,657**	**252,360**

*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/

**Increases to the employer contribution rate for NHS pensions since 1 April 2019 have been funded by NHS England. NHS providers continue to pay at the former rate of 14.3% with the additional amount being paid over by NHS England on providers' behalf. The full cost of employer contributions (23.7%, 2023/24: 20.6%) and related NHS England funding (9.4%, 2023/24: 6.3%) have been recognised in these accounts.

***Additional funding was made available directly to providers by NHS England in 2024/25 and 2023/24 for implementing the backdated element of pay awards where government offers were finalised after the end of the financial year. NHS Payment Scheme prices and API contracts are updated for the weighted uplift in in-year pay costs when awards are finalised.

**** During the 2024/25 financial year the Trust was designated as the lead provider for the Perinatal Provider Collaborative. The associated income is shown above, with the corresponding expenditure detailed within Note 6.1.

Note 3.2 Income from patient care activities (by source)

	2024/25 £000	2023/24 £000
Income from patient care activities received from:		
NHS England	24,928	24,301
Integrated care boards	224,796	206,049
Other NHS providers	27,710	20,768
Local authorities	246	571
Non-NHS: private patients	134	148
Non NHS: other	843	523
Total income from activities	**278,657**	**252,360**
Of which:		
Related to continuing operations	278,657	252,360
Related to discontinued operations	-	-

Note 4 Other operating income

	2024/25			2023/24		
	Contract income £000	Non-contract income £000	Total £000	Contract income £000	Non-contract income £000	Total £000
Research and development	632	-	**632**	686	-	**686**
Education and training	7,860	784	**8,644**	6,960	795	**7,755**
Non-patient care services to other bodies	9,890		**9,890**	8,591		**8,591**
Income in respect of employee benefits accounted on a gross basis	416		**416**	487		**487**
Receipt of capital grants and donations and peppercorn leases		13	**13**		186	**186**
Charitable and other contributions to expenditure		-	**-**		33	**33**
Revenue from operating leases		1,375	**1,375**		1,389	**1,389**
Other income	846	-	**846**	545	-	**545**
Total other operating income	**19,644**	**2,172**	**21,816**	**17,269**	**2,403**	**19,672**
Of which:						
Related to continuing operations			21,816			19,672
Related to discontinued operations			-			-

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

	2024/25 £000	2023/24 £000
Lease receipts recognised as income in year:		
Minimum lease receipts	1,375	1,389
Total in-year operating lease income	**1,375**	**1,389**

Note 5.2 Future lease receipts

	31 March 2025 £000	31 March 2024 £000
Future minimum lease receipts due in:		
- not later than one year	1,375	1,389
Total	**1,375**	**1,389**

Note 6.1 Operating expenses

	2024/25	2023/24
	£000	£000
Purchase of healthcare from NHS and DHSC bodies	1,366	1,611
Purchase of healthcare from non-NHS and non-DHSC bodies	6,347	4,669
Mental health collaboratives (lead provider) - purchase of healthcare from NHS bodies	2,128	-
Staff and executive directors costs	229,089	207,497
Remuneration of non-executive directors	163	178
Supplies and services - clinical (excluding drugs costs) **	5,404	3,035
Supplies and services - general	5,949	4,585
Drug costs (drugs inventory consumed and purchase of non-inventory drugs)	3,416	3,768
Consultancy costs	82	113
Establishment	2,801	2,957
Premises	14,561	15,734
Transport (including patient travel)	4,094	4,154
Depreciation on property, plant and equipment	9,304	9,574
Amortisation on intangible assets	1,062	1,318
Net impairments	1,021	10,229
Movement in credit loss allowance: contract receivables / contract assets	(10)	(17)
Increase/(decrease) in other provisions	(983)	(30)
Change in provisions discount rate(s)	-	(60)
Fees payable to the external auditor		
audit services- statutory audit *	132	114
Internal audit costs	142	152
Clinical negligence	1,735	1,591
Legal fees	253	164
Insurance	163	183
Research and development	1	2
Education and training	2,726	2,123
Expenditure on short term leases	341	515
Expenditure on low value leases	-	23
Redundancy	252	267
Charges to operating expenditure for on-SoFP IFRIC 12 schemes (e.g. PFI / LIFT)	813	732
Car parking & security	204	172
Hospitality	13	4
Losses, ex gratia & special payments	6	45
Other	224	241
Total	**292,799**	**275,643**
Of which:		
Related to continuing operations	292,799	275,643
Related to discontinued operations	-	-

* The audit fees included within Note 6 above are reported as the gross position, the value excluding VAT for 2024/25 is £110k (2023/24 £95k).

** Supplies and services - clinical includes £0k (2023/24: £33k) for utilisation of personal protective equipment consumables donated from DHSC for COVID response. Distribution of inventory by the Department ceased in March 2024.

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 £2,000k (2023/24: £2,000k).

Note 7 Impairment of assets

	2024/25	2023/24
	£000	£000
Net impairments charged to operating surplus / deficit resulting from:		
Abandonment of assets in course of construction	402	64
Changes in market price	619	10,165
Total net impairments charged to operating surplus / deficit	**1,021**	**10,229**
Impairments charged to the revaluation reserve	1,524	2,686
Total net impairments	**2,545**	**12,915**

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. No equivalent projects completed in 2024/25.

Note 8 Employee benefits

	2024/25	2023/24
	Total	Total
	£000	£000
Salaries and wages	153,006	136,746
Social security costs	15,248	14,435
Apprenticeship levy	745	704
Employer's contributions to NHS pensions	32,135	25,363
Pension cost - other	53	69
Termination benefits	252	267
Temporary staff (including agency)	28,721	31,440
Total staff costs	**230,160**	**209,024**
Of which		
Costs capitalised as part of assets	819	1,260

Note 8.1 Retirements due to ill-health

During 2024/25 there were 2 early retirements from the trust agreed on the grounds of ill-health (5 in the year ended 31 March 2024). The estimated additional pension liabilities of these ill-health retirements is £134k (£265k in 2023/24).

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

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 2025, is based on valuation data as at 31 March 2023, updated to 31 March 2025 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 Statement by the Actuary, which forms part of the annual NHS Pension Scheme Annual Report and 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 (considering recent demographic experience), and to recommend the contribution rate payable by 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 1 April 2024 to 23.7% of pensionable pay. 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.

The 2024 actuarial valuation is currently being prepared and will be published before new contribution rates are implemented from April 2027.

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.

	2024/25	2023/24
	£000	£000
Interest on bank accounts	1,027	1,081
Total finance income	**1,027**	**1,081**

Note 11 Finance expenditure

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

	2024/25	2023/24
	£000	£000
Interest expense:		
Interest on lease obligations	834	1,050
Finance costs on PFI, LIFT and other service concession arrangements:		
Main finance costs	897	929
Remeasurement of the liability resulting from change in index or rate	544	1,757
Total interest expense	**2,275**	**3,736**
Unwinding of discount on provisions	99	37
Other finance costs	-	23
Total finance costs	**2,374**	**3,796**

Note 12 Other gains / (losses)

	2024/25	2023/24
	£000	£000
Gains on disposal of assets	-	21
Losses on disposal of assets	-	(179)
Total gains / (losses) on disposal of assets	**-**	**(158)**

Note 13.1 Intangible assets - 2024/25

	Software licences	Internally generated information technology	Intangible assets under construction	Total
	£000	£000	£000	£000
Valuation / gross cost at 1 April 2024 - brought forward	**3,413**	**2,821**	**963**	**7,197**
Additions	-	-	1,945	**1,945**
Reclassifications	156	267	(963)	**(540)**
Valuation / gross cost at 31 March 2025	**3,569**	**3,088**	**1,945**	**8,602**
Amortisation at 1 April 2024 - brought forward	**2,185**	**1,095**	**-**	**3,280**
Provided during the year	558	504	-	**1,062**
Amortisation at 31 March 2025	**2,743**	**1,599**	**-**	**4,342**
Net book value at 31 March 2025	**826**	**1,489**	**1,945**	**4,260**
Net book value at 1 April 2024	**1,228**	**1,726**	**963**	**3,917**

Note 13.2 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 - as previously stated	**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 - as previously stated	**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 14.1 Property, plant and equipment - 2024/25

	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 2024 - brought forward	**20,546**	**102,121**	**1,708**	**905**	**69**	**9,718**	**122**	**135,189**
Additions	-	1,252	7,807	108	68	4	-	**9,239**
Impairments	(1,492)	(2,675)	(402)	-	-	-	-	**(4,569)**
Reversals of impairments	-	2,073	-	-	-	-	-	**2,073**
Revaluations	260	(3,172)	-	-	-	-	-	**(2,912)**
Reclassifications	-	13,732	(925)	-	-	818	-	**13,625**
Disposals / derecognition	-	(757)	-	-	-	-	-	**(757)**
Valuation/gross cost at 31 March 2025	**19,314**	**112,574**	**8,188**	**1,013**	**137**	**10,540**	**122**	**151,888**
Accumulated depreciation at 1 April 2024 - brought forward	**-**	**2,280**	**-**	**647**	**69**	**4,841**	**6**	**7,843**
Provided during the year	-	5,357	-	79	5	1,626	75	**7,142**
Impairments	-	4	-	-	-	-	-	**4**
Revaluations	-	(6,716)	-	-	-	-	-	**(6,716)**
Reclassifications	-	1,556	-	-	-	-	-	**1,556**
Disposals / derecognition	-	(757)	-	-	-	-	-	**(757)**
Accumulated depreciation at 31 March 2025	**-**	**1,724**	**-**	**726**	**74**	**6,467**	**81**	**9,072**
Net book value at 31 March 2025	**19,314**	**110,850**	**8,188**	**287**	**63**	**4,073**	**41**	**142,816**
Net book value at 1 April 2024	**20,546**	**99,841**	**1,708**	**258**	**-**	**4,877**	**116**	**127,346**

Note 14.2 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 - as previously stated	**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 - as previously stated	**-**	**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 14.3 Property, plant and equipment financing - 31 March 2025

	Land	Buildings excluding dwellings	Assets under construction	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000
Owned - purchased	19,314	95,557	8,188	287	63	4,073	41	**127,523**
On-SoFP PFI contracts and other service concession arrangements	-	15,293	-	-	-	-	-	**15,293**
Total net book value at 31 March 2025	**19,314**	**110,850**	**8,188**	**287**	**63**	**4,073**	**41**	**142,816**

Note 14.4 Property, plant and equipment financing - 31 March 2024

	Land	Buildings excluding dwellings	Assets under construction	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£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 15 Revaluations 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 full valuation of the Trust's land and buildings as at 31st March 2025. The previous full valuation having been 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 £1,710k of which £570k was taken to the Statement of Comprehensive Income and £2,280k taken to the revaluation reserve.

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 - 2024/25

	Property (land and buildings)	Plant & machinery	Transport equipment	Total	Of which: leased from DHSC group bodies
	£000	£000	£000	£000	£000
Valuation / gross cost at 1 April 2024 - brought forward	**42,175**	**14**	**149**	**42,338**	**13,069**
Additions	-	-	55	**55**	-
Remeasurements of the lease liability	3,142	-	(1)	**3,141**	320
Movements in provisions for restoration / removal costs	201	-	-	**201**	-
Impairments	(45)	-	-	**(45)**	-
Reclassifications	(13,085)	-	-	**(13,085)**	-
Disposals / derecognition	(114)	(14)	-	**(128)**	-
Valuation/gross cost at 31 March 2025	**32,274**	**-**	**203**	**32,477**	**13,389**
Accumulated depreciation at 1 April 2024 - brought forward	**6,749**	**14**	**73**	**6,836**	**1,146**
Provided during the year	2,106	-	56	**2,162**	721
Reclassifications	(1,556)	-	-	**(1,556)**	-
Disposals / derecognition	(114)	(14)	-	**(128)**	-
Accumulated depreciation at 31 March 2025	**7,185**	**-**	**129**	**7,314**	**1,867**
Net book value at 31 March 2025	**25,089**	**-**	**74**	**25,163**	**11,522**
Net book value at 1 April 2024	**35,426**	**-**	**76**	**35,502**	**11,923**
Net book value of right of use assets leased from other NHS providers					9,368
Net book value of right of use assets leased from other DHSC group bodies					2,154

Note 16.2 Right of use assets - 2023/24

	Property (land and buildings)	Plant & machinery	Transport equipment	Total	Of which: leased from DHSC group bodies
	£000	£000	£000	£000	£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 16.3 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.

	2024/25	2023/24
	£000	£000
Carrying value at 1 April	**34,306**	**28,632**
Lease additions	55	4,405
Lease liability remeasurements	3,141	3,587
Interest charge arising in year	834	1,050
Early terminations	-	(289)
Lease payments (cash outflows)	(13,891)	(3,079)
Carrying value at 31 March	**24,445**	**34,306**

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	Of which leased from DHSC group bodies:	Total	Of which leased from DHSC group bodies:
	31 March 2025	31 March 2025	31 March 2024	31 March 2024
	£000	£000	£000	£000
Undiscounted future lease payments payable in:				
- not later than one year;	1,212	107	2,788	702
- later than one year and not later than five years;	6,407	1,773	16,868	1,729
- later than five years.	21,039	11,199	19,610	11,358
Total gross future lease payments	**28,658**	**13,079**	**39,266**	**13,789**
Finance charges allocated to future periods	(4,213)	(1,823)	(4,960)	(1,891)
Net lease liabilities at 31 March 2025	**24,445**	**11,256**	**34,306**	**11,898**
Of which:				
Leased from other NHS providers		9,143		9,447
Leased from other DHSC group bodies		2,113		2,451

Note 17 Investment Property

	2024/25	2023/24
	£000	£000
Carrying value at 1 April - brought forward	**2,201**	**2,201**
Movement in fair value	-	-
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. Distribution of inventory by the Department ceased in March 2024.

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 2025	31 March 2024
	£000	£000
Current		
Contract receivables	4,880	1,910
Allowance for impaired contract receivables / assets	(85)	(95)
Prepayments (non-PFI)	2,393	1,650
PDC dividend receivable	-	387
VAT receivable	1,587	1,697
Other receivables	113	121
Total current receivables	**8,888**	**5,670**
Non-current		
Prepayments (non-PFI)	245	53
Other receivables	231	236
Total non-current receivables	**476**	**289**
Of which receivable from NHS and DHSC group bodies:		
Current	4,239	1,509
Non-current	231	224

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

	2024/25	2023/24
	Contract receivables and contract assets	Contract receivables and contract assets
	£000	£000
Allowances as at 1 April - brought forward	**95**	**120**
New allowances arising	-	31
Reversals of allowances	(10)	(48)
Utilisation of allowances (write offs)	-	(8)
Allowances as at 31 Mar 2025	**85**	**95**

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.

	2024/25	2023/24
	£000	£000
At 1 April	**17,399**	**19,685**
Net change in year	(5,384)	(2,286)
At 31 March	**12,015**	**17,399**
Broken down into:		
Cash at commercial banks and in hand	33	31
Cash with the Government Banking Service	11,982	17,368
Total cash and cash equivalents as in SoFP	**12,015**	**17,399**
Total cash and cash equivalents as in SoCF	**12,015**	**17,399**

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 2025	31 March 2024
	£000	£000
Bank balances	116	112
Total third party assets	**116**	**112**

Note 21 Trade and other payables

	31 March 2025	31 March 2024
	£000	£000
Current		
Trade payables	10,595	6,767
Capital payables	2,307	919
Accruals	9,055	9,747
Social security costs	1,856	1,803
Other taxes payable	2,114	1,788
PDC dividend payable	49	-
Pension contributions payable	2,751	2,499
Other payables	3	21
Total current trade and other payables	**28,730**	**23,544**
Of which payables from NHS and DHSC group bodies:		
Current	4,992	3,829

Note 22 Other liabilities

	31 March 2025	31 March 2024
	£000	£000
Current		
Deferred income: contract liabilities	808	981
Total other current liabilities	**808**	**981**

Note 23.1 Borrowings

	31 March 2025	31 March 2024
	£000	£000
Current		
Lease liabilities	781	1,802
Obligations under PFI, LIFT or other service concession contracts	416	979
Total current borrowings	**1,197**	**2,781**
Non-current		
Lease liabilities	23,664	32,504
Obligations under PFI, LIFT or other service concession contracts	12,551	12,466
Total non-current borrowings	**36,215**	**44,970**

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 2024	**34,306**	**13,445**	**47,751**
Cash movements:			
Financing cash flows - payments and receipts of principal	(13,058)	(1,020)	**(14,078)**
Financing cash flows - payments of interest	(833)	(899)	**(1,732)**
Non-cash movements:			
Additions	55	-	**55**
Lease liability remeasurements	3,141	-	**3,141**
Remeasurement of PFI / other service concession liability resulting from change in index or rate		544	**544**
Application of effective interest rate	834	897	**1,731**
Carrying value at 31 March 2025	**24,445**	**12,967**	**37,412**

	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**

Note 24.1 Provisions for liabilities and charges analysis

	Pensions: injury benefits	Legal claims	Other	Total
	£000	£000	£000	£000
At 1 April 2024	**1,171**	**280**	**3,129**	**4,580**
Change in the discount rate	-	-	(2)	**(2)**
Arising during the year	80	188	207	**475**
Utilised during the year	(140)	(27)	(234)	**(401)**
Reversed unused	-	(98)	(1,156)	**(1,254)**
Unwinding of discount	99	-	12	**111**
At 31 March 2025	**1,210**	**343**	**1,956**	**3,509**
Expected timing of cash flows:				
- not later than one year;	140	343	94	**577**
- later than one year and not later than five years;	560	-	30	**590**
- later than five years.	510	-	1,832	**2,342**
Total	**1,210**	**343**	**1,956**	**3,509**

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 £1,517k (2023/24 £2,983k) and the clinicians pension provision.

Note 24.2 Clinical negligence liabilities

At 31 March 2025, £11,739k 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 2024: £5,388k).

Note 25 Contingent assets and liabilities

	31 March 2025	31 March 2024
	£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	**-**	**-**

Note 26 Contractual capital commitments

	31 March 2025	31 March 2024
	£000	£000
Property, plant and equipment	1,369	3,882
Total	**1,369**	**3,882**

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	**£000**
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	**£000**
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 2025	31 March 2024
	£000	£000
Gross PFI, LIFT or other service concession liabilities	**18,757**	**19,872**
Of which liabilities are due		
- not later than one year;	1,258	1,842
- later than one year and not later than five years;	6,988	6,294
- later than five years.	10,511	11,736
Finance charges allocated to future periods	(5,790)	(6,427)
Net PFI, LIFT or other service concession arrangement obligation	**12,967**	**13,445**
- not later than one year;	416	979
- later than one year and not later than five years;	4,160	3,346
- later than five years.	8,391	9,120

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 2025	31 March 2024
	£000	£000
Total future payments committed in respect of the PFI, LIFT or other service concession arrangements	**32,717**	**34,178**
Of which payments are due:		
- not later than one year;	2,845	2,734
- later than one year and not later than five years;	11,380	10,937
- later than five years.	18,492	20,507

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:

	2024/25	2023/24
	£000	£000
Unitary payment payable to service concession operator	**2,846**	**2,672**
Consisting of:		
- Interest charge	897	929
- Repayment of balance sheet obligation	1,020	1,011
- Service element and other charges to operating expenditure	697	732
- Capital lifecycle maintenance	116	-
- Revenue lifecycle maintenance	116	-
Total amount paid to service concession operator	**2,846**	**2,672**

Note 28 Financial instruments

Note 28.1 Financial risk management

Financial reporting standard IFRS 7 requires disclosure of the role that financial instruments have had during the period in creating or changing the risks a body faces in undertaking its activities. Because of the continuing service provider relationship that the Trust has with 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 2025 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 28.2 Carrying values of financial assets

Carrying values of financial assets as at 31 March 2025	Held at amortised cost	Total book value
	£000	£000
Trade and other receivables excluding non financial assets	5,139	**5,139**
Cash and cash equivalents	12,014	**12,014**
Total at 31 March 2025	**17,153**	**17,153**

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**

Note 28.3 Carrying values of financial liabilities

Carrying values of financial liabilities as at 31 March 2025	Held at amortised cost	Total book value
	£000	£000
Obligations under leases	24,445	**24,445**
Obligations under PFI, LIFT and other service concession contracts	12,967	**12,967**
Trade and other payables excluding non financial liabilities	21,216	**21,216**
Clinical pension provision	-	**-**
Total at 31 March 2025	**58,628**	**58,628**

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**

Note 28.4 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 2025	31 March 2024
	£000	£000
In one year or less	24,433	23,637
In more than one year but not more than five years	13,395	23,162
In more than five years	31,550	31,346
Total	**69,378**	**78,145**

Note 28.5 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 29 Losses and special payments

	2024/25		2023/24	
	Total number of cases	Total value of cases	Total number of cases	Total value of cases
	Number	£000	Number	£000
Losses				
Cash losses	54	36	35	26
Bad debts and claims abandoned	-	-	14	4
Total losses	**54**	**36**	**49**	**30**
Special payments				
Compensation under court order or legally binding arbitration award	1	-	-	-
Ex-gratia payments	15	6	17	45
Total special payments	**16**	**6**	**17**	**45**
Total losses and special payments	**70**	**42**	**66**	**75**

Note 30 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 31 Events after the reporting date

There have been no material events after the reporting date

Note 32 Better Payment Practice code

	2024/25	2024/25	2023/24	2023/24
Non-NHS Payables	Number	£000	Number	£000
Total non-NHS trade invoices paid in the year	11,554	86,167	13,347	91,262
Total non-NHS trade invoices paid within target	10,954	83,033	12,312	88,938
Percentage of non-NHS trade invoices paid within target	94.8%	96.4%	92.2%	97.5%
NHS Payables				
Total NHS trade invoices paid in the year	1,220	8,218	1,276	7,489
Total NHS trade invoices paid within target	1,205	8,115	1,223	7,121
Percentage of NHS trade invoices paid within target	98.8%	98.7%	95.8%	95.1%

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

Note 33 Capital Resource Limit

	2024/25	2023/24
	£000	£000
Gross capital expenditure	14,380	20,791
Less: Disposals	-	(466)
Less: Donated and granted capital additions	(13)	(186)
Charge against Capital Resource Limit	**14,367**	**20,139**
Capital Resource Limit	14,367	20,204
Under / (over) spend against CRL	**-**	**65**

Note 34 Breakeven duty financial performance

	2024/25
	£000
Adjusted financial performance surplus / (deficit) (control total basis)	3,525
Remove impairments scoring to Departmental Expenditure Limit	402
Breakeven duty financial performance surplus / (deficit)	**3,927**

Note 35 Breakeven duty rolling assessment

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

	2017/18	2018/19	2019/20	2020/21	2021/22	2022/23	2023/24	2024/25
	£000	£000	£000	£000	£000	£000	£000	£000
Breakeven duty in-year financial performance	(1,224)	3,963	4,627	668	(4,388)	280	1,585	3,926
Breakeven duty cumulative position	(553)	3,410	8,037	8,705	4,317	4,597	6,182	10,108
Operating income	181,034	185,085	202,403	220,039	231,746	258,916	272,032	300,474
Cumulative breakeven position as a percentage of operating income	(0.3%)	1.8%	4.0%	4.0%	1.9%	1.8%	2.3%	3.4%