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Northamptonshire Healthcare
NHS Foundation Trust

ANNUAL REPORTS & ACCOUNTS 2017/2018

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MAKING A DIFFERENCE FOR YOU, WITH YOU

NORTHAMPTONSHIRE HEALTHCARE NHS FOUNDATION TRUST

Annual Report and Accounts 2017/18

Presented to Parliament pursuant to Schedule 7, paragraph 25 (4) (a) of the National Health Service Act 2006.

WELCOME

FROM THE CHIEF EXECUTIVE

As a Trust dedicated to making a positive difference and providing care with compassion, we put the person at the centre of what we do.

This year, we introduced our roadmap – what we call 54321. Designed as a path to our mission to *make a difference for you, with you*, it describes our values, leadership behaviours, directorates, and strategic enablers (to help us achieve our vision). On reflection of this past year, I am even more certain that this guiding path has and will continue to help us be a leading provider of outstanding, compassionate care.

After a comprehensive assessment of our services in January 2017, I am proud to share that the Care Quality Commission (CQC) rated the Trust overall as 'Good'. Additionally, we were rated as 'Outstanding' for Care, which is indicative of our commitment to our patients, service users, carers, friends and family.

Even with this recognition, there is more to improve. In particular, following the CQC's identification of areas requiring improvement, we have been highly focused on improving patient safety.

We have also been focused on innovation in patient care and safety. For example, the Recovery College NHFT was developed to support individuals with mental health difficulties to live the life they want to lead and become experts in their own self-care. This is just one of many milestones in services, treatments and care you can read about in our Quality Report.

We continue to involve our staff and stakeholders. Last year, we advanced our use of the online iWantGreatCare feedback tool. This year, we have firmly embedded it in our culture. And through our focus on keeping diversity as a key barometer in our planning and future activity, we were recognised with a shortlisting for the Global Equality and Diversity Awards, and were featured in NHS England's Inclusion Report 2017. Along with six other trusts, we were showcased for the work we have undertaken to promote racial equality and eliminate discrimination.

We've also worked hard to integrate our services locally and foster partnerships. As the new lead for the Northamptonshire Health and Care Partnership (previously known as STP or Sustainability and Transformation Partnership), I'm proud of how we are collaborating with partners to evolve new models of care and pathways. As part of our ongoing partnership with 3Sixty Care Partnership, we helped provide additional clinical pharmacists in general practice.

However, fostering partnerships comes with opportunities and challenges. Our work with First for Wellbeing was tested by the withdrawal of Northamptonshire County Council contracts, and we have faced significant financial challenges in our changing health and social economy.

Despite challenges and changes, the passion and dedication of our staff, governors, volunteers, involvement groups and Trust colleagues continues. We will be relentless with our continuous focus on safety, quality improvements and innovation to maximise outcomes for individuals and the populations that we serve.

Even with the pressures we continue to face as an NHS Foundation Trust, the development of our staff and leaders, investment in our strategic plan and continued commitment to involvement will help us to move forward.

With this commitment and our passion for compassionate care, I am confident that we will continue to achieve and improve next year.

Angela Hillery

Chief Executive

23 May 2018

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PERFORMANCE REPORT

INTRODUCTION

We are Northamptonshire Healthcare NHS Foundation Trust (NHFT). As a healthcare provider to the people of Northamptonshire, as well as some specialist services in bordering and nearby counties, we are dedicated to *making a difference for you, with you*. We deliver many of the NHS services that are provided outside of hospital and in the community, including physical, mental health and specialty services.

PERFORMANCE OVERVIEW

Because we put the person at the centre of all we do, we focus on delivering care that is as easy to access as possible. Our care extends to people in the communities of Northamptonshire and sites located in Corby, Daventry, Kettering, Northampton and Wellingborough, as well as in hospitals and clinics. This means many of our services can be provided at home, work or in schools.

We have a Board of Directors, which is responsible for overseeing the work and services of the Foundation Trust and setting our strategic future. The Board consists of both executive directors (employed directly by the Trust) and non-executive directors (appointed by the Council of Governors). Our governors represent the interests of staff, patients, public, service users and carers, as well as other local organisations, in the running of our Foundation Trust.

We face financial challenges because of the local health economy and our population is significantly changing. This is why our organisational structure, objectives and strategic plans are designed to provide high-quality, joined-up care based on our community's needs.

We are committed to delivering care for our patients in their own homes whenever possible and provide many services outside of hospitals and in the community. This performance review provides more information about our organisation, the community we serve, our vision, mission and strategic plans. It also summarises our biggest risks, and reviews our performance against national targets. After making enquiries, the directors have a reasonable expectation that Northamptonshire Healthcare NHS Foundation Trust has adequate resources to continue in operational existence for the foreseeable future. For this reason, they continue to adopt the going concern basis in preparing the accounts.

ABOUT US

As a health and wellbeing organisation that is dedicated to making a positive difference, our strategic and organisational objectives keep safe, quality care at the foundation of what we do every day. By continually innovating, and striving to make a difference to our community, and those working for our Trust, we aim to serve the people of Northamptonshire and surrounding areas with safe, quality care. We deliver this from an understanding of our local healthcare needs, economy and the changing demands of our community.

At NHFT, our values are like a compass. They help us make decisions and decide what matters most to us. Our values guide us along our path to *making a difference for you, with you*, along with our 54321 roadmap:

OUR SERVICE PORTFOLIO

ADULT MENTAL HEALTH AND SPECIALTY SERVICES

- Acute Liaison Service and Psychiatry for Older Persons
- Adult Inpatient ICU
- Adult Inpatient Low Secure
- Adult Inpatient Specialist
- Adult Inpatient Acute
- CATSS (Crisis Telephone Support Services)
- Changing Minds IAPT Service
- Community Mental Health Adult – Early Intervention N'Step
- Crisis cafes
- Criminal Justice Liaison and Diversion Team
- The Warren
- Custody Healthcare Team
- Eating Disorders Service
- Forensic Team
- Gender Identity Clinic
- Health Based Place of Safety
- Learning Disabilities
- Memory Assessment Service
- Mental Health Navigators
- Older Adults Community Mental Health Team (OACMHT)
- Older People's Inpatient Acute
- Northants Personality Disorder Hub
- Planned Care and Recovery Treatment Service (PCRT)
- Police Liaison & Triage
- Prisons
- Recovery College NHFT
- Sexual Assault Referral Centre (SARC)
- Treatment Centre (rTMS/ECT)
- Urgent Care and Assessment Team (UCAT)
- Younger Persons with Dementia Team

ADULT SERVICES

- ADHD & Asperger's
- Adult Community Hospital Inpatient Beds
- Adults' Speech & Language Therapy Services
- Community Brain Injury
- Community Nursing
- Continence Service
- Community Therapy Service
- Diabetes and High Risk Foot Service
- Diabetes MDT
- Diabetic Eye Screening Programme
- Dietetics
- Evening Community Nursing Team
- Falls Prevention Service
- MSK Occupational Therapy Hand Therapy
- Physiotherapy (MSK & ESP)
- Podiatric Surgery
- Specialist Dental Services
- Specialist Nursing – Heart Failure
- Specialist Nursing – Multiple Sclerosis
- Specialist Nursing – Parkinson's Disease
- Specialist Nursing – Tissue Viability
- Specialist Palliative Care
- TB Nursing Service
- Unplanned Intermediate Care Team

CHILDREN'S SERVICES

- CAMHS in the Community
- CAMHS Inpatients
- Children and Young People ADHD & Asperger's
- Children and Young People Community Eating Disorder Service
- Children's 0-19 Services
- Children's CTPLD
- Children's Therapy Services – Speech & Language Therapy Team
- Children's Therapy Services – Occupational Therapy
- Children's Therapy Services – Physiotherapy
- Community Children's Nursing
- Community Paediatrics
- Specialist Dental Services
- Looked After Children
- Short Breaks for Disabled Children and Young People
- Special School Nursing Team
- Referral Management Centre

OTHER SERVICES

- Communicare (Occupational Health)
- End of Life Care Practice Development Team
- Infection Prevention and Control
- Innovation and Research
- Library Services
- Pharmacy
- Safeguarding
- Spiritual Wellbeing

OUR HISTORY

We were formed in April 2001, following the merger of Northampton Community Healthcare NHS Trust and Rockingham Forest NHS Trust. Then known as Northamptonshire Healthcare NHS Trust, we became a Foundation Trust in May 2009.

Today, operating as Northamptonshire Healthcare NHS Foundation Trust, over 5,000 staff contribute to and provide dedicated healthcare to people in our community.

OUR COMMUNITY

According to Northamptonshire Analysis's website (accessed April 2018), Northamptonshire's current population of over 733,000 people is set to rise by 4% by 2030. Of this population, 20.1% are aged 0-15, 62.6% are aged 16-64 and 17.3% are over 65 years old.

Based on registered patient data from Nene and Corby CCGs, First for Wellbeing reports that 86% of people in Northamptonshire drink alcohol, 23% of which to unsafe levels, 67% are overweight, and 19% smoke.

They also report the following health statistics for Northamptonshire:

- Just under 27% of adults are inactive
- Life expectancy for women is lower than the national average, at 83 years
- 69% of deaths are attributable to three main causes:
  - 29% from cancer
  - 26% from circulatory
  - and 14% from respiratory

OUR DRIVERS

NHS England's *Five Year Forward View* (published in 2014) proposed the introduction of new care models that address gaps in health and wellbeing, care and quality, as well as finance and efficiency. These models put the patient at the heart of the system and promote greater personalisation, as well as emphasise local decision-making.

In March 2017, NHS England shared its *Next steps on the Five Year Forward View*. Urgent care and general practice, as well as cancer and mental health, are critical areas of focus, in addition to helping frail and older people to stay healthy and independent.

The NHS is also continuing to drive Sustainability and Transformation Partnerships, in order to integrate funding and services at a local level. In response, we have been developing new care models locally that foster partnerships with the wider NHS, local government (including social care and housing), the voluntary and community sectors and higher education.

These developments are aligned to the Northamptonshire Sustainability and Transformation Partnership (STP). Renamed as Northamptonshire Health and Care Partnership (NHCP) in late March 2018, our partnership brings commissioners and providers across Northamptonshire's health and social care economy together to 'improve the health and wellbeing of all people in Northamptonshire and reduce health inequalities by enabling people to help themselves'.

The Northamptonshire Health and Care Partnership (formerly STP) was created to evolve the local health and care system. With this work at both national and local levels, and our local community's demographic growth, the Trust is planning for increased demand on its services, an increase in focus on improvements to the most health deprived areas and a continued focus on services for frail, older and long-term users of health services.

OUR LOCAL COMMISSIONERS

We continue to align our plans with those of our commissioners and are working increasingly closely together in developing services for the future. As a trust, we hold contracts with four main commissioners – Corby CCG, Nene CCG, NHS England and Northamptonshire County Council (NCC).

New ways of working
Our contracts with these commissioners range from universal services for children, young people and families to specialist services for older people with complex physical and mental health needs.

Looking ahead, the Trust must also be adaptable to the change that comes from the new care models as prioritised by the NHCP. In particular, our focus is on:

1. Urgent care
2. Primary and community services
3. Mental health
4. Cancer

OUR LOCAL CONTEXT

As the Trust reported last year, we continue to operate in a mixed health economy made up of two acute trusts, four 'at scale' primary care organisations (three primary care federations and a 'super practice'), council services, independent sector providers and voluntary community sector organisations. Each organisation and sector plays a different role in patient care pathways, so it is important that we continue to approach ways of working together proactively and collaboratively.

Key providers operating in Northamptonshire include:

- Kettering General Hospital NHS Foundation Trust
- Northampton General Hospital NHS Trust
- The three GP federations: GP Alliance (Northampton), 3Sixty Care Partnership (North Northamptonshire) and DocMed (South Northamptonshire)
- The Lakeside GP 'super practice' (Corby and surrounding areas)
- Northamptonshire County Council / Olympus Care Services (OCS)
- First for Wellbeing
- St. Andrew's Healthcare
- A variety of third sector organisations represented by Voluntary Impact Northamptonshire and including Age UK and Mind
- East Midlands Ambulance Service (EMAS)

HOW THIS AFFECTS US

With a challenging economic context, we need to continue to develop more effective ways of working with organisations, our patients, service users and carers. These partnerships are critical to our delivery of our strategy and are based on the following strategic observations:

- The Trust needs to plan for demographic growth, which is expected to be slightly higher than the national average. This will mean more demand for our services.
- In particular, we need to focus on improvements to services in the most health deprived areas of the county.
- Likewise, we must give more attention to services for frail and older people, and those with long-term conditions, who are significant users of health services.
- The health and social care system has financial challenges, so the Trust must continue to work with its partners on ways of using the available resources to the best effect in the system.
- We must react to the move towards population health systems and outcomes-based commissioning.
- When services are tendered in our community, we must be prepared for strong local and national competition. Tenders in neighbouring regions could offer opportunities to grow.
- Our leading opportunity is to develop integrated services with partners in the community.

Fundamentally, our main objective is to make sure that our services are continually improving in quality, efficiency and cost effectiveness. This provides an increased capacity to meet the health demands of our population, keep health economy stakeholders on side, minimise competitive threats and capitalise on business development opportunities as they arise.

OUR VISION

Our vision is to be a leading provider of outstanding, compassionate care. The themes within our strategy are designed to support and guide our journey towards this.

Our overall strategy, named DIGBQ, has five themes. These themes – Develop, Innovate, Grow, Build, Quality – describe what we need to accomplish to achieve our vision. We have objectives aligned to each theme. These are:

- Develop in partnership
- Innovate
- Grow our staff capability
- Build a sustainable organisation
- Quality and safety at the foundation of all we do

OUR MISSION

Our mission is *making a difference for you, with you* and was chosen by our own staff and stakeholders. It means that in everything we do and through every service we provide, we want to make a positive difference in people's lives – for those we care for, those we work with and those who work for us. Everyone is part of our team.

OUR STRATEGIC PLANS

During 2017/18, the Trust took the opportunity to refresh its strategic plan, and involved key stakeholders in this process. The Board of Directors endorsed the 2018/19 – 2022/23 strategic plan at its March 2018 meeting.

We have developed strategic and business plans for our Adult and Children, and Mental Health, Learning Disability and Specialty Services directorates. These were developed mid-way through 2017 and extend to 2019. The plans support the delivery of Northamptonshire's Health and Care Partnership and NHS England's Five Year Forward View.

ADULT AND CHILDREN'S SERVICES

In order to respond to changing models of care, innovation and improvement, along with our wider economic and social context, our Adult and Children's strategic plans are focused on integrated, community-based services with a strong primary care interface at the heart.

Our programmes aspire to reduce reliance on secondary care, where there are suitable alternatives and a number of the obstacles to treatment in the community are now being addressed through the delivery of integrated care and strengthening of primary care.

Strategic aims
Designed to provide outcome driven, high-levels of care in the community for the population of Northamptonshire, our plans aim to focus on prevention as well as quality of care through partnership. By involving our clinical teams to drive the services forward, we develop and foster a culture of inclusivity, improvement, innovation and compassionate care. This is in line with national and local priorities and ensures service user and stakeholder engagement.

Universal Children's Services

- To meet all of the elements of the Northamptonshire Healthy Child Programme (NHCP) in an efficient and inclusive manner.
- To reduce health inequalities through evidence-based interventions.
- To ensure every child has the best start in life.

Specialist Ambulatory Services

- To work in partnership with colleagues in primary and secondary care, ensuring that individuals are treated as close to home as possible, and in line with the Five Year Forward View.
- To maximise the treatment available within NHFT.

- To work with commissioners to ensure contracts are retained and developed to meet the needs of the public.
- To develop roles and responsibilities to ensure opportunities are maximised and service users receive high quality care by appropriately trained teams.

Safeguarding

- To ensure the Trust has competent and confident staff, with awareness of their safeguarding responsibilities and a supportive internal response to incidents and concerns. These staff will, during their normal working duty, identify those vulnerable children and adults who are in need of protection or a risk to others and apply appropriate procedures/processes.
- To work in partnership with key agencies via the Northamptonshire Safeguarding Children's and Adult's Boards to provide high-quality and integrated processes for identifying and protecting our most vulnerable children and adults.
- To provide health input to the Multi Agency Safeguarding Hub (Children) in Northamptonshire in partnership with Northants Police and Northamptonshire County Council.

Children's and Adolescent's Mental Health Services

- To improve the availability and effectiveness of mental health interventions for children and young people by ensuring services meet demand and maximise the ability for early intervention.
- To treat young people as close to home as possible.

Specialist Children's Services

- To continue to provide high quality care to children and families.
- To provide equitable care across the county, which is in line with best practice and enables innovative practice.

Community Nursing

- To continue to identify areas for improvement and integrated working across the different services.
- To ensure that all patients receive high quality care by highly skilled members of staff at the right time and in the right place.
- To continue to work with colleagues in health and social care to reduce hospital admissions and strengthen the discharge process.
- To support both the urgent care programme and drive quality of care for the patients, by developing and evolving 'blue sky thinking' incorporating best practice nationally.

Adult Therapies, Podiatry and Specialist Nursing

- To develop services in line with the principles of the NHCP and provide equitable and integrated same day access across the county.
- To provide appropriate access for all patients and a simple and effective referral process.

Specialist Palliative Care and Community Inpatients

- To work with the CCG and charity commissioners to further develop services to palliative care patients.
- To continue to provide high quality, safe care in an efficient and effective manner, ensuring the 'SAFER' principles are adopted within the units and patients are placed in appropriate units.
- To strengthen the enablement process and reduce the length of stay.

MENTAL HEALTH, LEARNING DISABILITY AND SPECIALTY SERVICES

Our strategic plans are designed to provide outcome driven, high quality levels of care for the population of Northamptonshire, by working in partnership with others. Our focus is on prevention, primary and secondary care and developing seamless and easily accessible pathways.

As in our Adult and Children's Services plans, we are developing and fostering a culture of inclusivity, improvement, innovation and compassionate care by developing and enabling clinical teams to drive the services forward.

This involves working closely with commissioners, in line with national and local priorities and ensuring service user and stakeholder engagement. In addition, equality and proactive community engagement will ensure fairness and access is a key part of our plans and processes.

Learning Disability Services

- To transform services in line with the Transforming Learning Disability Care Agenda, focusing on care closer to home, reducing reliance on beds and creating capacity within community-based services to support individuals.
- To become a Lead Provider for Learning Disability Services by working in partnership with all agencies to deliver health and social care provision that is forward thinking, emphasises choice and control, is empowering and person-focused.

Specialty Services

- To support specialised commissioning and criminal justice commissioners by delivering well-respected and high quality safe care, utilising technology and innovative solutions for long-distance service provision.
- To pursue and retain all financially viable services within this setting.

Mental Health Inpatient Services

- To continue to provide high quality care to service users who are at the most acute phase of their illness and support recovery as a priority.
- To provide equitable care across the county that is in line with best practice and enables innovative practice.
- To work across pathways to ensure the need for these services is clear, focused and accessed as part of a holistic pathway approach.

Mental Health Community Services

- To improve the availability and effectiveness of mental health interventions for our population by ensuring services meet demand, maximise the ability for short-term and early intervention and promote recovery approaches.
- To ensure the continued close links with in-patient services will develop.

Crisis Pathway Services

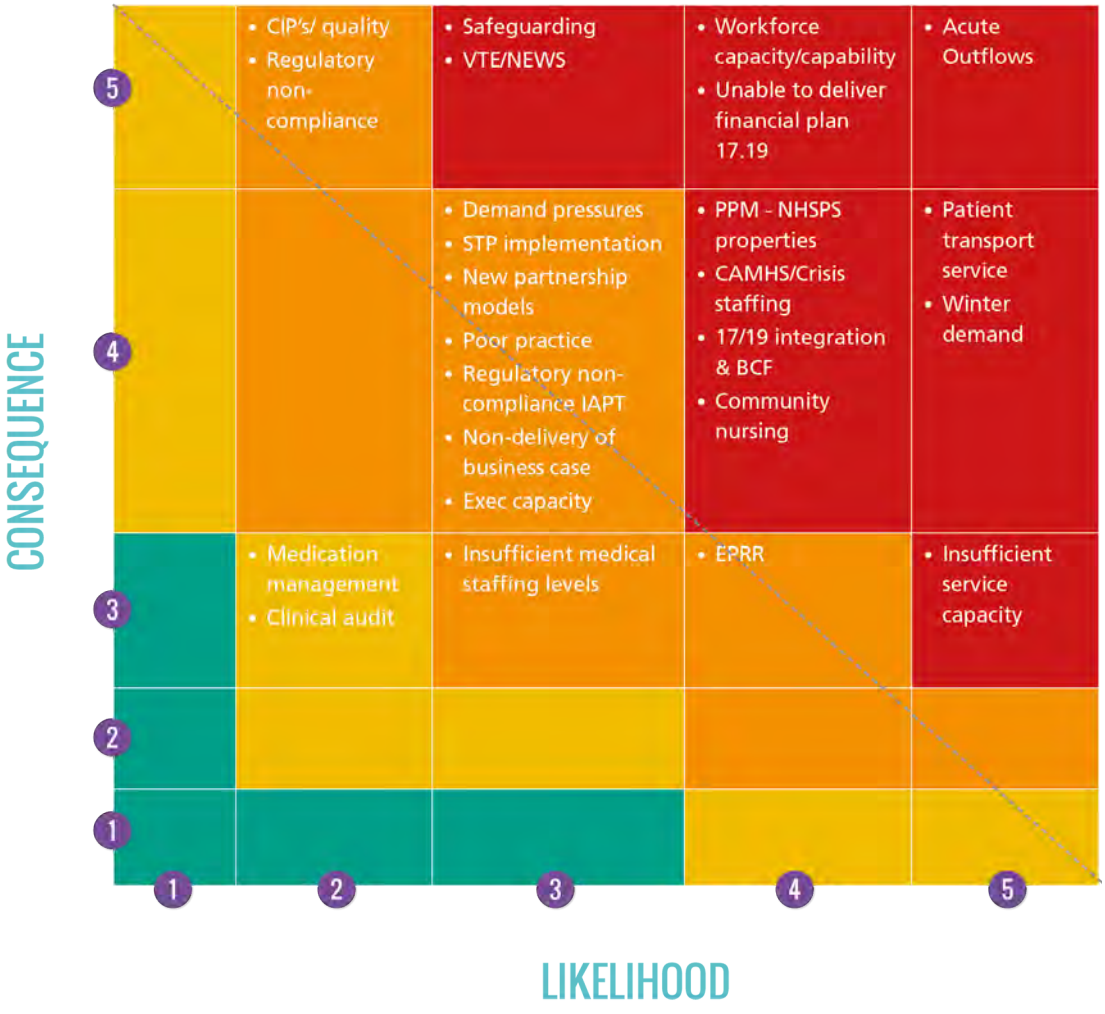
- To continue to interface with Urgent Care, Acute Care and the Crisis Concordat to ensure that developments are in line with national and local requirements.
- To create innovative responses to demand and evaluate each development, supporting the attainment of system-wide objectives.

Older Adult Services

- To continue to provide high quality care to our older adult population, either in inpatient wards or community settings.
- To provide equitable care across the county that is in line with best practice and enables innovative practice.

SUMMARY OF CURRENT ORGANISATIONAL RISKS

Our Board of Directors reviews our key organisational risks on a bi-monthly basis using the organisational risk register. As of March 2018, the key risks are shown in the following heat map.



OUR BIGGEST RISKS

During 2017/18, the most significant risks to the Trust included:

1. Acute outflows, which involve financial/reputational/quality risk
2. Being materially unable to deliver our 2017-19 financial plan
3. Being unable to maintain the right workforce capability and capacity to deliver our strategic plan
4. The standard of patient transport provided as part of our services
5. Insufficient urgent care system capacity to meet winter surges in demand

These risks were mitigated by action plans and control mechanisms including scrutiny and management of the Trust's financial performance, rolling recruitment programmes across all directorates and safe staffing monitoring and reporting. Risks two and three noted above will carry forward as significant risks into 2018/19.

REVIEW OF STATUTORY TARGETS

In 2017/18 we achieved five out of the nine of our statutory targets at Q4. Our performance against target is summarised in the following table. Three of the statutory targets currently under target in Q4 were new indicators introduced in 2017/18. These indicators are covered by national standard definitions.

SCORED INDICATORS 2017/18	2017/18 TARGET	2016/17 OUTTURN	Q1	Q2	Q3	Q4
18 week RTT (non admitted patients) - Incomplete Pathways	92%	100%	100%	99.90%	99.70%	100%
Early Intervention in Psychosis - patients seen within 2 weeks of referral	50%	95%	100%	100%	90.90%	100%
Ensuring that cardio-metabolic assessment and treatment for people for psychosis is delivered in a) Inpatient Wards (90%) (CQUIN cohort) - Patients admitted in month	90%	N/A		59.60%	58%	60%
Ensuring that cardio-metabolic assessment and treatment for people for psychosis is delivered in b) Early Intervention Team (90%) (CQUIN cohort) - Current caseload	90%	N/A		81%	83.30%	79.6%
Ensuring that cardio-metabolic assessment and treatment for people for psychosis is delivered in c) Community Mental Health service (people on CPA) Current caseload	65%	N/A		57.60%	44.70%	51.3%
Data Quality Maturity Index (DQMI)	95%	N/A			97.50%	97.3%
Improving Access to Psychological Therapies: Proportion of people completing treatment who move to recovery	50%	45.70%	42.50%	40.70%	43.60%	46.8%
Improving Access to Psychological Therapies: Patients seen within 6 weeks of referral	75%	80.60%	72.10%	62%	76.50%	89.3%
Improving Access to Psychological Therapies: Patients seen within 18 weeks of referral	95%	99.30%	99.30%	98.80%	99%	99.3%
Inappropriate out-of-area placements for adult mental health services (OBDs)			1523	1624	1028	765

CONCLUSION

Even with an ever-changing social, health and economic landscape within which it operates, the Trust has performed well in 2017/18.

As we head into the year of the NHS's 70th anniversary, it is vital that we continue to put improvement and adaptability on our agenda. This will enable us to remain an effective and agile organisation for our population. It is one of the reasons that we continue to review and adapt our strategy plans, as well as explore new and different services and pathways.

Our risks continue to be in the financial areas, along with workforce supply and the pressures of increased demand. This is why we scrutinise our financial performance and recruitment programmes, as well as our safe staffing monitoring and reporting.

2017/18 was a challenging year from a financial perspective, however the Trust continued to perform well and met its financial targets.

We suffered pressures from Mental Health Acute Outflow costs in the first half of the year. Despite this, we managed a turn around and exceeded our control total by reducing agency costs and increasing permanent staff. This means the Trust received all its core Sustainability and Transformation Fund (STF) funding and became eligible to receive Incentive and Bonus STF funding.

In January 2017, the Care Quality Commission (CQC) inspected the Trust and rated us as 'Good' overall, compared to our previous overall rating published in August 2015 of 'Requires Improvement'. We received an 'Outstanding' rating in the Caring domain. I am proud of this achievement, and want to acknowledge and thank everyone who contributed to delivering this overall position. As I mentioned in my welcome to this report, we have work to do in the Safety domain. As we develop improvements for patient safety, we will continue to strive and invest in quality improvements and actions to achieve 'Outstanding' in more domains.

In 2017/18, the Trust met its regulatory requirements under NHSI's Risk Assessment Framework and Single Oversight Framework. As the previous table shows, this year we achieved five out of the nine of our statutory targets at Q4 – three of the four that we did not meet were new indicators introduced in 2017/18. We exceeded our planned score of 2 against NHS Improvement's 'Use of Resources' metrics and were pleased to achieve a rating of '1' by year end.

Angela Hillery

Chief Executive
23 May 2018

PERFORMANCE ANALYSIS

OUR PERFORMANCE

At the Trust, performance analysis is critical to our effectiveness and continuous improvement.

EXTERNAL ANALYSIS

Like all Trusts, our performance is measured by NHS Improvement reviews using the Single Oversight Framework. We are also required to comply with the Care Quality Commission's and Ofsted's regulatory frameworks.

INTERNAL ANALYSIS

In order to continually improve the quality of care we provide to our patients, service users, families and carers, we internally analyse performance, as well as obtain feedback from our service commissioners and partners. We use surveys to determine qualitative and quantitative performance feedback, as well as service reviews and audits to identify areas of effectiveness, challenges and areas to focus on for improvement. In addition to reviews and surveys, we set financial, governance, incident and quality metrics for targets that we measure, review and analyse.

MEASURING OUR PERFORMANCE

We measure our performance in the following areas:

- Staff productivity, resource and performance
- Environmental matters
- Organisational equality and diversity
- Quality performance, assurance and improvement
- Patient safety, experience and feedback
- Health and safety
- Financial targets, plan and performance

The Board of Directors routinely receives and discusses an Integrated Performance Dashboard, which provides a summary of performance against key metrics and supporting narrative. The dashboard is subject to regular review and ongoing development.

ANTI-BRIBERY

The Trust has a Conflicts of Interest Policy, which was based on NHS England's model policy. The policy was developed following the issue of new guidance on managing conflicts of interest in the NHS, which came into effect 1 June 2017. The new policy incorporates an all-encompassing approach to managing conflicts of interest and has an increased focus on transparency.

STAFF PERFORMANCE, RESOURCE AND PRODUCTIVITY

Our ever-changing environment and internal transformation have required new approaches to staff and resource. In order to better evaluate our productivity and performance, we have introduced new systems and processes. We measure our staff productivity, resource and performance in the following ways.

STAFF PERFORMANCE

This year, appraisals have increased. Our internal records identify that 90% of staff received an appraisal this year, compared to 82% last year, and the quality of the appraisals improved. We also invested in job-related training, staff advocacy and open forums, as well as in pulse surveys, to help us further understand how we can positively impact performance and encourage the involvement and motivation of staff.

STAFF RESOURCE AND PRODUCTIVITY

In 2017/18, we implemented the roll out of the eRoster systems to all non-medical and dental staff. Medical and Dental Services have adopted the system to manage their absence records.

We are developing a plan to increase system functionality, including the roll out of the expenses claim and payroll element. Our next steps are to review the initial system set up with the assistance of the software owners, focusing on the Carter Metrics, in order to standardise best practices when managing a roster across the Trust.

ENVIRONMENTAL MATTERS

Our Sustainable Development Management Plan (SDMP), approved by our Board of Directors, has been designed to clarify our objectives on environmental matters, sustainable development and climate change. It also sets out a clear plan of action for the future. Sustainable development and carbon management are corporate responsibilities that we take very seriously. Our SDMP provides clear governance for an assurance process that considers all legal requirements, while taking into account the demands of providing high quality healthcare.

Based on the right mix of social, economic and environmental factors that are fundamental to creating a sustainable health service, our SDMP will also help our organisation to meet its carbon reduction commitments and make essential efficiency savings. In 2017/18 we continued to reduce our carbon emissions by a further 1.2% to 8,947 tCO2e.

Our SDMP helps us to:

- Meet minimum statutory and policy requirements of sustainable development
- Save money through increased efficiency and resilience
- Improve the environment in which care is delivered, for both patients and staff
- Have robust governance arrangements in place to monitor progress
- Demonstrate a good reputation for sustainability
- Align sustainable development requirements with the strategic objectives of the organisation

In 2017/18, we were recognised with the Investors in the Environment (iiE) Green Level Accreditation certificate. An acknowledgement of our commitment to reducing our environmental impact and the continual improvement of environmental performance, the accreditation shows we have made good progress with our carbon footprint reduction.

ORGANISATIONAL EQUALITY, DIVERSITY AND INCLUSION

With a large, diverse workforce and patient population, we recognise that promoting human rights, equality and diversity – while tackling inequality, discrimination and harassment – is central to the achievement of our vision and core values.

We seek to comply with the requirements of the Public Sector Equality Duty (PSED) to make sure that we consider the needs of all individuals across our policy development, delivery of services and employment practices. In line with our duties as an employer and provider of NHS services, we also have an equality and inclusion policy that provides a framework to ensure compliance with the Equality Act 2010 and Human Rights Act 1998.

We use the national performance tool for equality, the NHS Equality Delivery System 2 (EDS2). Designed to help NHS organisations understand how equality can drive improvements and strengthen the accountability of services to patients and the public, we are focused on addressing inequalities and delivering positive outcomes for all groups protected under the Equality Act 2010. Following on from our early EDS2 work, the information will be shared as part of the community engagement programme planned to commence in the spring of 2018.

We have complied with the NHS Workforce Race Equality Standard and have used it as a framework to help drive our work with staff networks. We have ensured that all electronic Trust systems comply with the NHS Accessible Information Standard so that disabled service users are provided with information in appropriate formats and that our patient records capture any specific communication needs our service users may have.

In addition, an analysis of our staff survey results from groups with protected characteristics highlighted several areas that the Trust will be focusing on.

ACTIVITIES THAT ENHANCED E&I THIS YEAR

- Our Equality and Inclusion Assurance Board and the Diversity Network Leads Meeting bring together Board members and champions of equality. This high level oversight, coupled with a ground level view from our Staff Network and Equality Champions, ensures equality and inclusion is maintained across the organisation.
- We have continued to promote equality through new and innovative projects and activities, such as The Freedom to Speak Up Champion. This year, our activity has meant the chair of the Black and Minority Ethnic (BME) Network was supported to be a champion and an additional point of contact – providing insight into the issues faced by colleagues in our Trust and to set the agenda for improvement.
- Another innovation has been to commence the Reverse Mentoring Project in partnership with the University of Nottingham. This will see the Trust's Executive Board members mentored by BME staff members to improve cultural awareness and establish a shared cause to act on behalf of disadvantaged groups. It remains compulsory for all staff to receive equality, inclusion and human rights training.
- We continue to work with our staff networks and local community to address discrimination and improve staff and patient experience and outcomes for all.

VOLUNTEER NETWORK

At the Trust, we value our dedicated 90 active volunteers, who give up their time to contribute to activities that support our work within the organisation and for our community.

This year, Voluntary Impact Northamptonshire (VIN) continued to provide volunteer management to the Trust. VIN was contracted by the Trust to help us find volunteers and match people with suitable volunteering opportunities to our organisation, and to give assurance that the appropriate processes are in place to recruit and manage volunteers.

In 2017/18, VIN established processes and procedures for the Trust's volunteering opportunities, and our Volunteering Development Officer (VDO) conducted project work to explore these development opportunities. We also recruited a Volunteer Coordinator, who supports our VDO with the coordination of volunteers and administration.

QUALITY PERFORMANCE, ASSURANCE AND IMPROVEMENT

Our culture of continuous quality improvement is linked to the five CQC domains in its planning and development. We have grouped our priorities for improvement into three areas – patient safety, patient experience and clinical effectiveness.

1. **Patient safety**
    - To reduce the level of risk associated with self-harm incidents
    - To embed the mortality and morbidity process across the organisation
    - To increase the levels of reporting associated with falls, ensuring that all relevant patients and service users in inpatients and community settings have a falls assessment completed, and those identified as being at risk have a falls care plan implemented

2. **Patient experience**
    - To collaboratively develop a recovery college model within the organisation
    - To increase the number of service users and carers involved in staff recruitment
    - Using iWantGreatCare (iWGC) and other sources of feedback to learn from and respond to patients and carers

3. **Clinical effectiveness**
    - To work collaboratively internally to share our patient safety experiences and outcomes in order to improve learning from incidents, complaints and compliments and reduce harm
    - Develop the skills and competence of all newly qualified Band 5 nursing staff and allied health professionals (AHPs)
    - To increase the reporting associated with completing physical examinations within the mental health services

PATIENT SAFETY, EXPERIENCE AND FEEDBACK

The quality of patient care, patient safety and experience is central to our philosophy as captured in our mission *making a difference for you, with you*. We measure this through a number of quantitative and qualitative methods, notably:

- Performance data
- Our response to incidents, complaints and PALS concerns

- Feedback, including compliments, PALS, iWantGreatCare, NHS Choices and patient opinion
- Information from our key stakeholders, such as local health providers, commissioners, Healthwatch and the voluntary sector
- Through close working with patients, service users and carers

During the year, we had a total of 25,089 reviews through our systematic feedback system iWantGreatCare.

93.89% of reviewers would recommend our services to friends and family, and they awarded us a rating of 4.81 out of 5 stars for their overall experience.

Throughout the year, we introduced a number of initiatives to improve patient safety and experience:

- We appointed a Mortality Lead to support the Learning from Deaths and Learning Disabilities Mortality Review. This was in line with the National Quality Board guidance on Learning from Deaths issued in March 2017.
- The Learning from Deaths policy has been ratified and guidance has been communicated to staff. This will strengthen the 'learning from deaths' processes. The practical effect of this change is that now, in addition to those deaths that already meet the threshold for full investigation, the care provided in many other cases prior to death is also reviewed and any learning identified, extracted and shared.
- A suicide thematic review was commissioned and shared with key members of staff within NHFT and the CCG.
- A Patient and Family Liaison Lead (P & FLL) was appointed to further establish the process for engagement with family and carers when an incidence of death that is subject to review or investigation occurs. Alongside this engagement process, the Patient and Family Liaison Lead is monitoring Datix incident reports for Duty of Candour (DOC) compliance.
- The Being Open/DOC Policy has been updated and provides practical guidance for staff. Face-to-face policy update sessions have been provided to the teams to ensure they are aware of the requirement of DOC.
- Advice and support booklet for families to explain the role of the P&FLL during the SI and Clinical Review Process has been devised and is shared with the families and patients. In addition, we prepared a signposting leaflet for families.
- Improved triangulation of information and data to identify trends and themes.
- Strengthening of the Quality Framework to ensure more effective ward-to-Board assurance.
- Improved training and communication in relation to reporting incidents on Datix.

HEALTH AND SAFETY

The health, safety and risk committee provides an overarching view of health, safety and welfare. It also provides assurance that non-clinical risks are managed effectively on behalf of the organisation.

During 2017/18, the committee supported changes to:

- Deliver a more practical fire training programme
- Improve statutory compliance reporting
- Develop online building management files and safety improvements to the patient environment

FINANCIAL TARGETS, PLAN AND PERFORMANCE

This year's financial plan was established in the context of a continuingly difficult national economic position, along with a challenging local health and social care economy. In response, our annual plan showed a surplus position in 2017/18 – this met the agreed control total and maintained an overall 'use of resources' risk rating of '1'.

We designed the plan to provide the necessary organisational stability while the Trust and the wider local health and social care economy developed further plans for the transformational change and efficiency gains required in future years.

In 2017/18, the Trust received income of £199 million, incurred expenditure of £187 million, and owned and operated £94 million of assets in order to provide a comprehensive range of mental health, community healthcare and sexual health services for the local population. Our key financial targets in the 2017/18 plan and performance against these are shown in the table below.

FINANCIAL TARGET	FINANCIAL TARGET	ACTUAL	VARIANCE
Control total Surplus/(deficit)	£1.6 million	£5.9 million	£4.4million
Sustainability and Transformation Funding	£1.5 million	£4.2 million	£2.7 million
Cost improvements (savings)	£7.0 million	£7.0 million	£nil
Net current assets	£6.6 million	£11.9million	£5.3 million
Agency Costs	£10.4 million	£7.5 million	
Use of resources rating	1	1	

The Trust has a strong record of planning and delivering a good 'use of resources' rating. We performed in line with our plan and main financial targets for the year, achieving a small surplus in line with the allocated control total. This means we can access additional Sustainability and Transformation (STF) funding to further boost our financial position.

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

The major financial risks to the Trust in 2018/19 will be the achievement of its financial strategy, including savings target of £6.9 million, 3.5% and the impact of the continuation of planned structural and organisational change in local health and social care services. The risk associated with the savings target is managed through the development of detailed savings plans, with clinical and service managers and an established performance management process that enables review and action planning on a routine basis, including at Trust Board level. Risk associated with structural and organisational change is managed through joint planning and ongoing engagement with the Trust's main commissioners and developing risk-sharing arrangements.

OUR YEAR IN BRIEF

The Trust operates in a complex and changing community, and while we manage competing priorities and challenges, we made significant progress and had many developments during 2017/18.

- The Trust achieved a Workplace Wellbeing Charter, recognising our commitment to workplace health, safety and wellbeing in November 2017.

- We achieved Disability Confident Employer level 2 status.

- Investors in the Environment awarded the Trust the Green Award 2018. We have seen continued positive progress in this area, with carbon emissions reduced by 24% across the organisation.

- The Trust was shortlisted for a number of awards, including:
  - CIPD's Best Learning & Development Initiative in the Public/third Sector (for our Leadership Matters programme)
  - HSJ Provider Trust of the Year Award
  - Global Equality and Diversity Awards

- In addition, members of the Trust were awarded recognition including:
  - Steph Buswell from the children and young people's response team won the Our Health Heroes Clinical Support Worker of the Year Award for the East Midlands region
  - The Breathing Space service in Northamptonshire won the Pathway Innovation of the Year Award at the National Primary Care Awards
  - Angela Hillery, Chief Executive, was named as 15th in the HSJ top 50 chief executives of the year – notably for her focus on a strong organisational culture and our partnerships.

New services, treatments and teams

- From April 2017, a due diligence process resulted in a comprehensive project to transfer Northampton General Hospital (NGH) staff into NHFT to provide a single, county wide Child Health Information Service (CHIS) across Northamptonshire. This process was fully supported by NHS England and partners in NGH and also included a full review and mapping of CHIS processes to align with NHS England's expectations of the service. The Trust was awarded a contract for two years, during which time the service model will be reviewed and transformed to match future expectations of the service.

- Also this year, we launched the Recovery College NHFT to support individuals with experience of mental health difficulties to live the life they want to lead and become experts in their own self-care. An educational approach is used to improve health and to compliment treatment already offered by the Trust. The college offers strength-based courses. These are co-produced and co-delivered by people with lived experience of mental health difficulties and mental health professionals. They provide a shared learning environment where those with lived experience and those who provide their support and NHS staff can learn together.

- Launched in May 2017, CAMHS Live was developed to help young people access the mental health services they might need, both live and online. The innovative service is being run by trained CAMHS advisors and is open to young people and their parents/carers.

- In September 2017, the Trust opened its female psychiatric intensive care unit (PICU). The unit, which is located at the Welland Centre, St Mary's Hospital, Kettering, is called Shearwater. The creation of the new unit should reduce the need for female patients requiring PICU admission to receive their placement out of county.

- The Trust created an Urgent Care and Assessment Team (UCAT) and a Planned Care and Recovery Team (PCRT) to support the crisis pathway, reduce admissions and manage patient flow.

- We introduced Repetitive Transcranial Magnetic Stimulation (rTMS) treatment, an innovative alternative to medication for treating depression.

- 'Social Stories™ as an individually tailored intervention for adults with Learning Disabilities (SSALD)' received Health Research Authority's (HRA) approval and is now open to recruitment.

Milestones

- 3Sixty Care Partnership successfully completed its bid for funding to help recruit, train and develop more clinical pharmacists to meet the commitment of providing additional clinical pharmacists in general practice.

  From March 2018 onwards, the 3Sixty Care Partnership hosted fourth-year medical students on an Integrated Care Block, working across the boundaries of primary and community care, under a contract with Leicester Medical School.

- Community teams conducted structured testing for several new patient pathways with GPs, including same day primary care for children under three years old and adults with musculoskeletal conditions, yielding positive feedback.

- Since July 2017 NHFT have worked in partnership with Kettering General Hospital (KGH) and Kettering Borough Council (KBC) to test the benefits of a Health and Housing Partnership Officer. This role was designed to improve patient flow through KGH, community hospitals, and mental health wards and to manage people with complex needs in the community to avoid unnecessary admission.

- iWantGreatCare (iWGC) feedback was culturally embedded at an organisational and service level. We have become more responsive to feedback, discussing comments with staff, patients, carers and external partners, and publicly responding and making changes.

- We launched our co-produced 54321 roadmap to articulate our vision, values and journey toward achieving our mission.

Systems and services improvements

- The Trust implemented a number of improvements including:
    - Community Early Warning System to identify and prevent deterioration for our patients in the community
    - A new self-harm pathway for children in crisis to reduce admissions and improve outcomes
    - Falls prevention training and bed rails training available for all clinical staff, as well as literature for staff, patients and service users in all clinical inpatient and community settings
    - A refreshed financial strategy and new longer term financial modelling as part of system-wide financial development
    - The roll out of ESR self-service with online payslip and change functionality, as well as the development of reporting systems, Agresso financial system and Management Information System v4, which supported significant work around vacancies and ESR reconciliation
    - Staff recruitment, including implementation of a recruitment system called Trac
    - Developing a 'one stop shop' for new starters and to support improved recruitment process

- The Trust also introduced a number of events for improvements:
    - Launched Shaping our Future Together (SOFT) events, bringing over 600 staff from across NHFT to explore ways to make a positive difference together, and develop our Strategic Plan to 2023
    - Successfully delivered Leadership Matters Events (staff conferences) focusing on diversity and inclusion, innovation and creativity, shaping our future together and delivering our DIGBQ strategy

ANALYSIS OF OUR PERFORMANCE THIS YEAR

PERFORMANCE HIGHLIGHTS	PERFORMANCE CHALLENGES
• The Care Quality Commission (CQC) rated the Trust 'Good' overall and 'Outstanding' in the Caring domain in March 2017. • All falls datixes were reviewed by the Falls Project Lead and actions implemented. There was an increase in the reporting of no harm and near miss falls, and a decrease in reported falls causing harm. • We now have 50 falls champions in 25 different clinical areas who receive regular specialist training, and lead on falls prevention in their areas. • We increased the number of service users/carers involved in staff recruitment from 66 (2016/17) to 115 (2017/18), an overall increase of 74%. • The number of iWGC responses where actions have been implemented has increased from 35% (2016/17) to 62% (2017/18). • We maintained maximum autonomy within segment one of NHSI's Single Oversight Framework (SOF), delivering cost improvement and financial performance. • The Trust released significant cost improvement through the implementation of estates strategy, including relocating finance directorate teams to St Mary's site. • The Trust was placed at number eight in the top 10 trusts with the biggest percentage increase in commercial contract research. These results represent the significant contribution we are making to national research. • In our staff survey results, our staff engagement score increased to 3.91 out of 5 (above average for trusts of a similar type). • We have the highest recommendation as place to work and receive treatment (3.90 out of 5) for trusts of our type. • We have the highest score for the effective use of patient and service user feedback (3.99 out of 5) for trusts of our type.	▪ The CQC rated the Trust as 'Requiring improvement' in the Safety domain. From the 15 reports received, five of these were identified as 'Requiring improvement'. After reviewing the feedback, we identified improvement strategies and developed a robust action plan that was bound by clear governance. ▪ As partners in the First for Wellbeing Community Interest Company alongside Northamptonshire County Council (NCC) and the University of Northampton, we experienced some challenges with the withdrawal of NCC contracts in First for Wellbeing. As a result, we were focused on making sure the county continued to have strong health promotion and prevention services. ▪ There were significant financial challenges in the health and social care economy facing a range of structural deficits. ▪ Our capacity in a lean corporate structure has begun to be reviewed. ▪ Staff sickness was above target levels, which was challenging as we received good feedback on our wellbeing support to staff. A renewed focus on policies and support was proposed to address this. ▪ An exploratory Joint Venture with a commercial company to develop satellite operations in the treatment of mental health conditions has proved challenging and the lessons learned are being taken forward. ▪ Our staff survey results show we have deteriorated in our ratings for the percentage of staff working extra hours and satisfaction with level of pay.

• We are above average (as benchmarked against trust of a similar type) for effective use of patient/service user feedback, staff recommendation of the organisation as a place to work or receive treatment, quality of appraisals, Percentage of staff satisfied with the opportunities for flexible working patterns. • iWantGreatCare received 16,000 positive comments with top ratings including patient/parent dignity and respect, staff kindness and compassion and patients feeling safe in our care. This gave us an overall star rating of 4.81 out of 5 – a great achievement (Note: around 60% of the patients, families and carers we see leave comments). • Datix compliments were strong, with 1,245 positive compliments recorded on Datix this year. The top reasons were: care and understanding, thank you's and quality of care. • This year, we saw the largest number of Quality Award nominations ever received. Staff, patients, families and carers nominated a total number of 178 individual and teams which gave us our annual award winners. • Our staff to staff thank you section on the 'Making a difference forum', located on The Staff Room (the Trust's intranet) has received 240 staff thank you notes.	▪ Although the number of staff working extra hours remains above average compared to similar trusts, this has decreased by 2% this year. Satisfaction with the rate of pay saw a significant drop nationally and the trust remains above average for trusts of our type.

LOCAL DEVELOPMENTS

At a local level, there was much change and progress. Below is a summary of key developments in the county and within our local healthcare context.

- As part of the NHS's national response to the recent global cyber security incident, in May 2017 the Trust implemented local contingency plans to mitigate the risks coming from this occurrence.

- In August 2017, there was a joint Board of Directors' and Council of Governors' event. The main focus of the session was to jointly explore the Board's and Council's respective leadership and governance responsibilities in the context of our ambition to move from 'Good' to 'Outstanding' in terms of the CQC's Well Led domain. The session, facilitated by NHS Providers, generated some excellent debate and contributions, as well as some practical ideas to further strengthen our leadership and governance processes.

- In September 2017, we announced that our Chief Executive, Angela Hillery, would also take on the lead role for the STP (now NHCP), on behalf of the Northamptonshire health and social care providers. NHS England and NHS Improvement support this proposal.

- In November 2017, the Trust launched a reverse mentoring initiative. Reverse mentoring involves senior grades of staff being mentored by colleagues in lower grades. The project will utilise NHFT BME colleagues as mentors for senior managers to create an open space for conversation and feedback. This will provide a unique insight into the barriers faced by BME colleagues and challenges or areas of concern within the Trust.

- The Trust was a case study in NHS England's Inclusion report 2017. We are referenced alongside six other trusts for the work we have undertaken to promote racial equality and eliminate discrimination. The report, which was published earlier in the year, brings together some of the best work taking place across the country to improve outcomes for staff and service users.

NATIONAL DEVELOPMENTS

National policy and directives inevitably inform the formulation of the Trust's strategies and plans. These key influences and developments are listed below.

- In July 2017, NHS England announced a new tranche of sites to test new approaches to delivering mental health services – cutting the number of people travelling long distances for care. 11 sites were tasked with bringing down the number of people who receive in-patient hospital treatment and for those who do need more intensive care, that this is available closer to home.

- In September 2017, NHS Improvement announced a new retention programme designed to improve staff retention across trusts in England and bring down the leaver rates in the NHS by 2020.

The programme included a wide range of support, including a series of masterclasses for directors to discuss ways to improve retention, targeted support for mental health providers to improve retention rates and guidance and webinars on how to improve retention rates.

- An independent review of mental health and employers by Lord Dennis Stevenson and Paul Farmer was published in October 2017. The review looked into how employers can better support the mental health of all people currently in employment and those with mental health problems or poor well-being to remain in and thrive through work.

- Going into 2018, the Health Select Committee endorsed the appointment of Baroness Harding as the next chair of NHS Improvement. In addition, Ian Dalton replaced Jim Mackey as NHS Improvement chief executive.

- In March 2018, NHS England published its planning guidance for 2018/19, which is a refresh of plans already prepared under the two-year NHS Operational Planning and Contracting Guidance 2017-2019. It sets out detail behind how the additional funding from the November 2017 budget will be allocated and the developments in national policy with regards to system level collaboration.

- The NHS confirmed extra funding will be made available to improve the mental health of at least 3,000 pregnant women and those who have recently given birth. The £23 million funding is part of a major programme of improvement and investment by NHS England. This will help an additional 30,000 women get specialist mental health care.

- Also in early 2018, NHS England commissioned Quality Health to run an online survey to gather feedback about people's experiences of personal health budgets in England. Commissioners and providers are encouraged to share details of the survey with all personal health budget holders in their area. The findings will be used to improve how personal health budgets are offered in England and the survey closes on 30 April 2018.

- NHS England has supported the launch of a joint consensus statement to improve people's health and wellbeing, prevent crime and protect the most vulnerable people. The statement between policing, health and social care organisations commits partners to working together to use shared capabilities and resources.

ACCOUNTABILITY REPORT

INTRODUCTION

Providing safe, compassionate care to our patients, service users, families and carers comes from a collaborative, inclusive and engaged staff and Trust community. Our care depends on how effectively we govern and review our processes, progress and opportunities to develop.

We actively seek feedback in these areas, and implement changes that develop our services to be safely, securely and realistically managed and provided. This report sets out to communicate how we govern our Trust, manage and engage our people, and how we engage with our stakeholders and the wider community.

DIRECTORS' REPORT

BOARD OF DIRECTORS

We believe in providing safe, quality care through a culture of involvement, collaboration and engagement. Our Board of Directors lead this culture and ensure we are efficiently and effectively balancing safety and quality, with the right governance. Their specialist skills, knowledge and experience are critical to our organisation's delivery of this standard of care.

Our directors are accountable for the development and implementation of our strategy, monitoring progress and leading strategic projects. The Board is satisfied that each of their directors is appropriately qualified to carry out key functions including setting strategy, monitoring and managing performance, and ensuring management capacity and capability. The finance director, medical director and director of nursing, AHPs and quality are professionally qualified, with relevant and substantial experience. They also maintain their registration in accordance with the requirements of their professional bodies.

All other Board members have the appropriate qualifications, skills or experience to support the services we provide.

We are required by the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 to ensure that our directors are fit and proper for their roles. To fulfil this responsibility, the Trust has undertaken appropriate Fit and Proper Persons checks for all directors during 2017/18.

Our directors are also committed to ensuring the Board operates effectively as a team, and this commitment is underpinned by ongoing Board development activity. All Board members regularly visit clinical service areas to directly gain insight and feedback from our staff and patients, as well as to identify areas of positive practice and issues requiring further attention.

The directors are responsible for preparing the Annual Report and Accounts, and consider the Annual Report and Accounts 2017/18 as a whole is fair, balanced, understandable and provides the necessary information.

OUR DIRECTORS

Directors with voting rights

The Board of Directors is responsible for overseeing the work and services of the Foundation Trust and setting our strategic future. The Board consists of both executive directors (employed directly by the Trust) and non-executive directors (appointed by the Council of Governors).

Crishni Waring, Chair

Crishni joined NHFT in 2016 from Coventry and Warwickshire Partnership NHS Trust (CWPT), where she was a non-executive director (NED) for over five years. Crishni has significant experience of leadership at senior level, both executive and non-executive. During her role as NED, Crishni was also CWPT Senior Independent Director. Her role supported Board members and Governors, to ensure effective working and championing of the Trust's Raising Concerns policy.

Crishni has more than twenty years of experience in business, change and HR management. She has a diverse industry background including healthcare, business services, retail, public sector, logistics and distribution. Crishni set up a consultancy business in 2010 providing consulting and interim management services to clients in public and private sectors. In addition, she is also Chair of the Warwickshire Wildlife Trust.

Angela Hillery, Chief Executive

With over 28 years of NHS leadership experience within community services and a Master's degree in development disorders, Angela is also a qualified speech and language therapist. Previously a Director of Operations for the Trust, Angela has served on the National Management Board of the Royal College of Speech and Language Therapy and held a partner role with the Health Professional Council.

Reflecting her commitment to innovation in healthcare, Angela is the new lead for the Northamptonshire Health and Care Partnership (previously known as STP or Sustainability and Transformation Partnership), and is on the national NHS Providers Board. In 2015 Angela was a finalist for 'Chief Executive of the Year' at the HSJ Awards and in early 2018 was listed as 15th in HSJ top 50 chief executives.

Moira Ingham, Non-Executive Director

A registered nurse, Moira has worked in several NHS trusts in the south and east of England, specialising in critical, high-dependency care, including the management of a 35-bed respiratory medicine unit.

With a Master of Science from Kings College, Moira has held several senior academic roles at the University of Northampton latterly as Dean of the School of Health. Since leaving in 2016, Moira has worked freelance on curriculum design and is a clinical assessor for the NMC Test of Competence. She is currently studying for a Doctor of Business Administration in higher education management at the University of Bath.

Richard Wheeler, Finance Director

Richard is a Chartered Accountant with 12 years of NHS experience, starting in 2005 as Head of Finance at the Leicestershire, Northamptonshire and Rutland Strategic Health Authority. He was then appointed Deputy Director of Finance at Oxford University Hospitals and prior to joining NHFT was Director of Finance of East Midlands Ambulance Service (EMAS).

Richard has a maths degree and was awarded Healthcare Finance Managers Association (HFMA) Deputy Finance Director of the Year in December 2012. He recently took over as Finance Lead for the Northamptonshire Health and Care Partnership (previously known as STP or Sustainability and Transformation Partnership).

Bev Messinger, Non-Executive Director and Senior Independent Director

Currently Chief Executive of the Institute of Occupational Safety and Health (IOSH), Bev has over thirty years of public service experience in local government, across seven local authorities, including Northamptonshire County Council.

Her diverse roles in the voluntary sector include director at a charity for the long-term unemployed, chair of the Coventry Citizens Advice Bureau and trustee of a national charity for people with learning difficulties and disabilities. Bev is also a Fellow of the Chartered Institute of Personnel and Development.

Prof Alex O'Neill-Kerr, Medical Director

Alex has been the Trust's Medical Director since 2003, and is currently visiting Professor in Neuromodulation at the University of Northampton, Clinical Lead for The Centre for Neuromodulation, and a consultant psychiatrist for the Trust.

A former member of the Board of Examiners and the Senior Course Organisers for the MRCPsych Examination, Alex is a co-opted member of the Royal College of Psychiatrists ECT, and lectures both nationally and internationally on rTMS at the Royal College of Psychiatry International Meeting and at the Royal College of Psychiatry ECT.

Alex was involved in the merger of two local mental health trusts (Northampton Community Healthcare and Rockingham Forest) in 2001. He also supported our successful foundation trust status application in May 2009 and was involved in the successful transfer of community services from the PCT in 2011.

Scott Adams, Non-Executive Director (From 8 May 2017)

Scott is Director of Integrated Health and Social Care within the Major and Public Sector of British Telecom and has responsibility for the definition and investment prioritisation of major and public sector growth strategy. His role is also aligned to the NHS and local government care providers.

Scott has worked for British Telecom for 19 years at senior managerial and director level and has experience in delivering transformational growth programmes. Scott has a Master's degree in Business Administration.

Paul Clark, Non-Executive Director (From 8 May 2017)

Currently Trustee at Watford Community Sports and Education Trust as well as a Peer Reviewer for the Home Office, Paul has more than 40 years' experience of front line social care services, with 20 of these at Director and senior management level.

Paul has held a number of advisory positions at national government level in policy development and service inspection globally and in the UK.

Julie Shepherd, Director of Nursing, Allied Health Professionals (AHPs) and Quality

Julie has extensive specialist nursing and leadership experience with a 36-year career in the NHS. As a registered general nurse, specialising in orthopaedics and in care of the elderly and intermediate care, Julie has first-hand knowledge of nursing care and holds a Master's degree in managing partnerships in health and social care. During her career Julie has spent a period of time working in social care and is committed to patient centred care, and prides herself on delivering quality, safe care.

Alastair Watson, Non-Executive Director

Alastair is currently Investment Director at Innisfree, a leading infrastructure investment group. He has twenty years of project finance and infrastructure experience and has worked in both the public and private sectors for businesses that range from start-ups to large multi-national corporates. He has worked in roles covering audit, financial advisory, equity and debt investment and he currently sits as a magistrate on the Leicestershire and Rutland bench. Alastair is a Fellow of the Institute of Chartered Accountants in England and Wales.

Melanie Hall, Non-Executive Director (From 1 January 2018)

Melanie has 15 years' board experience within the life sciences and healthcare sector, starting with the NHS Logistics Authority and latterly as Global Special Projects Officer at DHL, Global Life Sciences and Healthcare Division.

Having worked as a partner with the NHS for much of her career, Melanie has a wealth of experience in business and service transformation, and an excellent understanding of the challenges and broad strategic direction of the NHS. Melanie also brings knowledge and high standards of quality assurance and governance levels in regards to CQC standards and audits.

Directors in attendance without voting rights

Chris Oakes, Director of Human Resources and Organisational Development

Chris has a wealth of experience within healthcare, both in the NHS and the independent sector. He has been involved in developing high quality human resources services and leading significant culture change and organisational development (OD).

Chris was director of Workforce and OD at the Black Country Partnership NHS Foundation Trust and prior to that was the director of HR at St Andrew's Healthcare. Chris is a member of the Chartered Institute of Personnel and Development, has an MBA from Cass Business School (City University) and recently completed a Master of Science in Leadership at the University of Birmingham.

Sandra Mellors, Chief Operating Officer

Sandra's healthcare experience spans a 30-year career in the NHS, 22 of those as a physiotherapist before moving into managerial roles. Previously an Associate Director of adult, primary and urgent care at Tower Hamlets PCT, General Manager of Borough and Specialist Services at Bart's and London NHS Trust, Sandra joined the NHFT in 2012 as locality manager for Kettering.

In 2014, Sandra was promoted to Deputy Director of adult services for the Trust and in February 2016 assumed the role of Acting Director of Operations. In August 2016, after a recruitment and selection process, Sandra began her role as Chief Operating Officer.

David Williams, Director of Business Development (From 30 October 2017)

David was a Locality Director for NHS England in the West Midlands. David was responsible for commissioning primary care, dentistry and public health services, as well as supporting a number of Sustainability Transformation Partnerships.

In addition to his role in NHS England, David was also the Accountable Emergency Officer for the West Midlands with the responsibility for ensuring the NHS was prepared and able to respond to major incident situations. David has extensive experience in education, the voluntary healthcare sectors, as well as experience in partnership working and developing ways to work differently.

What our directors deliver

The purpose of our Board of Directors is to govern our organisation effectively and, in doing so, ensure our patients, service users, families and carers, as well as service partners and stakeholders, are assured of safe, quality healthcare.

Our directors' specific terms of reference

1. To formulate strategy for our organisation
2. To ensure accountability for the delivery of our strategy, and seek assurance that systems of control are robust and reliable
3. To shape a positive culture for the Board and organisation
4. To regularly hold meetings in public as part of its commitment to be accountable to the public and its other stakeholders

Our Board of Directors operate in accordance with the Trust's constitution and scheme of delegation. The constitution sets out the duties of the Board and Council of Governors, and the scheme of delegation sets out the type of decisions to be taken by the full Board and/or the Executive Board and individual directors.

NHS Improvement expects foundation trusts to carry out an external review of their governance arrangements every three years. In 2015/16, we engaged Ernst and Young LLP (EY) to undertake an external well-led governance review following a tender process. EY, who had no other connection to our Trust, produced a report with positive feedback on our Board of Directors and no major deficiencies were highlighted. It was a source of reassurance that the Board's own self-assessment very closely mirrored EY's independent assessment of how well the organisation was performing in each of these areas.

To further develop good governance practices, we responded to the report by developing an action plan.

During 2017/18, we regularly revisited the action plan and have ensured that all actions identified were incorporated into 'business as usual' for either the Board of Directors or its committees. We are currently working on our self-assessment for our well-led review in 2018/2019.

Each executive director's performance is evaluated through an annual appraisal process, held by the chief executive whose performance, in turn, is managed by the chair.

Our chair contributes to the executive director appraisal process, and reviews the performance of the non-executive directors annually. This appraisal process has been developed with and agreed by the Council of Governors. Our chair's performance is also appraised using specific, measurable and clearly defined objectives, following an agreed process with the Council of Governors. An appraisal panel, comprising the senior independent director and members of the Council of Governors' Nominations and Remuneration Committee, leads this process. The Council of Governors then approves the outcomes of the appraisal of the chair and non-executive directors.

In keeping with our ongoing improvement commitment, a number of Board development days and workshops were held during the year. Some were externally facilitated and some were in house and topics included:

- Outcome based commissioning
- Accountable care
- Working in partnership
- Corporate governance in health and safety
- Strategy development
- 'Game of threats' - potential cyber hacking exercise
- System leadership
- Team building
- Risk management
- Performance dashboard development/performance strategy refresh

In addition, during August 2017, we held an externally facilitated joint session with the Council of Governors. This session focused on the challenging landscape in which the Trust is operating, existing expectations of the Board and council leadership and governance roles, a reminder of the differences between roles and what assurance and holding to account means.

Following this session a number of proposals were developed by the Council of Governors to further strengthen its effectiveness. The Council endorsed these proposals at its March 2018 meeting.

OUR BOARD MEETINGS

Directors meet regularly, at both public and private sessions. Additional meetings are arranged when urgent items require immediate decision-making. Our Board of Directors and committees routinely review their performance against specific criteria at every meeting. Individual Board committees have either reviewed their performance against their terms of reference or have plans to review this in the near future.

Crishni Waring chairs the Board of Directors' meetings and meetings of the Council of Governors. She has no significant conflicts to declare. Her current term of office is due to expire on 31 October 2019.

In the event members and governors of our organisation wish to express concerns, and when other contact channels are inappropriate or have been ineffective, the senior independent director is available for consultation.

CHAIR	Crishni Waring
DEPUTY CHAIR	Bev Messinger
SENIOR INDEPENDENT DIRECTOR	Bev Messinger (until 31 July 2017) Moira Ingham (from 1 August 2017)
CHIEF EXECUTIVE	Angela Hillery

OUR NON-EXECUTIVE DIRECTORS

Our non-executive directors bring independent judgement, experience and expertise from outside the Trust and apply this for the benefit of our organisation, its stakeholders and the wider community. There are no relationships or circumstances that are likely to affect, or appear to affect, any director's independent judgement. For these reasons, the Board of Directors considers all non-executive directors to be independent.

Our Council of Governors is responsible for non-executive director appointment and termination, with the normal appointment term being three years. Non-executive directors are eligible for reappointment, but usually only for one further period of three years.

ATTENDANCE AT BOARD OF DIRECTORS' MEETINGS

1 April 2017 to 31 March 2018

	27 April 2017 (extra-ordinary)	25 May 2017	27 July 2017	13 September 2017 (extra-ordinary)	28 September 2017	30 November 2017	25 January 2018	29 March 2018
Crishni Waring	√	√	√	√	√	√	√	√
Bev Messinger	A	A	√	A	√	√	√	√
Moira Ingham	√	√	√	√	√	√	√	√
Alastair Watson	√	√	A	√	√	√	√	A
Scott Adams		√	√	√	√	√	√	√
Paul Clark		√	√	√	A	√	√	√
Melanie Hall							√	√
Angela Hillery	√	√	A	√	√	√	√	√
Professor Alex O'Neill-Kerr	A	√	√	√	√	√	√	√
Richard Wheeler	√	√	√	√	√	√	√	√
Julie Shepherd	A	√	√	A	√	√	√	√

A denotes apologies for absence
√ denotes present
Grey denotes no longer Board member/not in post at the time of the meeting

NOMINATIONS AND REMUNERATION COMMITTEE

The Nominations and Remuneration Committee is made up of all non-executive directors. It is led by the Trust's chair and meets at a minimum bi-annually, reporting to the Board of Directors at least once a year. As a matter of course, the chief executive is automatically co-opted as a voting member for all nominations (except for the identification and nomination of the chief executive). The committee will also act in accordance with the relevant provisions of the Fit and Proper Persons Requirement and Monitor's Code of Governance.

The director of human resources and organisational development routinely attends meetings to support the committee, and other directors and external advisors are invited to attend the committee where appropriate.

The Nominations and Remuneration Committee have appointed a substantive executive director member of the Board during the past year using an executive search company.

Nomination functions of the committee are:

1. To ensure there is a formal, rigorous and transparent procedure for the appointment of executive directors
2. To agree and lead the process for the identification and nomination of the Chief Executive, for approval by the Council of Governors
3. To agree and lead the process for the identification and appointment of executive directors
4. To regularly review, in conjunction with the Council of Governors' Nominations and Remuneration Committee, the structure, size and composition of the Board of Directors
5. To evaluate the balance of skills, knowledge and experience of the Board of Directors and, in light of this evaluation, prepare a description of the role and capabilities required for executive director appointments
6. To give full consideration to succession planning, taking into account the future challenges, risks and opportunities facing the Trust, and the skills and expertise required within the Board to meet them
7. To appoint executive search consultants with respect to executive director recruitment as required
8. To ensure there is a robust and transparent procedure for the appointment of nominated representatives, who are not already NHFT employees, to boards (or equivalent) of partnership/joint venture bodies

Remuneration functions of the committee are:

1. To ensure there is a formal and transparent policy on executive director remuneration
2. To determine and review the contractual arrangements of executive directors including, where appropriate, severance packages
3. To set the structure and levels of remuneration packages of all executive directors
4. To ensure there is a formal and transparent procedure for the appraisal of executive director performance
5. To monitor the performance of executive directors
6. To appoint, if deemed appropriate, independent consultants to advise on executive director remuneration
7. To consider and agree appropriate remuneration and contractual terms for the appointment of nominated representatives, who are not already Trust employees, to boards (or equivalent) of partnership/joint venture bodies

ATTENDANCE AT NOMINATIONS AND REMUNERATION COMMITTEE

1 April 2017 to 31 March 2018

	11 April 2017	11 May 2017	27 July 2017	26 October 2017	25 January 2018
Crishni Waring	√	√	√	√	√
Bev Messinger	√	√	√	√	√
Moira Ingham	√	√	√	√	√
Alastair Watson	√	√	√	A	√
Scott Adams		A	√	√	√
Paul Clark		A	√	A	√
Melanie Hall					√

A denotes apologies for absence
√ denotes present
Grey denotes no longer Board member/not in post at the time of the meeting

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AUDIT COMMITTEE

The Audit Committee is made up of three non-executive directors, with the finance director, the chief operating officer and other executive directors in attendance as appropriate. It welcomes representatives of internal and external audit services, PricewaterhouseCoopers and KPMG respectively. The local counter-fraud specialist attends on a regular basis and senior managers attend by invitation. The committee aims to meet five times a year.

The specific terms of reference of the Audit Committee cover:

1. Governance, risk management and internal control
2. Internal audit
3. External audit
4. Relationship with the Council of Governors
5. Assurance functions
6. Counter fraud
7. Financial reporting

Our directors are accountable for the management of the Trust's effectiveness and risk factors. Our Audit Committee reviews the reports and work programmes of our internal and external auditors. This provides assurance to the Board that our systems and processes are effective. The Audit Committee reviews its own effectiveness and that of the internal and external auditors, by considering at each of its meetings the work carried out and exercising any appropriate challenges as required.

The Audit Committee meets individually with the internal and external auditors on an annual basis so that they can raise any issues of concern or clarification in relation to their working relationship with the finance director and his team, as well as comment on their relationship with the internal or external auditors respectively. Only non-executive director Audit Committee members are involved in this debate, as the Trust's executive directors are excluded from the sessions.

OUR AUDITORS

Internal audit

PricewaterhouseCoopers (PwC) provides our internal audit service, which includes appropriate local counter fraud work. Our local counter fraud specialist (LCFS) is available for staff to raise any concerns and regularly attends Audit Committee meetings. Our staff are made aware of the LCFS's availability to talk in confidence about possible improprieties in financial irregularity or bribery.

Staff are also encouraged to raise any concerns they have about clinical quality, patient safety or any other matters through our whistleblowing policy: *Raising issues of concern – freedom to speak up*. The policy sets out clear routes through which staff can bring concerns to the attention of senior management. The policy clearly defines the role of our Freedom to Speak Up Guardian, who reports directly to the chief executive.

Our internal auditors have an annual work programme that is agreed at both executive Board and Audit Committee level and covers clinical and non-clinical aspects. Through the Audit Committee they ensure there is an effective internal audit function that meets mandatory government internal audit standards and provides appropriate independent assurance to the Audit Committee, the chief executive and the Trust's Board of Directors.

External audit

The Council of Governors appointed KPMG as the Trust's external auditors with effect from 1 November 2012 following an Official Journal of the European Union (OJEU) tender exercise and evaluation process. The Council of Governors and Audit Committee members were involved in the appointment, which was for a period of three years.

The three-year contract was due to expire during the course of 2015/16, and the Audit Committee proposed to exercise the extension option for KPMG's contract for a further two years until 31 October 2017. The Council of Governors endorsed this proposal.

In conjunction with the Finance, Planning and Performance sub-group of the Council of Governors, a process for the appointment of the Trust's External Auditors from 1 November 2017 was agreed. The sub-group was given delegated authority to undertake the process at the July 2017 Council of Governors' meeting. Members of this sub-group formed the Governor Audit Working Group. This group met in September 2017 and discussed the tenders received and the scoring, raising points of clarification where needed. This group, working alongside the Board's Audit Committee made a recommendation to the September 2017 Council of Governors meeting based on this discussion. This recommendation was approved at this meeting and KPMG were re-appointed as the Trust's External Auditors for four years from 1 November 2017.

The Audit Committee regularly reviews its own effectiveness and also evaluates the effectiveness of external audit, by considering at each of its meetings the work of the external auditors and exercising appropriate challenge as required.

The value of the external audit plan for 2017/18, as approved by the Audit Committee in December 2017, equates to £44,000 for the annual audit and opinion and £9,692 for the quality accounts opinion excluding value added tax. The external audit plan equates to audit services only. The Audit Committee agreed a policy for the engagement of external auditors for non-audit work in December 2012. Any non-audit services are commissioned in accordance with this policy.

It outlines threats to audit independence that theoretically exist and the mitigations that will be applied to ensure that auditor objectivity and independence is appropriately safeguarded.

During 2017/18, the Trust did not commission any non-audit services from KPMG and no additional costs were therefore incurred in year. If any non-audit work were to be completed by the auditors, then the related threats and safeguards will be reported to the Audit Committee.

Reporting on auditing
The Audit Committee meets regularly to review audit reports and provide assurance to the Board. While preparing and reviewing the annual accounts 2017/18, the Audit Committee considered accounting policies, accounting estimates and material judgments and the main changes as listed in the DH Group Accounting Manual (GAM) 2017/18.

The Audit Committee is required to review significant issues to be considered in the preparation of our Annual Accounts. These are considered to be as follows:

Valuation of property, plant and equipment
Each year the Trust is required to review the valuation of its property, plant and equipment in line with accounting standards. A formal valuation is required to be carried out every five years. The latest valuation has an effective valuation date of 31 March 2014.

Movement in the value of property, plant and equipment can be material to the overall financial position of the Trust and so is included as a significant item.

The Trust has engaged the District Valuation Service to carry out a book review of the value of land and buildings owned by the Trust projected to 31 March 2018.

No formal valuation is required in 2017/18, however the Trust must consider any movements in the property market since the last formal valuation. In addition, consideration must be given as to whether any assets have suffered an impairment and need to be written down at 31 March 2018, i.e. the Statement of Financial Position date.

The results of the valuation of the Foundation Trust's property, plant and equipment will be considered in the preparation of draft accounts submitted for audit in April 2018.

Accounting for joint ventures, joint operations and investments
As the Trust is now working in partnership with other organisations, consideration needs to be given as to whether the financial transactions resulting from the arrangements need to be consolidated into the Trust's financial statements (i.e. identifying if joint arrangements exist).

While the joint nature of an agreement may suggest a joint arrangement exists, the detail of each agreement might point to a different approach and it is possible that different accounting treatments may apply to different elements.

The arrangements that have been considered for joint venture accounting for 2017/18 are listed below.

ARRANGEMENT	DESCRIPTION
First for Wellbeing (FfW)	• Community Interest Company limited by guarantee • The Trust 'owns' a £38 guarantee along with Northamptonshire County Council (£51) and University of Northampton (£11)
3SixtyCare Ltd	• Company limited by shares • Shareholding is on a 50:50 basis with the GPs, and the total shareholding changing is in line with patient lists
rTMS Memorandum of Understanding with Smart TMS	• Memorandum of understanding signed during 2016/17, with limited trading during 2017/18

Accounting estimates and judgments
Included in note 1.4 of the accounting policies are those areas of critical accounting judgments and key sources of estimation likely to be included in the draft accounts for 2017/18. Given the short timescale available for producing the accounts it is inevitable that estimates and judgements will be necessary.

The likely areas of estimate and judgement are:

- Accruals for invoices and for annual leave not taken by staff in year
- Depreciation, based on the useful economic lives of capital assets
- PFI payments, including finance costs
- Provision of impairment of receivables, with an estimate made for irrecoverable debt
- Segmental analysis

Going concern assessment
In preparing accounts in accordance with the GAM, the Trust must consider whether the going concern assumption is appropriate. The Audit Committee discussed this at its meeting in March 2018 and concluded that, subject to clarification of the guidance in the FT Annual Reporting Manual and the Department of Health Group Accounting Manual, that the accounts should be prepared on a going concern basis.

The basis of this planning assumption is:

- The Foundation Trust continues to have a sound system of control and governance in place, with numerous sources of both internal and external assurance over the ongoing viability of the Foundation Trust operationally and financially.
- The Foundation Trust continues to develop and refine its financial plans and scenario planning which should ensure that management has planned for and can cope with the adverse effects of risks as they are identified.

ATTENDANCE AT AUDIT COMMITTEE MEETINGS

1 April 2017 to 31 March 2018

	25 May 2017 (ISA260 meeting)	15 June 2017	31 August 2017 (extra-ordinary)	14 September 2017	14 December 2017	8 March 2018
Alastair Watson	√	√	√	√	√	√
Paul Clark	√	A	A	A	√	A
Scott Adams	√	√	√	√	A	√
Melanie Hall (in attendance)						√
Moira Ingham (in attendance)	√	A	√	√		

A denotes apologies for absence
√ denotes present
Grey denotes no longer Board member/not in post at the time of the meeting

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CHARITABLE SUPPORT

There are three main charities providing support to the Trust: Cynthia Spencer Trust, Cransley Hospice Trust and Northamptonshire Health Charitable Fund.

They provide support to Cynthia Spencer Hospice, Cransley Hospice, and other causes and projects across the Trust. They each hold funds that have been received as donations, specific legacies to support activities and monies generated by fundraising. All three charities are governed by groups of independent trustees, and their involvement and support is much appreciated by the Trust.

Local governance of funds
Our local managers and directors recommend the specific projects where funds should be spent and there is a formal grant process for the two hospices. Each year, money is raised and spent across all areas of the Trust.

This year, we received the following grants:

- Cynthia Spencer £704,000
- Cransley Hospice £602,528
- Mental health and community services £100,000

Northamptonshire Health Charitable Fund contributed towards the following activities and equipment in 2017/18:

1. Creation of garden and outdoor therapy space for the Burrows unit at Berrywood Hospital
2. Purchase of a number of items of equipment for Danetre hospital
3. Patient amenities and activities
4. Support in funding the Global Corporate Challenge initiative
5. Part sponsorship of the Trust's staff awards evening

The Charity Team have also proactively worked with a number of the smaller care units, including working closely with the Children's Short Breaks Team.

DISCLOSURES

Northamptonshire Healthcare NHS Foundation Trust has complied with the cost allocation and charging requirements set out in HM Treasury and Office of Public Sector Information guidance. There are no political donations to declare.

The Better Payment Practice Code requires the Trust to aim to pay all undisputed invoices by the due date or within 30 days of receipt of good or a valid invoice, whichever is later. The Trust's payment performance against this code is shown in the Notes to the Accounts. The income received by the Trust, other than from the provision of goods and services for the purpose of the health service in England relates to rental income from non-NHS tenants of Trust properties, income generation from Communicare (occupational health services) and income from catering. This is deemed insignificant in value and therefore had no material impact on the Trust meeting its principal obligations. There are no known events after the reporting period that impact on the financial statements for 2017/18. The Trust is a partner of First for Wellbeing, a community interest company, which came into operation on 1 April 2016.

OUR QUALITY GOVERNANCE FRAMEWORK

Improving the governance of quality

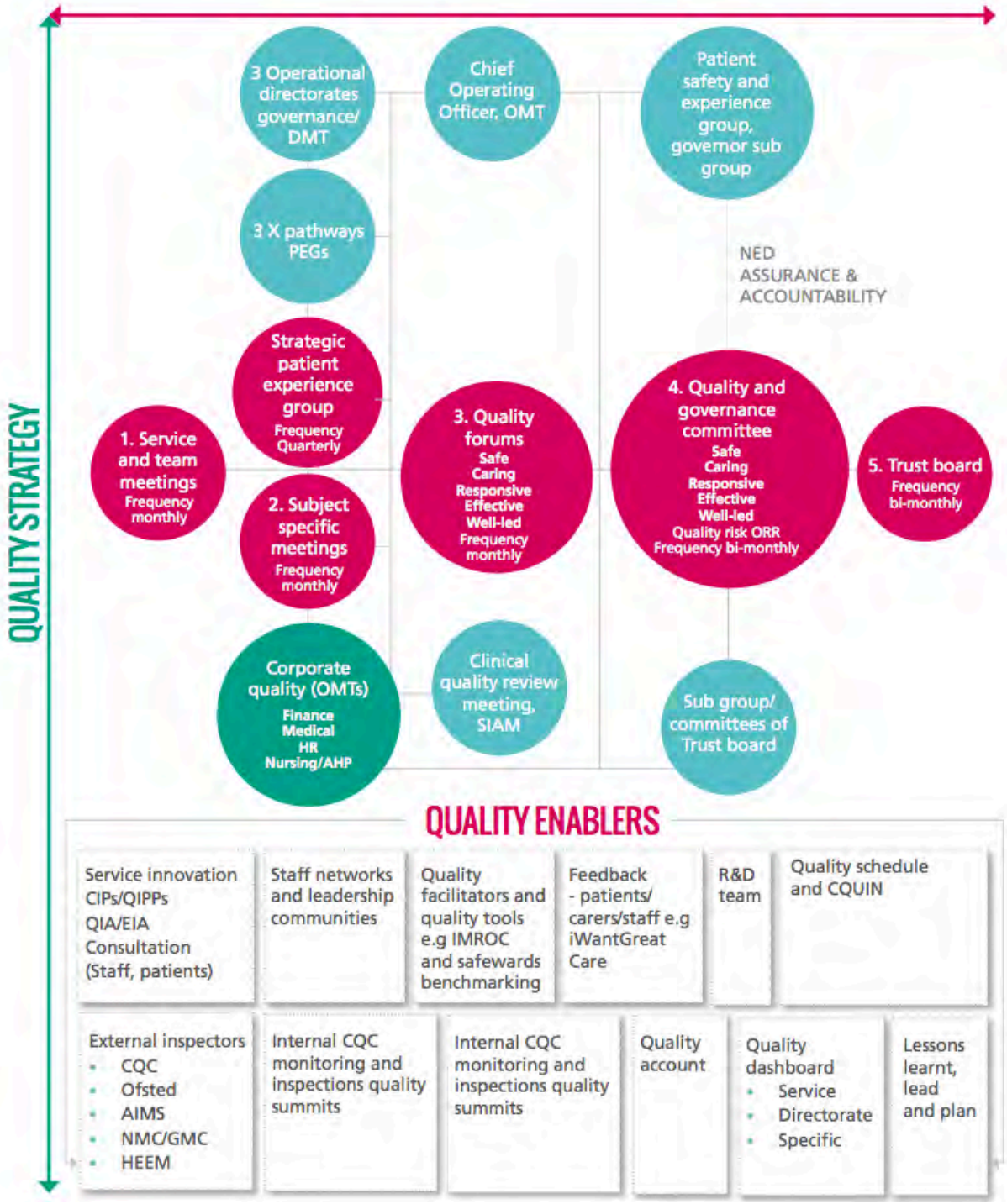
Our quality agenda is underpinned by a systematic quality governance framework, which was rolled out in 2016/17. The structure identifies the core governance arrangements at both a local (for example, team meetings) and strategic level, and links closely to the corporate governance agenda.

The Quality Forum is accountable for clinical quality governance. The forum is attended by clinical and corporate members from across the Trust. Its role is to provide assurance to the Quality and Governance Committee. In addition, items of risk and good practice are escalated as identified within the core business of the forum.

In 2018/19 the Trust will be continuing to ensure that our governance arrangements are robust and streamlined, using an evaluation of our current framework, systems and processes. This strengthening of core quality and governance meetings has meant that issues can be resolved at a local level, and assurance can be provided to the Quality and Governance Committee in a more succinct and measured way.

The Trust uses a robust Care Quality Commission (CQC) self-assessment process, supported by a 'confirm and challenge' system. Here, clinical senior leaders establish the validity of the self-assessment methodology. In addition, the annual audit plan identifies key areas of patient care that are reviewed in line with internal and external requirements. This provides the organisation with baseline and performance data for clinical activities such as record keeping and nutritional screening. These systems identify where improvements could be made, which is monitored locally by clinical leads. The Quality Team, who provides reports directly to the Quality Forum for review, also monitors it for corporate use.

We make sure that data relating to patient safety and our core quality indicators is brought together on a service line dashboard. This provides clear indication to managers and team leaders where there are any potential issues, concerns or areas of good practice across their area. The function provides a platform for action planning where improvement is required. This data is routinely interrogated as part of the internal triangulation process prior to meetings between quality and clinical teams, as well as part of our internal quality summit and governance processes. Looking ahead, the Trust is reviewing how we can develop this technology further to support the quality framework and further underpin the governance arrangements.


QUALITY STRATEGY
3 Operational directorates governance/ DMT
Chief Operating Officer, OMT
Patient safety and experience group, governor sub group
3 X pathways PEGs
NED ASSURANCE & ACCOUNTABILITY
Strategic patient experience group
Frequency Quarterly
1. Service and team meetings
Frequency monthly
2. Subject specific meetings
Frequency monthly
3. Quality forums
Safe
Caring
Responsive
Effective
Well-led
Frequency monthly
4. Quality and governance committee
Safe
Caring
Responsive
Effective
Well-led
Quality risk ORR
Frequency bi-monthly
5. Trust board
Frequency bi-monthly
Corporate quality (OMTs)
Finance
Medical
HR
Nursing/AHP
Clinical quality review meeting, SIAM
Sub group/ committees of Trust board
QUALITY ENABLERS
Service innovation
CIPs/QIPPs
QIA/EIA
Consultation
(Staff, patients)
Staff networks and leadership communities
Quality facilitators and quality tools e.g IMROC and safewards benchmarking
Feedback - patients/ carers/staff e.g iWantGreat Care
R&D team
Quality schedule and CQUIN
External inspectors
CQC
Ofsted
AIMS
NMC/GMC
HEEM
Internal CQC monitoring and inspections quality summits
Internal CQC monitoring and inspections quality summits
Quality account
Quality dashboard
Service
Directorate
Specific
Lessons learnt, lead and plan

GLOSSARY OF TERMS	
AHP	Allied health professionals
AIMS	Accreditation for in patient mental health services
CIPs	Cost improvement programmes
CQC	Care Quality Commission
CQUIN	Commissioning for Quality and Innovation
CRHTT	Crisis resolution home treatment team
DMT	Divisional management team
GMC	General medical council
PEGs	Patient experience groups
EIA	Equality impact assessment
HEEM	Health Education East Midlands
ImROC	Implementing recovery through organisational change
NED	Non-executive director
NMC	Nursing and midwifery council
Ofsted	Office for Standards in Education, Children's Services and Skills
OMTs	Operational management teams
ORR	Organisational risk register
QIA	Quality impact assessment
QIPPs	Quality, innovation, productivity and prevention programmes
R&D	Research and development
SIAM	Serious incident assurance meeting

Patient care

We are continuously striving to improve outcomes for patients and their carers, and developing our services to meet the needs of our community. From the 15 reports received from the CQC's inspection of the Trust in March 2017, five of these identified the 'Safe' domain as 'Requiring improvement'.

The teams reviewed the feedback and identified improvement strategies to address each area of concern. These were then fed into a robust action plan that was bound by clear governance, with clear reporting arrangements to the Board of Directors through the Quality and Governance Committee. This plan is updated regularly as CQC/Mental Health Act and CQC/HMIP inspections continue to be undertaken throughout the organisation's services.

Quality improvement in the Trust is supported by a systematic quality governance framework. This is continuously reviewed to ensure it is fit for purpose and that it provides quality assurance that is central to patient care. In 2016, we launched the 'Moving to good and beyond' programme, which provides a vehicle for monitoring, reviewing and instigating quality initiatives across the organisation.

From data analysis and through internal quality reviews, the group is able to identify areas of need and focused solutions across the full range of clinical services including estates, human resources and clinical systems. Following the CQC inspection, this group was renamed 'Beyond good' to reflect our improved position in terms of inspection outcome.

Quality feedback is gathered from complaints, incidents, PALS contacts, compliments and letters of appreciation and, more systematically, through the feedback tool iWGC.

The head of patient experience, iWGC manager, and head of quality surveillance work closely together to ensure that these varying forms of feedback are triangulated and inform other quality improvement and assurance processes. These include serious incident investigations and lessons learned (through the monthly bulletin, communications and meetings), as well as service reviews and inspections. Assurance from services is gained through the service management reporting structure, governance meetings and patient experience groups. Reviews, comments and responses through iWGC are also published on the iWGC public website.

The Trust uses iWGC to continuously collect feedback from patients and carers in all services, including prisons.

Responses can be given in a variety of formats and, in addition to the Friends and Family Test, respondents are asked to comment on a variety of patient experience measures. There is also room for free text. The numerical data is integrated with our performance reporting system, while free text comments are used to improve services through our patient experience and governance groups. Service managers respond to comments with details of actions taken. All comments are publicly available through the iWGC website with the exception of prisons, some sensitive services and where the respondent has expressly requested that the feedback is not publicly displayed.

Our staff survey is also used to improve quality and drive service development.

During 2017/18 the Trust focused on driving a robust and interactive leadership framework that included training, reverse mentoring opportunities, senior leadership team meetings and Leadership Matters events.

Staff wellbeing support has and will be continually reviewed. An example of this is the introduction of a new role for a cultural ambassador, which is being introduced across service lines.

Monitoring improvements
Quality is measured using a number of indicators, which includes a robust CQC internal review process. Our annual audit plan identifies key areas of patient care, which are reviewed in line with internal and external requirements. This provides the organisation with baseline and performance data for clinical activities such as patient observations and photographic identification. These systems also identify where improvements could be made, which are then monitored locally by clinical leads. Reporting is directly to the quality forum, with outputs feeding through to the Quality and Governance Committee as required.

Quality improvement is routinely identified from national initiatives and from best practice guidance such as NICE.

Directorate leads map this guidance against each service based on relevance and suitability. When new implementation measures are recommended, our deputy medical directors work together with services to develop the improvement plan and monitor progress.

We bring data relating to patient safety and our core quality indicators together on one service line dashboard.

This dashboard features patient safety measures, for example the number of complaints, falls, and serious incident reviews, as well as quality indicators such as safety thermometer findings, clinical supervision activity, self-assessment outcome and staffing levels.

This provides clear indications to managers and team leaders where any potential issues, concerns or areas of good practice are. Our dashboard measure also provides a platform for action planning, so that any improvements required are managed. It supports our reporting arrangements to clinical commissioners for the quality schedule.

This data is routinely interrogated as part of the internal triangulation process prior to the Quality Forum, the directorate quality meetings and as part of our internal quality summit process. Externally, the Trust works closely with commissioners to develop and maintain quality driven services that are responsive to the needs of the local population.

The Quality Forum is the central quality deposit for the organisation. Core quality indicators, data, patient feedback and safety requirements are routinely reported via this monthly meeting. In addition, an escalation process to the Trust Board, via the Quality and Governance Committee, is in place.

Services and performance against targets
Measuring our performance against targets requires focus on service user and patient needs, service development and the effectiveness of care delivery.

Our transformation programmes are linked to these key factors and rely on patient, carer and staff feedback to understand our progress.

This year, we responded positively to the requirements of the local and national quality schedules. Our Commissioning for Quality and Innovation (CQUIN) goals supported developments in Accident and Emergency care for mental health service users, transitions for Children and Mental Health Services (CAMHS) service users – from young people to adult services – and wellbeing for staff and service users via our flu vaccination programme, as well as changes to our café menus and snack bars.

Our evolution of services will continue as we move forward alongside Northamptonshire Health and Care Partnership (previously known as STP or Sustainability and Transformation Partnership), and the integrated and personalised care agenda.

Reviewing our performance against targets is a detailed, involved process that includes CQC rating reviews, staff survey results, NHS Improvement's core indicators, improvements in care from local and national audits, local and national quality metrics, and measures from our Datix reporting system.

As our community's healthcare needs grow, we are continually reviewing our performance of these healthcare targets, and recognise areas that are challenging to us, such as waiting times.

In 2018/19, further work will be undertaken to refine and develop the quality dashboards across the clinical services. This will support teams in defining the areas of need and good practices across their provision.

Sign up to safety
The national sign up to safety (SU2S) programme has an ambition of halving avoidable harm in the NHS over the next three years. The Trust agreed areas of patient safety improvement to focus on for the SU2S campaign this year.

As a member of one of the nine countywide health academic networks, a SU2S countywide group was formed to establish the way in which organisations can successfully support each other and provide improved joint working relations and share learning.

The group's focus is on reducing avoidable harm from failures or omissions in care, preventing incidents in healthcare by sharing learning and working collaboratively to improve patient safety.

The network agreed on eight themes to focus on, and the Trust was asked to lead the Board-to-ward theme for the county.

As part of the local campaign, the Trust's focus remains on National Early Warning Scores (NEWS), reduction of medication errors, reducing violence and aggression, suicide and self-harm prevention and information management and technology. Each of these areas has an agreed plan and lead. Progress on actions is monitored by the Trust's quality forum, and follows feedback from each of the areas in relation to performance, successes and next steps. The Trust will remain committed to this agenda moving forward.

Complaints handling
Internally, our complaints process and outcomes are reported to the Trust Board via the Complaints Review Committee (CRC).

Monitoring arrangements for the complaints process are in place, and information about complaints are held centrally. In order to further improve the complaints process, peer reviewing has been introduced to ensure objectivity in the way investigations are completed. This now involves our service users and carers, who use a pre-agreed proforma to review the process and the investigation pathway. The outcomes are then feedback to the CRC for evaluation.

We have a robust complaints policy that is reviewed a minimum of once every two years.

All complaint investigators are sent an 'investigation pack', which details the process and the steps needed to support them with reviewing the complainant's issues and concerns. All complainants are responded to within three working days to acknowledge the complaints and to identify next steps – the mode by which communication will take place is also agreed at that point. The complaints timeframe is 25 working days for a response to be formulated. In a small number of cases, the timeframe may need to be negotiated with the complainant so a full and detailed analysis of their complaint can be undertaken. During the CQC visit the complaints process was reviewed, and no improvement points were identified.

In 2017/18 the Complaints Team reviewed the complaint process for our service users in the prison service. Following a promotion of the service and amendments to the policy, this has resulted in an increased awareness of the complaints and Patient Advice and Liaison Service (PALS) across the prison teams.

Improvements in patient and carer information
Patient and carer information has evolved. We now ensure we include language and accessibility information on all our leaflets, so that staff, patients and carers are aware that we can provide the required information in a number of different languages and fonts. PALS and complaints information is available across the Trust in a variety of formats. In addition, the Trust hosts external agency leaflets pertinent to the services we offer.

Patient and carer information has also improved by the utilisation of technology. An example of this is the Trust's Twitter account, which is widely used to promote wellbeing and publicise events.
The Health Visiting Service has its own Facebook page, which has been very popular with families across Northamptonshire, and sexual health are developing an App for use across its population.

Stakeholder relations
We continually strive to develop positive partnerships with key stakeholders. This year, these relationships have been even more integral to the facilitation of quality improvement and healthcare across our patient, service user and carer population.

Our collaboration with our commissioners, NHS England and NCC, has helped shape what we provide locally and influenced care priorities that offer an opportunity to work more jointly across the health economy.

Using quality data and information to understand local needs has allowed us to identify gaps in service and link safe, quality-driven transformation to effective care.

Working with local commissioning groups for the Commissioning for Quality and Innovation (CQUIN) development has enabled us to pilot new healthcare initiatives, which will feed into any future planning and decision-making for care priorities.

Regular local level communication with Northamptonshire carers and other voluntary organisations has provided us with rich feedback on our services, and our relationship with local education providers remains positive and productive.

The Trust continues to be engaged in a three-way partnership with NCC and The University of Northampton for the development of a Community Interest Company (CIC) called First for Wellbeing.

While having challenges this year, we continue to look for ways to partner for the development and delivery of services that enhance the physical, emotional, social and economic wellbeing of the county's population. In addition, services linked to third sector organisations such as Marie Curie continue to be run in partnership with our palliative pathways and clearly aids our links with mental health and learning disability providers.

We also continue to build partnerships with The Implementing Recovery through Organisational Change (ImROC) Programme Team to carry out work in patient-centred care, including a co-production project in mental health between staff and service users. The ImROC work has developed an internal passion for co-production and during 2017/18 it supported a number of training events and the development of the new CPA documentation.

Internal processes are also in place to ensure staff, service users, patients and carers are involved and able to feedback on current and future service planning. Service user, patient and carer involvement is a core activity for us and we are passionate about ensuring it is embedded within our core values.

EQUALITY

Equality, inclusion and human rights
As a major employer and provider of health and wellbeing services in Northamptonshire, we strive to be a leader of equality promotion.

We do so by valuing diversity, tackling health inequalities and building strong and sustainable partnerships with local stakeholders.

With a large, diverse workforce and patient population, we recognise that promoting human rights, equality and diversity – while tackling inequality, discrimination and harassment – is central to the achievement of our vision and core values. This year, we have worked very closely with our commissioners to support our equality and inclusion work.

We are proud of the work we have undertaken across our health economy, in collaboration with our diverse communities, stakeholders and partners.

We seek to comply with the requirements of the Public Sector Equality Duty (PSED) to make sure that we consider the needs of all individuals across our policy development, delivery of services and employment practices. In line with our duties as an employer and provider of NHS services, we also have an equality and inclusion policy that provides a framework to ensure compliance with the Equality Act 2010 and Human Rights Act 1998.

This year, we refreshed our equality objectives to include a focus on making sure that they are more robust and outcome focused, to help drive our equality forward. In addition, we strengthened our governance for equality and inclusion, by refreshing our Equality and Inclusion Assurance Board, which provides both the governance and leadership to ensure that equality and inclusion is embedded and mainstreamed across the organisation.

We published our Annual Equality Information Report in January 2018, reporting on how we have met our duties under the Equality Act 2010 and provided an analysis of our workforce and service data.

We are proud of our active staff networks – specifically the BME Staff Network, Disability Network and LGBT and Allies Staff Network, which help to shape and influence our equality and inclusion work. In addition, a new network, the 'carers' network, is currently in its infancy and will be developed further in 2018/19. The networks are a core asset in terms of our staff stakeholder groups and feature with our governance frameworks.

We also ensure that we effectively use equality analysis for our decision-making and risk assessment across the organisation. In addition, as we continue to promote equality through bespoke projects and activities, it is compulsory for all staff to receive equality, inclusion and human rights training. An example of this is our Moving Ahead project, which aims to address health inequalities for BME communities and unconscious bias training.

We use the national performance tool for equality, the NHS Equality Delivery System 2 (EDS2). Designed to help NHS organisations understand how equality can drive improvements and strengthen the accountability of services to patients and the public, we are focused on addressing inequalities and delivering positive outcomes for all groups protected under the Equality Act 2010. Following on from our early EDS2 we are now implementing its outcomes and planning the next steps with a focus on external engagement with our diverse communities.

We have complied with the NHS Workforce Race Equality Standard and have used it as a framework to help drive our work with engaging our BME staff to improve diversity and representation across all levels of the organisation.

We have fully implemented the NHS Accessible Information Standard to ensure that disabled service users are provided with information in appropriate formats and that our patient records capture any specific communication needs our service users may have. We are committed to ongoing review of the progress to support the implementation of 'Easy Read' and any other accessible formats that improve patient communication.

In addition, an analysis of our staff survey results from groups with protected characteristics highlighted several areas that the Trust will be focusing on. We need to continue to work with our staff networks and local community to address discrimination and improve patient experience and outcomes for all. The Trust is committed to ensuring that we provide appropriate and responsive services across our diverse population and workforce.

STATEMENT OF DISCLOSURE

The Board of Directors of the Northamptonshire Healthcare NHS Foundation Trust are accountable for making all relevant information available to the auditor. Each director has ensured they are aware of all relevant information and enquired with their fellow directors and the auditors to this effect.

They have exercised reasonable care, skill and diligence to ensure the auditor has been made aware of all relevant information when preparing their report.

REGISTERS OF INTERESTS

Directors' interests are available from the Trust Board secretary by phoning 01536 452036. Governors' interests are available from the Foundation Trust office by phoning 01536 452059 or emailing foundationtrust@nhft.nhs.uk.

REMUNERATION REPORT

This report provides information about the salaries and pensions of our non-executive directors and executive directors, who, as in previous years and for the purpose of this report, have been classed as our most senior managers.

The nominations and remuneration committee is responsible for determining the pay and contractual arrangements for our executive directors and for monitoring and evaluating their performance. Further information about the nominations and remuneration committee can be found in the section on the Board of Directors and in the code of governance. Standardised terms and conditions of service apply to the executive directors, who are employed on open-ended contracts.

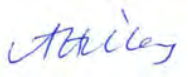
The contracts provide for six months of notice of termination, except in cases of gross misconduct when summary dismissal would be imposed. Directors' performance is assessed formally through our individual performance and development review process. Any termination payments made to executive directors were in accordance with agreed terms and conditions. All elements of executive reward are based on performance. Where an exceptional contribution had been made, non-recurrent cash awards were agreed.

The Nominations and Remuneration Committee agree the reward policy for executive directors. Payments in 2017/18 were made in line with this policy, which reflected the impact of public sector pay restraint on other staff within the Trust, market data, affordability, corporate and individual performance.

For 2017/18 there were three specific elements agreed that would determine any rewards paid: the achievement of Monitor (NHSI) and CQC driven corporate targets, the achievement of key strategic goals, and individual contribution. Corporate, strategic and individual performance objectives will again be agreed for 2018/19.

All directors (executive and non-executive) are paid through the payroll system as they are treated as office holders. Details of directors' remuneration and pension entitlements are covered in the following tables. The Trust Board secretary holds a register of directors' interests.

Angela Hillery



Chief Executive
23 May 2018

SALARIES & ALLOWANCES

1 April 2017 - 31 March 2018

Name and Title	2017 - 2018			
	Salary (bands of £5,000)	Performance pay and bonuses (bands of £5,000)	Clinical Excellence Awards (bands of £5,000)	Total (bands of £5,000)
Angela Hillery, Chief Executive*	160-165	5-10	0	170-175
Professor Alex O'Neill-Kerr, Medical Director *	155-160	0-5	35-40	195-200
Julie Shepherd, Director of Nursing, AHPs and Quality*	110-115	0-5	0	110-115
Chris Oakes, Director of Human Resources and Organisational Development	110-115	0-5	0	115-120
David Williams, Director of Business Development (from 30 October 2017)	45-50	0	0	45-50
Sandra Mellors, Chief Operating Officer	110-115	0	0	110-115
Richard Wheeler, Finance Director*	125-130	0-5	0	125-130

* Denotes voting right

Performance-related bonuses are awarded solely at the discretion of the Nominations and Remuneration Committee.
In 2017/18 four awards were made for significant contributions above and beyond those expected of directors.

Professor Alex O'Neill-Kerr has a clinical element to his role which is included in the table above.

SALARIES & ALLOWANCES

1 April 2017 - 31 March 2018

Name and Title	2017 - 2018						2016 - 2017					
	Salary (bands of £5,000)	Taxable Benefits to the nearest £100*	Performance pay and bonuses (bands of £5,000)	Long-term performance pay and bonuses (bands of £5,000)	All pension-related benefits (bands of £2,500)	Total (bands of £5,000)	Salary (bands of £5,000)	Taxable Benefits to the nearest £100*	Performance pay and bonuses (bands of £5,000)	Long-term performance pay and bonuses (bands of £5,000)	All pension-related benefits (bands of £2,500)	Total (bands of £5,000)
Paul Bertin, Chair* (until 31 October 2016)							25-30	0	0	0	0	25-30
Crishni Waring, Chair* (from 1 November 2016)	40-45	0	0	0	0	40-45	15-20	0	0	0	0	15-20
Sushel Ohri, Non Executive Director* (until 31 July 2016)							0-5	0	0	0	0	0-5
Bruce Minty, Non Executive Director* (from 1 April 2016 to 8 February 2017)							10-15	0	0	0	0	10-15
Jane Carr, Non Executive Director* (from 1 June 2016 to 31 December 2016)							0-5	0	0	0	0	0-5
Melanie Hall, Non Executive Director* (from 1 January 2018)	0-5	0	0	0	0	0-5						
Paul Clark, Non Executive Director* (from 8 May 2017)	10-15	0	0	0	0	10-15						
Scott Adams, Non Executive Director* (from 8 May 2017)	10-15	0	0	0	0	10-15						
Bev Messinger, Non Executive Director*	10-15	0	0	0	0	10-15	10-15	0	0	0	0	10-15
Moira Ingham, Non Executive Director*	10-15	0	0	0	0	10-15	10-15	0	0	0	0	10-15
Alastair Watson, Non Executive Director*	10-15	0	0	0	0	10-15	10-15	0	0	0	0	10-15
Angela Hillery, Chief Executive*	160-165	0	5-10	0	25-27.5	195-200	160-165	0	5-10	0	112.5-115	285-290
Professor Alex O'Neill-Kerr, Medical Director *	195-200	0	0-5	0	12.5-15	210-215	175-180	0	0	0	20-22.5	195-200
Bill McFarland, Finance Director (until 31 May 2016)						0	20-25	0	0	0	0	20-25
Julie Shepherd, Director of Nursing, AHPs and Quality*	110-115	0	0-5	0	160-162.5	270-275	95-100	0	0	0	12.5-15	110-115
David Williams, Director of Business Development (from 30 October 2017)	45-50	0	0	0	157.5-160	200-205						
Chris Oakes, Director of Human Resources and Organisational Development	110-115	0	0-5	0	0	115-120	110-115	0	0-5	0	0	115-120
Richard McKendrick, Chief Operating Officer (until 7 August 2016)						0	45-50	0	0	0	0	45-50
Sandra Mellors, Chief Operating Officer	110-115	0	0	0	45-47.5	155-160	100-105	0	0	0	75-77.5	175-180
Lucy Dadge, Director of Strategic Partnership	0	0				0	70-75	0	0	0	52.5-55	125-130
Richard Wheeler, Finance Director*	125-130	0	0-5	0	22.5-25	150-155	105-110	0	0	0	87.5-90	195-200

* Denotes voting right

No Benefits in Kind were paid during 2017/18 or 2016/17

Performance-related bonuses are awarded solely at the discretion of the Nominations and Remuneration Committee.
In 2017/18 four awards were made for significant contributions above and beyond those expected of Directors.

Professor Alex O'Neill-Kerr has a clinical element to his role which is included in the table above.

EXPENSES

Expenses paid to governors, executive and non-executive directors are detailed in the table below:

	2017/18			2016/17		
	Number			Number		
	Total	Receiving expenses	Expenses £'00	Total	Receiving expenses	Expenses £'00
Directors	7	7	99	9	8	62
Non-executive directo	7	5	45	8	8	58
Governors	37	16	51	39	15	59
Total	51	28	195	56	31	179

PENSION BENEFITS

Name and title	Real increase in pension at pension age (bands of £2,500) £000	Real increase in pension lump sum at pension age (bands of £2,500) £000	Total accrued pension at pension age at 31 March 2018 (bands of £5,000) £000	Lump sum at age 60 related to accrued pension at 31 March 2018 (bands of £5000) £000	Cash Equivalent Transfer Value at 1 April 2017 £000	Real Increase in Cash Equivalent Transfer Value £000	Cash Equivalent Transfer Value at 31 March 2018 £000	Employers Contribution to Stakeholder Pension To nearest £100
Angela Hillery, Chief Executive	2.5-5	0	60-65	160-165	1,013	84	1,108	0
Professor Alex O'Neill-Kerr, Medical Director *	0-2.5	2.5-5	35-40	110-115	740	70	818	0
Julie Shepherd, Director of Nursing AHP and Quality	7.5-10	22.5-25	50-55	150-155	808	202	1,018	0
Sandra Mellors, Chief Operating Officer	2.5-5	7.5-10	30-35	95-100	631	91	728	0
David Williams, Director of Business Development (from 30 October 2017)	2.5-5	5-7.5	25-30	55-60	247	46	359	0
Richard Wheeler, Finance Director	0-2.5	0	35-40	95-100	587	59	652	0

As non-executive directors do not receive pensionable remuneration, there will be no entries in respect of pensions for non-executive directo
As Chris Oakes was not in the pension scheme there are no entries in this table

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 pension payable from the scheme. A CETV is a payment made by a pension scheme, or arrangement to secure pension benefits in another pension scheme or arrangement when the member leaves a scheme and chooses to transfer the benefits accrued in their former scheme. The pension figures shown relate to the benefits that the individual has accrued as a consequence of their total membership of the pension scheme, not just their service in a senior capacity to which the disclosure applies. The CETV figures, and from 2004/05 the other pension details, include the value of any pension benefits in another scheme or arrangement which the individual has transferred to the NHS pension scheme. They also include any additional pension benefit accrued to the member as a result of their purchasing additional years of pension service in the scheme at their own cost. CETVs are calculated within the guidelines and framework prescribed by the Institute and Faculty of Actuaries.
Real Increase in CETV - This 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 pension scheme or arrangement) and uses common market valuation factors for the start and end of the period.

HUTTON NOTE

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

The mid point banded remuneration of the highest-paid director in Northamptonshire Healthcare Foundation Trust in the financial year 2017/18 was £197,500 (2016-2017, £177,500).

This was 7.5 times (2016/17, 6.1) the median remuneration of the workforce, which was £26,565 (2016/17, £28,462).

In 2017/18 no employee received remuneration in excess of the highest paid director. Remuneration ranged from £15,404 to £198,662 (2016/17 £15,251 to £175,036)

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

	2017/18 Total	2016/17 Total
	£	£
Mid point of band of highest paid director's total (£000s)	197.5	177.5
Trust median remuneration	26,565	28,462
Ratio	7.5	6.1

Disclosure of senior manager greater than the PM salary of £150,000

Highest remuneration	198,662
Lowest remuneration	15,404

INCREASE IN CETV

Name and title	CETV @ 31 March 2017 £	CETV @ 31 March 2018 £	CETV @ 31 March 2017 plus 1.0% CPI annual inflation £	Real Increase in accrued pension during current Financial Year * £	Employer Funded contribution to growth in CETV £
Angela Hillery, Chief Executive	1,013,483	1,108,101	1,023,618	84,483	59,138
Professor Alex O'Neill-Kerr, Medical Director	740,039	817,680	747,439	70,240	49,168
Julie Shepherd, Director of Nursing AHP and Quality	807,697	1,017,527	815,774	201,753	141,227
Sandra Mellors, Chief Operating Officer	630,584	728,382	636,890	91,493	64,045
David Williams, Director of Business Development (from 30 October 2017)	246,796	359,396	249,264	46,165	32,315
Richard Wheeler, Finance Director	587,301	651,891	593,174	58,717	41,102

As non-executive directors do not receive pensionable remuneration, there will be no entries in respect of pensions for non-executive directors.

As Chris Oakes was not in the pension scheme there are no entries in this table

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 pension

Real Increase in CETV - This 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 pension scheme or arrangement) and uses common market valuation factors for the start and end of the period.
The real increase calculation is done on a pro rata basis for those in post part of the financial year

STAFF REPORT

OUR STAFF

Our core strategy is to be an employer of choice, a great place to work and be known for a diverse and inclusive culture whose staff feel valued. To achieve this, we are focused on our strategic objective to 'Grow our staff capability'.

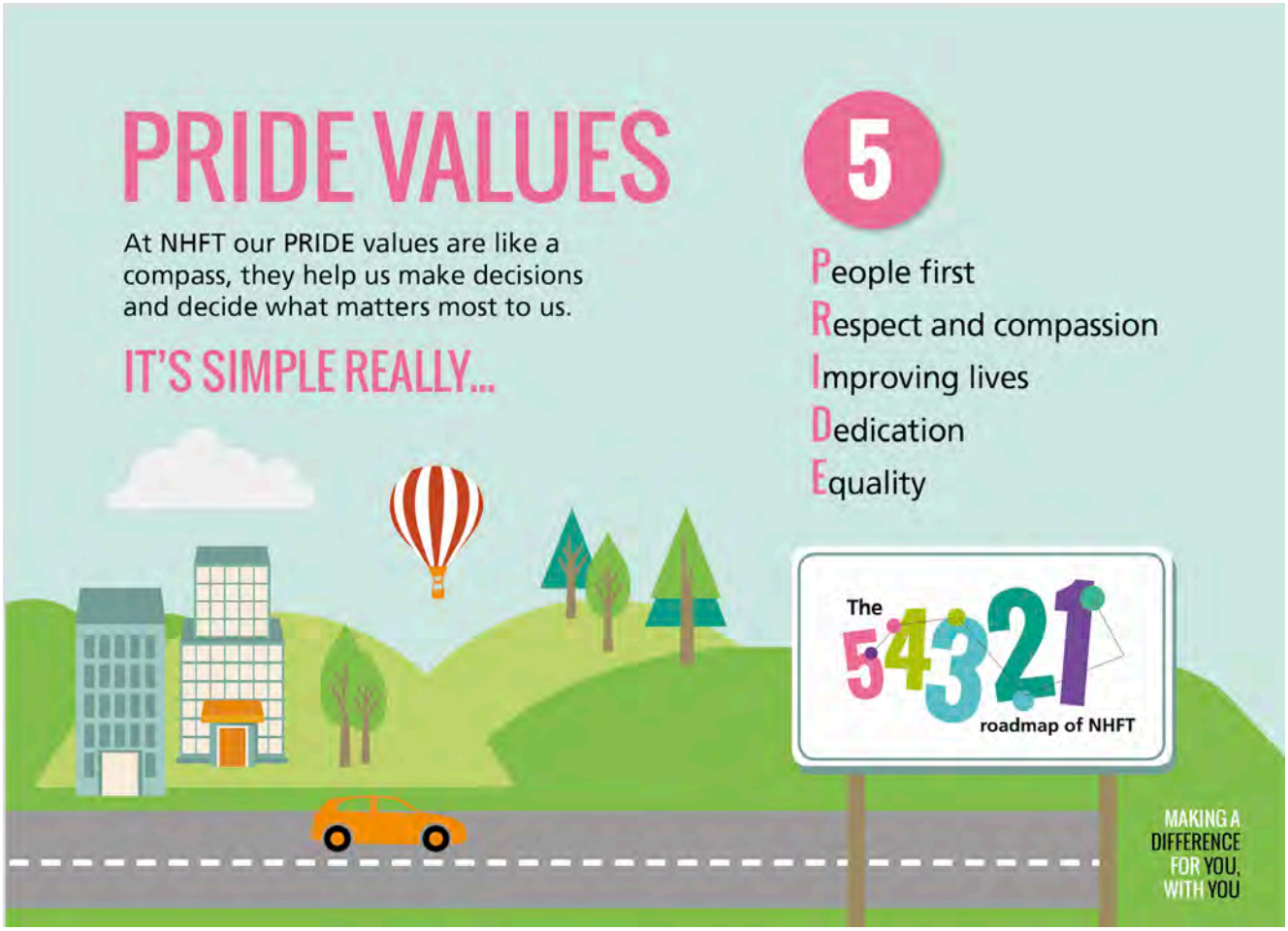
Every year, the Human Resources and Organisational Development Team put a workforce plan in place to make sure we allocate people and resources effectively and efficiently. We adopt a multi-faceted approach and often include reviews of service needs, analysis of key people and management data. We also gain feedback from key internal and external stakeholders.

We are committed to developing a flexible, skilled and motivated workforce, and aspire to be an employer of choice. We promote a positive organisational culture that attracts and retains staff.

Our values
The Trust has five core PRIDE values based on the national values that are set out in the NHS constitution.

We use communication and staff engagement plans to embed these values in everything we do. These values are designed to inspire and motivate the workforce to take pride in everything they do, and to provide excellent patient care.

1. People first
2. Respect and compassion
3. Improving lives
4. Dedication
5. Equality



Leadership Matters
In 2016, we developed our core leadership behaviours, in partnership with our staff, which are the basis of our distributed leadership approach and 'Leadership Matters' Trust organisational development initiative.

In July 2017, our Leadership Matters conference focused on team excellence, innovation and sharing. With teams showcasing their innovations, there was particular attention paid to staff engagement and team excellence.

Leadership matters

AVERAGE NUMBER OF EMPLOYEES

	Total 2017/18	Permenent	Other	Total 2016/17	Permenent	Other
	Number	Number	Number	Number	Number	Number
Medical and dental	106	98	8	115	101	14
Ambulance staff	0	0	0	0		
Administration and estates	632	548	84	586	496	90
Healthcare assistants and other support staff	926	740	186	907	705	202
Nursing, midwifery and health visiting staff	1,323	1,118	205	1,271	1,071	200
Nursing, midwifery and health visiting learners	14	14	0	21	21	
Scientific, therapeutic and technical staff	638	619	19	569	557	12
Healthcare science staff	0			0		
Social care staff	1	0	1	1		1
Other	0	0	0	0	0	0
Total average numbers	3,640	3,137	503	3,470	2,951	519
Of which:						
Number of employees (WTE) engaged on capital projects	6	4	2	3	2	1

STAFF SICKNESS ABSENCE

	2017/18 Number	2016/17 Number
Total days lost	53,204	50,995
Total staff years	2,984	2,982
Average working days lost (per WTE)	**18**	**17**

EXIT PACKAGES

	Number of compulsory redundancies	Number of other departures agreed	Total number of exit packages	Number of compulsory redundancies	Number of other departures agreed	Total number of exit packages
	2017/18	2017/18	2017/18	2016/17	2016/17	2016/17
Exit package cost band (including any special payment element)						
<£10,000	4	0	4	11	7	18
£10,000 - £25,000	3	0	3	10	10	20
£25,001 - 50,000	1	0	1	10	6	16
£50,001 - £100,000	1	0	1	7	0	7
£100,001 - £150,000	0	0	0	2	0	2
£150,001 - £200,000	0	0	0	1	0	1
>£200,000	0	0	0	0	0	0
Total number of exit packages by type	9	0	9	41	23	64
Total resource cost £000	200	0	200	1,560	364	1,924

	Agreements	Total value of agreements	Agreements	Total value of agreements
	Number	£000	Number	£000
	2017/18	2017/18	2016/17	2016/17
Exit packages: other (non-compulsory) departure payment				
Voluntary redundancies including early retirement contractual costs	0	0	0	0
Mutually agreed resignations (MARS) contractual costs	0	0	23	364
Early retirements in the efficiency of the service contractual costs	0	0	0	0
Contractual payments in lieu of notice	0	0	0	0
Exit payments following employment tribunals or court orders	0	0	0	0
Non-contractual payments requiring HMT approval (special severence payments)*	0	0	0	0
Total	0	0	23	364
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

RECRUITMENT

We are dedicated to building a fully inclusive organisation through the recruitment and retention of a high calibre workforce who are able to deliver a high quality service.

Our practices ensure that the principles of diversity and inclusion underpin all our recruitment policies and procedures, and we remain committed to promoting equality, valuing diversity and protecting human rights.

The Trust has recruitment processes and procedures in place that provide equality of opportunity, as well as fair and effective recruitment and selection of all staff groups. We welcome applications from people regardless of age, disability, gender, gender reassignment, race, religion or belief, sexual orientation, marital or civil partnership status, pregnancy or maternity status – and encourage applications from groups who are currently underrepresented in the organisation.

Our commitment to employing, retaining and developing disabled people in our workforce has led to our status as a level 2 Disability Confident Employer. This means we guarantee interviews for disabled persons if they meet the minimum criteria.

We also ensure that reasonable adjustments are made to our policies, processes and procedures to support disabled people to achieve their potential. We treat physical and mental health with equal importance and are currently a Mindful Employer, as well as training as a mental health first aider. We have also signed the 'Time to Change' pledge, which means that we are positive about mental health and support staff with mental health issues to keep well at work and seek support.

All of our recruitment procedures and processes comply with the relevant legislation and NHS guidance, and we make the appropriate training available to all staff engaged in the recruitment process. These recruitment and selection procedures and guidance have been established to cover all staff groups. This ensures that recruitment practices are effective, non-discriminatory and help us to find the best person available for any identified vacancy.

To promote good practice throughout the recruitment process, these procedures cover all stages of recruitment – from the point a vacancy first arises to appointment. This year, we have introduced a new electronic recruitment system called Trac, which has automated some of our more manual recruitment administration processes and has improved our time to hire statistics.

ABSENCE MANAGEMENT

Our target across all service areas is to achieve a sickness absence rate that is no greater than 4.2%.

This year, we began developing a new staff wellbeing strategy, which will be launched next year. The strategy is designed to develop staff health and wellbeing, to help to reduce sickness absence levels.

In early 2018, we were awarded the Workplace Wellbeing Charter, which is an opportunity for employers to demonstrate their commitment to the health and wellbeing of their workforce.

The impact that employment can have on health and wellbeing is now well documented. Evidence shows a healthy workforce can reduce sickness absence, lower staff turnover and boost productivity. This is good for employers, workers and the wider economy.

We continue to implement our local management of sickness absence through return-to-work interviews, supportive conversations, monitoring and review processes. Following periods of absence, postcards are issued to staff to highlight the supportive interventions we have available to assist their health and wellbeing. In addition, we reward exceptional attendance by individuals and continue to recognise them annually.

TRAINING AND DEVELOPMENT

We encourage all staff to apply for training and development opportunities. We also make sure that access to training is linked to each individual's objectives and the Trust's strategy. This continues to develop our leadership capability. Our Leadership Matters training and conference programme is designed to support and reinforce our Leadership Behaviours: Taking Responsibility, Embracing Change, Being Authentic and Working Together.

Our learning objectives are linked to our annual plan and are based on objective assessments of abilities. Training is routinely monitored to ensure fairness, so that we make sure there are no disparities between groups of staff who are trained. We are committed to ensuring our employees have opportunities to learn, train, develop and progress in the organisation. Where a particular group is underrepresented in the workforce or at a senior level, we consider positive action to redress the balance. This includes improving access to training and encouraging applications.

ENGAGEMENT

With continuing demand for healthcare in our community, our transformation agenda is evolving our services for the benefit of our patients, services users, carers and family.

We recognise that this transformation can bring a degree of uncertainty. We have worked hard to manage our transformation programmes in a sensitive, yet effective manner. This involved the continuation of significant investment in pre-consultation engagement to make sure that staff, patients and service users have the opportunity to understand the drivers for change, and our proposals. We also make sure they are actively contributing to the shaping of our future services.

Over the year, we have strengthened the governance processes for all change programmes affecting staff. Each programme that has a significant impact has oversight from the Executive Board and is underpinned by rigorous Quality Impact Assessment and Equality Impact Assessments.

As a result of our previous experience, the Trust recognises the value of engaging, listening and responding to staff and the positive impact that this has for both our workforce and our patients.

Examples of our actions include:

- The active promotion of our Freedom to Speak up Guardian and associated champions
- The launch of Equality Champions and Cultural Ambassadors

Our established staff networks – that we work in partnership with – help us to develop our equality practice. They are an important source of feedback and ideas for the Trust. Our networks include our staff disability and allies network, black minority and ethnic (BME) staff development network and LGBT and allies network and our newly formed Working Carers Network.

FRAUD

We recognise that while the majority of people who work in or use the NHS are honest, fraud does exist and is a serious issue. Fraud in the NHS – on any scale – diverts resources from patient care and services.

Our Local Counter Fraud Team's work includes making people aware that fraud is being tackled and of the methods used to combat fraud. This year, the team has shared quarterly fraud awareness newsletters and urgent security alerts with our workforce. The purpose of these communications was to raise staff awareness, highlight key cases and provide details of who to contact should our staff have concerns.

UK MODERN SLAVERY ACT 2015

Section 54 of the Modern Slavery Act 2015 requires all organisations to set out the steps that the organisation has taken during the financial year to ensure that slavery and human trafficking is not taking place within the organisation or its supply chains.

We make every effort to prevent slavery and human trafficking in our Trust, and in our supply chains. We do this by ensuring our employment standards, training, remuneration and policies reflect our commitment to be a high quality employer, conscious of safeguarding. Our safeguarding policies for adults and children are designed to minimise the risk of slavery and human trafficking and highlight to staff the steps they need to take if they come into contact with a vulnerable person they feel is at risk.

As part of the inter-agency Northamptonshire Safeguarding Adults and Children's Boards, we are committed to safeguarding training for all our staff at level 1 and 2.

Slavery and human trafficking has been highlighted as a category of abuse that we should all be aware of. In addition to this training and policy, we are committed to employment practices that are fair and equal, both internally and through our suppliers of services and equipment.

The Trust also subscribes to the UK Living Wage, which is significantly higher than the minimum wage. The Living Wage is calculated based on the basic cost of living in the UK and is voluntarily subscribed to by employers.

The Trust believes it has low risk of slavery or human trafficking. As we believe the area of highest risk is with our suppliers, we have reviewed our procurement practice to explicitly include the requirements of the Act.

OCCUPATIONAL HEALTH AND WELLBEING

We are fully committed to supporting the health and wellbeing of our employees. Our aims are to ensure that staff are aware of the services that are available to them and to develop new services to help improve their lives.

Wellbeing activities
The Occupational Health and Wellbeing Team provides an extensive range of services that are available to all staff. These include:

- Fitness testing
- Annual health checks and cholesterol testing
- Fitness classes at all of the larger main sites (for example, Tai Chi, lifestyle boot camp, weight management programme, fitsteps classes, pilates classes, zumba classes and yoga classes)

In 2017, 559 members of staff participated in these wellbeing activities.

The Trust also engaged in the Global Walking Challenge, where 560 members of staff participated in a 100-day step challenge, in competition with companies across the world and other NHS organisations.

Workplace Wellbeing Charter
In early 2017, we completed the Workplace Wellbeing Charter self-assessment against the Health & Wellbeing standards. Our aspiration is to achieve the National Workplace Wellbeing Charter Award. In December 2017, the Trust achieved the Workplace Wellbeing Charter Award, and was recognised with excellence in a number of categories.

Psychological wellbeing services
Following the demands on psychological services, we increased counsellor support. Now, there is cover five days a week, which has helped to get the waiting time down to two weeks. We have also increased the sites where counselling is available to accommodate staff. With the increase in days for psychological services the counsellors were able to offer Cognitive Behavioural Therapy and mindfulness to staff, as well as counselling.

Pastoral care
The Trust's Chaplaincy Service provides help and support not only for service users and their families, it also offers support to staff. During the year, the Chaplaincy Service has seen a number of staff for bereavement counselling and emotional support when dealing with crisis situations.

Mental Health First Aiders
At the time of writing, over 50 members of staff have received their mental health first aid training. More training is planned for the coming year.

Seasonal Flu Vaccination Programme
The 2017/18 seasonal flu vaccination programme was a great success, with 72.82% of front line staff receiving the vaccination.

Physiotherapy
In-house physiotherapy service continues to provide treatment for musculoskeletal problems with back, knees and shoulders being the main symptoms for referrals. On average, staff were triaged and/or seen within five working days.

STAFF IN POST

As at 31 March 2018

Female executive directors	3
Male executive directors	4
Senior managers	28
Senior managers band 8A and above	92
Of the above female senior managers	70
Of the above male senior managers	22
Total staff 2016/17*	4,545
Total staff 2017/18*	5,076
Female staff	4,217
Male staff	859
Bank staff	1,228
Permanent staff	3,591

*Figures include only primary assignments. If an employee has a substantive post, and a bank post, only the substantive post is counted.

STAFF SURVEY

Our Trust took part in the annual NHS staff survey 2017. The survey was open for all Trust staff to complete in late 2017. Official results from NHS England were released in early March 2018.

2017 staff survey results
48.3% of staff responded to the survey, an increase of 4.6% from last year. Overall, our measure of staff engagement was 3.91 (out of 5, 5 being high/positive), which is above (better than) average for trusts of our type.

There was a significant increase in our score for care of patients/service users being the organisation's top priority (82%), recommendation of the care provided by the trust (75%) and a 9% increase in recommendation as a place to work (66%).

Overall staff recommendation of the organisation as a place to work or receive treatment was 3.90 and is the highest score for trusts of our type in the country.

Top five ranking scores – areas where we scored more favourably compared to trusts of a similar type:

1. Effective use of patient/service user feedback
2. Staff recommendation of the organisation as a place to work or receive treatment
3. Quality of appraisals
4. Percentage of staff satisfied with the opportunities for flexible working patterns
5. Staff motivation at work

Bottom five ranking scores – areas where we scored less favourably compared to trusts of a similar type:

1. Percentage of staff working extra hours
2. Percentage of staff appraised in last 12 months
3. Percentage of staff/colleagues reporting most recent experience of harassment, bullying or abuse
4. Percentage of staff experiencing physical violence from staff in last 12 months
5. Percentage of staff/colleagues reporting most recent experience of violence

Although the number of staff working extra hours remains above average compared to similar trusts, this has improved by 2% in 2017. Taking into account the positive score from staff as a place to receive treatment and care, this could demonstrate the willingness of staff to 'go the extra mile' for our patients and service users.

Where staff experience has improved

- Staff satisfaction with resourcing and support (3.38, up from 3.25)*
- Recognition and value of staff by managers and the organisation (3.63, up from 3.52)*
- Staff recommendation of the organisation as a place to work or receive treatment (3.90, up from 3.74)*
- Percentage of staff reporting good communication between senior management and staff (44%, up from 37%)
- Organisation and management interest in and action on health and wellbeing (3.84, up from 3.75)*

*These scores are out of 5, 5 being high/positive.

Where staff experience has deteriorated

- Percentage of staff working extra hours
- Satisfaction with level of pay
- Although the number of staff working extra hours remains above average compared to similar trusts, this has decreased by 2% this year. Satisfaction with the rate of pay saw a significant drop nationally and the trust remains above average for trusts of our type.

Things we are proud of

- Effective use of patient/service user feedback (3.99) was the highest for trusts of our type, and the 3rd highest nationally for all trust types.
- Staff reporting the Trust as a place to work or receive treatment was highest for trusts of our type
- Our staff motivation remains higher than other similar trusts
- Improved communication between senior managers and staff than other trusts
- Staff reporting satisfaction with flexible working patterns improved and is better than average compared with trusts of our type. This was highest in part time staff

These results were communicated to staff in a one-page update, along with links to the full reports. Detailed analysis for each area of the trust has been shared on the trust staff room for all staff to access.

STAFF SURVEY 2017 RESULTS

OUR 2017 RESPONSE RATE

2016/2017 (PREVIOUS YEAR)	2017/18 (CURRENT YEAR)		TRUST IMPROVEMENT/ DETERIORATION
Trust	Trust	Benchmarking group (trust type) average	
43.8%	48.4%	45%	+4.6%

OUR SCORES, RANKED AGAINST TRUSTS OF SIMILAR TYPE

TOP FIVE RANKING SCORES				
	2016/2017 (PREVIOUS YEAR)	2017/18 (CURRENT YEAR)		TRUST IMPROVEMENT/ DETERIORATION
	Trust	Trust	Benchmarking group (trust type) average	
KF32. Effective use of patient / service user feedback	3.88	3.99	3.69	+0.11
KF1. Staff recommendation of the organisation as a place to work or receive treatment	3.74	3.90	3.68	+0.16
KF12. Quality of appraisals	3.25	3.35	3.10	+0.10
KF15. Percentage of staff satisfied with the opportunities for flexible working patterns	60%	63%	58%	+3%
KF4. Staff motivation at work	4.00	4.01	3.93	+0.01

BOTTOM FIVE RANKING SCORES				
	2016/2017 (PREVIOUS YEAR)	2017/18 (CURRENT YEAR)		TRUST IMPROVEMENT/ DETERIORATION
	Trust	Trust	Benchmarking group (trust type) average	
KF16. Percentage of staff working extra hours	76%	74%	71%	-2%
KF11. Percentage of staff appraised in last 12 months	84%	85%	92%	+1%
KF27. Percentage of staff / colleagues reporting most recent experience of harassment, bullying or abuse	56%	55%	57%	-1%
KF23. Percentage of staff experiencing physical violence from staff in last 12 months	2%	2%	2%	±0%
KF24. Percentage of staff / colleagues reporting most recent experience of violence	91%	88%	88%	-3%

FUTURE PRIORITIES AND TARGETS

Our staff engagement plan has been branded 'Let's talk'. This will be linked with the 54321 campaign under: '1 *Making a difference for you with you*'.

In order to give the organisation time to plan and deliver on key objectives, the engagement plan will be a two-year view, designed to achieve significant improvements by the National Staff Survey (NSS) 2019, with NSS 2018 being used as a benchmark.

Based on early analysis and the latest research published by Picker Europe and the King's Fund (Sizmur and Raleigh, 2018), our planned response will have two key drivers:

1. Care of patients/service users is my organisation's top priority
2. If a friend or relative needed treatment, I would be happy with the standard of care provided by this organisation

Under the Let's talk planned activity and using key analysis of our local results, our wider plan will be co-produced with staff from across the organisation through listening event roadshows and directorate objectives from the two clinical directorates and medical and corporate areas. A full trust-wide plan will be produced and published later in 2018, sharing details of each directorate's objectives, trust focus areas and measures of success.

ANNUAL REPORT DISCLOSURES

For all off-payroll engagements as of 31 March 2018, for more than £245 per day and that last longer than six months.

Number of existing engagements as of 31 March 2018	26
Of which:	
Number that have existed for less than one year at time of reporting	10
Number that have existed for between one and two years at time of reporting	3
Number that have existed for between two and three years at time of reporting	9
Number that have existed for between three and four years at time of reporting	1
Number that have existed for four or more years at time of reporting	3

For all new off-payroll engagements, or those that reached six months in duration, between 1 April 2017 and 31 March 2018, for more than £245 per day and that last longer than six months.

Number of new engagements, or those that reached six months in duration, between 1 April 2017 and 31 March 2018	18
Of which:	
Number assessed as within the scope of IR35	18*
Number assessed as not within the scope of IR35	0
Of which:	
Number engaged directly (via PSC contracted to trust) and are on the trust's payroll	0
Number of engagements reassessed for consistency/assurance purposes during the year	0
Number of engagements that saw a change to IR35 status following the consistency review	0

*All engagements noted here concern agency staff. The payroll deductions are made by the agency engaging the worker, following an IR35 assessment and direction by the Trust.
In addition to the assessments above, 15 workers were directly engaged via their Personal Service Company with deductions made via the Trust's payroll in 2017-18 where a reassessment of IR35 indicated they were inside the scope.

For any off-payroll engagements of board members, and/or, senior officials with significant financial responsibility, between 1 April 2017 and 31 March 2018.

Number of off-payroll engagements of Board members, and/or senior officials with significant financial responsibility, during the financial year	0
Number of individuals that have been deemed 'board members and/or senior officials with significant financial responsibility' during the financial year. This figure must include both off-payroll and on-payroll engagements.	48

GOVERNANCE

Effective governance allows us to grow and develop. By overseeing our processes, we maintain a compassionate, inclusive environment that provides safe, quality care and ensures high standards of welfare for all service users.

Northamptonshire Healthcare NHS Foundation Trust has applied the principles of the NHS Foundation Trust Code of Governance on a comply or explain basis. The NHS Foundation Trust Code of Governance, most recently revised in July 2014, is based on the principles of the UK Corporate Governance Code issued in 2012.

WHO CAN BE A GOVERNOR?

Any member of the Trust who is aged 16 or over can be elected as a governor. There are three constituencies: public, service users or carers, and staff. Each elected governor belongs to and is appointed by one of these constituencies.

We consult with our members, the Council of Governors and the public on topics of a strategic and operational nature (for example, the annual plan creation or local service redesigns).

We welcome the views of everyone and actively encourage input in a number of ways. The public have access to forums such as the Board of Directors' meeting. Our annual public and members' meeting was held on 15 September 2017. Members are invited to these meetings as a further opportunity to share their views with the Board of Directors. A register of governors' interests is updated annually and is available from the Northamptonshire Healthcare NHS Foundation Trust office.

How we have engaged our members this year

1. **Initial communications.** All new members receive a welcome letter and introductory information.
2. **Ongoing communications**. We continue to issue regular bulletins and reports from the chair. We also send out governor and organisational updates, and a membership survey.
3. **Website members' area.** We maintain a dedicated place to find information and updates.
4. **Promotional materials.** These help to encourage member recruitment of staff, service users and local carers. For example, the Trust services send out membership application forms to Trust service areas and staff inductions promote the benefits of membership to new employees.
5. **Member events.** These are held to share and discuss topics related to the Trust and the wider NHS. 2017/18 events have included inviting members to sessions across Involvement Week in March 2018 and inviting Members to find out about Becoming a Governor in February 2018.

OUR MEMBERSHIP STRATEGY

Our current strategy builds on all of our work to date, recruiting and developing an engaged and representative membership. The Council of Governors approved an updated strategy in November 2014. This strategy focuses on two main areas: current member engagement and the need for continued base number growth.

The strategy was due a refresh by the end of 2017 and the Membership & Governance sub-group has been leading this. It was agreed to extend the current membership strategy in December 2017 for a minimum of six months. This is due to on-going work to align the membership and involvement strategies. A number of workshops have been held in 2017/18 to discuss this integration and workshop attendees comprised governors and leads for membership, involvement and communications.

We aim to make membership engagement a central part of how we gain an even better understanding of our patients, service users, families, carers, staff and community. We have 12,300 members and their input directly contributes to the development of the Trust.

Our ultimate aim: to increase our members' sense of Trust ownership

Our membership recruitment programme has been ongoing since 2007. Public and patient constituencies are receiving particular focus.

This is in accordance with the Health and Social Care Act 2012 section 153 (2) (2), which requires membership to be representative of the people we serve.

To properly ensure that our membership is a true representation of the population we serve, we commissioned information from membership engagement services in November 2016. Our membership base was found to have no significant outliers, though there were areas with potential for improvement.

Members of the Board of Directors routinely attend the Council of Governors Membership & Governance sub-group, at which regular reports on membership are presented and discussed.

OUR MEMBERSHIP TARGETS

We carefully review targets prior to agreeing them, balancing aims for membership growth with investment in the meaningful involvement of existing members. The Council of Governors' membership and the governance sub-group oversees recruitment activities and recommends annual membership targets, for endorsement by the Council of Governors.

The Trust has successfully achieved the overall membership target for the year – there are approximately 300 (net) new members.

The Council of Governors has agreed a 1% membership growth target in 2017/18. This target was set and agreed by the Council of Governors via the Membership and Governance sub-group. The target reflects recruiting a modest increase in Members but recognising the focus on engagement with members.

MEMBERSHIP AT YEAR-END

	MARCH 2014	MARCH 2015	MARCH 2016	MARCH 2017	MARCH 2018
Public members	6945	7508	7963	8111	8299
Patient and carer members	2198	2343	2354	2344	2359
Staff members	1769	1684	1574	1557	1637
Total members	10912	11535	11891	12012	12295

If you would like to know more about becoming a member of the Trust or would like to contact your governor or directors, please contact us using the details below.

Foundation Trust office
Front Block
St Mary's Hospital
London Road
Kettering
Northamptonshire
NN15 7PW
Phone: 01536 452061
Email: foundationtrust@nhft.nhs.uk
Web: www.nhft.nhs.uk

REGISTERS OF INTERESTS

Directors' interests are available from the Trust Board secretary (phone 01536 452036). Governors' interests are available from the Foundation Trust office (phone 01536 452061 or email foundationtrust@nhft.nhs.uk).

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COUNCIL OF GOVERNORS

The Council of Governors is an important piece of the overall governance jigsaw for the Trust.

The Council of Governors is made up of elected and appointed governors of our Trust. The main functions carried out by the council include offering views on current issues and on our forward plan, as well as holding non-executive directors to account for the performance of the Trust. The council also discharges specific statutory responsibilities. As members of our organisation, governors always operate in accordance with our constitution.

Elected governors are appointed for up to three years. There are three constituencies: public, patients and carers, and staff. Each elected governor belongs to and is appointed by one of these constituencies. During the past year, elections were held for new governors. New and existing governors remain in post until one of the following situations occurs:

• There is a change in the constitution
• There is a change in the individual's circumstances, which means they are no longer able to be a governor
• Their tenure expires

The Council of Governors appoints a lead governor from its membership. From 1 December 2015 Michael Darling, Public Governor of Daventry and South Northamptonshire, was appointed Lead Governor. Governors contribute in various ways through committees and sub-groups. They appoint or remove the chair and non-executive directors, as well as hold responsibility for their remuneration. They also appoint or remove the external auditor.

The roles of our committees and sub-groups

• Nominations and remuneration committee

This committee appoints, removes and re-appoints the chair and nonexecutive directors, and determines their terms and conditions. A key focus of the committee's work in 2017/18 was to lead the process for the appointment of the three new non-executive directors.

Two appointments were successfully made by the Council of Governors at their May 2017 meeting. This followed a recruitment process led by the Nominations and Remuneration Committee, which included long listing, shortlisting and a final panel interview, including stakeholder groups containing executive and non-executive directors, as well as governors. An executive search company was appointed by the Council of Governors to support this recruitment process.

The Trust's Constitution was amended in July 2017 to increase the number of non-executive directors from five to six. Therefore another recruitment process was undertaken to fill this additional post. An appointment was successfully made by the Council of Governors at their November 2017 meeting. This followed a recruitment process led by the Nominations and Remuneration Committee, which included long listing, shortlisting and a final panel interview, including stakeholder groups containing executive and non-executive directors (NEDs), as well as governors. An executive search company was appointed by the Council of Governors to support this recruitment process.

During 2017/18 three of the non-executive directors were also successfully re-appointed by the Council of Governors, led by the Nominations and Remuneration Committee. These appointments were made at their July 2017 (Moira Ingham), November 2017 (Bev Messinger) and January 2018 (Alastair Watson) meetings.

Moira and Alastair were re-appointed for a further three-year term.

Bev Messinger was appointed for a further year, having already served a six-year term. Bev Messinger is Deputy-Chair of the Trust, Chair of the Performance Committee (until 31 March 2018) and is a member of another key Board Committee. She is the most experienced NED in the team and is also one of the longest-serving Board members. Two new NEDs joined the team in May 2017 and a further new NED joined in January 2018. A NExT Director candidate also started a placement with the Trust in October 2017, who required support through mentoring. This was the rationale behind the decision to appoint Bev Messinger for a further year to facilitate effective succession planning.

The Nominations and Remuneration Committee also supported a change to the Senior Independent Director (SID), from Bev Messinger to Moira Ingham (NEDs). This was approved at the July 2017 Council of Governors meeting.

• Membership and governance sub-group

This sub-group drives membership strategy and considers general items regarding the council and the Trust.

• Finance, planning and performance sub-group

Providing views on forward plans, this subgroup also examines financial and non-financial performance in specific areas, dictated by a defined work plan. The Finance, Planning & Performance sub-group was also involved in the process to appoint the Trust's External Auditor in 2017-18. The sub-group discussed the initial proposals for the process including criteria at its July 2017 meeting. The sub-group was given delegated authority to undertake the process at the July 2017 Council of Governors' meeting. Members of this sub-group formed the Governor Audit Working Group.

This group met in September 2017 and discussed the tenders received and the scoring raising points of clarification where needed. The group, working alongside the Board's Audit Committee, made a recommendation to the September 2017 Council of Governors meeting based on this discussion. This recommendation was approved at this meeting and KPMG were re-appointed at the Trust's External Auditors for four years from 1st November 2017.

• Patient safety and experience sub-group

This sub-group examines issues of patient safety and experience.

• Staff and resources sub-group

This sub-group examines issues of staff and resources.

• Corporate assessment sub-group

This sub-group reviews papers from the Board of Directors' meetings.

• Chair's sub-group

Comprising of the chair of the Council of Governors and the chairs of each committee and subgroup, as well as task and finish groups, this sub-group plans and discusses agendas for the Council of Governors' meetings.

In 2017/18, work was undertaken to further strengthen the effectiveness of the Council of Governors. As part of this, the Council of Governors agreed at their March 2018 meeting to:

- Amalgamate two of the sub-groups (Patient Safety & Experience and Staff & Resources)
- Dissolve the Corporate Assessment Group (moving the work of this group to the Chairs sub-group)
- Align the sub-groups, where there is a natural link to a relevant Board of Directors committee

Governor training and development
The membership and governance sub-group monitors ongoing governor training. In 2017/18, we made significant progress with identifying and meeting the training and development needs of governors. Governors have agreed to undertake mandatory training, which aligns them with the Skills for Health programme that all our staff must also follow. Governors have accessed a range of other training and development opportunities, some of which are NHS-wide and some of which are developed and delivered internally.

How we involve our governors
Directors attend the Council of Governors' main and sub-group meetings. This allows them to listen and respond to views and questions from governors.

Directors also attend key member events and routinely receive a written report from the chair that outlines key issues raised at council meetings. As part of the effectiveness review highlighted previously, it was agreed to strengthen arrangements so that governor sub-groups have a non-executive director lead. Executive Directors may still attend for relevant agenda items. If a formal disagreement between the Council of Governors and Board of Directors was to arise, our constitution contains a process for resolution.

The Council of Governors also features partner organisations. These organisations will sometimes carry out their own engagement activities within the local community.

Governors will announce any conflicts of interest or make declarations of interest where appropriate.

The chief executive highlights meetings with key partners in the local health and social care economy. This is communicated in a regular report, and gives governors another opportunity to declare shared interests of themselves or their members.

Arising from the the effectiveness review highlighted previously, the chair's report to the Board of Directors' meetings is now also included on the Council of Governors agenda. This provides additional opportunities for governors to be informed of, and raise any questions on issues covered by the chair's report.

Contribution to our annual plan
The Council of Governors' finance planning and performance subgroup has contributed views to the development of the Trust's refreshed 2017/19 operational plan. The Trust also has a successful track record in engaging members in the development of its annual plan through, for example, member events. Governors and members were also engaged through a series of events in the process to refresh the Trust's Strategic Plan 2018/19 to 2022/23, with discussions also taking place at Council of Governors meetings in January 2018 and March 2018.

Governors have a specific duty to engage members and are expected to seek their view on performance and progress. Some governors will write to members in their constituency, inviting them to express views and highlight any concerns.

GOVERNORS

We held six meetings of the Council of Governors during 2017/18.

GOVERNOR ATTENDANCE AT MEETINGS DURING THE YEAR

CONSTITUENCY	CLASS	NAME	NUMBER OF MEETINGS ATTENDED (SIX MEETINGS)
Public	Corby & Kettering	Joe Sims	0 of 6
	Corby & Kettering	Richard Dobson	6 of 6
	Corby & Kettering	Paul Joy (joined July 2017)	4 of 4
	Northampton	Des Savage	6 of 6
	Northampton	Gail Sutherland	5 of 6
	Northampton	Janet Lomax (joined July 2017) Sharon Tansley (left her post June 2017)	2 of 4 1 of 1
	Wellingborough & East Northants	John Walker	6 of 6
	Wellingborough & East Northants	Janet Hathaway	5 of 6
	Wellingborough & East Northants	Jon Collins (joined July 2017) Amanda Clayton (left her post June 2017)	1 of 5 0 of 1
	Daventry & South Northants	Antony Bagot-Webb	3 of 6
	Daventry & South Northants	Simon Leibling	2 of 6
Patients and carers	Daventry & South Northants	Michael Darling	6 of 6
	Adult Service User	Kevin Boyce	3 of 6
	Adult Service User	Colin Russell	1 of 6 *2 missed meetings were due to transport issues
	Adult Service User	Beverley Sturdgess	2 of 6
	Adult Service User	Hummad Anwar	1 of 6
	Adult Service User	Alan Clark	3 of 6
	Adult Service User	Tony Locock	6 of 6
	Younger Service User	Tremaine Richard-Noel	5 of 6

CONSTITUENCY	CLASS	NAME	NUMBER OF MEETINGS ATTENDED (SIX MEETINGS)
	Older Service User	Brian Lawrence	3 of 6
	Carer	Alan Devenish	3 of 6
	Carer	Sandra Wright	2 of 6
	Carer	Sandra Bemrose	3 of 6
	Carer	Priscilla Brown	0 of 6
Staff	Registered Nurses	Alex Scott (left his post December 2017)	3 of 4
	Non Clinical	Suzanne Johnson	5 of 6
	Other Clinical	Jacquie Gowans (left post March 2018)	2 of 6
	Doctors and Dentists	Nick Mann	0 of 6
	Unregistered Nurses	Stuart Fitzgerald	5 of 6
Partners	Borough & District Councils	Rosemary Herring	1 of 6
	Northamptonshire County Council	Christina Smith-Haynes (in post from January 2018) Stephen Legg (joined and left his post in July 2017)	2 of 2 1 of 1
	Northamptonshire Rights & Equality Council	Joe O'Neill	0 of 6
	Older People – Age UK Northamptonshire	Sue Watts (in post from 5th Jan 2018 Liam Condron (left his post November 2017)	2 of 2 3 of 4
	The University of Northampton	John Turnbull	5 of 6

Members of the Board of Directors are invited to attend Council of Governors' meetings. Directors are routinely invited to contribute to discussions and to present information on key issues.

DIRECTOR ATTENDANCE AT COUNCIL OF GOVERNOR MEETINGS

NAME OF DIRECTOR	TITLE	NUMBER OF MEETINGS ATTENDED (SIX MEETINGS)
Crishni Waring	Chair	6 of 6
Scott Adams (in post from May 2017)	Non-executive director	4 of 6
Paul Clark (in post from May 2017)	Non-executive director	4 of 6
Alastair Watson	Non-executive director	6 of 6
Bev Messinger	Non-executive director	5 of 6
Moira Ingham	Non-executive director	5 of 6
Melanie Hall (in post from January 2018)	Non-executive director	2 of 2
Angela Hillery	Chief executive	4 of 6
Prof. Alex O'Neill-Kerr	Medical director	3 of 6
Richard Wheeler	Finance director	6 of 6
Julie Shepherd	Director of nursing, AHPs and quality	5 of 6
Sandra Mellors	Chief operating officer	5 of 6
Chris Oakes	Director of human resources and organisational development	5 of 6
David Williams (in post from October 2017)	Director of Business Development	2 of 3

Key stakeholders

The Trust engages with key stakeholders on a range of issues that are both strategic (for example, the annual plan) and operational (for example, local services redesign). The interests of patients and the local community are represented in a number of ways, including through the structure of the Trust's Council of Governors, public access to Board of Directors' meetings and the annual public and members' meeting.

The Council of Governors is made up of partner organisations, some of which engage in activities within the local community. Governors will declare any conflicts of interest or declarations of interest, as appropriate. The chief executive, in her regular report to the Council of Governors, will routinely highlight meetings with key partners in the local health and social care economy, providing an opportunity for governors to raise any issues in which they and their members may have a shared interest. Staff governors are routinely invited to attend the Trust's staff partnership forum meetings.

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NHS IMPROVEMENT'S SINGLE OVERSIGHT FRAMEWORK

AREA	METRIC	2017/18 Q1 SCORE	2017/18 Q2 SCORE	2017/18 Q3 SCORE	2017/18 Q4 SCORE
Financial sustainability	Capital service capacity	2	2	2	1
	Liquidity	1	1	1	1
Financial efficiency	I&E margin	2	2	2	1
Financial controls	Distance from financial plan	1	1	1	1
	Agency spend	1	1	1	1
Overall scoring		1	1	1	1

NHS Improvement's Single Oversight Framework provides the framework for overseeing providers and identifying potential support needs. The framework looks at five themes:

1. Quality of care
2. Finance and use of resources
3. Operational performance
4. Strategic change
5. Leadership and improvement capability (well-led)

Based on information from these themes, providers are segmented from 1 to 4. The score 4 reflects providers receiving the most support, and 1 reflects providers with maximum autonomy. A foundation trust will only be in segments 3 or 4 where it has been found to be in breach or suspected breach of its licence.

The Trust is currently placed within segment 1 under the single oversight framework. The CQC carried out a comprehensive assessment of our services in January 2017 and rated the Trust overall as 'Good'. This was an improvement on the last inspection in 2015 when the Trust was rated 'Requires Improvement'. This segmentation information is the Trust's position as at 31 March 2018. Current segmentation information for NHS trusts and foundation trusts is published on the NHS Improvement website.

Under the single oversight framework, the Trust's overall finance and use of resources risk rating score is 1. The finance and use of resources theme is based on the scoring of five measures from 1 to 4, where 1 reflects the strongest performance. These scores are then weighted to give an overall score.

ANNUAL GOVERNANCE STATEMENT

Scope of responsibility

As Accounting Officer, I have responsibility for maintaining a sound system of internal control that supports the achievement of the Northamptonshire Healthcare NHS Foundation 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 Northamptonshire Healthcare NHS Foundation 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 Foundation Trust Accounting 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 the Northamptonshire Healthcare NHS Foundation 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 the Northamptonshire Healthcare NHS Foundation Trust for the year ended 31 March 2018 and up to the date of approval of the annual report and accounts.

Capacity to handle risk

The Quality and Governance Committee and the Performance Committee have delegated responsibility as part of the organisation's risk management strategy, on behalf of the Trust's Board of Directors.

This ensures the best leadership, coordination and prioritisation is received, on a strategic and operational basis, of the risk management agenda in relation to clinical, quality, workforce, operational and financial risks. This includes the identification of the full range of risks that are inherent in the delivery of healthcare.

The health, safety and risk committee provides an overarching view of health, safety and welfare and assurance that non-clinical risks are managed effectively on behalf of the organisation. Key health and safety developments during 2017/18 have included improvements in estates compliance reporting and focus on implementing more ward-based practical training in respect of fire safety. In November 2017, the Board held a corporate governance in health and safety workshop which focused good governance and best practice with respect to health and safety management.

The risk management structure is detailed in the Trust's risk management strategy. It describes the responsibilities and accountabilities of all directors, managers and staff, including the duty to identify and report risks of all kinds, and the duty to act upon these using their own skills and competencies in the management of risk. The Trust ensures, through our management structure, that we provide training and support on the delivery of risk management activities such as:

- Local and corporate induction training
- Health, safety and risk awareness
- Incident reporting and monitoring
- Risk management systems and processes

The risk and control framework

The significant risks in relation to the Trust's strategic objectives are described in the Trust-wide organisational risk register. During 2017/18, the most significant risks included:

- The Trust is unable to maintain the right workforce capability and capacity to deliver its strategic plan
- The Trust is unable to deliver its financial plan and support Sustainability and Transformation Plan implementation, 2017-19

- Acute outflows – financial/reputational/quality risk
- Insufficient urgent care system capacity to meet winter demand
- Standard of patient transport service provision

The risks above that relate to workforce and the financial plan will likely carry forward as significant risks into 2018/19. The Trust has put in place controls and action plans to mitigate these risks and these are described in the organisational risk register, for example, development of 'one stop shop' for recruitment checks and exception reporting to Performance Committee on acute outflows.

As part of its Board Development Programme, the Board held a Risk Management workshop in March 2018 which was facilitated by PwC, the Trust's internal auditors. Part of the workshop focused on reviewing the existing Organisational Risk Register in light of the Trust's strategy refresh process.

Emergency preparedness, risk and resilience (EPRR) remains on the organisational risk register as the Trust's EPRR arrangements continue to develop. During 2017/18, the Trust moved from 'substantial' to 'fully compliant' with EPRR Core Standards.

The Trust's internal audit programme supports the organisation in continuously strengthening its governance processes. As part of their work, Internal Auditors highlighted a high risk finding which related to their data quality work on Improving Access to Psychological Therapies (IAPT) in quarter two. The Trust has taken action following this outcome such that when our auditors repeated the testing in quarter 4, this finding did not reoccur. Our Internal Auditors also identified some high risk findings as part of their review of the controls and processes in place for reporting on admissions avoidance to ensure reported data is accurate and complete. The Trust is responding to these findings including the identified risks.

The Trust recognises the on-going challenges and risks associated with cyber security and therefore has a continuing focus on the issue, including initiatives designed to mitigate these risks and to meet NHS Digital requirements.

Future risks and associated mitigations are identified in a number of ways, including the Board's regular 'horizon scanning' of the environment in which the Trust is operating, as well as through the regular refresh of the organisational risk register following the annual planning process. The Trust also reviews and reports on the determination of its risk appetite using a matrix that comprises risk levels and key elements (for example financial, compliance, quality and patient benefit).

The principal risks to compliance with the Trust's condition 4 of the NHS provider licence relate to poor corporate governance arrangements, including ineffective performance management and reporting systems (with respect to quality, operations and finance), and inadequate business planning processes. Key measures in place to mitigate against these risks include:

1. The effectiveness of governance structures

    - Continued work has been undertaken to further improve Board processes, including content and format of papers, agenda planning and assurance reporting. Specifically, a new template has been developed for Board papers with input from both executive and non-executive colleagues, refreshed workplans are in the process of being introduced for the Board and all Committees and a revised assurance report based on a format used by another Trust is also being introduced. Board governance training workshops continue to be delivered to senior leaders across the Trust. Part of these workshops focused on the development of the requisite report writing skills.

- In August 2017 the Board of Directors and Council of Governors held a joint workshop to look at their respective leadership and governance roles, which was facilitated by NHS Providers. A number of positive proposals were developed from this event, which were endorsed by the Council of Governors at its March 2018 meeting.
- NHS Improvement expects foundation trusts to carry out an external review of their governance arrangements every three years. In 2015/16, we engaged Ernst and Young LLP (EY) to undertake an external well-led governance review following a tender process. EY, who had no other connection to our Trust, produced a report with positive feedback on our Board of Directors and no major deficiencies were highlighted. It was a source of reassurance that the Board's own self-assessment very closely mirrored EY's independent assessment of how well the organisation was performing in each of these areas. The Trust is planning to undertake its next externally facilitated developmental review of leadership and governance arrangements during 2018/19.
- To further develop good governance practices in future, we responded to the report by developing an action plan. We are currently working on our self-assessment for our well-led review in 2018/2019.
- Our Board of Directors and committees routinely review their performance against specific criteria at every meeting. Individual Board committees have either reviewed their performance against their terms of reference or have plans to review this in the near future.
- Representatives from the Council of Governors attend Board of Directors' meetings, at which governors are given the opportunity to raise questions and comments at appropriate points on agenda items being discussed by the Board. Reports from Council of Governors' meetings are regularly presented at Board of Directors' meetings thereby facilitating discussion and information sharing between these two forums.
- The Trust has robust information governance and data quality policies in place, accessible to all staff, which cover issues such as data security and systems data quality. The Trust also has a Board-appointed Senior Information Risk Owner and Caldicott Guardian.
- The Trust's constitution is regularly reviewed and updated to reflect legislative changes or organisational requirements with appropriate advice obtained from the Trust's legal advisors. The Council of Governors, in conjunction with the Board of Directors, reviewed aspects of the FT Constitution. Only one change was made in 2017/18, which was to change the establishment of non-executive directors from 'up to 5' to 'up to 6' and not fewer than 4 other non-executive directors.
- In preparing the Annual Governance Statement, there are no material inconsistencies identified between this Statement, the existing Corporate Governance Statement, Quality Report, Annual Report and reports arising from the CQC.

2. The responsibilities of directors and committees:

- Board committee terms of reference and membership are regularly reviewed.
- The Board of Directors' structure is regularly reviewed to ensure its continued effectiveness and that arrangements for talent management and succession planning are in hand.
- The Trust has a policy and effective procedures in place to ensure compliance with Fit and Proper Persons regulations.
- All Board directors undertake regular service visits to clinical areas, identifying areas of positive practice and issues for further attention.

3. Reporting lines and accountabilities between the Board, its committees and the executive team:

- These are clearly defined within the overall governance structures of the Trust and within the terms of reference of the Board committees. Reports and minutes from Board committees are included in the public and private sessions of the Board of Directors' meetings respectively.
- The Trust's governance pack, which provides a comprehensive picture of the overall governance structures operating within the organisation, is regularly updated to ensure it continuously reflects current practices.
- The structure and arrangements of executive team meetings have been further reviewed and strengthened during 2017/18 with the new format being introduced from April 2018. This builds on previous arrangements.
- Management of risk is allocated to two committees of the Board of Directors: the Performance committee and Quality and Governance committee, with the board taking an overarching responsibility for risk (including ensuring effective exchange between the two committees). The audit committee's terms of reference also include risk management responsibilities: The Committee reviews the establishment and maintenance of an effective system of integrated governance, risk management and internal control across the whole of the organisation's activities (both clinical and non-clinical), that supports the achievement of the organisation's objectives.

4. Submission of timely and accurate information to assess risks to compliance with the Trust's NHS provider licence:

- The Board routinely receives and reviews the organisational risk register as part of the Trust's robust and well-embedded risk management strategy.
- Monthly submissions and in-quarter ad-hoc exception reporting are made to NHSI.
- Specific monitoring and assurance arrangements have been established and agreed by the Quality and Governance Committee to ensure ongoing compliance with the Trust's provider licence conditions.

5. The degree and rigour of oversight the Board has over the Trust's performance:

- The Trust has well-established performance management systems in place with respect to our quality, operational and financial obligations, with appropriate links to the organisational risk register processes. The Board of Directors routinely receives and scrutinises performance reports at its meetings with ongoing development of a Trust-wide integrated Performance Dashboard. The Performance Committee and Quality and Governance Committee have key responsibilities within the overall performance management framework and quality strategy of the Trust.
- The Board takes leadership of the Trust's planning processes (both operational and strategic) and receives and reviews regular progress reports on delivery. Board sessions are held as part of the overall planning process, to which deputy directors (operational and clinical) are regularly invited. The Trust undertook a refresh of its Strategy during 2017/18, which included the engagement of key stakeholders. The Trust held a number of staff engagement events to help shape the updated strategy, which was considered and approved at the March 2018 Trust Board meeting.

The Trust has applied the principles of the NHS Foundation Trust Code of Governance on a 'comply or explain' basis. The NHS Foundation Trust Code of Governance, most recently revised in July 2014, is based on the principles of the UK Corporate Governance Code issued in 2012. The Trust is required to comply with its Foundation Trust Constitution, and governance processes are designed to underpin this requirement.

The Board has an established process to assure itself of the validity of its corporate Governance Statement required under NHS Foundation Trust Condition 4 (8) (b), with appropriate sources of assurance being provided to the Board, thereby allowing it to self-certify compliance with the statement.

The risk management strategy includes an explanation of the Trust's philosophy towards risk management within our strategic aims and objectives, and clear definitions of individuals' roles and responsibilities. The strategy, which is reviewed by the Board annually, outlines the Trust's approach to the following:

- The responsibility of every member of staff to recognise, respond to, report, record and reduce risks while they are undertaking work for the Trust.
- The provision of high-quality services to the public in ways aimed at securing the best outcome for all involved. To this end, the Trust ensures that appropriate measures are in place to reduce or minimise risks to everyone for whom we have a responsibility. These include patients, staff, contractors and visitors who are on Trust premises.
- The implementation of policies and training to ensure that all appropriate staff are competent to identify risks, are aware of the steps needed to address them and have authority to act.
- Management action to assess all identified risks and the steps needed to minimise them. This comprises continuous evaluation, monitoring and reassessment of these risks and the resultant actions required.
- The designation of executive officers with responsibility for the implementation of this strategy and the execution of risk management through operational and monitoring committees, as described in the risk management strategy and policy.
- Action plans to maintain compliance with the requirements for Care Quality Commission (CQC) registration, which contribute to delivery of the risk control framework and registration standards assurance.
- The process by which risks are evaluated and controlled throughout the organisation. In support of the risk management strategy and policy, a range of policies exist that provide clear guidance for staff on how to deal with concerns, complaints, claims, accidents and incidents on behalf of patients, visitors or themselves.

Risk management is embedded within the organisation as follows:

- Compliance with the mechanisms for the reporting of all accidents and incidents.

- Information from incident reporting data is integrated into new service developments through the Datix incident reporting system.

- All serious incidents are actively managed and monitored to ensure compliance with action plans and being open. Progress is monitored by the Board of Directors at each meeting, both in public and private session.

- Training and education programmes for staff, including induction programmes.

- Use of local, directorate and corporate risk registers and the National Patient Safety Agency grading matrix throughout the organisation.

- A financial risk assessment is incorporated into the bi-monthly financial reporting arrangements for the Performance Committee and the Board.

- A Freedom to Speak Up Guardian and policy are in place and awareness of this is promoted within the Trust, with clear reporting lines established within the Trust's governance structures.

- Outcomes from complaints, incidents and claims are used to mitigate future risks and these outcomes are also aggregated to identify Trust-wide risks.

The Trust's organisational risk register fulfils the functions as described in the guidance as it:

- Covers all the organisation's main activities.

- Identifies the Trust's strategic focus.

- Identifies, scores and risk profiles the key risks to achieving its objectives.

- Identifies and describes the significant systems of internal controls in place to manage the risk.

- Identifies the review and assurance mechanisms, and therefore the effectiveness of the systems of internal control.

- Identifies gaps in controls and assurance and the link to Board plans.

The organisational risk register describes the risks to achieving the organisation's strategic objectives. They are drawn from operational indicators of risk and from horizon-scanning discussions about external risks to achieving the strategic objectives. The organisational risk register is updated regularly through the year. Any gaps in controls that are identified are subject to the implementation of an action plan and assurances within the organisational risk register.

During 2017/18 further improvements have been made to the reporting and reviewing processes of the Organisational Risk Register as discussed and agreed at the December 2017 Audit Committee. The Performance Committee and Quality and Governance Committee continually review the organisational risk register, and assurance of the process and management of risks is reported to the Board of Directors in public session.

The Trust has a robust risk assessment and risk register process in place to identify both clinical and non-clinical risks at local, directorate/service and organisational levels. Those risks that cannot be eliminated or managed at a local or directorate/service level, and are assessed to be a significant risk, are escalated to the organisational risk register.

The Trust uses DatixWeb, a risk management information system incorporating the use of dashboards for real-time reporting and escalation of identified risks.

The Trust is required to be registered with either or both the Care Quality Commission (CQC) and Ofsted for delivery of our services. The Trust achieved registration for all of our services with the CQC from 1 April 2010, and Ofsted from 1 August 2013, without any conditions of registration. The CQC have undertaken Mental Health Act inspections across appropriate services within the organisation in 2017/18. Ofsted have also undertaken inspections in 2017/18 with positive outcomes being demonstrated and, where needed, actions being undertaken. The CQC did not take any enforcement actions against the Trust during 2017/18, nor has the organisation been required to participate in any special reviews or investigation by the CQC during the year.

Under its routine inspection programme, the CQC inspected the Trust in January 2017 and published its report in March 2017. The Trust achieved an overall rating of 'Good' in this inspection, with a rating of 'Outstanding' in the caring domain and 'Good' in the Well-Led domain. Prior to this, the CQC reviewed the organisation in February 2015 and published its resultant report in August 2015, which gave the organisation an overall rating of 'Requires improvement'.

The Trust took forward the learning from the CQC inspection in 2017 and has delivered consistently against the action plan reporting both to the Trust Board and the Quality and Governance Committee.

The Trust is fully compliant with the registration requirements of both the CQC and Ofsted. The organisation has robust quality governance arrangements in place, which is underpinned by the Trust's quality and governance framework, and the Quality Forum. The Trust has a compliance-monitoring process for all services, whereby each service undertakes a quarterly self-assessment, which is used to provide assurance that they are assessed against regulatory standards.

In addition, this information is reviewed and services are supported to develop solutions to any identified gaps or share good practice where this has been highlighted. Patients, service users, carers and visitors are encouraged to report any issue of concern, or suggest areas for improvement using iWantGreatCare, leaflets, comment cards (positioned in patient areas), and through discharge patient surveys. Our involvement pathway includes gathering feedback from external stakeholders as well as using patients' and carers' views.

This process enables these groups to feedback and scrutinise the Trust's activity ensuring that the patient and carer view is incorporated into our systems.

The organisation also has patient experience groups, where patients and carers are members, which oversee and monitor involvement and patient experience activity in the Trust.

Our patient advice and liaison service (PALS) provides central reporting of low level concerns and issues raised by patients, General Practitioners (GPs) and the public. It is also fully integrated with the complaints management process. These and other patient experience issues are considered at the pathway patient experience groups, which report to the patient experience steering group and then ultimately into the Quality and Governance Committee.

Complaints, along with other quality data, are reported in a quality dashboard that all managers and service leads can view and evaluate in terms of their own performance.

Additionally, the Trust has implemented the iWantGreatCare initiative, which has successfully generated unprecedented levels of feedback from our service users, carers and relatives.

Our Council of Governors has been in place from 1 May 2009, which has strengthened arrangements for the involvement and accountability of patients, carers, staff, partners and the public. The Council of Governors also has a sub-group structure in place, whose remits include finance, planning and performance, patient safety and experience, staff and resources, and membership and governance. These sub-groups help support the Trust's scrutiny and assurance processes. The Council of Governors' corporate assessment group reviews papers discussed at Trust Board of Directors' meetings held in public, as well as the agenda and minutes of the Board of Directors' meetings held in private session. Governor links with the quality agenda have continued to strengthen over the year. Revisions to the Council of Governors sub-group structure will be implemented from April 2018. As part of this process council sub-groups will be more closely aligned with Trust Board Committees.

In 2017/18, the Council of Governors received presentations, and had the opportunity to comment on the Trust's Strategic Plan and had an update from the Trust's Freedom to Speak up Guardian. The Council of Governors is an important piece of the overall governance jigsaw of the Trust.

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.

Similar controls are also in place for employees or individuals who contribute to the National Employment Savings Trust (NEST) pension scheme.

Control measures are in place to ensure that we comply with all our obligations under equality and human rights legislation. Compliance is reported on an annual basis in the published Equality Information Report, and in regular progress reports to the Board of Directors and Quality and Governance Committee. Our equality and inclusion work is assured via the Equality, Inclusion and Human Right Assurance Board (EIAB), chaired by the director of nursing, AHPs and quality. It includes a non-executive director (as the vice chair), governor, staff and carer representation. Its line of accountability feeds into the Quality and Governance Committee agenda via the quality forum. The Trust undertakes relevant and proportionate equality analysis to consider the effects of our policies, functions and actions in relation to groups protected under the Equality Act 2010. In addition, the same process is applied to organisational change, service redesign and cost improvement programmes. The organisation will be using the NHS Equality Delivery System (EDS2) and the Equality Information Report to support development of its services. The Trust also adheres to the NHS England Equality and Diversity Standards such as the Workforce Race Equality Standard and the Accessible Information Standard.

The Trust has undertaken risk assessments and carbon reduction delivery plans are in place in accordance with emergency preparedness and civil contingency requirements, as based on UK Climate Impacts Programme (UKCIP) 2009 weather projects, to ensure that this organisation's obligations under the Climate Change Act and the Adaptation Reporting requirements are complied with.

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

The Trust reviews economy, efficiency and effectiveness through the review of finance and performance at budget manager, service director and overall Trust level. In addition to a system of devolved budget management, the Trust operates a service review process where achievement of performance, quality standards and financial targets is considered. There is also a system of reporting finance and performance to the Board of Directors, supported by detailed performance and financial reporting to the Performance Committee.

For an indication of economy and efficiency in the organisation, the Trust used benchmarking information from 1 April 2017 to 31 March 2018. Information from the 2015/16 national reference costing exercise is being used to identify services where our reference costs are significantly higher than the national average. Further detailed work is being undertaken as part of the cost improvement planning process for 2018/19 and in support of ongoing efficiency improvement. This work will enable the Trust to understand why costs of individual services appear to be high and to identify opportunities to improve economy and effectiveness through our productivity and/ or cost improvement programmes. The Trust is a member of the NHS Benchmarking Network and has participated in several benchmarking exercises in 2017/18 for the following areas: mental health and learning disabilities, community inpatients and CAMHS.

The Trust has implemented informal Service Line Reporting (SLR) since March 2015. In addition to showing profitability and contribution by service lines the system also currently provides reference cost comparison with our service line unit costs and comparison by service line with reference costs of our statistical nearest neighbours, enabling internal benchmarking between wards and teams.

This is underpinned by a high level patient level costing that also enables comparison between patients and between clinicians.

Information governance

During the period 1 April 2017 to 31 March 2018 the Trust has continued to improve its information governance framework. The management of information governance risks has been reviewed through monitoring information assets, information flows and information governance incidents via our information governance team.

This activity supports the application and monitoring of compliance against the requirements of the Information Governance (IG) toolkit. Achievement against this is monitored through the Information Management and Technology (IM&T) Programme Board.

The Trust has exceeded the minimum standard for the IG toolkit submission and has established a framework to oversee information governance compliance within the organisation. The IM&T Programme Board receives reports on all key information governance issues.

The Information Governance Team received 383 incidents between 1 April 2017 and 31 March 2018. This figure includes any medical records incidents as well as the reported loss of smartcards. This figure also includes 10 incidents that relate to other organisations that have been logged by Trust staff on the Trust reporting system. There was one serious incident classified as Level 2 or above in the information governance incident national reporting tool. This incident related to disclosing inaccurate data. The incident was reviewed by the Information Commissioner's Office, who have determined that the Trust has taken appropriate action and no fines or penalties were levied towards the Trust.

Annual Quality Report

Under the Health Act 2009 and the National Health Service (Quality Accounts) Regulations 2010 (as amended), the directors are required to prepare Quality Accounts for each financial year.

NHSI has issued guidance to NHS foundation trust boards on the form and content of annual quality reports that incorporate the above legal requirements in the NHS foundation trust annual reporting manual.

The organisation has clear governance and leadership arrangements to ensure the development and achievement of quality improvements across the organisation, which is underpinned by a robust framework. Executive responsibility for quality rests jointly with the director of nursing, AHPs and quality and the medical director.

The Quality Team works with operational managers and deputy directors to monitor progress in delivering our core quality initiatives inclusive of Commissioning for Quality and Innovation (CQUIN), the quality schedule and the quality account.

Quality initiatives within the Trust continue to be reinforced by our quality framework, which is continually being reviewed and updated. The organisation has established arrangements for the regular review of service performance and monthly monitoring of a range of quality and effectiveness indicators. Additional processes are in place to support innovation, inclusive of quality improvements in efficiency and cost effectiveness.

The Quality Account is the key document for quality measurement and reporting, of which a quarterly update of the quality indicators is delivered to the Quality and Governance Committee. In addition, we have a monthly dashboard, subject to continuous development, which allows pathways to receive detailed information relating to their services in line with all aspects of quality and safety.

Data from the dashboard is reviewed and submitted in report format to the quality forum, where it is reviewed and areas of risk/good practice are escalated as appropriate to the Quality and Governance Committee. These concerns need to be highlighted so that actions can be developed to ensure the Trust maintains its vision to deliver high quality care for all.

Statutory reporting on elective wait times is required for only two Trust services, with waiting lists and access times fully monitored and triangulated. Data quality is assured via existing automated processes to identify the incorrect patient demographics (correct NHS numbers, Postcodes, GP registration etc.) and prevent duplicates in data and prevention of impossible errors (gender and age patient treatments are appropriately aligned) at patient level reporting for each service, for the reporting of both access times for patients seen and wait times for patients still waiting to be seen, through the organisation’s established performance framework meetings.

Internally, performance in this area is measured against an 18-week expectation with action planning required as standard for areas of under attainment.

Risks to data quality in this area are managed through weekly communication between the performance team and clinical service leads and dashboard reporting. In early 2018/19 a dedicated data quality team will be established to centralise and review and further strengthen clinical data quality processes across the trust.

The Quality and Governance Committee, on behalf of the Board of Directors, receives assurance on issues of patient safety, patient experience and patient outcomes and promotes the involvement of service users, carers and the public. In addition to this, thematic reviews of service areas or indicators of concern are commissioned by and shared with the Quality and Governance Committee as they arise.

Through these reviews and regular reporting, we have a clear understanding on where we need to focus to improve clinical practice and effectiveness and reduce the incidents of harm. In addition to this, the Trust's Board of Directors receives reports on issues impacting on quality, including:

- Progress on key strategic objectives
- Patient stories
- Serious incidents, GP concerns and complaints, iWantGreatCare patient feedback
- Safer staffing
- Equality and inclusion
- Infection prevention and control
- Safeguarding
- Agency usage
- Organisational risk registers

Clinical quality issues, particularly relating to best practice and national guidance, are scrutinised and discussed at the quality forum. Representatives from all relevant professional groups attend this forum to ensure clinical quality is reviewed. The forum also evaluates as needed impact assessments on the quality of care when there are changes in services, either as a result of the cost improvement programme or because of service redesign.

The forum receives papers from a variety of internal groups and quality focused committees (including pathway specific ones), its role is to scrutinise quality activity and report to the Quality and Governance Committee.

Review of effectiveness

As Accounting 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 managers and clinical leads within the Northamptonshire Healthcare NHS Foundation Trust who have responsibility for the development and maintenance of the internal control framework.

I have drawn on the content of the Quality Report attached to this Annual Report and other performance information available to me. My review is also informed by comments made by the external auditors in their management letter and other reports.

I have been advised on the implications of the result of my review of the effectiveness of the system of internal control by the Board, the Audit Committee, the Quality and Governance Committee and the Performance committee, and a plan to address weaknesses and ensure continuous improvement of the system is in place.

The organisational risk register provides me with evidence that the effectiveness of controls that manage the risks to the organisation achieving its principal objectives have been reviewed. My review is also informed by:

- Routine reporting on incidents to the Board of Directors
- PALS, GP concerns and complaints reports
- Delivering and monitoring safe staffing reports to the Board of Directors and the Quality and Governance Committee
- The Trust's assurance structure and reporting for statutory body registration requirements
- Internal audit assessment of the Trust's risk management structure processes

- Patient-led assessment of the care environment (PLACE) scores (which have replaced Patient Environment Assessment Team, PEAT, inspections)
- Board development days
- The work of the Audit Committee, the Quality and Governance Committee, the Performance Committee, the SI Review Committee and Complaints Review Committee
- Internal and external audit reports
- The work of the local counter-fraud specialist
- Operational service directorates presenting at the Trust Board and its committees
- Trust responses to external inquiries and reports
- Directorate and service performance reviews

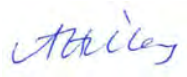
The review and maintenance of the effectiveness of the system of internal control is undertaken as follows:

- The Trust Board receives reports from the Quality and Governance Committee, the Performance Committee, the Audit Committee and the Council of Governors' in public session. These reports highlight issues of assurance and concern for the Board of Directors. In addition, minutes of Board committees are received in private session by the Board of Directors. The Audit Committee has oversight of corporate governance arrangements and receives appropriate external assurance.
- The Audit Committee ensures the establishment and maintenance of an effective system of internal control and risk management.
- All managers have the responsibility for developing and implementing the risk management strategy and policy through the line management of individual directorates.
- The Performance Committee assures effective control on financial and performance matters.
- The internal auditors verify that a suitable and effective system of risk management and internal control is in place on an annual basis. They have direct access to the chair of the Audit Committee to raise any issues of concern.
- The clinical audit programme is developed with input from internal audit and joint working is undertaken to minimise duplication and maximise effectiveness of audit activity.

Conclusion

My review confirms that the Trust has a generally sound system of internal controls that supports the achievement of our policies, aims and objectives and that any control issues have been addressed. No significant internal control issues have been identified. The Trust is committed to the continuous improvement of processes of internal control and assurance and as such may introduce additional controls within the forthcoming financial year (2018/19), as the Trust's Board of Directors deems necessary.

Angela Hillery



Chief Executive

23 May 2018

#weareNHFT

Northamptonshire Healthcare
NHS Foundation Trust

QUALITY REPORT
2017/2018

01604 682682
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MAKING A DIFFERENCE FOR YOU, WITH YOU

QUALITY REPORT

PART ONE

INTRODUCTION

As a leading healthcare provider, safety and quality are critical to our service delivery. In this report, we share our approach to the services we provide in our sites across the county and, the services we provide in the community, which include physical, mental health and specialty, both in county and in other counties.

We also share how we measure our performance and use our analysis of these measures to progress, continuously improve and deliver a positive experience for service users, their carers and families.

In this report, you can read about our quality priorities for next year and review our performance against those for this year. Our performance against mandatory quality indicators, local indicator and audit results can be found, along with information about our work on patient, service user and carer involvement, and staff engagement.

STATEMENT OF QUALITY

From Angela Hillery, Chief Executive

At the Trust, our dedication to quality and safety supports our mission to 'Making a difference for you, with you.' and our vision 'To be a leading provider of outstanding, compassionate care.' With involvement being a strong focus of our activities and ways of working, this year's Quality Report provides insight into how we deliver and maintain quality alongside patient experience.

We are proud to report that this year, as we did last year, we have made good progress against our quality priorities and delivered positive results. This follows the recognition from the Care Quality Commission (CQC) in 2017 when it awarded the Trust an overall rating of 'Good', and 'Outstanding' in the Caring domain.

Among some of the many areas recognised, the CQC rated the Trust as Good at treating patients with kindness, dignity and respect, and observed that communication was compassionate. It also recognised that we have robust governance and safeguarding systems, are committed to involvement and that we encourage candour, and honesty from staff.

While this recognition is a strong indicator that our efforts are making an impact, we are always mindful that there is work to do. In the Safe domain, we are rated as 'Requires improvement'. Specifically, the CQC identified that areas such as medicines management, and safeguarding training required improvement.

Since we received the report, we have invested a great deal of energy, resource and work into improving patient safety. You can read more about this in the Quality Report's Priorities for Improvement section.

Here, we share how we developed key safety-focused models such as the Recovery College, where a co-produced educational approach is used to improve health for individuals experiencing mental health challenges. The college is also an example of involvement in action. By involving people with related lived experiences, the programmes are shaped and delivered to more closely address their needs.

We have also been seeking opportunities to find new, more productive ways of managing safety. At the time of writing the Trust was notified that our pilot use of body worn cameras on mental health wards has been shortlisted for two prestigious awards – Patient Safety and RCNi Nurse Awards.

Critical to continuing this work in safety is our attention to engaging and further training staff, evolving our use of the iWantGreatCare (iWGC) tool, using this feedback to identify themes and sharing this information directly with staff providing care.

As we extend our work in these areas, we must continue to keep patient experience and involvement central – we know this keeps safe, quality and compassionate care at the foundation of all we do. Thank you for taking the time to explore our Quality Report, and to learn more about us. To the best of my knowledge, the information in the document is accurate. I welcome your feedback by contacting me at the details on the back cover.

Angela Hillery

Chief Executive

23 May 2018

STATEMENT FROM OUR DIRECTOR

Julie Shepherd, Director of Nursing, AHPs and Quality

We want to make a difference to people's lives, in everything we do and through every service we provide.

By learning from lessons, listening and using feedback to deliver improvements, as well as fostering a culture of involvement, the Trust focuses on embedding good practice for safe, quality care. Our CQC rating that we are a 'Good' provider of care demonstrates that we are developing from this feedback and involvement.

Being recognised with an 'Outstanding' rating in the Caring domain supports our belief that we are putting the right attention on our patient experience – that we are making a difference.

We must focus on evolving our identification and management of risks to quality care. This year, we invested in safety, to build on feedback from the CQC that our work in the Safe domain 'Requires Improvement'. With measurable action plans and opportunities for Board to floor programmes, we are confident that by strengthening our approaches to risk management, reporting, and governance we bring a continued robustness to our ability to deliver safe, quality care.

We're not afraid to learn lessons from serious incidents, complaints and concerns, and have used these to review and adjust our activities for improved care. Some examples of these include the number of falls risk assessments completed and falls care plans where required, and improvements in the level of risk reported in incidents around self-harm.

Overall, we are seeing evidence of the improvements in quality care and our feedback tools demonstrate this. 93.89% of people who used iWantGreatCare said they would recommend our service to friends and family. Our carers awarded the Trust 4.83 out of 5 stars for feeling supported.

By continuing to work closely with our patients, service users, carers and family, we collectively improve the quality, safety and efficiency of our care, based on the needs of our audiences. In turn, we are focused on the development of our staff, with feedback and training, sharing lessons and communicating to resolve quality issues and recognise good practice.

We also know that diversity, candour, and engagement are vital for staff development. We continue to be committed to involvement, co-production and partnership with patients and carers to improve our ability to deliver safe, quality care. Our aspiration is to progress from 'Good' to 'Outstanding' care.

I hope you enjoy reading our Quality Report 2017/18 and find it informative of our plans and priorities. I welcome your feedback, as well as from our stakeholders, partners, service users, carers and their families.

Julie Shepherd

Director of Nursing, AHPs and Quality
23 May 2018

INVOLVEMENT: AT THE HEART OF QUALITY

Our patients, service users, carers, and family are at the heart of our approach to quality. They each play an integral part in helping us develop services, re-design clinical pathways and support the organisation. Our strategy, plan and actions for the year show how we went about this.

OUR INVOLVEMENT STRATEGY 2016/17

WHAT IS INVOLVEMENT?

Involvement is a process to develop and support a culture that places quality of patient experience at the very heart of all we do, following the core principle of 'no decision about me without me.'

Involvement should promote the central value that patients, service users, carers and providers believe should be at the heart of a progressive Trust - enabling choice, inclusion and respect.

HOW WILL WE INVOLVE PEOPLE?

We have a number of on-going projects and plans for future involvement projects.

These include:

- The development of the Recovery College
- Staff training
- Staff Interviews
- ImROC (Implementing Recovery through Organisational Change)
- Reverse Commissioning Project

WHY IS INVOLVEMENT IMPORTANT?

Involvement of patients, service users, carers and families in the core business of our organisation is very important to us. It ensures that:

- Experiences are valued
- Lessons are learned
- Different skill sets are used
- Wellbeing is at the heart of our decision making process.

We are proud of our inclusivity and involvement work but there are always improvements to make and new Innovations to try.

WHO CAN GET INVOLVED?

- All NHFT staff
- All patients and service users who have previously used or are using services or carers providing care for service users
- Volunteers
- NHFT Members
- Governors
- Students

…. anyone can be involved, we all have something to contribute!

HOW WILL WE REVIEW AND EVALUATE INVOLVEMENT?

We will review, monitor and evaluate activity through:

- Assurance within our Quality and Governance Framework
- Our Steering (main) Patient Experience Group
- Our patient and carer feedback system iWantGreatCare

"True involvement provides assurance that we are doing the right things for those we care for."
Janice Anderson, Involvement Lead

OUR PLAN AND ACTIONS FOR 2017/18

PARTNERSHIP WORKING

Involvement is a process to develop and support a culture that places quality of patient experience at the very heart of all we do, following the core principle of 'no decision about me without me.'

Co-Production is a process where experts by training and experts through experience work together to design, develop and manage a project. Our involvement approach is centred on this co-production principle.

TRAINING

We will:

- Support the development of peer support workers within our recovery college
- Increase the numbers of patients, service users and carers involved in staff training
- Review the training we provide for our 'involvees' who support our recruitment processes
- Support the training needs of our 'involvees'.

PROMOTION

We will:

- Develop the expertise of 'involvees'
- Plan and undertake Involvement Week 2018
- Develop and implement a plan to externally promote our involvement activities
- To promote the Anne McWatt Award.

PROJECTS

We will support the following:

- Moving Ahead Project
- Patient Collaboration Scheme
- Expansion of involvement and co-production within Adults' and Children's services
- Inpatient & Community Recovery Groups
- Expansion of the involvement model to include the public, governors and members

LEADERSHIP

- Develop an involvement feedback process
- Ensure internal and external targets are met
- Carry out an Impact assessment of involvement and co-production
- Develop a transition process for service users – from children's to adult services.

PATIENT EXPERIENCE AND INVOLVEMENT

We strive to engage with patients, service users and carers to gain their views and perspectives. In 2017/18, we evolved our involvement activities. From reviewing leaflets to employing a patient by experience on one of our wards, our co-production activities are a powerful way of using patient experience and involvement to improve our quality of care.

INVOLVEMENT IN PRACTICE

With vital contributions to make in improving the quality of life for people who use our services, our patients, service users and carers are the focus of our work Implementing Recovery through Organisational Change (ImROC).

ImROC is the vehicle for our Patient Involvement Team to generate ideas, developments and improvements for co-production across our services and organisation. This year, our co-produced activities have meant more than sharing opinions – those involved have become equal partners and co-creators. We now have recovery and co-production groups in Mental Health Services (both inpatients and community) who promote co-production.

OTHER INVOLVEMENT ACTIVITIES

Other activities this year included:

- A recruitment drive involved patients, service users and carers to support interviews for a range of clinical and non-clinical positions.
- Patient stories continued to be well used and are a powerful way of conveying messages across the Trust.
- Feedback is gathered from complaints, incidents, PALS contacts, safeguarding, Freedom to Speak Up (F2SU) and safe care leads, compliments and letters of appreciation and, more systematically, through iWGC.
- Co-design of the new Care Programme Approach (CPA).
- CPA training for staff. Co-designed and co-delivered courses were developed for the recovery college and the implementation and the crisis house.
- The crisis pathway involvement approach starts with recruitment and continues with training and a co-production reference group. This has resulted in positive outcomes, ranging from performance and targets to service user and carer feedback.
- Patient involvement groups have been developed in one of the community bed units. This model will be rolled out across the other services in 2018/19.
- Our children and young people, and our service users from within our prisons have supported interview processes by developing questions and identifying the professional qualities they would like to see in the applicants.

CASE STUDY

HOW WE PROGRESSED INVOLVEMENT THIS YEAR

Last year, we set an objective to develop a recovery college model, as part of our priority to increase patient experience. In March 2017, we launched the new Recovery College NHFT.

The college supports individuals with experience of mental health difficulties to live the life they want to lead, and become experts in their own self-care. The college offers strength-based courses designed to contribute towards wellbeing and to enable hope, control and opportunity. This educational approach is used to improve health and to complement treatments we already offer.

All courses are co-produced and co-delivered by people with lived experience of mental health difficulties and mental health professionals, providing a shared learning environment where those with lived experience, those who provide their support and NHS staff can learn together. Courses are open to service users, their carers, friends and family, as well as Trust staff.

To find out more information about enrolling, please contact the recovery college office at: recovery.college@nhft.nhs.uk or call 01933 235449 (open Monday to Friday 9:30am to 4pm).

iWANTGREATCARE

We use iWantGreatCare (iWGC) to continuously collect feedback from patients, service users, carers and family for all services. Responses can be given in a variety of formats, including text message. Numerical data is integrated with our performance reporting system, while free text comments are used to improve services through our patient experience and governance groups.

In addition to the Friends and Family Test, respondents are asked to comment on a variety of patient experience measures. Service managers are alerted to reviews of their services weekly and can respond directly. In addition, the Patient Experience Team produces a monthly report detailing reviews requiring a response and posts responses on behalf of managers. Service managers respond to comments with details of actions taken.

All comments are publicly available through the iWGC website, with the exception of prison and sensitive services, and where the respondent has expressly requested that the feedback is not publicly displayed.

The Head of Patient Experience, iWGC Manager, Head of Performance and Head of Quality Assurance work closely to ensure that the varying forms of feedback are triangulated. This feedback informs other quality improvement and assurance processes such as serious incident investigations, lessons learned (through the monthly Lessons Learned Exchange), service reviews and inspection.

We gain assurance from services on actions and responses through the service management reporting structure, governance meetings and patient experience groups. Reviews, comments and responses through iWGC are published on the iWGC public website. While the vast majority of reviews are positive, we aim to respond to all reviews that contain or reveal room for improvement or an improvement suggestion.

iWANTGREATCARE RESULTS

2017/18

Reviews	25,059
Recommend the service to friends and family	93.89%
Average rating across all services*	4.81
Carers rating for feeling supported+	4.83
Carer reviews	4,749
Reviews responded to	941

* Respondents awarded us an average rating of 4.81 out of 5 stars across all services (including prisons).
+ Out of 5 stars

FULL RESULTS

During the year 941 reviews were responded to that revealed room for improvement or contained an improvement suggestion. The following table lists responses for the four main categories. There are 11 categories in all. The rating is out of 5, 5 being the highest.

MONTH/ YEAR	TOTAL NUMBER OF RESPONSES	LIKELY TO RECOMMEND	KINDNESS AND COMPASSION OF STAFF	INFO. ABOUT CARE AND TREATMENT	INVOLVEMENT	DIGNITY AND RESPECT	AVE. 5 STAR RATING
Apr	1763	94.67%	4.91	4.81	4.80	4.90	4.83
May	2529	95.29%	4.90	4.79	4.83	4.90	4.83
Jun	2610	93.05%	4.87	4.74	4.79	4.88	4.79
Jul	2057	93.99%	4.88	4.74	4.77	4.89	4.78
Aug	1994	95.39%	4.91	4.80	4.83	4.91	4.82
Sep	2289	91.79%	4.90	4.79	4.82	4.91	4.81
Oct	1915	94.36%	4.91	4.80	4.82	4.91	4.82
Nov	2003	93.01%	4.91	4.79	4.80	4.91	4.82
Dec	1596	95.38%	4.92	4.79	4.81	4.90	4.83
Jan	2407	94.18%	4.92	4.82	4.81	4.91	4.84
Feb	2056	93.35%	4.89	4.78	4.78	4.90	4.79
Mar	1840	93.64%	4.89	4.75	4.79	4.89	4.80
FULL YEAR	25,059	93.89%	4.90	4.78	4.80	4.90	4.81

STORIES FROM THIS YEAR

HOW INVOLVEMENT MAKES A DIFFERENCE

One of our service users shares testimonial on their involvement

"I have lived with Rheumatoid Arthritis for over 50 years, which has had a profound effect on my mental health. Throughout that time there have been many ups and downs. From hospitalisation (several times) and numerous joint replacements (I set buzzers off at airports) to bringing up two sons (now 31 and 26 years old) and working part-time for NHFT. In March 2013 the role in which I was employed, came to an end, leaving a void in my life. I had become accustomed to having a purpose – a reason to get up in the mornings.

By chance, from my previous association with other NHFT members of staff, I was introduced to Janice Anderson and the Involvement Team. I instantly felt a connection. After a discussion with Janice regarding involvement opportunities I knew this was my way forward.

What better use of my lived experience than to help others by improving health provision in Northamptonshire. I have a vested interest, as I grew up in this county.

Since then, I have been an active member of the Involvement Team. Examples include Staff Recruitment, Patient Representation at NHFT Meetings, sitting on the Quality Awards Judging Panel, a PLACE (Patient-Led Assessments of the Care Environment) Auditor.

In addition, I have been a member of the Recovery Community Group (formerly, ImROC Community Services Group) from its inception. I feel it a privilege to be part of such an enthusiastic and passionate group of people. The aim is to promote/reinforce recovery through co-production – service users working alongside health professionals. At present we are delivering power point presentations to Community Mental Health Teams. Finally, I am currently training to be a Peer Trainer with the Recovery College, which I am really excited about.

Being involved in this way has made a huge difference to me and my mental/physical wellbeing – I have more control over my health conditions and are able to manage them better, my self-esteem has increased, enhanced relationships with health professionals, I am a voice for other service users and have increased my skill set and there are many more.

Finally, none of this would have been possible without the unending support from Janice Anderson and Pradeep Rajguru (Involvement Team). Thank you."

CARER STRATEGY AND INVOLVEMENT

Our approach to carer involvement this year is summarised in our strategy below.

#weareNHFT

NHS
Northamptonshire Healthcare
NHS Foundation Trust

NHFT CARER STRATEGY 2017/18

WE WILL MAKE YOU FEEL SAFE

We want you to feel involved in the care and treatment of the person you care for and supported in your role as a carer.

We will:
- adhere to the Carer's Charter, which outlines how we will work with carers
- ensure that the carers view is known and taken into account
- involve the carer in line with confidentiality

WE WILL BE EFFECTIVE

We will provide our managers with the information and support needed to ensure they develop a culture where the carer is a true and respected partner in care.

We will:
- sign up to the County Carer Strategy 2016
- include the role of carers in leadership training
- promote the involvement of carers in the monitoring and development of services
- measure the effectiveness of this strategy through feedback and an increase in referrals to Northamptonshire Carers

OUR STAFF WILL BE WELL LED

We will make sure that we understand what matters to carers and involve them as partners in care.

We will:
- work in partnership with Northamptonshire Carers and Northamptonshire County Council
- listen to and take account of feedback from carers
- incorporate personal carer stories into carer awareness training
- establish carer groups

WE WILL BE CARING

We will treat all carers in accordance with the 6C's: care, compassion, competence, communication, courage and commitment.

We will:
- identify the main carer
- listen and respond to carers
- work with Northamptonshire Carers to support working carers, including our own staff
- ensure that carer themes are shared both within NHFT and with our partners

WE WILL BE RESPONSIVE

We will consider the needs of carers at all times, including young carers. We also understand that sometimes carers need support to continue in their caring role.

We will:
- include responsiveness to carer issues in assurance processes
- develop the role of Carer Ambassadors to champion carer issues
- promote the role of Northamptonshire Carers and the Carer Hub
- promote the work of Carer Support Workers
- promote the right to a carer's assessment

"If we are to provide the best possible care we must involve carers."
Hugh Jones, Carer Ambassador

CARER INVOLVEMENT IN PRACTICE

The involvement of carers in our activities is important for the improvement of patient experience and quality of care. We involve our carers in a number of ways, including through organised groups such as our Patient Experience Group and Task and Finish Group. These groups have contributed to many productive outcomes, such as the development of a common sense confidentiality agreement, a new Care Programme Approach model and 'My Story' documentation. Our carers have also supported some work around developing leaflets within our hospices and palliative care services.

We also welcome carer ambassadors to support family carers in line with the Carer's Charter. This year, we increased the number of carer ambassadors to 50. In addition, our services run events to involve carers. An example of this in 2017/18 was the NSTEP evening groups for carers, which focused on understanding the processes, medical conditions, and how support is provided to carers.

In 2017/18, the Trust has also supported staff who are also carers. This included the development of the Carer's Network, which is an emerging network that will be a designated support for staff. A staff wellbeing officer was also appointed to focus on the health of staff and to lead the required changes linked to staff feedback results across services.

CASE STUDY

HOW CARER INVOLVEMENT MAKES A DIFFERENCE

Our approach to developing End of Life care is centered on carer involvement. This starts with the support materials we produce, and continues right through to how we deliver care.

When we developed the 'When someone dies' leaflet, service users and carers were asked their opinion and contributed to the publication.

We invited a carer to speak of her personal journey caring for her husband with a progressive illness at End of Life care link groups. Gaining a carer's perspective was really powerful and made the learning real for the group members, which was reflected in feedback from the meeting.

The team worked with a production company to film the experience of a bereaved relative. The relative gave an honest and open account of her mother's death and the months leading up to this. We have been able to use this film for educational sessions to give a real perspective of care. Carers have fed back that this has had an impact upon their practice and have changed the way they have communicated with relatives regarding end of life care medication.

A young carer pathway flowchart has been developed with the support of Northamptonshire Carers. This is a major innovation dedicated to identifying and supporting young carers across Northamptonshire.

A snapshot of our carer involvement and partnership actions this year is below.

#weareNHFT

NHS
Northamptonshire Healthcare
NHS Foundation Trust

OUR PLAN AND ACTIONS FOR 2017/18

FEEL SAFE

- revise and relaunch the Carers Charter to meet the specific needs of care pathways
- introduce a requirement that all policies and procedures are assessed for their impact on carers
- review the content of carer packs and boards
- ensure that appropriate policies and protocols include reference to and involvement with carers

EFFECTIVE

- introduce quarterly meetings with Northamptonshire Carers to include strategic and operational issues
- develop iWantGreatCare to include the question, "do you feel supported as a carer?"
- formalise carer awareness training and involve Northamptonshire Carers and carers
- through Carer Ambassadors develop carer support groups

CARING

- ensure that carer awareness is included in all appropriate staff training
- work with Northamptonshire Carers to support working carers, including our own staff
- share carer feedback, themes, actions and good practice throughout NHFT and with partner organisations

RESPONSIVE

- review assurance processes to include responsiveness to carer issues
- develop the role of the Carer Ambassador, building on the existing role of Carer Lead
- develop the public website and the Staff Room carer resources
- promote the role of Northamptonshire Carers, Carer Support Workers and Carers Hub

WELL LED

- Chief Executive to sign-up to the County Carer Strategy 2016
- include the role and importance of carers in leadership training
- promote the involvement of carers in the development and monitoring of services
- ensure carer issues are included in team, management and patient experience meetings
- include carer themes in patient experience reports

STORIES FROM THIS YEAR

FEEDBACK FROM CARERS

Feedback from iWantGreatCare on how we make a difference to carers

"I cannot praise you enough. The hospice at home team came to us in the last week of our dad's life and we cannot thank them enough. We did not know about this service, but they gave both us and our dad great care and support at a very sad and difficult time. For weeks we had felt very alone in supporting our dad, but from the very first visit they showed great care and support for not only our dad, but for us too. We are so grateful; these ladies do a very valuable job. Thank you so much!"

"The staff here are amazing providing excellent care to my dad and also supporting myself at such a difficult time. Thank you." (Riverside Ward)

"My mother would be dead or very poorly if it was not for the Intermediate Care Team (ICT) CT (the staff member) was very friendly, knowledgeable, amazing."

"We are so grateful for everything you have done for us and the things you arranged - I don't know how we would have coped without your support." (Palliative Care Clinical Nurse Specialist)

"The nurse was really supportive and we really trusted her to ask in the patient's best interests. We have had a lot of interaction with the nurse on and off over several years and can't fault her care and professionalism." (Learning Disabilities)

MOVING AHEAD

Innovation in practice and improving access for black, minority and ethnic (BME) communities

Moving Ahead is an on-going project that looks at the inequalities in mental health care for members of BME communities. The project includes regular project steering and community engagement meetings.

As a mental health service provider, we need to be culturally capable and able to address the diverse needs of a multi-cultural population through effective and appropriate forms of assessment and interventions.

We have spoken with and involved BME communities, patients and carers, to help us make improvements. We value their support to help us ensure that our services better reflect the needs, values and experience of BME people.

This project focuses on three key areas, namely seclusion/control and restraint, detention under the Mental Health Act 1983 and Improving Access to Psychological Therapy (IAPT). Considerable progress has been made, for example with the use of body cameras that will encourage consistency and transparency in the care we provide during seclusion, control and restraint.

We are working with Northamptonshire Police to remove barriers, improve understanding between the Police and BME services users experiencing acute mental illness. This work continues to reduce incidences and experiences of poor treatment of BME service users who are experiencing acute mental illness.

We have removed the barrier for BME communities needing GP referals and are now accepting direct self-referrals to the IAPT service.

The Trust's Moving Ahead project led to feedback that two further questions should be added to iWantGreatCare (iWGC) in June 2017. This provides the opportunity to capture, by protected characteristics, anonymous patient and carer feedback.

The survey now includes questions about whether cultural and spiritual needs are being met.

We were 'Highly Commended' by the 2017 Global Equality & Diversity Award for our outstanding research methods and insight into diversity and equality for our Moving Ahead Project. We were also proud to be shortlisted for the HSJ 2017 Awards as the Provider Trust of the Year.

Moving forward for 2018, we will participate in a programme of engagement with BME communities within Northamptonshire. Our aim is to reach out to all BME communities so that we can build lasting relationships and ensure communities have the necessary information they need about our services and how they can access them.

PART TWO

PRIORITIES FOR IMPROVEMENT AND STATEMENTS OF ASSURANCE FROM THE BOARD

PATIENT SAFETY

CQC DOMAINS	PRIORITY	REASONS	HOW WE WILL ACHIEVE IT	HOW WE WILL MONITOR IT	HOW WE WILL MEASURE IT	REPORTING
Safe	To reduce the level of harm following a self-harm incident.	Due to the work undertaken last year to promote reporting of self-harm incidents the Trust considers that we have a better indication of occurrences. We will focus on reducing the level of harm to a patient following a self-harm incident through improved care planning, observation and engagement.	Develop a training programme for relevant staff with a trajectory of delivery	Measure against trajectory.	Training records.	6-monthly report to Quality Forum.
			Self-harm incidents that result in either death or severe harm that meet the criteria will be investigated as either a serious incident or as a clinical review.	6-monthly report to quality forum identifying trends and themes from self-harm.	Number of incidents resulting in moderate or severe harm will reduce.	2018/19 Quality Account.
			Learnings from the investigations will be shared with clinical team leads and the suicide prevention committee to identify actions.	Self-harm incidents will continue to be reported on the Trust's Datix system and will be reviewed in line with our policy.		
			Share learning across the Trust from the NHSI Observation and Engagement Collaborative undertaken on Avocet and Sandpiper Wards.			

CQC DOMAINS	PRIORITY	REASONS	HOW WE WILL ACHIEVE IT	HOW WE WILL MONITOR IT	HOW WE WILL MEASURE IT	REPORTING
Safe	To further embed and roll out the Learning from Deaths process across the organisation.	Following the publication of the National Guidance on Learning from Deaths (NQB 2017) the Trust has implemented clear processes for identification, reviewing, learning and reporting on deaths.	The Mortality Lead will work with service managers in the roll out areas to engage them and their teams in the process.	The Mortality Lead will provide regular updates to the Learning from Deaths Steering Group on progress with each action.	Feedback from the regular quarterly M&M review meetings across all clinical directorates.	Quarterly Learning from Deaths Steering Group.
		The Trust plans to roll out the processes to all unexpected deaths (as per the Mazars definition) enabling wider opportunity for learning. This will be complemented by the introduction of quarterly Trust-wide Mortality and Morbidity Review Meetings (M&M).	Mapping how we currently review deaths in community services to ensure an effective process.	Feedback from the Countywide and Trust-wide M&M meetings will be shared with the Learning from Deaths Steering Group.	Lessons Learned bulletins on The Staff Room.	2018/19 Quality Account.
			Through county-wide M&M meetings, we will liaise with partner agencies to enable joint reviews and share learning.	Quarterly reports to the Trust Board.	Steering group to receive formal updates against action plan.	Quarterly Learning from Deaths Trust Board Paper.
			Implement a Trust-wide M&M meeting.			
			Development plan to support further implementation.			

CQC DOMAINS	PRIORITY	REASONS	HOW WE WILL ACHIEVE IT	HOW WE WILL MONITOR IT	HOW WE WILL MEASURE IT	REPORTING
Safe	To increase the levels of reporting associated with falls, ensuring that all relevant patients and service users in inpatient and community settings have a falls risk assessment completed. And that those identified have a falls care plan implemented.	Falls are a major concern for patient safety and a marker of care quality. Nationally, a significant number of falls result in death or severe or moderate injury, at an estimated cost of £15m/year for immediate healthcare treatment alone.	Training around prevention of falls will be available for relevant staff.	90% of the relevant staff will undergo training.	Training records.	Locally within directorate meetings.
Caring		Locally in the Trust there was a slight increase in the number of falls reported on Datix for the previous period.	Develop the role of falls champions in the inpatient units.	Quarterly reporting on number of falls and completion of falls risk assessment and, if necessary, falls care plans.	Increase in the number of falls risk assessments completed and falls care plans where required.	Quarterly reporting to Quality Forum.
Effective				Falls champions in place throughout the inpatients units. Increase by 10%, base line 2017/18 50.	Quarterly thematic reports (if relevant) with actions to address issues, quarterly. Number of falls champions in place.	2018/19 Quality Account.

PATIENT EXPERIENCE

CQC DOMAINS	PRIORITY	REASONS	HOW WE WILL ACHIEVE IT	HOW WE WILL MONITOR IT	HOW WE WILL MEASURE IT	REPORTING
Safe	To collaboratively develop the recovery college model within the organisation.	Embedding a recovery-based approach will play a central role in achieving positive patient reported outcomes and improving patient experience.	Development of the Recovery College including:	Evidence of engagement of staff and patients in developing the Recovery College.	Number of trainers recruited.	CQUIN Implementation meeting.
Caring		This could lead to improved clinical outcomes, reduced lengths of stay and fewer readmissions.	• Identification of ongoing resource required.	Minutes of planning groups.	Number of sessions offered.	Quality Forum.
Effective			• Building on current courses developing a full prospectus and ongoing development of courses.	Course prospectus developed.	Percentage of patients attending sessions.	2018/19 Quality Account.
			• Continued recruitment of service users to participate in courses.	Outcome measures in place.	Outcome measures showing review of courses and changes made where necessary.	
			• Development of positive outcome measures to ensure course is achieving objectives.	More trainers recruited target increase 25%.	As the recovery model develops, we will be able to set targets for subsequent years.	
			• Ongoing recruitment of trainers and peer trainers to sustain growth in college.	Attendance for courses.		

CQC DOMAINS	PRIORITY	REASONS	HOW WE WILL ACHIEVE IT	HOW WE WILL MONITOR IT	HOW WE WILL MEASURE IT	REPORTING
Well Led	Further embed engagement of service users and carers in the recruitment process.	We recognise that service users and carers should play a key role in the recruitment of clinical staff. It is paramount that we appoint staff who have values and beliefs aligned to the needs of our service users and carers.	Continue to maintain database of service users and carers and their skills.	A database listing service users and carers willing to be involved in staff recruitment.	10% increase in number of service users and carers willing to be involved in staff recruitment (to be reported six-monthly).	Patient Experience Group.
		Including more service users and carers who would like to be part of the ongoing development of the Trust clearly shows our commitment to service user engagement.	Active recruitment of more service users and carers who are willing to be involved.	The patient involvement team will monitor how many service users and carers are requested to support with interview activity.	15% increase in service users and carers who have been a member of a recruitment panel compared to 2017/18 (monitoring of numbers to be reported quarterly).	Quality and Governance Committee.
			Educating staff about the usefulness of including service users and carers in recruitment process.		Six-monthly evaluation of post interview feedback and evidence of tailoring of processes where found to be necessary.	2018/19 Quality Account.
			Ensuring staff at the Trust are offered and include service users and carers when recruiting new staff.			

CQC DOMAINS	PRIORITY	REASONS	HOW WE WILL ACHIEVE IT	HOW WE WILL MONITOR IT	HOW WE WILL MEASURE IT	REPORTING
Responsive	Using iWantGreatCare (iWGC), and other sources of feedback to learn from and respond to patients and carers.	This was a priority for 2017/18 and continues to be vital to our drive to listen and use experience to shape care delivery and service design.	Patient service user and carer feedback will be gathered using the Trust's recognised systems.	The iWGC and patient experience teams will monitor the embedded feedback process and any required actions.	Quarterly reports outlining number of feedback reports required and received via iWGC.	Locally within directorate meetings.
Effective			Outcomes will be analysed and services will be required to respond to their feedback.		10% increase in the number of responses required within timescale based upon 2017/18 baseline (75%).	Quality Forum.
			Q1 timescales will be confirmed for responding to iWGC feedback.		Evidence in board and committee reports that the Trust triangulates iWGC feedback with other sources. For example, complaints, serious incidents and safe staffing.	Trust Board.
			iWGC data will be triangulated with other quality, workforce and staff feedback indicators to provide a ward level quality early warning system.			2018/19 Quality Account.

CLINICAL EFFECTIVENESS

CQC DOMAINS	PRIORITY	REASONS	HOW WE WILL ACHIEVE IT	HOW WE WILL MONITOR IT	HOW WE WILL MEASURE IT	REPORTING
Safe	To work collaboratively internally to share our patient safety experiences and outcomes in order to improve learning from incidents, complaints and compliments, and reduce harm.	This was a quality priority for 2017/18 and further work is required to ensure that learning is embedded effectively.	Continuing to consider additional innovative ways of sharing information arising from serious incidents, complaints and concerns in order to improve the sharing further. For example, the utilisation of social media to support lessons.	We will monitor our lessons learnt activity and platforms, and identify outcomes from these that have contributed to our internal safety agenda.	A six-monthly report outlining an evaluation of the ways that staff members learn and share information. For example, patient and carer stories, medicine bulletins, conferences, governance meetings, and Patient Experience Groups.	Quality Forum.
		In 2017/18 we undertook a survey to understand how staff would like to see lessons being learned across the organisation.	Implement the findings of the survey in 2017/18, and develop and action plan.	National and local circulation of risks, safety concerns and best practices will continue to be shared with staff groups via numerous mechanisms.	The number of investigations that have a joint focus will provide evidence of the need to share information and jointly plan for patient safety across the health system.	2018/19 Quality Account

CQC DOMAINS	PRIORITY	REASONS	HOW WE WILL ACHIEVE IT	HOW WE WILL MONITOR IT	HOW WE WILL MEASURE IT	REPORTING
				Delivery of action plan to be monitored via the lesson learnt exchange reporting to Quality Forum.		
Well Led	Develop the skills and competence of all newly qualified band 5 nursing staff and allied health professionals.	To ensure that newly qualified staff are supported and engaged quickly to develop their skills base and quality care.	Continuous evaluation of the preceptorship package to ensure effectiveness.	This will be carried out via the preceptorship programme and a report will be produced twice a year that will include:	A six-monthly report outlining progress and uptake of the preceptorship programme.	Trust Nursing and Advisory Committee (TNAC).
Safe			Development of the nurse apprentice programme.	• Attendance data • Evaluations • Successful completion • Identified clinical competences • Online supervision package	All newly qualified nurses are identified, and have taken part in and successfully completed the programme. 80% of cohort to undertake training.	2018/19 Quality Account.
				• Mentorship qualification (at the end of the programme)		

CQC DOMAINS	PRIORITY	REASONS	HOW WE WILL ACHIEVE IT	HOW WE WILL MONITOR IT	HOW WE WILL MEASURE IT	REPORTING
Safe	To increase the reporting associated with completed physical examinations in line with National CQUIN relating to physical health in mental health.	Improved physical health care for people with severe mental illness.	Continuing physical health training for staff and medics.	Quarterly reporting in line with CQUIN.	In line with CQUIN.	CQUIN implementation meeting.
Effective						Quality and Governance Committee.
						2018/19 Quality Account.

OUR 2018/19 PRIORITIES

PRIORITIES FOR IMPROVEMENT

We are passionate about embedding the principles of patient safety, experience and clinical effectiveness into our organisation. Our commitment to these principles means that this year's priorities are a continuation from those identified last year. This will ensure that they are fully embedded into clinical practice and will underpin the organisation's drive to benchmark and shape future care delivery.

Additionally, the priorities will support the Trust as we continue with our mission to make sure that safe, quality care is at the heart of all we do.

As a result, our priorities were developed in collaboration with our staff and patients as part of the 2017/18 Quality Report development phase.

For 2018/19, the quality priorities were again shared with our key stakeholders for comment and feedback. Those consulted included the quality team, Patient Experience Group (inclusive of patients and carers), quality account meeting members, the executive team, the Nursing Advisory Committee, the Allied Healthcare Professional Advisory Committee, colleagues from training and our staff group networks.

Our priorities for improvement are therefore as follows:

Patient safety

- To reduce the level of risk associated with self-harm incidents.
- To embed the mortality and morbidity process across the organisation.
- To increase the levels of reporting associated with falls, ensuring that all relevant patients and service users in inpatients and community settings have a falls assessment completed, and those identified at risk have a falls care plan implemented.

Patient experience

- To collaboratively develop the recovery college model with the organisation.
- To increase the number of service users and carers involved in staff recruitment.
- To use iWantGreatCare (iWGC) and other sources of feedback to learn from and respond to patients and carers.

Clinical effectiveness

- To work collaboratively internally to share our patient safety experiences and outcomes in order to improve learning from incidents, complaints and compliments and reduce harm.
- To develop the skills and competence of all newly qualified Band 5 nursing staff and allied health professionals (AHPs).
- To increase the reporting associated with completing physical examinations within the mental health services.

STATEMENTS OF ASSURANCE FROM THE BOARD

A REVIEW OF OUR SERVICES

During 2017/18, the Trust provided and/or sub-contracted 139 relevant health services (these are services we deliver within the Trust).

111 of these services were fully contracted service lines and 28 were sub-contracted services under service level agreement.

We have reviewed all the data available to us on the quality of care in 139 of these relevant health services.

The income generated by the relevant health services reviewed in 2017/18 represents 94% of the total income generated from the provision of relevant health services by the Trust for the year.

In 2017/18, **eight national clinical audits** and **one national confidential enquiry** covered the relevant health services that we provide.

During that period, the Trust participated in **100% of national clinical audits** and **100% of national confidential enquiries** of the national clinical audits and national confidential enquiries that were relevant to the Trust.

NATIONAL CLINICAL AUDITS

The national clinical audits and national confidential enquiries that we were eligible to participate in during 2017/18 were as follows:

- Cardio metabolic assessment and treatment for patients with psychosis (CQUIN)
- National Clinical Audit of Psychosis (NCAP)
- National Audit of Inpatient Falls – Community Hospitals round 2
- National Audit of Intermediate Care
- Hip Sprint Audit
- Falls and Fragility Fracture Audit Programme (FFAP)
- National Audit Parkinson's Disease (SECR)
- Prescribing observatory in mental health
- Early intervention in psychosis and national confidential enquiry into suicides and homicides

The national clinical audits and national confidential enquiries we participated in (and for which data collection was completed during 2017/18) are listed below, alongside the number of cases submitted to each audit or enquiry. These are noted as a percentage of the number of registered cases required by the terms of that audit or enquiry.

TITLE	%
Cardio metabolic assessment and treatment for patients with psychosis (CQUIN)	100% of eligible sample
Prescribing observatory in mental health Topic 1g & 3d Prescribing high dose and combined antipsychotics on adult psychiatric wards Topic 17: Use of depot/LA antipsychotic injections for relapse prevention	100% of eligible sample 100% of eligible sample
Topic 15: Prescribing valproate for bipolar disorder	100% of eligible sample
National Clinical Audit in Psychosis	100% of eligible sample
National Audit of Inpatient Falls – Community Hospitals round 2	This was a data capture exercise only
National Audit of Intermediate Care	100% of eligible sample
Hip Sprint Audit	100% of eligible sample
Falls and Fragility Fracture Audit Programme (FFAP)	100% of eligible sample
National Audit Parkinson's Disease (SECR)	100% of eligible sample
National confidential enquiry into suicides and homicides	This was a data capture exercise only

ACTIONS TO IMPROVE HEALTHCARE AS A RESULT

Cardio metabolic assessment and treatment for patients with psychosis (CQUIN)

- Data from this audit was collected in October and submitted online in November.

Prescribing observatory in mental health

- Topic 1g & 3d: Prescribing high dose and combined antipsychotics on adult psychiatric ward. The report was received 27th October 2017 and is being managed via the medicine management pathway.
- Topic 17: Use of depot/LA antipsychotic injections for relapse prevention. Data collection has been completed. The report was due in November, however this was delayed and was expected early 2018.
- Topic 15: Prescribing valproate for bipolar disorder. Data collection was in September and October 2017. The report was expected February 2018.

National confidential enquiry into suicides and homicides

- We have participated in the development of the Northamptonshire countywide suicide prevention strategy with public health (we are joint signatories). We have also attended prevention concordat meetings, which include the plans for enacting this strategy.
- We have continued to work on family and carer involvement, including the development of co-produced training and work with Information Governance to maximise opportunities for family/ carer involvement.
- We have reviewed the current training offer for suicide prevention and are in the process of developing a revised training strategy for the Board to consider.
- Suicide Prevention Group continues to function as a resource and members act as suicide prevention leads in their own areas. This includes sharing relevant guidance, feeding back from external events such as the National Suicide Prevention Alliance (NSPA) conference, and being asked to review and comment on specific Serious Incidents (Sis). We have also commenced investment in staff development such as Continuing Professional Development (CPD) time.

National Clinical Audit in Psychosis

- Data from this audit was collected in October and submitted online in November. We will develop an action plan as required when we receive the report.

National Audit of Intermediate Care

Actions for Hospital-based Intermediate care

- Introduction of the collection of outcome scores across all wards cross-county multi-agency working to review Intermediate Care pathway to reduce hand offs, provide a more integrated approach and increase flow.

Actions for Home-based Intermediate Care

- Joint working with acute colleagues to better understand appropriate referrals to ICT so maximising input and increasing conversion rates of patients successfully being transitioned back into the community. Cross-county multi-agency working to review Intermediate Care pathway to reduce hand offs, provide a more integrated approach.

Hip Sprint Audit

- Make better use of rehab assistants and other appropriate members of the MDT in hip fracture rehabilitation.
- Develop standardised hip fracture rehab programme to reflect acute hospital protocol.
- Liaise with ward matrons.
- More training for rehab assistants regarding exercise and hip precautions.
- Liaise with other community hospitals and implement.

Falls and Fragility Fracture Audit Programme (FFAP)

- The post falls protocol is now audited as part of the qualitative recordkeeping audit.
- Low level assessor training for Technical Appraisals (TAs) will be facilitated in the future.
- An additional section has been added to the doctor's initial assessment to ask about falls and included in action plan feedback.
- Fear of falling has now been added as a question on the SystmOne falls assessment.
- Information and guidance about lying and standing blood pressure has been disseminated to all areas, and ongoing promotion is being implemented by the Falls Champions.
- Falls prevention in hospital leaflets for patients and families has been updated and issued to all high risk inpatient areas.

National Audit Parkinson's Disease (SECR)

- Data collection ended 30/10/17. Service specific reports are expected March 2018, and UK-wide reports are expected May 2018.

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LOCAL CLINICAL AUDITS

YEAR AUDIT COMMENCED/ APPROVED	REPORTS REVIEWED BY THE CAEC IN 2017/18
2016/17	32
2017/18	45

ACTIONS AS A RESULT

We reviewed the reports of 45 local clinical audits in 2017/18, and have either completed or are in the process of taking the following actions to improve the quality of healthcare provided:

Identifying improvements in coeliac care

- We developed an individual review appointment where individual diets and concerns are addressed.

- The appointment letter and the invitation to group sessions now highlights that this will provide generic information relevant to all patients with coeliac disease.
- Patients are now encouraged to request and attend annual reviews with their gastroenterologist, GP or dietitian.

Identifying quality of puree meals in care home setting (Nutrition and Dietetics Team, in conjunction with Care Homes)

- Working with care homes to ensure patients requiring modified diet are offered a choice of high quality foods, consistent with the main menu.
- Developed training course for care home staff responsible for menu management and puree meal preparation to improve their knowledge and skills.

Malnutrition Universal Screening Tool (MUST) audit on Hazelwood Ward

- Staff have been reminded to ensure that the amounts of each meal eaten by the patient are recorded.
- Oral nutritional supplements are only given under the direction of a dietitian, when indicated by Advisory Committee on Borderline Substances (ACBS) criteria.
- All weekly MUST scores are recorded on a Saturday, even with patients whose MUST scores have been completed mid-week on admission. This is to prevent time periods of over one week between MUST assessments.
- An audit to look at drug prescribing competencies as advised by NICE.
- All prescribers now print their name as well as signing their prescriptions.

Antimicrobials point prevalence study

- Six-monthly audit shows prescribing is consistent with stewardship guidelines.

Fluoride provision in Special Care Dentistry

- Prescription forms were amended to identify the R4 number instead of NHS number.
- Disease risk on template changed to include caries or periodontal disease.

Medicines reconciliation audit

- The medication reconciliation questionnaire was redesigned and implemented throughout the Trust (completed January 2018).
- There was additional training on the use of questionnaires for pharmacy and junior doctors. The Rapid Tranquilisation policy was reviewed and the wording was clarified.
- Nurse training was reviewed and updated.
- We developed and delivered doctor specific training, and we conducted the first training session.
- The venous thromboembolism audit SystmOne template was reviewed to be more user friendly.
- Additional training was provided to doctors on completion of the template.
- A learning bulletin was produced and disseminated to doctors to highlight key results.

Prescribing standards audit

- The junior doctors induction was adapted to ensure that results from the audit are highlighted and discussed.
- An allergies learning bulletin was produced and disseminated across the Trust.

Audit of the identification, assessment and management of respiratory impairment as per NICE guidelines in patients with motor neurone disease followed up by the North Palliative Neurology Team

- Respiratory tests are now carried out every 3-4 months and requested from other centres. If respiratory tests are carried out less frequently, the reason for this is documented in the patients' records.
- Breath stacking exercises are discussed with all patients and recorded in the patients records.

Compliance to HIV in pregnancy guidelines

- Pregnancy care plans are now scanned into the patient's electronic clinic notes on Lilie.

Summers Unit (SU) audit on newly diagnosed HIV patients

- SU asks for a clinical summary of all the newly diagnosed HIV patients.
- All GPs and specialists are contacted if they have missed an early HIV diagnosis.

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ACCREDITATION SCHEMES

The following services have undertaken the following accreditation schemes during 2017/18. Participation in these schemes demonstrates that staff members are actively engaged in quality improvement and take pride in the quality of care they deliver.

SCHEME		SERVICE	ACCREDITATION STATUS
Gold Standards Framework (leads to the GSF Hallmark Award in End of Life Care)		Danetre Hospital (Community Beds)	GSF accreditation at Care Homes standard
Accreditation for Inpatient Mental Health Services (AIMS)	AIMS - WA (Working Age Units)	Mental Health In-patients (working age)	• **Cove: AIMS peer review** 11th September 2017 (awaiting report) • **Bay AIMS peer review** 21st September 2017 (awaiting report) • **Harbour AIMS Peer review** 20th September 2017 (awaiting report) • Kingfisher AIMS Peer review 12 October 2017 (awaiting report)

			• Avocet AIMS Peer review 27 June 2017 (awaiting report) • Sandpiper AIMS Peer review 21 June 2017 (awaiting report)
	AIMS - PICU (Psychiatric Intensive Care Units)	Intensive Care Unit – Mental Health	• **Marina** Accredited
	AIMS - OP (Wards for Older People)	Older People's Mental Health In-patient Service	• **Orchard & Spinney wards (The Forest Centre)** Accredited September 2016 • **Brookview and Riverside (Berrywood Hospital)** Accredited February 2015
	AIMS - Rehab (Rehabilitation wards)	In-patient Rehabilitation Mental Health	• **Meadowbank** Accredited June 2017
Quality Networks	Quality Network for Inpatient CAMHS (QNIC)	CAMHS Inpatient Services	• **The Burrows** Accredited May 2015 • **The Sett** QNIC Peer review 11 January 2018 (awaiting report)
	Quality Network for Forensic Mental Health Services (QNFMH)	In-patient Mental health – low secure	• **Wheatfield Peer review** 2 February 2018

ECT Accreditation Scheme (ECTAS)	The Treatment Centre	• **Accredited**
Eat out, Eat well Accreditation Scheme	The Trust's hospital cafes	• **Berrywood** Silver accreditation • **Cynthia Spencer** Gold accreditation • **Danetre** Gold accreditation • **Isebrook** Gold accreditation • **St. Mary's** Gold accreditation
Wellbeing charter		• **Accredited** November 2017
Investors in the Environment		• **Green Award 2018** For reducing our carbon emissions by 24%. (This is the reduction against the baseline measured in 2010)
Unicef Baby Friendly Initiative	0-19 service	• **Stage 1 and 2 accreditation**

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COMMISSIONING FOR QUALITY AND INNOVATION INCOME

A proportion of the Trust's income in 2017/18 was conditional, based on achieving quality improvement and innovation goals. These goals were agreed between the Trust and the person or body who entered into a contract, agreement or arrangement for the provision of relevant health services, through the Commissioning for Quality and Innovation Income (CQUIN) payment framework. Further details of the agreed goals and for the following 12-month period are available electronically at www.nhft.nhs.uk.

The total monetary income in 2017/18 that was conditional on achieving quality improvement and innovation goals was £3,341,502.
Of this, £3,127,811 was from Nene and Corby CCGs. 96% of the CCG CQUIN target as at the end of Q3 had been met. The total monetary income in 2016/17 that was conditional on achieving quality improvement and innovation goals was £3,016,937. Of this, £2,847,910 was from Nene and Corby CCGs. Achievement against the cumulative CQUIN target as at the end of quarter 3 was 88.4%. Quarter 4 achievement is still to be confirmed by CCG.

A number of patient-centred successes were noted as part of the CQUIN evaluation process.

These outcomes will have a positive and lasting effect for the service users and their carers, for example the transition of children from the Child and Adolescent Mental Health Services (CAMHS) to Adult Mental Health Services CQUIN.

This has encouraged us to better understand, assess and resolve issues around the transition process. We have reviewed our processes and have employed staff specifically to ensure this pathway is being effectively managed.

Further internal relationships have also been built as part of this CQUIN between Children's and Adolescent Mental Health and Community Mental Health Services.

We are also working with our acute colleagues to ensure that people who have attended A&E multiple times in the last year are able to meet with specialist mental health staff for assessment, review, and care planning.
It is hoped that this will reduce their attendance at A&E and improve the quality of their life.

The Trust has been working to ensure that service users are supported to reduce their tobacco and alcohol intake. Staff have been trained to offer interventions around smoking and alcohol and various means of communication have been used to raise awareness, inform and educate staff on the importance of screening, intervening and documenting care around tobacco and alcohol consumption.

The Estates and Catering teams have been focused on reviewing their food supplies in line with the CQUIN requirements. As a result, the café's offering has changed and healthier products are now more accessible to patients, service users, staff and carers.

Additionally, the organisation has recruited two CQUIN leads. One is leading and developing models to improve our outcomes within the physical health in mental health scheme. This CQUIN has been challenging for the teams to achieve, however with a renewed approach there has been a positive and steady improvement in our audit outcomes.

SECONDARY USES SERVICE

NHS Number and General Medical Practice Code Validity
The Trust submitted records during 2017/18 for the Secondary Uses Service. These are included in the latest published data for Hospital Episode Statistics.

The percentage of records in the published data that included the patient's valid NHS number was:

- ***99.9% for admitted patient care***
- ***100% for outpatient care***

The percentage of records in the published data that included the patient's valid General Medical Practice Code was:

- ***100% for admitted patient care***
- ***99.6% for outpatient care***

INFORMATION GOVERNANCE TOOLKIT

Our overall score for the Information Governance Assessment Report 2017/18 was 90% and was graded green.

CLINICAL CODING ERROR RATE

The Trust was not subject to the Payment by Results clinical coding audit during 2017/18.

LOCAL INDICATOR

Our auditors, KPMG, reviewed our local performance indicator and recorded physical health checks in specific mental health settings. The information below summarises the findings of their draft report.

FINDINGS

KPMG reviewed a sample of 10 patients from the audit databases held by the Trust, featuring physical health check information. For each patient, the records were evaluated to confirm that the physical health checks carried out had been recorded correctly. For all 10 patients, the audit database contained the correct information.

Our definition of this indicator is consistent with what has been presented in the Quality Report, and the way in which the indicator is calculated is appropriate and accurate.

Data comes directly from SMART reporting, which is designed to include all patients admitted within the last seven days with severe mental illness. Data is drawn from the patient records system SystmOne, which is updated by the clinical staff. However, the movement of patients from the SMART report to the audit database is a manual process and is completed individually on a patient by patient basis. As a result, it is possible for a patient to be missed due to human error. Our auditors have issued a recommendation to improve the controls in this area.

The data for this indicator is captured from SystmOne using cluster codes and IDC10 codes, which are specific to patients with severe mental health. This is relevant for reporting purposes as only patients with a diagnosis of severe mental health will be included.

There are cluster audits carried out within the Trust to gain assurance that patients have the correct cluster code relevant to their condition. This process has been introduced during the year and has only been in place consistently from quarter 2 onwards. Data is checked by confirming it to SystmOne. We focus on cases where the patient has not received the appropriate mental health checks and any missing information is followed up with the ward.

Overall, KPMG found that the design and operation of the controls in place to calculate this indicator are considered appropriate. The data on the SMART system is refreshed on a daily basis. Patients are then reviewed on a weekly basis once the performance report has been sent out. The reporting is completed on a quarterly basis. However, ICD10 codes can be added after discharge and therefore a patient may not be included within the reported data at the time of treatment, causing a delay as they are added to the audit database once discharged.

RECOMMENDATIONS

It was recommended that there be an implementation of a secondary review of the audit database comparing the patients to the relevant SMART reports. This would minimise the risk of human error by confirming the correct patients have been added to the database.

AGREED ACTION

A dip sample of patients will be identified on a specific day per month, the information will be compared with the relevant SMART reports. Updates on this action will be reported to the Quality Forum via the CQUIN quarterly update document.

Responsible Person: Sian Roberts, Head of Quality Compliance
Target Date: October 2018

SERIOUS INCIDENTS

Total reported in 2017/18	32
Downgrade requested*	8
Reported in Adult Mental Health and Learning Disabilities Specialty Services	25
For Adult and Children's Services	6
Originated in Corporate Support+	1

* There was no deviation from expected practice, act or omission that led or contributed to harm to the patient. As these incidents are not believed to meet the serious incident criteria, a downgrade was requested of commissioners.

+ An Information Governance breach, meeting the SI threshold.

Never Events
NHS Improvement describe Never Events as 'serious incidents that are entirely preventable because guidance or safety recommendations providing strong systemic protective barriers are available at a national level, and should have been implemented by all healthcare providers.'

In 2017/18, the Trust completed a joint investigation into a Never Event linked to the medication Methotrexate. This process involved collaborative working between the organisation and a general practice within Northamptonshire. The Never Event at time of reporting has been allocated to NHFT. There was no harm to the patient and lessons have been learnt across the organisations.

MANAGING SERIOUS INCIDENTS

The following explains how we managed Serious Incidents (SIs) this year, and our learnings to take forward into next year.

- Adult Mental Health, Learning Disabilities and Specialty Services review all of the incidents likely to require further investigation, prior to going through the Internal Assurance Meeting (IAM) process during their directorate team meetings.
- The IAM meeting reviews and evaluates incidents against the local policies and NHS England SI Framework and considers what level of further investigation is required.
- Adult and Children Services also review their incidents in the same way, which provides a wider degree of input into the IAM discussion to enhance the discussions and decisions made.

Attendees at these meetings include service managers, experienced clinical leaders and subject matter experts who provide a summary of discussion and a recommended level of investigation that is required to be incorporated into the IAM group. This represents further strengthening of the IAM process.

- During the early part of 2017/18, the Adults and Children's incidents were managed by the IAM.

- As standard and where appropriate, patients, service users and carers are offered the chance to participate in the investigation of incidents that they are involved in. This generally involves providing an account of the individual concerned, their individual circumstances and difficulties, as well as highlighting areas of concern that they wish to be addressed as part of the investigation. Their involvement contributes to the terms of reference prior to the investigation and includes engagement in a debrief with the investigator following the report's completion.

- This approach is also applied to clinical reviews (which are investigations that do not meet the criteria for a serious incident investigation, but meet the criteria for internal review).

- We have continued to review and improve the computer system for managing serious incidents and other levels of investigation, which now incorporate action plan deadlines and Duty of Candour compliance.

- The Datix incident reporting system was amended earlier in the year to allow staff to record that the incident has been discussed with the patient or their family, as well as record when it was undertaken and by whom.

- Recent improvements include a link for staff to the initial Duty of Candour flowchart, which aids decision-making and clarifies responsibilities and actions. Discussing patient safety incidents for those that have not met the serious incident or clinical review threshold in this way develops and supports a culture of openness, candour and transparency.

Training to support managing SIs:

- We now have three dedicated serious incident investigators who allow us to continue to develop the investigation process, extraction of learning and quality of investigation reports.

- Root Cause Analysis training continues to be available to appropriate staff via an external provider through the Trust's Learning and Development Service.

- We are currently developing alternative training that will be provided 'in-house' by the Patient Safety Team, which will be informed by external input, recent Human Factors work and locally developed expertise. A service user with extensive experience of incident investigation and of Human Factors is also very involved in this process. This training is expected to be in place by mid 2018/19.

Patient and Family Liaison

We also now have a dedicated Patient and Family Liaison Lead (P&FLL) who joined the Trust in September 2017. Their role is independent to the investigation, and supports patients, service users and their families or carers throughout the serious incident investigation or clinical review process.

The P&FLL ideally attends the first meeting of the investigator with the patient, service user, carer or family and supports according to need, in person or via phone or email. Their support is in relation to the investigation being carried out, until conclusion of the Investigation or Coroner's Inquest.

The P&FLL provides support in person or via phone or email and can signpost to other organisations as appropriate (a booklet of relevant organisations has also been developed).

They can also facilitate questions, explain terminology used in the investigation and if relevant provide information about what to expect at the inquest (Coroner's Court) and attend with the family. A record of all contact made is kept.

The P&FLL also manages the Trust's compliance with the initial notification element of the Duty of Candour process in relation to serious incidents and clinical reviews. They also monitor compliance for all other incidents that meet the threshold for Duty of Candour.

COMPLAINTS DATA

As at 31 March 2018

Complaints	241
Comparison with prior year	+15.9%
Contacts on Patient Advice and Liaison Service (PALS)	603
Comparison with 2016/17	+11.7%
GP concerns	27
Complaints responded to within 3 working days	96.6%
Resolution or final written response in 25 days*	100%
Complaints referred to PHSO+	39
Approved for investigation	7
Concluded in this periodo	2
Total contacts for 2017/18	1,678,000
Increase in contacts from 2016/17	+5.52%

*Or with an extended timeframe, as agreed with the complainant.

+ As confirmed by the Parliamentary and Health Service Ombudsman (PHSO), (this figure is inclusive of complaints received by the PHSO which do not meet their criteria, or where complainants had contacted them prior to the Trust).

oOf these one was partially upheld and the other was withdrawn. The remaining 5 complaints continue to be investigated.

We continue to review systems and processes to ensure that learning and improvements from complaints and concerns are part of our core activity and robust action is taken to put things right when required. We also continue to extend our partnership working with other trusts in order to undertake joint investigations and share learning.

We have a good working relationship with the Parliamentary and Health Service Ombudsman (PHSO) and Care Quality Commission (CQC).

Our peer review process is now run as a highly successful forum bringing together staff, service users and carers. This identifies learning and develops a high quality complaints management process.

In addition to managing queries from patients and carers, the Complaints and PALs Team continue to appropriately manage queries received from MPs and GPs. The team also ensures that detailed themed reports are provided to the Complaints Review Committee (CRC) on a quarterly basis and closely monitors complaints on an annual basis.

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LESSONS LEARNED

We adopt an open and transparent, positive organisational culture, and view opportunities to develop and learn positively. It is recognised that by actively promoting the importance of reporting, sharing and highlighting potential safety issues we reduce and minimise harm to patients.

It is also important to circulate good news stories with staff, so that we can celebrate our successes and share good practice. For example, the patient experience team have commenced an initiative where two compliments per week are shared with the Executive Team, Service Managers and on the Trust's intranet, 'The Staff Room'.

Communication
We continue to find innovative ways to reach staff with lessons learned. This year, the Learning Lessons Exchange Group commissioned a survey monkey to be sent to all staff asking how colleagues would like to learn from incidents, complaints, and compliments a full analysis of the results is underway.

We regularly share information in a number of ways across the organisation:

- Team meetings and training days to discuss serious incident or complaint outcomes
- Adapt training content to meet new guidelines or to meet an action plan requirement
- Share lessons learned from specific areas such as medication management via 'bullet-ins'
- The Quality Forum and other committees have standing agenda items
- Manager 'need to know' monthly emails
- Chief Executive update
- Weekly e-brief
- Pin board notices on the intranet
- Screen savers with key messages
- Lessons learned are also shared at staff conferences and leadership events
- Action plans linked to serious incidents and complaints

Duty of Candour
The 'Being Open' or Duty of Candour (DOC) policy has been updated and provides practical guidance for staff. Face-to-face policy update sessions have been provided to the teams to ensure they are aware of the requirement of DOC.

An advice and support booklet for families explains the role of the P&FLL during the SI and Clinical Review Process and is shared with the families and patients. In addition, a sign-posting leaflet for families has been prepared.

Human Factors
The Human Factors Analysis and Classification System (HFACS) project with the East Midlands Patient Safety Collaborative (EMPSC) has now finished.

The trusts involved will implement the elements of the project as deemed appropriate. We have already completed our first HFACS SI and the investigation report was submitted to the CCG in early November. The CCG is aware of the approach taken and feedback is expected shortly.

Lessons learned this year include:

- Due to an increased number of investigations completed relating to the death of a service user, the SIRC members requested a thematic review. The Mortality Lead completed this, with a brief to review all relevant cases (30) from May 2016 to May 2017.

- The data analysed showed some clear outcomes. The majority of the cases were male, and the average age range for death was 51-60. Individuals with co-morbidity were at higher risk of suicide (this could be illicit drug/ alcohol related or a physical health condition) and the most common diagnosis was depression with anxiety.

  These outcomes have been fed back into specific groups, in order to influence the development of the depression pathway and other clinical innovations.

- The organisation took part in the national clinical observation engagement work to review the way that staff undertake 'observations' within the mental health in-patient wards. The results are being disseminated across the relevant areas so that practice can be reviewed.

- A clinical refresh is being undertaken so that lessons learned from trialing documentation can be amended to the electronic patient record.

- The Trust has developed a two tier on line falls training package and has refreshed its post falls care planning advice following a serious incident.

- Lying and standing blood pressure reading and the roll out of CEWs within the community areas is supporting clinical decision making in the identification of the deteriorating patient.

- The pilot of CEW's within the community nursing team.

- Following a serious incident, a review of bed frames within mental health in-patient services has resulted in the purchasing of new beds.

- Work commenced in quarter 4 preparing a patient safety communication plan for 2018/19 based upon lessons learned to include updates and information in a variety of different sources appertaining to; suicide prevention, prevention and management of falls, medicine management, transitions from children's to adult services and preventing ill-health by risky behaviours (for example, alcohol consumption and smoking).

- Using Structured Judgement Review (SJR) methodology recognised by the Royal College of Physicians, the Trust will review deaths within a specific scope.

- This scope is outlined within the policy and will expand as the processes become embedded and further refined. The SJR tool will enable the reviewer to assess the quality of care provided and assess the level of avoidability of the death. The reviewer is able to identify key elements of learning and identify what went well in the care delivery. When an SJR is requested, a letter is sent to the deceased's family/carer to offer condolences, inform them a review is being undertaken and invites them to participate.

- The Trust includes learning from Mortality reviews within established governance structures with Trust Board oversight. This ensures that lessons learnt from mortality reviews and analysis of mortality data will result in change in organisational culture and practice.

LEARNING FROM DEATHS

The Trust implemented the National Quality Boards (NQB) Learning from Deaths guidance from Q3 2017/18. This implementation has prompted change in the way the Trust reports incidences of deaths. At this time, the Trust's approach to implementing the Learning from Deaths guidance was focused on a cohort of services that will expand in future across the organisation. Therefore, it is anticipated the deaths reported onto Datix, the Trust's incident reporting system, will increase. The Trust's initial scope during 2017/18 covered the following service areas:

- All inpatients, apart from hospices/end of life
- Custody including prisons
- If a family member or carer has raised a concern in care relating to a death

In 2017/18, 298 deaths were reported on Datix. During 2017/18, the reporting of all deaths on Datix has been strengthened Trust-wide and we are seeing an increase in reporting each quarter. In the past, only unexpected deaths were generally reported on Datix. This comprised the following number of deaths that occurred in each quarter of the year:

- 78 in Q1
- 57 in Q2
- 73 in Q3
- 90 in Q4

In 2017/18, 14 case record reviews and 30 investigations have been carried out in relation to 298 of the deaths noted above. In one case, a death was subjected to both a case record review and an investigation.

The number of deaths in each quarter for which a case record review or an investigation was carried out was:

- 12 in Q1
- 10 in Q2
- 14 in Q3
- 8 in Q4

In 2017/18, 0% of deaths were judged to be related to a problem in care. After a serious incident investigation or clinical review has been undertaken into the death of a service user, the outcomes are evaluated to identify whether the death was related to a problem in care. As the national framework for Serious Incidents identifies the investigation period as 60 working days this can cause a delay in reporting within the quarter or at year end.

All deaths that are reviewed or investigated are recorded as the date reported onto the Datix system, not the date of death. Therefore, there are no deaths reported before the start of the reporting period.

The following is a summary of what we have learnt from case record reviews and investigations conducted in relation to these deaths:

- Documenting every occurring medical review
- Nursing home placement efficiency
- Patient's family could have been contacted sooner to inform them of a 999 call
- Discussion with patient and family regarding management plan in the event of sudden physical deterioration and the risk of this happening
- A care plan was needed for cellulitis of leg or pneumonia
- There was difficulty managing a terminally ill patient overnight when the patient wished to remain at home (i.e. on prison wing) and balancing this against provision of care
- The system for allocation of keyworkers on the ward should be changed from using bedroom numbers to allocating based on the availability of keyworkers

The following is a summary of the actions that we have taken in 2017/18 and propose to take next year:

- Team of doctors to review method of documentation (for example, dictation software)
- Team will review care management referral processes
- Team manager has reviewed this learning with specific members of the team, including non-substantive staff
- Debrief with team to review findings and discuss timeliness of appropriate conversations and documentation of this, and discuss with doctors as part of morbidity and mortality review
- Prison to review 'open door' policy, including allowing access for out-of-hours services
- Keyworker allocation processes have been reviewed and a new process has been implemented by the Ward manager

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REPORTING AGAINST CORE INDICATORS

Our quality priorities for the coming year are outlined in this part of our account.

This table shows how we have performed against key quality indicators set by NHS Improvement. The Health and Social Care Information Centre offers data from outside the Trust for the following indicators. Unless indicated otherwise, Trust performance against indicators is based on data collected by the Trust and held on trust IT systems.

INDICATOR	TRUST SCORE 2015/16	TRUST SCORE 2016/17	2017/18 YEAR TO DATE	NATIONAL AVERAGE SCORE	FT HIGHEST SCORE 2017/18	FT LOWEST SCORE 2017/18	NON FT HIGHEST SCORE 2017/18	NON FT LOWEST SCORE 2017/18
The data made available to the Trust with regard to the percentage of patients on Care Programme Approach (CPA) who were followed up within seven days after discharge from psychiatric inpatient care during the reporting period.								
Percentage of patients on Care Programme Approach (CPA) followed up within seven days of discharge from an inpatient facility.	97.0%	97.7%	97.93%	96.07%	99.29%	87.10%	99.45%	79.87%
The data made available to the Trust with regard to the percentage of admissions to acute wards for which the Crisis Resolution Home Treatment Team (CRHTT) acted as a gatekeeper during the reporting period.								
Percentage of admissions to acute wards for which the Crisis Resolution Home Treatment Team acted as a gatekeeper during the reporting period.	98.9%	96.4%	96.67%	98.64%	100%	93.81%	100%	95.84%

INDICATOR	TRUST SCORE 2015/16	TRUST SCORE 2016/17	2017/18 YEAR TO DATE	NATIONAL AVERAGE SCORE	FT HIGHEST SCORE 2017/18	FT LOWEST SCORE 2017/18	NON FT HIGHEST SCORE 2017/18	NON FT LOWEST SCORE 2017/18
The data made available to the Trust by the Health and Social Care Information Centre with regard to the percentage of patients aged: (i) 0 to 14 and (ii) 15 or over readmitted to a hospital that forms part of the Trust, within 28 days of being discharged from a hospital that forms part of the Trust, during the reporting period. Notes: Benchmark data has not been updated since December 2013.								
(i) 0 to 15	4%	2.94%	3.51%	10.00%	13.6%	0% (5.74%)	14.94%	0% (3.75%)
(ii) 16 or over	7.69%	7.09%	5.35%	11.45%	17.15%	0% (4.88%)	17.72%	0% (3.35%)
Patient experience of community health services indicator score with regard to patient's experience of contact with either a health or social care worker. Notes: Data is taken from the Community Mental Health Survey. Questions used to complete this indicator are from Questions 4, 5 and 6 of the Mental Health Survey. Comparative data is based on the composition of the indicators in 2013 and has not been updated since then.								
Patient experience of community mental health services indicator score with regard to a patient's experience of contact with either a health or social care worker.	84%	87%	86%	89%	90.9%	80.9%	91.8%	81.6%
The data made available to the Trust by the Health and Social Care Information Centre with regard to the number and, where available, rate of patient safety incidents reported within the Trust during the reporting period, and the number and percentage of such patient safety incidents that resulted in severe harm or death. Note: 2017/18 data provided is as published by NRLS March 2018 for the period 1 April 2017 to 30 September 2017. The available data set that allows benchmarking of this information provides a rate per 1,000 bed days. As a mental health and community trust, our rate will show inflation, as it does not take into consideration community contacts. This will be an issue for all mental health and community trusts.								

INDICATOR	TRUST SCORE 2015/16	TRUST SCORE 2016/17	2017/18 YEAR TO DATE	NATIONAL AVERAGE SCORE	FT HIGHEST SCORE 2017/18	FT LOWEST SCORE 2017/18	NON FT HIGHEST SCORE 2017/18	NON FT LOWEST SCORE 2017/18
The number of patient safety incidents reported within the Trust during the reporting period.	1815	1963	2822	3160	7384	12	5119	1049
Where available, rate of patient safety incidents reported within the Trust during the reporting period.	33.16	35.83	54.24		97.4	20.73	126.47	16
Number of patient safety incidents resulting in severe harm or death.	4	7	14	32.48	172	1	69	2
Percentage of patient safety incidents resulting in severe harm or death.	0.22%	0.36%	0.50%	1%	8.30%	0.02%	2.30%	0.10%

STATEMENTS OF ASSURANCE FOR SELECTED CORE INDICATORS

Unless indicated otherwise, Trust performance against indicators is based on data collected by the Trust and held on Trust IT systems.

INDICATOR	TRUST SCORE	STATEMENT 1 THE TRUST CONSIDERS THAT THIS DATA IS DESCRIBED FOR THE FOLLOWING REASONS:	STATEMENT 2 THE TRUST HAS TAKEN THE FOLLOWING ACTIONS TO IMPROVE OUR TRUST SCORE, AND SO THE QUALITY OF ITS SERVICES, BY:
The data made available to the National Health Service Trust or NHS Foundation Trust with regard to the percentage of patients on Care Programme Approach who were followed up within seven days after discharge from psychiatric inpatient care during the reporting period.	97.93%	This data reflects how the Trust has maintained performance above the target for seven-day follow-ups from hospital.	The alert system implemented in 2016/17 from wards to community services continues to ensure all patients are prepared for discharge and follow-up arrangements are fully in place. The wards continue to ensure correct contact details for the service user are available to community services.
The data made available to the National Health Service Trust or NHS Foundation Trust with regard to the percentage of admissions to acute wards for which the Crisis Resolution Home Treatment Team acted as a gatekeeper during the reporting period.	96.7%	This data reflects how the Trust has maintained performance above the target for the gatekeeping of acute mental health admissions.	The continued deployment and development of the acute mental health liaison service, alongside improved reporting mechanisms continue to ensure performance is maintained above target.
The data made available to the National Health Service Trust or NHS Foundation Trust by	3.51%	This data reflects a very low rate of readmissions for this cohort.	Continued alignment between community and inpatient provision has helped maintain strong performance for this

INDICATOR	TRUST SCORE	STATEMENT 1 THE TRUST CONSIDERS THAT THIS DATA IS DESCRIBED FOR THE FOLLOWING REASONS:	STATEMENT 2 THE TRUST HAS TAKEN THE FOLLOWING ACTIONS TO IMPROVE OUR TRUST SCORE, AND SO THE QUALITY OF ITS SERVICES, BY:
the Health and Social Care Information Centre with regard to the percentage of patients aged 0 to 14 readmitted to a hospital, which forms part of the Trust within 28 days of being discharged from a hospital, which forms part of the Trust, during the reporting period.			indicator.
The data made available to the National Health Service Trust or NHS Foundation Trust by the Health and Social Care Information Centre with regard to the percentage of patients aged 15 or over readmitted to a hospital, which forms part of the Trust within 28 days of being discharged from a hospital, which forms part of the Trust during the reporting period.	5.35%	This data reflects a very low rate of readmissions for this cohort.	Continued alignment between community and inpatient provision has helped maintain strong performance for this.

INDICATOR	TRUST SCORE	STATEMENT 1 THE TRUST CONSIDERS THAT THIS DATA IS DESCRIBED FOR THE FOLLOWING REASONS:	STATEMENT 2 THE TRUST HAS TAKEN THE FOLLOWING ACTIONS TO IMPROVE OUR TRUST SCORE, AND SO THE QUALITY OF ITS SERVICES, BY:
Patient experience of community mental health services indicator score with regard to a patient's experience of contact with either a health or social care worker.	86%	This improvement is reflected in our reports from iWantGreatCare and service evaluations. Data is taken from the Community Mental Health Survey.	Continuing development and implementation of co-produced recovery groups, who review the production of care planning and delivery of care. This ensures our service users and carers are an integral part of our service planning and delivery both on an individual and strategic level.
The data made available to the National Health Service Trust or NHS Foundation Trust by the Health and Social Care Information Centre with regard to the number and, where available, rate of patient safety incidents reported within the Trust during the reporting period, and the number and percentage of such patient safety incidents that resulted in severe harm or death.	2822 0.50%	This score reflects that the Trust continues to make reporting of incidents a priority.	The Trust has invested resource into simplifying the incident data capture process and review and sign off processes encouraging the reporting of incidents and improving its accuracy to support learning.

OUR ACTIONS TO IMPROVE DATA QUALITY

Governance and leadership
The Finance Director holds corporate leadership of data quality. A newly created post of Deputy Director of Business and Performance, which brings together key corporate finance and business intelligence systems in one team, is supplementing this leadership.

Our assurance processes work from Board to Ward. We have an Integrated Performance Dashboard that allows the Board to scrutinise performance and triangulate data quality. This has worked very effectively and has been supplemented by similar dashboards at a directorate level, which are monitored and action taken by divisional management teams.

A workforce-focused dashboard has been developed and over the year has driven significant improvement in data quality for staff metrics including appraisal, supervision and training.

Policies
Our Systems Data Quality Policy establishes principles and standards that the Trust expects be achieved for all Trust data.

All staff members are responsible for implementing and maintaining data quality and are obligated to maintain accurate information legally (Data Protection Act 98), contractually (contract of employment) and ethically (professional codes of practice). They are also personally responsible for the quality of data entered by them, or on their behalf, onto NHFT electronic patient records and relevant electronic systems. This also applies to entry via laptops, tablets and mobile phones.

Risk management
All employees have an obligation to report breaches or potential breaches in Data Quality, as our Incident Policy explains. The small number of information losses reported to the Information Commissioners Office is reported promptly to the Trust Audit Committee.

Systems and processes
The integrated dashboards supplement and work alongside our SMART web-based reporting tool, which provides information to all staff. A business case was approved to invest and upgrade the Trust's Management Information System (MIS) and SMART reporting tool. The benefits include the implementation of a new infrastructure to improve data processing and provision of high quality dash boarding tools.

People and skills
Responsibilities for data quality for all staff is included in job descriptions, in accordance with the requirements of the Information Governance Toolkit (IGT), with targeted training available to assist staff and user forums for our core clinical system. Our IGT score for 2017/18 was 90%.

The Information Management & Technology (IM&T) Clinical Systems Team covers a wide range of services in support of the electronic patient record on SystmOne across the Trust. This involves SystmOne training, SystmOne support to end users, changes to configuration and the issuance of RA Smartcards allowing appropriate access to the system.

This year, a business case was approved to develop a methodology and implement professional resources for the rolling deployment of SystmOne functionality to existing services. The benefits include the ability to leverage the full potential of the Trust's primary clinical system and migrate all services to SystmOne, together with implementation of new functionality that will benefit services.

Data use and reporting
Our aim is to move more data to electronic capture and self-service for staff and teams. In 2017/18, there was a focus on using the full functionality of the Electronic Staff Record (ESR) that staff use to access on-line training, e-payslips and for recording appraisals, supervision and training. This focus, through data cleansing and reconciliation, alongside modernising our recruitment processes, have seen our vacancy rate reduce under the Trust target of 10%.

Since September 2016, we have used our Internal Audit service to undertake data quality reviews that have covered Patient Safety Indicator (low risk), Pressure Ulcers (low risk), IAPT (high risk, follow up put in place), Admission avoidance (awaiting report), and IAPT follow up.

A Board workshop was held on performance reporting and development work is in progress, including plans to supplement our integrated reporting with benchmarking from peer Trusts using the NHS Improvement Model Hospital Portal.

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PART THREE

PROGRESS AGAINST OUR 2016/17 PRIORITIES

This section shows our local improvement planning and progress made against our priorities in the 2016/17 Quality Report, since its publication. These indicators are not covered by a national definition unless indicated otherwise. We have refreshed our clinical priorities during the year and as such have new performance metrics that we are reporting against.

PATIENT SAFETY

CQC DOMAINS	PRIORITY	OBJECTIVES	WHAT WE ACHIEVED	HOW WE MONITORED IT	HOW WE MEASURED IT
Safe	To reduce the level of risk associated with self-harm incidents.	To understand themes and complexities around self-harm incidents, to learn lessons and improve service user outcomes.	The number of self-harm incidents in 2017/18 reported is 1529 compared to 1292 during 2016/17. This increase is due to the awareness training encouraging staff to report incidents.	Serious incident investigations relating to self- harm incidents were identified and reviewed collectively to identify any trends or commonality.	Six-monthly thematic reports (if relevant) with actions to address issues.
			There has been a reduction in the number of severe incidents and deaths as a result of self-harm during 2017/18 (32 compared to 41 in 2016/17.	Self-harm incidents continued to be reported on the Trust's Datix system and reviewed in line with our policy.	Improvements in the level of risk reported in incidents around self-harm were measured via Datix reporting.
Safe	To embed the mortality and morbidity process across the organisation.	Implementation of a Learning from Deaths process in line with the national guidance	The Learning Disabilities Mortality Review (LeDeR) programme is now active in the county. We participated in the CCG established Learning Disability Mortality Review Committee that supports the LeDeR programme. Members of the Patient Safety Team attend the committee.	Morbidity and mortality meetings will take place in all clinical directorates quarterly. Our morbidity and mortality steering group will oversee these.	Evidence of sharing and implementation of learning.
			Implemented a Learning from Deaths Steering Group.	Reviews will be considered collectively to identify any trends or commonality.	Staff trained.
			Following a pilot of initial mortality reviews to ensure processes were effective, systems were rolled out to all inpatient areas including community beds and custody/prisons.	3 staff trained in LeDeR reviewing.	Morbidity and mortality meetings will take place in all clinical directorates quarterly. Our morbidity and mortality steering group will oversee these.
			The clinical director has also arranged training of the NQB guidance and the Structured Judgement Review process for the Consultants. This training was also provided to other healthcare professionals to support multi-disciplinary reviews.		

CQC DOMAINS	PRIORITY	OBJECTIVES	WHAT WE ACHIEVED	HOW WE MONITORED IT	HOW WE MEASURED IT
			We hold a morbidity and mortality meeting within the pathways as well as participating in the countywide morbidity and mortality meetings. Learning from death reviews are shared within these meetings and at M&M presentation events.		
			We successfully recruited for the Mortality Lead and Patient and Family Liaison Lead posts. They have been in post for six months.		
			The Mortality Lead provides quarterly reports to the Trust Board, which includes data on unexpected deaths using the Mazars definition. The paper also advises on key trends and themes identified from reviews. The paper enables the Executive Team to fulfill their requirements in the NQB guidance which are to ensure a robust process is in place and challenge conclusions and actions.		

CQC DOMAINS	PRIORITY	OBJECTIVES	WHAT WE ACHIEVED	HOW WE MONITORED IT	HOW WE MEASURED IT
Safe	To increase the levels of reporting associated with falls, ensuring that all relevant patients and service users in inpatients and community settings have a falls risk assessment completed. And that those identified have a falls care plan implemented.	Falls are a major concern for patient safety and a marker of care quality.	The number of falls champions has increased from 0 to 50 during 2017/18, covering 27 different clinical areas (including palliative care, community beds, elderly and adult inpatient mental health, ICT, Learning disabilities, District Nursing and prisons).	The number of staff who have undergone training.	Training records
Caring		Nationally, a significant number of falls result in death or severe or moderate injury, at an estimated cost of £15m per annum for immediate healthcare treatment alone.	Falls prevention training at Level 1 and 2 has been in place and offered since May 2017. Training figures show an increase in staff undergoing training. At the end of Q4, 84.91% of staff have completed Level 1 training and 79.62% of staff have completed Level 2 training.	Quarterly reporting on number of falls and completion of falls risk assessment and, if necessary, falls care plans.	Increase in the number of falls risk assessments completed and falls care plans where required.
Effective		Locally in the Trust there was a slight increase in the number of falls reported on Datix from 294 (2015/16) to 382 for the same period in 2016/17. This included an increase in falls classified as: • Low harm from 115 (2015/6) to 132 (2016/17). • Moderate harm from 18 (2015/16) to 20 (2016/17). • Severe harm from 2 (2015/16) to 3 (2016/17).	Compliance in the high risk areas comprising of the elderly mental health wards, community beds and the hospices with Level 2 training is 99%.	Falls champions in place throughout the inpatient units.	Quarterly thematic reports (if relevant) with actions to address issues, quarterly.
			The number of falls reported on Datix: In 2017/18 of 733 falls-related datixes, 650 were inpatients, 83 were community. In 2016/17 of 672 falls-related datixes, 598 were inpatients, 74 were community. The details included: • Low harm – 132 reported Datix incidents (2016/7) to 117 in 2018/17. • Moderate harm - 20 reported Datix incidents (2016/7) to 18 in 2018/17. • Severe harm – 3 Datix incidents (2016/17) to 1 in 2018/17.	Updated process for reporting on Datix to ease reporting and identification of falls.	Number of falls champions in place.

PATIENT EXPERIENCE

CQC DOMAINS	PRIORITY	OBJECTIVES	WHAT WE ACHIEVED	HOW WE MONITORED IT	HOW WE MEASURED IT
Effective	To collaboratively develop a recovery college model within the organisation.	Embedding a recovery-based approach will play a central role in achieving positive patient reported outcomes and improving patient experience.	A full recovery college prospectus, including courses and dates, has been developed and was advertised during Quarter 1 offering courses starting in Quarter 2.	Evidence of engagement of staff and patients in developing the Recovery College.	Number of trainers recruited.
Safe		This could lead to improved clinical outcomes, reduced lengths of stay and fewer readmissions.	Recruitment for trainers continues to take place, four Peer Trainers and six Practitioner Trainers have been recruited and are available to deliver the courses.	Minutes of planning groups.	Number of sessions offered.
Responsive			Four courses have been developed during 2018/17 and each course has been offered on four different dates during the year.	Course prospectus developed.	Percentage of patients attending sessions.
			The number of people who have attended these courses is 76 people who have made 80 bookings.	Outcome measures in place.	Outcome measures showing review of courses and changes made where necessary.
				Trainers recruited.	As the recovery college model develops throughout the year we will be able to set targets for subsequent years.
				Course attendance.	

CQC DOMAINS	PRIORITY	OBJECTIVES	WHAT WE ACHIEVED	HOW WE MONITORED IT	HOW WE MEASURED IT
Well Led	Increase the number of service users and carers involved in staff recruitment.	We recognise that service users and carers should play a key role in the recruitment of clinical staff.	The number of service users and carers willing to be involved in staff recruitment has increased to 105 in 2017/18 from 19 in 2016/17, an increase of 453%	A database listing service users and carers willing to be involved in staff recruitment.	20% increase in number of service users and carers willing to be involved in staff recruitment (to be reported six-monthly).
		It is paramount that staff are appointed who have values and beliefs aligned to the needs of our service users and carers.	The number of service users and carers who have been a member of a recruitment panel has increased to 151 in 2017/18 from 66 in 2016/17, an increase of 129%	The patient involvement team will monitor how many service users and carers are requested to support with interview activity.	Increase by 50% number of service users and carers who have been a member of a recruitment panel compared to 2016/17.
		Including more service users and carers who would like to be part of the ongoing development of the Trust means increased likelihood of their needs being met.			

CQC DOMAINS	PRIORITY	OBJECTIVES	WHAT WE ACHIEVED	HOW WE MONITORED IT	HOW WE MEASURED IT
Responsive	Using iWantGreatCare (iWGC), and other sources of feedback to learn from and respond to patients and carers.	This was a priority for 2016/17 and continues to be vital to our drive to listen and use experience to shape care delivery and service design.	Quarterly reports are produced for services, directorates and the Trust.	The iWGC and patient experience teams will monitor the embedded feedback process and any required actions.	Quarterly reports outlining number of feedback reports required and received via iWGC.
Effective			iWGC (FFT) feedback is a standing agenda item on team and management meetings in line with Quality Framework and in response to feedback. Changes are discussed at patient experience groups.		10% increase in the number of responses required and number of actions taken as a result.
			Setting up guest WiFi was an important improvement implemented as a result of triangulating iWGC feedback, complaints and PALS responses.		Evidence in board and committee reports that the Trust is triangulating iWGC feedback with other sources of information, for example complaints, serious incidents, and safe staffing.
			However, themes relating to poor patient experience remain: delays in access to treatment in community based child and adult mental health services, some poor facilities and difficulty parking at most Trust hospitals and outpatient clinics. The Steering Patient Experience Group monitors these issues		
			Data available earlier in this document.		

CLINICAL EFFECTIVENESS

CQC DOMAINS	PRIORITY	OBJECTIVES	WHAT WE ACHIEVED	HOW WE MONITORED IT	HOW WE MEASURED IT
Safe	To work collaboratively internally to share our patient safety experiences and outcomes in order to improve learning from incidents, complaints and compliments, and reduce harm.	This was a quality priority for 2016/17. Further work is required to ensure that learning is embedded effectively within the organisation.	The number of serious incidents has reduced from 37 (2016/17) to 32 (2017/18). This is an overall drop of 13.5%.	We will monitor our lessons learnt activity and platforms, and identify outcomes from these that have contributed to our internal safety agenda.	A six-monthly report outlining an evaluation of the ways that staff members learn and share information. For example, webinars, patient and carer stories, medicine bulletins, conferences, governance meetings, and Patient Experience Groups.
			A review of the Learning Lessons Exchange identified a number of approaches that will be taken forward to further develop the effectiveness of the meeting and how the outputs and learning from the meetings can be disseminated and shared across the Trust. These included: o Via a staff questionnaire Increasing staff engagement Identifying how to share learning, what is being shared and with whom. o Linking with the acute providers to enable joint learning and sharing the stories via a county-wide forum.	National and local circulation of risks, safety concerns and best practices will continue to be shared with staff groups via numerous mechanisms.	The number of investigations that have a joint focus will provide evidence of the need to share information and jointly plan for patient safety across the health system.
			The Trust has developed a 'How do we learn lessons' poster to support its commitment to learning lessons. This is done through using the Trust's learning lessons exchange and by sharing this information through the Trust's many communication channels including Learning Lessons bulletins, pin board articles, e-brief, webinars, team meetings and more. This has also been made available on the Trust's intranet site.		
			The Human Factors Analysis and Classification System (HFACS) project with the East Midlands Patient Safety Collaborative (EMPSC) continues to progress. The project leader from EMPSC met with the Complaints and SI Investigator in February to discuss and provide support for undertaking a Serious Incident (SI) review by using both the RCA and HFACS tools. We identified a suitable SI investigation and have carried out our first investigation using the HFACS approach. The service user governor, who will be undertaking the role of Patient Safety Advisor from now on, will continue to support this process along with the Patient Safety Manager and Falls Lead.		
			County-wide discharge meeting.		

CQC DOMAINS	PRIORITY	OBJECTIVES	WHAT WE ACHIEVED	HOW WE MONITORED IT	HOW WE MEASURED IT
Well Led	Develop the skills and competence of all newly qualified band 5 nursing staff and allied health professionals.	To ensure that newly qualified staff are supported and engaged quickly to develop their skills base and quality care.	The preceptorship course for newly qualified Band 5 staff has been developed and is in place. Eight workshop dates are organised on ESR in order to allow attendance, reporting and data to be analysed in more detail. New staff can book onto required workshops.	This will be carried out via the preceptorship programme.	A six-monthly report outlining progress and uptake of preceptorship programme.
Safe			100% of staff enrolled completed the corporate programme. Staff also complete the supervision 270 ESR (NHFT) package via e-learning, and completion of this is recorded via ESR reports and 100% have completed this course.	A report will be produced twice a year that will include:	All newly quality nurses are identified, and have taken part in and successfully completed the programme.
			Feedback on the course is being collected and this has indicated that all of the attendees have found the course useful in contributing to their role development.	o Attendance data	
			The number of newly qualified staff identified within the Trust during 2017/18 was 17 and 17 of these have completed the course. This is 100% of those eligible.	o Evaluations o Successful completion o Identified clinical competences o Online supervision package Mentorship qualification (at the end of the programme).	
Effective	To increase the reporting associated with completed physical examinations within the mental health services. To increase the reporting associated with completed physical examinations within the mental health services.	Improved physical healthcare for people with severe mental illness.	All relevant staff have been trained to deliver physical health checks. The training programme is available to all clinical staff and covers processes for assessing, documenting and acting on cardio metabolic risk factors. The training is available as E-Learning via the Electronic Staff Records, as formal training sessions, training sessions within block training, train the trainer sessions and on the job training within the staff member's area of work.	Quarterly reporting for the following:	Inpatients and EIP:
Safe			Recruited project manager to co-ordinate and monitor achievement.	• Outlining number of staff who have had physical health training.	• 90% of patients have physical healthcare measurements recorded.
			Clear pathways for intervention and signposting have been developed and disseminated to all staff via e-brief statement and pathways poster.	• Progress with access to ICE system.	Community Mental Health services:
			Work to improve the functionality of the Physical Health template has been implemented with the Physical Health Champions in the Trust meeting to review the template to develop it further and improve ease of use.	• Results of audit around physical examinations with action plan.	• 2017/18 – 65% of patients have physical health measurements recorded.
			Auditing of the inpatient records has occurred with the results being fed back to the ward areas with clear actions when required. The audits have shown an increase in compliance from 53% in Q2 to 60% in Q4.		• 2018/19 – 75% have physical health measurements recorded.

CQC DOMAINS	PRIORITY	OBJECTIVES	WHAT WE ACHIEVED	HOW WE MONITORED IT	HOW WE MEASURED IT
			Audits showed that the key gap in the physical health check is the documentation of blood results once received from the local acute hospital. During 2018/19 the Trust will be working to improve communication and access to results.		
			Continuing work with staff to raise awareness of the need for physical health checks.		
			Training has been delivered to junior doctors.		
			Training is being developed for HCA within the community teams.		
			Working with the Older Adult Mental Health Inpatient and Community Teams to ensure that PHC are completed on all older adults with a Severe Mental Illness.		
			Inpatients and EIP		
			60% of patients have physical healthcare measurements recorded.		
			Community Mental Health 41% of patients have physical healthcare measurements recorded.		

PERFORMANCE AGAINST RELEVANT INDICATORS AND PERFORMANCE THRESHOLDS

In 2017/18 we achieved five out of the nine of our statutory targets at Q4. Our performance against target is summarised in the following table. Three of the statutory targets currently under target in Q4 were new indicators introduced in 2017/18. Unless indicated otherwise, Trust performance against indicators is based on data collected by the Trust and held on trust IT systems.

SCORED INDICATORS 2016/17	2017/18 TARGET	2016/17 OUTTURN	Q1	Q2	Q3	Q4
Early intervention in psychosis (EIP) – patients seen within 2 weeks of referral	50%	95%	100%	100%	90.9%	100%
Ensuring that cardio-metabolic assessment and treatment for people for psychosis is delivered in a) Inpatient Wards (90%) (CQUIN cohort) - Patients admitted in month	90%	N/A		59.6%	58%	60%
Ensuring that cardio-metabolic assessment and treatment for people for psychosis is delivered in b) Early Intervention Team (90%) (CQUIN cohort) - Current caseload	90%	N/A		81%	83.3%	79.6%
Ensuring that cardio-metabolic assessment and treatment for people for psychosis is delivered in c) Community Mental Health service (people on CPA)	65%	N/A		57.6%	44.7%	51.3%

SCORED INDICATORS 2016/17	2017/18 TARGET	2016/17 OUTTURN	Q1	Q2	Q3	Q4
Improving Access to Psychological Therapies (IAPT): Proportion of people completing treatment who move to recovery	50%	45.7%	42.5%	40.7%	43.6%	46.8%
Improving Access to Psychological Therapies: Patients seen within 6 weeks of referral	75%	80.6%	72.1%	62%	76.5%	89.3%
Improving Access to Psychological Therapies: Patients seen within 18 weeks of referral	95%	99.3%	99.3%	98.8%	99%	99.3%
Inappropriate out-of-area placements for adult mental health services (OBDs)	0		1523	1624	1028	765
% of patients on CPA who were followed up within 7 days after discharge from psychiatric inpatient care during the reporting period	95%	97.7%	98.1%	99.2%	97.6%	96.7%
Admissions to adult facilities under 16	0%	0%	0%	0%	0%	0%

CARE QUALITY COMMISSION

The Trust is required to register with the Care Quality Commission (CQC). We confirm that all our services are registered and we have no conditions of registration.

The CQC has not taken any enforcement action against the Trust during 2017/18. We have not participated in any special reviews or been investigated by the CQC during the reporting period.

CQC RATINGS

The CQC carried out a comprehensive assessment of our services in January 2017. In March 2017, the CQC rated the Trust overall as 'Good'. This was an improvement on the last inspection in 2015, when we received the rating 'Requires improvement'.

OUR RESULTS

OVERALL		**GOOD**
DOMAINS	**SAFE**	REQUIRES IMPROVEMENT
	EFFECTIVE	GOOD
	CARING	OUTSTANDING
	RESPONSIVE	GOOD
	WELL LED	GOOD

We have 15 service reports and one overall Trust report. Our results are listed in the table below by service grouping.

REPORT	SAFE	EFFECTIVE	CARING	RESPONSIVE	WELL-LED	OVERALL
Community Health Services for Adults	RI	G	G	G	G	G
Community Health Services for CYP	G	G	G	G	G	G
Community Dental Services	G	O	G	G	O	O
Community End of Life Care	G	G	O	G	G	G

REPORT	SAFE	EFFECTIVE	CARING	RESPONSIVE	WELL-LED	OVERALL
Community Health Inpatient Services	RI	RI	G	G	G	RI
Mental Health Crisis Services and HBPoS	RI	G	G	G	G	G
Community Based Mental Health Services for Adults	RI	G	G	G	G	G
Specialist Community Mental Health Services for CYP	G	G	G	G	G	G
Community Based Mental Health Services for Older People	G	RI	G	G	RI	RI
Community Based Mental Health Services for People with Learning Disabilities	G	G	O	RI	G	G
Acute wards for adults of working age and PICU	RI	G	G	G	G	G
Child and adolescent mental health wards	G	O	O	G	O	O
Forensic inpatient/secure wards	G	G	G	G	G	G
Long stay/rehabilitation mental health wards for adults	G	G	G	G	G	G
Wards for older people with mental health problems	G	G	O	G	G	G

Our results clearly indicate the dedication and hard work of our staff. Our patients, service users and carers are and have always been our highest priority – and we are delighted that we were rated as 'Outstanding' in the Care domain.

The CQC recognised that our team were helpful and empathetic, and that our service users were treated with kindness and dignity. They noted that our board-level leadership was outstanding, and the senior leadership team was instrumental in delivering the quality improvement work across the Trust.

We are encouraged that our management frameworks were outlined as sound, and we were reported to be effectively facilitating our continued quality improvement. We look forward to continuing to apply these frameworks across all our pathways of care and in all our partnership activity.

We also know that we continue to have work to do – and that our journey does not end here. In particular, we continue to focus on the Safe domain, and improving the safety of the services we provide.

The CQC conveyed that they are confident we will work to deliver these improvements on behalf of all of our patients. The CQC identified the following main themes that require improvement in some services: medicines management, infection control, environment, staff receiving supervision, mandatory training and appraisal, staff receiving the right level of safeguarding training to meet their role.

The CQC found that:

- Patients are treated with kindness, dignity and respect
- Staff attitudes were helpful and understanding
- Staff language was kind and supportive so patients would understand
- Staff communication was kind, respectful and compassionate
- We encouraged feedback with the online feedback website receiving 61,000 reviews since launch
- The Trust was committed to involvement, including a well-attended involvement group
- There was robust governance and safeguarding systems in place
- The Trust had a clear vision and set of values
- We have invested in an extensive range of staff wellbeing programmes
- Staff involved patients in their care plans
- All teams described effective and collaborative team working and had effective working relationships with external agencies
- The Trust board encouraged candour, openness and honesty from staff
- Staff felt supported by the board to work with change and felt able to provide feedback about their experiences

The full service reports and overall Trust report can be found on the CQC website.

OUR RATINGS GRID

Overall, our Trust received a rating of 'Good' in March 2017.

Following the inspection, we developed a comprehensive action plan to meet the requirements of the CQC. This plan has been actively managed and scrutinised by the Quality Forum and Quality and Governance Committee, with the Board's oversight.

As part of our relationship monitoring arrangements, the CQC inspection team have advised that they are satisfied with our methods for addressing our actions. Below is an overview of our approach to managing the required actions:

- Focus on project managing activity, building on previous good practice
- Establishing the process and ensuring staff are clear on their responsibility
- Sharing the good news with staff and stakeholders
- Clarity on our priority areas by focusing on the Safe domain, which is the only domain where the Trust was rated 'Requires improvement', requirement notices and areas requiring improvement
- Maintaining a future focus to ensure we have a resilient plan

CQC CRITERIA	RATING	HOW YOU PLAN TO ADDRESS ANY AREAS THAT REQUIRE IMPROVEMENT OR ARE INADEQUATE	DATE BY WHEN YOU EXPECT IT TO IMPROVE
SAFE	Requires improvement	The following are examples of some of the actions taken: • Development of SMART action plans at both service and Trust-wide levels. This contains actions to achieve requirement notices, must and should dos. • Development of a medication management action plan to: 1. Address omission medication audit cycle 2. Review and strengthen medicines management policy 3. Review and strengthen cold chain policy • Infection control Trust-wide audit process reviewed and strengthened. Planning NHS Improvement infection control review visit.	All completed as part of the CQC action plan 2017/18

CQC CRITERIA	RATING	HOW YOU PLAN TO ADDRESS ANY AREAS THAT REQUIRE IMPROVEMENT OR ARE INADEQUATE	DATE BY WHEN YOU EXPECT IT TO IMPROVE
		• Weston Favell Health Centre: 1. Infection control audit 2. Removal of out of date equipment and disposal of fridge 3. Formal request for multi-agency building meeting • Safeguarding training level three children for Tuberculosis nurses. • Supervision and mandatory training compliance: review of systems and process moving from paper to electronic data recording. • Organisational culture change. • Training on recording of data.	

We were rated 'Good' in the Effective, Caring and Well led domains, and 'Outstanding' in the Caring domain. As a result, these domains do not appear in the above table.

……

OUR STAFF AND CULTURE

Safe, quality care depends on openness and transparency, a culture of innovation driven by engagement and the structure of a safe working environment. In this section, we share our approach to our staff, culture and care.

DUTY OF CANDOUR

The Trust has embraced and actively undertaken its responsibility to implement regulation 20: Duty of Candour. The intention of this regulation is to ensure that organisations are open and transparent with the people who use its services. It is a legal duty of NHS trusts to inform and apologise to patients if there have been mistakes in their care that have led to significant harm.

Following an incident, the Trust makes contact with the service user and/or their carer to notify them of the safety incident – as soon as is reasonably practical after becoming aware of the incident. This is followed by a written notification within 10 working days, stating the details of the incident and including an apology. In the extremely rare case that Duty of Candour cannot be undertaken, it is escalated so that the decision can be confirmed or challenged. The Her Majesty's Prison (HMP) prisoner liaison officer at each prison undertakes the initial contact with carers and families for prison safety incidents on the Trust's behalf.

Service users, patients and their families are involved in serious incident investigations, and are contacted at the start of the investigation so that they have input into the terms of reference. It is also at this point that the investigator offers additional support to the individual and/or their carer. At the end of the process, the investigator gives feedback and a written copy of the investigation outcome to the service user, patient or carer. In some cases, the service user, patient or carer may choose not to receive feedback or be involved in the investigation – this right is noted and their wishes are respected.

In 2017/18, the Trust identified and reported one Duty of Candour breach. The breach had occurred in October 2016, however this was not identified until March 2017 when the incident was being investigated following notification from HM Coroner. By this time, the family had been spoken with and notice of the breach was highlighted by NHFT to Commissioners. The Trust was not fined for this incident.

SIGN UP TO SAFETY

The national Sign up to Safety (SU2S) drive aims for the NHS to become the safest healthcare system in the world, to deliver harm-free care for every patient, every time. At the Trust, SU2S underpins our approach to quality, and is an integral part of our way of working. Our quality priorities are fundamentally linked to SU2S.

Below are the five key areas of patient safety improvement to focus on, with examples of some of the actions we introduced in 2017/18:

1. **National Early Warning Score (NEWS)**
   In the Community Hospital setting recognition of Sepsis has been incorporated into the NEWS.

2. **Reduction in medication errors**
   We identified learning outcomes shared after each monthly Medicines Safety Group via Learning Lessons Bulletin.

3. **Reducing violence and aggression**
   Our pilot use of body worn cameras on mental health wards has been shortlisted for two prestigious awards – Patient Safety and RCNi Nurse Awards.

4. **Suicide and self-harm prevention**
   The Trust conducted a thematic review of suicides and implemented learning from this review.

5. **Information Management & Technology**
   Guest WiFi has been made available at key sites, access is being made available to staff, patients and their carers.

As a member of one of the nine countywide health academic networks, we are also part of and support a countywide group progressing the SU2S approach.

CASE STUDY

SIGN UP TO SAFETY IN PRACTICE

In November 2017, the PMVA team presented their findings of the Body Worn Camera (BWC) Feasibility study at 'Patient First' the UK's largest patient safety event.

The purpose of the study was to ascertain patient and staff acceptability of the BWC in acute mental health inpatient areas. The study revealed that both groups were in favour of the cameras and that violence during the study period decreased on three out of the five wards.

RESEARCH AND INNOVATION ADVICE AND SUPPORT

The Trust's organisational strategy highlights 'Innovate' as a key theme. This is supported by an innovation and research strategy called 'The Innovation Pathway', which is designed to address innovation and research across the Trust.

We implemented this last year to empower individuals, teams and services to develop their practice, demonstrate their clinical effectiveness, design and test new solutions to meet changing service need and improve outcomes.

Led by the Medical Director and supported by a team of specialist innovation and research staff, the ambition is for NHFT to be a diverse, contemporary organisation engaged in delivering and sharing evidence based innovations that are changing the future.

Our key objectives are to:

- Develop the culture, capacity and capability to support innovation and research within the Trust.
- Change practice and services while demonstrating improved clinical effectiveness through a programme of clinical and technological innovation and research.
- Maximise involvement and participation in innovation and research within the Trust, with patients/service users and carers and with our partners.

There are several initiatives associated with the Trust's innovation and research strategy that actively encourage staff to participate:

The Trust's Head of Innovation and Research is leading a significant piece of work to explore our 'Culture for Innovation'.

- By working with Trust staff to identify the baseline, barriers to innovation and explore solutions, an annual audit of the Trust's 'Culture for Innovation' will then quantify development in this area.
- The Trust is actively recruiting 'Ideas Champions' who can work within their teams to promote innovation and research. The Ideas Champions will be supported in their development by the innovation and research specialist team and the National Institute for Health Research (NIHR) Research Design Service. This acts as a gateway into both the regional and NIHR clinical academic careers programmes.
- A monthly Ideas forum chaired by the Trust's Senior Research and Evaluation Fellow allows any member of staff to submit an idea for support via the Trust's 'Innovation Space' on the Staffroom (the NHFT intranet). Ideas forum membership includes senior Trust medical staff, innovation and research specialists, senior managers and representatives from MEDILINK, and the University of Northampton. The forum supports staff through feedback on how ideas can be taken forward: identifying appropriate support and internal and external links.
- Special Research Interest Groups (SpRInGs) are being established to bring NHFT clinicians, Public Patient Involvement (PPI) representatives and academics together to focus on innovation and research ideas in areas of key importance to the Trust.
- In addition to this, staff can drop in or pick up the phone to the innovation and research Study Support Office where a generic email and phone line ensures there is always someone who can answer any queries.

- The strategy, opportunities to engage and routes for support are being widely communicated across the Trust. In January 2018, a Leadership Matters conference for 150 staff leaders focused on 'Innovation & Creativity' and was very positively received. We are continuing to build on the Trust-wide communication strategy.

- The extent and number of university and other organisation research collaborations has also developed, increasing our capacity to enable research of value to NHFT. We have collaborated on 13 bids for innovation and research funding with academic and commercial partners. Of particular note is an application funded by the National Institute for Health Research (NIHR) for a randomised controlled trial of theta burst transcranial magnetic stimulation versus standard repetitive transcranial magnetic stimulation for treatment of resistant depression.

This study is a collaborative effort between the University of Nottingham, Magstim Ltd and four NHS trusts. Prof. O'Neill-Kerr is the NHFT lead.

- The innovation and research team work closely with the NIHR Clinical Research Network (CRN) and the Collaboration for Leadership in Applied Health Research and Care (CLAHRC) in the East Midlands. Any member of staff who wishes to support the delivery of NIHR research is actively encouraged to make contact with the Study Support Office and Research Delivery Team. The Trust delivered 17 research studies, recruiting 250 patients in 2017/18.

- The Study Support Office is the first point of contact for students wishing to undertake research as part of PhD or MSc studies. 21 student projects were supported in 2017/18.

SAFE WORKING HOURS

FOR DOCTORS AND DENTISTS IN TRAINING

We are committed to ensuring that all our junior doctors and dentists in training are fully supported. The Trust has appointed a consultant to the role of Guardian of Safe Working Hours (GOSWH), who acts as champion for safe working hours. They actively monitor compliance with the Terms and Conditions of Service for Doctors & Dentists in Training (England) 2016.

The Trust currently has 30 Doctor in Training posts. During 2017/18, we have had two working time equivalent (WTE) vacancies per quarter. These vacancies put pressure on the system.

The vacancies have arisen as Health Education England was unable to recruit to training posts. By comparison with the significant shortage of junior doctors at all grades and in all specialties nationally, vacancies are commonplace.

There has been a year-on-year decrease in doctors going into third year postgraduate training (48% in 2017). As such, CT doctors in particular are lower in availability.

As an organisation, we are particularly vulnerable to medical vacancies – this is because psychiatry and general practice trainees mostly staff our rotas. These two specialties have particularly pronounced recruitment difficulties.

At a national level, steps have been taken to address this. This has included offering pay enhancements to junior doctors to encourage them to apply for these posts. While this is welcomed, it will take time to deliver an increase in the availability of qualified psychiatric doctors. Therefore, there is likely to be a continued shortfall in the medium term.

In all cases, the vacancies were subject to several recruitment rounds. Sourcing via agencies, even with escalated rates, has proved unsuccessful with the exception of out of hours on call cover, which the Trust does successfully cover.

We regularly hold junior doctor forums. There has been minimal feedback from junior doctors to indicate any major adverse impacts on working hours. There have been a small number of exceptions raised relating to not being able to take breaks and working over, however these are not systemic issues.

STAFF SURVEY RESULTS

The selected results from the 2017 national staff survey (in this financial year) look specifically at our Trust responses to key questions regarding bullying, harassment, equal opportunities and discrimination. These are key factors in the Workforce Race Equality Standard (WRES). We have highlighted the differences between responses for white and BME members of staff.

RESPONSES		THE TRUST IN 2016	THE TRUST IN 2017	AVERAGE (MEDIAN) FOR COMBINED MENTAL HEALTH LEARNING DISABILITY AND COMMUNITY
KF26 (percentage of staff experiencing harassment, bullying or abuse from staff in the last 12 months)	**White**	18%	19%	20%
	BME	29%	23%	23%
KF21 (percentage believing that the Trust provides equal opportunities for career progression or promotion) for the Workforce Race Equality Standard	**White**	88%	89%	88%
	BME	75%	73%	76%

STAFF ENGAGEMENT

The staff engagement score is a central part of the National Staff Survey (NSS) and consists of questions about motivation, involvement and advocacy. Engagement is critical to our organisation – there is clear evidence that highly engaged staff deliver better care, and patients and service user outcomes are higher. There are also indirect benefits to the organisation, including higher levels of retention of staff and reduced levels of sickness and absence.

In 2017, our staff engagement score increased to 3.91 – this is the second highest compared with trusts of our type.

The percentage of black, minority and ethnic (BME) staff experiencing harassment, bullying or abuse from patients, relatives, the public or staff has noticeably reduced. However, we consider the score still remains too high. The issues identified with bullying and harassment require separate focus, which is encompassed in both our work on our WRES and diversity action plans, and the Trust's work on 'freedom to speak up'.

Our action plan focuses on staff engagement to ensure that care is the Trust's top priority. We are also highly focused on staff recommending the treatment they received.

NHFT's staff engagement plan has been branded 'Let's talk'. This will be linked to the 5-4-3-2-1 campaign under: '1 - Making a difference for you with you'. In order to give the organisation time to plan and deliver on key objectives, this will be a two-year plan designed to achieve significant improvements by NSS 2019, with NSS 2018 being used as a benchmark.

A summary of the Trust's and each locality's results will be produced and shared with all staff through our internal communication channels. There will be a dedicated page on our intranet, 'The Staff Room', with results and resources available to demonstrate the openness and transparency of our approach.

Based on early analysis and the latest research published by Picker Europe and the King's Fund (Sizmur and Raleigh, 2018), our planned response will have two key drivers:

- Care of patients/service users is my organisation's top priority.
- If a friend or relative needed treatment, I would be happy with the standard of care provided by this organisation.

A full Trust-wide plan will be produced and published by the end of July 2018, sharing details of each directorate's objectives, trust focus areas and measures of success.

HOW OUR QUALITY ACCOUNT WAS PREPARED

Many people and health and wellbeing bodies were involved in developing our quality account and agreeing priorities for the next year. These included:

- Allied healthcare professional leads
- Healthwatch
- Education and Training Team
- Nursing Advisory Committee
- Governor sub-group
- Patient Involvement Team, including patients, service users and carers
- Pharmacy
- Quality Forum
- Quality Team
- The Trust's non-executive directors
- The Trust's executive team
- The Quality and Governance Committee

Themes identified in complaints and serious incidents were also used to help identify priorities for improvement during the next year.

OUR QUALITY CARE PRIORITIES

AN EASY READ VERSION:

These are things we will do to make your care better next year.

We reviewed our priorities and have kept them the same as last year.

We will make sure you are safe by:

Finding better ways to make sure people do not hurt themselves.

Making sure we always check how we do things.

Understanding why people may fall over and who might fall over. Then make plans to help them.

We will always check how patients are feeling by:

Creating courses that help people get better.

Getting more service users to help us decide who should work for us.

Finding more ways to help service users tell us what they think.

We will make sure your care is the best it can be by:

Sharing stories and information with our staff, to help us give better care.

Teaching our staff new ways to give you even better care.

Doing our best to always check your physical health.

ANNEX 1

STATEMENTS FROM STAKEHOLDERS

NHS Improvement's Annual Reporting Manual determines the Trust's mandatory obligations for items to be included in the Annual Report. We welcome suggestions from our key stakeholders regarding content and incorporate these suggestions where it is appropriate to do so. Clinical Commissioning Groups, Healthwatch and the Overview and Scrutiny Committee (OSC) were all invited to comment on our Quality Report and we welcome their responses. We include the feedback from our stakeholders exactly as it is received. Where we were able to make adjustments to the Quality Report we did so. We will continue to work with our stakeholder partners to provide further assurance that we deliver patient-centred, quality services.

NHS
Corby
Clinical Commissioning Group

NHS
Nene
Clinical Commissioning Group

Francis Crick House
6 Summerhouse Road
Moulton Park
Northamptonshire
NN3 6BF

TEL: 01604 651100

Private & Confidential

Julie Shepherd
Director of Nursing and Quality
Northamptonshire Healthcare NHS Foundation Trust
Huxlow House
St Mary's Hospital
London Road
Kettering
NN15 7PW

17th May 2018

Dear Julie,

Re: Quality Account 2017-18

Thank you for submitting your draft Quality Account; we welcomed the opportunity to review this. The Quality Account submitted by the Trust has been subject to a detailed review by NHS Nene and NHS Corby Clinical Commissioning Groups (CCGs); ensuring that the data and information reported in the account matches data submitted to the CCGs.

Please find attached the draft review agreed by myself on behalf of the CCGs. This will be formally approved by our Joint Quality Committee on 12 June 2018 and I will notify you of any changes at this time.

We look forward to continuing to work closely with the Trust in 2018-19.

Yours sincerely

Dr Matthew Davies
Medical Director

Enc.

POSITIVE ABOUT DISABLED PEOPLE

NHS
Corby
Clinical Commissioning Group

NHS
Nene
Clinical Commissioning Group

Northamptonshire Healthcare NHS Foundation Trust
Annual Quality Account 2017/18

The Northamptonshire Healthcare NHS Foundation Trust, (NHFT) annual quality account for 2017/18 has been reviewed by NHS Corby and NHS Nene Clinical Commissioning Groups (CCGs). It is noted that the report was reviewed whilst in draft format.

Core quality account indicators are included within the report.

Commissioning for Quality and Innovation (CQUIN) schemes for 2017-18 are included within the report. The trust should update the final report to reflect the achievement of the year-end position of all CQUINs.

The annual quality account has sought and included the views of patients.

The 2018-19 quality improvement priorities in relation to patient safety, clinical effectiveness and patient experience are supported by NHS Corby and NHS Nene CCGs.

Commissioners will continue to work closely with the trust and support their aspiration to progress from a 'Good' to an 'Outstanding' provider delivering safe, quality care.

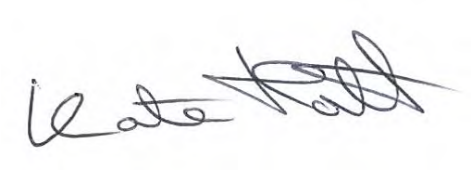
Healthwatch Northamptonshire statement on Northamptonshire Healthcare NHS Foundation Trust (NHFT) draft Quality Account 2017/18

The role of Healthwatch Northamptonshire is to support, challenge and assist our healthcare providers to improve current and future services for the people of Northamptonshire. During 2017/18 Healthwatch Northamptonshire has continued to represent the public on a number of NHFT groups and committees, including the Patient Experience Steering Group (where we are able to share feedback we have received from the public), Mental Health Patient Experience Group, and the Moving Ahead project and Community Engagement steering groups. We welcome the opportunity to be involved and will continue to work closely with NHFT to support, challenge and assist them in ensuring high quality, innovative and patient-centred care.

Healthwatch Northamptonshire believes that this Quality Account demonstrates the progress NHFT has made against their 2017/18 Quality Priorities and we support the decision to continue with these priorities for 2018/19 to ensure they are embedded.

We particularly congratulate NHFT for their continued commitment to patient and carer involvement, co-production and partnership across their organisation and for continuing to ensure that patient feedback is collected and used by all departments through 'iWantGreatCare'.

The feedback we receive from members of the public relating to services provided by NHFT is varied and as such it is difficult to identify common themes, however we pass on issues raised with us and thank NHFT for valuing this feedback and looking into these issues where appropriate. We will continue to work with NHFT and encourage them to strive to improve.



Kate Holt

CEO

Connected Together CIC (contract holder of Healthwatch Northamptonshire)

Northamptonshire County Council

FAO: Julie Shepherd
Director of Nursing, AHP's & Quality
Northamptonshire Healthcare NHS Trust
St Marys Hospital
London Road
Kettering
Northants NN15 7PW

Please ask for: Jenny Rendall
Tel: 01604 367560
Our ref:
Your ref:
Date: 17 May 2018

Dear Julie

Re: Quality Account 2017-18

The NCC Health Adult Care & Wellbeing Scrutiny Committee formed a working group of its members to consider a response to your Quality Accounts 2017-18. Membership of the working group was as follows:

- Councillor Eileen Hales MBE
- Councillor Chris Smith-Haynes
- Councillor Chris Stanbra
- Mr Andrew Bailey (Northamptonshire Carers Voice Representative)

The working group also considered the following in relation to all quality accounts:

- It was felt it would be useful for Scrutiny to receive summary quarterly updates from providers of progress data against the key actions taken to deliver the objectives set in the Quality Account for that year. This would be consistent with the Department of Health guidance that discussions between OSCs and providers of the Quality Accounts should be conducted throughout the reporting year.
- It might be useful if a statement was included that stated how MHFt viewed its position in terms of security of data.

The working group considered how far the quality account was a fair reflection of the healthcare services provided by NHFT, based upon members' knowledge of the provider. The formal response from the Health Adult Care & Wellbeing Scrutiny Committee based on the working group's comments is as follows:

- It was considered helpful to list all of the services provided by NHFT.

Northamptonshire County Council
Democratic Services
County Hall
Northampton NN1 1AT
w. www.northamptonshire.gov.uk
t. 01604 367560
f. 01604 236223
e. Jrendall@northamptonshire.gov.uk

- It was felt there was a lot of information on mental health services but not adequate information on community services.
- NHFT was complemented on the amount of effort it had taken to invove carers on the appointment of staff.
- NHFT was also complemented on having a carer strategy focus and including feedback from carers.
- The patient survey was considered to be good.
- The patient-family liaision was considered to be good.
- NHFT was complemented on having 0% of deaths reported against quality of care.
- The scores reported against core indicators appeared to be improving.
- NHFT were congratulated in a reduction in self harm and the learning disabilities mortality review was making good progress.
- It would have been nice to have a split between the number of falls in the community and in hospital.
- The ratings from the CQC had improved.
- There appeared to be good ambition and good work undertaken against research and innovation.
- The headings for the staff survey results

Please do not hesitate to contact Democracy Officer, Jenny Rendall should you have any queries relating to this response, whose contact details can be found at the bottom of the first page of this letter.

Yours sincerely
On behalf of the Health, Adult Care & Wellbeing Scrutiny Committee

Councillor Eileen Hales MBE
Chairman of the Quality Accounts Working Group

KPMG

INDEPENDENT AUDITOR'S REPORT TO THE COUNCIL OF GOVERNORS OF NORTHAMPTONSHIRE HEALTHCARE NHS FOUNDATION TRUST ON THE QUALITY REPORT

We have been engaged by the Council of Governors of Northamptonshire Healthcare NHS Foundation Trust to perform an independent assurance engagement in respect of Northamptonshire Healthcare NHS Foundation Trust's Quality Report for the year ended 31 March 2018 (the 'Quality Report') and certain performance indicators contained therein.

Scope and subject matter

The indicators for the year ended 31 March 2018 subject to limited assurance consist of the following two national priority indicators (the indicators):

- early intervention in psychosis (EIP): people experiencing a first episode of psychosis treated with a National Institute for Health and Care Excellence (NICE)-approved care package within two weeks of referral
- inappropriate out-of-area placements for adult mental health services

We refer to these national priority indicators collectively as the 'indicators'.

Respective responsibilities of the directors and auditors

The directors are responsible for the content and the preparation of the Quality Report in accordance with the criteria set out in the *NHS Foundation Trust Annual Reporting Manual* issued by NHS Improvement.

Our responsibility is to form a conclusion, based on limited assurance procedures, on whether anything has come to our attention that causes us to believe that:

- the Quality Report is not prepared in all material respects in line with the criteria set out in the *NHS Foundation Trust Annual Reporting Manual* and supporting guidance;
- the Quality Report is not consistent in all material respects with the sources specified in the *Detailed requirements for quality reports for foundation trusts 2017/18* ('the Guidance'); and
- the indicators in the Quality Report identified as having been the subject of limited assurance in the Quality Report are not reasonably stated in all material respects in accordance with the NHS Foundation Trust Annual Reporting Manual and the six dimensions of data quality set out in the *Detailed Requirements for external assurance for quality reports for foundation trusts 2017/18.*

We read the Quality Report and consider whether it addresses the content requirements of the NHS Foundation Trust Annual Reporting Manual and consider the implications for our report if we become aware of any material omissions.

We read the other information contained in the Quality Report and consider whether it is materially inconsistent with:

- Board minutes and papers for the period April 2017 to May 2018;
- papers relating to quality reported to the board over the period April 2017 to May 2018;
- feedback from commissioners, dated 17 May 2018;
- feedback from local Healthwatch organisations, dated 21 May 2018;
- feedback from Overview and Scrutiny Committee, dated 17 May 2018;
- the trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009;
- the latest national patient survey, dated 2 August 2017 and 23 October 2017;
- the latest national staff survey, dated 6 March 2018;

- Care Quality Commission Inspection, dated 28 March 2017;
- the 2017/18 Head of Internal Audit's annual opinion over the trust's control environment, dated 17 May 2018; and
- any other information included in our review.

We consider the implications for our report if we become aware of any apparent misstatements or material inconsistencies with those documents (collectively, the 'documents'). Our responsibilities do not extend to any other information.

We are in compliance with the applicable independence and competency requirements of the Institute of Chartered Accountants in England and Wales (ICAEW) Code of Ethics. Our team comprised assurance practitioners and relevant subject matter experts.

This report, including the conclusion, has been prepared solely for the Council of Governors of Northamptonshire Healthcare NHS Foundation Trust as a body, to assist the Council of Governors in reporting the NHS Foundation Trust's quality agenda, performance and activities. We permit the disclosure of this report within the Annual Report for the year ended 31 March 2018, to enable the Council of Governors to demonstrate they have discharged their governance responsibilities by commissioning an independent assurance report in connection with the indicators. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the Council of Governors as a body and Northamptonshire Healthcare NHS Foundation Trust for our work or this report, except where terms are expressly agreed and with our prior consent in writing.

Assurance work performed

We conducted this limited assurance engagement in accordance with International Standard on Assurance Engagements 3000 (Revised) – 'Assurance Engagements other than Audits or Reviews of Historical Financial Information', issued by the International Auditing and Assurance Standards Board ('ISAE 3000'). Our limited assurance procedures included:

- evaluating the design and implementation of the key processes and controls for managing and reporting the indicators;
- making enquiries of management;
- testing key management controls;
- limited testing, on a selective basis, of the data used to calculate the indicators back to supporting documentation;
- comparing the content requirements of the NHS Foundation Trust Annual Reporting Manual to the categories reported in the Quality Report; and
- reading the documents.

A limited assurance engagement is smaller in scope than a reasonable assurance engagement. The nature, timing and extent of procedures for gathering sufficient appropriate evidence are deliberately limited relative to a reasonable assurance engagement.

Limitations

Non-financial performance information is subject to more inherent limitations than financial information, given the characteristics of the subject matter and the methods used for determining such information.

The absence of a significant body of established practice on which to draw allows for the selection of different, but acceptable measurement techniques which can result in materially different measurements and can affect comparability. The precision of different measurement techniques may also vary. Furthermore, the nature and methods used to determine such information, as well as the measurement criteria and the precision of these criteria, may change over time. It is important to read the quality report in the context of the criteria set out in the *NHS Foundation Trust Annual Reporting Manual* and supporting guidance.

The scope of our assurance work has not included governance over quality or the non-mandated indicator, which was determined locally by Northamptonshire Healthcare NHS Foundation Trust.

Conclusion

Based on the results of our procedures, nothing has come to our attention that causes us to believe that, for the year ended 31 March 2018:

- the Quality Report is not prepared in all material respects in line with the criteria set out in the NHS Foundation Trust Annual Reporting Manual and supporting guidance;
- the Quality Report is not consistent in all material respects with the sources specified in the Guidance; and
- the indicators in the Quality Report subject to limited assurance has not been reasonably stated in all material respects in accordance with the NHS Foundation Trust Annual Reporting Manual and the six dimensions of data quality set out in the Guidance.

KPMG LLP.

KPMG LLP
Chartered Accountants
Birmingham

23 May 2018

ANNEX 2

STATEMENT OF DIRECTORS' RESPONSIBILITIES

The directors are required under the Health Act 2009 and the National Health Service (Quality Accounts) Regulations to prepare Quality Accounts for each financial year.

NHS Improvement has issued guidance to NHS foundation trust boards on the form and content of annual Quality Reports (which incorporate the above legal requirements) and on the arrangements that NHS foundation trust boards should put in place to support the data quality for the preparation of the Quality Report.

In preparing the Quality Report, directors are required to take steps to satisfy themselves that:

- The content of the Quality Report meets the requirements set out in the NHS foundation trust annual reporting manual 2017/18 and supporting guidance
- The content of the Quality Report is not inconsistent with internal and external sources of information including:

  - Board minutes and papers for the period April 2017-March 2018
  - Papers relating to quality reported to the board over the period April 2017-March 2018
  - Feedback from commissioners dated 17 May 2018
  - Feedback from Healthwatch dated 21 May 2018
  - Feedback from Overview and Scrutiny Committee dated 17 May 2018
  - The Trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009
  - The latest national patient surveys dated as below:
  - Community mental health survey 2 August 2017
  - Inpatient mental health survey 23 October 2017
  - The latest national staff survey dated 6 March 2018
  - The head of internal audit's annual opinion of the Trust's control environment dated 17 May 2018
  - CQC inspection report dated 28 March 2017

- The Quality Report presents a balanced picture of the Trust's performance over the period covered
- The performance information reported in the Quality Report is reliable and accurate
- There are proper internal controls over the collection and reporting of the measures of performance included in the Quality Report, and these controls are subject to review to confirm that they are working effectively in practice
- The data underpinning the measures of performance reported in the Quality Report is robust and reliable, conforms to specified data quality standards and prescribed definitions, is subject to appropriate scrutiny and review and

- The Quality Report has been prepared in accordance with NHS Improvement's annual reporting manual and supporting guidance (which incorporates the Quality Accounts regulations) as well as the standards to support data quality for the preparation of the Quality Report.

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

By order of the board

Crishni Waring

Chair
23 May 2018

Angela Hillery

Chief Executive
23 May 2018

FINANCE REPORT

INTRODUCTION

NHS Improvement, the sector regulator for health services in England, in exercise of powers conferred on it by paragraphs 24 and 25 of Schedule 7 of the National Health Service Act 2006, directs that the keeping of accounts and the annual report of each NHS Foundation Trust shall be in the form as laid down in the annual reporting guidance for NHS Foundation Trusts within the NHS Foundation Trust Annual Reporting Manual, known as the FT ARM, that is in force for the relevant financial period. The accounts have been prepared in accordance with paragraphs 24 and 25 of Schedule 7 to the National Health Service Act 2006 as laid down in the FT ARM.

These accounts cover the financial year 2017/18 and provide figures for 2016/17 for comparison where required. After making enquiries, the directors have a reasonable expectation that the Trust has adequate resources to continue in operational existence for the foreseeable future. For this reason, we continue to adopt the going concern basis in preparing our accounts. These pages include the following financial statements and information:

Statement of comprehensive income (SoCI)

Statement of financial position

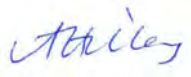
Statement of changes in taxpayers' equity

Statement of cash flows

Notes to the accounts

Accounting policies for pensions and other retirement benefits are set out in the notes to the accounts and details of senior managers' remuneration can be found in the remuneration report.

Angela Hillery



Chief Executive
23 May 2018

STATEMENT OF RESPONSIBILITIES

Statement of the chief executive's responsibilities as the accounting officer of Northamptonshire Healthcare NHS Foundation Trust

The NHS Act 2006 states that the chief executive is the accounting officer of the NHS foundation trust. The relevant responsibilities of the accounting officer, including their responsibility for the propriety and regularity of public finances for which they are answerable, and for the keeping of proper accounts, are set out in the NHS Foundation Trust accounting officer Memorandum issued by NHS Improvement.

NHS Improvement, in exercise of the powers conferred on Monitor by the NHS Act 2006, has given Accounts Directions which require Northamptonshire Healthcare NHS Foundation Trust to prepare for each financial year a statement of accounts in the form and on the basis required by those Directions. The accounts are prepared on an accruals basis and must give a true and fair view of the state of affairs of Northamptonshire Healthcare NHS Foundation Trust and of its income and expenditure, total recognised gains and losses and cash flows for the financial year.

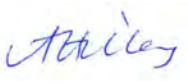
In preparing the accounts, the accounting officer is required to comply with the requirements of the Department of Health Group Accounting Manual and in particular to:

- Observe the Accounts Direction issued by NHS Improvement, including the relevant accounting and disclosure requirements, and apply suitable accounting policies on a consistent basis
- Make judgements and estimates on a reasonable basis
- State whether applicable accounting standards as set out in the NHS Foundation Trust Annual Reporting Manual (and the Department of Health Group Accounting Manual) have been followed, and disclose and explain any material departures in the financial statements
- Ensure that the use of public funds complies with the relevant legislation, delegated authorities and guidance and
- Prepare the financial statements on a going concern basis.

The accounting officer is responsible for keeping proper accounting records, which disclose with reasonable accuracy at any time the financial position of the Northamptonshire Healthcare NHS Foundation Trust and to enable them to ensure that the accounts comply with requirements outlined in the above-mentioned Act. The accounting officer is also responsible for safeguarding the assets of the Northamptonshire Healthcare NHS Foundation Trust and hence for taking reasonable steps for the prevention and detection of fraud and other irregularities.

To the best of my knowledge and belief, I have properly discharged the responsibilities set out in the NHS Foundation Trust Accounting Officer Memorandum.

Angela Hillery



Chief Executive

23 May 2018

Northamptonshire Healthcare NHS Foundation Trust has complied with the cost allocation and charging requirements set out in HM Treasury and Office of Public Sector Information guidance. The directors consider the annual report and accounts, taken as a whole, to be fair, balanced and understandable and provides the information necessary for patients, regulators and stakeholders to assess the Trust's performance, business model and strategy.

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FINANCIAL STATEMENTS

STATEMENT OF COMPREHENSIVE INCOME FOR THE PERIOD ENDED 31 MARCH 2018

	NOTE	2017/2018 £000	2016/2017 £000
Operating revenue			
Revenue from patient care activities	4	**186,736**	187,642
Other operating revenue	5	**12,171**	10,551
Operating expenses, of which:	6	**(187,077)**	(191,633)
Employee benefits	8	**(136,346)**	(133,282)
Other operating expenses	6	**(50,731)**	(58,351)
Net operating surplus/(deficit)		**11,830**	6,560
Financing			
Finance income	12	**92**	116
Finance cost - financial liabilities	14	**(2,710)**	(2,769)
Public dividend expense		**(1,429)**	(1,292)
Net finance costs		**(4,047)**	(3,945)
Gains/(losses) on disposal of assets	13	**110**	295
Share of profit/(loss) of associates/ joint ventures	19	**(148)**	148
Gain/(loss) on transfer by absorption	9	**0**	257
Retained surplus/(deficit) for the period*		**7,745**	**3,315**
Other comprehensive income			
Impairments and reversals taken to revaluation reserve	43	**(93)**	(2,094)
Gains on revaluations	15/16	**11,248**	310
Remeasurements of defined benefit pension scheme (liability)/assets	9	**0**	0
Net gain/(loss) on other reserves		**0**	0
Net gain/(loss) on available for sale financial assets		**0**	0
Asset disposals		**0**	0
Other reserve movements	9	**0**	117
Reclassification adjustments:			
- Transfers from donated and government grant reserves		**0**	0
- On disposal of available for sale financial assets		**0**	0
Total comprehensive income for the period		**18,900**	1,648

Note*

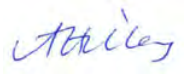
Includes Sustainability and Transformation Funding of	**4,243**	**2,634**
Retained surplus/(loss) excluding Sustainability and Transformation Funding	**3,502**	**681**

The notes that follow form part of these accounts.

STATEMENT OF FINANCIAL POSITION AS AT 31 MARCH 2018

	NOTE	31 March 2018 £000	31 March 2017 £000
Non-current assets			
Property, plant and equipment	15	**111,007**	97,247
Intangible assets	16	**2,287**	1,444
Investment in associate	19	**0**	148
Other investments	20	**76**	79
Other financial assets	23	**0**	0
Total non-current assets		**113,370**	98,918
Current assets			
Inventories	21	**85**	127
Trade and other receivables	22	**11,636**	7,957
Other financial assets	23	**0**	0
Other current assets	24	**0**	0
Cash and cash equivalents	25	**37,541**	35,436
		49,262	43,520
Non-current assets held for sale	15	**0**	0
Total current assets		**49,262**	43,520
Total assets		**162,632**	142,438
Current liabilities			
Trade and other payables	26	**(23,748)**	(23,106)
Other liabilities	28	**(2,488)**	(212)
Borrowings	27	**(1,005)**	(1,302)
Other financial liabilities	33	**0**	0
Provisions	34	**(6,467)**	(7,012)
Total current liabilities		**(33,708)**	(31,632)
Net current assets/(liabilities)		**15,554**	11,888
Total assets less current liabilities		**128,924**	110,806
Non-current liabilities			
Borrowings	27	**(34,029)**	(35,035)
Trade and other payables	26	**(237)**	0
Provisions	34	**(453)**	(466)
Other liabilities	28	**0**	0
Total assets employed		**94,205**	75,305
Financed by taxpayers' equity			
Public dividend capital	SoCITE	**37,255**	37,255
Retained earnings	SoCITE	**30,330**	22,585
Revaluation reserve	43	**26,620**	15,465
Total taxpayers' equity		**94,205**	75,305

These financial statements were approved by 'those charged with governance' on behalf of the board of directors on 23 May 2018 and signed on its behalf by:



Angela Hillery, Chief Executive

STATEMENT OF CHANGES IN TAXPAYERS' EQUITY

	Public dividend capital (PDC)	Retained earnings	Revaluation reserve	Donated asset reserve	Gov't grant reserve	Pension reserve	Total
	£000	£000	£000	£000	£000	£000	£000
Taxpayers equity at 1 April 2017	**37,255**	**22,585**	**15,465**	**0**	**0**	**0**	**75,305**
Retained surplus/(deficit) for the period	**0**	**7,745**	**0**	**0**	**0**	**0**	**7,745**
Transfers between reserves	**0**	**0**	**0**	**0**	**0**	**0**	**0**
Impairments and reversals	**0**	**0**	**(93)**	**0**	**0**	**0**	**(93)**
Net gain/(loss) on revaluation of property, plant, equipment	**0**	**0**	**11,248**	**0**	**0**	**0**	**11,248**
Asset disposals	**0**	**0**	**0**	**0**	**0**	**0**	**0**
Remeasurement of defined net benefit pension scheme asset/liability	**0**	**0**	**0**	**0**	**0**	**0**	**0**
Other reserve movements	**0**	**0**	**0**	**0**	**0**	**0**	**0**
Balance at 31 March 2018	**37,255**	**30,330**	**26,620**	**0**	**0**	**0**	**94,205**
Taxpayers equity at 1 April 2016	37,255	19,216	17,303	0	0	(117)	73,657
Retained surplus/(deficit) for the period	0	3,315	0	0	0	0	3,315
Transfers between reserves	0	0	0	0	0	0	0
Impairments and reversals	0	0	(2,094)	0	0	0	(2,094)
Net gain/(loss) on revaluation of property, plant, equipment	0	0	310	0	0	0	310
Asset disposals	0	54	(54)	0	0	0	0
Remeasurement of defined net benefit pension scheme asset/liability	0	0	0	0	0	0	0
Other recognised gains and losses	0	0	0			117	117
Balance at 31 March 2017	37,255	22,585	15,465	0	0	0	75,305

STATEMENT OF CASH FLOWS FOR THE PERIOD ENDED 31 MARCH 2018

	NOTE	31 March 2018 £000	31 March 2017 £000
Cash flows from operating activities			
Operating surplus/(deficit)	SoCI	**11,830**	6,560
Depreciation and amortisation	15/16	**4,800**	4,884
Impairments and (reversals)	17	**(1,754)**	561
Pension liability	9	**0**	0
(Increase)/decrease in inventories	21	**42**	22
(Increase)/decrease in trade and other receivables	22	**(3,966)**	(1,775)
(Increase)/decrease in other current assets	24	**0**	0
Increase/(decrease) in trade and other payables	26	**(1,423)**	1,503
Increase/(decrease) in other liabilities	28	**2,276**	36
Increase/(decrease) in provisions	34	**(571)**	82
Other movements in operating cash flows		**0**	0
Net cash inflow/(outflow) from operating activities		**11,234**	11,873
Cash flows from investing activities			
Interest received	12	**92**	116
Purchase of property, plant and equipment	15	**(3,321)**	(2,605)
Sale of property, plant and equipment	15	**198**	675
Purchase of intangible assets	16	**(959)**	(495)
Purchase of other investments	20	**0**	(79)
Sale of other financial assets	20	**3**	0
Net cash inflow/(outflow) from investing activities		**(3,987)**	(2,388)
Net cash inflow/(outflow) before financing		**7,247**	9,485
Cash flows from financing activities			
Public dividend capital received		**0**	0
Capital element of PFI obligations	32	**(1,298)**	(1,345)
Capital element of finance lease payments	29	**(5)**	(6)
Interest paid	14	**0**	(3)
Interest element of PFI obligations	32	**(2,695)**	(2,747)
Interest element of finance lease payments	29	**(2)**	(1)
PDC dividends paid		**(1,142)**	(1,368)
Cash flows from other financing activities		**0**	0
Net cash inflow/(outflow) from financing		**(5,142)**	(5,470)
Net increase/(decrease) in cash and cash equivalents		**2,105**	4,015
Cash and cash equivalents (and bank overdrafts) at the beginning of the period		35,436	31,421
Cash and cash equivalents (and bank overdrafts) at the end of the financial period	25	**37,541**	35,436

NOTES TO ACCOUNTS

1.0 Accounting policies and other information

NHS Improvement, in exercising the statutory functions conferred on Monitor, has directed that the financial statements of NHS foundation trusts shall meet the accounting requirements of the *Department of Health and Social Care Group Accounting Manual (GAM)* which shall be agreed with HM Treasury. Consequently, the following financial statements have been prepared in accordance with the GAM 2017/18 issued by the Department of Health and Social Care. The accounting policies contained in the GAM follow International Financial Reporting Standards (IFRS) to the extent that they are meaningful and appropriate to the NHS, as determined by HM Treasury, which is advised by the Financial Reporting Advisory Board. 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 NHS foundation trust for the purpose of giving a true and fair view has been selected. The particular polices adopted are described below. The accounting policies have been applied consistently in dealing with items considered material in relation to the accounts.

1.1 Going Concern

This Annual Report and Accounts have been prepared on a going concern basis.

Non-trading bodies in the public sector are assumed to be going concerns where the continued provision of a service in the future is anticipated, as evidenced by inclusion of financial provision for that service in published documents.

1.2 Accounting convention

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

1.3 Consolidation

1.3.1 Subsidiaries

Entities over which the foundation trust has the power to exercise control are classified as subsidiaries and consolidated. The foundation trust has control when it has the ability to affect the variable returns from the other entity through its power to direct activities.

The income, expenses, assets, liabilities, equity and reserves of the subsidiary are consolidated in full into the appropriate financial statement lines.

The capital and reserves attributable to non-controlling interests are included as a separate item in the Statement of Financial Position. Appropriate adjustments are made on consolidation where the subsidiary's accounting policies are not aligned with the foundation trust or where the subsidiary's accounting date is not coterminous.

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

The foundation trust has charitable funds that are managed alongside those from Northampton General Hospital NHS Trust (NGH). The charity responsible for managing the funds attained independent status in 1 April 2016 and as such the power to govern the financial and operating policies of the funds sits with them. As the value of the charitable funds is not considered to be material to the foundation trust's accounts and the funds are managed on its behalf by the independent charity, they have not been consolidated in these accounts.

The foundation trust has not accounted for any subsidiaries in the financial statements for this period.

1.3.2 Associates

Entities over which the foundation trust has the power to exercise a significant influence so as to obtain economic or other benefits are classified as associates and are recognised in these financial statements using the equity method. Per IAS 28 Investments in Associates and Joint Ventures, significant influence is considered to be a holding of 20% or more of the voting rights in an entity. The investment is initially recognised at cost.

It is increased or decreased later to reflect the foundation trust's share of the entity's profit or loss or other gains and losses (e.g. revaluation gains on the entity's property, plant and equipment) following acquisition. It is also reduced when any distribution e.g. share dividends are received by the foundation trust from the associate.

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

The foundation trust has accounted for its investment in First for Wellbeing as an associate as it holds 38% of the voting rights.

The investment in First for Wellbeing is accounted for using the equity method.

1.3.3 Joint arrangements

Arrangements over which the foundation trust has joint control with one or more other entities are classified as joint arrangements. A joint arrangement is either a joint operation or a joint venture.

A joint venture is a joint arrangement whereby the parties that have joint control of the arrangement have rights to the net assets of the arrangement. Joint ventures are recognised as an investment and accounted for using the equity method.

The Trust has not accounted for any joint ventures in the financial statements for this period.

A joint operation exists where the parties that have joint control have rights to the assets and obligations for the liabilities relating to the arrangement. Where the foundation trust is a joint operator it recognises its share of assets, liabilities, income and expenses in its own accounts.

The foundation trust has not accounted for any joint operations in the financial statements for this period.

1.3.4 Other investments

Investment in associates and joint ventures that are not considered to be material are accounted for as non-current financial assets.

The foundation trust has accounted for its investment in 3Sixty Care Ltd as a financial asset and has recognised the fair value of the shareholding within Other Investments. The foundation trust is deemed to have significant influence over the entity by way of the 50% shareholding but the share of profit and net assets of the entity are not considered to be material.

1.4 Critical accounting judgements and key sources of estimation uncertainty

In the application of the foundation trust's accounting policies, management is required to make various judgments, estimates and assumptions. These are regularly reviewed.

1.4.1 Critical judgements in applying accounting polices

The following are the judgments, apart from those involving estimations (see below) that management has made in the process of applying the foundation trust's accounting policies and that have the most significant effect on the amounts recognised in the financial statements.

1.4.1.1 Depreciation of property, plant and equipment

Judgments are required to give useful lives and residual values to property, plant and equipment. Key sources of those values are based on regular studies of actual asset lives and the intended use for those assets.

Changes in technology or the condition of the asset may mean that the actual life or remaining value is different to the estimate. Where the foundation trust decides that the useful life of property, plant and equipment should be shortened or residual value reduced, it depreciates the net book value in excess of the residual value over the revised remaining useful life, as a result increasing depreciation expense. Any change in an asset's life or residual value is shown in the foundation trust's financial statements when the change in estimate is decided.

1.4.1.2 Impairment of property, plant and equipment and intangible assets

The identification of impairment indicators and the deciding of the recoverable amount for assets need good judgment concerning the identification and proof of impairment indicators. Key sources on impairment indicators are found externally and internally.

External sources of information may be:

1. During the period, an asset's market value has declined a lot more than would be expected during normal use over time
2. Significant changes in technology and regulatory environments and
3. Significant dips in the economy

Internal sources of information may be:

4. Out of date or physical damage
5. Not able to perform to the expected level now or in the future and

6. Large changes in the use of its assets or the strategy for its overall use

The foundation trust decides any impairment by comparing the carrying values of assets to their net realisable value. Net realisable value represents fair value as assessed through valuation on a modern equivalent assets basis.

1.4.1.3 Revenue recognition

Revenue, which does not include discounts, represents the amount due for services provided to customers and is accounted for on an accrual basis to match revenue with the provision of service. Revenue is recognised monthly as services are provided. Where services are invoiced in advance, revenue is deferred and recognised when the service is delivered. Revenue for unbilled services is accrued. Judgment is required in how these principles are applied and the specific guidance for foundation trust revenues.

1.4.1.4 Fair value estimation

The fair value of financial instruments that are not traded in an active market is agreed by using valuation techniques. The foundation trust uses a variety of methods and makes assumptions that are based on the market conditions at each statement of financial position date.

In the application of the foundation trust's accounting policies, management is required to make judgments, estimates and assumptions about the carrying amounts of assets and liabilities that are not obvious from other sources. The estimates and associated assumptions are based on historical experience and other helpful factors.

Actual results may differ from those estimates and the estimates and underlying assumptions are continually reviewed.

Revisions to accounting estimates are recognised in the period they affect, when the estimate is revised. That may be only one period or in the period of the revision and future periods.

The nominal value less estimated credit adjustments of trade receivables and payables are assumed to approximate their fair values. The fair value of financial liabilities for disclosure purposes is estimated by discounting the future contractual cash flows at the current market interest rate that is available to the foundation trust for similar financial instruments.

The following are the critical judgments, apart from those involving estimations (see below) that management has made in the process of applying the foundation trust's accounting policies and that have the largest effect on the amounts included in the financial statements.

1.4.2 Key sources of estimation uncertainty

The following are assumptions about the future and other major sources of estimation uncertainty that have a significant risk of resulting in a material adjustment to the carrying amounts of assets and liabilities within the next financial year.

1.4.2.1 Provisions

The identification of impairment indicators and the deciding of the recoverable amount for assets need good judgment concerning the identification and proof of impairment indicators. Key sources on impairment indicators are found externally and internally.

1.5 Transfers of functions

As public sector bodies are deemed to operate under common control, business reconfigurations within the DHSC group are outside the scope of IFRS 3 Business Combinations. Where functions transfer between two public sector bodies, the GAM requires the application of 'absorption accounting'. Absorption accounting requires that entities account for their transactions in the period in which they took place. Where assets and liabilities transfer, the gain or loss resulting is recognised in the Statement of Comprehensive Income, and is disclosed separately from operating costs.

1.6 Pooled budgets

The foundation trust has not entered into any pooled budgets in the financial year.

1.7 Operating segments

Income and expenditure are analysed in the Operating Segments note and are reported in line with management information used within the foundation trust.

1.8 Revenue

The main source of revenue for the foundation trust is contracts with commissioners in respect of healthcare services. Revenue in respect of services provided is recognised when, and to the extent that, performance occurs, and is measured at the fair value of the consideration receivable. At the year end, the foundation trust accrues income relating to activity delivered in that year.

Where a patient spell (where applicable) is incomplete at the year end, revenue relating to the partially completed spell is accrued and agreed with the commissioner.

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

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

Income from the sale of non-current assets is recognised only when all material conditions of sale have been met, and is measured as the sums due under the sale contract.

Revenue in respect of services provided is recognised when, and to the extent that, performance occurs, and is measured at the fair value of the consideration receivable.

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

1.9 Expenditure on employee benefits

1.9.1 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, including non-consolidated performance pay earned but not yet paid.

The cost of 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 allowed to carry forward leave into the following period.

1.9.2. Retirement benefit costs

1.9.2.1 NHS Pension Scheme

Past and present employees are covered by the NHS Pension Schemes. These schemes are unfunded, defined benefit schemes that covers NHS employers, general practices and other bodies, allowed under the direction of Secretary of State, in England and Wales.

The schemes are not designed to be run in a way that would enable NHS bodies to identify their share of the underlying scheme assets and liabilities. Therefore, the schemes are accounted for as though they were defined contribution schemes: the cost to the foundation trust or participating in a scheme is taken as equal to the contributions payable to the scheme for the accounting period.

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

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

1.9.2.2 National Employment Savings Trust (NEST)

The Pensions Act 2008 requires the foundation trust to automatically enrol all eligible staff into a workplace pension scheme.

If staff meet the eligibility criteria for the NHS Pension scheme they will be automatically enrolled into it. If staff are eligible under auto enrolment law but do not meet the eligibility criteria for the NHS Pension scheme they will be automatically enrolled into the NEST scheme, which is the foundation trust's designated alternate scheme.

NEST is a defined contribution pension scheme and details of the contributions paid by the Trust on behalf of employees are shown in note 9.3 to the accounts.

1.10 Other expenses

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

1.10.1 Value Added Tax (VAT)

Most of the activities of the foundation 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 non-current assets. Where output tax is charged or input VAT is recoverable, the amounts are stated net of VAT.

1.11 Corporation Tax

NHS foundation trusts must pay corporation tax if they are delivering large scale commercial activities that are not part of core health care delivery, like running a commercial laundry.

The majority of the foundation trust's income is core health care and so corporation tax was not payable by the Trust in 2017/2018.

1.12 Property, plant and equipment

1.12.1 Recognition

Property, plant and equipment is capitalised where:

- It is used for delivering services or for administrative purposes
- It is probable that future economic benefits will flow to, or service potential be provided to the foundation trust
- It is expected to be used for more than one financial year
- The cost of the item can be measured reliably, and either
- The item has a cost of at least £5,000 or
- Collectively, a number of items have a cost of at least £5,000 and individually have a cost of more than £250,where the assets are functionally interdependent, had broadly simultaneous purchase dates, are expected to have simultaneous disposal dates and are under single managerial control or
- Items are part of the initial equipping and setting-up cost of a new building, ward or unit, whatever their individual or group cost.

Leased assets valued at the start of the lease at less than £5,000 will not be capitalised and will be expensed through the Statement of Comprehensive Income.

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

1.12.2 Measurement

1.12.2.1 Valuation

All property, plant and equipment assets are measured to begin with at cost, representing the cost directly attributable to acquiring or constructing the asset and bringing it to the location and condition necessary for it to be capable of operating in the manner intended by management. Assets that are held for their service potential and are in use are measured subsequently at their current value in existing use. Assets that are most recently held for their service potential but are surplus are measured at fair value where there are no restrictions preventing access to the market at the reporting date.

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

Revaluations of property, plant and equipment are performed with sufficient regularity to ensure that carrying amounts are not materially different from those that would be determined at the end of the reporting period.

Current values in use are determined as follows:

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

The foundation trust carried out a valuation based on modern equivalent assets at 31 March 2014 and this is how the properties are valued in the foundation trust's accounts. An annual desktop review of asset values is carried out by an External Valuer for the foundation trust to make sure that any significant changes are identified and shown in the accounts.

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

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 economic lives or low values or both, as this is not considered to be materially different from current value in existing use.

An increase arising on revaluation is taken to the revaluation reserve except where it reverses an impairment for the same asset previously recognised in expenditure, in which case it is credited to expenditure to the extent of the decrease previously charged there.

A revaluation decrease that does not result from a loss of economic value or service potential is recognised as an impairment charged to the revaluation reserve to the extent that there is a balance on the reserve for the asset, and thereafter to expenditure. Gains and losses recognised in the revaluation reserve are reported as other comprehensive income in the Statement of Comprehensive Income.

1.12.2.2 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.

1.12.2.3 De-recognition

Assets intended for disposal are reclassified as Held for Sale once all of the following criteria are met:

- The asset is available for immediate sale in its present condition subject only to terms which are normal 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 will go ahead without major changes

Following reclassification, the assets are measured at the lower of their existing carrying amount and their fair value minus the selling costs. Depreciation stops being charged and the assets are not revalued, except where the fair value minus selling costs becomes less than 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 economic life is adjusted. The asset is de-recognised when scrapping or demolition takes place.

1.13 Investment properties

Investment properties are measured at fair value. Changes in fair value are recognised as gains and losses in income/expenditure.

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.

1.14 Intangible assets

1.14.1 Recognition

Intangible assets are non-monetary assets without physical substance, which are capable of sale separately from the rest of the foundation trust's business or which arise from contractual or other legal rights. They are recognised only when it is probable that future economic benefits will flow to, or service potential be provided to, the foundation trust; where the cost of the asset can be measured reliably; and where the cost is at least £5,000.

Software that is integral to the operating of hardware, e.g. an operating system, is capitalised as part of the relevant item of property, plant and equipment.

Software that is not integral to the operation of hardware, e.g. application software, is capitalised as an intangible asset.

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

Expenditure on research is not capitalised: it is recognised as an operating expense in the period in which it is incurred.

Internally generated assets are recognised if, and only if, all of the following have been demonstrated:

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

1.14.2 Measurement

Intangible assets acquired separately are recognised initially at cost. The amount initially recognised for internally-generated intangible assets is the sum of the expenditure incurred when the criteria for recognition are initially met. Where no internally-generated intangible asset can be recognised, the expenditure is recognised in the period in which it is incurred.

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

Revaluation gains and losses and impairments are treated in the same manner as for property, plant and equipment.

1.15 Depreciation, amortisation and impairments

Freehold land is considered to have an endless life and is not depreciated.

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

Otherwise, depreciation or amortisation is charged to write off the costs or valuation of property, plant and equipment and intangible assets, less any residual value, on a straight line basis over their estimated useful economic lives. The estimated useful life of an asset is the period over which the foundation trust expects to obtain economic benefit or service potential from the asset. This is specific to the foundation trust and may be shorter than the physical life of the asset itself. Estimated useful lives and residual values are reviewed each year end, with the effect of any changes recognised on a prospective basis.

The foundation trust has decided the useful economic lives for each category of asset to be:

- Buildings determined by working with an External Valuer
- Plant and machinery 5-15 years
- Medical and other equipment 5-15 years
- Transport equipment 7 years
- Information technology 5-10 years
- Mainframe IT equipment 8 years
- Fixtures and fittings 5-10 years
- Software
  by reference to the licencing agreement

Assets held under finance leases are depreciated over the shorter of the lease term and the useful economic life, unless the foundation trust expects to acquire the asset at the end of the lease term, in which case the asset is depreciated in the same manner as for owned assets.

Property, plant and equipment that have been reclassified as Held for Sale stop being depreciated when they are reclassified.

Assets being built 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.

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

Impairment losses that arise from a clear consumption of economic benefit are taken to expenditure. Where an impairment loss subsequently reverses, the carrying amount of the asset is increased to the revised estimate of the recoverable amount but capped at the amount that would have been determined had there been no initial impairment loss. The reversal of the impairment loss is credited to expenditure.

1.16 Donated assets

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

1.17 Government grant funded assets

Government grant funded assets are capitalised at current value in existing use, if they will be held for their service potential, or otherwise at fair value on receipt, with a matching credit to income. Deferred income is recognised only where conditions attached to the grant preclude immediate recognition of the gain.

1.18 Leases

Leases are classified as finance leases when substantially all the risks and rewards of ownership are transferred to the lessee. All other leases are classified as operating leases.

1.18.1 The foundation trust as lessee

Property, plant and equipment held under finance leases are initially recognised, at the inception of the lease, at fair value or, if lower, at the present value of the minimum lease payments, with a matching liability for the lease obligation to the lessor.

Lease payments are apportioned between finance charges and reduction of the lease obligation to achieve a constant rate of interest on the remaining balance of the liability. Finance charges are recognised in the Statement of Comprehensive Income. The lease liability is de-recognised when the liability is discharged, cancelled or expires.

Operating lease payments are recognised as an expense on a straight-line basis over the lease term. Lease incentives are recognised initially as a liability and subsequently as a reduction of rentals on a straight line basis over the lease term.

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

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

1.18.2 The foundation trust as lessor

Amounts due from lessee under finance leases are recorded as receivables at the amount of the foundation 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 foundation trust's net investment outstanding in respect of the leases.

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

1.19 Private Finance Initiative (PFI) transactions

PFI transactions that meet the IFRIC 12 definition of a service concession, as interpreted in HM Treasury's FReM, are accounted for as on-Statement of Financial Position by the foundation trust.

In accordance with IAS17, the underlying assets are recognised as property, plant and equipment, together with an equivalent finance lease liability.

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

- Payment for the fair value of services received
- Repayment of the finance lease liability, including finance costs, and
- Payment for the replacement of components of the asset during the contract 'lifecycle replacement'.

1.19.1 Services received

The cost of services received in the year is recorded under the relevant headings within 'operating expenses'.

1.19.2 PFI assets, liabilities and finance costs

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

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

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

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

The element of the annual unitary payment increase due to cumulative indexation is treated as contingent rent and is expensed as incurred.

1.19.3 Lifecycle replacement

Components of the asset replaced by the operator during the contract ('lifecycle replacement') are capitalised where they meet the foundation trust's criteria for capital expenditure. They are capitalised at the time they are provided by the operator, and are measured initially at cost.

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

Where the fair value of the lifecycle component is less than the amount determined in the contract, the difference is recognised as an expense when the replacement is provided.

If the fair value is greater than the amount determined in the contract, the difference is treated as a 'free' asset and a deferred income balance is recognised.

The deferred income is released to operating income over the shorter of the remaining contract period or the useful economic life of the replacement component.

Any material changes in asset values will be identified through the five yearly revaluations of property, plant and equipment.

1.19.4 Assets contributed by the foundation trust to the operator for use in the scheme

Assets contributed for use in the scheme continue to be recognised as items of property, plant and equipment in the foundation trust's Statement of Financial position.

1.19.5 Other assets contributed by the foundation trust to the operator

Other assets contributed ,e.g. cash payments, surplus property, etc. by the foundation trust to the operator before the asset is brought into use, where these are intended to defray the operator's capital costs, are recognised initially as prepayments during the construction phase of the contract. When the asset is made available to the foundation trust, the prepayment is treated as an initial payment towards the finance lease liability and is set against the carrying value of the liability.

1.20 Inventories

Inventories are valued at the lower of cost and net realisable value using the first in, first out (FIFO) method. This is considered to be a reasonable approximation to fair value.

1.21 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 three 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 foundation trust's cash management. Cash, bank and overdraft balances are recorded at current values.

1.22 Provisions

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

The receivable is recognised as an asset if it is virtually certain that some or all of the economic benefits needed to settle a provision will be recovered from a third party and the amount of the receivable can be measured reliably.

Early retirement provisions are discounted using HM Treasury's pension discount rate of 0.10% (2016-17: 0.24%) in real terms.

All other provisions are subject to three separate discount rates according to the expected timing of cashflows from the Statement of Financial Position date:

- A short term rate of negative 2.42% (2016-17: negative 2.70%) for expected cash flows up to and including 5 years
- A medium term rate of negative 1.85% (2016-17: negative 1.95%) for expected cash flows over 5 years up to and including 10 years
- A long term rate of negative 1.56% (2016-17: negative 0.80%) for expected cash flows over 10 years.

All percentages are in real terms.

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

1.23 Clinical negligence costs

NHS Resolution operates a risk pooling scheme under which the foundation trust pays an annual contribution to the NHS Resolution, which in turn settles all clinical negligence claims. The contribution is charged to expenditure. Although the NHS Resolution is administratively responsible for all clinical negligence cases, the legal liability remains with the foundation trust.

The total value of clinical negligence provisions carried out by the NHS Resolution on behalf of the foundation trust is disclosed at note 34 but is not recognised in the foundation trust's accounts.

1.24 Non-clinical risk pooling

The foundation trust takes part in the Property Expenses Scheme and the Liabilities to Third Parties Scheme. Both are risk pooling schemes where the foundation trust pays an annual contribution to the NHSLA and in return receives assistance with the costs of claims arising. The annual membership contributions, and any excesses payable in respect of particular claims, are charged to operating expenses as and when they become due.

1.25 Carbon Reduction Commitment scheme (CRC)

The CRC scheme is a mandatory cap and trade scheme for non-transport CO2 emissions. The foundation trust is registered with the CRC scheme, and is therefore required to surrender to the Government an allowance for every tonne of CO2 it emits during the financial year. A liability and related expense is recognised in respect of this obligation as CO2 emissions are made.

The carrying amount of the liability at the financial year end will therefore reflect the CO2 emissions that have been made during that financial year, less the allowances (if any) surrendered voluntarily during the financial year in respect of that financial year.

The liability will be measured at the amount expected to be incurred in settling the obligation. This will be the cost of the number of allowances required to settle the obligation.

Allowances acquired under the scheme are recognised as intangible assets.

1.26 Contingencies

A contingent liability is:

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

A contingent liability is disclosed unless the possibility of a payment is remote.

A contingent asset is a possible asset that arises from past events and whose existence will be confirmed by the occurrence or non-occurrence of one or more uncertain future events not wholly within the control of the foundation trust. A contingent asset is disclosed where an inflow of economic benefits is probable.

Where the time value of money is material, contingent liabilities and contingent assets are disclosed at their present value.

1.27 Financial assets

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

Financial assets are initially recognised at fair value. Fair value is determined by reference to quoted market prices where possible, otherwise by valuation techniques.

The effective interest rate is the rate that exactly discounts estimated future cash receipts through the expected life of the financial asset, to the initial fair value of the financial asset.

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

1.27.1 Financial assets at fair value through profit and loss

Financial assets at fair value through profit and loss are held for trading.

A financial asset is classified in this category if it has been acquired principally for the purpose of selling in the short-term. Derivatives are also categorised as held for trading unless they are designated as hedges.

Embedded derivatives that have different risks and characteristics to their host contracts, and contracts with embedded derivatives whose separate value cannot be ascertained, are treated as financial assets at fair value through profit and loss. They are held at fair value, with any resultant gain or loss recognised in calculating the foundation trust's surplus or deficit for the year. The net gain or loss incorporates any interest earned on the financial asset.

1.27.2 Held to maturity investments

Held to maturity investments are non-derivative financial assets with fixed or determinable payments and fixed maturity, and where there is a positive intention and ability to hold to maturity. After initial recognition, they are held at amortised cost using the effective interest method, less any impairment. Interest is recognised using the effective interest method.

1.27.3 Loans and receivables

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

1.27.4 Available for sale financial assets

Available for sale financial assets are non-derivative financial assets that are designated as available for sale or that do not fall within any of the other three financial asset classifications.

When items classified as "available-for-sale" are sold or impaired, the accumulated fair value adjustments recognised are transferred from reserves and recognised in "finance costs" in the Statement of Comprehensive Income. They are included in long-term assets unless the foundation trust intends to dispose of them within 12 months of the Statement of Financial Position date.

1.27.5 Impairment

At the end of the reporting period, the foundation trust assesses whether any financial assets, other than those held at 'fair value through profit and loss', are impaired.

Financial assets are impaired and impairment losses recognised if there is objective evidence of impairment as a result of one or more events that occurred after the initial recognition of the asset and that have an impact on the estimated future cash flows of the asset.

For financial assets carried at amortised cost, the amount of the impairment loss is measured as the difference between the asset's carrying amount and the present value of the revised future cash flows discounted at the asset's original effective interest rate. The loss is recognised in expenditure. Where uncertainty over collectability of a receivable exists at the reporting date a provision for doubtful debts is established, the charge for which is recognised immediately in expenditure.

If, in a subsequent period, the amount of the impairment loss decreases and the decrease can be related objectively to an event occurring after the impairment was recognised, the previously recognised impairment loss is reversed through expenditure to the extent that the carrying amount of the receivable at the date of the impairment is reversed does not exceed what the amortised cost would have been had the impairment not been recognised.

1.28 Financial liabilities

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

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

1.28.1 Financial guarantee contract liabilities

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

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

1.28.2 Financial liabilities at fair value through profit and loss

Embedded derivatives that have different risks and characteristics to their host contracts, and contracts with embedded derivatives whose separate value cannot be ascertained, are treated as financial liabilities at fair value through profit and loss.

They are held at fair value, with any resultant gain or loss recognised in the foundation trust's surplus/deficit. The net gain or loss incorporates any interest payable on the financial liability.

1.28.3 Other financial liabilities

All other financial liabilities are recognised initially at fair value, net of transaction costs incurred, and after initial recognition, are measured at amortised cost using the effective interest method, except for loans from Department of Health and Social Care, which are carried at historic cost. The effective interest rate is the rate that exactly discounts estimated future cash payments through the life of the asset, to the net carrying amount of the financial liability. Interest is recognised using the effective interest method.

Determination of fair value for financial assets and financial liabilities carried at fair value, the carrying amounts are determined from quoted market prices, independent appraisals and discounted cash flow analysis as appropriate.

1.29 Public dividend capital

Public dividend capital (PDC) is a type of public sector equity finance, which represents the Department of Health and Social Care's investment in the foundation trust. HM Treasury has determined that, being issued under statutory authority rather than under contract, PDC is not a financial instrument within the meaning of IAS 32.

At any time, the Secretary of State can issue new PDC to, and require repayments of PDC from, the foundation trust. PDC is recorded at the value received.

An annual charge, reflecting the cost of capital utilised by the foundation trust, is payable to the Department of Health and Social care as PDC dividend. The charge is calculated at the real rate set by the Secretary of State with the consent of HM Treasury (currently 3.5%) on the average relevant net assets of the foundation trust. Relevant net assets are calculated as the value of all assets less all liabilities, except for:

- donated assets (including lottery funded assets)
- average daily cash balances held with the Government Banking Services (GBS) and National Loans Fund (NLF) deposits, excluding cash balances held in GBS accounts that relate to a short-term working capital facility, and
- any PDC dividend balance receivable or payable.

The average relevant net assets are calculated as a simple average of opening and closing relevant net assets.

Under the requirements laid down by the Department of Health and Social Care, the dividend for the year is calculated on the actual average relevant net assets as set out in the 'pre-audit' version of the annual accounts. The dividend thus calculated is not revised should any adjustment to net assets occur following the audit of the annual accounts. The PDC dividend calculation is based upon the foundation trust's group accounts, i.e. including subsidiaries, but excluding consolidated charitable funds if applicable.

1.30 Foreign currencies

The foundation trust's functional currency and presentational currency is pounds sterling, and figures are presented in thousands of pounds unless expressly stated otherwise. Transactions denominated in a foreign currency are translated into sterling at the spot exchange rate on the date of the transaction. At the end of the reporting period, monetary items denominated in foreign currencies are retranslated at the spot exchange rate on 31 March.

Exchange gains and losses on monetary items (arising on settlement of the transaction or on retranslation at the Statement of Financial Position date) are recognised in the Statement of Comprehensive Income in the period in which they arise.

1.31 Third party assets

Assets belonging to third parties (such as money held on behalf of patients) are not recognised in the accounts since the foundation trust has no beneficial interest in them. Details of third party assets are given in note 39 to the accounts.

1.32 Losses and special payments

Losses and special payments are items that Parliament would not have considered 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 accrual basis, including losses which would have been made good through insurance cover had the foundation trust not been bearing their own risks (with insurance premiums then being included as normal revenue expenditure).

However 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.

1.33 Gifts

Gifts are items that are voluntarily disclosed, with no preconditions and without the expectation of any return. Gifts include all transactions economically equivalent to free and unremunerated transfers, such as the loan of an asset for its expected useful life, and the sale or lease of assets at below market value.

1.34 Accounting standards and amendments issued but not yet adopted

The DHSC GAM does not require the following Standards and Interpretations to be applied in 2017/2018.

These standards are still subject to HM Treasury FReM adoption, with IFRS 9 and IFRS 15 being for implementation in 2018/2019, and the government implementation dates for IFRS 16 and IFRS 17 still subject to HM Treasury consideration.

- IFRS 9 Financial Instruments – application required for accounting periods beginning on or after 1 January 2018, but not yet adopted by the FReM: early adoption is not therefore permitted
- IFRS 15 revenue from contracts with customers – application required for accounting periods beginning on or after 1 January 2018, but not yet adopted by the FReM: early adoption is not therefore permitted. A high level review of income contracts has been undertaken and has concluded that the majority are on a block basis with performance obligations running on an annual achievement basis. Therefore, as the performance obligations under the contracts are expected to have been met by each 31 March reporting period there is not likely to be a material impact on income the recognition basis to that currently used
- IFRS 16 leases – application required for accounting periods beginning on or after 1 January 2019, but not yet adopted by the FReM: early adoption is not therefore permitted

- IFRS 17 insurance contracts – application required for accounting periods beginning on or after 1 January 2021 but not yet adopted by the FReM; early adoption is not therefore permitted
- IFRIC 22 foreign currency transactions and advance consideration – application required for accounting periods beginning on or after 1 January 2018
- IFRIC 23 uncertainty over income tax treatments – application required for accounting periods beginning on or after 1 January 2019.

1.35 Accounting standards issued that have been adopted early

There are no accounting standards issued that have been adopted early for this financial period.

2. OPERATING SEGMENTS

The Foundation Trust operates under only one material segment which is healthcare and income is almost totally for the supply of services.

Management information is produced on a monthly basis to enable the chief operating decision maker to make informed decisions on the allocation of resources.

Under IFRS 8, reporting segments para 13, the quantitative threshold is 10% or more of combined revenue in determining a segment.

Non-patient care income is 6.1% (5.3% in 2016/2017) and therefore disclosure is not required.

3. INCOME GENERATION ACTIVITIES

The Foundation Trust undertakes income generation activities with an aim of achieving profit, which is then used in patient care.

The Foundation Trust does not have any income generation activities whose full cost exceeds £1 million in a full year or is otherwise material. Income from the sale of goods is immaterial.

4. REVENUE FROM PATIENT CARE ACTIVITIES

4.1 OPERATING INCOME BY SOURCE

	31 March 2018	31 March 2017
	£000	£000
NHS		
NHS trusts	**1,041**	1,013
CCGs	**127,184**	126,023
NHS England	**30,144**	31,706
Foundation trusts	**1,372**	1,523
NHS other	**0**	22
Non-NHS		
Local authorities (healthcare services)	**26,306**	26,925
Private Patients	**67**	23
Other	**622**	407
Total	**186,736**	187,642

The Foundation Trust has no income from the injury cost recovery scheme (nil to 31 March 2017).

There was no income arising from exchange of goods/services (nil to 31 March 2017).

4.2 OPERATING INCOME BY NATURE	31 March 2018	31 March 2017 Restated
	£000	£000
Mental health trusts		
Block contract income	**66,435**	66,183
Other clinical income from mandatory services	**1,637**	1,387
Community trusts (any trusts providing community services)		
Income from CCGs and NHS England	**89,879**	90,656
Income not from CCGs, NHS England	**28,719**	29,393
All trusts		
Private patient income	**66**	23
Other clinical income	**0**	0
Total income from activities	**186,736**	187,642

All income from activities has been deemed to have arisen from commissioner requested services.

4.3 PRIVATE PATIENT INCOME	31 March 2018	31 March 2017
	£000	£000
Private patient income	**66**	23
Total patient related income	**186,736**	187,642
Proportion (as percentage)	**0%**	0%

4.4 INCOME FROM OVERSEAS VISITORS (RELATING TO PATIENTS CHARGED DIRECTLY BY THE FOUNDATION TRUST)

The Foundation Trust did not have any income from overseas visitors in 2017/2018 (2016/2017 £nil).

5.OTHER OPERATING INCOME	31 March 2018	31 March 2017
	£000	£000
Research and development	**408**	462
Education and training	**2,958**	2,961
Charitable and other contributions to expenditure	**1,308**	1,438
Non-patient care services to other bodies	**563**	574
Rental revenue from operating leases	**143**	167
Income in respect of staff where accounted on a gross basis	**795**	451
Sustainability and Transformation Fund income	**4,243**	2,634
Other revenue*	**1,753**	1,864
	12,171	10,551
* Other revenue includes:		
Canteen income	**289**	274
IT recharges	**216**	386
Estates recharges	**462**	698
Miscellaneous	**786**	506
	1,753	1,864

6. OPERATING EXPENSES

	31 March 2018	31 March 2017 Restated
	£000	£000
Purchase of healthcare from non-NHS and non-DHSC bodies	**4,517**	4,709
Staff and executive directors costs	**134,452**	131,518
Non-executive directors	**119**	111
Supplies and services – clinical (excluding drugs costs)	**12,938**	9,544
Supplies and services - general	**2,101**	3,468
Drugs costs	**6,844**	6,845
Consultancy	**188**	655
Establishment	**2,026**	1,940
Premises - business rates collected by local authorities	**691**	563
Premises - other	**5,439**	5,406
Transport (business travel only)	**2,764**	2,669
Transport - other (including patient travel)	**626**	574
Depreciation	**4,209**	4,498
Amortisation	**591**	386
Impairments net of (reversals)	**(1,754)**	561
Increase/(decrease) in impairment of receivables	**(736)**	2,298
Audit fees payable to the external auditor:		
Audit services - statutory audit	**44**	51
Other auditor remuneration (payable to external auditor only)	**10**	14
Internal audit - non-staff	**75**	152
Clinical negligence - amounts payable to NHS Resolution	**257**	236
Legal fees	**203**	405
Insurance	**70**	88
Research and development - staff costs	**410**	476
Research and development - non-staff	**0**	11
Education and training - staff costs	**534**	502
Education and training - non-staff	**1,045**	636
Operating lease expenditure (net)	**4,189**	4,542
Redundancy costs - staff costs	**730**	281
Charges to operating expenditure for on-SoFP IFRIC 12 schemes	**1,448**	1,361
Car parking and security	**26**	64
Other losses and special payments - staff costs	**0**	364
Other losses and special payments - non-staff	**17**	38
Other services (e.g. external payroll)	**3,747**	3,394
Other	**(743)**	3,273
Total operating expenditure	**187,077**	191,633
Related to continuing operations	**187,077**	191,633

6.1 OTHER AUDIT REMUNERATION (PAID TO THE EXTERNAL AUDITOR)

	31 March 2018	31 March 2017
	£000	£000
Audit-related assurance services	**10**	14
Total	**10**	14

6.2 LIMITATION ON AUDITOR'S LIABILITY

	31 March 2018	31 March 2017
	£000	£000
Limitation on auditor's liability	**1,000**	500

7. OPERATING LEASES

7.1 AS LESSEE

The significant lease arrangements where the Foundation Trust is the lessee relate to lease of buildings and office equipment (photocopiers) over various lease periods.

Renewal and any restrictions imposed by the lease arrangement will be as per the individual lease agreements held by the relevant managers within the Foundation Trust.

Limited purchase options are available as per the lease contracts.

	31 March 2018	31 March 2017
	£000	£000
Payments recognised as an expense		
Minimum lease payments	**4,189**	4,542
Contingent rents	**0**	0
Less: sub-lease payments received	**0**	0
Total	**4,189**	4,542

	31 March 2018	31 March 2017
	£000	£000
Total future minimum lease payments payable:		
Not later than one year	**4,814**	3,968
Between one and five years	**479**	345
After five years	**13**	56
Total	**5,306**	4,369

No future sub-lease payments are expected to be received.

7.2 AS LESSOR

The leasing arrangements where the Foundation Trust is lessor relate to leasing of vacant areas of buildings where the Foundation Trust is the owner or the main occupier.

	31 March 2018	31 March 2017
	£000	£000
Rental Revenue		
Minimum lease receipts	**143**	167
Contingent rent	**0**	0
Other	**0**	0
Total rental revenue	**143**	167

	31 March 2018	31 March 2017
	£000	£000
Total future minimum lease receipts receivable:		
Not later than one year	**134**	141
Between one and five years	**182**	243
After five years	**0**	0
Total	**316**	384

8. EMPLOYEE COSTS

	31 March 2018	31 March 2017
	£000	£000
Salaries and wages	103,750	100,418
Social security costs	10,751	9,367
Employer contributions to NHS Pension Scheme	13,108	12,430
Apprenticeship levy	512	0
Other pension costs	11	11
Other post-employment benefits	0	0
Other employment benefits	0	0
Termination benefits (on an accruals basis)	730	645
Agency/contract staff	7,484	10,411
Total gross staff costs	136,346	133,282
Less income where netted off expenditure	0	0
Total staff costs	136,346	133,282
	31 March 2018	31 March 2017
Of the total above:	£000	£000
Employee benefits charged to capital	220	141
Employee benefits charged to revenue	136,126	133,141
Total	136,346	133,282

9. PENSION COSTS

9.1 NHS PENSION SCHEME

Past and present employees are covered by the provisions of the two NHS Pensions Schemes.

Details of the benefits payable and rules of the Schemes can be found on the NHS Pensions website at www.nhsbsa.nhs.uk/pensions.
Both are unfunded defined benefit schemes that cover NHS employers, GP practices and other bodies, allowed under the direction of the Secretary of State, in England and Wales. They are not designed to be run in a way that would enable NHS bodies to identify their share of the underlying scheme assets and liabilities.

Therefore, each scheme is accounted for as if it were a defined contribution scheme: the cost to the NHS body of participating in each scheme is taken as equal to the contributions payable to the 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) Full actuarial (funding) valuation

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

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

The next actuarial valuation is to be carried out as at 31 March 2016 and is currently being prepared. The direction assumptions are published by HM Treasury which are used to complete the valuation calculations, from which the final valuation report can be signed off by the scheme actuary. This will set the employer contribution rate payable from April 2019 and will consider the cost of the Scheme relative to the employer cost cap. There are provisions in the Public Service Pension Act 2013 to adjust member benefits or contribution rates if the cost of the Scheme changes by more than 2% of pay. Subject to this 'employer cost cap' assessment, any required revisions to member benefits or contribution rates will be determined by the Secretary of State for Health after consultation with the relevant stakeholders.

b) Accounting valuation

A valuation of scheme liability is carried out annually by the scheme actuary (currently the Government Actuary's Department) as at the end of the reporting period. This utilises an actuarial assessment for the previous accounting period in conjunction with updated membership and financial data for the current reporting period, and are accepted as providing suitably robust figures for financial reporting purposes. The valuation of the scheme liability at 31 March 2018, is based on the validation data as at 31 March 2017, updated to 31 March 2018 with summary global member and accounting data.

In undertaking this actuarial assessment, the methodology prescribed in IAS19, relevant FReM interpretations, and the discount rate prescribed by HM Treasury have been used.

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

9.2 LOCAL GOVERNMENT PENSION SCHEME (LGPS)

Under TUPE, following a tender process for the children's respite service, 31 staff working for Northamptonshire County Council (NCC) transferred to the Foundation Trust as members of the Local Government Pension Scheme (LGPS). The LGPS is a defined benefit statutory scheme which provides its members with defined benefits relating to pay and service. The scheme is administered by NCC in accordance with LGPS Regulations. The Foundation Trust became a contributing member of the LGPS with effect from 1 August 2013 when the children's respite service transferred.

All staff were transferred out of the scheme with an effective date of 31 March 2016. The Foundation Trust's liability ended at that date but as the information was not available until after the financial statements for 2015/2016 were closed and are not considered to be material to either party, the entries are shown in the 2016/2017 financial statements.

The transaction has been treated as a 'Transfer by Absorption' as it is between organisations within the Whole of Government accounting boundary.

The disclosure notes required under IAS19 are included to support the comparative figures.

9.3 NATIONAL EMPLOYEE SAVINGS TRUST PENSION SCHEME (NEST)

Employees of the Foundation Trust may also be members of the NEST scheme. Under the Pensions Act 2008, the Foundation Trust had a responsibility from 1 August 2013 to have a pension scheme available for all staff meeting the criteria to be enrolled under the legislation. In some cases staff may not be eligible to join the NHS Pension Scheme and so the Foundation Trust has set up the NEST scheme as an alternative.

Contributions paid by the Foundation Trust on behalf of employees was £11k in 2017/18 (£9k in 2016/17), and is shown within operating expenses.

10 RETIREMENTS DUE TO ILL-HEALTH

In the period to 31 March 2018 there were 2 early retirements (3 in the period ending 31 March 2017) from the Foundation Trust agreed on the grounds of ill-health.

The estimated additional pension liabilities of these ill-health retirements will be £105k (£57k in the period to 31 March 2017).

The cost of these ill-health retirements will be borne by the NHS Business Services Authority - Pensions Division.

11. PAYMENT PERFORMANCE

11.1 BETTER PAYMENT PRACTICE CODE

	Number	£000
2017/2018		
Total non-NHS trade invoices paid in the period	**34,490**	**93,507**
Total non-NHS trade invoices paid within target	**32,309**	**89,722**
Percentage of non-NHS trade invoices paid within target	**94%**	**96%**
Total NHS trade invoices paid in the period	**757**	**6,831**
Total NHS trade invoices paid within target	**705**	**6,638**
Percentage of NHS trade invoices paid within target	**93%**	**97%**
2016/2017		
Total non-NHS trade invoices paid in the period	42,594	74,994
Total non-NHS trade invoices paid within target	36,759	70,738
Percentage of non-NHS trade invoices paid within target	86%	94%
Total NHS trade invoices paid in the period	825	6,994
Total NHS trade invoices paid within target	775	6,676
Percentage of NHS trade invoices paid within target	94%	95%

The Better Payment Practice Code requires the Foundation Trust to aim to pay all undisputed invoices by the due date or within 30 days of receipt of goods or a valid invoice, whichever is later.

11.2 THE LATE PAYMENT OF COMMERCIAL DEBTS (INTEREST) ACT 1998

	31 March 2018 £000	31 March 2017 £000
Amounts included in finance costs from claims made under this legislation	**0**	0
Compensation paid to cover debt recovery costs	**0**	0
Total	**0**	0

12. FINANCE INCOME

	31 March 2018 £000	31 March 2017 £000
PFI finance lease revenue:		
- planned	**0**	0
- contingent	**0**	0
Other finance lease revenue	**0**	0
Interest revenue:		
- Bank accounts	**92**	83
- Other	**0**	33
Total	**92**	116

13. OTHER GAINS AND LOSSES

	31 March 2018 £000	31 March 2017 £000
Gain/(loss) on disposal of property, plant and equipment	**110**	295
Total	**110**	295

The loss on disposal does not relate to land and buildings assets used in the provision of commissioner requested services.

14. FINANCE COST - INTEREST EXPENSE

	31 March 2018 £000	31 March 2017 £000
Interest on obligations under finance leases	**2**	1
Interest on obligations under PFI contracts:		
- main finance cost	**1,851**	1,922
- contingent finance cost	**844**	825
Interest on late payment of commercial debt	**0**	0
Other interest expense	**0**	3
Total interest expense	**2,697**	2,751
Unwinding of discount on provisions	**13**	18
Total interest expense	**2,710**	2,769

15. PROPERTY, PLANT AND EQUIPMENT

15.1 PROPERTY, PLANT AND EQUIPMENT 2017/18

	Land	Buildings excluding dwellings	Dwellings	AUC*	Plant and machinery	Transport equipment	IT	Furniture and fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Cost/valuation at 1 April 2017	15,340	77,391	1,658	922	772	56	15,189	2,022	**113,350**
Additions purchased	0	1,195	0	268	464	0	2,669	552	**5,148**
Additions leased	0	0	0	0	0	0	0	0	**0**
Impairments charged to operating expenses	0	(65)	0	(1)	0	0	0	0	**(66)**
Impairments charged to the revaluation reserve	0	(93)	0	0	0	0	0	0	**(93)**
Reversal of impairments credited to operating incomes	0	1,820	0	0	0	0	0	0	**1,820**
Reclassifications	0	137	0	(911)	0	0	774	0	**0**
Revaluation/indexation gains	15	11,211	22	0	0	0	0	0	**11,248**
Transfer to disposal group as held for sale	0	0	0	0	0	0	0	0	**0**
Disposals/derecognition	0	(91)	0	0	(112)	0	(1,635)	(184)	**(2,022)**
Cost/valuation at 31 March 2018	15,355	91,505	1,680	278	1,124	56	16,997	2,390	129,385
Depreciation at 1 April 2017	0	5,562	43	0	337	32	9,022	1,107	16,103
Charged during the period	0	1,911	22	0	81	5	1,951	239	**4,209**
Transfer to disposal group as held for sale	0	0	0	0	0	0	0	0	**0**
Disposals/derecognition	0	(59)	0	0	(103)	0	(1,633)	(139)	**(1,934)**
Depreciation at 31 March 2018	0	7,414	65	0	315	37	9,340	1,207	18,378
Net book value									
Purchased	15,355	84,091	1,615	278	809	19	7,657	1,183	**111,007**
Donated	0	0	0	0	0	0	0	0	**0**
Government granted	0	0	0	0	0	0	0	0	**0**
Net book value total at 31 March 2018	15,355	84,091	1,615	278	809	19	7,657	1,183	111,007
Asset financing									
Owned	15,355	28,670	1,615	278	809	0	7,657	1,183	**55,567**
Finance leased	0	0	0	0	0	19	0	0	**19**
On-SoFP PFI contract	0	55,421	0	0	0	0	0	0	**55,421**
Net book value total at 31 March 2018	15,355	84,091	1,615	278	809	19	7,657	1,183	111,007

* = Assets under construction

15. PROPERTY, PLANT AND EQUIPMENT

15.2 PROPERTY, PLANT AND EQUIPMENT 2016/17

	Land	Buildings excluding dwellings	Dwellings	AUC*	Plant and machinery	Transport equipment	IT	Furniture and fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Cost/valuation at 1 April 2016	15,125	78,064	1,636	464	648	31	14,422	1,989	**112,379**
Cost/valuation at 1 April 2016	15,125	78,064	1,636	464	648	31	14,422	1,989	**112,379**
Additions purchased	0	1,469	0	922	177	0	743	68	**3,379**
Additions leased	0	0	0	0	0	25	0	0	**25**
Impairments charged to operating expenses	0	(600)	0	0	0	0	0	0	**(600)**
Impairments charged to the revaluation reserve	0	(2,094)	0	0	0	0	0	0	**(2,094)**
Reversal of impairments credited to operating incomes	0	39	0	0	0	0	0	0	**39**
Reclassifications	0	440	0	(464)	0	0	24	0	**0**
Revaluation/indexation gains	215	73	22	0	0	0	0	0	**310**
Transfer to disposal group as held for sale	0	0	0	0	0	0	0	0	**0**
Disposals	0	0	0	0	(53)	0	0	(35)	**(88)**
Cost or valuation at 31 March 2017	15,340	77,391	1,658	922	772	56	15,189	2,022	**113,350**
Depreciation at 1 April 2016 as previously state	0	3,598	21	0	301	28	6,802	918	**11,668**
Reclassifications	0	0	0	0	0	0	0	0	**0**
Reclassified as held for sale	0	0	0	0	0	0	0	0	**0**
Prior period adjustments	0	0	0	0	0	0	0	0	**0**
Depreciation at 1 April 2016	0	3,598	21	0	301	28	6,802	918	**11,668**
Charged during the period	0	1,964	22	0	89	4	2,220	199	**4,498**
Transfer to disposal group as held for sale	0	0	0	0	0	0	0	0	**0**
Disposals	0	0	0	0	(53)	0	0	(10)	**(63)**
Depreciation at 31 March 2017	0	5,562	43	0	337	32	9,022	1,107	**16,103**
Net book value									
Purchased	15,340	71,829	1,615	922	435	24	6,167	915	**97,247**
Donated	0	0	0	0	0	0	0	0	**0**
Government granted	0	0	0	0	0	0	0	0	**0**
Net book value total at 31 March 2017	15,340	71,829	1,615	922	435	24	6,167	915	**97,247**
Asset financing									
Owned	15,340	25,493	1,615	922	435	0	6,167	915	**50,887**
Finance lease/Private finance initiative	0	46,336	0	0	0	24	0	0	**46,360**
Donated	0	0	0	0	0	0	0	0	**0**
Net book value total at 31 March 2017	15,340	71,829	1,615	922	435	24	6,167	915	**97,247**

15. PROPERTY, PLANT AND EQUIPMENT (CONT.)

There are no donated assets in year.

The effective date of revaluation of property, plant and equipment is 31 March 2014 with an assessment of changes in value made by the district valuer at 31 March 2018 using available industry indices and market information. The revaluation is based on a District Valuer Services valuation by a MRICS qualified surveyor, on a modern equivalent asset basis.

Asset lives for each class of asset held are as follows and represent the range of component parts that make up each asset:	Min. life (Years)	Max. life (Years)
Buildings excluding dwellings	1	72
Dwellings	30	90
Plant and machinery	1	10
Transport equipment	1	5
Information technology	1	10
Furniture and fittings	1	10
Software licences (purchased)	1	5

At 31 March 2018, of the total non-current asset values, £370k (£355k at 31 March 2017) related to land valued at open market value and £1,105k (£1,105k at 31 March 2017) related to buildings valued at open market value.

There is no compensation from third parties for assets impaired, lost or given up and therefore nil is included in the income statement.
The gross carrying amount of fully depreciated tangible assets still in use is £6,732k (£5,125k at 31 March 2017).

15.3 PROPERTIES LEASED TO THIRD PARTIES BY THE FOUNDATION TRUST

	Gross cost	Accum deprn	Deprn in year	Revaluation in year	Totals
Asset	£'000	£'000	£'000	£'000	£'000
12 Wales Street	240	0	0	10	250
399 Cottingham Road	245	0	0	5	250
39 Billing Road	675	0	0	0	675
Total	1,160	0	0	15	1,175

There are £nil (£nil in 2016/17) of impairments recognised and £nil (£nil in 2016/17) of impairments reversed for these assets.

15.4 NON-CURRENT ASSETS HELD FOR SALE

	Property, plant and equipment	Land	Total
	£000	£000	£000
Net book value at 1 April 2017	**0**	**0**	**0**
Plus assets classified as held for sale in the year	**0**	**0**	**0**
Less assets sold in the year	**0**	**0**	**0**
Less impairments of assets held for sale	**0**	**0**	**0**
Plus reversal of impairment of assets held for sale	**0**	**0**	**0**
Net book value at 31 March 2018	**0**	**0**	**0**
Net book value at 1 April 2016	175	180	355
Plus assets classified as held for sale in the year	0	0	0
Less assets sold in the year	(175)	(180)	(355)
Plus reversal of impairment of assets held for sale	0	0	0
Net book value at 31 March 2017	0	0	0

16.INTANGIBLE ASSETS

	Software licences purchased	AUC	Website	Total
	£000	£000	£000	£000
2017/18				
Cost or valuation at 1 April 2017	2,081	137	0	2,218
Additions purchased/internally generated	1,330	0	104	1,434
Reclassifications	0	(137)	137	0
Disposals	(104)	0	0	(104)
Cost or valuation at 31 March 2018	3,307	0	241	3,548
Amortisation at 1 April 2017	774	0	0	774
Disposals	(104)	0	0	(104)
Charged during the period	570	0	21	591
Amortisation at 31 March 2018	1,240	0	21	1,261
Analysis of net book value total at 31 March 2018				
Purchased	2,067	0	220	2,287
Finance leased	0	0	0	0
Net book value total at 31 March 2018	2,067	0	**220**	**2,287**
2016/17				
Cost or valuation at 1 April 2016	1,654	84	0	1,738
Additions purchased	419	61	0	480
Reclassifications	8	(8)	0	0
Cost or valuation at 31 March 2017	2,081	137	0	2,218
Amortisation at 1 April 2016	388	0	0	388
Charged during the period	386	0	0	386
Amortisation at 31 March 2017	774	0	0	774
Analysis of net book value total at 31 March 2017				
Purchased	1,307	137	0	1,444
Finance leased	0	0	0	0
Net book value total at 31 March 2017	1,307	137	0	1,444

16.INTANGIBLE ASSETS (CONT.)

The intangible assets within these financial statements relate to externally procured software. In line with the valuation policy for tangible IT assets, intangible assets have not been revalued. The current values are considered to be fair in that they are the result of the application of amortisation on a straight line basis. The carrying amount of the intangible assets at cost is £2,287k (£1,444k at 31 March 2017). There are no intangible assets which have indefinite lives and the finite lives of the intangible assets are between nil and five years. There are no intangible assets acquired by government grant. The value of intangible assets still in use, which have been fully amortised is £101k (£119k at 31 March 2017). There are no intangible assets controlled by the Foundation Trust that are not recognised as assets because they did not meet the recognition criteria of IAS 38.

17. IMPAIRMENTS

An impairment review was carried out at the end of the financial period and an impairment of £159k (£2,694k in the 12 months to 31 March 2017) on land and buildings has been recognised.

The year end review of values in conjunction with the district valuer also identified an increase in land and building assets that had previously been impaired of £1,820k (£39k in the 12 months to 31 March 2017).

The net impact on the SoCI is a reversal of impairment of £1,754k, and impairment (£561k) in the 12 months to 31 March 2017).

No impairments were recognised prior to the disposal of assets during the year (2016/2017 £nil).

The overall revaluation impact was to increase the value of the Foundation Trust's estate by £12,908k (decrease of £2,345k in the 12 months to 31 March 2017) with a £11,155k increase (£1,784k decrease in the 12 months to 31 March 2017) to revaluation reserves.

17.1 IMPAIRMENT OF ASSETS

	31 March 2018	31 March 2017
	£000	£000
Impairments/(reversals) charged to operating surplus/deficit		
Loss or damage from normal operations	0	0
Over specification of assets	0	0
Abandonment of assets in the course of construction	0	0
Changes in market price	(1,754)	561
Total impairments/(reversals) charged to operating surplus	(1,754)	561
Impairments charged to the revaluation reserve	93	2,094
Total impairments	(1,661)	2,655

18. CAPITAL COMMITMENTS

Contracted capital commitments not otherwise included in these financial statements	31 March 2018	31 March 2017
	£000	£000
Property, plant and equipment	0	0
Intangible assets	0	0
Total	0	0

19. INVESTMENTS IN ASSOCIATES

	31 March 2018	31 March 2017
	£000	£000
Carrying value at 1 April	148	0
Share of profit/(loss)	(148)	148
Carrying value at 31 March	0	148

The Foundation Trust holds a 38% share of voting rights in First for Wellbeing which is a community interest company limited by guarantee. First for Wellbeing, which started trading during 2016/17, is a joint venture between the Foundation Trust, Northamptonshire County Council and the University of Northampton. The full extent of the Foundation Trust's guarantee is £38.

The draft financial statements for First for Wellbeing show a net profit of £nil, a gross asset position of £nil million and a net asset position of £nil.

The investment has been accounted for on an equity basis and an estimate of the Foundation Trust's share of the net assets has been included on the face of the Statement of Comprehensive Income.

There is not considered to be an active market for the investment in First for Wellbeing.

20. OTHER INVESTMENTS

	31 March 2018	31 March 2017
	£000	£000
Carrying value at 1 April	79	0
Acquisitions in year	0	79
Disposals	(3)	0
Carrying value at 31 March	76	79

In 2016/17 the Foundation Trust purchased shares in 3Sixty Care Ltd which is a Multispecialty Community Provider; the Foundation Trust's share constitutes 50% of the voting rights.

3Sixty Care Ltd, whose trading name is the 3Sixty Care Partnership, has been formed with partners in the 3Sixty Care GP Federation (covering Corby, East Northants, Wellingborough and surrounding areas).

The investment has been accounted for at fair value and the carrying value of the investment is considered to be supported by the net assets.

There is not considered to be an active market for the investment in 3Sixty Care Ltd.

21. INVENTORIES

21.1 INVENTORIES

	31 March 2018	31 March 2017
	£000	£000
Consumables	61	100
Other	24	27
Total	85	127

21.2 INVENTORIES RECOGNISED IN EXPENSES

	31 March 2018	31 March 2017
	£000	£000
Inventories recognised as an expense in the period	(796)	(770)
Write-down of inventories recognised as an expense	0	0
Reversal of any write-downs of inventories resulting in a reduction of recognised expenses	0	0
Total	(796)	(770)

22.TRADE AND OTHER RECEIVABLES

	31 March 2018	31 March 2017
	£000	£000
Current		
Trade receivables - revenue	**10,461**	8,231
Provision for the impairment of receivables	**(99)**	(2,408)
Deposits and advances	**1**	1
Prepayments	**611**	1,257
PDC receivable	**69**	356
VAT receivable	**520**	422
Other receivables - revenue	**73**	98
Total	**11,636**	7,957
Of which receivable from NHS and DHSC group bodies:	**9,169**	7,543
Non-current		
Total	**0**	0

The majority of trade is with CCGs as commissioners for NHS patient care services.
As CCGs are funded by government to buy NHS patient care services, no credit scoring of them is considered necessary.

22.1 AGEING OF RECEIVABLES

	31 March 2018	31 March 2017
	£000	£000
Ageing of impaired receivables		
0 - 30 days	**4**	2,346
30 - 60 days	**0**	2
60 - 90 days	**5**	0
90 - 180 days	**9**	7
180 - 360 days	**81**	53
Total	**99**	2,408

Ageing of non-impaired receivables		
0 - 30 days	**3,686**	2,458
30 - 60 days	**201**	98
60 - 90 days	**179**	54
90 - 180 days	**156**	137
180 - 360 days	**891**	1,055
Total	**5,113**	3,802

22.2 PROVISION FOR IMPAIRMENT OF RECEIVABLES

	31 March 2018	31 March 2017
	£000	£000
Balance at start of period	**2,408**	130
Increase in provision	**77**	2,374
Amounts utilised	**(1,573)**	(20)
Unused amounts recovered	**(813)**	(76)
Balance at end of period	**99**	2,408

Receivables impaired relate to trade receivables which have been examined on a case by case basis in terms of their potential recovery.

23. OTHER FINANCIAL ASSETS

There are no other financial assets.

24. OTHER CURRENT ASSETS

There are no other current assets.

25. CASH AND CASH EQUIVALENTS

	31 March 2018	31 March 2017
	£000	£000
Balance at 1 April	**35,436**	31,421
Net change in period	**2,105**	4,015
Balance at 31 March	**37,541**	35,436

Made up of:		
Cash with Government Banking Service	**37,473**	35,363
Commercial banks and cash in hand	**68**	73
Current investments	**0**	0
Cash and cash equivalents as in SoFP	**37,541**	35,436
Bank overdraft	**0**	0
Cash and cash equivalents as in SoCF	**37,541**	35,436

26. TRADE AND OTHER PAYABLES

	31 March 2018	31 March 2017
Current	£000	£000
Trade payables - revenue	**3,048**	3,520
Other trade payables - capital	**3,362**	1,297
Social security costs	**1,521**	1,352
Other taxes payable	**1,070**	964
Other payables	**1,800**	1,654
Accruals	**12,947**	14,319
Total current trade and other payables	**23,748**	23,106

Non-current		
Other trade payables - capital	**237**	0
Total non-current trade and other payables	**237**	0

26.1 EARLY RETIREMENTS IN NHS PAYABLES

There are no early retirements in NHS payables.

27. BORROWINGS

	31 March 2018	31 March 2017
Current	**£000**	£000
Finance lease liabilities	**4**	4
Obligations under PFI, LIFT or other service concession	**1,001**	1,298
Total current borrowings	**1,005**	1,302

Non-current		
Finance lease liabilities	**10**	15
Obligations under PFI, LIFT or other service concession	**34,019**	35,020
Total non-current borrowings	**34,029**	35,035

Finance lease liabilities relate to commitments on vehicles which have been capitalised. Expected dates of settlement are consistent with lease termination dates which range between one and five years.

Date of settlement for the Welland PFI scheme is 2035 (30 years from date of completion of construction).

Date of settlement for the Berrywood PFI scheme is 2037 (30 years from date of completion of financial close).

28. OTHER LIABILITIES

	31 March 2018	31 March 2017
Current	**£000**	£000
Deferred income	**2,488**	212
Total current other liabilities	**2,488**	212

There are no non-current liabilities.

29. FINANCE LEASE OBLIGATIONS

The Foundation Trust leased vehicles with leasing companies, there are no purchasing options at the end of lease and there are no favourable terms of renewal.

No contingent rent is payable.

	Minimum lease payments	
	31 March 2018	31 March 2017
Amounts payable under finance leases:	**£000**	£000
Gross lease liabilities of which liabilities are:	**21**	27
Within one year	**7**	7
Between one and five years	**14**	20
After five years	**0**	0
Less future finance charges	**(7)**	(8)
Net lease liabilities of which liabilities are due:	**14**	19
Within one year	**4**	4
Between one and five years	**10**	15
After five years	**0**	0
Total amounts payable under finance leases	**14**	19

30. FINANCE LEASE RECEIVABLES, I.E. AS LESSOR

There are no finance lease receivables and there is no finance lease rental revenue.

31. FINANCE LEASE COMMITMENTS

Finance leases above £5,000 are capitalised.

	31 March 2018	31 March 2017
Total obligations for finance leases due:	**£000**	£000
Gross finance leases of which liabilities are due:	**21**	27
Not later than one year	**7**	7
Later than one year, not later than five years	**14**	20
Later than five years	**0**	0
Gross Finance Lease liabilities	**21**	27
Finance charges allocated to future periods	**(7)**	(8)
Net Finance Leases of which liabilities are due:	**14**	19
Not later than one year	**4**	4
Later than one year, not later than five years	**10**	15
Later than five years	**0**	0
Net Finance Liabilities	**14**	19

32. PRIVATE FINANCE INITIATIVE CONTRACTS

32.1 PFI SCHEMES OFF-STATEMENT OF FINANCIAL POSITION

There are no off-Statement of Financial Position PFI schemes.

32.2 PFI SCHEMES ON-STATEMENT OF FINANCIAL POSITION

There are two PFI schemes:

- the Welland scheme in Kettering, which opened in December 2005 and comprises two treatment wards and an assessment ward. The term of the agreement is 30 years from the date of the handover of the asset, which is December 2035.

- the Berrywood scheme in Northampton, which opened in December 2008 and comprises four assessment wards, an ICU, elderly beds, low secure beds and rehab beds. The term of the agreement is 30 years from the commencement of construction of the asset, which is the end of October 2037.

Under IFRIC 12, the PFI assets are treated as assets of the Foundation Trust; as the substance of the contract is that the Foundation Trust has a finance lease and payments comprise two elements – imputed finance lease charges and service charges. Details of the imputed finance lease charges are shown in the table below.

At the end of the contract period the facilities and equipment will be handed back to the Foundation Trust in a specified condition, at no cost. If this condition is not met then the operator may be required to compensate the Foundation Trust, under the terms of the agreement. No renewal options are noted.

The contracts may be terminated by either party if specified default conditions are met. There are voluntary termination options within the contracts, although there is a financial penalty if these are exercised. No changes to the contractual arrangements have occurred during 2017/18.

32.2 PFI SCHEMES ON-STATEMENT OF FINANCIAL POSITION (CONT.)

Total obligations for on-Statement of Financial Position PFI contracts due:	**31 March 2018**	31 March 2017
	£000	£000
Gross PFI liabilities of which liabilities are due:	**55,537**	58,686
Not later than one year	**2,788**	3,150
Later than one year, not later than five years	**11,953**	11,509
Later than five years	**40,796**	44,027
Gross PFI liabilities	**55,537**	58,686
Finance charges allocated to future periods	**(20,517)**	(22,368)
Net PFI liabilities of which liabilities are due:	**35,020**	36,318
Not later than one year	**1,001**	1,298
Later than one year, not later than five years	**5,374**	4,680
Later than five years	**28,645**	30,340
Net PFI liabilities	**35,020**	36,318

	31 March 2018	31 March 2017
	£000	£000
Total future payments committed in respect of PFI, LIFT or other service concession arrangements of which liabilities are due:	**84,568**	87,012
Not later than one year	**5,534**	5,477
Later than one year, not later than five years	**20,702**	20,491
Later than five years	**58,332**	61,044

The PFI contracts set the required performance standard, including availability, and set out the associated penalty deductions for unavailability.

There are no other obligations to acquire or build items of property, plant and equipment other than the equipment replacement specified in the lifecycle values within the unitary charge.

There are no other rights and obligations noted in the contracts.

32.3 CHARGES TO EXPENDITURE

The total charged in the period to expenditure in respect of the service element of on-Statement of Financial Position PFI contracts was £1,448k (£1,361k 2016/17).

	31 March 2018	31 March 2017
Commitments in respect of the service element:	**£000**	£000
Not later than one year	**1,214**	1,200
Later than one year, not later than five years	**5,291**	5,218
Later than five years	**23,864**	25,592
Total	**30,369**	32,010

32.4 AMOUNTS PAYABLE TO SERVICE CONCESSION OPERATOR

	31 March 2018	31 March 2017
Analysis of amounts paid to service concession operator:	**£000**	£000
Interest charge	**1,851**	1,922
Repayment of finance lease liability	**1,298**	1,345
Service element	**1,448**	1,361
Capital lifecycle maintenance	**509**	344
Contingent rent	**844**	825
Total	**5,950**	5,797

33. OTHER FINANCIAL LIABILITIES

The Foundation Trust has pledged £38 as a guarantee on formation of First for Wellbeing, a community interest company limited by guarantee. The value of the guarantee is not deemed to be material to either entity.

34. PROVISIONS

	31 March 2018	31 March 2017
Current	**£000**	£000
Pensions relating to other staff	**26**	26
Legal claims	**56**	93
Other	**6,385**	6,893
Total	**6,467**	7,012
Non-current		
Pensions relating to other staff	**423**	436
Other	**30**	30
Total	**453**	466

Legal claims are as advised by NHS Resolution who administer claims on behalf of the Foundation Trust and outstanding claims are expected to clear by 31 March 2019.

Pension provisions relate to staff who have retired early on ill health grounds from the NHS Pensions Scheme. They are calculated in accordance with Department of Health and Social Care guidance. There is no uncertainty with regard to timing or values.

Other includes:
- £3,283k (£4,356k at 31 March 2017) service change/reprovision costs that are based on calculated entitlements and are expected to materialise by the end of 2018/2019.
- £30k (£30k at 31 March 2017) for dilapidation works expected at the end of property leases.

£2,336k (£1,446k at 31 March 2017) is included in the provisions of NHS Resolution in respect of clinical negligence liabilities of the Foundation Trust.

34. PROVISIONS (CONT.)

	Pensions relating to other staff	Legal claims	Other	Total
	£000	£000	£000	£000
At 1 April 2017	462	93	6,923	**7,478**
Arising during the period	0	28	4,577	**4,605**
Used during the period	(26)	(29)	(115)	**(170)**
Reversed unused	0	(36)	(4,970)	**(5,006)**
Unwinding of discount	13	0	0	**13**
At 31 March 2018	**449**	**56**	**6,415**	**6,920**
Expected timing of cash flows:				
Not later than one year	**26**	**56**	**6,385**	**6,467**
Later than one year and not later than five years	**104**	**0**	**0**	**104**
Later than five years	**319**	**0**	**30**	**349**
At 31 March 2018	**449**	**56**	**6,415**	**6,920**

At 1 April 2016	469	51	6,858	7,378
Arising during the period	0	67	5,208	5,275
Used during the period	(25)	0	(1,365)	(1,390)
Reversed unused	0	(25)	(3,778)	(3,803)
Unwinding of discount	18	0	0	18
At 31 March 2017	462	93	6,923	7,478
Expected timing of cash flows:				
Not later than one year	26	93	6,893	7,012
Later than one year and not later than five years	104	0	0	104
Later than five years	332	0	30	362
At 31 March 2017	462	93	6,923	7,478

35. CONTINGENCIES

35.1 CONTINGENT LIABILITIES

The Foundation Trust has contingent liabilities arising from claims being assessed by the NHS Litigation Authority of £22k at 31 March 2018 (£54k at 31 March 2017).

The Foundation Trust has contingent liabilities of £1.3 million arising from the sale of land in 2010 at the former Princess Marina Hospital.

35.2 CONTINGENT ASSETS

There are no contingent assets.

36. FINANCIAL INSTRUMENTS

36.1 FINANCIAL ASSETS

	Loans and receivables	Total
	£000	£000
Receivables	**10,363**	**10,363**
Cash and cash equivalents	**37,541**	**37,541**
Non-current assets held for sale	**0**	**0**
Other financial assets	**0**	**0**
Other investments	**76**	**76**
Total at 31 March 2018	**47,980**	**47,980**
Receivables	5,820	5,820
Cash and cash equivalents	35,436	35,436
Other financial assets	0	0
Other investments	227	227
Total at 31 March 2017	41,483	41,483

36.2 FINANCIAL LIABILITIES

	Other	Total
	£000	£000
Obligations under finance leases	**14**	**14**
Obligations under PFI contracts	**35,020**	**35,020**
Payables	**19,594**	**19,594**
Provisions under contract	**85**	**85**
Other financial liabilities	**0**	**0**
Total at 31 March 2018	**54,713**	**54,713**
Obligations under finance leases	19	19
Obligations under PFI contracts	36,318	36,318
Payables	19,136	19,136
Provisions under contract	123	123
Other financial liabilities	0	0
Total at 31 March 2017	55,596	55,596

36.3 MATURITY OF FINANCIAL LIABILITIES

	31 March 2018	31 March 2017
	£000	£000
In one year or less	**20,417**	20,561
In more than one year but not more than two years	**1,223**	1,006
In more than two years but not more than five years	**4,398**	3,689
In more than five years	**28,675**	30,340
	54,713	55,596

36.4 FAIR VALUE OF FINANCIAL ASSETS

	£000	£000
	Book value	Fair value
Non current trade and other receivables excluding non-financial liabilities	0	0
Other investments	76	76
Other	0	0
Total	76	76

36.5 FAIR VALUE OF FINANCIAL LIABILITIES

	£000	£000
	Book value	Fair value
Non current trade and other payables excluding non-financial liabilities	0	0
Provisions under contract	85	85
Loans	0	0
Other	0	0
Total	85	85

36.6 FINANCIAL RISK MANAGEMENT

Financial reporting standard IFRS7 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 Foundation Trust has with Clinical Commissioning Groups (CCGs) and the way those CCGs are financed, the Foundation Trust is not exposed to the degree of financial risk faced by private sector 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 Foundation 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 Foundation Trust in undertaking its activities.

The Foundation Trust's treasury management operations are carried out by the finance department.

Currency risk

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

Interest rate risk

The Foundation Trust is free to borrow from commercial or public sector sources for capital expenditure, subject to limits set by NHSI, the independent regulator, and as specified in their terms of authorisation. Therefore, it has a relatively low exposure to interest rate fluctuations.

Credit risk

Because the majority of the Foundation Trust's income comes from contracts with other public sector bodies, the Foundation Trust has low exposure to credit risk. The maximum exposures as at 31 March 2018 are in receivables from customers, as disclosed in the trade and other receivables note.

Liquidity risk

The majority of the Foundation Trust's operating costs are incurred under contracts with CCGs and NHS England, which are financed from resources voted on annually by Parliament. The Foundation Trust funds its capital expenditure from internally generated cash from operations and asset sales. The Foundation Trust is not, therefore, exposed to significant liquidity risks.

37. EVENTS AFTER THE REPORTING PERIOD

There are no known events after the reporting period that impact on the financial statements for 2017/18.

38. RELATED PARTY TRANSACTIONS

During the period none of the Foundation Trust board of directors or members of the key management staff, or parties related to any of them, has undertaken any material transactions with Northamptonshire Healthcare NHS Foundation Trust.

During the year Northamptonshire Healthcare NHS Foundation Trust has had a significant number of material transactions with related parties, as detailed below:

	Receipts from related party	Payments to related party	Amounts due from related party	Amounts owed to related party
2017/2018	**£000**	**£000**	**£000**	**£000**
Board of directors	**0**	**0**	**0**	**0**
Key staff members	**0**	**0**	**0**	**0**
Department of Health and Social Care	**22**	**0**	**0**	**0**
Nene CCG	**110,952**	**680**	**3,158**	**2,269**
Corby CCG	**13,226**	**17**	**0**	**49**
Northampton General NHS Trust	**1,476**	**1,454**	**41**	**117**
Kettering General NHS Foundation Trust	**1,577**	**791**	**491**	**13**
Greater East Midlands Commissioning Support Unit	**0**	**0**	**0**	**0**
NHS England	**34,402**	**0**	**4,277**	**185**
Other NHS bodies	**6,494**	**8,605**	**980**	**2,041**
Charitable funds	**0**	**0**	**5**	**0**
Northamptonshire County Council	**25,601**	**4,370**	**138**	**2,834**
NHS Pensions Agency	**0**	**13,108**	**0**	**1,799**
First for Wellbeing CIC	**329**	**0**	**91**	**0**
3Sixty Care	**147**	**0**	**42**	**149**
Other	**1,222**	**12,557**	**705**	**3,141**
Total	**195,448**	**41,582**	**9,928**	**12,597**

2016/2017				
Board of directors	0	0	0	0
Key staff members	0	0	0	0
Department of Health and Social Care	19	2,870	356	0
Nene CCG	121,768	302	2,449	277
Corby CCG	8,816	44	133	8
Northampton General NHS Trust	1,354	1,245	5	37
Kettering General NHS Foundation Trust	1,604	792	568	3
Greater East Midlands Commissioning Support Unit	0	55	0	0
NHS England	34,361	4	2,663	100
Other NHS bodies	5,622	6,766	1,369	1,561
Charitable funds	0	0	3	0
Northamptonshire County Council	20,340	4,120	531	1,521
NHS Pensions Agency	0	12,430	0	1,652
First for Wellbeing CIC	264	0	0	0
3Sixty Care	86	598	1	0
Local Government Pension Scheme	0	0	0	0
Other	837	12,587	1,027	3,160
Total	195,071	41,813	9,105	8,319

First for Wellbeing is a community interest company limited by guarantee in which the Foundation Trust holds 38% of the voting rights.

3Sixty Care is a company limited by shares in which the Foundation Trust holds a 50% shareholding.

39. THIRD PARTY ASSETS

The Foundation Trust held £6k (£8k at 31 March 2017) cash and cash equivalents at 31 March 2018 which relates to monies held by the NHS Foundation Trust on behalf of patients. This has been excluded from the cash and cash equivalents figure reported in the accounts.

40. INTRA-GOVERNMENT AND OTHER BALANCES

	Current receivables	Non-current receivables	Current payables	Non-current payables
	£000	£000	£000	£000
Balances with Department of Health and Social Care	0	0	0	0
Balances with Public Health England	1	0	3	0
Balances with NHS England and CCGs	8,244	0	2,503	0
Balances with Health Education England	58	0	546	0
Balances with NHS Trusts	158	0	160	0
Balances with other FTs	528	0	114	0
Balances with Special Health Authorities	7	0	0	0
Balances with NDPBs	95	0	95	0
Balances with Other DH bodies	10	0	1,348	0
Balances with Local Government	260	0	2,976	0
Other WGA Bodies	520	0	4,703	0
Intra-government balances	9,881	0	12,448	0
Balances with bodies external to government	1,755		11,300	
At 31 March 2018	11,636	0	23,748	0
Balances with Department of Health and Social Care	356	0	0	0
Balances with Public Health England	5	0	0	0
Balances with NHS England and CCGs	5,555	0	386	0
Balances with Health Education England	6	0	12	0
Balances with NHS Trusts	80	0	38	0
Balances with other FTs	624	0	166	0
Balances with Special Health Authorities	0	0	0	0
Balances with NDPBs	0	0	0	0
Balances with Other DH bodies	917	0	1,384	0
Balances with Local Government	1,133	0	2,001	0
Balances Central Government	425	0	4,332	0
Intra-government balances	9,101	0	8,319	0
Balances with bodies external to government	(1,144)	0	14,787	0
At 31 March 2017	7,957	0	23,106	0

41. LOSSES AND SPECIAL PAYMENTS

	31 March 2018	31 March 2018	Restated 31 March 2017	Restated 31 March 2017
Losses	Number	£000	Number	£000
Losses of cash	12	9	21	21
Bad debts and claims abandoned	2	0	1	4
Total losses	14	9	22	25
Special Payments				
Compensation payments	7	103	4	31
Ex-gratia payments	4	1	14	32
Extra contractual payments to contractors	0	0	1	2
Other employment payments	1	0	24	364
Total special payments	12	104	43	429
Total losses and special payments	26	113	65	454

Losses and special payments are accounted for on an accruals basis excluding provisions for future losses.

42. OTHER FINANCIAL COMMITMENTS

The Foundation Trust has not entered into any non-cancellable contracts which are not leases, PFI contracts or other service concession arrangements.

43. REVALUATION RESERVE

	Revaluation reserve: property, plant and equipment	Revaluation reserve: assets held for sale	Total revaluation reserve
	£000	£000	£000
At 1 April 2017	**15,465**	**0**	**15,465**
Impairments	**(93)**	**0**	**(93)**
Revaluations	**11,248**	**0**	**11,248**
Disposals	**0**	**0**	**0**
Transfer of the excess of current cost depreciation over historical cost depreciation to the Income and Expenditure Reserve	**0**	**0**	**0**
Other reserve movements	**0**	**0**	**0**
Movements on other reserves	**0**	**0**	**0**
Revaluation reserve at 31 March 2018	**26,620**	**0**	**26,620**

At 1 April 2016	17,249	54	17,303
Impairments	(2,094)	0	(2,094)
Revaluations	310	0	310
Disposals	0	(54)	(54)
Transfer of the excess of current cost depreciation over historical cost depreciation to the Income and Expenditure Reserve	0	0	0
Other reserve movements	0	0	0
Movements on other reserves	0	0	0
Revaluation reserve at 31 March 2017	15,465	0	15,465

AUDITOR'S REPORT

KPMG

Independent auditor's report

to the Council of Governors of Northamptonshire Healthcare NHS Foundation Trust only

Opinions and conclusions arising from our audit

Our opinion is unmodified

We have audited the financial statements of Northamptonshire Healthcare NHS Foundation Trust ("the Trust") for the year ended 31 March 2018 which comprise the Statement of Comprehensive Income, Statement of Financial Position, the Statement of Changes in Taxpayers Equity and the related notes, including the accounting policies in note 1.

In our opinion:

- the financial statements give a true and fair view of the state of the Trust's affairs as at 31 March 2018 and of its income and expenditure for the year then ended; and
- the Trust's financial statements have been properly prepared in accordance with the Accounts Direction issued under paragraphs 24 and 25 of Schedule 7 of the National Health Service Act 2006, the NHS Foundation Trust Annual Reporting Manual 2017/18 and the Department of Health Group Accounting Manual 2017/18.

Basis for opinion

We conducted our audit in accordance with International Standards on Auditing (UK) ("ISAs (UK)") and applicable law. Our responsibilities are described below. We have fulfilled our ethical responsibilities under, and are independent of the Trust in accordance with, UK ethical requirements including the FRC Ethical Standard. We believe that the audit evidence we have obtained is a sufficient and appropriate basis for our opinion.

Overview		
Materiality: Financial statements as a whole	£3.5 million (2016/17: £3.5 million) 2% (2016/17: 2%) of income from operations	
Risks of material misstatement		**vs 2016/17**
Recurring risks	Valuation of Land and Buildings	◀▶
	Recognition of NHS and non NHS income and receivables	◀▶

2. Key audit matters: our assessment of risks of material misstatement

Key audit matters are those matters that, in our professional judgment, were of most significance in the audit of the financial statements and include the most significant assessed risks of material misstatement (whether or not due to fraud) identified by us, including those which had the greatest effect on: the overall audit strategy; the allocation of resources in the audit; and directing the efforts of the engagement team.

We summarise below the key audit matters (unchanged from 2016/2017), in decreasing order of audit significance, in arriving at our audit opinion above, together with our key audit procedures to address those matters and our findings from those procedures in order that the Trust's governors as a body may better understand the process by which we arrived at our audit opinion. These matters were addressed , and our results are based on procedures undertaken, in the context of, and solely for the purpose of, our audit of the financial statements as a whole, and in forming our opinion thereon , and consequently are incidental to that opinion, and we do not provide a separate opinion on these matters.

	The risk	Our response
Valuation of land and buildings (£111.007 million; 2017: (£97.247 million) *Refer to page 51 (Audit Committee Report), page 211 (accounting policy) and page 234 (financial disclosures).*	**Subjective Valuation** Land and buildings are initially recognised at cost. Non-specialised property assets in operational use are subsequently recognised at current value in existing use (EUV). Specialised assets(such as hospitals) where a market value is not readily ascertainable, are subsequently recognised at the depreciated replacement cost of a modern equivalent asset that has the same service potential as the existing property (DRC). There is significant judgement involved in determining the appropriate basis for each asset (EUV or DRC) according to the degree of specialisation or the assets, as well as over the assumptions made in arriving at the valuation. When considering the cost to build a replacement asset the Trust may consider whether the asset would be built to the same specification or in the same location. Valuation is completed by an external expert engaged by the Trust, using construction indices. Therefore accurate records of the current estate are required. Full valuations are completed every five years, with interim desktop valuations completed in interim periods. In 2017/18, the valuer undertook a desktop revaluation of the Trust's land and buildings at the 31 March 2018 resulting in a £11.2 million increase in the value of the land and buildings. Valuations are inherently judgmental, therefore our work focused on whether the valuer's methodology, assumptions and underlying data, are appropriate and correctly applied.	Our procedures included: — **Assessing valuer's credentials:** We assessed the expertise of the valuer, who performed the valuation for the Trust. We reviewed the instructions provided to the valuer and assessed their independence and objectivity to the terms under which they were engaged by management; — **Methodology choice:** We assessed whether the underlying approach and methodology used in preparing the desktop valuation was appropriate and permissible within The Department of Health and Social Care Group Accounting Manual 2017/18 (GAM); — **Benchmarking assumptions:** We assessed other assumptions in the valuation, such as the BCIS (Build Cost Information Service) Index and location factors by compared the factors used to those applied across the NHS; — **Tests of details:** • We agreed the valuations provided by the valuer as a result of the desktop valuation to entries recorded within the Fixed Asset Register; • We considered the directors' assessment of any need for an impairment across its asset base either due to loss of value or reduction in future benefits that would be achieved; and; • We considered the accuracy of the data provided to the valuer and undertook testing to ensure both its completeness and accuracy, including reviewing changes in floor area measurements. Our findings: We found the resulting valuation of land and buildings to be balanced.

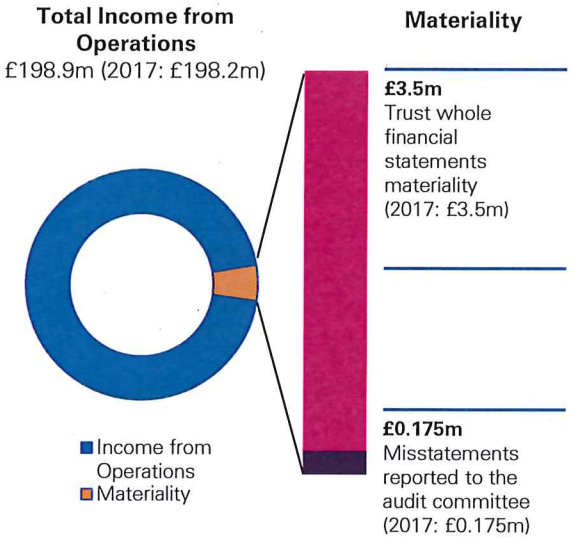
	The risk	Our response
NHS and non-NHS income Income: (£198.907 million; 2016/17: £198.193 million) *Refer to page 52 (Audit Committee Report), page 209 (accounting policy) and page 226 (financial disclosures).*	**Subjective estimate** Of the Trust's reported total income, £157.328 million (2016/17, £157.729 million) came from Clinical Commissioning Groups (CCG) and NHS England. The remaining was sourced from local authorities and other counterparties and carried a greater risk in terms of pricing and recoverability. In 2017/18 the Trust has received transformation funding from NHS Improvement. This is received subject to achieving defined financial and operational targets on a quarterly basis. The Trust was allocated £4.243 million of transformation funding. The Trust participates in the national Agreement of Balances (AoB) exercise for the purpose of ensuring that intra-NHS balances are eliminated on the consolidation of the Department of Health's resource accounts. The AoB exercise identifies mismatches between receivable and payable balances recognised by the Trust and its commissioners, which will be resolved after the date of the approval of these financial statements. For these financial statements the Trust identifies the specific cause, and accounts for the expected future resolution of each individual difference. The Trust reported total income of £12.171 million (2016/17: £10.551 million) from other activities, primarily education and training and research and development.	Our procedures included: — **Tests of details:** • Within the listing of contracts held by the Trust, we agreed for the five largest commissioners of Trust activity that signed contracts were in place. We investigated contract variations and reconciled accounting entries to the original contract; • We assessed the outcome of the agreement of balances exercise with CCGs and other NHS providers. Where there were any mismatches we sought explanations for variances greater than £300,000. We observed whether the Trust is in formal dispute in relation to any material income balances and examined the supporting correspondence; • We performed testing of a sample of income received before and after 31st March 2018 to support the completeness assertion over income balances recorded in the financial statements and confirming that income has been recorded in the correct accounting period; and; • We tested material other income balances by agreeing a sample of income transactions through to supporting documentation. This included the transformation funding. Our findings: We found the resulting estimates of NHS and non-NHS income to be balanced.

3. Our application of materiality

Materiality for the Trust financial statements as a whole was set at £3.5 million (2016/17: £3.5 million), determined with reference to a benchmark of operating income (of which it represents approximately 2%, 2016/17 2%). We consider operating income to be more stable than a surplus- or deficit-related benchmark.

We agreed to report to the Audit Committee any corrected and uncorrected identified misstatements exceeding £0.175 million (2016/17:(£0.175 million), in addition to other identified misstatements that warranted reporting on qualitative grounds.

Our audit of the Trust was undertaken to the materiality level specified above and was largely performed at the Trust's headquarters in Kettering.



4. We have nothing to report on going concern

We are required to report to you if we have concluded that the use of the going concern basis of accounting is inappropriate or there is an undisclosed material uncertainty that may cast significant doubt over the use of that basis for a period of at least twelve months from the date of approval of the financial statements. We have nothing to report in these respects.

5. We have nothing to report on the other information in the Annual Report

The directors are responsible for the other information presented in the Annual Report together with the financial statements. Our opinion on the financial statements does not cover the other information and, accordingly, we do not express an audit opinion or, except as explicitly stated below, any form of assurance conclusion thereon.

Our responsibility is to read the other information and, in doing so, consider whether, based on our financial statements audit work, the information therein is materially misstated or inconsistent with the financial statements or our audit knowledge. Based solely on that work we have not identified material misstatements in the other information.

In our opinion the other information included in the Annual Report for the financial year is consistent with the financial statements

Remuneration report

In our opinion the part of the remuneration report to be audited has been properly prepared in accordance with the NHS Foundation Trust Annual Reporting Manual 2017/18.

Corporate governance disclosures

We are required to report to you if:

— we have identified material inconsistencies between the knowledge we acquired during our financial statements audit and the directors' statement that they consider that the annual report and financial statements taken as a whole is fair, balanced and understandable and provides the information necessary for stakeholders to assess the Trust's position and performance, business model and strategy; or

— the section of the annual report describing the work of the Audit Committee does not appropriately address matters communicated by us to the Audit Committee; or

— the Annual Governance Statement does not reflect the disclosure requirements set out in the NHS Foundation Trust Annual Reporting Manual 2017/18, is misleading or is not consistent with our knowledge of the Trust and other information of which we are aware from our audit of the financial statements.

We have nothing to report in these respects.

6. Respective responsibilities

Accounting Officer's responsibilities

As explained more fully in the statement set out on page 198, the Accounting Officer is responsible for the preparation of financial statements that give a true and fair view. They are also responsible for: such internal control as they determine is necessary to enable the preparation of financial statements that are free from material misstatement, whether due to fraud or error; 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

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 our opinion in an auditor's report. Reasonable assurance is a high level of assurance, but does not 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 aggregate, they could reasonably be expected to influence the economic decisions of users taken on the basis of the financial statements.

A fuller description of our responsibilities is provided on the FRC's website at www.frc.org.uk/auditorsresponsibilities

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REPORT ON OTHER LEGAL AND REGULATORY MATTERS

We have nothing to report on the statutory reporting matters

We are required by Schedule 2 to the Code of Audit Practice issued by the Comptroller and Auditor General ('the Code of Audit Practice') to report to you if:

— any reports to the regulator have been made under Schedule 10(6) of the National Health Service Act 2006.

— any matters have been reported in the public interest under Schedule 10(3) of the National Health Service Act 2006 in the course of, or at the end of the audit.

We have nothing to report in these respects.

We have nothing to report in respect of our work on the Trust's arrangements for securing economy, efficiency and effectiveness in the use of resources

Under the Code of Audit Practice we are required to report to you if the Trust has not made proper arrangement for securing economy, efficiency and effectiveness in the use of resources.

We have nothing to report in this respect.

Respective responsibilities in respect of our review of arrangements for securing economy, efficiency and effectiveness in the use of resources

The Trust is responsible for putting in place proper arrangements for securing economy, efficiency and effectiveness in the use of resources

Under Section 62(1) and Schedule 10 paragraph 1(d), of the National Health Service Act 2006 we have a duty to satisfy ourselves that the Trust has made proper arrangements for securing economy, efficiency and effectiveness in the 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 the use of resources are operating effectively.

We have undertaken our review in accordance with the Code of Audit Practice, having regard to the specified criterion issued by the Comptroller and Auditor General (C&AG) in November 2017, as to whether the Trust had proper arrangements to ensure it took properly informed decisions and deployed resources to achieve planned and sustainable outcomes for taxpayers and local people. We planned our work in accordance with the Code of Audit Practice and related guidance. Based on our risk assessment, we undertook such work as we considered necessary.

Report on our review of the adequacy of arrangements for securing economy, efficiency and effectiveness in the use of resources

We are required by guidance issued by the C&AG under Paragraph 9 of Schedule 6 to the Local Audit and Accountability Act 2014 to report on how our work addressed any identified significant risks to our conclusion on the adequacy of the Trust's arrangements for securing economy, efficiency and effectiveness in the use of resources. The 'risk' in this case is the risk that we could come to an incorrect conclusion in respect of the Trust's arrangements, rather than the risk of the arrangements themselves being inadequate.

We carry out a risk assessment to determine the nature and extent of further work that may be required. Our risk assessment includes consideration of the significance of business and operational risks facing the Trust, insofar as they relate to 'proper arrangements'. This includes sector and organisation level risks and draws on relevant cost and performance information as appropriate, as well as the results of reviews by inspectorates, review agencies and other relevant bodies.

The significant risks identified during our risk assessment are set out overleaf together with the findings from the work we carried out on each area.

Significant Risk	Description	Work carried out and judgements
Working with partners and other third parties	**Governance arrangements over partnership working** The Trust is involved in partnership working and continues to develop and expand its deliver of services in this manner. The Trust has a subsidiary, 3Sixty Care Ltd formed with partners over the 3Sixty Care GP Federation. Secondly, the Trust set up a Community Interest Company (First for Wellbeing) in 2016/17. The risk is that there are inadequate governance arrangements in place to cover these partnership agreements.	Our work included: **Governance and reporting arrangements:** We reviewed the current governance arrangements in place and the reporting structure to the Board. We reviewed the training mechanism in place to ensure key members of staff involved in partnerships are aware of their governance responsibilities. We reviewed the governance framework over the STP in light of the reset of this plan which was undertaken during the year. **Our findings on this risk area:** We consider the arrangements in place to be adequate.
Sustainable resource deployment	**Financial sustainability and CIPs** The Trust faced significant challenges relating to the achievement of its cost improvement program (CIP) in 2017/18 and faces continuing financial pressures in 2018/19. We therefore carried out work to consider the adequacy of the Trusts arrangements for planning its finances effectively to support the sustainable delivery of strategic priorities and the maintenance of its statutory functions. As at 31 March 2018, the Trust has met its CIP target of £7.0m, with a new target of £7m to meet in 2018/19.	Our work included: - **Cost Improvement Plans**: We reviewed the Trust's CIP schemes and the split between recurrent and non recurrent achievement. - **Underlying Surplus/Deficit:** We looked at the underlying financial position of the Trust to understand the impact of recurrent and non-recurrent measures on the Trust's outturn. - **Financial Sustainability:** We reviewed the 2018/19 financial plan and the assumptions on which it is based to ascertain how challenging the future CIPs will be. **Our findings on this risk area:** We consider the arrangements in place to be adequate.

THE PURPOSE OF OUR AUDIT WORK AND TO WHOM WE OWE OUR RESPONSIBILITIES

This report is made solely to the Council of Governors of the Trust, as a body, in accordance with Schedule 10 of the National Health Service Act 2006 and the terms of our engagement by the Trust. Our audit work has been undertaken so that we might state to the Council of Governors of the Trust, as a body, those matters we are required to state to them in an auditor's report, and the further matters we are required to state to them in accordance with the terms agreed with the Trust, and for no other purpose. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the Council of Governors of the Trust, as a body, for our audit work, for this report, or for the opinions we have formed.

CERTIFICATE OF COMPLETION OF THE AUDIT

We certify that we have completed the audit of the accounts of Northamptonshire Healthcare NHS Foundation Trust in accordance with the requirements of Schedule 10 of the National Health Service Act 2006 and the Code of Audit Practice issued by the National Audit Office.

Andrew Bostock for and on behalf of KPMG LLP
Chartered Accountants and Statutory Auditor
One Snowhill
Snowhill Queensway
Birmingham
B4 6GH

23 May 2018

KPMG

Now you can follow our progress, find out more about our services, read reports from our meetings, keep up-to-date on our news and send us your comments and views.

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