UNIVERSITY OF LEICESTER
Affiliated Teaching Hospital

NHS
Kettering General Hospital
NHS Foundation Trust

Annual Report and Accounts 2017/18

Kettering General Hospital NHS Foundation Trust

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

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1 Statement from the Chairman, Alan Burns

I was delighted to be appointed as Chair of Kettering General Hospital in September 2017 and, while joining the Trust at a very challenging time, I have always believed that KGH has the potential to become an outstanding hospital.

I hope that through the pages of this report the journey of sustainable improvement in both quality and operational performance is evident. The energy and enthusiasm of our staff in delivering real change whilst retaining a well-earned reputation for being a caring organisation is something I am especially proud of. Over this past year I have worked hard not only in supporting and driving improvement within the Trust but also across the wider health and care economy.

It is very clear to me that if KGH is to truly succeed we have to work much more closely in partnership with our commissioners and other providers across the county. KGH recognises the key role it plays in local partnerships in transforming healthcare services and performance to ensure affordable quality healthcare for the populations we serve. I am particularly pleased to reflect on the strengthened relationships that have resulted and the system wide approach to addressing issues of demand and capacity that have impacted upon the Trust's performance over the past year and for which we must be better prepared.

In November 2017 the Trust was inspected by the CQC across urgent and emergency care, surgery, maternity, children and young peoples' services, outpatient and diagnostic imaging. Following this inspection the Trust received an overall rating of "requires improvement" – which the board and myself felt was a fair reflection of the hard work undertaken across the organisation since being rated "inadequate" the previous year. It is clear that effort must continue, embedding changes that have been made, learning from areas of good and outstanding practice (both within and outside the Trust) and ensuring that we continue to improve to earn a reputation with local people and our regulators as a quality service provider.

During the year the composition of the leadership team has changed – with the departure of our Chairman, Graham Foster and three non-executive directors, John Hawksfield, Stephen Ramsden (who was also Vice Chair) and Alan Ball and of Fiona Wise as Interim Chief Executive who left in February. My thanks to each of those named, and in particular, to Fiona for her unfailing commitment to driving forwards improvement. My non-executive team has been joined by Professor Christopher Welsh who brings a wealth of experience.

And so we face the year ahead with a new Chief Executive, Simon Weldon, who joins the Trust from the national team in NHS England. He brings a strong focus on system working, quality and performance. I am extremely excited about the potential that exists within KGH that Simon wants to unlock.

There remain many challenges ahead; I am committed to ensuring that the additional support the Trust currently receives as a consequence of being in Special Measures helps to transform the

Trust into a high performing organisation. I strongly believe that through its greatest resource, its staff, that KGH is capable of great things.

ALAN BURNS
CHAIRMAN

31st March 2018

2 Performance Report

2.1 Overview of performance

Purpose of the overview

The purpose of this section of the report is to provide a summary of the clinical, quality and financial performance of the Trust for 2017/18. It gives a summary of the organisation, its purpose, key risks and performance over the year. Detailed information that supports this summary is included throughout the document and is referenced as appropriate. It opens with a statement from our Chief Executive.

Chief Executive's Statement

On behalf of the Board, I'd like to welcome you to this annual report on the Trust's performance in the year from 1st April 2017 to 31st March 2018. I was delighted to be appointed as Kettering's Chief Executive. It is my firm belief that Kettering has the potential to be an excellent organisation; although I have only recently joined the Trust, I have already seen many examples of excellence in the services provided here. We need to build on these. I have also seen a real focus on patient safety, and we need to demonstrate that focus across the whole Trust as we continue our journey out of special measures. Finally, no hospital exists as an island state in today's NHS, I have seen the willingness of our staff to work in partnership across Northamptonshire; I will support this.

Performance

I am pleased to report that the year has again seen ongoing improvements in overall performance. We ended the year with strong performance on all cancer standards, having significantly improved our referral to treatment position and having maintained and delivered strong performance on hospital infections. There are, however, some challenging performance areas, particularly with respect to the national A&E performance standard. Demand for services has continued to be high, particularly in the winter period, and there has been a keen national debate as to how services should respond. Locally, system leaders have come together to learn the lessons from last winter and to jointly plan the capacity that is needed in the year ahead. This joint work reflects the developing and strengthening relationships across the system.

Our performance against cancer targets remains good and most measures of clinical quality, safety and mortality were maintained, and in some cases, improved, despite the pressures being felt day in, day out in a very busy hospital.

Finance

The Trust ended the financial year 2017/18 with a deficit of £34.7m (£33.6m excluding the impact of non-performance technical adjustments – impairments, donated asset movements and loss on disposal of assets). This marked an underachievement against the £19.9m deficit plan.

This year has been challenging financially, in particular the impact of winter and the loss of theatres and endoscopy suites (due to delays in refurbishment) which have impacted on day case and elective income. The reactive nature of winter escalation and delays in estates work means the organisation could not deploy these resources elsewhere. The Trust has also seen a number of unplanned impacts on its income position through the HRG 4+ impact on Non Elective and a reduction in critical care activity.

Despite the challenging environment the Trust delivered £14.2m (6.2%) CIPs and a number of corporate recovery actions to contain the deficit.

For 2018-2019, the Board has again set a financial plan with the aim of being challenging but achievable. After a detailed financial planning process, the Board has agreed a plan for the year of £15.3m deficit (excluding PSF funding). The efficiency saving required in 18/19 is £14.5m, which at 6.6% is at the upper end of what is regarded as deliverable in the NHS.

The year ahead

Among our key challenges in the year ahead I will be focusing on with the Board, I would highlight:

- The challenge of taking the Trust out of special measures: while the CQC have recognised the improvements we have made in their most recent inspection, there is more to do. Central to the work we need to do is embedding the culture of patient safety in everything we do as a Trust.
- We need to secure support for our capital development which would deliver an Urgent Care Hub on the site. The initial design would include an emergency department on the ground floor with a short-stay assessment and treatment area on the floor above. The proposal includes a single front door for all adult self-presenting patients, allowing effective and prompt triage and treatment; there will be a separate primary care zone where all appropriate patients can be streamed from the traditional emergency department into GP led primary care treatment; a dedicated paediatric entrance, waiting area and treatment and observation areas and dedicated diagnostic suite including an x-ray and CT that will be at the centre of the floor and easily accessible to any patient.
- We need to deliver our operational plan for 2018/19. We expect to conclude final discussions on this by the end of June. We will face a challenging set of asks both operationally and financially, but I see a willingness from partners across the system to support us in delivery.
- We need to continue to work in a collaborative and integrated way with our partners.

Over the course of the year, we have continued to work hard as a team, both within the organisation and with our local and national partners, and we've continued to deliver well in a difficult environment for the NHS. My congratulations and thanks to all of my colleagues for their hard work in delivering for patients and the community through the year.

Purpose and activities of the Foundation Trust

Business model and environment

Kettering General Hospital NHS Foundation Trust is a not-for-profit, public benefit corporation forming part of the wider NHS and providing health care services. We provide and develop healthcare according to core NHS principles of free care, based on need and not ability to pay.

We are accountable to our local communities through our Members and Governors; our commissioners through contracts; Parliament (in that we lay our annual report and accounts before Parliament); the Care Quality Commission (through the legal requirement to register and meet the associated standards for the quality of care we provide); and NHS Improvement through the NHS Provider Licence.

NHS Improvement's role as the sector regulator of health services in England is to protect and promote the interests of patients by providing services which are effective, efficient and economical and which maintain or improve their quality of care.

Organisational structure

Anyone who lives in the trust-wide geographical area or works for our Foundation Trust can become a Member. Members elect our Council of Governors, who appoint the Chairman and Non-Executive Directors as well as approve the appointment of our Chief Executive. The Council of Governors is responsible for holding the Non-Executive Directors to account for their performance in the Board, and for representing the views of Members to inform decision making.

The Non-Executive Directors together with the Chief Executive appoint the Executive Directors and, together, they form the Board of Directors. The Board as a whole is responsible for decision making for the Foundation Trust. Executive Directors each have a portfolio of responsibilities.

The Trust has recently been reorganised into four clinical Divisions, each with a Lead (a clinician), a Head of Nursing and a Divisional Director. Divisions are also responsible for the delivery of clinical services, and are organised as follow:

- Medicine: including Urgent and Emergency Care and acute medicine
- Surgery: including all types of surgery and critical care
- Family Health: including maternity, children's services, outpatients and diagnostics
- Corporate: including end of life care.

Please note, though, that for the period of these accounts, the previous structure of Clinical Business Units each led by a Business Unit Director and General Manager was in place.

Objectives

In 2017/18 we confirmed and maintained our four strategic aims from 2016.17:

- Provide high quality care to individuals, communities and the populations we serve
- Be a strong and effective partner in the wider health and social care community
- Maintain a fulfilling and developmental working environment for our staff
- Be a clinically and financially sustainable organisation

To be a clinically and financially sustainable organisation in the future, the Trust recognises that the other three strategic aims are all fundamental aims to achieve, and the annual operational objectives give key steps to enable progress against these aims.

Local partner collaboration

Set against a backdrop of an aging population nationally; local population growth in the county higher than the national average; increasing demand for healthcare; tighter national financial constraints; and national workforce shortages in certain specialties of healthcare, the Trust needs to work even more closely with partners if it is to find innovative ways of meeting these challenges.

Recognising that no hospital is an island, throughout 2017/18, Kettering Hospital continued to work with Northampton General Hospital to build closer alignment of secondary care activity delivery in Northamptonshire. The aim of such work is to improve the care we deliver to our patients through:

- Reducing clinical variation
- Improving outcomes and safety standards
- Delivering best practice pathways
- Ensuring equity of access to high quality care for all patients

Clinicians are working across the two acute providers, and with partners in community and primary care to improve patient pathways and ensure care is delivered in the most suitable setting as close to their homes as possible. Progress has been made during the year on orthopaedic and cardiology pathways. This will continue in 2018/19 and beyond as we seek to build a strong secondary care sector for the county.

Strategies

The organisational vision was agreed by Board in 2016. It provides an all-encompassing picture of what Kettering General Hospital is aspiring to:.

‘To provide safe high quality CARE to our communities’

The CARE values continue to permeate everything we do at work. They represent our culture, and the behaviours and responsibility staff should always be exhibiting to our patients and to our colleagues. Our values are:

Compassionate Accountable Respectful Engaging.

The values have been further embedded throughout the organisation and are a common theme in staff appraisal paperwork, training sessions and publications. Monthly staff awards during 2017/18 centre on individuals who have shown excellence with respect to our values.

The diagram below links our values, strategic objectives and operational aims:

Northamptonshire Sustainability and Transformation Plan

In July 2017 a national assessment ranked the degree of progress of Sustainability and Transformation Partnerships (STPs) and their associated plans ranked Northamptonshire system in the lowest category. A change in leadership of during 2017 led the STP to refresh the original programmes of work to align with the four national operational priorities set out in the Next Steps for the Five Year Forward View. All local health and social care organisations are newly committed to focusing efforts and resource to addressing our local challenges and improvement plans in these four key areas[1].

Our principle efforts relate to the A&E performance and cancer services programmes, but there is recognition that we also have a role to play in assisting with the successful delivery of GP and mental health services. Strong primary and community services that work effectively to meet the needs of our local population have a positive effect on how patients use the acute sector. This inevitably impacts on how successful we can be in delivering improvements in A&E performance and cancer services. Senior managers and clinical staff from the organisation are actively engaged in all work streams and continue to ensure that any changes are in the best interests of patients, and support the strategic objectives of the Trust.

[1] The four areas are: improving A&E performance, strengthening access to high quality GP services, improvements to Cancer Services, and improvements to Mental Health

Service developments

Bowel Screening Service 10th anniversary and expansion

During the reporting year the Trust celebrated 10 years of providing life-saving bowel screening for local people. The Trust went live with its first bowel screening patient in December 2007 when it became screening centre for the Leicestershire, Northamptonshire and Rutland area as part of a national scheme to introduce bowel cancer screening across the country. Since starting the programme it has screened 9,151 patients, found 796 cancers, 3,095 polyps and 1,635 patients have been managed under a polyp surveillance programme. The Trust now has four endoscopy consultants, two other Bowel Scope consultants and seven Specialist Screening Practitioners who deliver the screening service. The Trust plans to increase Bowel Scope lists in 2018 from seven lists a week to ten and to enable it to expand the service fully across the county. This will also include a close working relationship with Northampton General Hospital.

Antibiotic App for Staff Mobile Phones

In March 2018 the Trust launched an antibiotic App for mobile phones which will help ensure patients get the right treatments quickly. The App is used by doctors and nurses to swiftly check exactly which antibiotics to prescribe, in what dose and in what way – for example in tablet form, IV, or liquid. It also gives staff the most up to date national and local guidance to help tackle bacteria that are becoming resistant to antibiotics. This is especially important locally as patterns of antibiotic resistance in the Trust area are known, meaning it is important to use the right kind of antibiotics to ensure effectiveness. During Antibiotics Awareness Week November 13-19, 2017, the Trust also did extensive public awareness work on the importance of using antibiotics correctly.

Pressure Tissue Damage Awareness

The Trust has held various initiatives to increase staff awareness of pressure tissue damage during the reporting year. Teams of ‘Pressure Heroes’ swooped on our wards and had a stand in main reception during World Wide Pressure Injury Prevention Day, November 16, 2017. These were members of Trust staff who had volunteered to become pressure tissue damage champions.

Trust’s first Head and Neck Cancer Nurse Specialist

During the reporting year the Trust took on its first head and neck cancer nurse specialist to support patients with cancers of the mouth, throat and thyroid. Hayley Steptoe has worked at Trust for the last 14 years in a variety of roles including staff nurse and sister. She took on the new role in June 2017, to strengthen the hospital’s support for patients with head and neck cancers. She had also been working closely with patients in the run-up to the new role being designed and formalised. Each year there are about 100 new patients with head and neck cancers diagnosed at Kettering General Hospital. In addition, there are dozens of patients with re-occurrences of cancer and hundreds having routine follow-up checks.

End Pyjamas Paralysis Campaign

During the reporting year the Trust launched a campaign to encourage certain patients to wear day clothes rather than pyjamas. The campaign, End Pyjamas Paralysis, was designed to help appropriate patients to stay active and mobile while in hospital and prevent the deconditioning that can result from long stays in hospital where people spend a lot of time inactive and in bed. The campaign was launched on Lamport and Twywell Wards in July 2017.

"Listen to Me" initiative in Maternity

An initiative to improve communications with mothers-to-be in our maternity unit has reduced complaints and boosted teamwork. The Trust's Lead Midwife, Mara Tonks, introduced her 'Listen To Me' campaign in response to a successful pilot study that was undertaken a KGH with support from the national Atain workgroup in collaboration with NHS improvement. The Atain workgroup found nationally that women and their birthing partners did not always feel listened to and were not necessarily given choices regarding their care during labour. The national findings were also mirrored by local findings where women who raised a complaint following their delivery sometimes felt that they weren't being listened to, or they raised concerns during their care but felt they were not taken seriously. The Trust's campaign made it easier for women to raise concerns with their midwife at the point of care and ensure that all women felt that they have been listened to and had been given choice. The success of the campaign has led other maternity units in other parts of the country to take it on and it was showcased at an NHS Improvement Conference.

History of the Foundation Trust and statutory background

The Trust is a medium sized hospital that provides general acute services to the population of North Northamptonshire. It has been a Foundation Trust since 2008 and in the following period has continued to develop as an acute provider of care. It is the only acute provider (but not the only provider) Foundation Trust currently in Northamptonshire.

Services are funded primarily through contracts with Corby and Nene Clinical Commissioning Groups, NHS England Specialised Commissioners and other CCGs and Public Health bodies.

The hospital sits within a health economy that faces a system wide financial deficit, which is expected to grow over the next five years unless collaborative action is taken. This has led to the local health economy being subject to a number of external reviews.

This is why it is necessary to ensure alignment of the Trust strategy and operational plans with the local STP, described above.

Key issues and risks

The Board recognises that the delivery of the objectives that it has set for the Trust can be affected by a range of issues. There is a policy and process in place that enables the Trust, through the Board, its Committees and management, to identify risk, set out and measure mitigating actions and manage risk, and identify potential impact where a risk eventuates.

The Board maintains a Board Assurance Framework (BAF) which sets out the strategic risks that the Board has identified as affecting the achievement of the strategic objectives. During the year, the BAF was reviewed, and updated.

For 2017/2018, the key strategic risks identified by the Board were:

1. The challenges in the recruitment and retention of sufficient staff with the skills and experience to ensure that services are delivered in a safe way and providing a good patient experience
2. Ensuring that the Trust is able to deliver the agreed financial plan (including the challenging efficiency plans)

3. Ensuring that there are effective partnership arrangements for the Trust's work with partners at the local and regional health economy levels, which will deliver the anticipated benefits from the integrated provision of services by the partners

Risks, and the Trust approach to risk management, are discussed in more detail in the governance report and annual governance statement.

Going concern disclosure

International Accounting Standard 1 requires the Board to assess, as part of the accounts preparation process, the Trust's ability to continue as a going concern. In the context of non-trading entities in the public sector the anticipated continuation of the provision of a service in the future is normally sufficient evidence of going concern. The financial statements should be prepared on a going concern basis unless there are plans for, or no realistic alternative other than, the dissolution of the Trust without the transfer of its services to another entity within the public sector.

In preparing the financial statements the Board of Directors have considered the Trust's overall financial position against the requirements of IAS1.

The Trust has recorded operating deficits of £4.2 million in 2014/15, £10.3 million in 2015/16, £22.7 million in 2016/17 and £32.0 million in 2017/18. Consequently, the Trust has received financial support, in the form of loans from the DHSC, the outstanding balance as at 31 March 2018 is £119.4 million. The Trust plans to incur a £7.8 million financial deficit in 2018/19 and anticipates it may be some time before it can achieve financial balance on a sustainable basis. It requires additional loans of £34.8 million in 2018/19 from this it is expecting to repay £12.1 million revenue loan and £3m capital loans. This working capital loan support has not, as at the date of these accounts, been confirmed.

The Board of Directors has carefully considered the principle of “Going Concern” and the Directors have concluded that there are material uncertainties related to the financial sustainability (profitability and liquidity) of the Trust.

Although these factors represent material uncertainties that may cast significant doubt about the Trust’s ability to continue as a going concern, the Directors, having made appropriate enquiries, still have reasonable expectations that the Trust will have adequate resources to continue in operational existence for the foreseeable future. As directed by the 2017/18 Department of Health Group Accounting Manual the Directors have prepared the financial statements on a going concern basis as they consider that the services currently provided by the Trust will continue to be provided in the foreseeable future. On this basis, the Trust has adopted the going concern basis for preparing the financial statements and has not included the adjustments that would result if it was unable to continue as a going concern.

The Trust has agreed contracts with its local commissioners for 2018/19 and services are being commissioned in the same manner as in previous years and there are no discontinued operations. Similarly, no decision has been made to transfer services or significantly amend the structure of the organisation at this time. The Board of Directors also has a reasonable expectation that the Trust will have access to adequate resources in the form of financial support from the DHSC to continue to deliver the full range of mandatory services for the foreseeable future. During the year to 31 March 2018 the Trust received an Interim Revenue Loan of £28.9 million. Further interim funding is

available in 2018/19 and the Trust plans to draw an additional £26.1 million in revenue support and £8.0 million to support strategic capital developments.

The Directors consider that this provides sufficient evidence that the Trust will continue as a going concern for the foreseeable future. The Trust has received significant support in the recent past, has made no decision to request dissolution from the Secretary of State and has no reason to believe that support will not be provided.

2.2 Performance analysis

Measuring performance

The Trust measures and monitors its performance on a frequent basis and compares this both with prior performance and national benchmarks. Key Performance Indicators (KPIs) are defined through the Board, its Committees and the Divisions. These are monitored on periodically, dependent on the KPI.

An Integrated Governance Report which incorporates a core set of KPIs is reviewed by the Board on a monthly basis. This allows for the identification of KPIs not on target, or not on a recovery trajectory, and the associated risks and mitigating actions.

Operational performance

The Trust has a duty to achieve a series of national targets. An overview of our performance against all of the mandatory national targets during 2017-18 is provided in the table below:

Targets 2017-18	Target/ Plan	Q1	Q2	Q3	Q4
Clostridium difficile year on year reduction – national target 26 for the year (Cumulative)	Max of 26	9	14	19	21
31 day wait for second or subsequent treatment – cancer surgery	94%	100%	100%	100%	100%
31 day wait for second or subsequent treatment – anti cancer drug treatments	98%	100%	100%	100%	100%
Maximum wait of 31 days from diagnosis to treatment for all cancers	96%	100%	99.4%	99.7%	98.9%
62 day wait for first treatment from urgent GP referral to treatment: all cancers	85%	89.0%	85.3%	85.6%	89.3%
62 day wait for first treatment from consultant screening	90%	94.7%	93.1%	94.9%	96.3%

Targets 2017-18	Target/ Plan	Q1	Q2	Q3	Q4
service referral: all cancers					
Referral to treatment waiting times – Incomplete	95%	76.0%	80.6%	79.6%	79.2%
Maximum waiting time of 4 hours in A&E from arrival to admission, transfer or discharge	95%	86.3%	85.7%	82.0%	83.1%
Maximum waiting time of 2 weeks from urgent GP referral to first outpatient appointment for all urgent suspect cancer referrals	93%	96.6%	97.4%	98.4%	95.9%
Two week wait from referral to date first seen – symptomatic breast patients	93%	93.8%	98.2%	99.0%	99.1%
Governance rating					

The demand for Trust services during the last three years is summarised in the table below:

Area	2015-16	2016-17	2017-18	Change
Inpatients	36,176	40,016	39,914	0.3% reduction
Outpients	243,213	254,590	274,649	7.9% increase
Day Case	36,950	41,224	37,895	8.1% reduction
Accident & Emergency	82,986	87,505	87,497	-

The quality report contains more detailed performance against our quality standards.

Performance analysis

The Trust performed well across a range of operational performance standards during 2017/18, achieving national standards for our cancer patients across the year. This achievement is particularly noteworthy in the context of the last winter. We also performed well against access to diagnostic targets.

However, the Trust has not delivered against Referral to Treatment Time (RTT) targets and the maximum waiting of four hours in A&E targets. Despite the disappointing RTT performance there has been significant improvement in reducing the number of patients waiting over 52 weeks for planned treatment; in April 2018 the number of patients waiting over 52 weeks was zero.

Our non-elective demand in 2017/18 has been at a consistent level to that of the previous year. The Trust has seen very high peak levels of A&E attendances, and significant demands for its beds by elderly medical patients with more complex needs and this has increased the lengths of stay in hospital. This has impacted upon our capacity to treat elective patients, alongside a national directive to reduce elective activity to aid the urgent (non elective) care bed pressures over the winter months. Elective activity has also been affected due to a planned theatre refurbishment and has impacted our ability to deliver the RTT target. Work is now in hand to finish the refurbishment which will support the Trust delivering its elective activity plan this year.

Throughout 2017/18 many patients have presented with chronic long-term conditions and complex care needs which have led to longer lengths of stay, delayed transfers of care (DTOCs) and greater demand on out-of-hospital care support. This has impacted upon the number of DTOCs to our partner organisations; although the overall number of delays reduced, our reliance on partner organisations continues to be critical.

We have continued to challenge our own practice and procedures to review how patients are admitted and discharged in the hospital. National evidence suggests that people typically experience increased numbers of long-term problems as they get older (sometimes called multi-mobidity). With an ageing population, this continues to pose a significant challenge in Northamptonshire.

The Trust has responded to the emergency care pressures in 2017/18 through the opening of additional escalation beds to maintain patient safety, with this impacting upon staffing and the Trust finances and during the latter part of the year we have started to implement a new process within our hospital to assist in addressing our emergency pressures.

Referral to Treatment Time (RTT)

Throughout 2017/18 the Trust has continued to work on reducing its backlog of patients waiting for treatment. We reduced the number of long wait patients (those waiting over 52 weeks) from 319 in April 2017 to three in March 2018. Most recent data, from April 2018, indicate that the Trust has now reduced this number to zero.

Urgent & Emergency Care

The Trust did not achieve the four-hour standard in 2017/18. This overall target does mask some progress, for example the Trust's average wait for initial assessment during 2017-18 was five minutes; our average wait to treatment is 74 minutes; and the average time a patient spent in our A&E department was 3 hours 24 minutes.

The Trust continues to work hard on improving managing patient flow to ensure we move patients out of A&E into an appropriate bed or discharge them home within four hours. The Trust's performance for the A&E transit time is routinely measured on a quarterly basis, as shown in the table below:

	% within 4 hours (Kettering General)			% within 4 hours (health system)		
	Total attendances	Breaches of Standard	% within 4 hours	Total attendances	Breaches of Standard	% within 4 hours
Apr - Jun	22,113	3,035	86.3%	22,113	3,035	86.3%
Jul - Sep	22,022	3,159	85.7%	22,022	3,159	85.7%
Oct - Dec	21,827	5,075	76.7%	28,367	5,116	82.0%
Jan - Mar	21,535	6,718	68.8%	39,868	6,748	83.1%

Source: Data Source: Monthly UNIFY SiTREP Returns

Overall year performance for 2017/18 was 83.9% which meant the Trust failed the 2017/18 A&E transit time target.

Cancer Waiting times

The Trust continues to perform well against all cancer waiting times standards in 2017/18, with all seven applicable cancer targets being achieved every quarter throughout the year. Significant improvements have been made to waiting times for first outpatient attendances. The Trust continues to work on ensuring patient pathways are effective and enable high quality care to be provided in a timely manner.

Financial performance

Review of Financial Performance

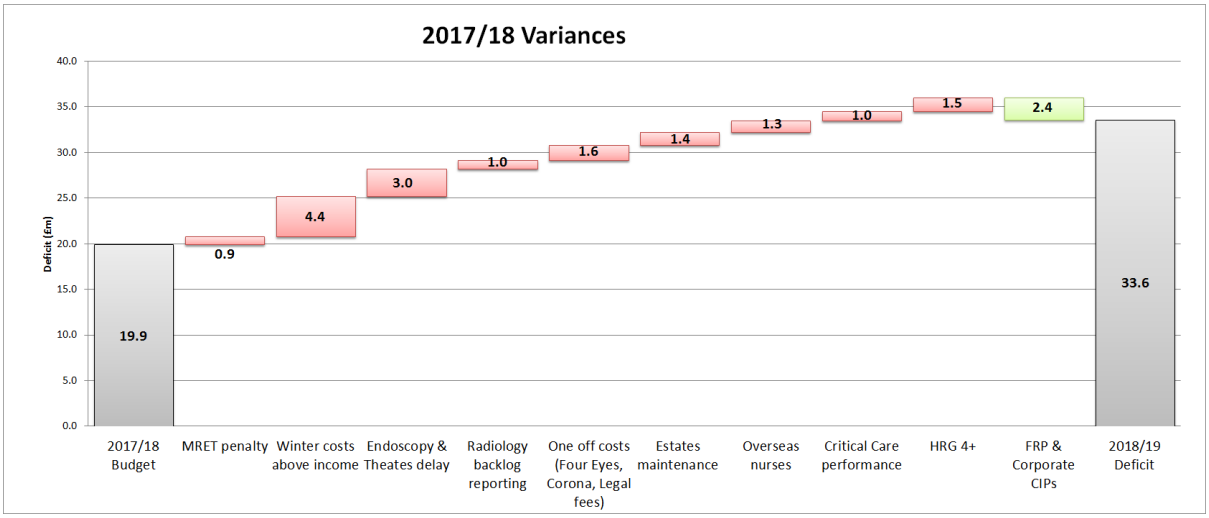
The Trust ended the financial year 2017/18 with a deficit of £34.7m (£33.6m after excluding the impact of non-performance technical adjustments – impairments, donated asset movements and loss on disposal of assets). The financial plan agreed with the regulator was a total deficit of £19.9m. This excluded Sustainability and Transformation funding as the Trust rejected its Control Total.

Description	Year to Date				
	Plan	M10 reforecast	Actual	Variance to Plan	Variance to re-forecast
	£ '000	£ '000	£ '000	£ '000	£ '000
NHS Clinical Income	224,178	217,361	215,180	(8,998)	(2,181)
Other Operating Income	13,946	14,496	15,129	1,183	633
Income	**238,124**	**231,858**	**230,309**	**(7,815)**	**(1,548)**
Contracted Pay (inc bank)	(158,073)	(158,646)	(159,847)	(1,774)	(1,201)
Agency Staff	(14,231)	(12,980)	(13,234)	997	(253)
Pay	**(172,303)**	**(171,626)**	**(173,080)**	**(777)**	**(1,454)**
Non-Pay (inc Depreciation)	**(82,435)**	**(87,514)**	**(88,460)**	**(6,025)**	**(946)**
Fixed Asset Impairments	-	-	**(807)**	**(807)**	**(807)**
OPERATING DEFICIT	**(16,614)**	**(27,283)**	**(32,038)**	**(15,424)**	**(4,756)**
Non Operating Expenditure	(3,329)	(2,665)	(2,643)	686	22
I&E Surplus/ (Deficit)	**(19,943)**	**(29,948)**	**(34,681)**	**(14,738)**	**(4,733)**
Adjustments to financial performance	400	310	1,117	717	807
NHSI Adjusted Surplus / (Deficit)	**(19,543)**	**(29,638)**	**(33,564)**	**(14,021)**	**(3,926)**

The table below compares this year against last year as shown below:

	2016/17	2017/18
Actual income and Expenditure Deficit	(25.6)	(34.7)
Less:		
Impairments/ reversals	0.6	0.8
Donated assets movements	0.2	0.3
Loss on disposal of assets	0.2	0.0
Regulatory surplus / (deficit)	**(24.6)**	**(33.6)**
Non Recurrent items	3.8	10.7
Underlying surplus / (deficit)	**(20.8)**	**(22.9)**

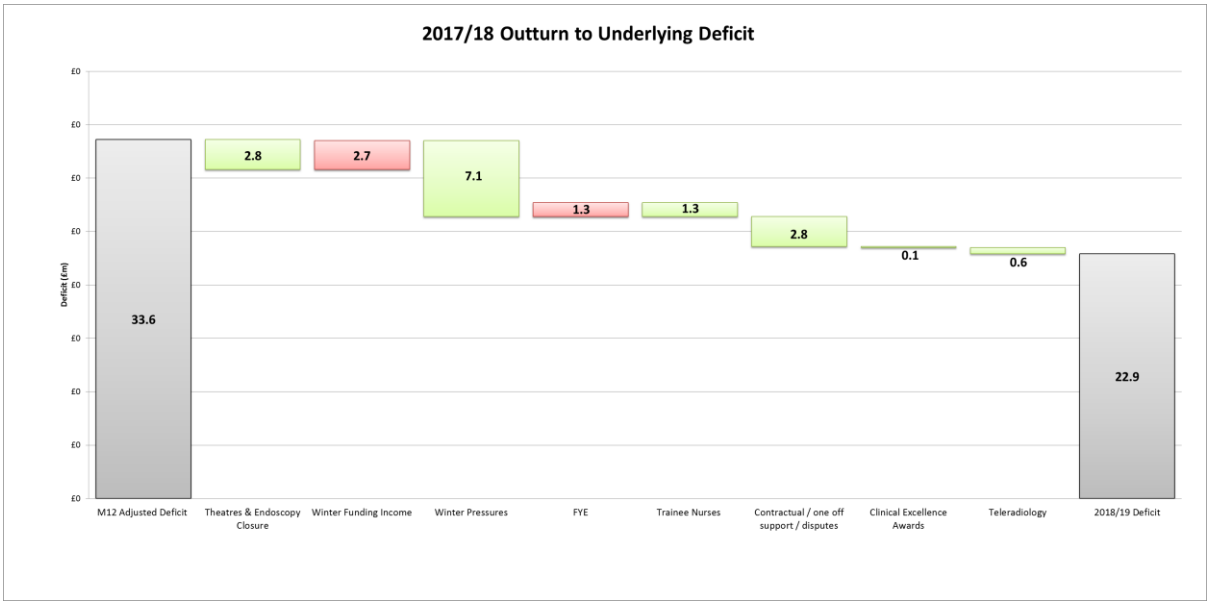
The normalised deficit after removing non-recurrent items was £22.9m compared to £20.8m in 2016/17. The drivers behind the deterioration from plan are both non-recurrent and recurrent and are shown in the chart below:



£11.2m of the variances are income related and largely driven by delays in capital estates work and bed occupancy levels over 99% that impact on the Trusts ability to realise day case and elective income. The reactive nature of winter escalation and delays in estates work means the organisation cannot deploy resource elsewhere. The Trust has also seen a number of unplanned impacts on its income position through the HRG 4+ impact on non-elective and a reduction in critical care activity.

Despite the challenging environment the Trust delivered £14.2m (6.2%) CIPs and a number of corporate recovery actions to reduce the deficit. The Trust did not plan to open escalation areas but due to capacity constraints opened them in December and occupied these areas into April 2018. This comes at a premium cost and in total winter cost were £7.1m with £2.7m of additional national funding bridging some of the gap.

Within the 2017/18 financial position are a number of non-recurrent items as set out in the chart below:



The Trust spent £15.0m on the 2017/18 capital programme. The capital programme was allocated to address estates infrastructure risks, health and safety issues, critical equipment, IT infrastructure and cyber security and modernisation regimes required to comply with latest NHS standards or legislation.

Regulatory Financial Performance

As a Foundation Trust, the Trust is required to demonstrate that it is operating within NHS Improvement's Risk Assessment Framework with four measures, known as Continuity of Service Risk Ratings (CoSRRs). The four metrics are:

- Liquidity ratio – this ratio indicates whether the provider can meet its operational cash obligations, i.e. is its liquidity a concern (expressed in days of liquid assets); and
- Capital servicing capacity ratio – this ratio indicates whether the provider can meet its financing obligations, i.e. is it ability to service debt or other financing obligations a concern.
- Underlying performance (I&E Margin) – a measure of the deficit compared to the total income of the Trust
- Agency staffing – the proportion of agency staffing costs compared to total ceiling given by NHS Improvement.

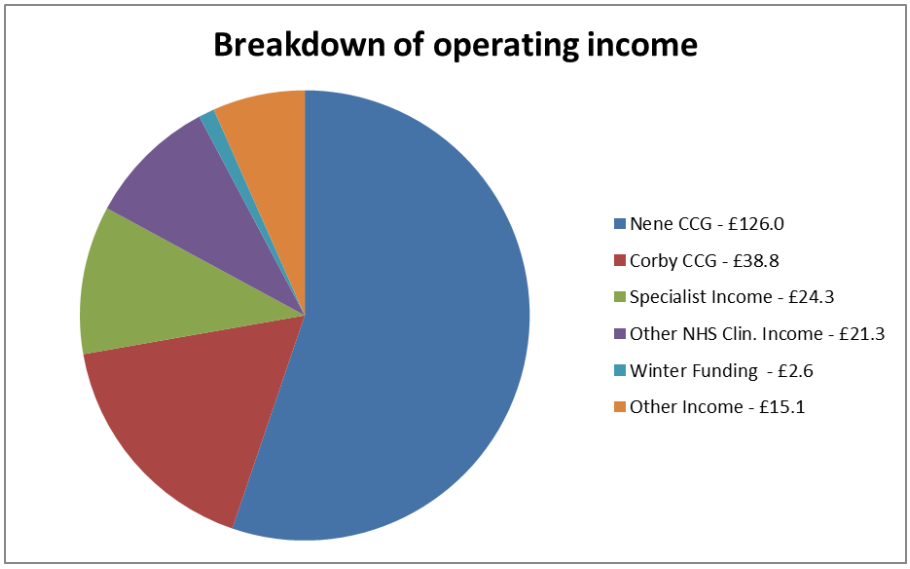
The performance against the ratings is shown below:

Risk Rating	2017/18			2016/17
	Plan	Actual	Variance to Plan	Actual
Capital service cover rating	4	4	-	4
Liquidity rating	4	4	-	4
I&E margin rating	4	4	-	4
I&E margin: distance from financial plan		4		4
Agency rating	2	2	-	4
Risk rating after overrides		**4**		**4**

Trust Income

NHS Clinical Income for the year was £213.0m which is 93.4% of the total operating income for the Trust. This represented a reduction on 2016/17 of £2.4m (1.1% decrease). Compared to 2016/17 non-elective activity reduced by 1.3%, however income was 9.1% higher. Emergency activity was 0.6% lower with an 11.4% increase in income.

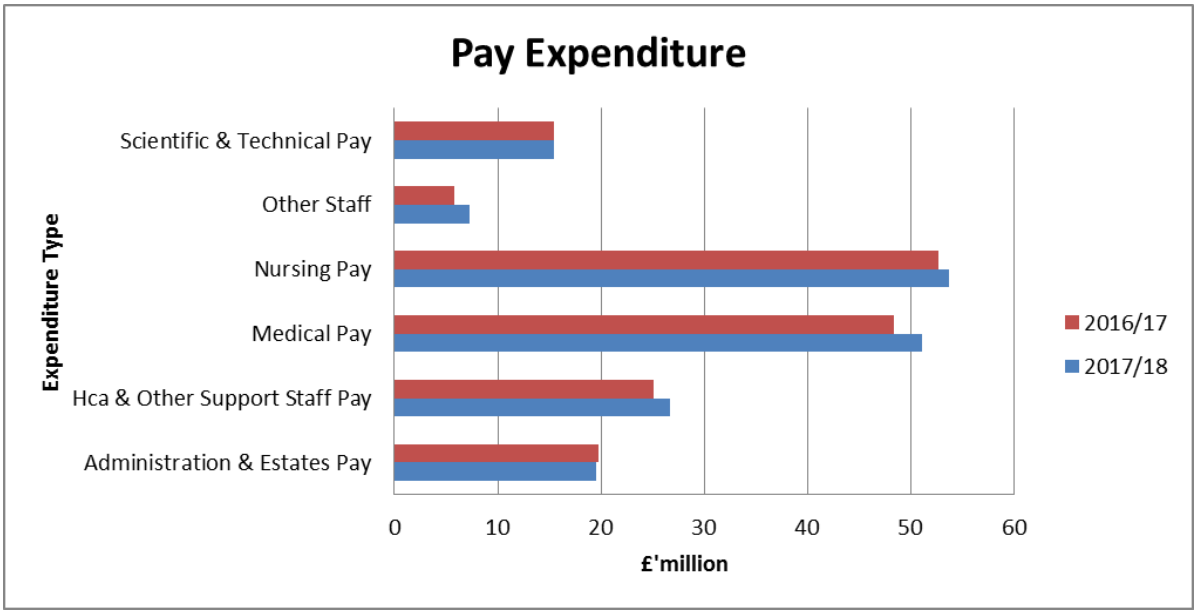
77% of the Trust's clinical income was received from Nene CCG and Corby CCG. The chart below summarises the different sources of income:



Within the 'other income' figure of £15.1m is £7.6m received from Health Education England to provide teaching for undergraduate medical students and to provide further training for post-graduate doctors as well as training for other clinical staff.

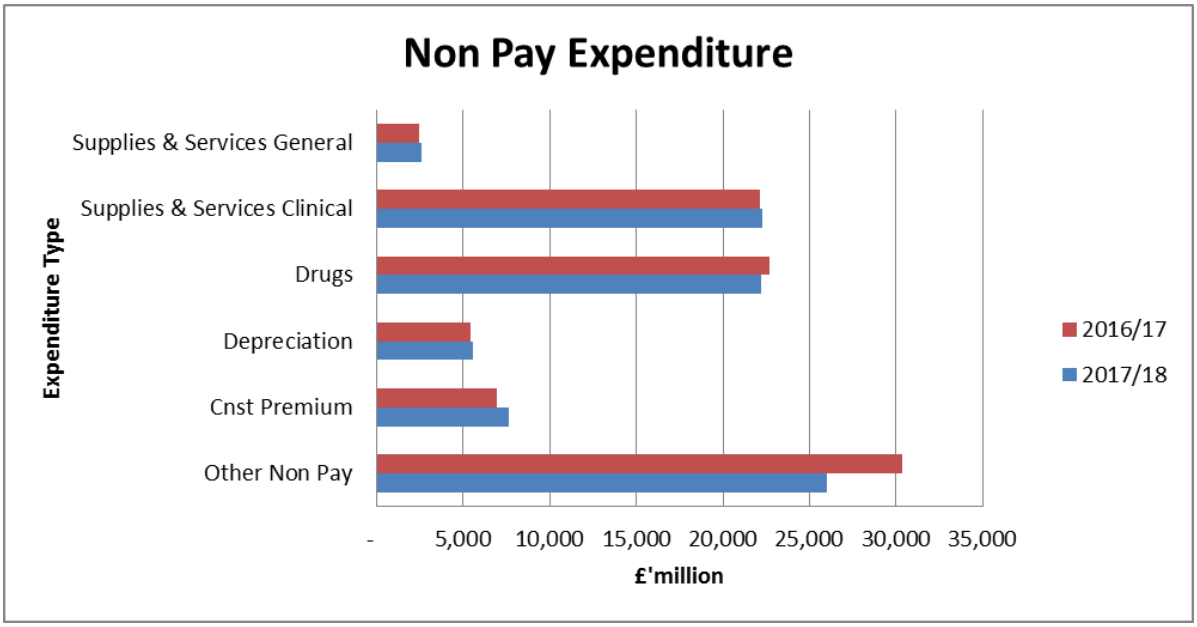
Trust Expenditure

Pay costs represent 68.2% of total operating expenditure (excluding depreciation). Contracted staff pay has increased by £12.6m (9%) and agency pay costs decreased by £6.7m (34% reduction).



Non-pay spend has decreased since 2016/17 by 4%. This reduction is mainly due to a £2.6m bad debt provision in 2016/17, reduction in external consultancy of £1.6m (mainly Four Eyes and Cymbio). However, the Trust has seen areas of increased spend since 2016/17:

- CNST premium has increased by 10% since 2016/17 (£0.7m).
- Other Non-Pay - Services received 30% increases since 2016/17, Bank Partners, continued tele-radiology & CT Scanner over spends, NGH Maternity invoices and Claremont.



Delivering value for money

The implied efficiency within the national tariff for 2017/18 was 0.1%. To ensure the Trust can continue to invest in its services and meet cost pressures the Trust set a QIPP target for productivity and efficiency of £15.6m for the financial year, representing 6.5% of planned turnover. As at the end of the year the Trust delivered £14.2m of efficiencies.

The Department of Health released the 2016/17 Reference Costs Index (RCI) for each NHS provider. Kettering General Hospital scored 1.03 on this index which is 3% above national average.

Cash flow and Capital

The Trust had a cash balance of £2.8m at the end of the year. The Trust received £11.9m capital funding from the Department of Health, and interim revenue loans of £28.9m.

The Trust capital expenditure for the year is £15.0m. This is significantly more than the internally generated resources. The scale of the programme in 2017/18 reflected the need to resolve underlying capacity and compliance issues as well as some site developments. The major areas being:

- 5th Endoscopy Suite (£2.8m)
- Theatre Refurbishment (£1.5m)
- CT Scanner (£0.9m)
- Car Park Deck (£1.4m)
- Medical Equipment (£4.3m)

- IT hardware and IT software (£2.0m)

Accounting policies

NHS Improvement has directed that the financial statements of NHS foundation trusts shall meet the accounting requirements of the Department of Health General Annual Reporting Manual for Accounts agreed with HM Treasury. Consequently, the financial statements have been prepared in accordance with the 2017/18 General Annual Reporting Manual issued by NHS Improvement.

The accounting policies contained in that manual follow International Financial Reporting Standards to the extent that they are meaningful and appropriate to NHS foundation trusts, as determined by HM Treasury, which is advised by the Financial Reporting Advisory Board. The accounting policies have been applied consistently in dealing with items considered material in relation to the accounts.

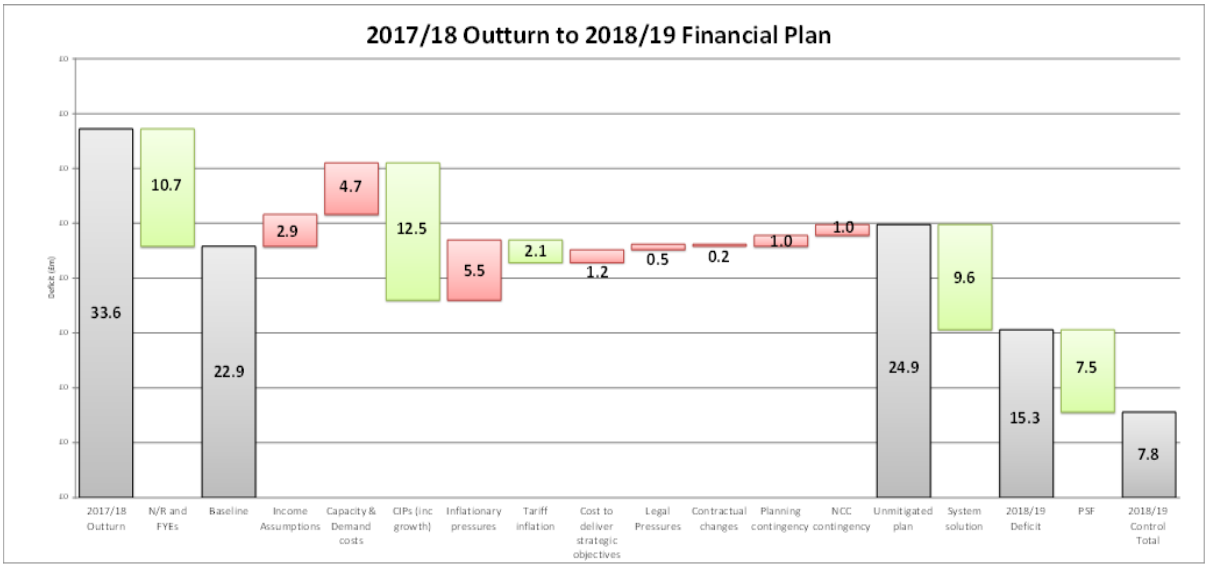
The Trust undertook an interim revaluation of the Trust estate in March 2017/18. The valuation led to a net impairment charge to expenditure of £0.8m.

The Trust applies standard payment policy terms of 30 days to suppliers of the Trust (see better payment policy section below). So far as the directors are aware, there is no relevant information of which the auditors are unaware. In addition, the Foundation Trust has complied with the cost allocation and charging requirements set out in HM Treasury and Office of Public Sector Information guidance.

Trust Outlook

The Trust is planning a deficit of £15.3m in 2018/19. This results in achievement of the NHS Improvement Control Total with the associated £7.5m of PSF funding. The deficit including PSF income is £7.8m.

In 2018/19 the Trust will seek to deliver £14.5m of savings through cost reduction and improved productivity (£12.5m net of £2m delivery cost). However, the deficit plan of £15.3m (excluding PSF) has an assumption of system led solutions of £9.6m, this is currently assessed as a risk to delivery of the plan. Discussions with system partners to close the gap are on-going. Below is a bridge detailing the move from 2017/18 outturn position of £33.6m to plan of £7.8m:



Below is the I&E plan for 2018/19:

2018/19 Financial Plan	£'000
Operating income from patient care activities	236,751
Other operating income	20,928
Employee expenses	(174,963)
Operating expenses excluding employee expenses	(86,921)
OPERATING DEFICIT	**(4,205)**
Non Operating expenditure	(3,596)
I&E Surplus / (Deficit)	**(7,801)**

2.3 Environmental matters

The Trust is committed to the sustainability agenda and is aware of our corporate social responsibility. We have developed a sustainable development plan in response to the NHS Carbon Reduction Strategy, which will build on the work carried out in our Carbon Management Plan and was developed in partnership with the Carbon Trust.

We recognise the impact that the Trusts operations have on the environment, as well as the strong link between sustainability and the health of the public. We are committed to deliver significant improvements with the help of all our staff, patients, visitors and other stakeholders.

The Trust has implemented:

- A food digester that enables the catering department to divert over 100 tonnes of food waste per year from landfill by evaporation and converting any residue into a flock that can be used as fuel
- Fully segregated recycling in office areas, converting them to be Zero Landfill in partnership with our waste management contractor
- Issuing staff with water bottles and coffee cups to encourage the use of reusable instead of a disposable bottles and cups.

In the period 2017/18 the Trust has prepared a Carbon Management Plan in support of the organisations sustainability agenda. The plan seeks to map out a strategy for reducing energy consumption and, in turn, reducing carbon emissions. Baselines have been determined for the present consumption of utilities; these will be used to benchmark the performance proposed changes and likely impact in improving the performance of the estate. The plan will include a strategy to identify:

- Easy wins
- Medium-term objectives
- Longer-term objectives (linked to the development of the estate)

Already, the introduction of simple measures to improve the effective management of utilities has seen a 3.2% reduction in carbon emissions against the base year 2014/15 against the backdrop of increasing demand on clinical services.

The strategy will address the following areas:

- Effective building environmental controls
- Energy efficient lighting schemes
- Sitewide heating strategy

To delivery this strategy the trust will investigate a variety of delivery options to include:

- Self-financing spend to save initiatives
- SALIX interest free loans
- Carbon Energy Fund

In the future, the Trust will seek to achieve BREEAM excellent rating for all new estate developments. This will help meet our environmental and sustainability targets. This means the developments enhance the well-being of the people who live and work in them and help protect natural resources.

2.4 Social, community, anti-bribery, and human rights

As a significant organisation in the local economy, the Trust recognises that it will have an impact on the local communities that it serves. In particular, as the main provider of secondary healthcare in the area, we are both a significant employer and contract with local suppliers for goods and services.

The Trust has adopted policies related to procurement that recognise that there may be advantages to locally-sourcing some products or services. Our policy, consistent with that of Government, is to ensure that local providers, and particularly small and medium-sized enterprises in the locality, obtain a fair opportunity to bid to provide goods or services when required by the Trust. Details of opportunities to bid are available on the national contracting service web-sites. All procurement exercises are undertaken in accordance with the Trust's local control systems, and also the Public Contract Regulations 2015 where they apply.

The Trust has adopted control systems, through the Standing Financial Instructions and other arrangements, to actively seek to prevent fraud, bribery and corrupt payments. A Local Counter-Fraud service is maintained to support the Trust in this area, and actively investigates allegations. During the year there have been a number of investigations, which have in appropriate cases resulted in both disciplinary and external action.

We are committed to applying the highest standards of ethical conduct and integrity and to delivering the highest standards of patient care, this means being focused on safeguarding the funds needed for this.

Anti-bribery policy

Bribery is defined within the Bribery Act 2010 as the giving or receiving of a financial or other advantage in exchange for improperly performing a relevant function or activity. Under no circumstances is the giving, offering, receiving or soliciting of a bribe acceptable. We do not tolerate this in any form. This applies to all staff, volunteers and Non-Executives, together with any external agents working or acting on our behalf.

Our zero-tolerance approach to bribery, and commitment to the Bribery Act 2010, is set out in further detail within the Counter Fraud and Anti-Bribery Policy, and across a range of other Trust

policies and procedural documentation. All staff and volunteers, Non-Executives and other relevant parties are responsible for familiarising themselves with the requirements of this and for complying with these at all times.

NHS Protect has responsibility for all policy and operational matters relating to the prevention, detection and investigation of fraud, bribery and corruption in the NHS. Any investigations will be handled in accordance with NHS Protect guidance.

We do not do business with any external parties that does not support our anti-bribery commitments. We reserve the right to terminate any contracts where there is evidence of acts of bribery have been committed.

2.5 Compliance with the Modern Slavery Act 2015

The Trust is understood not to be formally subject to the reporting provisions set out in Part 6 of the Modern Slavery Act 2015, as it is not a 'commercial organisation' as defined in the Act. However, the Board has decided that it will give an overview as if these responsibilities applied to the Trust.

As part of the National Health Service, the majority of the supplies used by the Trust are obtained through the NHS supply chain arrangements, which operate nationally and provide support to all NHS providers. The NHS supply chain arrangements include arrangements to ensure that supplies provided to the NHS can be reasonably assured not to have involved slavery or human trafficking; and the Trust relies of these arrangements as its assurance for supplies obtained through the NHS supply chain.

For supplies obtained outside of the NHS supply chain arrangements, the Trust's procurement arrangements include undertakings by suppliers that the goods have been obtained in a manner compliant with the Modern Slavery Act, and that the appropriate checks have been undertaken for the earlier parts of the supply chain. The Trust retains a right of inspection if a query is raised as to the provenance of any goods supplied.

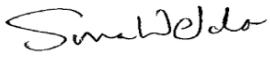
The Trust is also aware of the potential for certain operations, such as building works undertaken on site, to involve offences under the Act. We require contractors to provide proof that the individuals working on site are lawfully able to be present in the UK and to work, are paid and taxed according to law, and otherwise meet the requirements in place to comply with the Modern Slavery Act. These requirements are also imposed on any sub-contractors down the chain for works being undertaken on site.

2.6 Significant events post 1 April 2018

There have been no significant events since 1 April 2018 affecting the Trust’s strategy and key objectives.

2.7 Overseas operations

The Trust did not have any overseas operations during the period.



SIMON WELDON
CHIEF EXECUTIVE

25th MAY 2018

3 Accountability Report

3.1 Directors' Report

During the course of the year, the following have served as Directors of the Trust:

Non-Executive Directors	Executive Directors
Alan Burns – **Chairman**	Simon Weldon – **Chief Executive***
Phil Harris-Bridge – **Vice Chair / Senior Independent Director**	Rebecca Brown**
Janet Gray	Andrew Chilton
Lizzie Hanna	Leanne Hackshall
Trevor Shipman	Nicola Briggs
Graham Foster (until September 2017)	Mark Smith
Alan Ball until (until March 2018)	Fiona Wise (Chief Executive, until March 2018)
John Hawksfield (until June 2017)	
Stephen Ramsden (until December 2017)	

Notes: * Simon Weldon joined as Chief Executive in April 2018, but is included here for completeness
** Rebecca Brown operated in the role of Acting Chief Executive from March-April 2018

Directors' and Governors' Interests

The NHS introduced new national requirements and expectations for the management of potential conflicts of interest during the year, with the aim to have a consistent approach across the service as a whole. This has led to a considerable increase in the range of interests expected to be declared. Directors also remain subject to the statutory requirements set out in S151(2) of the Health and Social Care Act 2012.

Information on the interests of the Directors, and those in other groups identified in the national policy, is available online. This information is available at all times, proactively published and updated in real-time. Individuals are also able to directly update their entries when required. The register of interests can be accessed at: http://www.kgh.nhs.uk/about-us/trust-management/ .

Governors are outside of the scope of the new national policy, and the rules for the management of their interests are set out in the Standing Orders of the Council. Details of their declarations are available from the Trust Secretary.

Cost allocation and charging

Throughout the year ended 31st March 2018, and at all subsequent times until the approval of this annual report by the Board, the Trust has been compliant with the guidance on cost allocation and charging that has been issued for the NHS by Her Majesty's Treasury.

Political donations

No political donations were made during the period. Any donations made would be recorded in the register of interests.

Better payment policy

The Trust applies standard payment policy terms of 30 days to suppliers of the Trust. Detail of the Trust's performance in 2017/18 is shown below and we achieved 90.2% versus the 95% target for number of trade invoices paid within target.

	2017/18 Number	2017/18 £'000	2016/17 Number	2016/17 £'000
Total Non- NHS trade invoices paid in the year	61,008	87,690	59,753	98,581
Total Non- NHS trade invoices paid within target	54,996	77,933	56,280	88,135
Percentage of Non-NHS trade invoices paid witin target	**90.15%**	**88.87%**	**94.19%**	**89.40%**
Total NHS trade invoices paid in the year	2,041	8,560	2,226	7,039
Total NHS trade invoices paid within target	1,646	6,589	1,859	5,913
Percentage of NHS trade invoices paid witin target	**80.65%**	**76.98%**	**83.51%**	**84.00%**

There have been no payments of interest under the Later Payment of Commercial Debts Act 1998.

NHS Improvement's 'well-led' framework

The Trust is subject to regulatory action by the CQC and was placed in special measures in April 2017 after a CQC inspection took place in October 2016. This found that the Trust needed to make urgent improvements in a number of areas to ensure it was consistently delivering care which was safe, effective, caring, and responsive to people's needs in services that are well-led.

Following reinspection in October 2017 the CQC noted progress and that a number of improvements had been delivered. The report published in March 2017 rated us 'requires improvement' overall. We recognise that there is more to do, and the progress made over the past year provides a strong foundation on which to strengthen and continue to improve our performance.

The Trust's overall approach to governance, and compliance and reporting against NHS Improvements well-led framework and code of governance is contained in the governance report, below, and the annual governance statements. Further information on our approach to ensuring that services are well-led is also contained in the quality report. There are no inconsistencies between these reports.

Our operational performance and progress against our quality improvement programme is reported to NHS Improvement through our monthly performance review meetings. During these meetings we also provide updates on financial, operational and staffing performance as well as clinical governance, strategies and partnership working.

The Trust endeavours to achieve continual improvement by encouraging patients and relatives to express concerns if they are dissatisfied with the service they have received. We investigate complaints in an open and honest way and with a willingness to learn and make service improvements where indicated. More detailed information on our complaints policy is contained in the quality report.

Patient care

The Trust has had a Quality Strategy in place since 2014 which has complete engagement and commitment from the Board and the wider organisation. The core of the Quality Strategy is an "I Will" Patient Safety Campaign with ambitious targets for reduction in avoidable harm and clear KPI's set for a period of two years and achievement is monitored monthly from ward to board.

The established Quality Assurance Framework aligns with the CQC fundamental standards and is integrated with the Trust risk management processes. It is the organisations intention to deliver the KPI's set out for 2017/18. The quality strategy enables the Trust to adhere to the principles of 'responsible consultants, informed patients'. Responsible consultants and named nurses provide, coordinate, navigate and communicate the care journey. During 2017/18 the Trust aims to take steps to strengthen and standardise practice and further embed the critical role of Key Nurse throughout all areas of the organisation.

Reporting of quality improvement and outcomes is undertaken in the following ways:

1. On a monthly basis a quality dashboard is used to monitor patient experience and outcomes. This is used in a range of forums and at the Clinical Business Unit performance review meetings
2. A trust-wide dashboard is presented to the Integrated Governance Committee, a Board Sub-Committee Chaired by a Non-Executive Director
3. Nurse Sensitive Indicators enable teams to capture and report on compliance against fundamental aspects of nursing and midwifery practice. A monthly audit, aligned with the Safety Thermometer is undertaken with findings incorporated into the quality assurance framework. The audit data is displayed on ward boards to facilitate open discussion with staff and the public. The current processes are developing into an 'I Will' ward accreditation to more formally recognise areas of best practice. Mock inspections are used to apply external scrutiny to compliance and to award accreditation in the future.
4. Communication regarding compliance with practice standards is enhanced by the use of 'Comms Cells'. In this the Ward Matron uses the available dashboard data to highlight areas of best practice and those requiring improvement. This facilitates greater ownership through knowledge and empowerment to act. This demonstrates that the organisation has embedded the use of quality data to underpin improvement. An example dashboard is displayed opposite.
5. The Trust works closely with Healthwatch Northampton who conduct 15 Steps Audits in the Trust throughout the year to provide an independent perspective of patient care and the environment in which is it delivered, and the results are included in the quarterly governance reports

Further information on quality governance is contained in the quality report. In addition, service developments continue to be made and are referenced in the performance report.

Stakeholder relations

Our collaborative working across the local health economy is described in the strategic objectives described in the performance report. This seeks to improve the care that patients receive across Northamptonshire. The performance report also describes the local STP, the primary route to system alignment.

Where required, the Trust support the activities of the Health Overview and Scrutiny Committee of Northamptonshire County Council.

Information on fees and charges

Information on fees and charges, and relevant declarations, are included in the annual accounts.

Director's disclosure to the Trust Auditors

The Directors, individually and collectively, acknowledge their responsibility for the accuracy and reliability of the contents of this Annual Report. Each individual who is a Director of the Trust at the date of the approval of this Report confirms that:

- So far as each Director is aware, there is no relevant audit information which the Auditor is unaware of
- Each Director has taken all steps that they should have taken as a Director, in order to (a) make themselves aware of any relevant audit information, and (b) establish that the Auditor was also aware of the information.

Income disclosures required by Section 43(2A) of the NHS Act 2006

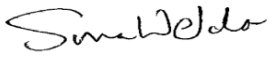
For 2017/18 income from the provision of goods and services for the purposes of the health service in England was greater than income from the provision of goods and services for any other purposes. Income from other sources has supported the provision and development of health services.

Information and disclosures related to the income from the provision of goods and services are included in the annual accounts. See note 2 for a breakdown on income sources.

Director's responsibility for the Annual Report and Accounts

The Directors acknowledge that they are responsible for the accuracy and reliability of the contents of the Annual Report, the Quality Report and the Annual Accounts for the year ended 31st March 2018. The Board has been supported by its Committees in the preparation of these documents, and by the Internal Audit service and the external auditors; however, the responsibility for the contents of the documents remains with the Directors themselves.

Having carefully reviewed the contents of the documents and taking into account the advice of the Audit Committee and the Quality and Governance Committee, the Directors consider that taken as a whole the Annual Report and Accounts are fair, balanced, and understandable; and provides the information necessary for patients, regulators and other stakeholders to be able to assess the Trust's performance, business model and strategy.



SIMON WELDON
CHIEF EXECUTIVE

25th MAY 2018

3.2 Remuneration report

Annual statement on remuneration

Major decisions on Senior Managers' remuneration

The Remuneration committee met three times over the course of the year. More detail on these meetings is contained in the annual remuneration report, below.

During the year, the following major decisions have arisen for the Committee-

- Arrangements for the appointment of a new Chief Executive Officer
- Reviewing the remuneration of the Executive team, aligned to benchmarking information from NHS providers.
- Arrangements to provide for appropriate cover for Director of Integrated Governance until a permanent appointment could be made

Substantial changes made to Senior Managers' remuneration

During the course of the year there were no substantial changes made to the remuneration of Senior Managers'. During the year no Director received more than £150,000 in remuneration. In respect of the Medical Director, the Committee has had regard to the level of remuneration that would be payable for a full-time Consultant of equivalent experience, recognising that the Medical Director also has additional responsibilities as a Director.

Statement for the Chair of the Remuneration Committee

Please note that the Chair of the Remuneration Committee changed during 2017/18, with one Chair (Graham Foster) for two meetings and another for the third (Alan Burns). For the purpose of declaring that the major decisions are a true and fair reflection of the matters discussed, this is confirmed by Mark Smith, Director of HR, who supported all meetings.

Senior Managers' remuneration policy

For the purpose of the accounts and remuneration report, the Chief Executive has agreed the definition of a "senior manager" to be Directors only.

The Trust does not have performance-related salaries and the terms and conditions of contracts for its senior managers are subject to the normal terms and conditions of other NHS staff. The Directors are not entitled to receive any benefit under share options or money and assets under long term incentive schemes. In addition no advances, credits or guarantees have been made on behalf of any of the Directors.

Policy on remunerating Executive Directors

The Trust recognises that, in order to ensure that the Trust is led by Executive Directors with the skills, capacity and leadership required to provide an outstanding service to the public of the Kettering area, it must adopt a remuneration policy that will attract and retain individuals with the necessary skills and personality. Equally, as an organisation funded by the public purse, it recognises that it must not pay excess amounts for the services of its Executive Directors, as this would not meet the requirement to be economic, efficient and effective.

At appointment, a Director is placed at the appropriate salary as determined by the Nomination & Remuneration Committee, having considered previous experience. Any request for a review of salary is presented to the Committee and is not automatic or linked to length of service but is a true reflection of performance in the role as assessed through an effective appraisal system. For Directors, other than the Chief Executive, the Chief Executive provides the Committee with a report on each Director summarising the achievement of specific objectives within the wider frame of the performance for the whole organisation.

The salary component for Executives supports the short- and long-term strategic objectives of the Trust as it assists the Trust in attracting and retaining senior managers who have the necessary skills and experience to lead the Trust and take forward the identified objectives.

Salaries are paid through the normal payroll processes and there is no specified maximum on the level of remuneration which could be paid but account would be taken of available benchmarking information and the relationship with the salaries available to other staff.

Pension arrangements for the Chief Executive and all Executive Directors are in accordance with the NHS Pension Scheme.

Executive Directors remuneration does not feature a performance-related variable element. This therefore does not form a part of the total remuneration for Senior Managers'. Full details of remuneration are provided in the Annual Remuneration Report, below.

Policy on remunerating Non Executive Directors

The current policy of the Council of Governors is to pay a Non-Executive Directors a reasonable fee for the services provided in office, having regard to the overall position of fees in the NHS and also that this is a public service position. The Non-Executive Directors are not retained on an employed basis and are not eligible for secondary benefits such as pension provision in relation to their office.

Details of Non-Executive remuneration is provided in the annual remuneration report, below.

Service contract obligations

Service contracts are explained in the annual remuneration report, below.

Policy of payment on loss of office

The Trust's approach to setting the notice period for Directors is that, unless specific circumstances indicate otherwise, a period of six months' notice on each side. In line with relevant legislation and the Code of Governance, the notice period will only be shortened with the agreement of the Nomination and Remuneration Committee and following a risk assessment.

The Trust provides contractual arrangements related to redundancy payments in appropriate circumstances. Where ill-health arises that means that an Executive Director cannot continue in office, they can also benefit from the statutory arrangements for ill-health retirement under the national pension scheme arrangements, managed by the NHS Business Services authority.

Statement of consideration of employment conditions elsewhere in the foundation trust

In setting the remuneration of Executive Directors, the Nomination and Remuneration Committee takes into account a number of factors, including the national settlements in respect of other

employees in the Trust. These are largely identified through the Agenda for Change and medical contract arrangements, negotiated between NHS Employers and the staff trade unions. For the 2017-2018 year, these arrangements gave staff (in general) a 1% increase in salary levels.

In setting remuneration for Executive Directors, the Nomination and Remuneration Committee has had regard to comparative information, including the information available through NHS Providers, in order to meet the twin goals of providing sufficient remuneration to recruit and retain Executive Directors with sufficient knowledge and experience to lead the Trust, whilst not paying more than is required having regard to the duty to be economic, efficient and effective. The Trust has not consulted with staff or their representatives in setting the policy.

Annual remuneration report

Service contracts

The Executive Directors have provisions in their service contracts that reflect the relevant provisions in the Agenda for Change provisions to provide for payments based on salary and length of service. Reckonable salary is capped at £80,000 and payments are based on one month's salary for each completed year of service, up to 24 month's payment. The maximum total payable is £160,000.

All Executive Directors are eligible to participate in the statutory NHS Pension Scheme. This is a contributory scheme which provides benefits based on salary and length of service. Current joiners will obtain benefits based on an average of their salary across their service in the NHS; certain Directors will obtain benefits based on their final salary, as they joined the scheme when those benefits were offered. All participants obtain benefits related to their length of service in the NHS.

Remuneration committee

The Remuneration Committee met on three occasions during 2017/18, attendances at each are detailed below:

	26/05/17	28/07/17	29/09/17
Graham Foster (former Chair)	Yes	Yes	N/A
Alan Burns (current Chair)	N/A	N/A	Yes
Alan Ball	Yes	Yes	Yes
Janet Gray	Yes	Yes	Yes
Phil Harris-Bridge	Yes	Yes	Yes
Lizzie Hanna	Yes	Yes	Yes
John Hawksfield	Yes	Yes	N/A
Stephen Ramsden	Yes	Yes	Yes
Trevor Shipman	Yes	Yes	Yes

The Committee's work during the year has been supported by the following

- Fiona Wise Chief Executive Officer
- Mark Smith, Director of HR
- Sharan Madeley- Trust Secretary

During the year, the following major decisions have arisen for the Committee-

- Arrangements for the appointment of a new Chief Executive Officer
- Reviewing the remuneration of the Executive team, aligned to benchmarking information from NHS providers.
- Arrangements to provide for appropriate cover for Director of Integrated Governance until a permanent appointment could be made

The context in which the Committee considered these matters was the need to ensure that the Trust is able to recruit and retain an Executive team that is able to provide the necessary leadership to the Trust and its staff, in a challenging situation, whilst not over-rewarding. This is clearly a difficult balance, and the Committee has regard to the various benchmarking information available in reaching its judgements. During the year NHS Improvement published more detailed expectations for salary ranges across various types of NHS provider organisations. These have been taken into account as appropriate.

Non Executive Director and Governor expenses

The following information relates to the expenses paid to our Non Executive Directors and Governors during 2017/18:

	Non Executive Directors	Governors
Total number	8	25
Number receiving expenses	5	9
Total expenses paid	£5,410	£1,962.69

Senior Managers' remuneration

The Nomination & Remuneration Committee is a sub-committee of the Board which oversees the process for identification and nomination of senior posts including the Chief Executive. Non-Executive Directors, including the Chairperson, are appointed by the Council of Governors and can be appointed for a minimum of 3 and a maximum of 7 years. The Appointments & Remuneration Committee of the Council has been appointed to agree a transparent process for the appointment of Non Executive Directors.

The Trust does not have performance-related salaries and the terms and conditions of contracts for its senior managers are subject to the normal terms and conditions of other NHS staff. The Directors are not entitled to receive any benefit under share options or money and assets under long term incentive schemes. In addition, no advances, credits or guarantees have been made on behalf of any of the Directors.

Directors									
Financial Year 2017/18				**Salary (bands of £5000)**	**Benefits in kind (travel /lease benefit) (Rounded to the nearest £100)**	**Annual performance-related bonuses (bands of £5,000)**	**Long-term performance-related bonuses (bands of £5,000)**	**Pension related benefits (Rounded to the nearest £2,500)***	**TOTAL REMUNERATION (Bands of £5,000)**
Name	**Title**	**Start date**	**End date**	**£000**	**£**	**£000**	**£000**	**£000**	**£000**
Mr D Sissling	Chief Executive	1 Apr 2014	30 Sep 2017	90-95	-	-	-	2.5-3	95-100
Mrs F Wise	Interim Chief Executive	27 Feb 2017	2 Mar 2018	140-145	300	-	-		140-145
Mrs R Brown	Chief Operating Officer (& Acting Chief Executive w.e.f. 2nd Mar 2018)	1st Feb 2016		125-130	400	-	-	132.5-135	260-265
Miss N Briggs	Director of Finance	1st Dec 2016		120-125	-	-	-	85-87.5	205-210
Dr A Chilton	Medical Director	2nd Jun 2010		210-215	5,100	-	-	40-42.5	255-260
Ms L Hackshall	Director of Nursing & Quality	1st Oct 2014		100-105	-	-	-	97.5-100	200-205
Mr M Smith	Director of HR & Org Dev	2nd Jun 2014		105-110	-	-	-	25-27.5	135-140
Mr Phillip King	Director of Corporate Governance & Communications	1st Aug 2017	31st Jan 2018	50-55	-	-	-		50-55

Ms Jenna Davies	Interim Director of Integrated Governance	5th Feb 2018		10-15	-	-	-		10-15

The Trust paid employers National Insurance and pension contributions of £219k in respect of the salaries quoted in the table above.

* The pension related benefits figures are the differences in estimated benefits comparing the start to the end of the year for a Director's pension entitlements including any lump sum and adjustments for inflation. This figure is calculated using the HMRC formula derived from s229 of the Finance Act 2004.

The salary for Dr Chilton includes £105-£110k in respect of clinical duties.

SIMON WELDON
CHIEF EXECUTIVE

25th MAY 2018

Chairman and Non-Executive Directors									
Financial Year 2017/18				**Salary (bands of £5000)**	**Benefits in kind (travel /lease benefit) (Rounded to the nearest £100)**	**Annual performance-related bonuses (bands of £5,000)**	**Long-term performance-related bonuses (bands of £5,000)**	**Pension related benefits (Rounded to the nearest £2,500)***	**TOTAL REMUNERATION (Bands of £5,000)**
Name	**Title**	**Start date**	**End date**	**£000**	**£**	**£000**	**£000**	**£000**	**£000**
Mr G Foster	Chairman	1st Sep 2013	1st Sep 2017	15-20	-	-	-	-	**15-20**
Mr A Burns	Chairman	2nd Sep 2017		25-30	-	-	-	-	**25-30**
Mr J Hawksfield	Non-Executive Director	13th Dec 2012	30th Jun 2017	0-5	-	-	-	-	**0-5**
Mr S Ramsden	Non-Executive Director	1st Sep 2013	31st Dec 2017	5-10	-	-	-	-	**5-10**
Mr T Shipman	Non-Executive Director	18th Apr 2017		10-15	-	-	-	-	**10-15**
Mr P Harris-Bridge	Non-Executive Director	1st Sep 2013		10-15	-	-	-	-	**10-15**
Mrs E Hanna	Non-Executive Director	7th Sep 2015		10-15	-	-	-	-	**10-15**
Mr A Ball	Non-Executive Director	18th Apr 2017	31st Mar 2018	10-15	-	-	-	-	**10-15**
Mrs J Gray	Non-Executive Director	27th Oct 2014		10-15	-	-	-	-	**10-15**
Mr C Welsh	Non-Executive	1st Feb 2018		0-5	-	-	-	-	**0-5**

	Director								

The Trust paid employers National Insurance contributions of £10k in respect of the salaries quoted in the table above

SIMON WELDON
CHIEF EXECUTIVE

25th MAY 2018

Fair pay multiple

Reporting bodies are required to disclose the relationship between the remuneration of the highest paid director in the organisation and the median remuneration of the organisations workforce. The calculation is based on the full time equivalent staff of the entity at the reporting period end date (31 March) on an annualised basis. This Trust has defined "remuneration" as detailed below:

Total remuneration includes salary, benefits in kind as well as severance payments. It does not include employer pension contributions and the cash equivalent transfer value of pensions.

The employees counted for this purpose and the method of calculating their remuneration are:

10. Permanent staff - the full time equivalent basic contracted pay plus enhancements, overtime, shift allowances etc.
11. Bank staff – as for permanent staff but excludes bank staff who already have a permanent post and only includes bank staff paid in March.
12. Agency staff – the average cost of agency staff less commission who worked in March multiplied by the Whole Time Equivalent number of staff that worked in March.

The banded remuneration of the highest paid director in Kettering General Hospital NHS Foundation Trust in the financial year 2017/18 was £210,000-£215,000 (This is the annualised full time equivalent of the payments made in 2017/18). This was 7.95 times the median remuneration of the workforce which was £26,539. The banded remuneration of the highest paid director in Kettering General Hospital NHS Foundation Trust in the financial year 2016/17 was £190,000-£195,000 (This is the annualised full time equivalent of the payments made in 2016/17). This was 7.3 times the median remuneration of the workforce which was £26,597.

Total pension entitlements

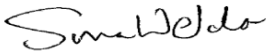
A Cash Equivalent Transfer Value (CETV is the actuarially assessed capital value of the pension scheme benefits accrued by a member at a particular point in time). The benefits valued are the member's accrued benefits and any contingent spouse's pension payable from the scheme. A CETV is a payment made 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 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. There will be no CETV for employees aged 60 or above.

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.

2017/18 Name	Title	**Real increase in pension at age 60 (bands of £2500)**	**Real increase in lump sum at age 60 (bands of £2500**	**Total accrued pension at age 60 at 31ST March 2018 (bands of £5000)**	**Lump sum at age 60 related to accrued pension at 31st March 2018 (bands of £5000)**	**Cash Equivalent Transfer Value (CETV) at 31st March 2018**	**Cash Equivalent Transfer Value (CETV) at 31st March 2017**	**Real Increase in Cash Equivalent Transfer Value ***
		£000	**£000**	**£000**	**£000**	**£000**	**£000**	**£000**
Mr D Sissling	Chief Executive	0-2.5	0-2.5	50-55	155-160			
Mrs R Brown	Chief Operating Officer/Acting Chief Executive(w.e.f. 2 Mar2018)	5-7.5	12.5-15	40-45	105-110	726	575	145
Miss N Briggs	Director of Finance	5-7.5	0	10-15	0	114	68	45
Dr A Chilton	Medical Director	2.5-5	7.5-10	55-60	170-175	1192	1087	94
Ms L McLean	Director of Nursing & Quality	2.5-5	12.5-15	45-50	135-140	854	711	135
Mr M Smith	Director of HR & Org Dev	0-2.5	0	5-10	0	52	36	16

*The Real Increase in pension, lump sum and CETV figures factors in the rate of inflation (CPI) and is not therefore the absolute difference between one year and the next.

CPI is 1% in 2017/18



SIMON WELDON
CHIEF EXECUTIVE

25th MAY 2018

Payment for loss of office

No payments were made to Senior Manager's for loss of office. Full details of exit packages across the organisation are included in the Staff Report.

Payments to past Senior Managers

No payments we made to past Senior Managers in this reporting period.

3.3 Staff Report

Summary of Trust staff

The summary of the average numbers of persons employed is shown in the table below:

Average number of persons employed (WTE basis)	Permanently employed	Other	Total 2017/18	Total 2016/17
	Number	Number	Number	Number
Medical and dental	410	68	**478**	**482**
Administration and estates	682	50	**732**	**705**
Healthcare assistants and other support staff	863	120	**983**	**944**
Nursing, midwifery and health visiting staff	1,038	206	**1,244**	**1,208**
Scientific, therapeutic and technical staff	226	17	**243**	**237**
Healthcare science staff (new classification)	185	0	**185**	**178**
Other	88	1	**89**	**83**
Total	**3,492**	**462**	**3,954**	**3,837**
Of which, number engaged on capital projects	0	0	0	6

Staff expenses

	Permanently employed	Other	Total 2017/18	Total 2016/17
	£000	£000	£000	£000
Salaries and wages	118,416	14,055	**132,471**	**122,526**
Social security costs	12,373	0	**12,373**	**11,428**
Apprenticeship levy	637	0	**637**	**0**
Employers contributions to NHS Pensions Agency	14,606	0	**14,606**	**13,582**
Pension Costs – other	4	0	**4**	**4**
Agency/contract staff	0	13,388	**13,388**	**19,941**
SUB-TOTAL	**146,038**	**27,433**	**173,479**	**167,481**
Less salaries re-charged to capital	(378)	(154)	(532)	(449)
TOTAL	**145,658**	**27,289**	**172,947**	**167,032**

Staff exit packages

Exit package cost band	Number of compulsory redundancies		Number of other departures agreed		Total number of exit packages by cost band	
	2017/18	2016/17	2017/18	2016/17	2017/18	2016/17
<£10,000	0	0	0	0	**0**	**0**
£10,001 - £25,000	0	0	0	1	**0**	**0**
£25,001 - £50,000	0	0	0	1	**0**	**1**
£50,001-£100,000	0	0	0	0	**0**	**0**
£100,001-£150,000	0	0	0	0	**0**	**0**
TOTAL NUMBER	**0**	**0**	**0**	**1**	**0**	**1**
	£000	**£000**	**£000**	**£000**	**£000**	**£000**
TOTAL COST	**0**	**0**	**0**	**32**	**0**	**32**

Analysis of other departure payments	2017/18		2016/17	
	Number	£000	Number	£000
Voluntary redundancies	0	0	0	0
Contractual payments in lieu of notice	0	0	1	32
Exit payments following Employment Tribunals or court	0	0	0	0
Non-contractual payments requiring HMT approval	0	0	0	0
TOTAL	**0**	**0**	**1**	**32**
Of which:				
Non-contractual payments where payment value was more than 12 months of their annual salary	0	0	0	0

Staff profile

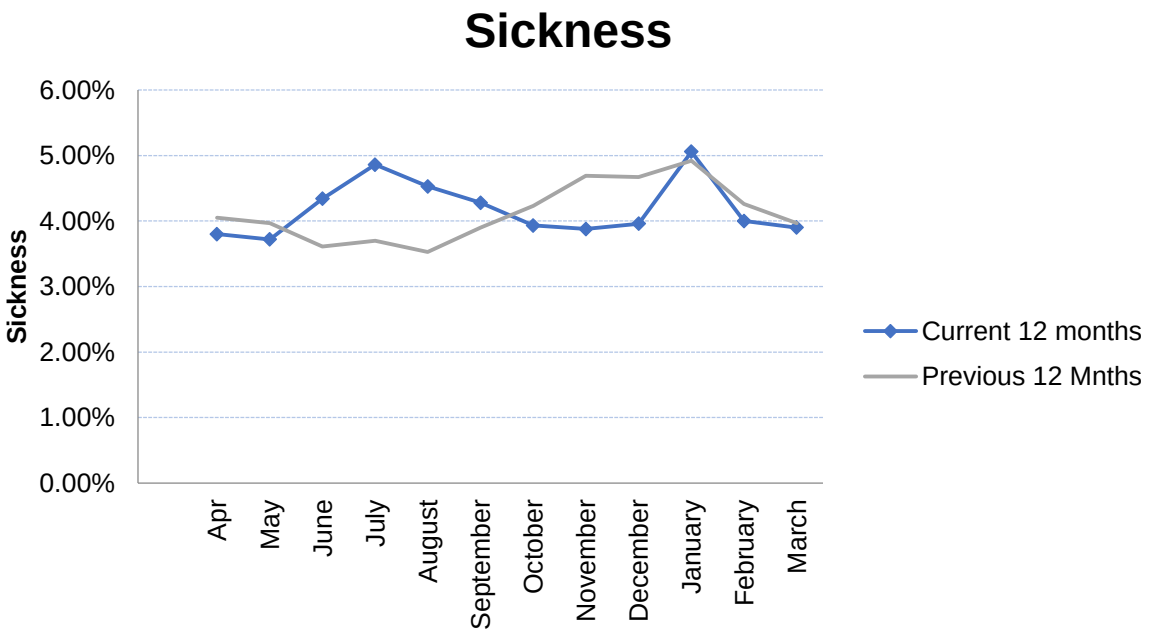
The profile of our staff is shown in the table below:

Staff Group	Male	Female
Directors	6	6
Other Senior Managers (not Directors and at 8b or above)	9	13
All Employees	809	3229

Sickness absence data

The Trust collects sickness absence data on a monthly basis, with a KPI that sickness is below 4% for the Trust. The table and chart below show performance over 2017/18.

Sickness	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Current 12 months	3.80%	3.72%	4.34%	4.86%	4.53%	4.28%	3.93%	3.88%	3.96%	5.06%	4.00%	3.90%
Previous 12 months	4.05%	3.97%	3.61%	3.70%	3.53%	3.90%	4.23%	4.69%	4.67%	4.92%	4.26%	3.97%



Giving full and fair consideration to all applications for employment by disabled persons

The Trust takes its obligations under Equality Legislation very seriously. The Trust aims to provide fair and equitable treatment to, and value diversity in, its staff, patients and visitors. In doing so it aims to ensure that its actions and working practices comply with both the spirit and intention of the Human Rights Act (1998) and the current Equality Act which aims to consolidate all legislation relating to the six strands of diversity i.e. race, gender, disability, religion/faith, sexual orientation and age. The Trust is committed to reviewing its workforce practices, policies and procedures on an ongoing basis to ensure that they take our equality and diversity commitments into account. This obligation is equally applied to recruitment policies, which aim to ensure that all applications are given full and fair consideration.

Policies for training, career development and promotion of disabled employees

We follow a clear governance structure for the approval and ratification of policies and procedures for matters relating to current and prospective staff members. Each policy document contains an equality impact assessment covering all relevant equality strands. This ensures that we are able to mitigate any possible areas of direct or indirect discrimination as part of the approval and ratification process.

The associated staff member policies capture aspects from the commencement of employment, identifying relevant statutory and mandatory training, and ensuring development to support career progression. Our policies also establish minimum expectations in relation to conduct, behaviour and

performance, as well as supportive approaches to allow staff members to raise matters of concern in a safe and protected way.

Actions taken in the year to consult employees about decisions likely to affect their interests

The Trust maintains an excellent relationship with staff side representatives through established employee and management consultation and negotiating forums (Joint Staff Consultation and Negotiating Committee, Local Negotiating Committee and Junior Doctors forum). These forums continue to provide invaluable feedback to Trust management on matters of concern to employees and allows for consultation of any proposed changes.

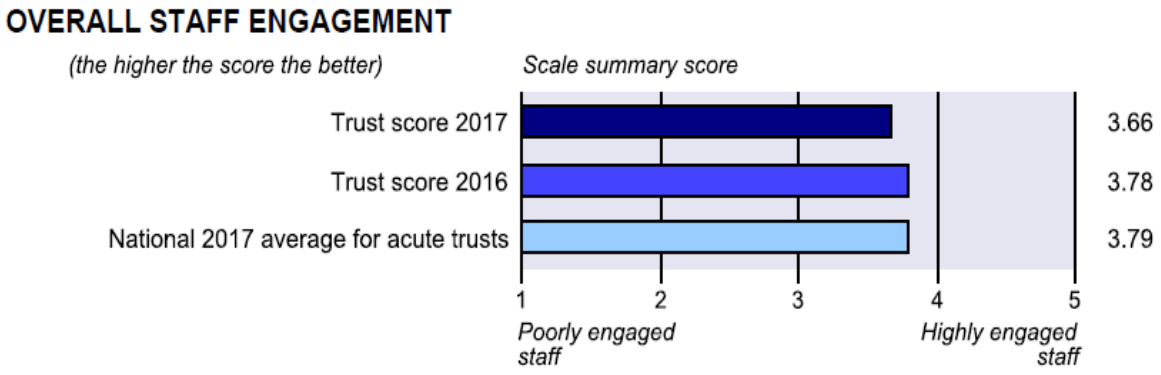
Information on health and safety performance and occupational health

The Trust continues to maintain the Department of Health and Social Care's principle of improving the working lives of staff and supports the NHS agenda of maintaining healthy work environment for all staff. Our Occupational Health service delivers health awareness and offers health surveillance programmes for staff and maintains a comprehensive counselling service. The group has worked in setting up weight management classes, the provision of healthy food being made available a series of health celebration days including the Random Acts of Kindness. During 2017/18 the Trust achieved a take up of the Flu vaccination of 65%, this was below the previous year's 75% and the Trust's aim of 70%.

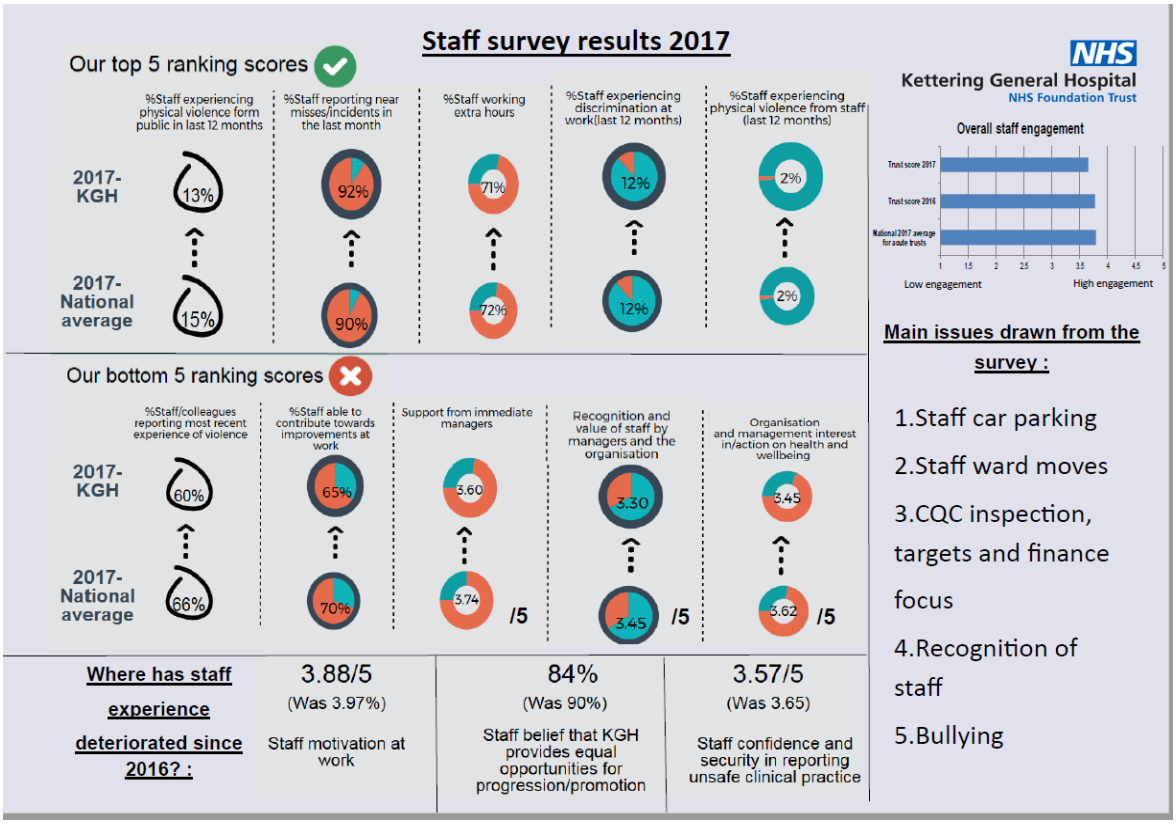
Staff survey

During early 2017 the Work Foundation conducted a case study, highlighting the actions that the Trust had taken in improving staff engagement from 2014 to 2016, as the Trust was acknowledged to have continued improvement in staff engagement results. Despite this, the NHS National Staff Survey results for the Trust in 2017 showed a decline in staff engagement.

The 2017 NHS National Staff Survey was undertaken by Quality Health for Kettering General Hospital. The survey is carried out every year at all NHS Trusts and designed to help identify how staff feel about important issues and highlight areas of good practice and areas of concern. The response rate for 2017 was 35%, an increase of 3% from 2016; however, was in the lowest 20% for responses when benchmarked against other acute NHS providers. The Trust Overall Engagement Score in 2017 is outlined below.



Compared with other acute providers the Trust has 15 areas in the lowest 20%, up from 3 in 2016, and 2 areas within the top 20%, down from 3. Benchmarking the 2016 to 2017 surveys shows there was 14 areas of deterioration and no areas of improvement against the survey key findings. The below picture was sent to all Trust staff on the 7th March 2018, following the publication of the staff survey results, to provide all staff an overview of the survey results and findings.



The Trusts Top and Bottom 5 ranking scores from the survey when benchmarked nationally are:

KEY FINDING		2017	
		Trust	National Average
TOP 5 RANKING SCORES	KF22 - Percentage of staff experiencing physical violence from patients in last 12 months	13%	15%
	KF29 - Percentage of staff reporting errors, near misses or incidents witnessed in the last month	92%	90%
	KF16 – Percentage of staff working extra hours	71%	72%
	KF20 – Percentage of staff experiencing discrimination at work in the last 12 months	12%	12%
	KF23 – Percentage of staff experiencing physical violence from staff in the last 12 months	2%	2%
BOTTOM 5 RANKING SCORES	KF10 – Support from immediate line managers	3.60	3.74
	KF24 – Percentage of staff/colleagues reporting most recent experience of violence	60%	66%
	KF5 – Recognition and value of staff by managers and the organisation	3.30	3.45
	KF7 – Percentage of staff able to contribute towards improvements at work	65%	70%
	KF19 – Organisation and management interest in and action on health and wellbeing	3.45	3.62

The survey results are disappointing considering the positive position the Trust had moved to in the past few years. They demonstrate that the Trust is required to take further actions to enable staff to feel valued listened to and supported as an organisation. The five main themes/areas for improvement as stated by staff include, staff car parking, staff ward moves, an issue with a focus on targets, CQC and finance, staff recognition and bullying with comment specifically stating an issue with the way people are speaking to each other particularly in times of pressure.

The Trust has taken some immediate actions upon receipt of the results which include:

- Communicated survey findings to all Trust Staff
- Presented staff survey results to forums such as Link Listeners, Leadership Brief, TMC, JCNC
- Review of our Communications function and development of Comms Strategy and Plan
- Commissioned focus groups with graphic scribes as to what action should be taken to address the concerns raised in the staff survey – asking three main questions:
    - What is it like working at KGH now?
    - What could it be like in the future?
    - What is needed to make that happen?

These sessions were conducted with different staff groups across the Trust

The next steps to be taken following the feedback, inclusive of the Leadership Development mentioned earlier includes:

- Staff Engagement Action Plan
- Staff Health and Wellbeing Action Plan
- Embedding the new Divisional Structure
- Refresh of the Workforce Development Strategy
- Communication Strategy
- New website

Whilst part of a detailed plan each action will be monitored at various forums and committees including:

- Monthly Workforce Report
- Monthly Safe Staffing NQB Data
- Trust Management Committee
- Quality Governance Steering Group

  Trust Board
- Learning and Education Group
- CBU Performance Meetings
- Staff Health and Wellbeing Focus Group
- Workforce Development Committee
- Staff Friends and Family Quarterly Survey

Expenditure on Consultancy

The Trust only uses external consultancy support sparingly, and where skills and capabilities cannot be sourced internally in a timely manner. This is supported by the appropriate regulatory approval. In 2017/18 total expenditure on consultancy was £1,505k

Off Payroll Employees

The Government has reformed the Intermediaries legislation, introducing Chapter 10 Part 2 Income Taxes (Earnings and Pensions) Act 2003 (ITEPA 2003) supporting Chapter 8 Part 2 ITEPA 2003, often known as IR35. The legislation for the off-payroll working rules within the public sector applies to payments made on or after 6 April 2017.

Under the reformed off-payroll working rules, Departments must determine whether the rules apply when engaging a worker through a Personal Service Company (PSC).

Departments and their arm's length bodies should publish information in relation to the number of off payroll engagements for all off-payroll engagements for more than £245 per day and more than six months in duration. The following information is to be provided:

- The number of these engagements which were assessed as within the scope of IR35
- The number of these engagements which were assessed as not within the scope of IR35
- The number that were engaged directly (via PSC contracted to Trust) and are on the Trust's payroll
- The number that were reassessed for consistency/ assurance purposes during the year and
- The number that saw a change to IR35 status following the consistency review.

For all off-payroll engagements as of 31 March 2018, for more than £245 per Day and that last longer than 6 months:

	Number
Number of existing engagements as of 31 March 2018	7
Of which, the number that have existed:	
for less than one year at time of reporting	4
for between one and two years at the time of reporting	2
for between two and three years at the time of reporting	0
for between three and four years at the time of reporting	1
For 4 or more years at the time of reporting	0

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 for longer than 6 months:

	Number
No. of new engagements, or those that reached six months in duration, between 1 April 2017 and 31 March 2018	5
Of which:	
No. assessed as being caught by IR35	5
No. assessed as being not caught by IR35	0
No. engaged directly (via PSC contracted to department) and are on the departmental payroll	0
No. of engagements reassessed for consistency / assurance purposes during the year.	0
No. of engagements that saw a change to IR35 status following the consistency review	0

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

	2017-18	2016-17
No. of off -payroll engagements of board members, and/or, senior officials with significant financial responsibility, during the financial year.	0	0
No. of individuals that have been deemed "board members and/or senior officials with significant financial responsibility" during the financial year. This figure should include both off-payroll and on payroll engagements	17	17

The Trust Board will always aim to recruit senior manager positions (as defined HM Treasury *Review of Tax Arrangements of Public Sector Appointees)* using on-payroll engagements. However key posts may require temporary staff in the interim who are paid using off-payroll contracts. These appointments will be kept for a minimum time until a permanent recruitment has been achieved and the tax assurances outlined above will be obtained in every case.

The Trust Board will always aim to recruit senior manager positions (as defined HM Treasury Review of Tax Arrangements of Public Sector Appointees) using on-payroll engagements. However key posts may require temporary staff in the interim who are paid using off-payroll contracts. These appointments will be kept for a minimum time until a permanent recruitment has been achieved and the tax assurances outlined above will be obtained in every case.

Director's Biographies

Board of Directors: Non-Executive Directors

Alan Burns, Chairman from September 2017

Alan has worked in the NHS for 43 years in a variety of senior roles and has also run his own consultancy business supporting leadership and improving performance through coaching. Alan is also the Chairman of Princess Alexandra Hospital in Harlow and was Chairman of Hinchingbrooke Hospital. Before that, he has spent 24 years as a Chief Executive of a number of Strategic Health Authorities.

Alan has been involved in national work on public sector reform and research and development and was Vice Chairman of the NHS Confederation

Phil Harris-Bridge, Non-Executive Director

Phil Harris-Bridge, Non-Executive Director was appointed in September 2013 and reappointed in 2016 for a further term. Phil is a Governor at 3 local Academy Schools and Chair of Governors at an Academy in Corby. He and his wife currently run a consultancy firm which is focused upon business strategy, marketing, business development, customer services and sales. He has previously worked for RS Components in Corby and has held senior positions within Fujitsu/ICL as Head of Business Strategy and Planning/Competitive Marketing Manager/Regional Sales Manager. Phil was appointed Vice Chairman/Senior Independent Director from December 2017.

Janet Gray, Non Executive Director

Janet Gray, Non-Executive Director was appointed in October 2014 and re-appointed for a further 3-year term in [insert date]. Janet is CEO of the Academy for Healthcare science, a UK wide organisation which brings together the entire Healthcare Science Profession to improve patient care and advance and promote the Healthcare science workforce. Janet has a long career in healthcare, building on her work as a clinician, in Nursing and Midwifery, to move into teaching and later management. She has a wide portfolio of experience in executive, Chief executive and non-executive roles in public, private and third sector organisations.

Lizzie Hanna, Non-Executive Director

Lizzie Hanna, Non-Executive Director was appointed in September 2015. Lizzie has lived in the East Midlands with her family for circa 25 years. Lizzie has had a very successful career in the private sector and with extensive Board level experience and the delivery of large-scale change, technology and efficiency programmes. Using her skills, Lizzie wishes to use her business experience to help KGH to deliver a high quality and excellent service to its users and offer extensive support to the changes now being implemented within the Trust.

Lizzie attends the Finance, Performance and Resource Committee

Trevor Shipman, Non- Executive Director

Trevor has extensive experience in the NHS and was Finance Director of Central and Northwest London NHS Foundation Trust. He is a member of the Association of Certified Chartered Accountants and brings a wealth of experience in audit and finance to the Board.

Trevor Chairs Audit Committee, and also attendees the Finance, Performance and Resource Committee.

Christopher Welsh, Non Executive Director

Chris joined the Trust in March 2018. Chris has extensive experience within the NHS, he was the Medical Director for NHS Yorkshire & Humber, and Medical Director & Chief Operating Officer at Sheffield Teaching Hospitals NHS Foundation Trust. Former vascular surgeon.

Chris Chairs the Quality and Safety Committee and also a member of Audit Committee and Workforce Development

All Non-Executive Directors are appointed initially for a 3 year term. On review by the Appointment & Remuneration Group of the Council, this can be extended for a further term of office of 3 years. Following a six year period, Governors will review each request for re- appointment on a yearly basis up to a maximum of nine years. The Board of Directors has a succession plan in place for the Non-Executive Directors. All Non-Executive Directors on the Board of Directors are considered independent.

Executive Directors

Simon Weldon, Chief Executive

Simon Weldon, Chief Executive was appointed in April 2018. Simon has held a number of national senior management positions including Director of Operations and Delivery with NHS England. Simon's previous roles have included Regional Chief Operating Officer for NHS England for the London Region with responsibility for commissioning public health, specialised commissioning and primary care contracting and regional lead for emergency planning. Simon also has extensive experience of acute contracting and performance.

Dr. Andrew Chilton, Medical Director

Dr. Andrew Chilton, was appointed in June 2010. Dr Chilton is a consultant gastroenterologist and hepatologist and honorary senior lecturer. He is also a bowel cancer screening colonoscopist and therapeutic endoscopist. He has a strong interest in quality assurance authoring the national QA colonoscopy guidelines for bowel cancer screening, and works at a regional and national level in this area.

Rebecca Brown, Chief Operating Officer

Rebecca was appointed in February 2016. Rebecca joined the Trust from Northampton General Hospital where she was the Deputy Chief Operating officer. Rebecca is an experienced operational and strategic Director with general management experience in Cardio-Respiratory, Renal, Urology and Clinical Transplant. In 2000, Rebecca was awarded the MBE by Her Majesty the Queen for Service to Nursing. Rebecca held the role of Acting Chief Executive from February 2018 – March 2018.

Nicola Briggs, Director of Finance

Nicola was appointed in December 2016. Nicola commenced her employment at the Trust in 2010 in the role of Business Partner taking up the Head of Financial Management in 2012 and was promoted to the role Director of Transformation. Nicola has extensive financial & change management experience previously working for Northamptonshire Police and Cambridge County Council.

Leanne Hackshall, Director of Nursing & Quality

Leanne was appointed in September 2015. Leanne is a senior nurse with 30 years of experience working in the NHS and remains passionate about patient care. Leanne has a particular interest in the development of leadership in the nursing and allied health professional workforce to facilitate and grow competent and confident staff believing this to be the key in the delivery of a safe and positive patient experience.

Mark Smith, Director of Human Resources & Organisational Development

Mark joined the Trust in June 2014 in this key role, with lead responsibility for developing a highly skilled, trained and well-led workforce. Mark has the responsibility for creating systems and processes that engage all staff in living the values of the organisation. Mark has held a number of roles in Human Resources within the NHS since 2004 and prior to this held roles within the private sector.

3.4 Governance report

Corporate Governance

Introduction

The Trust seeks to have effective corporate governance throughout the organisation, in order to ensure that decision-making is undertaken in a considered manner and having reviewed all the relevant information that can reasonably be made available.

Corporate governance within the Trust takes place in the structure defined in the National Health Service Act 2006, and in particular Schedule 7 of that Act (as amended by the Health and Social Care Act 2012). It is also informed by the expectations of the Care Quality Commission, and the Code of Governance for NHS Foundation Trusts published by Monitor (now part of NHS Improvement).

The major corporate governance bodies within the Trust are the Council of Governors, largely elected by Trust members with responsibility for holding the Board to account and ensuring that the views of the public are represented to the Trust; and the Board of Directors, who are responsible for setting the direction and strategy of the Trust and for oversight of delivery. The Trust operates in a closely-regulated environment, with the main (but not only) statutory regulators being Monitor (now NHS Improvement) and the Care Quality Commission.

Statement of the application of the Code of Governance

Kettering General Hospital NHS Foundation Trust has applied the principles of the NHS Foundation Trust Code of Governance, published by Monitor, on a comply or explain basis. The Code of Governance, most recently revised in July 2014, is based on the principles of the UK Corporate Governance Code issued in 2012.

The information in this report about our compliance, or explanations for non-compliance, with the Code of Governance is subject to review by the external Auditors.

Explanations for areas of non-compliance with the Code

No areas of non-compliance with the provisions of the Code of Governance for NHS Foundation Trusts have been identified during the year.

The Board of Directors and Council of Governors

High-level overview

Under the structure set out in the National Health Service Act 2006, and the Trust Constitution, the Board of Directors is ultimately responsible for the operation of the Trust, and for exercising the powers that the Trust has. The Council of Governors has a limited set of specified decisions that the Act has reserved to them, including the appointment of Non-Executive Directors and external Auditors, and which the Board cannot undertake; together with some other decisions where they must be consulted prior to the Board taking a decision.

The Board meets regularly for the formal transaction of business, usually with a session open to public observation and a further limited session in private. The regular agenda includes reviewing financial and operational performance; consideration of the risk environment affecting the Trust, both internal and external; and receiving assurance, positive or negative, from the detailed work undertaken by Board Committees. The Board also regularly considers the development of strategy, including external changes and challenges, in both formal and informal sessions. During 2017, the Board met on a monthly basis save in August and December.

The Board in public receives an integrated performance report which includes information on Quality, Workforce, and Financial and Operational performance. In addition, the Board receives a summary of the key issues, and escalations from each of the Board Committees. The Board also on a quarterly basis reviews the BAF and the Corporate risk register. This enables our Governors and members of the public any major developments or issues effecting the organisation.

The Council is responsible generally for representing the views of the public and Membership and holding the Board to account for its decisions through the Non-Executive Directors. Council meets on a scheduled basis of four meetings in each year, with additional meetings being held if required to deal with urgent business. Each meeting is open to the public to observe, except where specific business needs to be considered in private; the Council regularly receives a report on the decisions made by the Board, which is used to hold the Board to account. Governors also regularly receive the papers for the public sessions of the Board, to support them holding the Board to account.

The Board has approved detailed delegations of powers from the Board to Board Committees and Executive Directors, as set out in Standing Financial Instructions, a Schedule of Delegations and a Schedule of Matters Reserved to the Board. Under the Standing Orders, there is a general rule that any powers not otherwise dealt with are delegated to the Chief Executive, who may sub-delegate as they judge appropriate.

Fit and proper person test

Requirements are included in the eligibility criteria for Directors regarding the need to meet the “fit and proper” persons test described in the provider licence. Directors are required to confirm that they meet these requirements on an annual basis.

Board of Director Meetings

The Board meets monthly, in public and there were 11 meetings held during 2017/18:

Name	Title	Attendance
Alan Burns (September 2017)	Chairman	7/7
Phil Harris-Bridge	Non-Executive Director Vice Chairman/Senior Independent Director	10/11
Janet Gray	Non-Executive Director	6/11
Lizzie Hanna	Non-Executive Director	9/11
Trevor Shipman	Non- Executive Director	11/11

Name	Title	Attendance
Fiona Wise	Interim Chief Executive	10/11
Rebecca Brown	Chief Operating & Deputy Chief Executive	9/11
Leanne Hackshall	Director of Nursing & Quality	10/11
Mark Smith	Director of Human Resources & Organisational Development	7/11
Andrew Chilton	Medical Director	9/12
Nicola Briggs	Director of Finance	10/11
Graham Foster (until September 2017)	Non-Executive Director	4/4
John Hawksfield (until June 2017)	Non-Executive Director	2/3
Alan Ball (until March 2018)	Non-Executive Director	9/11
Stephen Ramsden (until December 2018)	Non- Executive Director/Vice Chairman/Senior Independent	9/9

Independent Non-Executive Directors

The independence of the Non-Executive Directors has been reviewed during the year, having regard to the criteria in the Code of Governance, to identify any factors that might indicate that a Non-Executive Director was no longer independent.

Having considered those matters, the Board considers that all of the Non-Executive Directors are independent of the management of the Trust. No matters have been identified that might indicate that a Non-Executive Director was not in fact independent from Trust Management.

The Chair's other major commitments are as a Non-Executive Directors at the Information Commissioner's Office; and as an External Member of the House of Commons Commission.

Completeness, balance and appropriateness of the Board

Details of the skills, expertise and experience of the individual Directors can be found in the biography section, in the staff report.

During the year, an external review of the Trust against the Well led domain was undertaken, the balance of skills and experience of Directors was reviewed, having regard to the challenges facing the Trust. This review fed into the recommendations to the Council of Governors regarding the skills and experience to be sought in appointing a new Trust Chair and Non-Executive Directors during the year.

Performance Evaluation

The Board recognises that having effective performance review of its work, the detailed work undertaken in Committee, and of individual Directors is important to ensure that the Board as a whole continues to effectively lead and set the strategic direction for the Trust. It is also a requirement in order to have continuing compliance with the requirements of the NHS Improvement provider licence, Condition FT4.

Individual Directors are subject to performance evaluation through the appraisal process. For Executive Directors, the process is applied in the same way as for all other employees, with objectives being set at the start of the year, progress being reviewed, and the appraisal at the end of the year. Recognising their position as Directors and members of a unitary Board, the objectives and appraisal include an element reflecting their contribution to the Board, both in their direct area of responsibility and across the general responsibilities of the Board as a whole. The Non-Executive Directors are subject to a similar process, which mainly focuses on their contribution to the Board and effective governance; with the Chair's objectives being set in a process led by the Senior Independent Director. The outcomes of the process are reported to the Nomination and Remuneration Committee in respect of Executive Directors, and the Council of Governors (via the Council's Nomination Committee) in respect of the Non-Executive Directors.

The Trust had a Well-Led Review undertaken by Price, Waterhouse, Cooper in August 2017. The Finding of which were considered by the Board, and a Governance Improvement plan was developed this was refined and updated in March 2018. In agreement with NHS Improvement, the Board of Directors did not conduct a review against the monitor "Well-Led NHS Foundation Trust" guidance. A Well led Self-assessment will be undertaken in September 2018

Audit Committee

The Audit Committee is responsible to the Board of Directors to provide an independent view of financial and corporate governance and risk management. The committee is responsible for the relationship with the Trust's auditors.

The committee's duties include; reviewing systems of internal control, approach to risk management, monitoring the integrity of financial systems, monitoring counter fraud arrangements and compliance with legislation and other regulatory requirements. The Audit Committee receives instructions from the Board of Directors on areas where additional assurance is required and formally reports to the Board.

External Auditors

The Council of Governors approved the appointment of Grant Thornton as external auditors from April 2017. Grant Thornton fees of £42,000 in respect of statutory audit fees for the year and £6,000 in respect of the audit of the Quality Account were accrued in 2017/18.

Internal Auditors

During the year ended 31 March 2018, the Trust's internal audit function was carried out by TIAA Ltd, an independent business assurance provider delivering services to the public and private sectors.

Council of Governors and Membership

Role and Responsibilities of the Council

Kettering General Hospital NHS Foundation Trust is accountable to the public membership through our Council of Governors. The Council of Governors represents the interests of the members of the trust, the local community, patients, public, staff, and stakeholders through sharing information about key decisions and listening to their views.

The Council of Governors has clear statutory duties which include holding the Non-Executive Directors, both individually and collectively, to account for the performance of the Board of Directors. Our council of governors are invited to observe both the Board of Director meetings and all Board Sub-Committee meetings to improve their understanding of Trust matters and see our Non-Executive Directors in action.

It has been a very busy year for our governors who, together with attending the Council of Governors meetings also attended numerous governors' training and development sessions, membership engagement events, and various committees. These included Trust board committees where governors act as observers and report back to Council of Governor meetings. This reflects another excellent year of working together, with governors and board members being involved in a number of events and visits. This activity supports us in our continuous efforts to improve healthcare delivery, as well as enabling governors to be visible within both their constituencies and the Trust so they can engage with members and the general public. We acknowledge and respect the unique contribution of individual governors and the Council of Governors as a whole in contributing to the future development of our Trust.

Our Council of Governors, on appointment, are Governors are issued with a Code of Conduct to outline the requirements and expectations of the role of Governor. In turn the Trust provides Governors with a Statement of Expectations outlining what the Trust will aim to deliver to Governors with regard to training and support. In December 2017 the Council decided to combine the Code of Conduct and Statement of Expectations into one document 'The new Code of Conduct for Governors'. During December 2017 – January 2018 a new Governor Handbook was developed with input from our governors which is now issued on appointment.

All governors complete a register of interests which are available to the public by phoning the Foundation Trust office.

Council of Governors

The Council of Governors comprises of 25 members from three constituencies:

- 13 public governors
- 4 staff governors
- 8 stakeholder governors

There were a number of changes to the Council in 2017. Elections were held from September 2017 with the results declared on 2nd December 2017.

- Mr Stuart Lake was voted in for a second 3 year term for Wellingborough constituency.
- Mr Peter Woolliscroft was voted in for his first 3 year term representing the constituency of Kettering.
- Dr Mabel Blades was voted in for a second 3 year term for East Northamptonshire.
- Mr Reginald Talbot was voted in for his first 3 year tem representing the constituency of East Northamptonshire.
- Mr James Noble was voted in for a 3 year term representing the staff constituency.

There were no resignations from the Council during 2017-18.

Membership of the Council of Governors 1st April 2017 – 31st March 2018

PUBLIC ELECTED GOVERNORS			
Name	*Constituency*	*Appointment*	*End of Term*
Peter Woolliscroft	Kettering	2 December 2017	2 December 2020
Gail Chapman	Kettering	18 October 2016	18 October 2019
Mohamed Latif	Kettering	2 December 2014	2 December 2020
David Everitt	Corby	2 December 2014	2 December 2020
Ray Lilley	Corby	18 October 2016	18 October 2019
Anne Royal	Corby	12 December 2016	2 December 2020
Stuart Lake	Wellingborough	2 December 2014	2 December 2020
Pat Jackson	Wellingborough	2 December 2017	2 December 2020
Graham Lawman	Wellingborough	18 October 2016	18 October 2019
Tilottama Biswas	East Northants	2 December 2014	2 December 2017
Mabel Blades	East Northants	2 December 2014	2 December 2020
Reginald Talbot	East Northants	2 December 2017	2 December 2020
Eileen Jones	East Northants	18 October 2016	18 October 2019
David Phelan	Rest of UK	18 October 2016	left 21June 2017
STAFF ELECTED GOVERNORS			
Name	*Constituency*	*Appointed*	*End of term*
James Noble	Staff	12 December 2016	2 December 2020
Melanie Moore	Staff	18 October 2016	18 October 2019
Michael Szarvas	Staff	2 December 2014	2 December 2017
Michelle Creighton	Staff	18 October 2016	18 October 2019
Andy Frost	Staff	2 December 2017	2 December 2020
STAKEHOLDER APPOINTED GOVERNORS			
Name	*Constituency*	*Appointed*	*End of term*
Tansi Harper	Corby Clinical Commissioning Group	February 2014	February 2023
Vijay Sharma	University of Leicester	March 2014	March 2023
Wendy Brackenbury	Local Authority Representative	March 2014	March 2023
Sonia Bray	Voluntary/ Charitable Sector	April 2015	April 2024

Sue Watts	Voluntary/ Charitable Sector	March 2015	March 2024
Dr Andrew Stephen	Voluntary/ Charitable Sector	April 2016	April 2025
Sheila White	Healthwatch	December 2017	December 2026
Wendy Patel	Healthwatch	December 2017	December 2026

Council of Governors Meeting Attendance 1st April 2017 – 31st March 2018

Name	21/06/17	05/10/17	07/12/17	11/01/18	15/03/18	Total
Peter Woolliscroft	-	-	√	√	√	3/3
Gail Chapman	√	√	√	√	√	5/5
Mohamed Latif	A	√	√	√	A	3/5
David Everitt	√	√	A	√	√	4/5
Ray Lilley	√	A	√	√	√	4/5
Anne Royal	A	√	√	A	√	3/5
Stuart Lake	√	√	√	√	√	5/5
Graham Lawman	√	√	A	√	√	4/5
Tilottama Biswas	√	√	-	-	-	2/2
Eileen Jones	√	A	A	√	√	3/5
Mabel Blades	√	A	√	√	√	4/5
Reginald Talbot	-	-	√	√	√	3/3
David Phelan	√	-	-	-	-	1/1
James Noble	√	√	√	√	√	5/5
Melanie Moore	A	A	A	A	√	1/5
Michelle Creighton	√	√	√	√	√	5/5

Michael Szarvas	√	A	A	-	-	1/3
Andy Frost	-	-	√	A	A	1/3
Tansi Harper	A	√	A	A	A	1/5
Wendy Brackenbury	A	√	A	A	√	3/5
Vijay Sharma	√	√	A	√	A	3/5
Sonia Bray	√	√	√	√	A	4/5
Sue Watts	A	A	√	√	√	3/5
Dr Andrew Stephen	√	√	√	A	√	4/5
Sheila White	-	-	√	√	-	2/2
Wendy Patel	-	-	√	√	√	3/3

Key:

√ - Attended meeting
A - Apologies
N - No longer a Council Governor Non-attendance

Nominated Lead Governor

The Council of Governors elect one of their members to be the Lead Governor. The Lead Governor co-ordinates any communication that might be necessary between NHS Improvement and the other governors, and acts a main point of contact for the Chairman. The Lead Governor during 2017-18 was Mr Stuart Lake, Public Governor for Wellingborough with Dr Mabel Blades representing East Northamptonshire as Deputy Lead Governor.

Governor Group Meetings

Appointments and Remuneration Committee

The Appointments and Remuneration group, comprising nine governors, is responsible for advising annually on the remuneration of the Chairman and Non-Executive Directors (NEDs); advising on the appointment of the NEDs and the Chairman; receiving performance/appraisal information relating to the Chairman/NEDs to assist in considering re-appointments to the role; Members of the Group are invited to observe or participate in the Executive Director recruitment process.

All members of the Appointment and Remuneration Group are informed in a report from the Trust Board Secretary of the process and steps taken in the recruitment process for either Non- Executive Directors or a Chairman in advance of the commencement of the process. Members of the group will be provided with the views of the Board on appointment of any non-executive director taking into consideration the skills and experience required to compliment the board as whole. Governors are involved in the interview process together with current non-executive directors, the chairman and the director of HR and any other appropriate person.

In 2017 Governors of the Appointment and Remuneration Group received a report on bench marking market testing of the remuneration levels for the Chairman and Non-Executive Directors.

During 2017-2018 Governors of the Appointment and Remuneration Group were involved in the appraisals of the Chairman and Non-Executive Directors. Governors were invited to meet informally with the new Chairman of the Trust during his appointment. The Appointments and

Remuneration Group were involved in the recruitment of a new Non-Executive Director, Professor Christopher Welsh. During 2017 the Group considered the proposals for the successful reappointment of a number of Non-Executive Directors.

The Appointments and Remuneration group met on 3 occasions during 2017-18.

Performance Group

The work remit of the Performance Group is to assist Council of Governors to hold the NEDs individually and collectively to account for the financial standing and overall performance of the Trust with specific responsibilities relating to Operational Performance including key performance indicators, Financial Performance, Estates, Health & Safety, Risk, and Audit.

During the 2017-18 the Group was involved in the appointment process for the Trust's new external auditors, Grant Thornton.

The Performance group met on 4 occasions to December 2017.

Governance Group

The main area of work that this group focussed on was quality and patient safety, including the patient experience. The group further receives the Board's Integrated Governance Reports on workforce, staffing, and quality. The Governance Group is responsible for focusing on the trust's membership and communications.

The Governance group met on 5 occasions to December 2017

In January 2017 following the outcome of an extensive piece of work by three members of the council, the format of governor meetings changed. The new process implemented was to hold a new 'Governor

Overview Group' on a monthly basis which aligned with the board of directors and board sub-committee meetings to ensure that information received was as up to date as possible. On months where a formal Council meeting was scheduled, it was agreed the overview group would be incorporated into the main council meeting so as to ensure all reports were timely, ensuring governors were kept up to speed with trust matters.

Governor Overview Group

The first Overview Group took place in February 2018 which in effect incorporated the two previous groups of Governance and Performance into one. The group now receives timely information on all aspects of performance, finance, quality and safety, audit, workforce and any other relevant trust issues or matters of importance. The group is also focuses on membership and communication.

The Governor Overview Group met on 3 occasions to March 2018

The Council of Governors: Relationship with the Board of Directors

During 2017-2018 there were five Council of Governor meetings which all Non-Executive Directors attend. Our governors have taken a lead in requesting the Chief Executive or Executive Directors to attend their meetings where necessary to provide information or updates on aspects of strategy, key developments in the Trust, finances, national initiatives or any areas of concern or interest that governors may have. Our Non-Executive Directors take away any key concerns that governors may have and raise these at board committees on behalf of the council.

Governors have an invitation to meet informally with the Chairman at any time to discuss concerns, and all members of the Board are willing to provide assurances, information or feedback to governors where required or meet at request. As a Trust we endeavour to ensure that there is open and transparent communication between the Council and the Board.

Governors are provided with information to enable them to carry out their duties and keep fully informed about Trust matters. All CEO emails, A&E data, staff survey, media releases any other important information is circulated on receipt directly to governors. To ensure our governors are well informed the agenda and reports of all Board of Director and Board Sub-committees are circulated to the full council for information. All governors are invited to attend and observe Board of Directors meetings and all Board Sub-committee meetings.

The nominated governors to the Board of Directors and Board Sub-Committee meetings request any comments, concerns or queries from the Council in advance, and have the opportunity to meet with the Chair of the committee to discuss these matters prior to the meeting to gain assurances on behalf of the Council.

Members of the Board of Directors have provided training sessions for governors to ensure they are up to date with the trust plans, understand the key challenges, and are actively engaged in the development of the strategy and operational plans of the trust.

Keeping our Governors Informed

We provide a training and induction programme that runs through the year on all key aspects of NHS business including finance, audit, quality, statutory duties, patient experience and any other relevant training required or requested. On appointment governors complete a skills audit. Our governors attend the trust's non-patient facing mandatory training. All governors can attend the Governwell Training courses run by NHS Providers and any other ad-hoc conferences that take place across the UK.

Clinical and non-clinical teams regularly provide governors with updates on new developments and plans for improvement in individual departments of the hospital. Governors can undertake site visits in the hospital following the protocol provided in the governor handbook.

Governors are involved in the CARE Smile Awards judging panel; are members of the Patient Experience Group; have been involved in the urgent care hub business plan group; members of a discharge team project; set up a global challenge team; and supported the Head of Patient Experience with the launch of the 'Coffee and Cake' public engagement events engaging with the public.

Keeping the Directors aware of Governor and Member views

The Board acknowledges the need to keep Directors, and in particular Non-Executive Directors, aware of the views of Members and the public; and the views of Governors as their elected representatives. Directors attend the formal meetings of Council, both to support Council in holding the Board to account and listen to the views and concerns that Governors are expressing. Directors also attend the Annual Members' Meeting, where Members and the public can express their views directly on the performance and future strategy of the Trust. More widely, the Directors have a number of contact-points in the community, including with groups such as patient feedback groups, which provides a further perspective on views and opinions.

Membership

The Trust has two categories of membership:

- Public members
- Staff Members

All staff who have been employed for a 12 month period by the Trust automatically become members of the KGH Foundation Trust and are eligible to vote in elections. The public membership is defined as 'those people aged 16 and over living in the UK'. The majority of the KGH Foundation Trust members are drawn from Kettering, Corby, East Northamptonshire, Wellingborough, East Leicestershire and Northampton, these being the principal areas that the hospital serves.

As at 31st March 2018 the Trust had 4,752 public members, with constituencies as described below:

Constituency	Number of Members 31 March 2018
Kettering	1647
Corby	739
Wellingborough	1008
East Northamptonshire	1029
Rest of UK	329

Membership is overseen by the Governors Overview Group which receives bi-monthly reports. The Board of Directors further receives a report on the council of governors and membership and engagement.

The Trust has made the decision to ensure that we have effective and meaningful engagement with our membership rather than increasing the numbers of members.

The Trust further aims to focus on the diversity of membership and to increase contact with members in under-represented socio-economic groups to obtain their views on the hospital. The Trust will continue to focus on increasing membership from hard-to-reach groups by holding events, giving talks and having stands at community events across the constituencies and working together with the equality and diversity manager.

Public engagement, recruitment and promotion of the Trust is carried out by the Corporate Governance and Membership Manager, and supported by our Council of Governors. The Trust endeavours to analyse our membership distribution and focus on recruitment and engagement in those areas, including membership by age and ethnicity.

Through attendance at a wide range of public engagement events across the constituencies and focusing on areas of under representation, the Trust will strive to achieve a membership which reflects our local community and the area the hospital serves.

Membership Engagement

During 2017 a programme of health events was organised across the constituencies the hospital serves. These remain very popular with both the membership and general public with attendance up to 60 -100 persons. Feedback during the last year has shown that these events serve to fill a gap in community needs, providing reassurance, support, and an understanding of health issues. The events further promote the Trust and the services it provides. Governors will frequently attend such events and meet with members of the public. The programme of health events will continue and it is hoped to continue to reach a wider membership and public audience and improve engagement.

There have been a number of public engagement events in the community that have been attended by the Corporate Governance & Membership Manager together with governors in 2017. With the

appointment of a governor membership lead, Dr Mabel Blades, it is hoped to further increase public engagement and gain views of the community the hospital serves.

Trust members receive a copy of the KGH Together magazine three times a year, which support in keeping our members informed with news and updates about the hospital and this will continue going forward. In early 2018 we revamped the email newsletter to create a more professional image. Email newsletters are sent out approximately every month to those members on email.

During 2017 a number of Trust members have been invited to sit on patient groups for projects undertaken by the transformation team including the development of new pathways or ward structure changes.

Our Annual Members Meeting was held on 19th July and attracted a good public response. Members enjoyed viewing the large number of stands showcasing the Trust's services. The Annual Members meeting gave members of the public an opportunity to ask questions of the Executive Team and speak to Governors who took the opportunity to engage with the membership. The Lead Governor gave members an overview of the work governors had undertaken during the year and invited input from the members on the trusts plans.

The Trust has set up patient groups within the hospital and engaged with members inviting them to participate and share views. Members have been invited into the Trust to take part in surveys and assessments on behalf of the Trust including carrying out audits and being involved in patient engagement exercises. Governors participate in and listen to views on healthcare and gauge public opinion at a wide range of public / patient participation groups, older people's forums, clinical commissioning groups, GP practice patient groups to understand better the needs of the communities the hospital serves. Our Governors have given talks to groups in the community and have been involved in a number of presentations to the public across our constituencies.

Improving membership engagement continues to be monitored by the Council of Governors Overview Group.

Contacting Governors

Members can contact Governors via:

Foundation Trust Office
Kettering General Hospital, Glebe House, Rothwell Road Kettering. Northamptonshire NN16 8UZ

Telephone: 01536 491362
Email: council.members@kgh.nhs.uk

3.5 NHS Improvement Single Oversight Framework

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

- Quality of Care
- Finance and Use of Resources
- Operational Performance
- Strategic Change
- Leadership and Improvement capability (well-led)

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

The Single Oversight Framework applied from Quarter 3 of 2016/17. Prior to this Monitor's Risk Assessment Framework (RAF) was in place. Information for the prior year and first two quarters relating to the RAF has not been presented as the basis of accountability was different. This is in line with NHS Improvement's guidance for annual reports.

Segmentation

NHS Improvement has reviewed the Trust's performance and information available to it and place the Trust in Segment 4. (Segment 4 = Providers in special measures: there is actual or suspected breach of licence with very serious and/or complex issues. The Provider Regulation Committee has agreed it meets the criteria to go into special measures).

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.

Use of resources rating

Risk Rating	2017/18			2016/17
	Plan	Actual	Variance to Plan	Actual
Capital service cover rating	4	4	-	4
Liquidity rating	4	4	-	4
I&E margin rating	4	4	-	4
I&E margin: distance from financial plan		4		4
Agency rating	2	2	-	4
Risk rating after overrides		**4**		**4**

3.6 Statement of Accounting Officer's Responsibilities

Statement of the Chief Executive's responsibilities as the accounting officer of Kettering General Hospital 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 regulatory of public finances for which they are answerable, and for the keeping of proper accounts, are set in the NHS Foundation Trust Accounting Officer Memorandum, issued by NHS Improvement.

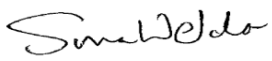
NHS Improvement, in exercise of the powers conferred on Monitor by the NHS Act 2006, has given Accounts Directions which require Kettering General Hospital NHS Foundation Trust to prepare for each financial year a statement of accounts in the form and on the basis set out in the Annual Direction. The accounts are prepared on an accruals basis and must give a true and fair review of the state of affairs of Kettering General Hospital 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 the keeping proper accounting records which disclose with reasonable accuracy at any time the financial position of the NHS Foundation Trust and to enable him/her to ensure that the accounts comply with the requirements outlined in the above mentioned Act. The Accounting Officer is also responsible for safeguarding the assets of the 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.



SIMON WELDON
CHIEF EXECUTIVE

25th MAY 2018

4 Annual Governance Statement

4.1 Scope of responsibility

As Accounting Officer, I have responsibility for maintaining a sound system of internal control that supports the achievement of the 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 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.

4.2 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 Kettering General Hospital 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 Kettering General Hospital NHS Foundation Trust for the year ended 31 March 2018 and up to the date of approval of the annual report and accounts.

4.3 Capacity to handle risk

Leadership

The Board of Directors has the ultimate responsibility for risk management and must be satisfied that appropriate policies and strategies are in place and that systems are functioning effectively. The Audit Committee will assist the Board in this process by performing an annual review of the effectiveness of the risk management activities and it will be helped in this by the Chief Internal Auditor's annual work, report and opinion on the effectiveness of the system of internal control.

The Board of Directors receives minutes and reports from the Audit, Integrated Governance, Workforce Development and Performance, Finance and Resources Committee Meetings and discusses and notes progress with risk management actions as necessary. The Board, in exercising its responsibility, also considers key indicators capable of showing improvements in risk management and/or providing early warning of risk (e.g. incident and complaints statistics, progress in compliance with registration requirements of Care Quality Commission.)

The Board of Directors reviews and approves on an annual basis the Trust's Risk Management Strategy.

Equipping staff to manage risk

Management of risk in the organisation is carried out through:

- The Board Assurance Framework, which is a top down approach and undertaken collectively by the Risk Management group, Board Committees and the Board, involving scoping, reviewing and managing the risk to the corporate objectives of the Trust
- Operational Risk, which is a bottom up approach undertaken by the staff and managers of all services, by which, risks are logged onto the Divisional Risk Register for Operations and escalated to the Corporate Risk Register

Risk management training has been improved in 2017/18 and is part of corporate inductions as well as a mandatory training requirement. Risk Management training is delivered via a number of methods including classroom-based training sessions, one to one sessions and support is available via the Trust Risk Manager. The Trust is moving to a new divisional structure and Governance and Improvement Managers are now in place to support divisions in areas such as risk management, patient safety, health and safety, and quality improvement. This expertise will support in the effective management of operational, corporate and strategic risks.

Established organisational learning mechanisms enable us to continue to improve the level of risk awareness at all levels of the organisation, these include: the use of root cause analysis in incident investigations; policy and process reviews; clinical and organisational audit; data analysis; improvement planning; internal communication channels; and training programmes. This supports our aim to achieve continuous improvement in the quality and safety of services, and to wholeheartedly embrace a culture of learning.

The risk and control framework

The Risk Management Strategy and Policy continues to define the organisation's approach to risk, the roles and responsibilities of the Board and senior management, and the risk management framework that is in place. The Trusts risk management steering group receives regular reports from clinical divisions and corporate departments in relation to significant corporate and operational risks, and assurance.

The Trust identifies, assesses, prioritises and records its risk profile through a variety of systems, both internal and external. The review of risks and current control measures enables risks to be prioritised and supports the Trust in determining the degree of risk that the Trust will accept, i.e. its risk appetite. Strategic risks are identified within the Board Assurance Framework and assurance that the risks are appropriately managed is sought from both external and internal sources as appropriate.

In the year there were 290 new risks identified and 156 risks were closed. This reflects the continued work undertaken to improve and embed our risk management arrangements. As part of this commitment the Board undertook a complete review of the BAF in March 2018, and as a result only two BAF risks remained from the previous iteration; five BAF risks were closed; and eight new risks were added. The following BAF risks were added within the year:

- Failure to care for patients in an appropriate inpatient placement or environment, due to bed pressures or absence of community or social care support, could lead to:
  - compromising patient outcomes
  - patients and carers/families not having an excellent experience
  - services falling below reasonable public expectations with ensuing publicity and criticism of the organisation and the wider Health & Social Care system
- Failure to develop and deliver our financial plans and efficiency programme
- Failure to: (I) meet consistently quality standards for clinical care; (ii) address variability across quality standards; or (iii) reconcile conflicting quality standards or guidance, will result in poorer outcomes for patients and poorer patient safety and experience
- If we do not improve patient flow in order to create bed capacity in line with emergency demand, we will fail national quality and performance standards and also fail to ensure that our clinical teams have manageable workloads
- The Trust may not benefit from the opportunities of strengthening partnerships, collaboration and developing high quality safe and sustainable systems due to slow progress of the STP
- Failure to improve staff engagement and morale, which impacts on the staff survey results
- Failure to have right people and time, well trained and motivated, able to deliver the right level of individual care
- Failure to meet Trusts trajectory with compliance on statutory and mandatory training

Serious Incidents affect service users and staff. Ensuring these are reported effectively and in a timely manner helps the Trust to learn the most from such incidents so that safety can be improved. The Trust has a robust process for making sure that Serious Incidents are acted upon promptly and that resulting actions are followed up. All Serious Incident investigations are presented to the relevant Trust Committee or review groups to identify actions and learning themes.

30 Serious Incidents were reported in 2017/18. Key themes include, diagnostic incident including delay (including failure to act on test results) and slips, trips and falls.

The governance of the Trust is led by the Board of Directors, with the Council of Governors exercising a representative function and performing some specific functions that Parliament has reserved to it. Regulators have set out required standards of governance, linking across both the Care Quality Commission and NHS Improvement, through the Well-Led process and the related Key Lines of Enquiry (KLOE) for CQC inspection processes. Current policy is for all provider trusts to have their governance inspected (through the “Are they well-led?” strand) on an annual basis, and the Trust undertook an external well led review in 2017/18. The recommendations from this report have been incorporated into an action plan which is being driven by the Executive team. A well led self-assessment exercise will commence in September 2018.

Board sub-committees have responsibilities in respect of monitoring and leading on aspects of risk management across the Trust in accordance with their terms of reference. The terms of reference of the sub-committees will be kept under review by the chairs of those committees to ensure they remain relevant to the objectives of the Trust. Changes to the terms of reference may be made by the Chairs following appropriate consultation and agreement.

Escalation of risk issues is through the Divisional Governance structure that allows two-way communication from the Board, its main Committees and Trust wide committees/operational groups which report into the Quality Governance Steering Group. Each Divisional governance meeting on a monthly basis considers risk, quality and performance information alongside the risk registers for the service areas. Themes or specific issues requiring escalation are taken to the monthly Risk Management Steering Group for consideration and potential inclusion in the Corporate Risk Register.

Corporate governance and risk management

Kettering General Hospital NHS Foundation Trust has applied the principles of the NHS Foundation Trust Code of Governance, published by Monitor, on a comply or explain basis. The Code of Governance, most recently revised in July 2014, is based on the principles of the UK Corporate Governance Code issued in 2012.

The information in this report about our compliance, or explanations for non-compliance, with the Code of Governance is subject to review by the external Auditors.

No areas of non-compliance with the provisions of the Code of Governance for NHS Foundation Trusts have been identified during the year.

Risk management embedded into daily practice

Risk management is embedded in the activity of the organisation through the Trust's quality governance arrangements:

- Quality Governance Structure which includes 6 groups which are chaired by either the Director of Integrated Governance, Director of Nursing or the Medical Director whose purpose is to provide the Quality and Safety Committee with assurance that high standards of care are provided by the Trust and in particular, that adequate and appropriate governance structures, processes and controls are in place across the organisation to identify and mitigate risks and issues with regard to quality governance
- Significant work has been undertaken to improve risk registers, through enhanced risk management processes overseen by the risk management Steering group
- Appropriately skilled members of the Board of Directors provide rigorous challenge to the quality governance processes through receipt of reports relating to quality governance, including the quality aspects of the Single Oversight Framework Integrated Performance Report, which are overseen by the Director of Integrated Governance, Director of Nursing and Medical Director
- Internal and external audit reports are reported to the Audit Committee
- Each strategic risk identified on the BAF has an appropriate executive director lead
- The quality improvement plan comprises a number of themes linked to the Quality Strategy, each with an appropriate executive director lead and supported by the programme management office and divisional leads
- The Raising Concerns (Whistleblowing) Policy is in place and is supported by a 'freedom to speak up' guardians who have received focused training in order to support staff in raising concerns

4.4 Involvement of public stakeholders

Kettering General Hospital NHS Foundation Trust is accountable to the public membership through our Council of Governors. The Council of Governors represents the interests of the members of the Trust, the local community, patients, public, staff, and stakeholders through sharing information about key decisions and listening to their views.

The Council of Governors has clear statutory duties which include holding the Non-Executive Directors, both individually and collectively, to account for the performance of the Board of Directors. Our council of governors are invited to observe both the Board of Director meetings and all Board Sub-Committee meetings to improve their understanding of Trust matters and see our Non-Executive Directors in action.

Council meets on a scheduled basis of four meetings in each year, with additional meetings being held if required to deal with urgent business. Each meeting is open to the public to observe, except where specific business needs to be considered in private; the Council regularly receives a report on the decisions made by the Board, which is used to hold the Board to account. Governors also regularly receive the papers for the public sessions of the Board, to support them holding the Board to account.

On a quarterly basis the Board reviews the BAF and the Corporate risk register. This enables our Governors and members of the public any major developments or issues effecting the organisation.

4.5 Care Quality Commission

We were placed in special measures in April 2017 after a CQC inspection took place in October 2016. CQC found that the Trust needed to make urgent improvements in a number of areas to ensure it was consistently delivering care which was safe, effective, caring, and responsive to people's needs in services that are well-led.

The Trust was re-inspected in October 2017, and the CQC noted that progress had been made and a number of improvements had been delivered. The report published in March 2017 rated us as requiring improvement overall. The progress made over the last year provides a strong foundation to continue the efforts to improve our performance.

Our operational performance and progress against our quality improvement programme is reported to NHS Improvement through our monthly performance review meetings. During these meetings we also provide updates on financial, operational and staffing performance as well as clinical governance, strategies and partnership working.

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

4.6 Pension Controls

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.

4.7 Equality, diversity and human rights

Control measures are in place to ensure that all the organisation's obligations under equality, diversity and human rights legislation are complied with.

4.8 Carbon Reduction

The Foundation 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 UKCIP 2009 weather projects, to ensure that this organisation's obligations under the Climate Change Act and the Adaptation Reporting requirements are complied with.

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

During the last year the Trust's financial position was extremely challenging resulting in a deficit of £33.6m, marking an underachievement against the £19.9m deficit plan. It is recognised that this will require long term financial recovery planning and service transformation to address the underlying position. The Board has been sighted on the drivers of the deficit and the plans to address financial recovery moving forward.

The Trust is currently formally in breach of its Licence, specifically conditions CoS3(1)(a) and (b), CoS3(2)(c), and FT4(5)(a),(d), and (f). This is due to continued financial pressures and the inability to maintain and improve financial sustainability, efficiency and compliance with sector controls. Unprecedented operational pressure has seen increased cancellations of elective activity resulting in reduced income.

The Trust breached its A&E target in three quarters during 2017/18. This reflects the considerable activity pressures locally and is also consistent with the position nationally. Whilst the Trust will take all actions within its control, there remains a risk to delivery due to factors / system issues outside the Trust's control. The performance of the Trust is being monitored by NHS England.

4.10 Information governance

The Trust uses the Information Governance Toolkit to identify and manage information risks. During the in-year assessment against the Toolkit, the Trust achieved a score of 60% which has been assessed as "unsatisfactory".

Information Governance incidents are captured through the Trust's incident reporting system, Datix. Incidents are reviewed frequently by the Information Governance Manager and where serious issues are identified the incidents are scored in accordance with the NHS Digital (formerly Health and Social Care Information Centre) 'Checklist Guidance for Reporting, Managing and Investigating Information Governance and Cyber Security Incidents Requiring Investigation'.

One serious level 2 incident was reported to the Information Commissioner in June 2017. This was investigated, and as a result no further action was taken against the Trust.

Data Security

The Trust has invested £2m in new IT hardware and software over 2017/18. This has included updates to data security measures.

4.11 Annual Quality Report

The directors are required under the Health Act 2009 2009 and the National Health Service (Quality Accounts) Regulations 2010 (as amended) to prepare Quality Accounts for each financial year. NHS Improvement (in exercise of the powers conferred on Monitor) has issued guidance to NHS Foundation Trust Boards on the form and content of Annual Quality Reports which incorporate the above legal requirements in the NHS Foundation Trust Annual Reporting Manual.

The Quality Report presents a balanced picture of Kettering General Hospitals Foundation Trust's performance over the period covered from April 2017 to 31 March 2018 and indicates that there are appropriate controls in place to ensure the accuracy of data.

These controls include:

- Corporate level leadership for the quality account is assigned to the Director of Nursing and operationally led by the Deputy Director of Nursing
- Quality governance and quality and performance reports are include in the Trust's performance management framework
- Internal audits of some of our indicators have tested how the indicators included in the Quality Report are derived, from source to reporting, including validation checks

Key individuals involved in producing the report are recruited on the basis that they have the appropriate skills and knowledge to deliver their responsibilities
All indicators included within the Quality Report are reported on a regular basis.
The Quality Report is included within the Annual Report and Accounts and describes how we have engaged with a wide range of stakeholders in our activity to improve the quality of care provided.

4.12 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 Kettering General

Hospital NHS Foundation Trust who have responsibility for the development and maintenance of the internal control framework. I have drawn on the content of the Annual 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 Trust Board, the Audit Committee, the Integrated Governance Committee and the Performance, Finance & Resources Committee and a plan to address weaknesses and ensure continuous improvement of the system is in place.

The Head of Internal Audit provides me with an opinion on the overall arrangements for gaining assurance on the controls reviewed as part of the internal audit work. The monthly performance reports provide me with evidence that the effectiveness of the controls in place to manage the risks to the organisation achieving its principal objectives have been reviewed.

The escalation of risk issues is through the Divisional Governance structure that allows two-way communication from the Board, its main Committees and Trust wide committees/operational groups which report into the Quality Governance Steering Group. Each Divisional governance meeting on a monthly basis considers risk, quality and performance information alongside the risk registers for the service areas. Themes or specific issues requiring escalation are taken to the monthly Risk Management Steering Group for consideration and potential inclusion in the Corporate Risk Register.

Board sub-committees have responsibilities in respect of monitoring and leading on aspects of risk management across the Trust in accordance with their terms of reference. The terms of reference of the sub-committees will be kept under review by the chairs of those committees to ensure they remain relevant to the objectives of the Trust. Changes to the terms of reference may be made by the Chairs following appropriate consultation and agreement.

4.13 Conclusion

There were no significant internal control issues identified during 2017/18.

SIMON WELDON
CHIEF EXECUTIVE

25th MAY 2018

Kettering General Hospital NHS Foundation Trust

QUALITY REPORT 2017 - 2018

COMPASSIONATE
ACCOUNTABLE
RESPECTFUL
ENGAGING

Independent Practitioner's Limited Assurance Report to the Council of Governors of Kettering General Hospital NHS Foundation Trust on the Quality Report

We have been engaged by the Council of Governors of Kettering General Hospital NHS Foundation Trust to perform an independent limited assurance engagement in respect of Kettering General Hospital NHS Foundation Trust's Quality Report for the year ended 31 March 2018 (the "Quality Report") and certain performance indicators contained therein against the criteria set out in the 'NHS foundation trust annual reporting manual 2017/18' and additional supporting guidance in the 'Detailed requirements for quality reports 2017/18' (the 'Criteria').

Scope and subject matter

The indicators for the year ended 31 March 2018 subject to the limited assurance engagement consist of the national priority indicators as mandated by NHS Improvement:

- Percentage of incomplete pathways within 18 weeks for patients on incomplete pathways at the end of the reporting period; and
- Percentage of patients with a total time in A&E of four hours or less from arrival, admission, transfer or discharge.

We refer to these national priority indicators collectively as the 'Indicators'.

Respective responsibilities of the directors and Practitioner

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 2017/18' and supporting guidance 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 2017/18' and supporting guidance;
- the Quality Report is not consistent in all material respects with the sources specified in NHS Improvement's 'Detailed requirements for external assurance for quality reports 2017/18'; 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 2017/18' and supporting guidance and the six dimensions of data quality set out in the ''Detailed requirements for external assurance for quality reports 2017/18'.

We read the Quality Report and consider whether it addresses the content requirements of the 'NHS foundation trust annual reporting manual 2017/18' and supporting guidance, 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 for the period 1 April 2017 to 25 May 2018;
- papers relating to quality reported to the Board over the period 1 April 2017 to 25 May 2018;
- feedback from NHS Nene CCG and NHS Corby CCG dated 18/05/2018;
- feedback from governors dated 09/05/2018;
- feedback from Healthwatch Northamptonshire dated 17/05/2018;
- feedback from Northamptonshire County Council Overview and Scrutiny Committee dated 17/05/2018;
- the Trust's complaints report published under regulation 18 of the Local Authority Social Services and National Health Service Complaints (England) Regulations 2009, dated April 2018;
- the national patient survey dated 31/05/2017;

- the national staff survey dated 06/03/2018;
- the Care Quality Commission inspection report dated 27/02/2018; and
- the Head of Internal Audit's annual opinion over the Trust's control environment dated 23/05/2018.

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.

The firm applies International Standard on Quality Control 1 (Revised) and accordingly maintains a comprehensive system of quality control including documented policies and procedures regarding compliance with ethical requirements, professional standards and applicable legal and regulatory requirements.

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 Kettering General Hospital NHS Foundation Trust as a body, to assist the Council of Governors in reporting Kettering General Hospital 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 Kettering General Hospital 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
- limited testing, on a selective basis, of the data used to calculate the indicators tested against supporting documentation
- comparing the content requirements of the 'NHS foundation trust annual reporting manual 2017/18' and supporting guidance 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 that 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 2017/18' and supporting guidance.

The scope of our limited assurance work has not included governance over quality or non-mandated indicators, which have been determined locally by Kettering General Hospital NHS Foundation Trust.

Our audit work on the financial statements of Kettering General Hospital NHS Foundation Trust is carried out in accordance with our statutory obligations. This engagement will not be treated as having any effect on our separate duties and responsibilities as Kettering General Hospital NHS Foundation Trust's external auditors. Our audit reports on the financial statements are made solely to Kettering General Hospital NHS Foundation Trust's members, as a body, in accordance with paragraph 24(5) of Schedule 7 of the National Health Service Act 2006. Our audit work is undertaken so that we might state to Kettering General Hospital NHS Foundation Trust's members those matters we are required to state to them in an auditor's report and for no other purpose. Our audits of Kettering General Hospital NHS Foundation Trust's financial statements are not planned or conducted to address or reflect matters in which anyone other than such members as a body may be interested for such purpose. In these circumstances, to the fullest extent permitted by law, we do not accept or assume any responsibility to anyone other than Kettering General Hospital NHS Foundation Trust and Kettering General Hospital NHS Foundation Trust's members as a body, for our audit work, for our audit reports, or for the opinions we have formed in respect of those audits.

Conclusion

Based on the results of our procedures, as described in this report, 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 2017/18' and supporting guidance;
- the Quality Report is not consistent in all material respects with the sources specified in NHS Improvement's 'Detailed requirements for external assurance for quality reports 2017/18'; and
- the indicators in the Quality Report identified as having been subject to limited assurance have not been reasonably stated in all material respects in accordance with the 'NHS foundation trust annual reporting manual 2017/18' and supporting guidance.

Grant Thornton UK LLP

Grant Thornton UK LLP
Chartered Accountants
The Colmore Building
20 Colmore Circus
Birmingham
B4 6AT

25 May 2018

INTRODUCTION

The purpose of this quality report is to detail for patients, their families and carers, staff, members of local communities and our health and social care partners, the quality of services that the Trust provides.

The quality report is one aspect of the continued drive to improve the quality and safety of the services we provide.

Our **CARE** standards underpin our values, embraced by our most valuable resource, our staff.

In **Part One**, there is a statement on quality from our Chief Executive, Simon Weldon.

In **Part Two**, we have provided details of nine specific priorities for quality improvement that we intend to deliver in 2018/19. A summary of our quality pledges within our Quality Strategy for 2018-2021 are also summarised. We have described the actions taken to date to continue our journey of improvement to good and outstanding in relation to our 'Requires Improvement' rating from the CQC in 2017.

There are also a number of Statements of Assurance regarding specific aspects of service provision. The Trust is required to provide these statements to meet the requirements of NHS Improvement.

Part Three describes how we performed against the quality priorities set for 2017/18, together with performance against key national priorities in line with NHS Improvement Risk Assessment Framework.

The latter section outlines feedback from the Trust's key stake holders and how we have addressed the feedback in this Quality Report.

Throughout all parts of this quality report, where information on performance in previous years is available, this has been included. The most up to date national and local information has also been included throughout.

Thank you for taking the time to read our quality report. If you would like to comment on any aspect of this document, we would welcome your feedback.

You can contact us at: pals@kgh.nhs.uk

CONTENTS

Part One: Statement on quality from the Chief Executive

Welcome to our Quality Report for 2017/18.

I am delighted to have joined the Trust as Chief Executive Officer in April 2018. It has been rewarding to see the journey of improvement during 2017/18 as recognised in our 2017 Care Quality Commission (CQC) inspection.

This is the start of our journey from a CQC rating of 'Requires Improvement' to 'Outstanding' and is testament to our most valuable resource, our staff. Our CQC rating of 'Good' for caring across all services demonstrates staff commitment and compassion in support of our CARE values.

Despite demand for our services at unprecedented levels during 2017/18 and with bed occupancy averaging 99%, our staff maintained safe, qualify care and I am extremely impressed with the focus and energy of staff. Some highlights include:

- Reporting fewer Clostridium Difficile infections than the ceiling number set by our commissioners;
- Achievement of more than 1,000 days since the last reported case of hospital acquired MRSA;
- Reducing the backlog of radiology plain film reporting with a clear plan for 2018/19 to report plain film images within 10 working days for routine referrals and within 2 working days for urgent referrals;
- Delivered on all seven cancer standards, significantly reducing 52 week waits to 3 by March 2018;
- Improved patient safety incident reporting with an average of 3 median days from incident date to notifying the National Reporting and Learning System so that more responsive learning actions can be taken (an improvement from 34 median days);
- Launched our patient engagement and involvement community events, improved responding to concerns within agreed timescales and involved our local population in making improvements to our services and the design of our new electronic feedback system, to be installed during 2018/19;
- Development of our patient safety electronic system for improved 'real time' reporting of incidents and risks with plans to launch dashboards with triangulated 'real time' information;
- Development of our governance structures and clinical leadership within our new Divisions of Medicine, Surgery and Family Health.

Our focus during 2018/19 will be on high quality safe care in an environment that meets the needs and expectations of our local population. We have listened to the views of our staff and organisational development will be a continued priority underpinned by our CARE values. The reintroduced clinical excellence awards are a key part of recognising the exceptional care and innovation across the Trust.

We will continue with our business case for a new Urgent Care Hub, working closely with NHS Improvement and local stakeholders including partnership working with the Northamptonshire Health and Social Partnership.

In response to the Well-Led Review in 2017, the Trust has restructured from 7 Clinical Business Units to 3 Divisions to strengthen clinical leadership and accountability. A robust accountability and governance framework will support our new Divisions to take further ownership of quality, whilst effectively managing risks and safety, providing the Trust Board of Directors with a clear line of sight across the organisation.

Our Quality Improvement Plan will underpin how we will monitor and achieve our objectives and the recommendations from our November 2017 CQC Inspection. Our revised Quality Strategy 2018-2021 sets the vision for quality improvement and how we will monitor achievement of our patient safety and quality ambitions.

A particular focus that impacts on quality will be to improve how we manage capacity demands on our service and a continued focus on prevention of pressure tissue damage, medicines management and timely discharge processes.

Simon Weldon
Chief Executive

24 May 2018

I hope that you will find our Quality Report for 2017/18 informative on our achievements and plans to make further improvements in the year ahead. The specific quality priorities detailed in this Quality Report and summarises below are taken from our Quality Strategy and is the result of wide consultation with staff and key stakeholders.

Patient Safety

- Preventing avoidable deterioration (sepsis management).
- Safe assessment and response to the needs of mental health patients in A&E
- Improve and embed learning from outcomes across the Trust for all staff.

Patient Experience

- Improving how we manage pain for patients
- Improving how we communicate with patients about waiting times when referred for treatment.
- Reducing noise at night on our wards

Clinical Effectiveness

- Increasing the number of mortality reviews
- To reduce to number of term babies admitted to the neonatal unit with a primary reason of respiratory conditions.
- Improving our compliance with mandatory safeguarding training standards

Part Two

Priorities for Improvement 2018/19

As part of the quality report process, the Trust is required to set priorities for improvement. These are issues considered important to patients, local communities and our stakeholders.

Governors and our local community have been involved in setting our priorities. Our Governors selected assessment and management of Sepsis, a patient safety priority as a local quality indicator for audit by our external auditors. They audited quarter 4 sepsis screening rates reported as 70% for ED and 85% for inpatients and the one hour antibiotic administration rates for new cases of red flag sepsis, 90% for ED and 68% for inpatients.

Progress made since the publication of the 2016/17 quality account is described in Part Three.

Patient Safety Priorities 2018/19

To continue to reduce avoidable harm three key priority areas were identified and selected through consultation and approved by Trust Board:

Preventing Avoidable Deterioration (Sepsis Management) – This priority was selected by Trust Governors

Why have we chosen this priority?

As a national priority and a CQUIN (commissioning for quality and innovation) from our commissioners, we recognise that there is more work to do in order to ensure that there is early recognition and management of deteriorating patients. We wish to intervene rapidly for all such patients in an effective way in order to prevent avoidable harm. The intended impact on patients is through rapid recognition and treatment for those suspected to have sepsis in an effective way in order to prevent avoidable harm and potentially improve outcomes.

This is therefore a priority from the previous two years that we wish to continue to embed and sustain for further improvements during 2018/19.

How will we improve?

- Continue our work with East Midlands Patient Safety Collaborative, utilising expertise throughout the Trust.
- Produce and embed a Paediatric Sepsis Guideline.
- Produce and embed a Paediatric antibiotic policy.
- Undertake assessment of practice against NICE Quality Standards.
- Develop a sepsis e-learning programme.
- Ensure robust interventions with relevant patients in our emergency department within the ‘golden period of response’ time for treatment.

How will we measure our improvement and what are our targets?

- We will produce reports from our CQUIN audits.
- Report on compliance with training.
- Report on assessment of practice and engage with the Clinical Audit Team on the NICE quality standard assurances.

How will we report and monitor our progress?

- The Sepsis Steering Group meetings monthly and will review audit results and monitor progress.
- Results will be escalated quarterly to the Quality Governance Steering Group and to the CQUIN Assurance Panel.
- Audits will be reported into the Clinical Audit Committee.

Safe Assessment and response to the needs of mental health patients in A&E

Why have we chosen this priority?

We have achieved compliance with risk assessments and our environment in A&E for mental health patients. However, we have more work to do on ensuring there is a person centred approach to assess and treat this patient group. The CQC 2017 Inspection also identified this as an area for improvement.

How will we improve?

- We will comply with national guidance from the Royal College of Emergency Medicine in order that there is a multi-disciplinary approach to the assessment and treatment of mental health patients that includes ongoing management whilst in our care.
- We will improve our documentation.

How will we measure our improvement and what are our targets?

- We have a mental health CQUIN in place whereby an audit is undertaken.
- Patient feedback.
- External feedback as a result of partnership working.
- Progress reporting through our Quality Improvement Plan.

How will we report and monitor our progress?

- Weekly Quality Improvement Plan meetings with reporting to our Safety and Quality Committee and to the Trust Board.
- CQUIN group and external reporting to our commissioners.

Improve and embed learning from outcomes across the Trust for all staff

Why have we chosen this priority?

We have introduced new ways of sharing learning over the past year and sustained existing mechanisms such as our Patient Safety Lessons Learnt Forum (PSLLF) and Learning Bulletins. As a result of our CQC Inspection in 2017, we recognise that there is more we can do to ensure that all staff understand learning actions so that we can improve patient safety further.

How will we improve?

- We will introduce a learning message of the week and share through patient safety huddles and team meetings.
- We will ensure that staff who investigate our serious incidents, present the learning to the team in the area/ward where the incident occurred.
- Place learning bulletins that are issued to specific areas, onto our Knet page for all staff to access.
- Enhance learning messages in our Trust induction training.
- We will invite more multidisciplinary staff to our PSLLF.

How will we measure our improvement and what are our targets?

- We will measure themes and trends of incidents to identify the impact of learning knowledge, seeking a reduction of key learning themes.
- We will undertake quality assurance visits on a rolling programme across the Trust and will test staff knowledge of learning from outcomes for improvement of patient safety.

How will we report and monitor our progress?

- We will monitor processes for sharing learning.
- We will monitor attendance at the PSLLF.
- We will report on key themes from outcomes in patient safety reports.
- We will report on compliance with evidence against our learning actions.
- Quality assurance visits will report against individual and team knowledge and understanding of learning.
- Quarterly patient safety reports and Quality Assurance Reports will be provided to the Quality Governance Steering Group and Quality and Safety Committee.
- Divisional Governance Meetings will produce reports specific to their divisional specialties on learning assurances and quality assurance visit outcomes and actions.

Patient Experience Priorities 2018/19

Improving how we manage pain relief for our patients

Why have we chosen this priority?

Our inpatient survey results published in 2017 indicated that a number of patients felt that we did not help with pain relief as effectively as we could have.

How will we improve?

- We will improve our communication with patients to understand their pain.
- We will ensure improved compliance with our observation standards of patients' pain.

How will we measure our improvement and what are our targets?

- We will audit the frequency of documentation of pain in our clinical records.
- We will seek assurance from Matrons in our Quality Assurance Visits on standards of pain management.
- We will monitor concerns raised.

How will we report and monitor our progress?

- We will report to the Quality Governance Steering Group.

Reducing noise at night for our inpatients

Why have we chosen this priority?

Our Friends and Family Test responses indicate that noise at night on inpatient areas impacts on our patients. This was a priority for 2016/17 and we introduced initiatives for noise reduction. This is a continued priority in order that we can monitor how effective our planned interventions are.

How will we improve?

- We will launch our campaign on 'Sleep Sound in Hospital'.
- We will enforce our uniform policy in relation to footwear.
- We will continue with our pilot of 'sleep well kits' comprising of eye masks and ear plugs.
- We will work to ensure soft close bins are in place in all inpatient areas.

How will we measure our improvement and what are our targets?

- We continue to obtain feedback from patients via FFT, PALS concerns, surveys and complaints.
- We will undertake Quality Assurance Visits and speak with patients about noise at night.
- We will assess the replacement of old bins with new soft close bins.
- We will seek assurance that ward staff are working to the 'sleep sound in hospital' initiative.

How will we report and monitor our progress?

- We will report in our quarterly Patient Experience Reports to the Patient Experience and Involvement Steering Group and annually to Trust Board.

Improving how we communicate with patients about waiting times when referred for treatment

Why have we chosen this priority?

Our community engagement events received feedback that patients felt that communication could be improved on how long they may need to wait when referred for treatment.

How will we improve?

- We will continue to work to our Referral to Treatment (RTT) standards.
- We will launch a campaign for improved communication at outpatient appointments for those patients who are referred for treatment after initial assessment.

How will we measure our improvement and what are our targets?

- We will sample audit outpatient clinical records for documentation standards on potential waiting times and how this has been communicated with patients.
- We will analyse patient feedback trends.
- We will continue to monitor our RTT standards compliance.

How will we report and monitor our progress?

- By reporting to our Performance, Finance and Resource Committee;
- Reporting to the RTT Executive Assurance Group;
- Monitoring with our Divisional Performance Review Meetings.

Clinical Effectiveness Priorities 2018/19

Increasing the number of mortality reviews

Why have we chosen this priority?

The Trust has led countywide mortality reviews and is performing well on the number of mortality reviews undertaken in order to identify learning for patient safety and to also identify best practice. We want to increase the number of mortality reviews being undertaken to greater than 50% of all reported deaths within the scope reviewed. This relates to all adult inpatients with the exception of maternity patients.

How will we improve?

- We will undertake more than 50% reviews of all patients within the scope of patients.
- We will increase the number of multi-disciplinary staff participating in mortality reviews.

How will we measure our improvement and what are our targets?

- Number of mortality reviews undertaken.

How will we report and monitor our progress?

- Mortality reports to the Patient Safety Advisory Group and Quality and Safety Committee.
- Bi-annual reports to the Trust Board.

Reducing the number of unexpected term babies being admitted to the neonatal unit with respiratory factors as the primary cause for admission

Why have we chosen this priority?

Work which has taken place locally in 2017/2018 reviewing admissions of term babies as part of the maternity safety plan and ATAIN(Avoiding Term Admissions Into Neonatal) work. It is recognised that this requires further consideration to accurately inform a quality improvement project in order to reduce term admissions to neonatal unit in 2018/19. This review work has demonstrated that a number of the babies admitted were following elective caesarean sections and data obtained from NMPA (National Maternity Perinatal Audit) has highlighted locally, a lower than national average of VBAC therefore a potential outcome from the QI project will be an increase in women having VBAC (Vaginal Birth After Caesarean) which would reduce elective caesarean section rate and therefore admissions of term babies to neonatal unit with a primary cause of admission being respiratory disorders. As this has been recognised as a potential link more in depth analysis is required to fully inform the framework of the QI project.

How will we improve?

- We want to reduce the numbers of unexpected term babies being admitted to the neonatal unit with respiratory factors as the primary cause for admission.

How will we measure our improvement and what are our targets?

- A reduction in unexpected admissions of term babies with respiratory factors

How will we report and monitor our progress?

Reports will go quarterly to Divisional Governance regarding the project. There will be initial preparation work to establish as a QI project as part of the National Maternity Safety Work Wave 3 implementation in quarter 3 with NHSI. Progress will then be monitored both internally and externally reporting to Patient Safety Forum, Trust Governance structures and NHSI.

Improving our compliance with mandatory safeguarding training standards

Why have we chosen this priority?

Safeguarding vulnerable patients is a key priority and it is important that staff are trained appropriately and have the competencies required to safeguard this patient group. Our target compliance with safeguarding mandatory training is 85% compliance and we do not consistently maintain this across the Trust in all staff groups. The CQC 2017 Inspection also identified this as an area for improvement.

How will we improve?

- Clinical leaders will ensure that there is a plan in place to release staff to attend training.
- There will be robust follow up of non-compliance with training.

How will we measure our improvement and what are our targets?

- We will measure compliance of safeguarding training.

How will we report and monitor our progress?

- Monthly compliance reports will be provided to the Workforce Development Committee and Safeguarding Committee.
- Divisional Governance Reports will detail compliance and interventions being taken to address areas of non-compliance.

PART TWO

Statements of assurance from the board of directors

These statements of assurance follow the statutory requirements for the presentation of quality accounts, as set out in the Department of Health's quality accounts regulations.

Implementing our Duty of Candour

CQC Regulation 20: Duty of Candour requires all registered services to be open and transparent with patients and their families (where appropriate) about the care and treatment they receive, particularly when things go wrong. For all patient safety incidents resulting in moderate or greater harm (defined by the CQC as a notifiable incident), this statutory duty requires the trust to inform people about the incident, provide reasonable support, truthful information and an apology.

Our Patient Safety Team support clinical staff to engage with patients and their families, to apologise and offer the opportunity for them to be involved in investigations including contributing to the investigation terms of reference. Patients and their families are also offered the opportunity to be informed of the outcomes from the investigation and any learning that has taken place as a result will also be shared.

The choice is also given to patients and their families to meet with clinical staff to discuss the investigation to gain a better understanding of what happened.

The trust places great importance on the Duty of Candour, regularly monitoring, auditing and measuring our compliance against the requirement using the trust electronic management system Datix.

Assurance of our compliance is included in our investigation reports, which are shared with the 'relevant person' (patient or family member), staff and our commissioners. Assurance of compliance is also given within Monthly and Quarterly Patient Safety reports that are produced for the trust Quality Governance Steering Group.

Radiology Reporting

The radiology department is part of the East Midlands Radiology Consortium (EMRAD) which is a collaboration of some NHS Trusts in the region with image sharing and reporting capabilities delivered utilising a regional PCAS (Picture Archive and Communication System). The aim is to allow all clinicians to see patient data at point of need, regardless of location alongside the implementation of high quality clinical information and operational governance structures to keep patient data secure. During the implementation of this new system at the Trust, initial technical difficulties were encountered, delaying timely reporting of images.

Other Trusts in the region experienced similar delays and commissioners and Trust Regulators, including the CQC and NHS Improvement, were kept informed of the issues and actions being taken to address the backlog.

Patient safety is a key priority for the Trust and timely reporting of images is recognised as a patient safety concern when reporting is delayed. Any study with a delayed report that shows a pathology is recorded via the Datix system and is fully investigated to assess the level of harm if any.

During 2017/18 the Trust established an Executive Assurance Group chaired by the Chief Executive Officer in order to monitor the reduction in delayed image reporting and that patient safety reviews are taking place for those patients experiencing delays. The CQC has approved the Trust's Improvement Plan and also note the process for undertaking clinical harm reviews.

To support the reduction in delayed image reporting, the Radiology Service utilises in-house consultant staff, highly trained and experienced reporting radiographers, plus the services of carefully chosen locum staff and tele-radiology providers. Alongside this the service has developed a comprehensive programme to review and update the data held on the Radiology Information System. This programme has been externally validated to ensure that all images requiring reporting are identified and a formal report issued. In addition the service has developed and implemented clear standard operating procedures for reporting priorities and clear performance metrics for report turnaround times.

The majority of routine imaging studies are now reported within 14-21 days. Work is planned to continue on the backlog reduction to ensure that the agreed performance indicators can be consistently maintained or improved upon on an ongoing basis.

Delivery of our new CT scanner in March 2018

Our Patient Safety Improvement Plan as part of the NHS Sign up to Safety Campaign

A national 'Sign up to safety' campaign was launched in 2014 with the overall aim of reducing avoidable harm in the NHS by 50% and saving 6000 lives (nationally). The Trust signed up to the Campaign in August 2014.

The Trust continues to support this ambition and has continued to develop its Patient Safety Improvement Plan (approved in April 2016). It sets out how the Trust will continue to develop the Patient Safety Campaign, quality improvement projects and methodologies.

Our Patient Safety Advisory Group (PSAG) monitors progress of the plan and agrees the projects together with identifying leads for each.

Our patient safety target areas and progress during 2017/18

Management of the deteriorating patient (NEWS – National Early Warning Score)

Audit of NEWS & Escalation Strategy-Evaluation of the revised NEWS & Deteriorating Patient Escalation Documentation was carried out and concluded that these are fit for purpose. Continual monitoring via Root Cause Analysis (RCA's), Nurse Sensitive Indicators (NSIs) along with spot checking of clinical areas will make certain that all clinical areas adhere to Trust policy

Mortality Review

From March 2018, we have a Mortality Manager who oversees mortality reviews within the Trust. A minimum of 50% of all deaths are reviewed monthly and reported at the Patient Safety Advisory Group and Integrated Governance Committee, monthly. It is also reported to the Board, quarterly.

Safe Discharge

Medical staff together with our Chief Pharmacist are undertaking a review of discharge information. We also plan to work with our Transformation Team to ensure that our IM&T infrastructure supports this project and regional Sustainability and Transformation Plans.

Reducing Falls

We have detailed the work achieved during 2017/18 on pages 61-62 of this report. The Falls Prevention Group continues to develop Trust wide learning to reduce falls.

Pressure Tissue Damage Reduction

The Pressure Tissue Damage Incident Validation Group undertakes a thematic review of all incidents. This is to draw out the learning that informs the annual improvement programme for reduction in harm from such incidents.

Prevention of Deep Vein Thromboembolism

Throughout 2017/18, our VTE Prevention team has engaged with Mortality Reviews and continued with teaching sessions throughout the Trust. We are establishing Haemostasis and Thrombosis Patient Improvement Facilitators.

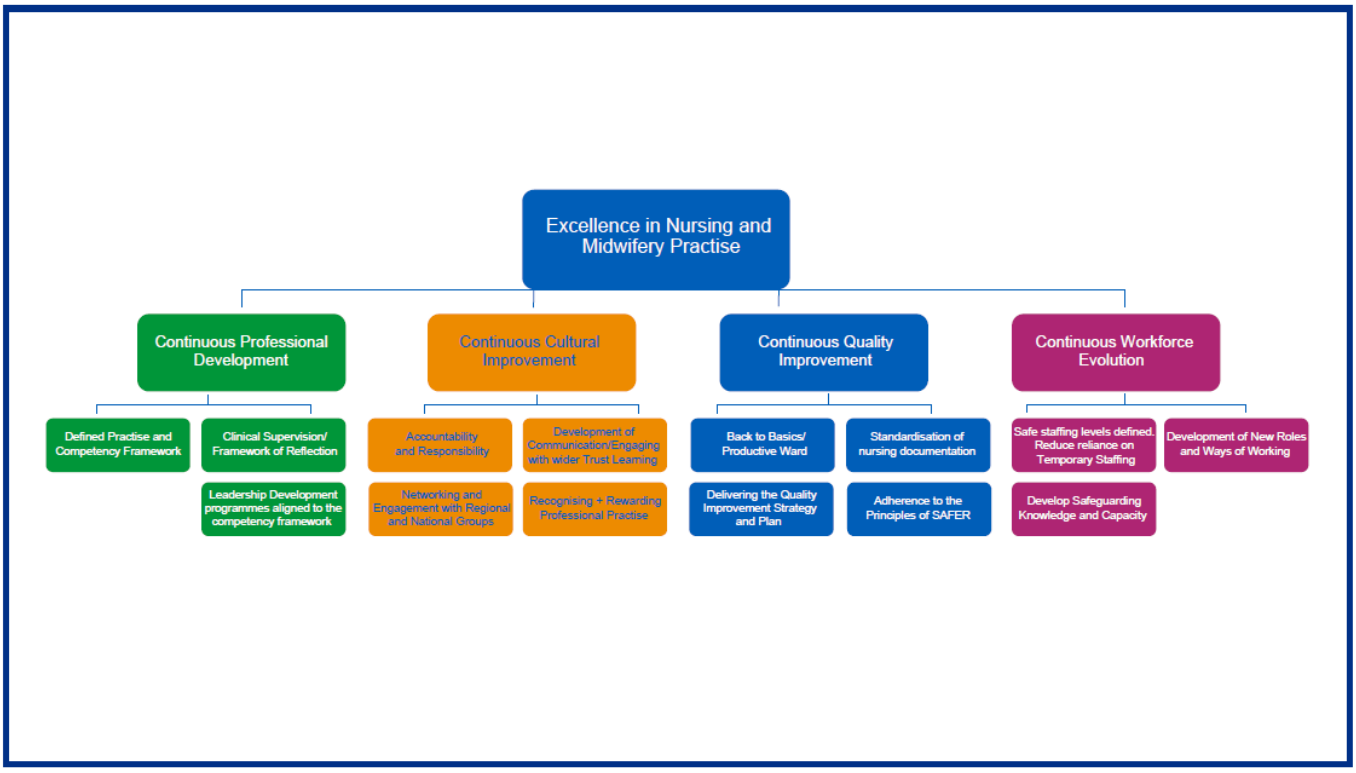
Quality Improvement Projects

During 2017/18, we commenced Quality Improvement Training Sessions facilitated by the East Midlands Patient Safety Collaborative. A number of quality improvement project audits were undertaken throughout 2017/18 with excellent contribution from junior doctors and student nurses. These include:

- CT Pulmonary Angiogram in Diagnosing Pulmonary Embolism
- Optimising heart failure management in KGH
- Documentation of Troponin and cholesterol requests and results

Assessing our Patient Safety Culture The Pascal Metrics Safety Culture Survey (led by East Midlands Patient Safety Collaborative) is due to be completed for A&E and Maternity Services during March 2018.	**Improvement Methodologies** Project plans are agreed, together with project leads. Methodologies being implemented include PDSA cycles (plan, do, study, act), audits and data measurement via statistical process control charts (SPCs). **How will we report and monitor our progress?** We will report monthly to the Patient Safety Advisory Group and quarterly to the Quality Governance Steering Group with summary reporting to the Integrated Governance Committee.

Our Nursing and Midwifery Framework of Excellence 2018-2021 supports delivery of our quality improvements through the assurance structure below:



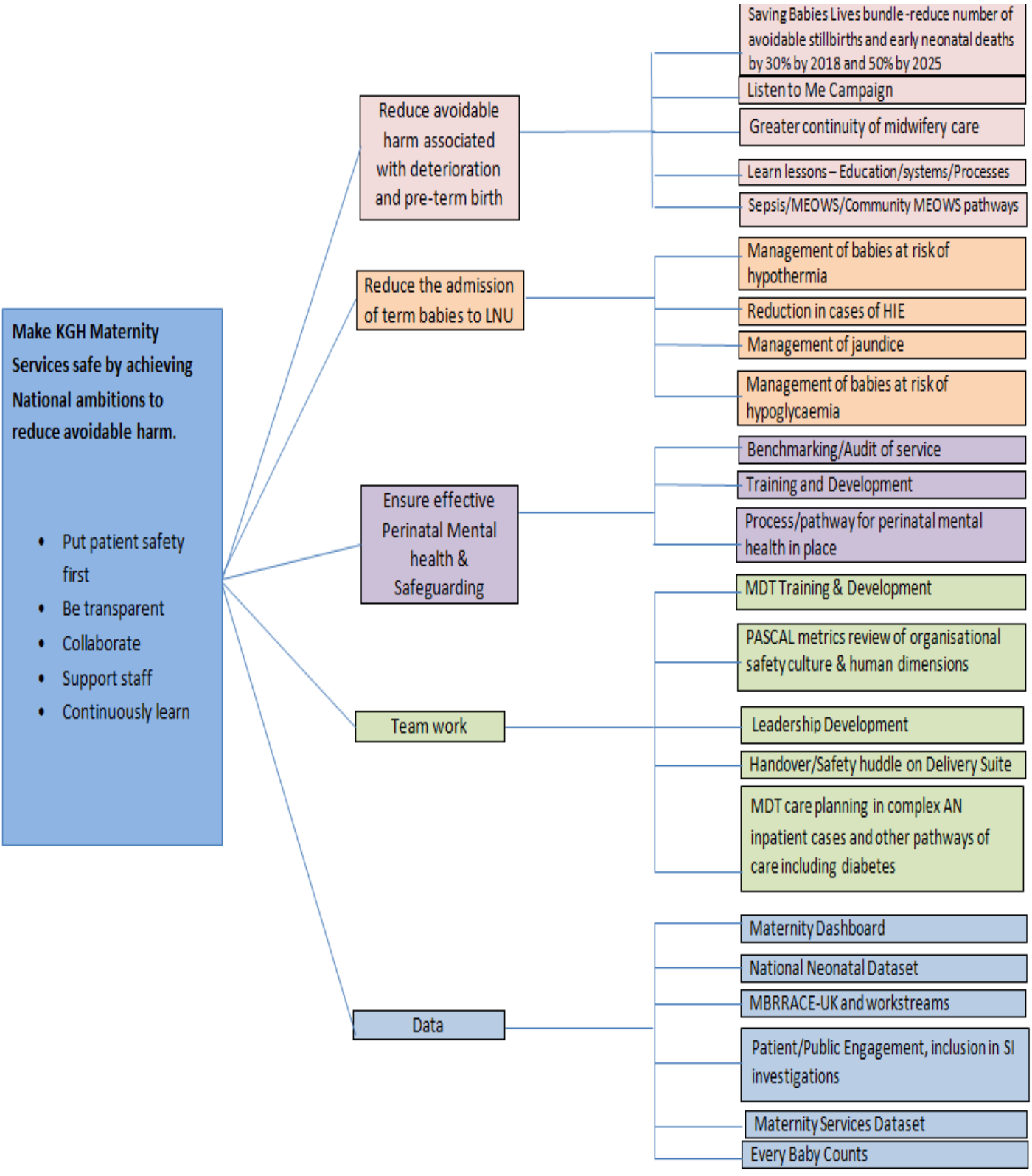
In order to develop the service to be as safe as it can be, we recognise the importance of strong leadership within the team. Strong leadership promotes a professional culture which facilitates and empowers teams to provide the best possible care. Strong leadership enables the fostering and development of collaborative relationships across networks to support the delivery of safer maternity care. A Board level Maternity Champion to be appointed and a bespoke Maternity Safety Plan to be made public and included within the quality account will strengthen Leadership and focus Maternity Services at Board Level. In order to develop the service to be as safe as it can be, we recognise the importance of strong leadership within the team.

Strong leadership promotes a professional culture which facilitates and empowers teams to provide the best possible care. Strong leadership enables the fostering and development of collaborative relationships across networks to support the delivery of safer maternity care. A Board level Maternity Champion to be appointed and a bespoke Maternity Safety Plan to be made public and included within the quality account will strengthen Leadership and focus Maternity Services at Board Level.

We recognise the importance of promoting a culture of safety that is underpinned by openness and a desire to learn lessons from investigations. We share a drive to continuously improve and benchmark our local service which is key to provide a focus on prevention and quality, and review of local actions that may be required to further develop the overall service and take action to apply best practise to the care that we deliver.

We appreciate the importance of investing in the capability and skills of the multi-disciplinary team and we are committed to provide access to evidenced based training and development for the entire multi-disciplinary team. A developed and motivated team provides safer care. We are committed to the use of electronic systems to improve local and National **data** collection, and as such will continue to contribute to national and local surveys. We need to ensure the Trust is reporting to maternity Services Dataset and other key data sets such as MBRRACE-UK, RCOG, Each Baby Counts, National Neonatal Dataset and National Maternity and Perinatal Audit.

Innovation within the team is supported and encouraged. Innovation leads to improvement and the opportunity to share learning both within, and outside of the organisation to drive up standards. We propose to work collaboratively with Northants Local Maternity Systems (LMS) to achieve the outcomes of Maternity Transformation Programmes. To will take part in the new Maternal and Neonatal Health Quality Improvement Programme. This Plan will include an update twice a year captured within the body of the document, with an exception report for supporting detail. Where the service is on target, progress will be noted within the plan. In areas where progress is off plan, remedial actions will be given in an action plan at the foot of the document.


Make KGH Maternity Services safe by achieving National ambitions to reduce avoidable harm.
Put patient safety first
Be transparent
Collaborate
Support staff
Continuously learn
Reduce avoidable harm associated with deterioration and pre-term birth
Saving Babies Lives bundle -reduce number of avoidable stillbirths and early neonatal deaths by 30% by 2018 and 50% by 2025
Listen to Me Campaign
Greater continuity of midwifery care
Learn lessons – Education/systems/Processes
Sepsis/MEOWS/Community MEOWS pathways
Reduce the admission of term babies to LNU
Management of babies at risk of hypothermia
Reduction in cases of HIE
Management of jaundice
Management of babies at risk of hypoglycaemia
Ensure effective Perinatal Mental health & Safeguarding
Benchmarking/Audit of service
Training and Development
Process/pathway for perinatal mental health in place
Team work
MDT Training & Development
PASCAL metrics review of organisational safety culture & human dimensions
Leadership Development
Handover/Safety huddle on Delivery Suite
MDT care planning in complex AN inpatient cases and other pathways of care including diabetes
Data
Maternity Dashboard
National Neonatal Dataset
MBRRACE-UK and workstreams
Patient/Public Engagement, inclusion in SI investigations
Maternity Services Dataset
Every Baby Counts

Our Ratings from the Care Quality Commission (CQC)

Kettering General Hospital NHS Foundation Trust is required to register with the Care Quality Commission and its current registration status is unconditional.

Kettering General Hospital NHS Foundation Trust has no conditions on registration. The Care Quality Commission has not taken enforcement action against Kettering General Hospital NHS Foundation Trust during 2017/18.

The Trust was inspected by the CQC in November 2017. This involved an inspection of six core services (Diagnostics; Maternity; Outpatients; Services for Children and Young people; Surgery; Urgent and Emergency services) and a Well-Led review which looks at how well leaders create an environment that encourages improvement.

The Trust was rated as 'Requires Improvement'. The full inspection report can be found at http://www.cqc.org.uk/sites/default/files/new_reports/AAAH0193.pdf

Inspectors noted:

> ***"The Trust was embedding a systematic approach to improving quality of its services and safeguarding high standards of care by aiming to create an environment in which excellence in clinical care would flourish."***

Similar to previous years, the Trust was again rated 'Good' for 'Caring'. In all of the areas inspected there were no areas in which our performance deteriorated.

The ratings given to the Trust are detailed below:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Urgent and emergency services	Inadequate → ← Feb 2018	Requires improvement ↑ Feb 2018	Good → ← Feb 2018	Requires improvement → ← Feb 2018	Inadequate → ← Feb 2017	Inadequate → ← Feb 2018
Medical care (including older people's care)	Requires improvement Apr 2017	Requires improvement Apr 2017	Good Apr 2017	Good Apr 2017	Requires improvement Apr 2017	Requires improvement Apr 2017
Surgery	Requires improvement → ← Feb 2018	Good → ← Feb 2018	Good → ← Feb 2017	Requires improvement → ← Jan 2018	Good → ← Feb 2018	Requires improvement → ← Feb 2018
Critical care	Good Apr 2017	Good Apr 2017	Good Apr 2017	Good Apr 2017	Good Apr 2017	Good Apr 2017
Maternity	Requires improvement Feb 2018	Requires improvement Feb 2018	Good Feb 2018	Requires improvement Feb 2018	Requires improvement Feb 2018	Requires improvement Feb 2018
Services for children and young people	Requires improvement ↑ Feb 2018	Requires improvement → ← Feb 2018	Good → ← Feb 2018	Requires improvement → ← Feb 2018	Requires improvement ↑ Feb 2018	Requires improvement ↑ Feb 2017
End of life care	Good Apr 2017	Requires improvement Apr 2017	Good Apr 2017	Good Apr 2017	Good Apr 2017	Good Apr 2017
Outpatients	Good Feb 2018	N/A	Good Feb 2018	Requires improvement Feb 2018	Good Feb 2018	Good Feb 2018
Diagnostic imaging	Inadequate Feb 2018	N/A	Good Feb 2018	Requires improvement Feb 2018	Inadequate Feb 2018	Inadequate Feb 2018
Overall*	Requires improvement ↑ Feb 2017	Requires improvement → ← Feb 2018	Good → ← Feb 2018	Requires improvement → ← Feb 2017	Requires improvement ↑ Feb 2018	Requires improvement ↑ Feb 2018

Actions to address areas for improvement:

With the report the Chief Inspector of Hospitals made recommendations to the Trust for improvement actions to be taken.

In order to monitor delivery and evidence of improvement, the Trust has developed a Quality Improvement Plan that is reviewed weekly by clinical leads and our governance team, with reporting to the Trust Board of Directors. Each element has been risk assessed and recognised within our risk registers to ensure any risks are appropriately addressed.

This includes work related to:

- Timely care and assessment in the Emergency Department
- Radiology results waiting times and procedures
- Staff training
- Infection control
- Staffing levels
- Premises/environment/impact on dignity

External assurances

- The Trust continues to be supported by NHS Improvement (NHSI) with the appointment of an Improvement Director.
- Updates to the CQC through the Relationship Manager and NHSI via Quality Improvement Review Meetings.
- Assurances of progress are monitored at bi-monthly oversight meetings attended by NHSI, CQC and the Clinical Commissioning Groups.

Information on the review of services

During 2017/18 Kettering General Hospital NHS Foundation Trust provided and/or subcontracted with 15 relevant health services providers.

Kettering General Hospital NHS Foundation Trust has reviewed all the data available to them on the quality of care in these relevant health services.

During 2017/18 Kettering General Hospital NHS Foundation Trust held two key contracts with NHS commissioners to provide services. The Trust's lead commissioner is Corby Clinical Commissioning Group who also commissions on behalf of NHS Nene Clinical Commissioning Group, this contract constitutes a range of acute hospital services including elective, non-elective, day case and outpatients.

In addition the Trust holds a contract with NHS England for Prescribed Specialised Services such as the provision of a special baby care unit, specialised cardiac interventions, neonatal intensive care and other specialised services.

The Trust also provides a variety of services to other NHS organisations, public sector organisations and private sector companies.

Key contracts are held with:

- Northampton General Hospital NHS Trust
- University Hospitals Leicester NHS Trust
- Northamptonshire Healthcare NHS Foundation Trust
- Ramsay Healthcare United Kingdom
- Lakeside Plus Limited
- Woodsend Medical Centre.

Provision of services includes medical staffing and support services, such as Pathology and Radiology.

The income generated by the relevant health services in 2017/18 represents 93.7% of the total income generated by Kettering General Hospital NHS Foundation Trust.

In addition the Trust has maintained contracts for services specifically aimed at supporting the delivery of the 18 week referral to treatment target with Ramsay Health Care UK Operations Limited, Medinet Clinical Services Limited and Spire Leicester Hospital.

The Trust has a number of contracts with Medicines Homecare providers which include: Healthcare At Home, Lloyds Pharmacy Clinical Homecare, Pharmaxo, Healthnet and Alcura.

The Trust has a contract with Stor-a-file Limited for the provision of offsite medical records storage and retrieval.

Contract/performance management frameworks exist for the main contracts held by the Trust and through these commissioner and provider responsibilities are clearly stated and monitored. The Trust holds regular contract meetings with sub-contractors to monitor performance against the contract. However concerns raised about the quality of subcontractors can also be raised at any point in the year and a formal contract meeting will take place to discuss concerns and address issues.

The quality of services sub-contracted is also reviewed by the Trust via regular contracting and quality review meetings.

The Trust also reserves the right to undertake unannounced visits to relevant in-patient areas in order to check the quality of service provision.

Services sub-contracted by the Trust

During 2017/18 Kettering General Hospital NHS Foundation Trust subcontracted services to 18 key organisations for relevant health services.

These sub-contracted services include: Services for medical staffing with Northampton General Hospital NHS Trust, Oxfordshire University Hospitals NHS Trust, Heart of England NHS Foundation Trust, University Hospitals Leicester NHS Trust, Ramsay Healthcare United Kingdom, Spire Healthcare and Nottingham University Hospitals NHS Trust.

Northamptonshire Healthcare NHS Foundation Trust for delivery of therapy services including; Physiotherapy, Occupational Therapy, Speech and Language Therapy, Dietetics, and Podiatry; Specialist Nursing (including, but not limited to adult and paediatric diabetes Nursing,), primary care streaming, consultant medical input to Care of the Elderly and Palliative Care, and Special Needs Dentistry.

The Trust has a contract with Brighterkind Limited for the provision of an off-site bed provision for those patients who are well enough to be transferred pending discharge packages.

The Trust also commissions 4Ways Healthcare Limited and Everlight Radiology for the provision of Radiology Reporting services and Inhealth Limited with respect to mobile MRI services.

Some Quality Highlights

Launch of our Antibiotic App helping to ensure patients receive the right treatment quickly.

- Achieved the target for C-Diff, reporting less than the ceiling trajectory set for 2017/18
- > 1000 days since last trust acquired MRSA bacteraemia
- Reduced falls that result in harm for the past three years
- British Medical Journal patient safety awards runner up (2014)
- End of Life Care moved from inadequate to good at CQC inspection (2017/18)
- Trust Led countywide mortality reviews and learning
- Maintained quality and safety during extreme operational pressures in 2017/18

National Clinical Audit

Information on participation in clinical audits and national confidential enquiries:

During 2017/18, 36 national clinical audits and 6 national enquiries covered relevant health services that Kettering General Hospital NHS Foundation Trust provides.

During that period, Kettering General Hospital NHS Foundation Trust participated in 78% of national clinical audits and 83% of national confidential enquiries of the national clinical audits and national confidential enquiries which it was eligible to participate in. 100% was not achieved as a result of consultant vacancies and the Trust not having any relevant cases present in the audit period.

The national clinical audits and national confidential enquiries that Kettering General Hospital NHS Foundation Trust was eligible to participate in during 2017/18 are as follows:

National Clinical Audit

- Acute Coronary Syndrome or Acute Myocardial Infarction (MINAP)
- BAUS Urology Audits - Female Stress Urinary Incontinence Audit
- BAUS Urology Audits - Nephrectomy audit
- Bowel Cancer (NBOCAP)
- Bronchoscopy
- Cardiac Rhythm Management (CRM)
- Case Mix Programme (CMP)
- Coronary Angioplasty/National Audit of Percutaneous Coronary Interventions (PCI)
- Diabetes (Paediatric) (NPDA)
- Elective Surgery (National PROMs Programme)
- Falls and Fragility Fractures Audit programme (FFFAP)
- Fractured Neck of Femur (care in emergency departments)
- Head and Neck Cancer Audit
- Inflammatory Bowel Disease (IBD) programme / IBD Registry
- Learning Disability Mortality Review Programme (LeDeR)
- Major Trauma Audit
- National Audit of Dementia
- National Cardiac Arrest Audit (NCAA)
- National Chronic Obstructive Pulmonary Disease (COPD) Audit programme
- National Clinical Audit for Rheumatoid and Early Inflammatory Arthritis (NCAREIA)
- National Comparative Audit of Blood Transfusion programme
- National Diabetes Audit - Adults
- National Emergency Laparotomy Audit (NELA)
- National End of Life Care Audit
- National Heart Failure Audit
- National Joint Registry (NJR)
- National Lung Cancer Audit (NLCA)
- National Maternity and Perinatal Audit (NMPA)
- National Neonatal Audit Programme - Neonatal Intensive and Special Care (NNAP)
- National Ophthalmology Audit
- National Prostate Cancer Audit
- Oesophago-gastric Cancer (NAOGC)

- Pain in Children (care in emergency departments)
- Procedural Sedation in Adults (care in emergency departments)
- Sentinel Stroke National Audit programme (SSNAP)
- UK Parkinson's Audit: (incorporating Occupational Therapy, Speech and Language Therapy, Physiotherapy, Elderly care and neurology)

National Confidential Enquiries
- Child Health Clinical Outcome Review Programme (NCEPOD)
  - Chronic Neurodisability
  - Young People's Mental Health
  - Cancer in Children, Teens and Young Adults
- Medical and Surgical Clinical Outcome Review Programme (NCEPOD)
  - Acute Heart Failure
  - Perioperative Diabetes
- Maternal, Newborn and Infant Clinical Outcome Review Programme (MBRRACE)

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National Clinical Audit
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- Major Trauma Audit
- National Cardiac Arrest Audit (NCAA)
- National Chronic Obstructive Pulmonary Disease (COPD) Audit programme
- National Comparative Audit of Blood Transfusion programme
- National Diabetes Audit - Adults
- National Emergency Laparotomy Audit (NELA)
- National Heart Failure Audit
- National Joint Registry (NJR)
- National Lung Cancer Audit (NLCA)
- National Maternity and Perinatal Audit (NMPA)
- National Neonatal Audit Programme - Neonatal Intensive and Special Care (NNAP)
- National Prostate Cancer Audit
- Oesophago-gastric Cancer (NAOGC)
- Pain in Children (care in emergency departments)
- Procedural Sedation in Adults (care in emergency departments)

National Confidential Enquiries

- Child Health Clinical Outcome Review Programme (NCEPOD)
  - Chronic Neurodisability
  - Young People's Mental Health
- Medical and Surgical Clinical Outcome Review Programme (NCEPOD)
  - Acute Heart Failure
  - Perioperative Diabetes
- Maternal, Newborn and Infant Clinical Outcome Review Programme (MBRRACE)

The national clinical audits and national enquiries that Kettering General Hospital NHS Foundation Trust 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 as a percentage of the number of registered cases required by the terms of that audit or enquiry.

National Clinical Audit	KGH Participation Rate
Acute Coronary Syndrome or Acute Myocardial Infarction (MINAP)	100%
BAUS Urology Audits - Female Stress Urinary Incontinence Audit	100%
BAUS Urology Audits - Nephrectomy audit	Ongoing until April 2018
Bowel Cancer (NBOCAP)	100%
Bronchoscopy	90%
Cardiac Rhythm Management (CRM)	Ongoing until April 2018
Case Mix Programme (CMP)	Ongoing until April 018
Coronary Angioplasty/National Audit of Percutaneous Coronary Interventions (PCI)	Ongoing until April 2018
Diabetes (Paediatric) (NPDA)	100%
Elective Surgery (National PROMs Programme)	62%
Falls and Fragility Fractures Audit programme (FFFAP)	ongoing until April 2018
Fractured Neck of Femur (care in emergency departments)	Publication due Aug 2018
Learning Disability Mortality Review Programme (LeDeR)	Ongoing
Major Trauma Audit	100%
National Cardiac Arrest Audit (NCAA)	Ongoing until April 2018
National Chronic Obstructive Pulmonary Disease (COPD) Audit programme • Pulmonary • Secondary Care	Ongoing until April 2018
National Comparative Audit of Blood Transfusion programme	Ongoing
National Diabetes Audit - Adults	Ongoing
National Emergency Laparotomy Audit (NELA)	>90%
National Heart Failure Audit	73% ongoing until 2019
National Joint Registry (NJR)	100%
National Lung Cancer Audit (NLCA)	100%
National Maternity and Perinatal Audit (NMPA)	>90%
National Neonatal Audit Programme - Neonatal Intensive and Special Care (NNAP)	>70%
National Prostate Cancer Audit	Data not published at time of writing the report
Oesophago-gastric Cancer (NAOGC)	100%
Pain in Children (care in emergency departments)	100%
Procedural Sedation in Adults (care in emergency departments)	100%

National Confidential Enquiries	Participation in terms of % required
Child Health Clinical Outcome Review Programme (NCEPOD) o Chronic Neuro-disability o Young People's Mental Health	Chronic Neuro-disability - 83% Young People's Mental Health - 75%
Medical and Surgical Clinical Outcome Review Programme (NCEPOD) o Acute Heart Failure o Perioperative Diabetes	Acute Heart Failure - 60% Perioperative Diabetes - 57%
Maternal, infant and newborn clinical outcome review programme (MBRRACE-UK)	100%

Local clinical audits

The reports of 6 national clinical audits were reviewed by the provider in 2017/18 and Kettering General Hospital NHS Foundation Trust intends to take the following actions to improve the quality of healthcare provided.

National Pregnancy in Diabetes Audit Report 2016

The audit measures the quality of care and outcomes for women with pre-existing diabetes and support improvement plans. National Audit data for deliveries 1/1/15-31/12/15 inclusive. Data was collected once consent obtained. Measured against Nice NG3.

The aim of the Audit is to improve care / outcomes for Pre-existing diabetics.

The key questions are:-

- Were women adequately prepared for pregnancy?
- Were appropriate steps taken to minimise adverse outcomes?
- Did any adverse outcomes occur?

Key Actions were highlighted as the following:

GPs/ Practice Nurses need to be more proactive with advice given to all women of childbearing age and how to access pre conceptual care. Increase awareness. In order to achieve this, liaison with GPs/ Practice nurses is required to see current practice. Patient information leaflet to be sent to GP surgery's and practice nurse education sessions by DSNs.

To continue education and promote efficient referral to Diabetes Midwife and Diabetes Nurses. It is hoped that through continual education either via email/ verbal to community midwives, and ensuring staff are up to date with the referral process should help to achieve this. This is a joint approach between the Diabetes nurses, consultant and the Diabetes Midwife.

The next audit is due in January 2018 and will re-audit the above.

National Hip Fracture Database (NHFD) annual report 2017

Summary of Main findings:

- Poor perioperative medical assessment of Fracture of neck of femur patients
- Poor physiotherapy assessments
- Poor delirium assessments
- Not enough Total Hip Replacements being offered
- Not enough Nailings being done (Query around data entry)

Key Successes:

- Prevention of pressure ulcers
- 62% admitted to ward within 4 hours
- Mental test score recorded
- Nutritional risk assessment completed

Key concerns:

- Trust losing Best Practice Tariff (BPT) for Fracture Neck of Femur patients.

National Hip Fracture Database (NHFD) annual report 2017

Key Actions were highlighted as the following:

While the audit is a surgical audit, it relies heavily on a multidisciplinary approach, as do the resulting actions. Ortho-geriatric, Orthopaedic, Anaesthetic, Physio and occupational therapy input is required. Therefore it is recommended for recommendations to by looked at within regular ward rounds. The surgical team will identify eligible patients to ascertain if the poor results are coming from poor data entry, or if more procedures need to be carried out.

National Lung Cancer Audit 2016: Key findings for patients and carers

Summary of Main Findings:

a) Performance status entered down to 85%
b) Stage Completeness 97%
c) Pathological Confirmation rates 81%
d) NSCLC NOS rate 12%
e) % seen by lung cancer CNS 79.2%
f) Anti-cancer treatment rates 59.6% Odds Ration = 77%
g) Surgical resection rates for NSCLC 21.3%
h) Chemo rates for SCLC 50%

Key Successes:

Areas b, c, d, f, g are above the expected target figure and also well above the national average, this is an overall improvement from the 2015 audit. Area g the surgical resection rate, is an area where KGH excel and is considered to be an excellent performance indicator

Key Concerns:

Areas a and e are below the expected target but still above the national average.
However in area h the chemotherapy rates for SCLC patients is below the expected target and the national average too. Access to oncology for lung cancer at KGH is recognised as a risk and in the cancer improvement plan from cancer services

Key Actions:

Ensuring data completeness is optional and uploaded is ongoing. There is a written audit form completed on every patient diagnosed with lung cancer. This is checked by the MDT coordinator to double check all the data is entered.

Discussions with the oncologist and explore the reasons for low SCLC treatment rates is met, and is now discussed at the business meeting. Lack of oncologist for lung cancer is a recognised risk at KGH.

Cancer Services is to address the recognised risk to obtain higher level of oncologists for lung cancer patients.

National Heart Failure (HF) Audit Report April 2015-March 2016

Summary of Main Findings:

- We have improved our case ascertainment to 89% (previously 83%) and are comfortably above the 70% minimum requirement for the BPT.
- In hospital care:
  - 68.3% of our HF patients are cared for in cardiology (National 45.7%)
  - 95.3% have input from a specialist (National 79%)
  - 75.2% of the specialist reviews by a cardiology consultant (national 56.9%)
  - 94.2% patients received an echo or had an echo in the last 12 months

The audit demonstrates the importance of specialist input in improving mortality. KGH is delivering good practice and service provision. BPT requires 60% of patients to be seen by a specialist which is achieved.

- Prescribing levels of the 3 disease modifying drugs on discharge have prognostic benefits. KGH prescribing levels are generally good with above national prescribing levels: ACEI/ARB 78.7% (National 73.7%) Betablockers 90.4% (national 80.4%). MRA's 60% (national 45.4%)

Education around prescribing priorities must be maintained especially as post discharge mortality rates at 1 year is independently associated with use of the 3 key modifying medications.

- Cardiology follow up good at 75.3% (national 47.2%) and is an increase of 6% from previous report. 68.9% have HFNS f/u (National 54.8%) 87% of patients with LVSD have f/u by HFNS (National 70.8%) Some of these will have been referred to community HFNS however it reflects the volume of Outpatient work undertaken.
- Referral for Cardiac Rehab has increased but remains low at 3.3% (National 12.1 %) Expansion of the CR Team since this audit is facilitating greater access to CR services for our HF patients. The Leads for CR and HFNS have met to develop robust referral processes. Some patients are referred at their f/u apt which is not always captured on the NHFA data on discharge.
- Mortality: Hospital level mortality is not published however national inpatient mortality has reduced in this reporting year from 9.6% to 8.9%. A small, significant difference but still not acceptable and on-going attention to service delivery required. The Audit demonstrates the importance of patients being cared for in cardiology as it has statistically significant impact on post discharge mortality. We are making efforts to signpost more patients into cardiology.

Key Actions:
In regards to the standard of "Chronic HF QS Statement 8: Patients with CHF, and no precluding condition, offered a supervised group exercise based CR programme including education and psychological support", the Trust is partially compliant. Patients have historically been screened out before being referred. No robust process for referrals which have been ad hoc.

In order to meet this, HFNS team to routinely refer post discharge with CR identifying patients declining the service, rather than prior to referral. Automatic referral system from cardiology wards to be set up similar to ACS.

National Audit of Dementia Care in General Hospitals 2016-2017: Third Round of Audit Report

Audit Themes:
1. Assessment: National Average 83.7% KGH 85.7%
2. Information and Communication: Carer rating: National Average 64.4% KGH – Did not submit Staff rating: National Average 64.8% KGH Rating 66.4%
3. Staffing and Training – No score as insufficient data nationally.
4. Nutrition: National Average 83.8% KGH 87.5%
5. Discharge: National Average 72.7% KGH: 72.1%
6. Governance: National Average 65.1% KGH: 100%

A detailed action plan has been formulated and is regularly reviewed at the Dementia Steering Group and Quality Governance Steering Group. This has been attached separately as it is large in size.

Myocardial Ischaemia National Audit Project Annual Report: April 2015 – March 2016

Key findings from 2015/2016 report:

Definite MI = STEMI
ACS = NSTEMI (troponin positive) and unstable angina

Initial diagnosis:

	KGH	National
Definite MI	39.75%	31%
Acute coronary syndrome	41.5%	50.25%
Chest pain ? cause	11.25%	10%
Other diagnosis	6.75%	8.75%

Admission Method:

	KGH	National
999	68%	61.75%
Self present	7.25%	14.75%
In hospital already	3%	3%
Intra hospital transfer	8.5%	15%
Other (patients admitted from clinics or becoming ill while visiting hospital)	13.5%	4.75%

All tests are highlighted as being non-compliant with the standard if it does not achieve 95%.

STEMI

KGH	Door To Balloon 90 mins	Call To Balloon 150 mins	Call To Balloon 120 mins
KGH - 2014/2015	93%	91.3%	79.1%
National - 2014/2015	88.9%	82.3%	53.9%
KGH – 2015/2016	93.9%	89.5%	67.6%
National – 2015/2016	88.9%	74.9%	50.1%

Delays in door to balloon

Accepted delays already removed; there were 15 delays in total, 6 due to percutaneous coronary intervention complications with the Patient, 3 due to other reasons, including cardiac arrest, and 6 due to hospital administration failures. The administration failures have been discussed in the monthly Acute myocardial infarction meeting on a monthly basis, and action planned accordingly.

Delays in Call to balloon

Accepted delays already removed from data there were 22 in total. 6 were due to hospital administration delays 2 due to catheter lab access, 6 pre PCI complications and 7 due to ambulance delays. These have been discussed in the monthly Acute myocardial infarction meeting on a monthly basis, and action planned accordingly.

Care of NSTEMI

In 2015/2016 not only have we increased from 2014/2015, the percentage of patients who are seen by cardiology, who are admitted to CCU/cardiology area, and the proportion of patients who had angiography during admission, but we are also are above national average.

Discharge medications

Although we have gone down slightly in 2015/2016, the 5 secondary prevention medications that patients should be on following a STEMI or NSTEMI, we are achieving over 99% if indicated.

Length of Stay

For 2015/2016 our length of stay for both STEMI and NSTEMI patients is 2 days

Key Actions:

- That glucose sample is taken on all cardiac patients
- That cholesterol sample is taken on all cardiac patients
- That height and weight is recorded on all cardiac patients
- That all patients who self-present to A&E have an ECG recorded within 15 minutes of arrival and acted upon accordingly
- That patients who present to KGH as an STEMI via EMAS, should achieve a call to balloon of less than 150 minutes

All patients who are cardiac in nature should have all of the above performed on arrival to hospital and it be escalated accordingly.

Information on use of the CQUIN Framework

CQUINs (Commissioning for Quality and Innovation) schemes across the NHS can be separated into two categories, those indicators which are national and therefore broadly mandated for all Acute Trusts, and local CQUINs which are agreed between Trusts and their local Commissioners. For 2017/18 the CQUIN schemes are nationally mandated.

2015/16 performance

Of the projects the Trust participated in 2015/16 we achieved all of these except those relating to sepsis and dementia care. In 2015/16 the Trust completed the self-assessment for all CQUIN indicators, but as the Trust selected the default tariff option within in 2015/16, no proportion of the Trust's income was conditional on achieving quality improvement and innovation goals through the Commissioning for Quality and Innovation payment framework.

2016/17 performance

In 2016/17, of the projects the Trust participated in, we achieved all except those relating to sepsis and dementia care.

Overall achievement for 2016/17 is shown below. The Trust achieved almost 72% for all the CQUIN schemes as well as 100% for the NHS England schemes.

2017/18 – performance to date

The Trust's performance against CQUINs is shown below.

Performance for Quarters 1 and 2 has been assessed by our commissioners. Performance for quarters 1, 2 and 3 for 2017/18 has been assessed by our commissioners. Quarter 4 is pending sign off from our commissioners as at the date of this Quality Report.

2017/18 CQUIN Assessment	Mar-18		Q1 + 2 + 3 CCG confirmed, Self-Assessment 4				
Indicator	Indicator weighting (% of CQUIN scheme available)	Approx Value (£000)	Q1	Q2	Q3	Q4	Payment
Introduction of health and wellbeing initiatives	33.3% of 0.25% CCG	£140				£105	£105
Healthy food for NHS staff, visitors and patients	33.3% of 0.25% CCG	£140				£70	£70
Achieving an uptake of flu vaccinations by frontline clinical staff of 70% (Feb 18)	33.3% of 0.25% CCG	£140				£140	£140
Reducing the impact of serious infections (Antimicrobial Resistance and Sepsis)	0.25% CCG	£420	£0	£11	£42	£79	£132
Improving services for people with mental health needs who present to A&E	0.25% CCG	£420	£42	£168	£42	£168	£420
Offering Advice & Guidance	0.25% CCG	£420	£105	£105	£0	£105	£315
NHS e-referrals	0.25% CCG	£420	£105	£105	£0	£105	£315
Supporting proactive and safe discharge	0.25% CCG	£420	£0	£168	£21	£168	£357
NHSE (Specialised and Dental) Indicator	**Indicator weighting (% of CQUIN scheme available)**	**Approx Value (£)**					
Medicines Optimisation	1%	£144	£36	£36	£5	£36	£113
Devices Optimisation	1%	£144	£36	£36	£36	£36	£144
Secondardy Care Dental	3%	£83	£21	£21	£21	£21	£83
			£345	£650	£167	£1,033	£2,194

Key	
	Achieved
	Partially achieved
	Not achieved
	No requirement to report

CQUIN		Data Source
CQUIN 1a	Improvement of health and wellbeing of NHS staff	NHS Annual Staff Survey
CQUIN 1b	Healthy food for NHS staff, visitors and patients	Internal data collection and point of sales via external food supplier
CQUIN 1c	Improving the uptake of flu vaccinations for front line staff within Providers	Cumulative data monthly via ImmForm Website
CQUIN 2a	Timely identification of sepsis in emergency departments and acute inpatient settings	Local Audit
CQUIN 2b	Timely treatment for sepsis in emergency departments and acute inpatient settings	Local Audit
CQUIN 2c	Antibiotic review	Local Audit
CQUIN 2d	Reduction in antibiotic consumption per 1,000 admissions	Hospital Episode System (HES) / Public Health England
CQUIN 4	Improving services for people with mental health needs who present to A&E	A&E Hospital Episode System (HES) / NHS Digital SDCS Collection
CQUIN 6	Offering Advice and Guidance	Referral Data already captured on Hospital Episode System (HES) / Secondary User Service (SUS) Local reports linked to HES/SUS data to quantify performance.
CQUIN 7	NHS e-Referrals	e-RS System and local reporting
CQUIN 8	Supporting proactive and safe discharge	Hospital Episode System (HES) / Secondary User Service (SUS)

Information relating to registration with the Care Quality Commission and periodic/special reviews:

Kettering General Hospital NHS Foundation Trust has not participated in any special reviews or investigations by the CQC during the reporting period.

Submission of records to the Secondary Uses Service for inclusion in the Hospital Episode Statistics

Kettering General Hospital NHS Foundation Trust submitted records during 2017/18 to the Secondary Uses Services for inclusion in the Hospital Episode Statistics which are included in the latest published data. The percentage of records in the published data which included the patient's valid NHS number was:

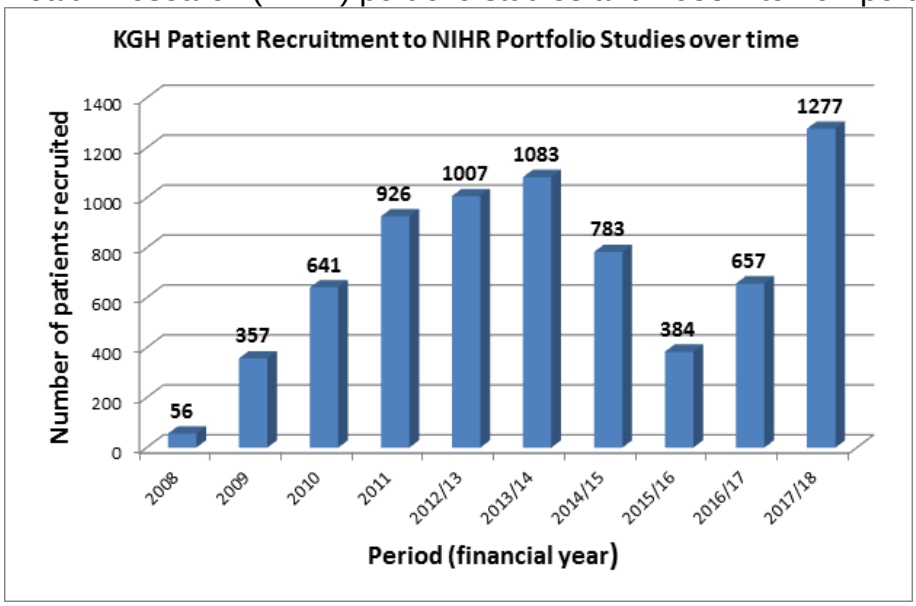
99.4% for admitted patient care
99.7% for outpatient care and
95.7% for accident and emergency care

Which included the patient's valid General Medical Practice Code was:

100% for admitted patient care
100% for outpatient care
100% for accident and emergency care

Information on participation in clinical research

The number of patients receiving relevant health services provided or sub-contracted by Kettering General Hospital NHS Foundation Trust in 2017/18 that were recruited during that period to participate in research approved by a research ethics committee was 3215 patients. This consisted of 1277 patients recruited into National Institute of Health Research (NIHR) portfolio studies and 1938 into non-portfolio studies.



Data source: Internal local audit

Information on the quality of data:

Kettering General Hospital NHS Foundation Trust submitted records during 2017/18 to the Secondary Uses service for inclusion in the Hospital Episode Statistics which are included in the latest published data. The percentage of records in the published data which included the patient's valid NHS Number was:

- 99.4% for admitted patient care
- 99.7% for outpatient care
- 95.7% for accident and emergency care

which included the patient's valid General Medical Practice Code was:

- 100% for admitted patient care
- 100% for outpatient care
- 100% for accident and emergency care

Information Governance

Kettering General Hospital NHS Foundation Trust's Information Governance Assessment Report overall score for 2017/18 was 61% and was graded Red rating.

The Information Governance improvement plan is being developed in order to deliver the wider and changing Information Governance remit. This includes the delivery of the replacement for the IG Toolkit (IGT), the Data Security and Protection Toolkit and will encompass the implementation plan for the organisation to comply with the General Data Protection regulations. An overriding high level plan is being supported by individual action plans in order to achieve these objectives and will ensure the organisation is compliant with level 2 of the required standards of the defunct IGT.

Payment by results

Kettering General Hospital NHS Foundation Trust was not subject to the Payments by Results clinical coding audit during 2017/18.

Quality of data

Kettering General Hospital NHS Foundation Trust will be taking the following actions to improve data quality:

- Continue provision of training to staff on data quality and verification checks.
- Sustained clinical coding data verification work between clinical coding staff and healthcare professionals.
- Continue rolling audit programme of admitted patient care, critical care, outpatients, elective admission list and A&E
- Continue routine audits of RTT and Infection Control
- Maintain the Data Quality and Audit Group, overseeing relevant documentation, accountability and improvement
- Review of standards of reporting from Datix (patient safety incidents)
- Introduce electronic integrated governance reports

PART TWO: Reporting against core indicators

All Trusts are now required to report against a core set of indicators using a standardised statement set out in the NHS (quality accounts) Amendment Regulations 2012. Some of the indicators are not relevant to this trust, for instance, ambulance response times which are relevant to ambulance trusts only.

Since 2012/13 NHS Foundation Trusts have been required to report performance against a core set of indicators using data made available to the trust by the Health and Social Care Information Centre (HSCIC). Where available from the HSCIC we have shown a comparison of numbers, percentages, values, scores or for each of the indicators that are applicable to this Trust, with regard to:

- The national average for the same; and Those NHS Trusts and the NHS Foundation Trusts with the highest and lowest of the same.

We are required to report against core indicators that include mortality ratios.

What is the Hospital Standardised Mortality Ratio?

The Hospital Standardised Mortality Ratio (HSMR) is an indicator of healthcare quality that measures whether the mortality rate at a hospital is higher or lower than you would expect. Like all statistical indicators, HSMR is not perfect. If a hospital has a high HSMR, it cannot be said for certain that this reflects failings in the care provided by the hospital. However, it can be a warning sign that things are going wrong.

What is the Summary Hospital-level Mortality Indicator?

The Summary Hospital-level Mortality Indicator (SHMI) is a high level hospital mortality indicator that is published by the Department of Health on a quarterly basis. The SHMI follows a similar principle to the general standardised mortality ratio; a measure based upon a nationally expected value. SHMI can be used as a potential smoke alarm for potential deviations away from regular practice.

Our HSMR and SHMI information available for the reporting period is detailed in the following pages.

Measurement of SHMI

Data period: December 2016 to November 2017

Metric	Result
HSMR	**105.1** 'as expected' range
HSMR position vs. peers	KGH is 1 of 4 Trusts within the peer group of 9 that sit within the 'as expected' range.
HSMR outlying groups	There are 0 outlying groups.
HSMR Weekday/Weekend Analysis	There is a significant difference between the weekday (higher than expected) and weekend (as expected) HSMR for emergency admissions.
Coding analysis	• Palliative care coding rate (HSMR basket) = 3.39% vs. national rate of 4.05% • Upper quartile co-morbidity = 26.2% vs national rate of 25%
All Diagnosis SMR	All Diagnosis SMR is **104.0** and is within the 'as expected' range There are 3 outlying groups attracting significantly higher than expected deaths – 1 new outlier since last month • Cardiac and circulatory congenital abnormalities – NEW ALERT THIS MONTH
New CUSUM alerts this month	0 new CUSUM diagnosis group alert triggered since last month:
SHMI (Jul 16 to Jun 17)	SHMI = 107.43 'as expected' (band 2) • 7 outlying groups

From	To	HSMR	SHMI
01.04.2016	31.03.2017	103.0	104.87
01.04.2015	31.03.2016	101.69	109.18
01.04.2014	31.03.2015	91.43	100.92

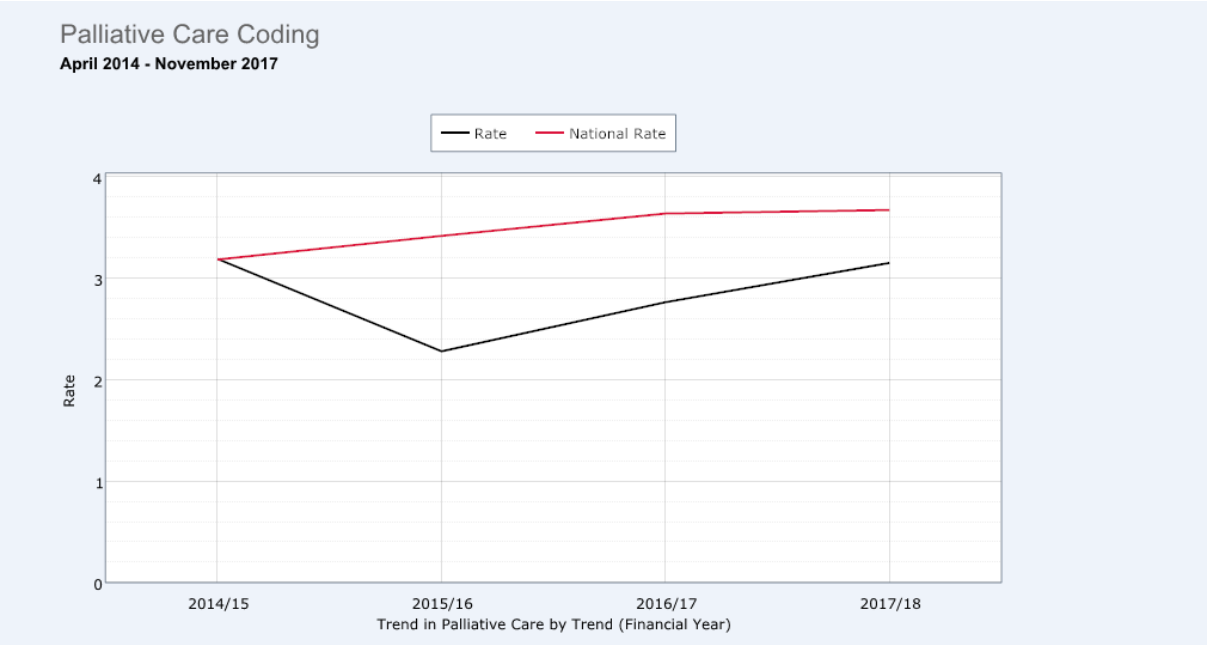
HSMR – National average: 100
SHMI – Our rates are as expected.

We extract our mortality data from Dr Foster. The Trust's HSMR for the most recent 12 month period (December 2016 to November 2017) is **105.1** which is statistically within the expected range considering our case mix of patients and the national picture. Previous year's data is shown above. This data was last presented at the Quality and Safety Committee in March 2018.

HMSR mortality rates for emergency admissions weekday and weekend are within or beneath the statistical confidence limits (National comparison shown by graph below)

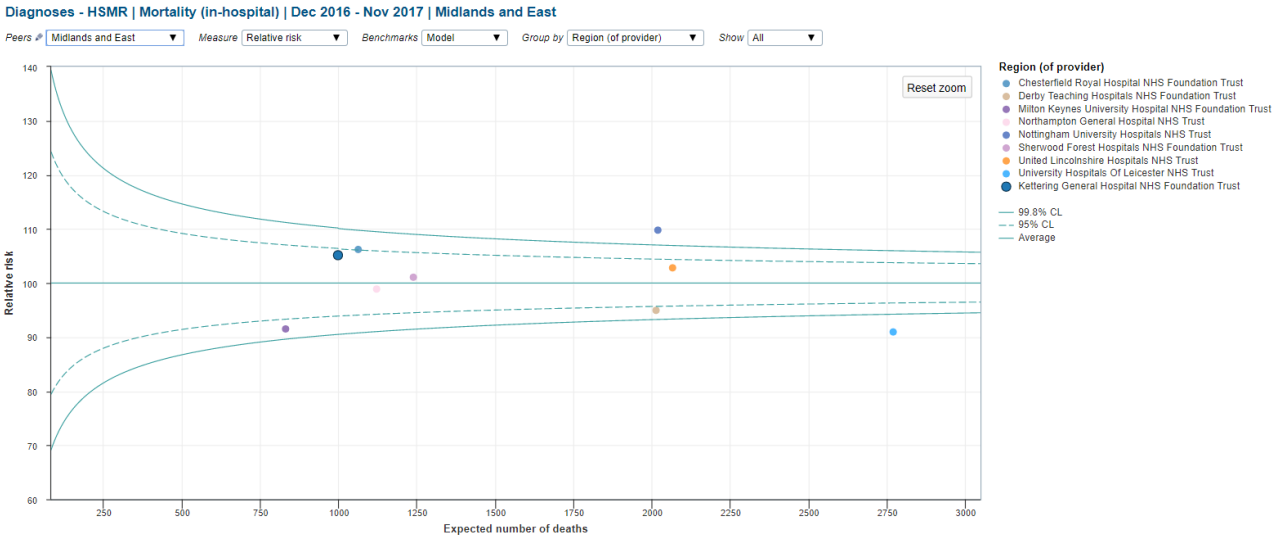
Palliative Care Coding Rate Vs National (HSMR Basket)

Trend (Financial Year)	Spells	Observed	Rate (%)	National Rate (%)
2014/15	16,350	522	3.19	3.19
2015/16	17,185	392	2.28	3.42
2016/17	18,913	523	2.77	3.64
2017/18	11,989	378	3.15	3.67



HSMR 12 Month Peer Comparison

The Trust is 1 of 4 Trusts (within the peer group of 9) with an HSMR within the 'as expected' range. The crude rate is 3.4% (vs 3.50% for the peer group).



Prescribed Information

(a) The value and banding of the summary hospital level mortality indicator ("SHMI") for the trust for the reporting period; and (b) the percentage of patient deaths with palliative care coded at either diagnosis or specialty level for the trust for the reporting period. Kettering General Hospital NHS Foundation Trust considers that this data is as described for the following reasons:

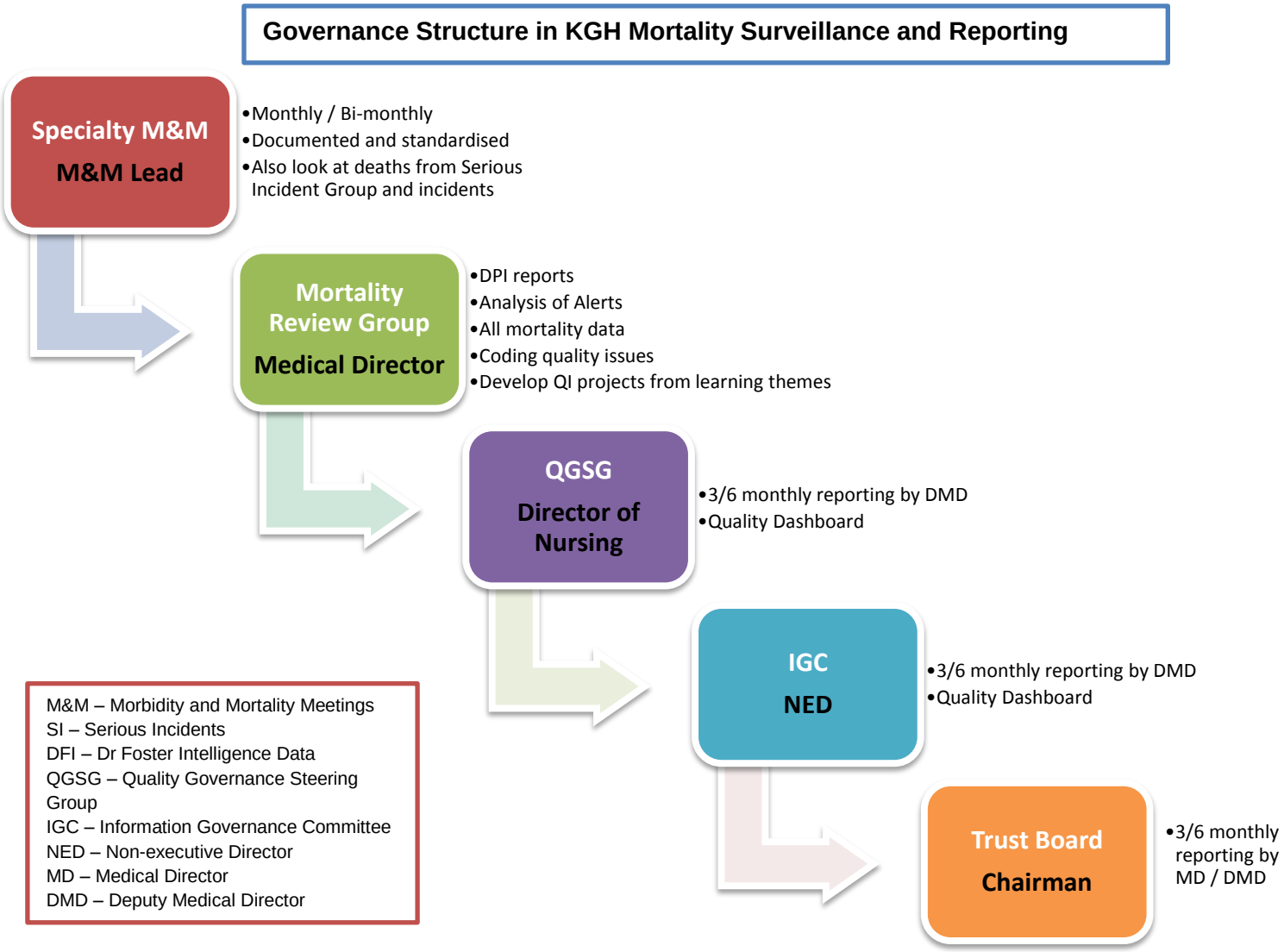
- Regular reporting is in place considered by the Patient Safety Advisory Group, Quality Governance Steering group and Clinical Business Unit Mortality Groups.
- There are Trust-wide presentations in place and alerts are discussed at the Patient Safety Advisory Group.
- Mortality is on the Trust Quality Dashboard and discussed at Integrated Governance Committee monthly and at each Trust Board.

We review and monitor morbidity and mortality as part of our governance patient safety processes and below is a summary of this work:

- In line with the Learning from Deaths National Guidance, published in March 2017, we have since published a new policy which includes our two stage methodology for reviewing deaths. The reviews are completed by using a Screening Tool and Structured Judgement Review form.
- Dr. Foster's data is reviewed every month at Patient Safety Advisory Group (PSAG), and alerts are then reviewed by a Clinician, looking at Root causes and learning is shared.
- Following LFD guidance KGH has published a Mortality Review Policy for Adult inpatient deaths on the website in November 2017. There is a monthly dashboard which is presented to Integrated Governance Committee (chaired by Non-Exec Directory) and a Quarterly Mortality Dashboard presented to the Trust Board since September 2017. Dashboard includes LFD requirements, learning themes, actions for the learning themes and Dr Foster Data including response various Alerts.
- Standardised Morbidity and Mortality (M&M) Meetings - Every Clinical Business Units has standardised M&M meetings using Royal College of Anaesthesia guidelines. Lessons learnt are shared within teams and also trust-wide.
- Trust- wide and County-wide M&M meetings have proved an important focus point for improvement of quality of M&M meetings, sharing lessons and platform for open and transparent discussions.
- Patient Safety Lessons Learnt Forum (PSLLF) chaired by Medical Director (every 8 weeks) is trust-wide multi-disciplinary forum, including Non-executive Directors. PS LLF provides a platform for sharing lessons learnt from never events, serious incidents, and M&M meetings
- SI (Serious Incidents) meetings (weekly) review all unexpected mortality and investigate using Trust guidelines.
- Learning themes identified are currently being considered as Quality Improvement projects which will be piloted in certain clinical areas. Examples of current Quality Improvement projects include: Sepsis recognition and

management in Urgent Care and improvement in capturing comorbidities on two wards areas.

The flowchart below illustrates the Governance structure for Review of Mortality from Ward to Board.



Summary and actions from reviews of alerts during 2017/18:

- Monthly dashboard presented to Patient Safety Advisory Group and Integrated Governance Committee including outcomes from mortality reviews and learning themes.
- Alerts reviewed have not had any avoidable deaths so far.
- There have been problems in health care and these have been identified as learning themes
- All results and learning themes have been presented in Patient safety lessons learnt forum and in Departmental M&M meetings.
- Coding issues: Further training has been provided by Dr Foster Specialist
- Audits to verify accuracy of coding has commenced in coding department

- Education to clinicians about importance of documentation of accurate Primary diagnosis and capturing co-morbidities has been emphasised using key messages as below.
- Improvement of accuracy in primary diagnosis, co-morbidities and palliative care coding will increase depth of coding for KGH patients and this will in turn affect HSMR and SHMI.
- Coding Team are working with Clinical teams to improve accuracy of primary diagnosis and increase the capturing of comorbidities.

Quarter 3 Mortality Review Dashboard – Presented to Trust Board in March 2018

UNIVERSITY OF LEICESTER
Affiliated Teaching Hospital

KGH Quarter 3 2017/18 Review Dashboard

NHS
Kettering General Hospital
NHS Foundation Trust

Table 1: Learning From Deaths – Total Reviewed

Mortality Reviews (Adult In-Patients, excluding maternity, neonates and perinatal mortality) Monthly Dashboard – January 2018						
2017-18	Total Number of Adult In-patients Deaths	Number Reviewed using screening tool	Avoidable Deaths	Number referred to SIRG	Number declared as SI	Number reviewed using SJR
April	97	55	0	0	*N/A*	4
May	110	59	0	0	*N/A*	2
June	90	50	0	1	Internal *(SJR 5)*	5
July	78	41	0	1	Not an SI *(SJR 4)*	2
August	91	45	0	1	External SI *(SJR 2)*	1
September	104	55	0	1	Internal *(SJR 5)*	3
October	80	40	0	2	0	5
November	106	54	0	1	0	4
December	125	50	*Pending Internal Investigation Outcome*	1	Internal *(SJR 4)*	3

Table 2: Learning Disability Deaths – Total Reviewed

Mortality Reviews (Learning Disability Deaths) *In conjunction with the Learning Disabilities Mortality Review (LeDeR) Programme*				
2017-18	Total LD deaths	Screening Score	SJR Outcome	Avoidable LD deaths
April	1	1x - Likert 6	N/A	0
May	1	1x - Likert 6	N/A	0
June	1	1x - Likert 6	N/A	0
July	1	1x – Likert 6	N/A	0
August	1	1x – Likert 6	N/A	0
September	1	1x – Likert 6	N/A	*Local Screening - 0*
October	1	1x – Likert 6	N/A	*Local Screening - 0*
November	2	1x – Likert 6 *1x Pending Review*	N/A	*Local Screening - 0*
December	5	1x Likert 4 2x Likert 5 *2x Pending Review*	1x Downgraded to Likert 5 2x Downgraded to Likert 6	*Local Screening - 0*

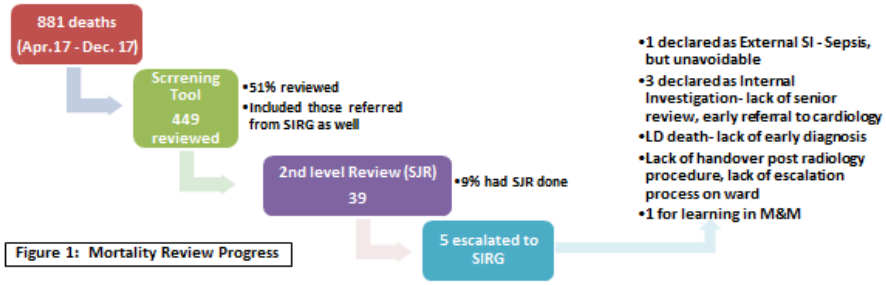


Figure 1: Mortality Review Progress

Table 3: Learning Themes Q1 – Q3 2017/18

Learning Themes from Mortality Reviews during 2017/18 YTD		
Quarter 1 - 2017/18	**Quarter 2 - 2017/18**	**Quarter 3 – 2017/18**
o Good care, No learning points 35% of reviews had no learning points	Good Care, No learning points • 63% of reviews had no learning points	Good Care, No learning points • 56% of reviews had no learning points
Improve Documentation- 12% o Initiate trust-wide and ward based QI themes	Improve Documentation • 9% of notes had poor documentation	Improve Documentation • 10% of notes had poor documentation
Earlier use of DNACPR / EoL- 22% EoL Nurse to audit and do focused teaching sessions	Earlier use of DNACPR / EoL • 10% of notes overall, 50% of these were attributed to community • Education and awareness has been raised by EoLC Team	Earlier use of DNACPR / EoL • 8% of reviews – could have had DNACPR completed earlier
Sepsis Tool- early antibiotics- 11% • CQUIN Measurement • Admission Areas have focused education and training sessions	Sepsis Tool not used • 4% of cases • QI project continues to reduce incidence in all wards	Other Learning Themes • 7% of cases had learning points outside of the standard learning themes • VTE Assessment, patient bloods incorrectly allocated and poor vascular care (forwarded to NGH).
	Clinical Diagnostic issues • 7% of cases • Include review and follow up of results.	Clinical Diagnostic issues • 6% of cases • Include review and follow up of results

Overview: 50-60% of reviews had overall good care, no learning points.

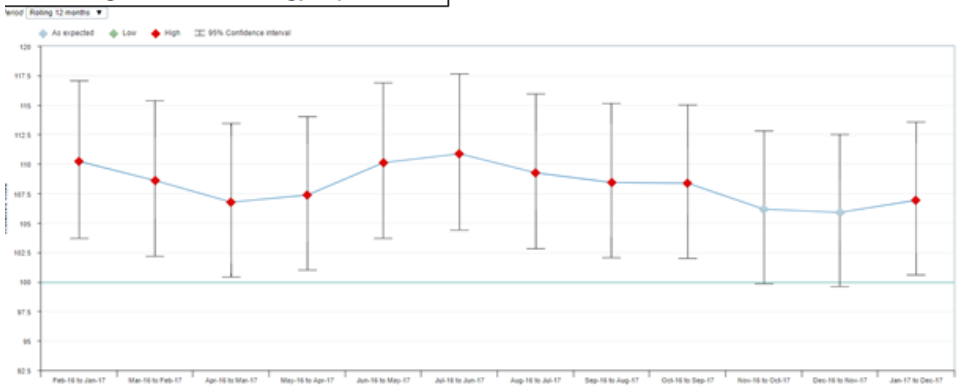
Reviews: completing 50% every month, but backlog and 2 months behind- due to increase in number of deaths in winter.

Learning themes: M&M meetings/ Leads are discussing each SJR, Screening tool and sharing lessons learnt. Process in some specialities are very robust and clinical teams keen to improve care using QI methodology, like sepsis, use of co-morbidity sheets.

Overall reduction in learning themes relating to sepsis management, use of sepsis tool and earlier use of DNACPR

Plan for 2018-19- Refresh and update policy in line with national guidance. Look for alternative accommodation, identify QI themes in specialities and support embedding QI themes.

Figure 3: HSMR - 3 Month Rolling (Trend)



Dr Foster Report: January 2017 – December 2017

HSMR – 106.9, higher than expected. **Crude rate is within peer group rate.**

Depth of coding: Charlson co-morbidity scoring of 0 is lower than the national average.

SHMI- for period of October 2016 - September 2017: 108.99 'as expected'

Alerts under SHMI - are currently under investigation.

Coding team continue to have second level checks of certain primary diagnosis, including 'senility and organic mental disorders'

Improvements in capturing co-morbidities: Plans in place to incorporate co-morbidity sheet as part of clerking document.

CQC outlier alert- Septicaemia (see Table 5) October 2016- August 2017

Mortality Manager – recruited and started in full-time position during March 2018.

Table 4: Dr Foster Metrics – Rolling Month

Dr Foster Metrics	October 2016 – September 2017	November 2016 – October 2017	December 2016 – November 2017	January 2017 – December 2017
HSMR (rolling 12m average)	105.5 'as expected'	104.9 'as expected'	105.1 'as expected'	106.9 'higher than expected'
Alerts	Senility, Respiratory Failure, Acute and unspecified Renal Failure and Peripheral and visceral atherosclerosis	Senility and organic mental disorders	0 Outlying Groups	Other Liver Disease and Urinary Tract Infections
Crude Rate (HSMR)	3.5% vs Peer group rate of 3.60%	3.4% vs Peer group rate of 3.50%	3.4% vs Peer group rate of 3.50%	3.4% vs Peer group rate of 3.60%
Palliative care coding (%)	3.27% vs national 3.66%	3.26% vs national 3.70%	3.39% vs national 4.05%	3.41% vs national 4.04
Charlson co-morbidity scoring (%)	Score of 0 = 51.2% vs National 49.0%	Score of 0 = 51.3% vs National 49.0%	Score of 0 = 51.3% vs National 49.7%	Score of 0 = 49.4% vs National 51.1%
Upper Quartile Co-morbidity			26.2% vs National 25.0%	49.4% vs National 51.1%
SMR	103.6 'as expected'	103.7 'as expected'	104.0 'as expected'	106.4 'higher than expected'
SHMI (Oct 16 - Sept 17)	108.99 'as expected' (band 2)			

Table 5: Dr Foster Alerts and Outcomes

Table 2: Dr Foster Alerts – Outcomes of Reviews

Alerts	Obs vs expected	No: notes reviewed	Avoidable deaths	Learning Points	Actions
Other Liver Disease (Jan-Dec 2017)	10 vs 4.7	3 - Ongoing	0	One Likert 5-For speciality M&M	
Urinary Tract Infection (Jan- Dec 2017)	64 vs 49	21 – Ongoing	0 so far 11/21- good care, no learning points	Learning points for speciality M&M	By M&M
Septicaemia (CQC) (Aug16-Jul 17)	66 vs 57.4	31	0	33/37- Likert score of 5 &6	4 Cases – for M&M
Senility & Sepsis Septicaemia alert	Included in reviews every month	Ongoing	0	Learning points To Specialty M&M and PSLLF	

Abbreviations:
RCP SJR – Royal College of Physicians methodology based Structured Judgement Review
LD – Learning Disability deaths
M&M – Morbidity and Mortality meetings
PSLLF – Patient Safety Lessons Learnt Forum

Avoidability of death judgement score (RCP SJR)
Score 1- Definitely avoidable
Score 2 - Strong Evidence of Avoidability
Score 3 - Probably avoidable (more than 50:50)
Score 4 - Possibly avoidable but not very likely (less than 50:50)
Score 5 – Slight evidence of avoidability
Score 6 – Definitely not Avoidable

Learning from Deaths

Total Number of Deaths:
During 2017/18, 1236 of Kettering General Hospital patients died. This comprised the following number of deaths which occurred in each quarter of that reporting period: 297 in the first quarter; 273 in the second quarter; 311 in the third quarter; 311 in the fourth quarter.

Total Number of Case Records Reviewed:
By 31st March 2018, 459 case record reviews and 39 investigations have been carried out in relation to 1236 of the deaths included above.

In 39 cases 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 (using screening tool) or an investigation (using SJR) was carried out was: 164 in the first quarter, 141 in the second quarter, 144 in the third quarter, 10 in the fourth quarter.

The objective for 2017/18 is to complete case record reviews on 50% of deaths every month. Kettering General Hospital has achieved this objective up to Quarter 3 2017/18. Quarter 4 2017/18 reviews are ongoing.

Number of Deaths reviewed which were more likely than not to have been due to problems in the care provided to the patient:
2 representing 0.2% of the patient deaths during the reporting period are judged to be more likely than not to have been due to problems in the care provided to the patient.

In relation to each quarter, this consisted of: 0 representing 0% for the first quarter; 1 representing 0.1% for the second quarter; 1 representing 0.1% for the third quarter; 0 representing 0% for the fourth quarter.

These numbers have been estimated using the initial screening process. A screening tool is used, followed by a Structured Judgement Review (SJR) if evidence of problems in healthcare is identified. An avoidability score (Likert score) is given to each screening and SJR undertaken. Likert score of 3 and <3 is escalated to the Serious Incident Review Group (SIRG) for further consideration and Duty of Candour initiated if the criteria is met.

Lessons Learnt and Actions Taken from Case Record Reviews:
Of the two cases detailed above, one is still currently under investigation with the final report due to be finalised in April 2018. One case has been finalised (January 2018) and the following learning was identified:

1. More frequent senior reviews and inter-team discussions and ward rounds
2. Identifying high risk patient early and ensure close monitoring
3. To adhere to expert advice

Learning from deaths has produced themes which have been shared at local level Mortality and Morbidity (M&M) meetings, Trust-Wide Patient Safety Lessons Learnt Forum (PSLLF) and County-Wide M&M meetings. Themes identified at present are:

- Improve documentation
- Earlier consideration of Do Not Attempt Cardiopulmonary Resuscitation (DNACPR)
- Better use of sepsis tool
- Escalation of deteriorating patient
- Better capture of co-morbidities

The themes from Quarter 1 2017/18 were predominantly due to lack of use of sepsis tool and this has since improved Trust-Wide using a Quality Improvement initiative led by the Sepsis Nurse Practitioner. Themes from Quarter 2 2017/18 and Quarter 3 2017/18 were related to earlier DNACPR. An audit to assess the impact of learning is currently ongoing. Case record reviews are underway for Quarter 4 2017/18 and learning themes will be identified once complete.

Total Number of Case Record Reviews or Investigations relating to 2016/17

15 case record reviews and 3 investigations completed after 2017/18 which related to deaths which took place before the start of the reporting period. 0 representing 0% of the patient deaths before the reporting period, are judged to be more likely than not to have been due to problems in the care provided to the patient. This number has been estimated using the screening process detailed above (*Number of Deaths reviewed which were more likely than not to have been due to problems in the care provided to the patient*). 0 representing 0% of the patient deaths during 2016/17 are judged to be more likely than not to have been due to problems in the care provided to the patient.

Dr Foster Metrics	September 2016 – August 2017	October 2016 – September 2017	November 2016 – October 2017	December 2016 – November 2017
HSMR (rolling 12m average)	104.9 'as expected'	105.5 'as expected'	104.9 'as expected'	105.1 'as expected'
Alerts	Senility, Respiratory Failure, Acute CVA, Acute and unspecified Renal Failure	Senility, Respiratory Failure, Acute and unspecified Renal Failure and Peripheral and visceral atherosclerosis	Senility and organic mental disorders	0 Outlying Groups
Crude Rate (HSMR)	3.3% vs Peer group rate of 3.60%	3.5% vs Peer group rate of 3.60%	3.4% vs Peer group rate of 3.50%	3.4% vs Peer group rate of 3.50%
Palliative care coding (%)	3.10% vs national 3.61%	3.27% vs national 3.66%	3.26% vs national 3.70%	3.39% vs national 4.05%
Charlson co-morbidity scoring (%)	Score of 0 = 51.4% vs National 49.2%	Score of 0 = 51.2% vs National 49.0%	Score of 0 = 51.3% vs National 49.0%	Score of 0 = 51.3% vs National 49.7%
SMR	101.9 'as expected'	103.6 'as expected'	103.7 'as expected'	104.0 'as expected'
SHMI (July 16 - June 17)	107.43 'as expected' (band 2)			

Seven Day Services

In describing seven day services 10 standards have been adopted, 4 of which (see below) are identified as priorities by NHS Improvement.

Regular assessment against the priority standards is undertaken as part of national review.

- Standard 2 – Time to first consultant review
- Standard 5 – Access to diagnostic tests
- Standard 6 – Access to consultant-directed interventions
- Standard 8 – Ongoing review by consultant twice daily if high dependency patients, daily for others

The Trust is fundamentally compliant with standards 5, 6 and 8.

The major challenge is the availability of interventional radiology and access to immediate radiotherapy. This is part of a complex systems gap which will need to be addressed as part of a larger system wide workforce and service deficit.

Clinical standard 2 – Time to first consultant review - a gap analysis has been undertaken. We continue to work towards compliance with the standard and have embarked upon a system wide review of service specification as part of the Northamptonshire Health and Social Partnership.

Reporting of Patient Reported Outcome Measures (PROMS):

Patient Reported Outcome Measures (PROMs) assess the quality of care delivered to NHS patients from the patient perspective. Currently covering four clinical procedures, PROMs calculate the health gains after surgical treatment using pre- and post-operative surveys.

The procedures are:

- hip replacements
- knee replacements
- groin hernia
- varicose veins*

*Kettering General Hospital NHS Foundation Trust does not conduct varicose vein procedures.

PROMs measure a patient's health status or health-related quality of life at a single point in time, and are collected through short, self-completed questionnaires. This health status information is collected before and after a procedure and provides an indication of the outcomes or quality of care delivered to NHS patients.

PROMS are collated quarterly, and due to information captured, the surveys run at least 2 quarters behind. Therefore, the data included is for the last full year (2016/17). Published data for 2017/18 is pending as at the date of this Quality Report for 2017/18.

	Health Status Questionnaire Percentage on health gain responses from patients	
	Finalised data for April 15 to March 16 (Published August 2016)	
	National	**KGH**
Groin Hernia	57.4%	46.6%
Hip Replacement	86.9%	64.5%
Knee Replacement	96.4%	54.7%
	Provisional data for April 16 to Mar 17 (Published February 2018)	
	National	**KGH**
Groin Hernia	57.8%	55.7%
Hip Replacement	85.9%	66.9%
Knee Replacement	94.6%	72.4%

Comparative data against previous years is shown on the next page.

Prescribed Information

An improvement in participation rates can be seen between 2015/16 and 2017/18. For Hip and Knee operations, 2016-17 saw the introduction of the “Joint School” on Ashton Ward. Attended by Ward Manager, Physiotherapist, OT and member of the Clinical Audit Team, the patient’s expectations around the operation outcomes are discussed and outlined.

The number of completed questionnaires for hip and knee operations has increased due to Joint School.

The Trust intends to continue to take the following actions to continue to improve these outcomes scores, and the quality of its services in 2018/19 by:

- Continuing to attend the Joint School for Hip and Knee operations.

- The Clinical Audit Department will work with general surgeons around Hernia operations to ensure a robust process is in place for the completion of pre-operative questionnaires on site.

- The Clinical Audit Department will continue to match post-operative information to the pre-operative questionnaires in real time to ensure that any change in reporting figures can be shared and addressed at that point, rather than wait until results are published.

Reporting of Re-admissions:

Quality of care together with safe and appropriate discharge is essential. Monitoring the rate of re-admissions to our hospital for those discharged within 28 days enables us to assess and investigate where necessary, reasons for re-admissions.

Data for the reporting period 2017/18 is unavailable at the date of this Quality Report.

The Health and Social Care Information Centre (HSCIC) has not published national readmission rates by year since 2013. And as a result we are unable to benchmark our performance nationally, this national data is due to be updated in August 2018.

0-15 Years:

From	To	Value
01.04.2016	31.03.2017	10.4%
01.04.2015	31.03.2016	9.9%
01.04.2014	31.03.2015	9.0%

16+:

From	To	Value
01.04.2016	31.03.2017	8.1%
01.04.2015	31.03.2016	7.4%
01.04.2014	31.03.2015	8%

Data Source: Trust internal data: Dr Foster

Prescribed information

Percentage of patients (i) 0 – 15 and (ii) 16 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.

Kettering General Hospital NHS Foundation Trust considers that this data is as described for the following reasons:

The information is provided to the Hospital Episode Statistics and is published. We have analysed this information from Dr Foster, a national system available to all Trusts.

Kettering General Hospital NHS Foundation Trust has taken the following actions to improve these percentages, and the quality of its services by:

- Improving care pathways, use of ambulatory care and improvements to our discharge processes.

The Trust's responsiveness to the personal needs of its patients

We want to ensure our patients, their families and carers receive the best experience possible. We welcome all feedback; compliments, suggestions, concerns and complaints and use them as a source of information for learning and improvement.

Our Head of Patient Experience and Involvement with Corby Steel Gate Way Group Leader, of 36 years, Trevor Wright.

Our Patient Experience and Involvement Steering Group receive assurance on implementation of the strategy and the group has membership from staff, Healthwatch Northamptonshire, Trust Governors, patient representatives and volunteers.

During 2017/18 the Head of Patient Experience and Involvement launched a series of community engagement events which will form part of a rolling programme. Other local services have attended to share information. Health Watch Northamptonshire and the Care Quality Commission have also supported at the events. The aim of these events is to:

- Inform the public how they can be involved with the hospital
- Share information and seek feedback about services
- Promote and develop with the public the electronic patient feedback system

Feedback received form the event is reported to the Patient Experience and involvement Steering Group, following the completion of the first 4 events all feedback will be collated, reviewed and action plans implemented to address any areas for improvement.

The Trust will also be taking part in the Experience of Care Week (23 - 27 April 2018) giving services an opportunity to show case what they have done locally to improve the patient experience.

The Head of Patient Experience and Involvement has also attended other groups across the North of the county;

- Young Healthwatch Northamptonshire to help develop the new feedback system and also ask younger adults what's important to them in terms of quality.

- Corby Steel Gateway Learning Disability Group (Mencap) to talk about experiences and seek feedback on what's important and what our priorities should be.

We measure our improvement through various feedback methods such as the Friends and Family Test, NHS Choices, patient stories, local surveys, safety and quality walkabouts, feedback from Healthwatch Northamptonshire.

We have used our Listening Booth to promote giving feedback across the Trust, this has also been used in the promotion of FFT. Our patient representatives have supported us by staffing the both in different locations of the hospital and at that the Trusts Annual Members Meeting as well as Clinical Commissioning Groups Events.

Example of positive from NHS Choices during 2017/18:

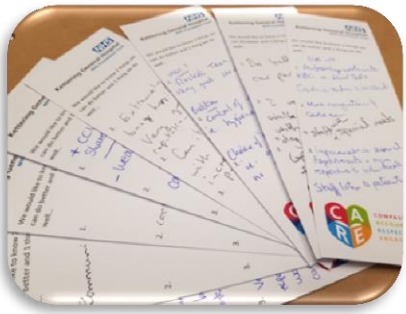
★★★★★
Accident and Emergency

"Came into A&E yesterday and was seen by a doctor who was such a lovely woman and hope this gets back to her. Really appreciated everything she did for me when I came in with myself, my brother and my baby.

A big thank you and such a nice lady"

★★★★★
Endoscopy

"Thank you so much to all the staff in Endoscopy. I went for a bronchoscopy which I was very concerns about. The whole team were brilliant and I cannot praise them enough or thank them enough. I was met by a nurse who took me through all the details an helped put me at ease before the procedure



Friends and Family Test Indicator

At the beginning of 2017/18 the Trust changed the metric in which it records the FFT, previously a Net Promoter Score was used and is an index ranging from -100 to 100 that measures the willingness of people to recommend a service. To Bring the Trust in line with NHS England reporting, a percentage recommendation rate is now used.

Period	Trust Average %	National Average	Lowest Score Nationally	Highest Score Nationally
2015/16	95%	95%	72%	100%
2016/17	95%	95%	67%	100%
2017/18	96%	95%	70%	100%

Prescribed Information
The data made available and covering services for inpatients and patients discharged. (Gateway reference 00931)

Kettering General Hospital NHS Foundation Trust considers this data is as described for the following reasons:

- We actively survey patients following their discharge in relation to the national Friends and Family Test (FFT). All comments received via the Friends and Family surveys are shared with the relevant teams, reported in our Quality Dashboard and to our Patient Experience and Involvement Steering Group and Integrated Governance Committee.

Kettering General Hospital NHS Foundation Trust has taken the following actions to improve this percentage, and the quality of its services, by:

- Improving how many FFT responses are completed is one of our patient experience priorities for 2017/18.
- Updated questionnaire in collaboration with the Trust Learning Disability Lead Nurse to ensure it is accessible.
- In order to increase response rates, we will continue to promote FFT. Data continues to be collected through a paper based system, however the Trust is in the process of implementing an electronic feedback system, which will include FFT. This will make providing feedback more accessible.

Improvements in the response rate to the FFT test means we will have a better understanding of what our patients think of our services, enabling us to work towards continuous quality improvement.

Data Source: Local data collection, Patient Experience Headlines Tool (NHS Improvement)

Pictured is Wendy Patel and Sheila White two of our long standing patient representatives with James

Complaints Management

Listening and acting on feedback, including complaints, is essential to improving quality. Monitoring the timeliness of responses to complainants can be an indication of the priority organisations give to acting on feedback. Reducing the number of formal complaints received can be an indication of issues being resolved in other ways; Patient Advice and Liaison Service (PALS) and directly by staff "on the spot" which is often an immediate resolution, learning action and personalised outcome for the person. Formal complaints are those complainants who wish to receive a response in writing.

What we achieved in 2017/18 to improve complaints management

- Implement tracking system to identify delays and hotspot areas
- Complaints investigation training Matrons, lead nurses and medical staff.
- Further improve compliance with our performance targets in responding to formal complaints.
- Purchase of digital recording equipment to enable complaints meetings to be recorded, where there is agreement.
- Restructure of the Patient Experience Team.
- Distribution of the new learning action sheet to capture learning and evidence of improvements from complaints.
- Patient Experience Training in collaboration with Preceptorship Nurse training programme.
- Development of the complaints E-learning package. This has been live since May 2017 and has been completed by over 1,300 staff.
- We have improved patient and family engagement
- Patient appointment letters have been improved as a result of feedback. They now detail the area of hospital that the appointment is being held and advise of the most appropriate entrance to use.
- We have created a platform on our reporting system Datix to allow staff to log locally resolved concerns and compliments.

We set our performance target higher for 2017/18 from 85% to 90% to respond within agreed timescales. Not only did our performance improve, we exceeded our targets in almost all months.

Month	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Annual Performance
Internal Target	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	
2017/18	91%	87%	92%	98%	97%	91%	79%	68%	94%	100%	100%	100%	91%

Month	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Annual Performance
Internal Target	85%	85%	85%	85%	85%	85%	85%	85%	85%	85%	85%	85%	
2016/17	90%	93%	90%	82%	63%	89%	90%	93%	93%	95%	100%	91%	89%

Month	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Annual performance
Internal Target	80%	80%	80%	80%	80%	80%	80%	80%	80%	80%	80%	80%	
2015/16	43%	43%	51%	28%	42%	38%	33%	43%	37%	61%	54%	68%	45%

Data Source: Datix Complaints Module

Measurement of staff who would recommend the Trust as a provider of care to their family and friends

Period	Value who recommend for this Trust	National Average	Lowest Score Nationally	Highest Score Nationally
2017 Survey	3.50	3.75	3.34	4.12
2016 Survey	3.67	3.76	2.82	4.84
2015 Survey	3.54	3.76	2.86	4.52

Prescribed Information
The percentage of staff employed by, or under contract to, the Trust during the reporting period who would recommend the Trust as a provider of care to their family or friends.

Kettering General Hospital NHS Foundation Trust considers that this data is as described for the following reasons:
The results of the 2017 NHS staff survey were reported to the Trust Board on 6th April 2018.

Kettering General Hospital NHS Foundation Trust has taken the following actions to improve this percentage, and the quality of its services by:

In terms of action, we are running a number of sessions across the Trust regarding the CARE values and how we use these in our behaviour, these sessions are using an information scribe in the same way we developed the CARE values in order to develop an action plan which addresses staff concerns. We are establishing a mediation pool in order to address low level issues of concern/conflict matters. The Trust is also providing a number of training opportunities, some of which will be targeted to certain groups/areas.

Our Apprenticeship awards celebrating the 2018 National Apprenticeship week.

Measurement of Clostridium Difficile (C Diff) cases:

Period		Number	Rate per 100,000 bed days	National Average
From	To			
01.04.2017	31.03.2018	21	Not published until July 2018	
01.04.2016	31.03.2017	21	9.4	13.2
01.04.2015	31.03.2016	26	13.2	14.9

For each of the three years above, a ceiling of no more than 26 incidents per year was set by our commissioners.

Data Source: Public Health England taken from the national HCAI database

Prescribed information

There is wide recognition that the epidemiology of CDI is changing. The C. difficile ribotype (ribotype 027) associated with the high numbers of CDI cases in the early 2000s is no longer as prevalent. The reduction in the prevalence of this ribotype may also be associated with reductions in the case fatality rate of CDI. Changes in the time to onset for CDI cases and increasing proportions of cases that were not inpatients were noted in last year's annual epidemiologic commentary. The current trust apportioning algorithm does not take into account complex healthcare pathways that CDI patients may have.

A new trust-apportioning mechanism was introduced in April 2017 and will collect data on prior health exposures. Data from this mechanism will be presented in future reports. Better understanding of prior health care exposures among those with community-onset CDI will enable the design and implementation of further interventions to tackle this infection and will present the opportunity to harmonise definitions used by the mandatory surveillance of CDI in England with those used by ECDC and other international health organisations.

Reference; Annual Epidemiological Commentary Mandatory MRSA, MSSA and E. coli bacteraemia and C. difficile infection data 2016/17, Public Health England

Kettering General Hospital NHS Foundation Trust has taken the following actions to improve this rate, and the quality of its services, by:

The sustained effort into the Diarrhoea Roadshow. Reiterating the key messages and practices needed to manage diarrhoea and assessing for infective diarrhoea effectively. These efforts have been;

- Maintaining the league table, detailing the numbers of days free from a hospital acquired Cdiff. Sending the numbers out with messages regarding best practice and highlighting areas of good practice too.
- Using SIGHT within the rhyming message to add some fun to the emails.
- Rewarding achievements within ward and department areas with Cakes.
- Engaged with the week-long patient safety messages to promote the mnemonic SIGHT.
- Using the RCA's from cases in mandatory refreshers to share learning.
- Attending the wards board round of an episode within 48 hours to provide feedback and areas of concern or for improvement.
- Monitoring if numbers and all receiving a RCA, and themes collated via the team through meetings and fed into the IPCC accordingly.

Measurement of Patient Safety Incidents

Period	Number of Patient Safety Incidents (including near misses)	NRLS calculation rate of patient safety incidents per 1,000 bed days	Percentage of severe harm as reported to NRLS	Percentage of death as reported to NRLS
		NRLS calculations latest available are for period 01.04.17 to 30.09.17		
2017/18	7161	30.24	1%	0.10%
2016/17	7326	30	1.1%	0.01%
2015/16	6105	29.8	0.53%	0.11%

Data Source: Datix and National Reporting and Learning System (NRLS)

Prescribed information
The number 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.

Kettering General Hospital NHS Foundation Trust considers that this data is as described for the following reasons:

A validation exercise has been undertaken to ensure that the patient safety incidents are correct for 2017/18 and the previous year.
During 2017/18, data mapping of patient safety incidents using the NRLS mapping tool has resulted in a more efficient upload of only incidents that are related to patient safety. Data collected for 2017/18 is based on a 12 month period and based on the average number of incidents reported each month the Trust will report approximately the same number of incidents as in 2016/17.

The percentage of deaths reported to the CQC as a result of a patient safety incident shows a reduction for 2017/18 as only incidents where patient safety is found to contribute to death are confirmed to the National Reporting and Learning System. The NRLS requires incidents relating to fractures of neck of femurs to be severe harm and these were historically graded by the Trust as moderate harm. This, combined with an increase in Hospital Acquired Thrombosis incidents accounts for the increase percentage incidents, accounts for the increase percentage reported for 2017/18 compared to previous years. It has now been identified that HAT incidents were being wrongly graded as severe and we therefore expect to see a reduction in this grade of incident going forward.

Staff are encouraged to report incidents in a blame free culture and sharing lessons learned from the analysis of incidents is vital to ensuring improvements and reducing the risk of similar occurrences. Our incident reporting system is monitored to ensure all services in the Trust are able to report incidents.
Encouraging the reporting of all incidents and feedback about changes in practice implemented locally which may be usefully shared more widely to improve the quality of care and safety.

Kettering General Hospital NHS Foundation Trust has taken the following actions to improve this number and/or rate, and the quality of its services by:

- Improved awareness on the importance of incident reporting, including near misses;
- Improved embedded learning from all incidents is in place.
- Improved frequency of uploading patient safety incidents to the

NRLS (reduction in median days from 34 to 3)
- Creation of dashboards in Datix with ‘live data’ charts to help clinicians better understand their patient safety risks.
- Incident database to enable staff to produce real time incident trends to share with wards and teams.
- Improved training for staff together with how to’ information sheets for incident reporting.
- Improvements on Datix to make feedback from incident reporting mandatory.

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PART THREE: Other information

How we performed against the priorities set for 2017/18

NHS Foundation Trusts must specifically use Part Three of the quality report to present an overview of the quality of care offered by the NHS Foundation Trust based on performance in 2017/18 against indicators selected by the board in consultation with stakeholders.

The indicators set must include:

- At least three indicators for patient safety
- At least three indicators for clinical effectiveness
- At least three indicators for patient experience

The quality indicators for 2017/18 were chosen following consultation with Trust Governors to determine what was important. The indicators were approved by our Trust Board.

Patient Safety Priorities 2017/18

Reducing Falls

This was a continued priority from 2016/17. We have successfully reduced the number of no harm incidents as a result of falls but during 2016/17 there was an overall increase in falls where any level of harm is recorded, predominantly low harm. We therefore said we would reduce the number of falls resulting in harm. We want to make improvements on identifying the risk of falling and manage this effectively to improve safety, without compromising patient's privacy and dignity.

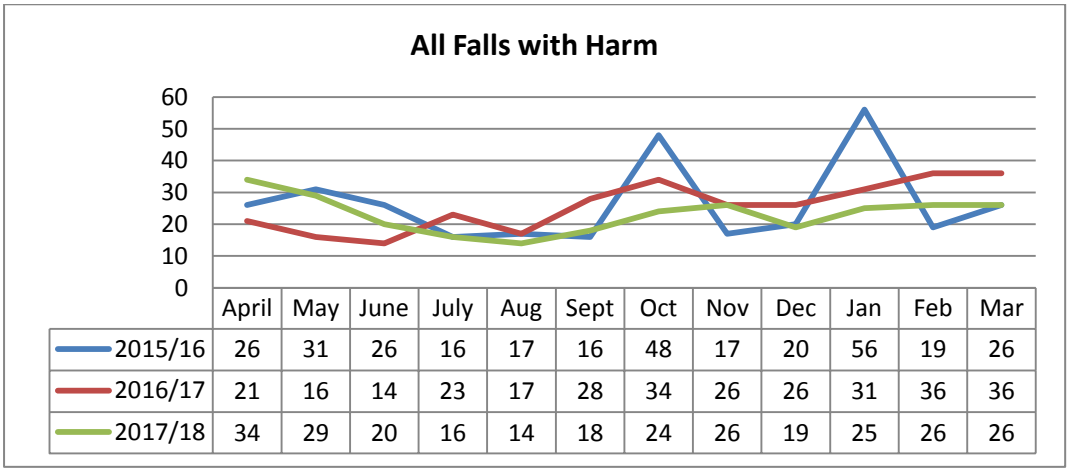
We said we would:

- Develop a Trust action plan informed by learning from previous incidents.
- Continue to promote incident reporting awareness to improve learning, particularly around near miss incidents.
- Undertake an audit on the effectiveness of bedrails and bells.
- Improve teaching on falls prevention on our wards.
- Introduce a Falls web page for staff to promote best practice and raise awareness of risks.
- Introduce anti-embolism stockings that have grip feet.
- Introduce slipper socks in different sizes.

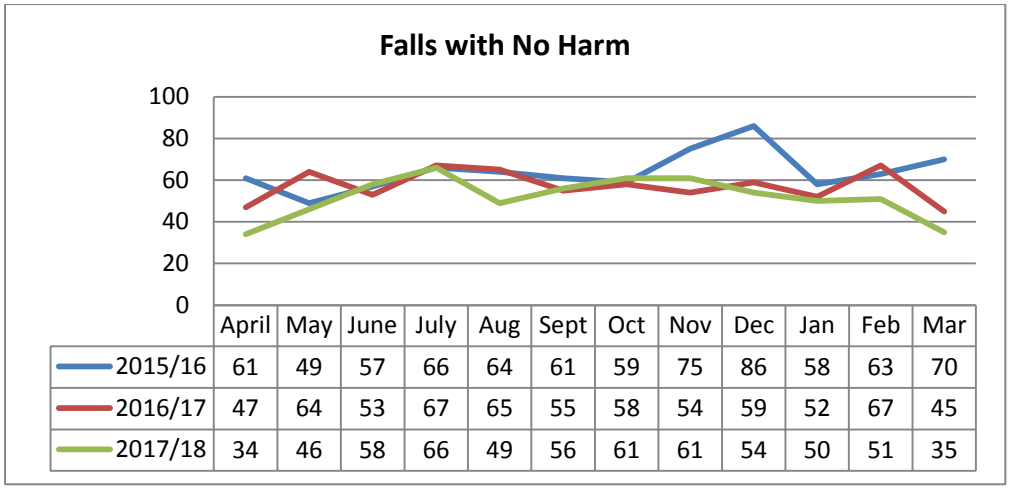
What we achieved in 2017/18 to reduce falls:

Reducing Falls:

We have reduced our falls with harm this year compared to last year.



	April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar
2015/16	26	31	26	16	17	16	48	17	20	56	19	26
2016/17	21	16	14	23	17	28	34	26	26	31	36	36
2017/18	34	29	20	16	14	18	24	26	19	25	26	26



	April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar
2015/16	61	49	57	66	64	61	59	75	86	58	63	70
2016/17	47	64	53	67	65	55	58	54	59	52	67	45
2017/18	34	46	58	66	49	56	61	61	54	50	51	35

Improving awareness and prevention around falls continues to be a challenge to improve the patient experience and reduce harms.

What we have achieved 2017/18:

- A Trust Action plan has been developed for the prevention of falls.
- Incident reporting has been promoted throughout the trust to include near misses.
- Updated our falls action plan with lessons learnt from falls incidents at our Matrons Forum to guide and improve practice around falls prevention.
- Bench marked ourselves against the Falls and Fragility Fracture Audit Programme and participated in the National Audit of In- Patient Falls.
- Completed a Call Bell and Bed Rail Audit to influence practices around falls prevention.
- Falls prevention training has been carried out by the Lead Nurse and Practice Development team whilst validating falls and through 1 to 1 with staff when care planning and risk assessing.
- Developed a falls web page for staff to access the falls care Bundle. The information on falls awareness and prevention is available for staff to access resources and information.
- Worked with procurement to purchase and enable wards to order different sizes of slipper socks and Anti- Embolitic stockings.
- Produced a Falls Patient Information leaflet for all patients on admission

How did we report and monitor our progress

- Monthly to the falls Prevention Group and onward to Patient Safety Advisory Group.
- Monthly to the Quality Governance Steering Group.
- Monitored against targets within the Quality Dashboard monthly to integrated Governance Committee.
- Quarterly falls report to our Integrated Governance Committee.

National Early Warning System (NEWS) - Sepsis

This was a continued priority from 2016/17 because robust sepsis management continues to be a national priority (Sepsis 6 Campaign) and a national CQUIN (commissioning for quality and innovation).

Early recognition and management of the deteriorating patient is critical to be able to intervene rapidly and effectively to avoid harm to our patients.

What we have achieved:

- An ongoing Quality Improvement Project has started in conjunction with East Midlands Patient Safety Collaborative within escalation wards.
- Actively provide training to clinical staff, including trust induction and Annual clinical refresher day.
- The Trust now has a Sepsis K-Net page.
- The Sepsis nurse or other member of the Acute Illness Response Team attends the safety huddle 3 times a week.
- The Trust now has an Adult Sepsis Guideline which details best clinical practice.
- Paediatric sepsis screening tools were launched in April 2017.
- Sepsis and Antimicrobial teams continue to work closely together.
- Case reviews and learning opportunities to improve safety and findings shared with consultants and ward matrons.
- Sepsis simulation scenarios used within paediatric training.

How we measured our improvement:

- There is a continuous monthly audit within ED (& inpatients) around screening and treatment (CQUIN).

How we reported progress:

The Sepsis Steering Group and the Sepsis Working Group meet alternate months. The CQUIN Assurance Panel meets monthly, with final sign off from Quality Governance Steering Group.

We recognise there is more work to do to continue to safety identify and treat sepsis and this will continue to be a priority during 2018/19.

Reducing Grade 3 Pressure Tissue Damage (PTD) Incidents

A PTD incident is where a patient has an injury to the skin and/or underlying tissue. We risk assess patients in order to plan to avoid such damage and we grade the damage ranging from 2 to 4, with 4 being the most damage to the layers of the skin.

We reported that we should be more ambitious with our reduction strategy for preventing avoidable grade 3 PTD incidents. This is also reflected in our Quality Strategy 2018-2021.

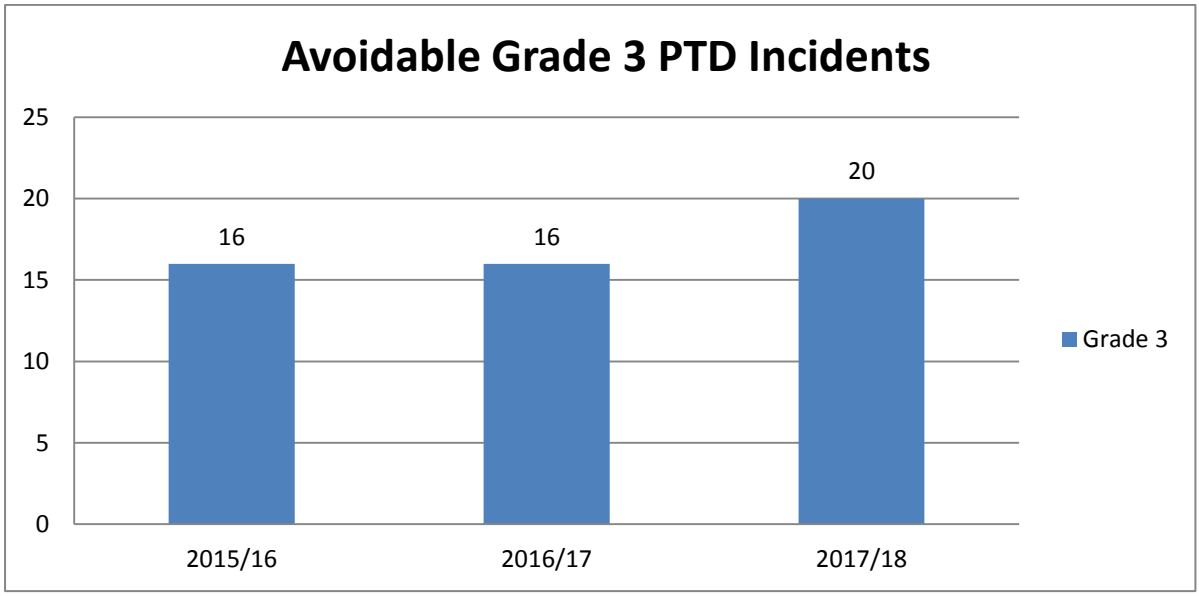
Our target during 2017/18 was that no more than 7 patients would experience an avoidable grade 3 PTD incident.

We said we would:

- Ensure each ward/department with at risk patients have an action plan informed by improvement plans and methods set by our Tissue Viability Lead.
- Ensure that the TVN or practice development nursing team will visit any patient reported to have a grade 3 PTD to assess the injury and standard of practice.

We did not achieve our reduction trajectory for the year. We reported 20 avoidable grade 3 PTD incidents during 2017/18.

Investigation outcomes have identified that record keeping standards require improvement in terms of recording and evidencing assessment of patients and preventative actions. In addition to this, practice standards in some areas that report avoidable PTD incidents are to be improved. These improvements are being led by the Practice Development Nurses and monitored closely through quality dashboard reporting and the governance reporting structure within the Trust. We also feel that the enhanced assessments of incidents on the day reported may be contributing to more accurate grading of ulcers at Grade 3. It is important to understand the correlation between a higher than average admission of people over 85 years and high clinical acuity and incidents of PTD. The Trust is seeking to understand this better.



Data source: Datix

Actions taken during 2017/18:

Most wards/departments with incidents of at risk patients have developed their own action plan around care and practice. This includes increasing quality assurance checks, recording of all patients admitted with pressure ulcers or at risk are checked daily by the ward matrons and sisters to ensure these are recorded and care given appropriately.

The Tissue Viability Nurse and Practice Development Team visit all patients reported to have a grade 3 to assess, confirm and validate to improve standard of care.

The Practice Development Team are delivering education and development in their ward areas around pressure ulcer prevention and management.

A 'Stop the Pressure' Day was held in November 2017 to promote pressure relief for all patients and involving staff with regard to awareness and prevention. They also promoted good practice around Heels and Sacrum Ulcers.

A poster has been developed to increase awareness regarding using equipment available to staff on the ward areas.

Professional education study days in wound care and evaluation have been taking place. This course is over 6 months and includes all wound care and evaluation skills.

Patient Experience Priorities 2017/18

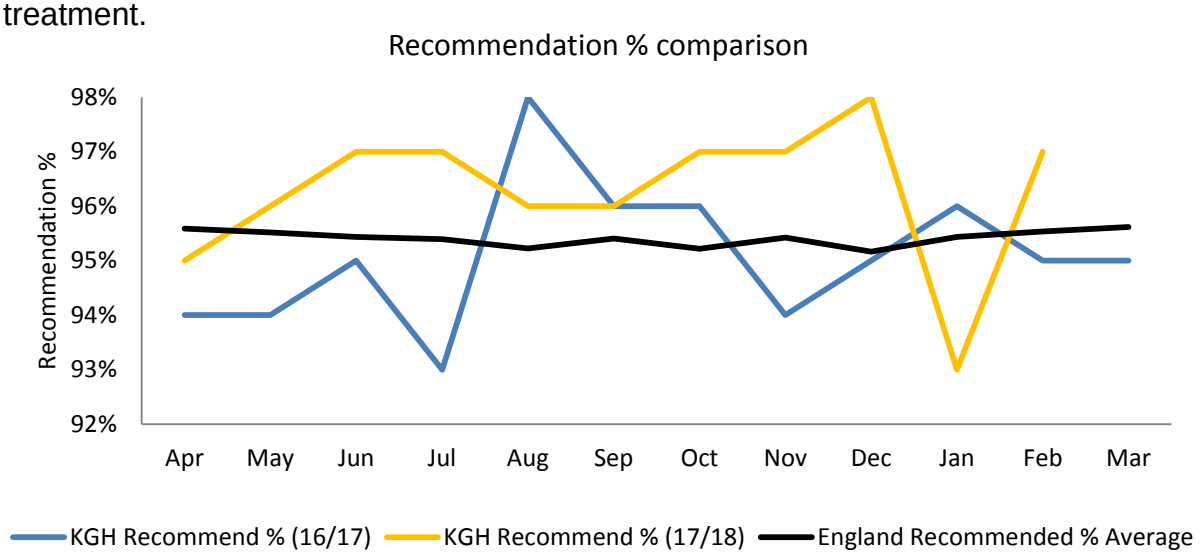
Engagement with Friends and Family Test (FFT)

We said we would

- Promote FFT by use of our 'Listening Booth' visiting all areas of the Trust.
- Seek alternative systems to collect FFT feedback in place of paper based systems.
- Utilise our volunteer staff to assist with collation of FFT responses.

What we have achieved

The Trust has improved its position with regards to the uptake of the Friends and Family Test which is demonstrated in the increased response rate. In addition to this the Trust wide recommendation percentage has remained in the high 90's. This related to those respondents who would recommend the Trust as a place to received treatment.



Data Source: Local data collection and Patient Experience Headlines Tool (NHS Improvement)

NB: 2015 Data not available for comparison due to reporting changes.

Promoting FFT and utilising our volunteer staff

We have worked with volunteers to promote the questionnaire via out Listening Booth. Other areas of the hospital have been targeted such as the Discharge Lounge and the Emergency Department.

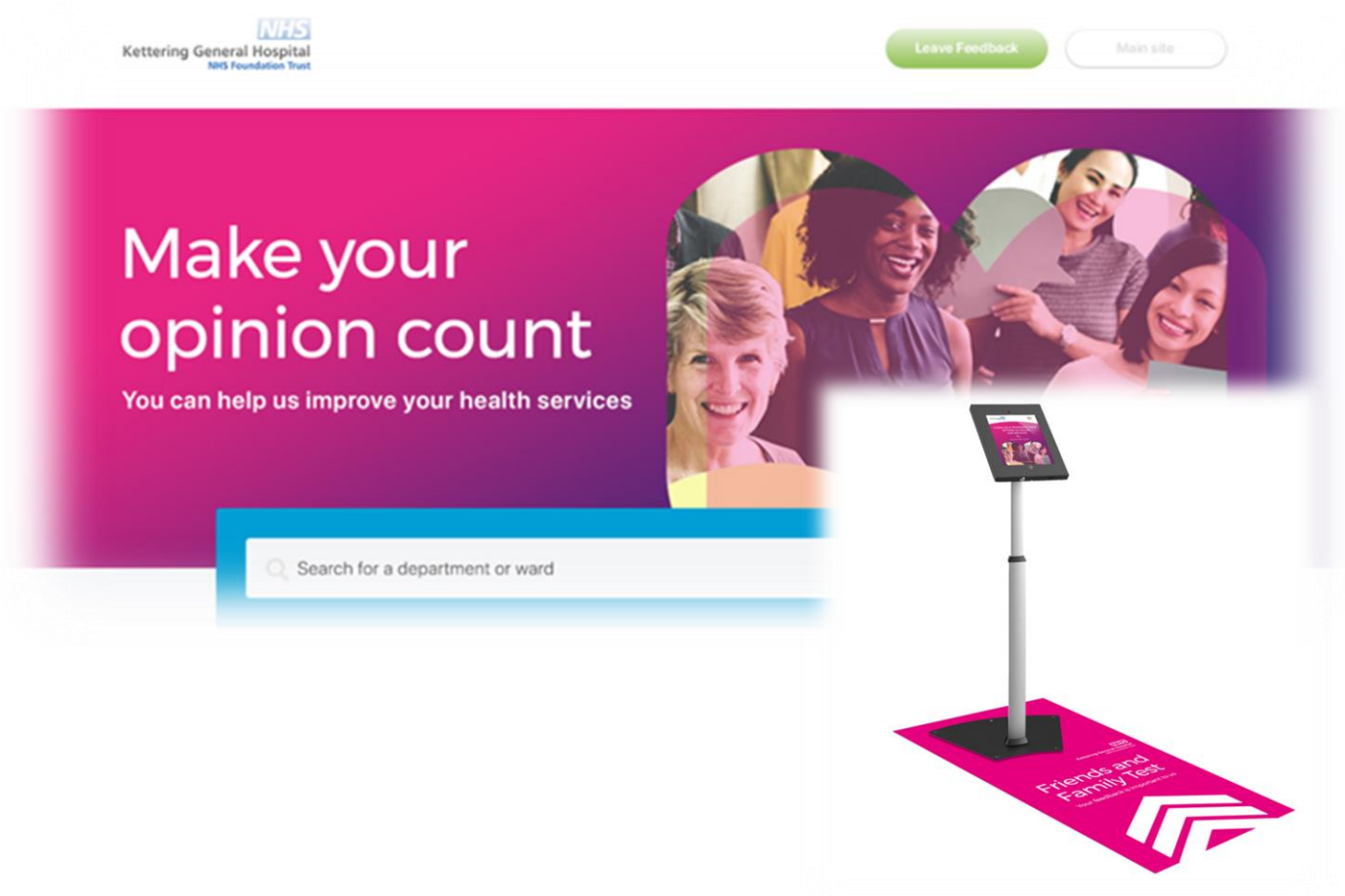
We have improved accessibility for FFT for out Learning Disability patient. Further steps are being taken with the implementation of an electronic patient feedback system which will be implemented during 2018/19.

Improving accessibility for FFT

This will make providing feedback more accessible as patient, carers and family members and staff will be able to provide feedback, which will include FFT. This will also capture staff FFT meaning that patients and staff experience will be brought closer together.

The design of the electronic system is being produced with the support of patient representatives and outreach work has taken place with Young Healthwatch Northamptonshire.

Feedback will be collected via dedicated feedback stations, social media, a smart phone or tablet device as well as via the traditional paper method. We have ensured that we consulted through our Patient Experience and Involvement Steering Group and via community engagement events on the design of this new system, a sample of which is shown below.



Discharge Experience

We said we would

- Improve the quality and timeliness of sending discharge letters to General Practitioners
- Implement learning from our audit undertaken in 2015/16 about delayed discharges
- Implement our Patient Experience and Involvement Strategy
- Work closely with other healthcare providers so that timely discharge to their services is improved
- Continue to engage with Healthwatch Northamptonshire

What we have achieved

113 concerns received during 2017/18 related to discharge. This includes complaints and enquires via the Patient Advice and Liaison Service. This is an improved positon compared to 184 received during 2016/17.

Improve the quality and timeliness in letters to GPs

The timeliness of the production of discharge letters is monitored monthly. The Trust target is 99% for discharge letters to be produced on the day of discharge. During 2017/18 we achieved 85%, an improved position compared to 82% in 2016/17.

Implement learning from our audit

The discharge letter audit carried out in 2015/16 identified that the Emergency Department (ED) was a problematic area and was a continued challenged during 2017/18. Training has taken place within the department, together with promoting the importance of the quality of discharge letters.

We conducted a survey in our Discharge Lounge over a four week period and involved patient representatives. Patients reported that they were being informed about discharge shortly before it took place and that they did not feel involved in the process. This enabled us to improve communications with patients around discharge planning and we are continuing this work into 2018/19.

Engage with Healthwatch Northamptonshire and other healthcare providers

Healthwatch Northamptonshire also carried out a survey across the county speaking to our patients. There are some key recommendations from the Healthwatch report which the Trust has taken steps to address. This resulted in discharge being discussed earlier, with patients advising they felt more involved in the process.

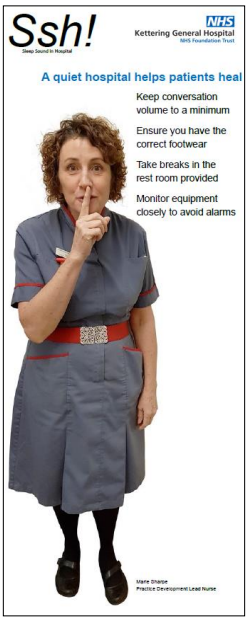
We are implementing the “The Patients Journey: Admission and Discharge Pack”. This is initially being trialled on the urgent care wards with a view to then roll out to other areas of the hospital. This is being led by the Practice Development Nurses. This pack will follow the patient through to discharge and will provide other health and social care providers with the all the information relating to the patients journey, care and treatment.

Reducing Noise at Night for our Inpatients

We said we would:

- Implement a campaign to promote reduction of noise at night utilising posters and our intranet
- Purchase of soft close bins
- Revisit our uniform policy and reinforce standards of footwear
- Explore environmental systems to reduce noise and undertake assessments of areas.

What we have achieved



Implemented a Campaign

We produced Trust wide communications to support the promotion of the importance of quiet wards. We have prepared to launch the "*SSH"* "Sleep Sound in Hospital" Campaign.

Life size banners will be erected around the hospital site to provide further information on how noise at night impacts on recovery and what can be done to help reduce noise. The Patient Experience Team are also running a trial of sleep well kits which include an eye mask and ear plugs. 200 packs have been ordered.

Purchase of soft close bins

Only soft close bins are able to be purchased for clinical areas when being replaced to help support a quiet ward. The Trust uniform policy has also been reinforced to ensure appropriate footwear by our staff.

Explore environmental systems

A sound assessment was carried out in our maternity unit and in one of our urgent care wards. This measured the noise levels in decibels. The test identified that the urgent care ward noise levels were higher than recommended, but similar to those reported in ward environments at other comparable hospitals. We plan to reassess levels of noise to evaluate our campaign.

Clinical Effectiveness Priorities for 2017/18

Measurement of Venous Thromboembolism (VTE)

Kettering General Hospital NHS Foundation Trust considers that this data is as described for the following reasons:

The Trust's VTE risk assessment compliance is monitored by an established audit process. Data has been taken from the EasyNote Discharge Summary Review which includes all patients admitted to the Trust.

Data is reported via a monthly report to the Clinical Business Units. The VTE Steering Group is in place.

The Trust has taken the following actions to improve this percentage, and the quality of its services by:

- All junior doctors, medical staff and new clinical staff starters received VTE prevention education at induction.
- VTE prevention education provided at Statutory Refresher twice a month.
- Engagement with the Regional Thrombosis Meeting co-ordinating regional policy/guidelines/good practice.
- VTE prevention team participation in Morbidity & Mortality reviews and provided teaching sessions throughout the medical teams.
- A second Nurse Education Day run for nursing staff in the East Midlands.
- Nurse led clinic fully established.
- Establishing Haemostasis and Thrombosis Patient Improvement Facilitators to improve the patient experience when on the wards.

From	To	Admissions	VTE Assessed	Value
01.04.2017	31.03.2018	69325	68662	99.0%
01.04.2016	31.03.2017	82178	81503	99.18%
01.04.2015	31.03.2016	57021	56627	99.31%

VTE Return – Data Submissions

Month	Number of Risk Assessments	Number of Admissions	% Compliance	Target
Apr 17	6523	6583	99.1%	95%
May 17	7128	7186	99.2%	95%
Jun 17	7218	7270	99.3%	95%
Jul 17	6869	6930	99.1%	95%
Aug 17	6806	6884	98.9%	95%
Sep 17	6866	6916	99.3%	95%
Oct 17	6993	7041	99.3%	95%
Nov 17	7232	7305	99.0%	95%
Dec 17	6409	6491	98.7%	95%
Jan 18	6618	6719	98.5%	95%
Feb 18	5804	5922	98.0%	95%
Mar 18	6460	6580	98.2%	95%

Data Source: Trust EasyNote System

From the quarterly information available from NHSE, the Trust has calculated the Trust's VTE risk assessment performance against the national average score for Acute Trusts in England.

	Q1					
	Admissions	VTE Assessed	This Trust	National Score	Lowest National Score	Highest National Score
2015/16	18297	18178	99.30%	96%	86.1%	100%
2016/17	20447	20335	99.45%	95.64%	80.6%	100%
2017/18	21039	21039	99.2%	95.11%	51.38%	100%
	Q2					
	Admissions	VTE Assessed	This Trust	National Score	Lowest National Score	Highest National Score
2015/16	18737	18620	99.40%	95.90%	75.0%	100%
2016/17	20833	20652	99.13%	95.45%	72.1%	100%
2017/18	20730	20730	99.1%	95.21%	71.88%	100%
	Q3					
	Admissions	VTE Assessed	The Trust	National Score	Lowest National Score	Highest National Score
2015/16	19987	19829	99.20%	95.50%	78.5%	100%
2016/17	20935	20741	99.07%	95.57%	76.5%	100%
2017/18	20837	20837	99.0%	95.30%	76.08%	100%
	Q4					
	Admissions	VTE Assessed	The Trust	National Score	Lowest National Score	Highest National Score
2015/16	19370	19234	99.30%	95.45%	78.06%	100%
2016/17	20447	20335	99.45%	95.65%	80.65%	100%
2017/18	The NHS Improvement Publications Calendar states the data will be released on 1st June 2018					

Data Source: NHS Improvement

Meeting the Needs of Mental Health A&E Patients

Why have we chosen this priority?
Ensuring the safety of mental health patients in A&E is essential. The environment must be suitable for both the safety and dignity of our patients who present with mental health related issues. Our CQC inspection in October 2016 also identified this as an area for improvement.

How we have improved?

- Our environment and management of the environment for assessment of mental health patients will be safe and meet the requirements of the Royal College of Psychiatry Liaison Accreditation.
- The Psychiatry room fully complies with the latest Royal College recommendations and has been re-assessed by NHFT as compliant in all areas
- We will ensure risk assessments are undertaken in line with Emergency Department Operational Policy Mental Health Triage Assessment Tool and that there is cohesive engagement with our mental health and social care partners.
- Mental Health screening tool is in place and utilised for both children and adults, this was re-designed in conjunction with NHFT and Social Care partners.
- Assurance regarding the mental health room has been sighed off as per NHFT RA.

How did we measure our improvement and what are our targets?

- We audit the environment and our use of the mental health assessment room for compliance against standards.
- An audit undertaken by Northamptonshire Healthcare NHS Foundation Trust reporting full compliance
- Monitoring of patient feedback.
- Audit against Royal College of Emergency Medicine (RCEM) standards proactively

How we reported progress:

- Weekly monitoring of risk assessment standards for both children and adult patients, reported to the Emergency Department Governance group on a monthly basis.
- Audit reports to department governance meeting monthly
- Reports to the Quality Governance Steering Group via a departmental quality dashboard on a monthly basis.

Paediatric inpatient standards for those identified at risk of self-harm

There are a number of children and young people who are admitted to our Paediatric inpatient service following an episode of self-harm or suicidal ideation. These patients usually require acute inpatient care in order to be assessed by mental health and/or social care partners before discharge. Our CQC inspection in 2016 also identified this as an area for improvement.

We said we would:

- Ensure that our staff are competent in the assessment and management of self-harm risks by patients.
- Ensure that risk assessments are undertaken when patients are identified as potentially at risk of self-harm.
- Ensure that risk assessments and care planning addresses identified risks.
- Ensure that the environment is safe,

What we achieved and reporting and monitoring our progress:

We have worked to ensure that those young people identified at risk of self-harm are cared for in an environment which is safe, where staff are appropriately trained to care for them and where potential risks are identified early and clearly documented.

Ward staff have now been signed off as competent in the assessment and management of self-harm risks by patients following training and guidance from the Northamptonshire Child and Adolescent Mental Health Service.

Further support and training is now available for all new starters to Skylark, with plans under development with our Lead Nurse and Practice Development Nurse to look at possible annual updates.

As part of the introduction and trial of the new self-harm pathway across Northamptonshire including our partners at Northampton General Hospital, a streamlined risk assessment has been introduced for patients upon arrival at paediatric ED. A further risk assessment will be undertaken if the young person needs admission to Skylark Ward, which will include a full environmental risk assessment.

Our first ligature audit was completed in July 2017, which has highlighted the risks posed by our environment and / or storage and equipment areas, where ligature points may be present. The ward has also ensured that identified shower and bedside curtain rails and window blinds are now anti-ligature.

Care planning for the young person who has mental health concerns, or who requires a formal risk assessment is now included as part of the pilot self-harm pathway documentation. Care planning will be completed across all specialities including from Crisis team, ED and Skylark Staff.

Environmental improvements:

- Netting was put up against the balcony to ensure that no one was able to get any access over the balcony. This was well received by the CQC following its recent inspection in November 2017.

- As mentioned previously, a ligature audit was undertaken in July 2017, which highlighted those areas where potential ligature risks had been found, leading to in particular, replacement of window blinds and shower curtains rails to anti-ligature.

- The ward self-harm risk assessment incorporated an environment assessment which is completed for all young people admitted following an episode of self-harm, which includes for example removal of tubing / electronic cables which could be used by a young person to harm themselves, with other elements which cannot be removed such as bed sides incorporated into the ligature audit as potential risks.

- CCTV and electronic access by swipe card was also introduced to Skylark Ward. Further concerns around staff and visitors tailgating through the automatic doors were also raised by the CQC during its recent inspection in November, and this has now been changed so that the entrance to Skylark no longer has automatic opening doors, and staff and visitors must open the doors themselves.

- The Lead Nurse for paediatrics undertakes monthly self-harm audits and monitors the number of young people admitted to Skylark following an episode of self-harm, length of stay, reasons for admission and particular concerns or issues. This information is then reported through governance groups, and shared with our multi-agency partners.

- A further environment and security audit has also been completed which included care planning and ward risk assessments for self-harm patients. Issues raised through monthly self-harm reporting and lessons learnt are shared by the lead nurse as part of the multi-agency self-harm pathway steering group and with members of the Skylark staff to inform future learning and training.

Performance against 2017/18 key national priorities

The Trust continues to review the services it provides and the systems and processes that support them, in order to make sure that they are accessible to patients. Kettering General Hospital NHS Foundation Trust recognises that providing timely access contributes to a positive patient experience.

The table below sets out the performance of the Trust against the key national priorities from Monitor's Risk Assessment Framework.

Other information

The Trust must provide a copy of the draft quality report to the Clinical Commissioning Group which has responsibility for the largest number of people to whom the provider has provided relevant health services during the reporting period for comment before publication and we have included their comments.

Comments from Healthwatch Northamptonshire, Trust Governors and Northamptonshire County Council Overview and Scrutiny Committee are also included in this Quality Report.

Annexes:

- Comments from commissioners
- Comments from Healthwatch Northamptonshire
- Comments from governors
- Comments from Northamptonshire County Council Overview and Scrutiny Committee
- Statement of directors' responsibilities in respect of the quality report.

External auditors' limited assurance report is provided at the front of this Quality Report.

NHS Improvement Risk Assessment Framework – Targets and Indicators with thresholds

				2015-2016 %				15/16 Total	2016-2017 %				16/17 Total	2017-2018 %				17/18 Total
Area	**Indicator**	**Threshold**	**Weighting**	**Q1**	**Q2**	**Q3**	**Q4**		**Q1**	**Q2**	**Q3**	**Q4**		**Q1**	**Q2**	**Q3**	**Q4**	
Access	Maximum time of 18 weeks from point of referral to treatment in aggregate – admitted	Position at Quarter end										62.4	62.4	56.7	54.9	62.8	62.6	59.2
	Maximum time of 18 weeks from point of referral to treatment in aggregate – non-admitted											82.3	82.3	80.7	83.4	81.9	79.3	81.3
	Maximum time of 18 weeks from point of referral to treatment in aggregate – patients on an incomplete pathway											62.3	Qtr end cen-sus	76	80.3	79.6	77.1	77.1
	A&E: Maximum waiting time of four hours from arrival to admission/transfer/ discharge	95%	1	84.5	88.5	87.8	78.9	84.9	87.6	87.9	82	75.9	83.4	86.3	85.7	82	83.1	83.9
	All cancers: 62 day wait for first treatment from urgent GP referral for suspected cancer	85%	1	78.9	76.7	87.8	83.4	81.9	86.3	88.9	86.9	82.6	86.2	89	85.3	85.6	89.3	87.2
	All cancers: 62 day wait for first treatment from NHS Cancer Screening Service referral	90%	1	95.8	99.2	95.3	95.4	96.5	88.2	91.3	85.9	90.1	89.1	94.7	93.1	94.9	96.3	94.9
	All cancers: 31 day wait for second or subsequent treatment comprising surgery	94%	1	97.1	98	100	96.9	98.7	100	100	100	97	99.2	100	100	100	100	100

				2015-2016 %				15/16 Total	2016-2017 %				16/17 Total	2017-2018 %				17/18 Total
Area	**Indicator**	**Threshold**	**Weighting**	**Q1**	**Q2**	**Q3**	**Q4**		**Q1**	**Q2**	**Q3**	**Q4**		**Q1**	**Q2**	**Q3**	**Q4**	
	All cancers: 31 day wait for second or subsequent treatments comprising anti-cancer drug treatments	98%	1	99.3	100	100	100	99.8	100	100	100	100	100	100	100	100	100	100
	All cancers: 31 day wait for second or subsequent treatment comprising radiotherapy	Not Applicable																
	All cancers: 31 day wait from diagnosis to first treatment	96%	1	99.4	99.7	99.7	98	99.2	97.1	98.8	98.8	97.9	98.1	100	99.4	99.7	98.9	99.5
	Cancer: 2 week wait from referral to date first seen comprising all urgent referrals (cancer suspected)	93%	1	94.7	92.7	97.9	96.3	95.4	95.9	97.8	97.7	96.8	97.1	96.6	97.4	98.4	95.9	97.1
	Cancer: 2 week wait from referral to date first seen comprising symptomatic breast patients (cancer not initially suspected)	93%	1	96.2	98.4	98.3	97.2	97.5	97.4	97.7	96.9	95.3	96.8	93.8	98.2	99	99.1	97.5
Out-comes	Clostridium (C.) difficile – meeting the C. Diff objective	14/15 = 28 15/16 = 26 16/17 = 26	1	10	6	6	4	26	6	3	4	8	21	9	5	5	2	21
	Certification against compliance with requirements regarding access to health care for people with learning disability			Fully achieved					Fully achieved					Fully achieved				

Data Source: National Data Collection Tools (Unify, Open Exeter)

Annexes

Feedback from our key stakeholders is detailed in the following pages. In finalising the 2017/18 Quality Report, the feedback contained in the following pages has been addressed within the Quality Report as follows:

Northamptonshire County Council	
Include a statement on the Trust's position on security of data	Page 36 details: The Information Governance improvement plan is being developed in order to deliver the wider and changing Information Governance remit. This includes the delivery of the replacement for the IG Toolkit (IGT), the Data Security and Protection Toolkit and will encompass the implementation plan for the organisation to comply with the General Data Protection regulations. An overriding high level plan is being supported by individual action plans in order to achieve these objectives and will ensure the organisation is compliant with level 2 of the required standards of the defunct IGT.
Ceiling for number of C.Diff incidents not shown, would be helpful to give the ceiling for this.	This is included on page 65.
Corby and Nene Clinical Commissioning Groups	
Include a view on the quality of relevant health services it provided or sub-contracted during 2017/18.	Chief Executive statement on quality now included that was previously missing from draft shared with stakeholders at page 6.
Declaration that information is accurate to be included.	Page 88, Statement of Directors responsibilities includes declaration of accuracy.
Referral to Treatment (RTT) data on monitoring and reporting arrangements needs populated.	Page 11 now includes monitoring and reporting information.
Sepsis Management Quality Priority – include statement on intended impact for patients.	Page 8 details: The intended impact on patients is through rapid recognition and treatment for patients suspected to have sepsis in an effective way in order to prevent avoidable harm and potentially improve outcomes.
Radiology Reporting section page 15,	This is now included on page 15.

include that the CQC have approved the improvement plan and also note the process for undertaking clinical harm reviews.	
Include a statement on why the Trust did not participate in all the national clinical audits and national enquiries that it was eligible to.	Page 25 details that the Trust did not participate in all the national audits that it was eligible to due to two factors; the Trust not having any relevant cases present in the audit period or due to resources where a consultant vacancy existed.
CQUIN end of year position to be updated	This has been updated on page 33.
it would be helpful to note the improvements made through implementation of the Sepsis CQUIN.	Achievements listed on page 63.
Strengthen the section by inclusion of the plans to become more compliant with Standard 2 re Seven Day Services.	Page 56 details: Clinical standard 2 – Time to first consultant review - a gap analysis has been undertaken. We continue to work towards compliance with the standard and have embarked upon a system wide review of service specification as part of the Northamptonshire Health and Social Partnership.

Feedback from Clinical Commissioning Groups

NHS Corby Clinical Commissioning Group

NHS Nene Clinical Commissioning Group

Dear Susan,

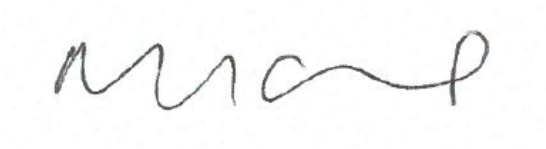
Re: Quality Account 2017-18

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.

Kettering General Hospital NHS Foundation Trust

Annual Quality Account — CCG Feedback May 2018

The Kettering General Hospital NHS Foundation Trust (KGHFT) annual quality account for 2017/18 has been reviewed by NHS Corby and NHS Nene CCGs. It is noted that the report was reviewed whilst in draft format.

The introduction on page 4 includes a section on what has changed within the report following feedback from commissioners — this feedback has yet to be received and will need to be updated to reflect the feedback as detailed below:

Part One

The Quality Account does not contain a statement summarising the trust's view of the quality of relevant health services it provided or sub-contracted during 2017/18.

There is no declaration at the end of Part One, signed by the Chief Executive, that to the best of their knowledge the information in the document is accurate.

Part Two

NHS Corby and NHS Nene Clinical Commissioning Groups support the 2017/18 quality priorities as set by KGHFT in relation to improving patient safety, clinical effectiveness and patient experience.

The Quality Account identifies how the trust intends to measure improvement — it would be helpful to identify the intended impact for patients rather than just highlight the process for capturing improvement for the Sepsis Management priority on page 8. There is no data included on page 11 on how the trust intends to report and monitor progress for the priority: improving how we communicate with patients about waiting times when referred for treatment.

It may be helpful to include within the Radiology Reporting Section on page 15 that the CQC have approved the improvement plan and also note the process for undertaking clinical harm reviews.

Information on the participation in national clinical audits and confidential enquiries is included although provides no explanation for not participating in all of those that it was eligible to.

The achievement for the Commissioning for Quality and Innovation (CQUIN) schemes for 2015/16 and 2016/17 is detailed within the report. The Trust position within the report for 2017/18 will need to be updated in the final report to reflect the year-end position. It would be helpful to include the impact of implementation of CQUINs on patient care.

Nationally mandated elements are included in the report together. The section on compliance with requirements of the Seven Day Services standards would be strengthened by the inclusion of the plans to become compliant with Standard 2.

Part Three

Achievement against the quality priorities outlined in the report is noted. It would be helpful to note the improvements being made through implementation of the Sepsis CQUIN on page 63.

Commissioners will continue to work closely with the Trust and support ambitions to sustain high quality standards of care for people who use services via incentivising quality improvements, quality review assessments and performance management.

Feedback from Healthwatch Northamptonshire

Healthwatch Northamptonshire statement on Kettering General Hospital NHS Foundation Trust (KGH) draft Quality Account 2017/18

Healthwatch Northamptonshire has continued to work with Kettering General Hospital over the past year through our representation on the Patient Engagement Steering Group, through our volunteers who gather the views of inpatients on the wards the '15 Steps' tool, our Young Healthwatch visit to Skylark ward and Paediatric ED, and by participating in the regular engagement sessions organised by the Head of Patient Experience and Involvement in different localities.

We were pleased that the outcome of the Care Quality Commission inspection undertaken in November 2017 resulted in a move from the Trust being rated 'Inadequate' to 'Requires Improvement'. It was also noted that the Inspectors felt "The Trust was embedding a systematic approach to improving quality of its services and safeguarding high standards of care by aiming to create an environment in which excellence in clinical care would flourish". We congratulate the Trust in continuing to be rated 'Good' for 'Caring' in all of the categories. Whilst there is still some way to go, this is a significant step in the right direction.

We welcome the appointment of Simon Weldon as Chief Executive of the Trust, who describes this new rating as the start of a journey, but also points out the unprecedented level of demand for services in 2017-18, with a bed occupancy level averaging 99%. We note the commitment to "the focus during 2018/19 will be on high quality safe care in an environment that meets the needs and expectations of our local population."

We applaud the Trust's commitment in the past year to embedding learning from patient experience and feedback into its planning and delivery processes. It is noted that the views of governors, patients and the local community via engagement events, have influenced the choice of nine specific improvement priorities for the coming year. It is important that there is feedback on the progress of these priorities to all stakeholders, so that they can see evidence that their views are heard and they do make a difference.

Healthwatch Northamptonshire also supports the inclusion of "Safe assessment and response to the needs of mental health patients in Accident and Emergency" as another priority and the acknowledgement there is more work to be done to ensure

there is a person centred approach in assessment and treatment of this vulnerable patient group.

The Trust is congratulated on achieving more than 100 days since the last reported case of hospital acquired MRSA, and the lower number of Clostridium Difficile infections than ceiling number set by commissioners.

Similarly, there has been good performance on the delivery of all seven cancer standards.

There have clearly been challenges with the East Midlands Radiology Consortium collaboration, along with other Trusts involved. However, Healthwatch Northamptonshire is pleased to know quick and effective action was taken to reduce the difficulties created, and the majority of routine imaging studies are now reported within 14-21 days and an Executive Assurance Group has been created to monitor the reduction in delayed image reporting and ensure patient safety reviews are taking place.

It is noted that the KGH Information Governance Assessment Report score for 2017/18 was 61% and graded Red rating. We look forward to receiving reports of the results of actions taken to improve data quality in the coming year.

It is also noted that Hospital Standardised Mortality Ratio (HSMR) over the last 12 month period is within the expected range for a hospital with the case mix of patients at KGH. We welcome the introduction of a new policy which includes a two stage methodology for reviewing deaths. The report gives information about the governance structure as well as a summary of the work undertaken to review and monitor morbidity and mortality within the hospital, and learning themes are identified. This work is important to both the hospital and also families of patients.

Healthwatch Northamptonshire welcomes the report on the work undertaken relating to Sepsis, including the Quality Improvement Project started in conjunction with East Midlands Patient Safety Collaborative within escalation wards. We look forward to reports relating to this important issue in the coming months.

Collecting information on re-admissions is very important and we would welcome having greater detail about the nature/reasons, both locally, as well as comparative information should it become available following the national data update when it is available.

Healthwatch Northamptonshire has been pleased to promote and be involved with the Trust's programme of engagement events in various locations. Whilst numbers attending have not been huge, the feedback from attendees has been very positive, with members of the public clearly pleased to have the opportunity to 'have their say'. Healthwatch Northamptonshire has suggested that it may also be worthwhile KGH identifying some key community events, where there is a ready audience to

give information and feedback about their experiences and views of KGH. We have also been pleased that our Young Healthwatch Northamptonshire members have been involved in helping to develop a new feedback system for children and young people and thank KGH for facilitating their visit to the children's areas.

We welcome the results of the latest Family and Friends Test, which at 95% is at the national average, and also to learn of the work undertaken with the Trust Learning Disability Lead Nurse to ensure it is accessible. In the longer term it would be interesting to know which areas of feedback have actually influenced change and improvement.

It is noted that Safeguard Training has increased. As this is a statutory requirement, Healthwatch Northamptonshire was surprised to learn that implementation was deficient. It is hoped there will be full implementation of this important issue in the future.

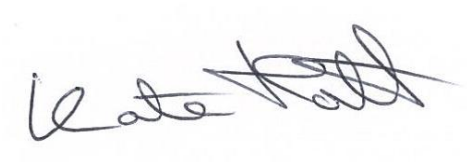
We are pleased to read avoidance/reduction of pressure tissue damage incidents continues to be a high priority. However, it is disappointing to read the reduction trajectory for the year was not achieved and there was an increase in grade 3 PTD incidents compared with 2016/17. We look forward to hearing a more positive report from the actions taken in the current year.

Whilst Healthwatch Northamptonshire recognises and welcomes the reduction in concerns relating to discharge in 2017/18 (113) compared with the previous year (184), this is still a significant number. We are pleased to learn that KGH has adopted some of the key recommendations contained in the Healthwatch Northamptonshire Discharge and Follow-Up report, including beginning the discharge process much earlier and the trialling of the 'Patients Journey: Admission and Discharge Pack'.

We welcome the introduction of the 'Sleep Sound in Hospital' campaign to help reduce noise at night within the hospital, which includes a range of action, such as soft close bins, review of staff footwear and a trial of 'sleep well kits', which include an eye mask and ear plugs.

The safe care of children admitted to hospital is absolutely vital, especially for those who are at particular risk following an episode of self-harm or suicide. The work undertaken to identify those at risk is absolutely key and we are pleased to learn staff are appropriately trained to care for them, identify potential risks and, most importantly, document them. The various audits undertaken to identify risks across the whole environment are also applauded and, in particular, the ligature audit completed in July 2017, which highlighted the risks posed by the environment and/or storage and equipment areas, where ligature points may be present.

We are also pleased to learn ward staff undertake training and guidance from the Northamptonshire Child and Adolescent Mental Health Service, and of the partnership with Northampton General Hospital which has created a streamlined risk assessment for use with patients on arrival at Paediatric ED. We endorse the introduction of monthly self-harm reporting and lessons learnt sharing, as part of the multi-agency self-harm pathway steering group and also with members of the Skylark staff to inform future learning and training.



Kate Holt

CEO

Connected Together CIC (contract holder of Healthwatch Northamptonshire)

Feedback from Governors

The Council of Governors appreciate the opportunity to review and comment on Kettering General Hospital NHS Foundation Trust's 2017-2018 Quality Account.

Governors have opportunities throughout the year to observe and contribute to the business of the Trust. They note the continued focus which the Trust places on areas of concern, whilst recognising the steady improvement evidenced within 'business as usual' and the recent CQC inspection.

The quality assurance process is clearly documented throughout the report and further in depth scrutiny is evidenced through nominated governors attending Sub-Committees of the Board. This has demonstrated greater rigour, ensuring that topics are current, that reports are fit for purpose and there is greater emphasis on accountability.

During the year many changes in the Executive occurred which have now been stabilised with the appointments of the Chairman and the Chief Executive Officer and initial contacts have given rise to confidence that the Trust will go forward in a positive manner.

As part of the quality account process, the Trust involved governors in setting priorities for improvement. Governors chose Preventing Avoidable Deterioration (Sepsis Management) as a patient safety priority local quality indicator for audit by the Trust's external auditors.

The Governors also welcome the Trust's emphasis on raising the profile of safeguarding, recognising the importance of this for both service users and staff.

It is pleasing to note developments in relation to Patient Experience and Involvement. Governors look forward to continued improvements as a direct result of patient and public engagement.

Governors appreciate the time and effort which has been spent in producing the Quality Account. They commend the Trust in evidencing improved practice, and in delivering this wide reaching service within significant financial constraints. The report provides evidence of working collaboratively and effectively to provide an improved service for the future and governors look forward to continued improvements in service delivery for service users.

Feedback from Northamptonshire County Council Overview and Scrutiny Committee

Northamptonshire County Council

Dear Susan

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 Kettering General Hospital 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 KGH, 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 felt the layout was poor and very confusing. There was no flow to the Quality Account.
- There were blank parts of the Quality Account for instance: how they would report and monitor on progress.
- There were no figures for data results.

- A glossary of terms would have been helpful.
- A lot of information was given around C-Diff but the ceiling for these points was not given.
- There was clairification on losing their 'Best Practice Tariff. Were they losing it? At Risk of losing it. The consequences were unclear.
- KGH was complemented on the Lung Cancer Audit with some key successes. They would have expected however a similar statement for Hip Fractures.
- Data was not included for Quarter 3 although the working group felt sure KGH would have known it. There was also no data in the table on page 61 which related to performance targets.
- The working group were disappointed in the health status questionnaires which were below the national figures.
- The working group were disappointed to note the survey figures relating to staff who would recommend the Trust as a provider of care appeared to be worsening.
- Although data for C-Diff was not available until July it also appeared to be worsening.
- KGH was complemented on stating why priorities had been chosen.
- The easy read version at the rear of the document was welcomed.
- The working group was pleased to see improvements in CQC ratings going from requires improvement to good.
- The working group were pleased to see it had been some time since a MRSA case had been experienced.

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

EASY READ PRIORITIES FOR 2018/19

Statement of Directors' Responsibilities

The Directors are required under the Health Act 2009 and the National Health Service (Quality Accounts) Regulations to prepare quality account for each financial year. NHS Improvement has issued 2017/18 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 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 to May 2018
- Papers relating to quality reported to the Board over the period April 2017 to May 2018.
- Feedback from Trust Governors received May 2018.
- Feedback from Healthwatch Northamptonshire received May 2018
- Feedback from NHS Nene Clinical Commissioning Group received May 2018.
- Feedback from Northamptonshire County Council Overview and Scrutiny Committee received May 2018.
- The National Staff Survey published in March 2018 and presented to Trust Board on 6 April 2018.
- The Head of Internal Audit's annual opinion over the Trust's control environment dated May 2018.
- The Trust's complaints/patient experience report published under Regulation 18 of the of the Local Authority Social Services and NHS Complaints Regulations 2009, dated April 2018
- The latest national patient survey from 2017.
- CQC Inspection Report dated 27th February 2018.
- The Quality Report presents a balanced picture of the NHS Foundation 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 quality indicators 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 account 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 for 2017/18. By order of the Board.

Simon Weldon
Chief Executive Officer

Alan Burns
Chairman

24th May 2018

We will keep you safe……

By helping people in A&E who have mental health problems

By checking that you are not becoming more unwell

By making sure we learn so we can make your care safer

We will improve your stay in hospital …

By keeping you informed about waiting times for treatment

By making sure we help you with your pain

By keeping the wards quiet at night

We will improve our work……

Helping new born babies be healthier

By making sure we are trained in keeping you safe

By looking at care records so we can help give better care.

Kettering General Hospital NHS

NHS Foundation Trust

6 Annual Accounts 2017/2018

1 CONTENTS

Independent auditor's report to the Council of Governors of Kettering General Hospital NHS Foundation Trust

Report on the Audit of the Financial Statements

Opinion

Our opinion on the financial statements is unmodified

We have audited the financial statements of Kettering General Hospital NHS Foundation Trust (the 'Trust') for the year ended 31 March 2018 which comprise the Statement of Comprehensive Income, the Statement of Financial Position, the Statement of changes in taxpayers equity, the Statement of cash flows and the related notes to the accounts, including the Accounting Policies. The financial reporting framework that has been applied in their preparation is applicable law and the NHS foundation trust annual reporting manual 2017/18.

In our opinion the financial statements:

- give a true and fair view of the financial position of the Trust as at 31 March 2018 and of its expenditure and income for the year then ended; and
- have been properly prepared in accordance with International Financial Reporting Standards (IFRSs) as adopted by the European Union, as interpreted and adapted by the NHS foundation trust annual reporting manual 2017/2018; and
- have been prepared in accordance with the requirements of the National Health Service Act 2006.

4.14 Basis for opinion

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

Who we are reporting to

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. Our audit work has been undertaken so that we might state to the Trust's Council of Governors those matters we are required to state to them in an auditor's report and for no other purpose. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the Trust and the Trust's Council of Governors, as a body, for our audit work, for this report, or for the opinions we have formed.

Material uncertainty related to going concern

We draw attention to note 1.1 in the financial statements, which indicates that the Trust recorded operating deficits of £4.2 million in 2014/15, £10.3 million in 2015/16, £22.7 million in 2016/17 and £32.0 million in 2017/18. Consequently the Trust has received financial support, in the form of loans from the Department of Health and Social Care, the outstanding balance as at 31 March 2018 is £119.4 million. The Trust plans to incur a £7.8 million financial deficit in 2018/19 and anticipates it may be some time before it can achieve financial balance on a sustainable basis. It requires additional loans of £34.8 million in 2018/19 from this it is expecting to repay £12.1 million revenue loan and £3m capital loans. This working capital loan support has not, as at the date of these accounts, been confirmed. These events or

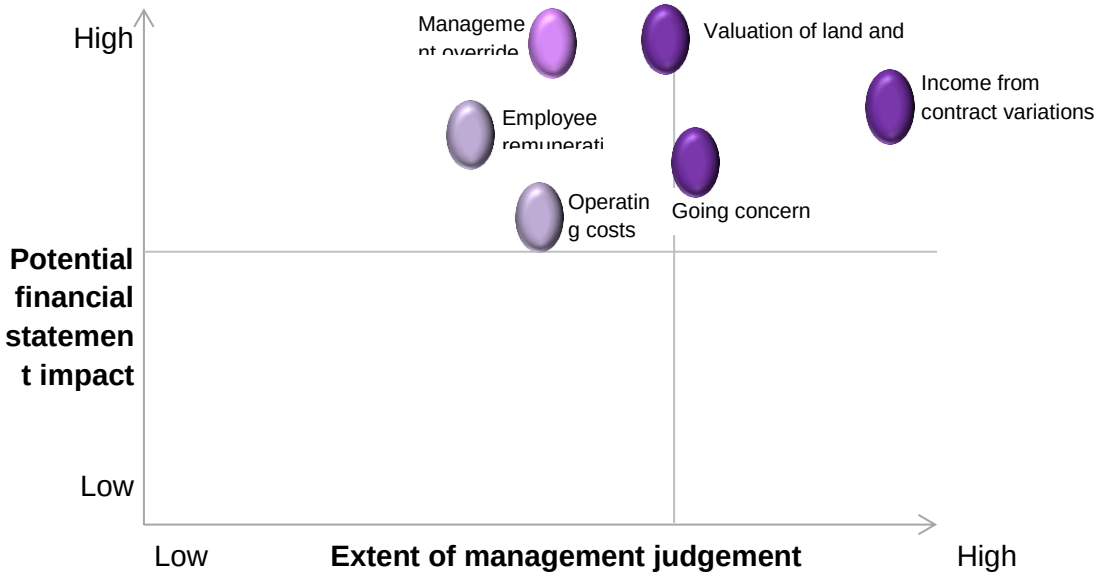
conditions, along with the other matters explained in note 1.1, indicate that a material uncertainty exists that may cast significant doubt about the Trust's ability to continue as a going concern. Our opinion is not modified in respect of this matter.

Overview of our audit approach

- Overall materiality: £3,857,000, which represents 1.5% of the Trust's gross operating costs (consisting of operating expenses and finance expenses);
- Key audit matters were identified as:
  - Going concern material uncertainty,
  - Income from contract variations, and
  - Valuation of land and buildings.
- This was our first year as auditor of the Trust. We have tested the Trust's material income and expenditure streams and assets and liabilities covering over 99% of the Trust's income and expenditure and 96% of the Trust's net assets.

4.15 Key audit matters

4.16 The graph below depicts the audit risks identified and their relative significance based on the extent of the financial statement impact and the extent of management judgement.



4.17

4.18 Key audit matters are those matters that, in our professional judgment, were of most significance in our audit of the financial statements of the current year and include the most significant assessed risks of material misstatement (whether or not due to fraud) that we identified. These matters included those that had the greatest effect on: the overall audit strategy; the allocation of resources in the audit; and directing the efforts of the engagement team. These matters were addressed in the context of our audit of the financial statements as a whole, and in forming our opinion thereon, and we do not provide a separate opinion on these matters. In addition to the matter described in the *Material Uncertainty Related to Going Concern* section, we have determined the matters described below to be the key audit matters to be communicated in our report.

4.19 Key Audit Matter	4.20 How the matter was addressed in the audit
Risk 1 – Income from contract variations Approximately 93% of the Trust's income is from patient care activities and contracts with NHS commissioners. These contracts include the rates for and level of patient care activity to be undertaken by the Trust. The Trust recognises patient care activity income during the year based on the completion of these activities. Patient care activities provided that are additional to those incorporated in these contracts (contract variations) are subject to verification and agreement by the commissioners. As such, there is the risk that income is recognised in the accounts for these additional services that is not subsequently agreed to by the commissioners. We have identified the occurrence and accuracy of income from contract variations as a significant risk, which was one of the most significant assessed risks of material misstatement.	Our audit work included, but was not restricted to: • evaluating the Trust's accounting policy for recognition of income from patient care activities for appropriateness; • gaining an understanding of the Trust's system for accounting for income from contract variations and evaluating the design of the associated controls; • obtaining an exception report from the Department of Health and Social Care (DoHSC) that details differences in reported income and expenditure between NHS bodies; agreeing the figures in the exception report to the Trust's financial records; and for differences calculated by the DoHSC as being in excess of £300,000, obtaining corroborating evidence to support the amount recorded in the financial statements by the Trust; • agreeing, on a sample basis, income from contract variations to signed contract variations, invoices or other supporting evidence such as correspondence from the Trust's commissioners. The Trust's accounting policy on income recognition, including contract income, is shown in note 1.8 to the financial statements and related disclosures are included in note 3. **Key observations** We obtained sufficient audit evidence to conclude that: • the Trust's accounting policy for income from patient activities is in accordance with the Department of Health and Social Care Group Accounting Manual 2017/18 and has been properly applied; and • income from contract variations is not materially misstated.
Risk 2 – Valuation of land and buildings The Trust revalues its land and buildings on a quinquennial basis to ensure that carrying value is not materially different from fair value. This represents a significant estimate by management in the financial statements. We identified the valuation of land and buildings, in particular revaluations and impairments, as a significant risk which was one of the most significant assessed risks of material misstatement.	Our audit work included, but was not restricted to: • evaluating management's processes and assumptions for the calculation of the estimate, and the appropriateness of the instructions issued to valuation experts, the basis of valuations and the scope of their work; • assessing the competence, capabilities and objectivity of any management experts used by the Trust; • discussions with the valuer about the basis on which the valuation was carried out and challenge of the key assumptions; • challenging the information used by the valuer to ensure it is complete and consistent with our understanding; • assessing the overall reasonableness of the valuation movement; • testing, on a sample basis, of revaluations made during the year to ensure they were input correctly into the Trust's asset register; and

4.19 Key Audit Matter	4.20 How the matter was addressed in the audit
	• evaluating the assumptions made by management for those assets not revalued during the year and how management has satisfied themselves that these are not materially different to current value. The Trust's accounting policy on the valuation of land and buildings is shown in note 1.13 to the financial statements and related disclosures are included in note 11. **Key observations** We obtained sufficient audit assurance to conclude that: • the basis of the valuation of land and buildings was appropriate and the assumptions and processes used by management in determining the estimate were reasonable; • the valuation of land and buildings disclosed in the financial statements is reasonable.

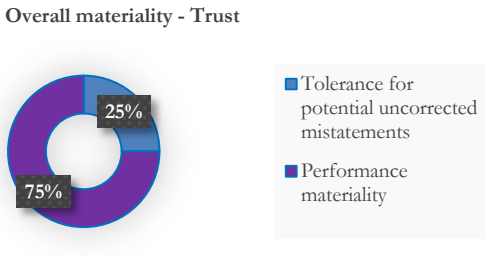
4.21 Our application of materiality

We define materiality as the magnitude of misstatement in the financial statements that makes it probable that the economic decisions of a reasonably knowledgeable person would be changed or influenced. We use materiality in determining the nature, timing and extent of our audit work and in evaluating the results of that work.

Materiality was determined as follows:

Materiality Measure	Trust
Financial statements as a whole	£3,857,000 which is 1.5% of the Trust's gross operating costs. This benchmark is considered the most appropriate because we consider users of the financial statements to be most interested in how it has expended its revenue and other funding.
Performance materiality used to drive the extent of our testing	75% of financial statement materiality
Specific materiality	We applied a specific level of materiality of £100,000 to the senior officer remuneration disclosures in the Remuneration Report due to the public interest in these disclosures and the statutory requirement for these to be made.
Communication of misstatements to the Trust Board	£192,000 and misstatements below that threshold that, in our view, warrant reporting on qualitative grounds.

The graph below illustrates how performance materiality interacts with our overall materiality and the tolerance for potential uncorrected misstatements.



4.22 An overview of the scope of our audit

Our audit approach was a risk-based approach founded on a thorough understanding of the Trust's business, its environment and risk profile and in particular included:

- Gaining an understanding of and evaluating the Trust's internal control environment including its IT systems and controls over key financial systems;
- Assessing whether the accounting policies are appropriate to the Trust's circumstances and have been consistently applied and adequately disclosed;
- Assessing the reasonableness of significant accounting estimates made by the Chief Executive as Accounting Officer;
- Testing, on a sample basis, all of the Trust's material income streams covering 99% of the Trust's income;
- Testing,, on a sample basis, for 99% of the Trust's expenditure;
- Testing, on a sample basis, property plant and equipment and 96% of the Trusts other assets and liabilities.

4.23 Other information

The Accounting Officer is responsible for the other information. The other information comprises the information included in the Annual Report set out on pages 4 to 79, other than the financial statements and our auditor's report thereon. Our opinion on the financial statements does not cover the other information and, except to the extent otherwise explicitly stated in our report, we do not express any form of assurance conclusion thereon.

In connection with our audit of the financial statements, our responsibility is to read the other information and, in doing so, consider whether the other information is materially inconsistent with the financial statements or our knowledge of the Trust obtained in the course of our work including that gained through work in relation to the Trust's arrangements for securing value for money through economy, efficiency and effectiveness in the use of its resources or otherwise appears to be materially misstated. If we identify such material inconsistencies or apparent material misstatements, we are required to determine whether there is a material misstatement in the financial statements or a material misstatement of the other information. If, based on the work we have performed, we conclude that there is a material misstatement of this other information, we are required to report that fact.

We have nothing to report in this regard.

In this context, we also have nothing to report in regard to our responsibility to specifically address the following items in the other information and to report as uncorrected material misstatements of the other information where we conclude that those items meet the following conditions:

- Fair, balanced and understandable set out on page 30 in accordance with provision C.1.1 of the NHS Foundation Trust Code of Governance – the statement given by the directors that they consider the Annual Report and financial statements taken as a whole is fair, balanced and understandable and provides the information necessary for patients, regulators and other stakeholders to assess the Trust's performance, business model and strategy, is materially inconsistent with our knowledge of the Trust obtained in the audit; or

- Trust Board reporting set out on page 59 in accordance with provision C.3.9 of the NHS Foundation Trust Code of Governance – the section describing the work of the Audit Committee is materially inconsistent with our knowledge obtained in the audit.

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

Under the Code of Audit Practice published by the National Audit Office on behalf of the Comptroller and Auditor General (the Code of Audit Practice) we are required to consider whether the Annual Governance Statement does not meet the disclosure requirements set out in the NHS foundation trust annual reporting manual 2017/18. We are not required to consider whether the Annual Governance Statement addresses all risks and controls or that risks are satisfactorily addressed by internal controls.

We have nothing to report in this regard.

Our opinion on other matters required by the Code of Audit Practice is unmodified

In our opinion:

- the parts of the Remuneration Report and the Staff Report to be audited have been properly prepared in accordance with IFRSs as adopted by the European Union, as interpreted and adapted by the NHS foundation trust annual reporting manual 2017/18 and the requirements of the National Health Service Act 2006; and
- based on the work undertaken in the course of the audit of the financial statements and our knowledge of the Trust gained through our work in relation to the Trust's arrangements for securing economy, efficiency and effectiveness in its use of resources, the other information published together with the financial statements in the Annual Report for the financial year for which the financial statements are prepared is consistent with the financial statements.

4.25 Matters on which we are required to report by exception

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

- we have reported a matter in the public interest under Schedule 10 (3) of the National Health Service Act 2006 in the course of, or at the conclusion of the audit; or
- we have referred a matter to the regulator under Schedule 10 (6) of the National Health Service Act 2006 because we had reason to believe that the Trust, or a director or officer of the Trust, was about to make, or had made, a decision which involved or would involve the incurring of expenditure that was unlawful, or was about to take, or had taken a course of action which, if followed to its conclusion, would be unlawful and likely to cause a loss or deficiency.

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

4.26 Responsibilities of the Accounting Officer and Those Charged with Governance for the financial statements

As explained more fully in the Statement of Accounting Officer's responsibilities set out on pages 70 to 71, the Chief Executive, as Accounting Officer, is responsible for the preparation of the financial statements in the form and on the basis set out in the Accounts Directions included in the NHS foundation trust annual reporting manual 2017/18, for being satisfied that they give a true and fair view, and for such internal control as the Accounting Officer determines is necessary to enable the preparation of financial statements that are free from material misstatement, whether due to fraud or error.

In preparing the financial statements, the Accounting Officer is responsible for assessing the Trust's ability to continue as a going concern, disclosing, as applicable, matters related to going concern and using the going concern basis of accounting unless the Trust lacks funding for its continued existence or when policy decisions have been made that affect the services provided by the Trust.

The Board is Those Charged with Governance.

4.27 Auditor's responsibilities for the audit of the financial statements

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

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

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

Adverse conclusion

Because of the significance of the matter described in the basis for adverse conclusion section of our report we are not satisfied that, in all significant respects Kettering General Hospital NHS Foundation Trust put in place proper arrangements for securing economy, efficiency and effectiveness in its use of resources for the year ended 31 March 2018.

Basis for adverse conclusion

Our review of the Trust's arrangements for securing economy, efficiency and effectiveness in its use of resources identified the following matters:

- The Trust reported a deficit of £34,670,000 in the year ended 31 March 2018, which represents a significant increase compared to its budgeted deficit of £26,100,000.
- The Trust is also forecasting a deficit of £16,230,000 for the year ending 31 March 2019 which is dependent on the Trust achieving transformational savings of £14,600,000, representing 5.4% of operating costs.
- On 12 April 2017, NHS Improvement placed the Trust into financial special measures.
- These matters identify weaknesses in the Trust's arrangements for setting a sustainable budget with sufficient capacity to absorb emerging cost pressures due to the current configuration of services.

These matters are evidence of weaknesses in proper arrangements for sustainable resource deployment in planning finances effectively to support the sustainable delivery of strategic priorities and maintain statutory functions.

Responsibilities of the Accounting Officer

The Accounting Officer is responsible for putting in place proper arrangements for securing economy, efficiency and effectiveness in the use of the Trust's resources.

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

We are required under paragraph 1 of Schedule 10 of the National Health Service Act 2006to be satisfied that the Trust has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources and to report where we have not been able to satisfy ourselves that it has done so. We are not required to consider, nor have we considered, whether all aspects of the Trust's arrangements for securing economy, efficiency and effectiveness in its use of resources are operating effectively.

We have undertaken our review in accordance with the Code of Audit Practice, having regard to the guidance on the specified criterion issued by the Comptroller and Auditor General in November 2017, as to whether in all significant respects, 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. The Comptroller and Auditor General determined this criterion as that necessary for us to consider under the Code of Audit Practice in satisfying ourselves whether the Trust put in place proper arrangements for securing economy, efficiency and effectiveness in its use of resources for the year ended 31 March 2018, and to report by exception where we are not satisfied.

We planned our work in accordance with the Code of Audit Practice. Based on our risk assessment, we undertook such work as we considered necessary to be satisfied that the Trust has put in place proper arrangements for securing economy, efficiency and effectiveness in its use of resources.

Report on other legal and regulatory requirements - Certificate

We certify that we have completed the audit of the financial statements of Kettering General Hospital NHS Foundation Trust in accordance with the requirements of Chapter 5 of Part 2 of the National Health Service Act 2006 and the Code of Audit Practice.

Mark Stocks
Partner
for and on behalf of Grant Thornton UK LLP

The Colmore Building
20 Colmore Circus
Birmingham B4 6AT

25 May 2018

6 FOREWORD TO THE ACCOUNTS

KETTERING GENERAL HOSPITAL NHS FOUNDATION TRUST

These accounts, for the year ended 31 March 2018, have been prepared by Kettering General Hospital NHS Foundation Trust in accordance with paragraphs 24 & 25 of Schedule 7 within the National Health Service Act 2006.

Chief Executive: 

Simon Weldon Date: 25th May 2018

STATEMENT OF COMPREHENSIVE INCOME FOR THE YEAR ENDED 31 MARCH 2018

	Note	2017/18 TOTAL £000	2016/17 TOTAL £000
Operating income from continuing operations	3-4	230,309	234,480
Operating expense from continuing operations	5	(262,347)	(257,152)
Operating deficit		**(32,038)**	**(22,672)**
Finance income	9.1	27	21
Finance expense – financial liabilities	9.2	(2,420)	(1,529)
Finance expense – unwinding of discount on provisions	21.1	0	(6)
PDC dividends payable		(271)	(1,195)
Net finance cost		**(2,664)**	**(2,709)**
(Loss)/gain on disposal of assets	8	21	(209)
RETAINED DEFICIT FOR THE YEAR *		**(34,681)**	**(25,590)**
Other Comprehensive Income			
Gain on revaluation of property, plant and equipment		5,747	2,132
Impairments	9.3	(203)	(553)
TOTAL COMPREHENSIVE EXPENSE FOR THE PERIOD		**(29,137)**	**(24,011)**

NHS Improvement Control Total surplus/deficit

	2017/18 £000	2016/17 £000
Surplus/(Deficit) as above	**(34,681)**	**(25,590)**
Add back net impairments on buildings	807	637
Surplus/(deficit) before impairments and transfers	**(33,874)**	**(24,953)**
Less redundancy cost	0	0
Add back Depreciation on donated assets	310	425
Less income received in respect of donated assets	0	(233)
Adjusted net surplus/(deficit) as reported to NHS Improvement	**(33,564)**	**(24,761)**

* The Trust ended the year with a financial performance deficit of £33.6m (£24.8m 2016/17) after including the impact of technical adjustments – impairments, disposal of assets and movements in respect of donated assets).
**Please note the treatment of the CQUIN risk reserve. This has been recognised as income in the KGH Accounts, however in the national TAC forms the reserve is stripped out as an adjusting item
The notes on pages 6 to 39 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:			
Intangible assets	10	1,679	1,383
Property, Plant and Equipment	11	126,069	112,166
Trade and other receivables	15	781	786
Total non-current assets		**128,529**	**114,335**
Current assets:			
Inventories	14	3,376	3,880
Trade and other receivables	15	5,755	7,728
Cash and cash equivalents	16	2,670	1,204
Total current assets		**11,801**	**12,812**
Current liabilities			
Trade and other payables	18	(20,571)	(18,608)
Borrowings	19	(15,248)	(2,007)
Provisions	21	(598)	(333)
Other liabilities	18.3	(1,316)	(1,551)
Total current liabilities		**(37,733)**	**(22,499)**
Total assets less current liabilities		**102,597**	**104,648**
Non-current liabilities:			
Borrowings	19	(105,539)	(78,739)
Provisions	21	(450)	(464)
Total non-current liabilities		**(105,989)**	**(79,203)**
TOTAL ASSETS EMPLOYED		**(3,392)**	**25,445**
Financed by taxpayer's equity:			
Public dividend capital	22	61,129	60,829
Revaluation reserve	23	26,424	21,325
Income and expenditure reserve		(90,945)	(56,709)
TOTAL TAXPAYERS' EQUITY		**(3,392)**	**25,445**

The financial statements on pages 1 to 39 were approved by the Board on 24th May 2018 and signed on its behalf by:

Chief Executive: Simon Weldon Date: 25th May 2018

STATEMENT OF CHANGES IN TAXPAYERS' EQUITY

2017/18	Total £000	Public Dividend Capital (PDC) £000	Revaluation Reserve £000	Income and expenditure reserve £000
Balance at 1 April 2017	**25,445**	**60,829**	**21,325**	**(56,709)**
Retained deficit for the year	**(34,681)**	0	0	(34,681)
Transfer between reserves	**0**	0	(445)	445
Net impairments	**(203)**	0	(203)	0
Revaluations - property, plant and equipment	**5,747**	0	5,747	0
Public Dividend Capital received	**300**	300	0	0
At 31 March 2018	**(3,392)**	**61,129**	**26,424**	**(90,945)**

2016/17	Total £000	Public Dividend Capital (PDC) £000	Revaluation Reserve £000	Income and expenditure reserve £000
Balance at 1 April 2016	**49,456**	**60,829**	**20,109**	**(31,482)**
Retained deficit for the year	**(25,590)**	0	0	(25,590)
Net gain on revaluation of property, plant and equipment	**2,132**	0	2,132	0
Impairments	**(553)**	0	(553)	0
Transfer of excess current cost depreciation over historical cost depreciation	**0**	0	(363)	363
Balance at 31 March 2017	**25,445**	**60,829**	**21,325**	**(56,709)**

STATEMENT OF CASH FLOWS FOR THE YEAR ENDED 31 MARCH 2018

	Note	2017/18 £000	2016/17 £000
Operating deficit from continuing operations		**(32,038)**	**(22,672)**
Depreciation and amortisation		5,569	5,425
Impairments		807	637
Non- cash donations/grants credited to income		0	(233)
(Increase)/decrease in trade and other receivables		1,930	(2,143)
(Increase)/decrease in inventories		504	(163)
Increase/(decrease) in trade and other payables		660	350
Increase/)(decrease) in other liabilities		(235)	155
Increase/(decrease) in provisions		251	235
Net cash used in operations		**(22,552)**	**(18,409)**
Cash flows from investing activities			
Interest received		29	21
(Payments) to acquire tangible fixed assets		(11,761)	(9,256)
(Payments) to acquire intangible fixed assets		(823)	(353)
Sale of property, plant and equipment		21	0
Net cash used in investing activities		**(12,534)**	**(9,588)**
Cash flows from financing activities			
Public Dividend Capital received		300	0
Public Dividend Capital repaid		0	0
New Loan received		40,851	30,698
Loans repaid to the Foundation Trust Financing Facility		(2,086)	(1,715)
Capital element of finance lease rental payments		(98)	(31)
Interest paid		(2,181)	(1,497)
Interest element of finance lease		(9)	(5)
Dividends paid		(225)	(1,412)
Net cash generated from/(used in) financing activities		**36,552**	**26,038**
(Decrease)/increase in cash and cash equivalents	**16**	**1,466**	**(1,959)**
Cash and Cash equivalents at 1 April		**1,204**	**3,163**
Cash and Cash equivalents at 31 March	**16**	**2,670**	**1,204**

Note 1 ACCOUNTING POLICIES

Basis of Preparation
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's Group Accounting Manual (GAM), which shall be agreed with HM Treasury. Consequently, the following financial statements have been prepared in accordance with the DHSC Group Accounting Manual 2017-18, issued by the Department of Health. The accounting policies contained in the GAM follow International Financial Reporting Standards to the extent that they are meaningful and appropriate to the NHS, as determined by HM Treasury, which is advised by the Financial Reporting Advisory Board. Where the DHSC Group Accounting Manual 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 policies adopted are described below. These have been applied consistently in dealing with items considered material in relation to the accounts.

1.1 Going Concern

International Accounting Standard 1 requires the Board to assess, as part of the accounts preparation process, the Trust's ability to continue as a going concern. In the context of non-trading entities in the public sector the anticipated continuation of the provision of a service in the future is normally sufficient evidence of going concern. The financial statements should be prepared on a going concern basis unless there are plans for, or no realistic alternative other than, the dissolution of the Trust without the transfer of its services to another entity within the public sector.

In preparing the financial statements the Board of Directors have considered the Trust's overall financial position against the requirements of IAS1.

The Trust has recorded operating deficits of £4.2 million in 2014/15, £10.3 million in 2015/16, £22.7 million in 2016/17 and £32.0 million in 2017/18. Consequently the Trust has received financial support, in the form of loans from the DHSC, the outstanding balance as at 31 March 2018 is £119.4 million. The Trust plans to incur a £7.8 million financial deficit in 2018/19 and anticipates it may be some time before it can achieve financial balance on a sustainable basis. It requires additional loans of £34.8 million in 2018/19 from this it is expecting to repay £12.1 million revenue loan and £3m capital loans. This working capital loan support has not, as at the date of these accounts, been confirmed.

The Board of Directors has carefully considered the principle of "Going Concern" and the Directors have concluded that there are material uncertainties related to the financial sustainability (profitability and liquidity) of the Trust.
Although these factors represent material uncertainties that may cast significant doubt about the Trust's ability to continue as a going concern, the Directors, having made appropriate enquiries, still have reasonable expectations that the Trust will have adequate resources to continue in operational existence for the foreseeable future. As directed by the 2017/18 Department of Health Group Accounting Manual the Directors have prepared the financial statements on a going concern basis as they consider that the services currently provided by the Trust will continue to be provided in the foreseeable future. On this basis, the Trust has adopted the going concern basis for preparing the financial statements and has not included the adjustments that would result if it was unable to continue as a going concern.

The Trust has agreed contracts with its local commissioners for 2018/19 and services are being commissioned in the same manner as in previous years and there are no discontinued operations. Similarly no decision has been made to transfer services or significantly amend the structure of the organisation at this time. The Board of Directors also has a reasonable expectation that the Trust will have access to adequate resources in the form of financial support from the DHSC to continue to deliver the full range of mandatory services for the foreseeable future. During the year to 31 March 2018 the Trust received an Interim Revenue Loan of £28.9 million. Further interim funding is available in 2018/19 and the Trust plans to draw an additional £26.1 million in revenue support and £8.0 million to support strategic capital developments.

The Directors consider that this provides sufficient evidence that the Trust will continue as a going concern for the foreseeable future. The Trust has received significant support in the recent past, has made no decision to request dissolution from the Secretary of State and has no reason to believe that support will not be provided.

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 liabilities.

1.2.1 Financial Position

The accounts have been prepared on the basis that the Trust is a going concern. The Trust incurred a deficit of £34.7m in 2017-18, £33.6m adjusted deficit reported to NHSI which included non-recurring expenditure of £10.8m (an underlying deficit of £22.8m) The Trust funded this deficit through revenue loans from the Department of Health and movements in its working balances.

The Trust has submitted its 2018-19 plan to NHS Improvement with a planned deficit of £7.8m including a cost improvement program of £14.5m and Provider Sustainability Funding of £7.5m. The plan also includes Revenue and Capital loan support from the Department of Health for which approval from the Department of Health and NHS Improvement is required.

The Trust has prepared a detailed cash flow forecast for 2018-19, based on assumptions within the financial plan. We will continue to report its cash position monthly to the Performance, Finance & Resources Committee and Trust Board, with rolling 12 month forecasts produced for internal review. The key assumptions supporting the cash flow forecasts for 2018/19 are:

- The receipt of £34.8m Revenue and Capital Loans to fund the planned in-year deficit, the capital program and repayment of existing loans.
- The achievement of a capital program of £14.3m
- The delivery of a planned revenue deficit of £7.8m
- The achievement of a cost improvement plan of £14.5m

1.3 Consolidation

1.3.1 NHS Charitable Funds

The Trust's charitable funds are controlled by the Trust, as corporate Trustee and in accordance with IAS27 the charitable funds are considered to be a subsidiary. However, under IAS8, the Trust deems the charitable funds to be immaterial and have not been consolidated. However donated assets or income to support revenue expenditure are reflected in the appropriate notes to these accounts. A separate set of annual accounts for charitable funds is made available to members of the public and registered with the Charity Commission.

1.3.2 Other Subsidiaries, Associates, Joint ventures and Joint arrangements

The Trust does not have Subsidiaries, Associates, Joint ventures and Joint arrangements

1.4 Critical accounting judgements and key sources of estimation

In the application of the Trust's accounting policies, management is required to make judgements, estimates and assumptions about the carrying amounts of assets and liabilities that are not readily apparent from other sources. The estimates and associated assumptions are based on historical experience and other factors that are considered to be relevant. Actual results may differ from those estimates and the estimates and underlying assumptions are continually reviewed. Revisions to accounting estimates are recognised in the period in which the estimate is revised if the revision affects only that period or in the period of the revision and future periods if the revision affects both current and future periods.

1.4.1 Critical judgements in applying accounting policies

The following are the critical judgements, apart from those involving estimations (see below) that management has made in the process of applying the Trusts accounting policies and that have the most significant effect on the amounts recognised in the financial statements.

a) Going Concern status

Accounting policy 1.1 states that directors consider that the Trust will continue as a going concern for the foreseeable future. The evidence for which is detailed further at accounting policy 1.1. This is considered to be a critical judgement.

b) The income and bad debt provision for income due from the Compensation Recovery Unit (CRU) Accounting Notes 3.2 and 16.

The income due from the CRU is based on information received from that organisation. The Trust is unable to validate independently the outstanding debt and therefore relies upon the CRU who is responsible for the collection of the income on behalf of the Trust to provide accurate and up to date information to the Trust. The Trust undertakes regular reviews of the potential bad debt provision against this income. The Trust uses the proposed % provided by the CRU at 22.84% (2016/17 22.94%) as the estimation for bad debt. The gross debt included in other receivables in Note 15 of the accounts is £2.065m with a bad debt provision of £0.504m. The level of gross debt is therefore significant, accounting for over 20% of trade and other receivables and the Trust has identified the bad debt provision estimation policy as a critical judgement.

Work in progress (WIP)

Revenue relating to patient care spells that are part-completed at the year-end are apportioned across the financial years on the basis of length of stay at the statement of position date compared to expected total length of stay/costs incurred to date compared to total expected costs. For 2017/18 the estimate of work in progress has been based on the work in progress at 31st March 2018. Work in progress also includes maternity care. Care delivered under the maternity pathway payment system may span more than one financial year. In April 2018 some women will receive care who started their pathway in the 2017/18 financial year and the Trust accounts for some income received in 2017/18 as deferred income. See paragraph 1.8.

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:

a) Valuation of Property

The value of land and property together with asset lives are obtained from the valuer Cushman & Wakefield Ltd. The Trust relies upon the experience and knowledge of the valuer using the Royal Institute of Chartered Surveyors (RICS) Appraisal and Valuation Manual to provide a fair value under IAS16. A full valuation was obtained in respect of 1 April 2014 and interim valuations at 31 March 2015 and 31 March 2016.Further interim desktop valuation were performed at 31 March 2017 and 31 March 2018 and this included a site visit to review major asset changes. A full revaluation will be undertaken by 31 March 2019.

Due to changing land and property prices in the current economic climate this valuation may change in the next financial year. Valuations are accounted in accordance with paragraph 1.8.2 of these policies.

b) Provisions

The Trust has made a provision for legal claims made against the Trust. Due to the uncertainty and value of the claims a provision has been made based upon internal opinion and external legal advice. The claims are reviewed on a regular basis and estimations revised where necessary. The Trust also includes a contingent liability in respect of these claims. The provision for these claims is shown in Note 26 to the accounts.

The Trust also provides for the full cost of permanent injury allowances payable to ex-staff who have been awarded allowances under the NHS Pension scheme. These allowances are paid for the life of the individual unless their circumstances change. The provision is therefore an estimate based on the persons expected life span (data provided by the Government Actuaries Department) and assumes the same amount will be paid continuously.

1.5 Transfer 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. The Trust has had no transfer of functions in the accounting year

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1.6 Pooled Budgets

The Foundation Trust has not entered any into any pooled budget arrangements.

1.7 Segmental Reporting

The Trust operates as a single operating segment. The Board of Directors, led by the Chief Executive is the chief operating decision maker within the Trust. It is only at this level that revenues are fully reported and the overall financial and operational performance of the Trust is assessed. In addition, full service line reporting by Business Units are not currently provided on a regular basis to the Board of Directors.

1.8. Income recognition

The main source of revenue for the Foundation Trust is its 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 care spell is incomplete at the year end, revenue relating to the partially complete spell is accrued and agreed with the commissioner.

Care delivered under the maternity pathway payment system may span more than one financial year. At the year ends some women will receive care who started their pathway in the current financial year but not complete the pathway until the following financial year and the Trust will account for some income received as deferred income.

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 Pension's Compensation Recovery Unit that the individual has lodged a compensation claim. The income is measured at the agreed tariff for the treatments provided to the injured individual, less a provision for unsuccessful compensation claims and doubtful debts.

Interest revenue is accrued on a time basis, by reference to the principal outstanding and interest rate applicable.

1.9 Employee Benefits

1.9.1 Short term employee benefits

Salaries, wages and employment-related payments 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 annual leave entitlement earned but not taken by employees at the end of the period is recognised in the financial statements to the extent that employees are permitted to carry forward leave into the following period.

1.9.2 Retirement benefit costs

Pension costs - NHS Pension Schemes

Most past and present employees are covered by the provisions of the two NHS Pension Schemes subject to not opting out. 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 that scheme for the accounting period.

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

a) Accounting valuation

A valuation of scheme liability is carried out annually by the scheme actuary (currently the Government Actuary’s Department) as at the end of the reporting period. This utilises an actuarial assessment for the previous accounting period in conjunction with updated membership and financial data for the current reporting period, and is accepted as providing suitably robust figures for financial reporting purposes. The valuation of the scheme liability as at 31 March 2018, is based on valuation data as 31 March 2017, updated to 31 March 2018 with summary global member and accounting data. In undertaking this actuarial assessment, the methodology prescribed in IAS 19, relevant FReM interpretations, and the discount rate prescribed by HM Treasury have also been used.

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

b) Full actuarial (funding) valuation

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

The 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.

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.

1.11 Value Added Tax

Most of the activities of the Trust are outside the scope of VAT. 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.

1.12 Corporation Tax

The Trust is a Health Service Body within the meaning of s519A ICTA 1988 and accordingly is exempt from taxation in respect of income and capital gains within categories covered by this but the Trust is potentially within the scope of corporation tax in respect of activities where income is received from a non-public sector source. However the Trust has determined that it is has no corporation tax liability as all activities are either ancillary to healthcare or below the de-minimus level of profit at which tax is payable.

1.13 Property, plant and equipment

1.13.1 Recognition

Property, plant and equipment is capitalised where:

- it is held for use in delivering services or for administrative purposes;
- it is probable that future economic benefits will flow to, or service potential be provided to, the Trust;
- it is expected to be used for more than one financial year;
- the cost of the item can be measured reliably
- individually have 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 greater than £250, where the assets are functionally interdependent, they had broadly simultaneous purchase

dates, are anticipated to have simultaneous disposal dates and are under single managerial control; or

- form part of the initial equipping and setting-up cost of a new building or refurbishment of a ward or unit, irrespective of their individual or collective cost.

Where a large asset, for example a hospital, includes a number of components with significantly different asset lives e.g. the separate buildings and the external works, then these components are depreciated separately over their own useful economic lives.

1.13.2 Measurement

All property, plant and equipment assets are measured initially at cost, representing the costs directly attributable to acquiring or constructing the asset and bringing it to the location and condition necessary for it to be capable of operating in the manner intended by management. All assets are measured subsequently at their current value in existing use/. Assets that were 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.

The carrying values of property, plant and equipment are reviewed for impairment in periods if events or changes in circumstances indicate the carrying value may not be recoverable.

A full revaluation of land and property will be performed at least every 5 years, and the Trust will undertake an annual review to ensure that carrying amounts are not materially different from those that would be determined at the statement of financial position date.

Valuations are carried out by professionally qualified valuers in accordance with the Royal Institute of Chartered Surveyors (RICS) *Appraisal and Valuation Manual*. The last full asset valuation was undertaken in April 2014 with interim valuations in March 2015 and March 2016, and further interim desktop valuations 31 March 2017 and 31 March 2018.

Fair values are determined as follows:

- Land and non-specialised buildings – market comparison basis
- Specialised buildings – depreciated replacement cost, modern equivalent basis

HM Treasury has adopted a standard approach to depreciated replacement cost valuations based on modern equivalent assets (MEA) and, where it would meet the location requirements of the service being provided, an alternative site can be valued. The Trust values land and buildings on the MEA alternative site basis.

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.

Revaluation gains and losses

Increases arising on revaluation are taken to the revaluation reserve except when it reverses a revaluation decrease for the same asset previously recognised in the expenditure statement, in which case it is credited to the expenditure statement 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 and charged to the revaluation reserve to the extent that there is a balance on the reserve for the asset, and thereafter to expenditure.

Gains

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

Impairments

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

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

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

1.13.3 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 an item will flow to the Trust and the cost of the item can be determined reliably.

1.14 Investment properties

Investment properties are measured at fair value. Changes in fair value are recognised as gains or losses in income/expenditure.

The Trust does not have investment properties at the Statement of Financial Position date

1.15 Intangible assets

Intangible assets are non-monetary assets without physical substance, which are capable of sale separately from the rest of Foundation Trusts 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, for example an operating system, is capitalised as part of the relevant item of property, plant and equipment. Software that is not integral to the operation of hardware, for example application software, is capitalised as an intangible asset.

Expenditure on research activities is recognised as an 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 use the intangible asset
- how the intangible asset will generate probable future economic benefits
- the availability of adequate technical, financial and other resources to complete the intangible asset and use it
- the ability to measure reliably the expenditure attributable to the intangible asset during its development

1.15.2 Measurement

Intangible assets acquired separately are initially recognised at cost. Purchased computer software licences are amortised over the shorter of the term of the licence and their useful economic lives.

The amount initially recognised for internally-generated intangible assets is the sum of the expenditure incurred from the date when the criteria above are initially met. Where no internally-generated intangible asset can be recognised, the expenditure is charged to the income statement 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 active 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.

Revaluations and impairments are treated in the same manner as for property, plant and equipment.

1.16 Depreciation, amortisation and impairments

Freehold land, 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 lives. The estimated useful life of an asset is the period over which the Foundation Trust expects to obtain economic benefits 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.

Assets held under finance leases are depreciated over the shorter of the lease term and the estimated useful life, unless the 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.

The useful economic lives including the range within which useful economic lives fall for the main classes of asset is detailed below.

Asset category	Min life (years)	Max life (years)
Software Licences	5	5
Patents	5	5
Development Expenditure	5	5
Buildings exc dwellings	Determined by the valuer	
Dwellings	15	90
Plant & Machinery	5	15
Information Technology	5	5
Furniture & Fittings	7	10

1.17 Donated assets

Donated non-current 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. 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.

1.18 Government grant funded assets

The Trust does not have Government grant funded assets.

1.19 Leases

1.19.1 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.

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 (where the lease value is not material and the lease does not separate the land and building elements; an estimate is made of the separate component values).

1.19.2 Foundation Trust as lessor

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

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

The Trust does not have any finance leases where it acts as the lessor

1.20 Private Finance Initiative (PFI) transactions

The Trust does not have PFI schemes.

1.21 Inventories

Inventories are valued at the lower of cost or net realisable value. The cost of inventories is measured using current or weighted average cost. This is considered to be a reasonable approximation to fair value due to the high turnover of stocks. Work-in-progress comprises goods in intermediate stages of production.
The ward consumable stocks with low values will be estimated using average top up levels. Inventories within the Statement of Financial Position is valued based on the 28th February 2018 stock count. Management consider this to be a close approximation to the year-end value. Departments have since indicated that the stock levels have not significantly changed since the end of February.

1.22 Cash and cash equivalents

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

These balances exclude monies held in the NHS Foundation Trust's bank account belonging to patients (see "third party assets" below). Account balances are only set off where a formal agreement has been made with the bank to do so. Accounts held with the Government Banking Service are netted off as approved by the Department of Health. In all other cases overdrafts are disclosed within creditors. Interest earned on bank accounts and interest charged on overdrafts is recorded as, respectively, "interest receivable" and "interest payable" in the periods to which they relate. Bank charges are recorded as operating expenditure in the periods to which they relate.

1.23 Provisions

Provisions are recognised when the Trust has a present legal or constructive obligation as a result of a past event, it is probable that the Trust will be required to settle the obligation, and a reliable estimate can be made of the amount of the obligation. The amount recognised as a provision is the best estimate of the expenditure required to settle the obligation at the statement of position date, 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 the discount rates published and mandated by HM Treasury except for early retirement and injury benefit provisions which both use the HM Treasury pension discount rate of 0.1% (0.24% 2016/17).

1.24 Clinical negligence costs

The NHS Litigation Authority (NHSLA) operates a risk pooling scheme under which the Trust pays an annual contribution to the NHSLA which in return settles all clinical negligence claims. The contribution is charged to the income statement. Although the NHSLA is administratively responsible for all clinical negligence cases the legal liability remains with the Trust. The total value of clinical negligence provisions carried by the NHSLA on behalf of the Trust is disclosed at note 22.

1.25 Non-clinical risk pooling

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

1.26 Carbon Reduction Commitment (CRC) Energy Efficiency Scheme

The CRC scheme is a mandatory cap and trade scheme for non-transport CO2 emissions. The 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.

1.27 Contingencies

A contingent liability is:

- a possible obligation that arises from past events and whose existence will be confirmed only by the occurrence or non-occurrence of one or more uncertain future events not wholly within the control of the Trust, or
- a present obligation that is not recognised because it is not probable that a payment will be required to settle the obligation or the amount of the obligation cannot be measured sufficiently reliably.

A contingent liability is disclosed unless the possibility of a payment is remote. 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 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.

1.28 Financial assets

Financial assets are recognised when the Trust becomes party to the financial instrument contract or, in the case of trade receivables, when the goods or services have been delivered. Financial assets are derecognised when the contractual rights have expired or the asset has been transferred.

Financial assets are initially recognised at fair value. Fair value is determined by reference to quoted market prices where possible, otherwise by valuation techniques. (Specify – see IAS 39 AG 76.)

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.

1.28.1 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 Trusts surplus or deficit for the year. The net gain or loss incorporates any interest earned on 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.

1.28.2 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.

1.28.3 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.

1.28.4 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. They are measured at fair value with changes in value, other than impairment losses, taken to Other Comprehensive. Accumulated gains or losses are recycled to the Statement of Comprehensive Income on de-recognition**.**

1.28.5 Impairment

At the end of the reporting period, the Trust assesses whether any financial assets, other than those held at 'fair value through profit and loss', are impaired. Financial assets are impaired and impairment losses recognised if there is objective evidence of impairment as a result of one or more events 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.

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.

1.29 Financial liabilities

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

Loans from the Department of Health are recognised at historic cost. Otherwise, financial liabilities are initially recognised at fair value.

1.30 Public Dividend Capital (PDC) and PDC dividend

Public dividend capital is a type of public sector equity finance, which represents the Department of Health's investment in the 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 trust. PDC is recorded at the value received.

An annual charge, reflecting the cost of capital utilised by the trust, is payable to the Department of Health 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 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 Service (GBS) and National Loans Fund (NLF) deposits (excluding cash balances held in GBS accounts that relate to a short term working capital facility)

1.31 Foreign currencies

The Trusts 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.

1.32 Third party assets

Assets belonging to third parties (such as money held on behalf of patients) are not recognised in the accounts since the Trust has no beneficial interest in them. Details of third party assets are given in a note to the accounts.

1.33 Losses and Special Payments

Losses and special payments are items that Parliament would not have contemplated when it agreed funds for the health service or passed legislation. By their nature they are items that ideally should not arise. They are therefore subject to special control procedures compared with the generality of payments. They are divided into different categories, which govern the way each individual case is handled.

Losses and special payments are charged to the relevant functional headings in the income statement on an accruals basis, including losses which would have been made good through insurance cover had NHS Trusts not been bearing their own risks (with insurance premiums then being included as normal revenue expenditure).

1.34 Gifts

Gifts are items that are voluntarily donated, 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.

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

The DHSC GAM does not require the following Standards and Interpretations to be applied in 2017-18. These standards are still subject to HM Treasury FReM adoption, with IFRS 9 and IFRS 15 being for implementation in 2018-19, and the government implementation date 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

● 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.

Note 2 Segmental Reporting

As stated in section 1.7 above, the Trust does not operate segmental reporting

Note 3 Operating income from patient care activities

Note 3.1 Income from patient care activities (by nature)

Income by activity	2017/18 £000	2016/17 £000
Elective income	34,554	37,226
Non elective income	76,455	68,060
Outpatient income	31,090	33,174
A & E income	12,044	10,811
Other NHS clinical income	61,037	68,316
Private patient income	144	210
Other clinical income	2,081	740
TOTAL	**217,405**	**218,537**

Note 3.2 Income from patient care activities (by source)

Income from patient care activities received from:

	2017/18 £000	2016/17 £000
NHS England	34,789	27,162
Clinical commissioning groups	180,241	190,035
Department of Health and Social Care	44	0
Other NHS providers	1,182	278
NHS Other	106	112
Non NHS: Private patients	144	175
Non-NHS: Overseas patients (chargeable to patient)	142	35
NHS injury cost recovery scheme**	702	693
Non NHS: Other	55	47
Total income from activities	**217,405**	**218,537**
Of which:		
Related to continued operations	217,405	218,537
Related to discontinued operations	0	0

NHS commissioners are responsible for planning and purchasing healthcare services for their local population. This responsibility includes deciding which services need the protection of the continuity of services provisions of the NHS provider licence. These are called ‘commissioner requested services’ (CRS). Of the total clinical income received from CCG’s and NHS England, £178.1m (CCG169.2m and NHSE 8.9m) related to commissioner requested services.

** NHS Injury cost recovery income is subject to a provision for doubtful debts of 22.84%.

Note 3.3 Overseas visitors (relating to patients charged directly by the provider)

	2017/18 £000	2016/17 £000
Income recognised this year	142	35
Cash payments received in-year	39	12
Amounts added to provision for impairment of receivables	10	2
Amounts written-off in-year	40	30

Note 4.1 Other operating income

	2017/18 £000	2016/17 £000
Research and development	490	513
Education and training	7,599	8,172
Receipt from charitable funds – donation of physical assets	0	233
Non-patient care services to other bodies	1,811	2,337
Rental revenue from operating leases	229	216
Sustainability and Transformation Fund income	0	1,900
Charitable fund incoming resources	29	0
Other – see table below	2,746	2,572
TOTAL OTHER OPERATING INCOME	**12,904**	**15,943**

Breakdown of Other Operating Income:	2017/18 £000	2016/17 £000
Car Parking	1,296	1,288
Catering	32	41
Property rentals	11	9
Clinical excellence awards	46	72
Water supply charges to Housing Association	32	30
Rebate from suppliers	399	389
Sale of surplus equipment	12	8
Other	918	735
Total	**2,746**	**2,572**

Note 4.2 Operating lease income

	2017/18 £000	2016/17 £000
Operating Lease Revenue		
Rental revenue from operating leases - minimum lease receipts	156	150
Rental revenue from operating leases - contingent rent	73	66
TOTAL	**229**	**216**

	2017/18	2016/17

	£000	£000
Future minimum receipts due on lease of buildings		
- not later than one year;	156	150
- later than one year and not later than five years;	622	600
- later than five years.	324	462
TOTAL	**1,102**	**1,212**

Note 5.1 Operating expenses :

	2017/18 £000	2016/17 £000
Purchase of healthcare from NHS and DHSC bodies	3,979	3,716
Purchase of healthcare from non-NHS and non-DHSC bodies	6,015	4,240
Staff and executive directors costs	171,743	167,032
Non-executive directors	134	118
Supplies and services – clinical (excluding drugs costs)	20,799	21,329
Supplies and services - general	2,569	2,430
Drugs costs (drugs inventory consumed and purchase of non-inventory drugs)	22,049	22,719
Inventories written down (net including drugs)	104	216
Consultancy	1,505	3,314
Establishment	1,575	1,378
Premises - business rates collected by local authorities	1,408	929
Premises - other	9,407	8,437
Transport - other (including patient travel)	583	622
Depreciation	5,137	5,038
Amortisation	432	387
Impairments net of (reversals)	807	637
Increase/(decrease) in impairment of receivables	(300)	2,577
Provisions arising / released in year	347	0
Change in provisions discount rate	9	63
External Auditor fees –statutory audit(inc VAT)- see note 5.2	51	51
External Auditor fees – other (inc VAT) – see note 5.2	7	18
Internal Audit fees	150	165
Clinical negligence - amounts payable to NHS Resolution (premium)	7,631	6,937
Legal fees	160	97
Insurance	322	254
Research and development - staff costs	488	0
Education and training - staff costs	716	0
Education and training - non-staff	481	708
Operating lease expenditure (net)	1,473	1,262
Car parking and security	735	1,087
Hospitality	8	11
Other losses and special payments - non-staff	143	93
Other services (e.g. external payroll)	488	418
Other NHS charitable fund resources expended	29	0
Other	1,163	869
TOTAL	**262,347**	**257,152**

Note 5.2 Audit Remuneration	2017/18 £000	2016/17 £000
External audit services – prior year adjustment	0	0
External audit services – Audit of the Accounts	42	42
External audit services – Audit of the Quality Account	6	15
	48	**57**
VAT	10	12
Charge to Trust	**58**	**69**
Limitation on auditors liability	£1m	£0.5m

Arrangements containing an operating lease

5.3 Payments recognised as an expense

	2017/18 £000	2016/17 £000
Minimum lease payments –plant and machinery	669	815
Minimum lease payments - buildings	608	285
Minimum lease payments - land	196	162
TOTAL	**1,473**	**1,262**

Note 5.4 Future minimum lease payments due

2017/18	Land £000	Buildings £000	Other £000	Total £000
- not later than one year	196	359	902	**1,457**
- later than one and not later than five years	707	1,437	1,074	**3,218**
- later than five years	779	2,372	0	**3,151**
TOTAL	**1,682**	**4,168**	**1,976**	**7,826**

2016/17	Land £000	Buildings £000	Other £000	Total £000
- not later than one year	196	359	658	**1,213**
- later than one and not later than five years	749	1,437	410	**2,596**
- later than five years	932	2,731	0	**3,663**
TOTAL	**1,877**	**4,527**	**1,068**	**7,472**

Note 6 Employee expenses and Numbers

Note 6.1 Employee expenses

	Permanently employed £000	Other £000	Total 2017/18 £000	Total 2016/17 £000
Salaries and wages	118,416	14,055	**132,471**	**122,526**
Social security costs	12,373	0	**12,373**	**11,428**
Apprenticeship levy	637	0	**637**	**0**
Employers contributions to NHS Pensions Agency	14,606	0	**14,606**	**13,582**

Pension Costs – other	4	0	**4**	**4**
Agency/contract staff	0	13,388	**13,388**	**19,941**
SUB-TOTAL	**146,036**	**27,443**	**173,479**	**167,481**
Less salaries re-charged to capital	(378)	(154)	(532)	(449)
TOTAL	**145,658**	**27,289**	**172,947**	**167,032**

Note 6.2 Average number of persons employed (WTE basis)	**Permanently employed Number**	**Other Number**	**Total 2017/18 Number**	**Total 2016/17 Number**
Medical and dental	410	68	**478**	**482**
Administration and estates	682	50	**732**	**705**
Healthcare assistants and other support staff	863	120	**983**	**944**
Nursing, midwifery and health visiting staff	1,038	206	**1,244**	**1,208**
Scientific, therapeutic and technical staff	226	17	**243**	**237**
Healthcare science staff (new classification)	185	0	**185**	**178**
Other	88	1	**89**	**83**
Total	**3,492**	**462**	**3,954**	**3,837**
Of which, number engaged on capital projects	5	2	**7**	**6**

Note 6.3 Employee benefits

There were no staff benefits in the period (nil in 2016-17)

Note 6.4 Early retirements due to ill health

During 2017/18 there were 4 early retirements from the Trust agreed on the grounds of ill-health (2016/17 – 2 cases). The estimated additional pension liabilities of these ill-health retirements will be £254,271 (2016/17 £147,047). The cost of these ill-health retirements will be borne by the NHS Business Services Authority-Pensions Division.

Note 6.5 Staff exit packages

Exit package cost band	**Number of compulsory redundancies**		**Number of other departures agreed**		**Total number of exit packages by cost band**	
	2017/18	**2016/17**	**2017/18**	**2016/17**	**2017/18**	**2016/17**
<£10,000	0	0	0	0	**0**	**0**
£10,001 - £25,000	0	0	0	0	**0**	**0**
£25,001 - £50,000	0	0	0	1	**0**	**1**
£50,001-£100,000	0	0	0	0	**0**	**0**
£100,001-£150,000	0	0	0	0	**0**	**0**
TOTAL NUMBER	**0**	**0**	**0**	**1**	**0**	**1**
	£000	**£000**	**£000**	**£000**	**£000**	**£000**
TOTAL COST	**0**	**0**	**0**	**32**	**0**	**32**

Note 6.6 Analysis of other departure payments	2017/18		2016/17	
	Number	£000	Number	£000
Voluntary redundancies	0	0	0	0
Contractual payments in lieu of notice	0	0	1	32
Exit payments following Employment Tribunals or court	0	0	0	0
Non-contractual payments requiring HMT approval	0	0	0	0
	0	**0**	**1**	**32**
Of which:				
Non-contractual payments where payment value was more than 12 months of their annual salary	0	0	0	0

Note 7 Public sector payment policy

Note 7.1 The late payment of commercial debts (interest) Act 1998

	2017/18 £000	2016/17 £000
Amounts included within other interest payable arising from claims made under this legislation	0	0
Compensation paid to cover debt recovery costs under this legislation	0	0

7.2 Better Payments Practice Code – measure of compliance

	2017/18 Number	2017/18 £000	2016/17 Number	2016/17 £000
Total Non-NHS trade invoices paid in the year	61,008	87,690	59,753	98,581
Total Non-NHS trade invoices paid within target	54,996	77,933	56,280	88,135
Percentage of Non-NHS trade invoices paid within target	**90.15%**	**88.87%**	**94.19%**	**89.4%**
Total NHS trade invoices paid in the year	2,041	8,560	2,226	7,039
Total NHS trade invoices paid within target	1,646	6,589	1,859	5,913
Percentage of NHS trade invoices paid within target	**80.65%**	**76.97%**	**83.5%**	**84.0%**

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 goods or a valid invoice, whichever is later unless other terms have been agreed.

Note 8 Disposal of non-current assets

	2017/18 £000	2016/17 £000
Gain/(loss) on disposal of land and buildings	21	(207)
Gain/(loss) on disposal of other property, plant and equipment	0	(2)
TOTAL	**21**	**(209)**

Note 9 Finance Income/Costs

Note 9.1 Finance income

	2017/18 £000	2016/17 £000
Bank and Government Banking Service interest	27	21
TOTAL	**27**	**21**

Note 9.2 Finance Cost - interest expense

	2017/18 £000	2016/17 £000
Capital loans from Department of Health	653	593
Revenue support / working capital loans	974	325
Revolving working capital facilities	784	605
Interest on finance lease obligations	9	6
	2,420	**1,529**

Note 9.3 Impairment of assets (PPE and intangibles)

	2017/18 Charge to expenditure £000	2017/18 Charge to Rev Reserve £000	2017/18 Total £000	2016/17 Total £000
Change in market price	1,673	203	**1,876**	**1,240**
Other changes	0	0	**0**	**309**
	0	**0**	**0**	**1,549**
Change in market price-reversal of impairments from previous years (increase in value)	(866)	0	**(866)**	**(359)**
TOTAL	**807**	**203**	**1,010**	**1,190**

The change in market price relates to interim valuations of the estate undertaken by the Independent Valuer in 2016/17 and March 2018.

Note 10 Intangible Assets

Note 10.1 Intangible assets - 2017/18

	Software licences	Total
	£000	£000
Valuation / gross cost at 1 April 2017 - brought forward	**2,855**	**2,855**
Additions	815	**815**
Reclassifications	(87)	**(87)**
Gross cost at 31 March 2018	**3,583**	**3,583**
Amortisation at 1 April 2017 - brought forward	**1,472**	**1,472**
Provided during the year	432	**432**
Amortisation at 31 March 2018	**1,904**	**1,904**
Net book value at 31 March 2018	**1,679**	**1,679**
Net book value at 1 April 2017	**1,383**	**1,383**

Note 10.2 Intangible assets - 2016/17

	Software licences	Total
	£000	£000
Valuation / gross cost at 1 April 2016 - as previously stated	**4,002**	**4,002**
Valuation / gross cost at 1 April 2016 - restated	**4,002**	**4,002**
Additions	361	**361**
Disposals / derecognition	(1,508)	**(1,508)**
Valuation / gross cost at 31 March 2017	**2,855**	**2,855**
Amortisation at 1 April 2016 - as previously stated	**2,593**	**2,593**
Amortisation at 1 April 2016 - restated	**2,593**	**2,593**
Provided during the year	**387**	**387**
Disposals / derecognition	(1,508)	**(1,508)**
Amortisation at 31 March 2017	**1,472**	**1,472**
Net book value at 31 March 2017	**1,383**	**1,383**
Net book value at 1 April 2016	**1,409**	**1,409**

Note 11.1 Property, plant and equipment - 2017/18

	Land	Buildings excluding dwellings	Assets under construction	Plant & machinery	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000
Valuation/gross cost at 1 April 2017 - brought forward	**4,500**	**95,779**	**13**	**31,541**	**5,355**	**98**	**137,286**
Additions	0	4,921	3,398	4,709	1,183	5	**14,216**
Impairments	0	(1,876)	0	0	0	0	**(1,876)**
Reversals of impairments	0	866	0	0	0	0	**866**
Revaluations	450	3,584	0	0	0	0	**4,034**
Reclassifications	0	1,376	(1,375)	0	86	0	**87**
Disposals / derecognition	0	0	0	(2,085)	(18)	(44)	**(2,147)**
Valuation/gross cost at 31 March 2018	**4,950**	**104,650**	**2,036**	**34,165**	**6,606**	**59**	**152,466**
Accumulated depreciation at 1 April 2017 - brought forward	**0**	**0**	**0**	**22,341**	**2,721**	**58**	**25,120**
Provided during the year	0	1,713	0	2,530	890	4	**5,137**
Revaluations	0	(1,713)	0	0	0	0	**(1,713)**
Disposals / derecognition	0	0	0	(2,085)	(18)	(44)	**(2,147)**
Accumulated depreciation at 31 March 2018	**0**	**0**	**0**	**22,786**	**3,593**	**18**	**26,397**
Net book value at 31 March 2018	**4,950**	**104,650**	**2,036**	**11,379**	**3,013**	**41**	**126,069**
Net book value at 1 April 2017	**4,500**	**95,779**	**13**	**9,200**	**2,634**	**40**	**112,166**

Note 11.2 Property, plant and equipment - 2016/17

	Land	Buildings excluding dwellings	Assets under construction	Plant & machinery	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000
Valuation / gross cost at 1 April 2016 - as previously stated	**4,500**	**89,720**	**342**	**29,595**	**5,328**	**90**	**129,575**
Valuation / gross cost at 1 April 2016 - restated	**4,500**	**89,720**	**342**	**29,595**	**5,328**	**90**	**129,575**
Additions	0	5,138	1,427	2,717	520	43	**9,845**
Impairments	0	(1,240)	(309)	0	0	0	**(1,549)**
Reversals of impairments	0	359	0	0	0	0	**359**
Revaluations	0	562	0	0	0	0	**562**
Reclassifications	0	1,240	(1,240)	0	0	0	**0**
Disposals / derecognition	0	0	(207)	(771)	(493)	(35)	**(1,506)**
Valuation/gross cost at 31 March 2017	**4,500**	**95,779**	**13**	**31,541**	**5,355**	**98**	**137,286**
Accumulated depreciation at 1 April 2016 - as previously stated	**0**	**0**	**0**	**20,503**	**2,356**	**90**	**22,949**
Accumulated depreciation at 1 April 2016 - restated	**0**	**0**	**0**	**20,503**	**2,356**	**90**	**22,949**
Provided during the year	0	**1,570**	0	**2,607**	**858**	**3**	**5,038**
Revaluations	0	(1,570)	0	0	0	0	**(1,570)**
Disposals/ derecognition	0	0	0	(769)	(493)	(35)	**(1,297)**
Accumulated depreciation at 31 March 2017	**0**	**0**	**0**	**22,341**	**2,721**	**58**	**25,120**
Net book value at 31 March 2017	**4,500**	**95,779**	**13**	**9,200**	**2,634**	**40**	**112,166**
Net book value at 1 April 2016	**4,500**	**89,720**	**342**	**9,092**	**2,972**	**0**	**106,626**

Note 11.3 Property, plant and equipment financing - 2017/18

	Land	Buildings excluding dwellings	Assets under construction	Plant & machinery	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000
Net book value at 31 March 2018							
Owned - purchased	4,950	100,524	2,023	10,825	2,988	41	**121,351**
Finance leased	0	1,444	0	56	0	0	**1,500**
Owned - donated	0	2,682	13	498	25	0	**3,218**
NBV total at 31 March 2018	**4,950**	**104,650**	**2,036**	**11,379**	**3,013**	**41**	**126,069**

Note 11.4 Property, plant and equipment financing - 2016/17

	Land	Buildings excluding dwellings	Assets under construction	Plant & machinery	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000
Net book value at 31 March 2017							
Owned - purchased	4,500	93,274	0	8,364	2,589	40	**108,767**
Finance leased	0	0	0	85	0	0	**85**
Owned - donated	0	2,505	13	751	45	0	**3,314**
NBV total at 31 March 2017	**4,500**	**95,779**	**13**	**9,200**	**2,634**	**40**	**112,166**

Note 12 Non-current assets for sale and assets in disposal groups

The Trust had no non-current assets for sale at the Statement of Financial Position date.

Note 13 Investments

The Trust held no investments at the Statement of Financial Position date.

Note 14 Inventories

Inventory movements 2017-18	Total	Drugs	Consumables
	£000	£000	£000
Carrying value at 1 April 2017	**3,880**	**1,160**	**2,720**
Additions	**32,515**	20,312	12,203
Inventories recognised in expenses	**(32,915)**	(20,525)	(12,390)
Write-down of inventories (including losses)	**(104)**	(35)	(69)
Carrying value at 31 March 2018	**3,376**	**912**	**2,464**

Inventories recognised in expenses for the year were £32,915k (2016/17: £30,676k). Write-down of inventories recognised as expenses for the year were £104k (2016/17: £216k).

Inventory movements 2016-17	Total	Drugs	Consumables
	£000	£000	£000
Carrying value at 1 April 2016	**3,717**	**1,106**	**2,611**
Additions	**31,055**	20,788	10,267
Inventories recognised in expenses	**(30,676)**	(20,664)	(10,012)
Write-down of inventories (including losses)	**(216)**	(70)	(146)
Carrying value at 31 March 2017	**3,880**	**1,160**	**2,720**

Note 15 Trade and other receivables

Note 15.1 Trade and other receivables

	Total 31 Mar 2018 £000	Total 31 Mar 2017 £000
Current (amounts falling due within one year):		
NHS Receivables	2,334	**6,680**
Provision for impaired receivables	(504)	**(3,019)**
Prepayments	1,347	**1,644**
Interest receivable	0	**2**
PDC receivable	9	**55**
VAT receivable	504	**676**
Other receivables	2,065	**1,690**
Total current trade and other receivables	**5,755**	**7,728**
Non-current (amounts due after more than one year):		
Prepayments	44	**0**
Other debtors	737	**786**
Total non-current trade and other receivables	**781**	**786**
Total trade and other receivables	**6,536**	**8,514**

Note 15.2 Provision for impairment of receivables

	2017/18 £000	2016/17 £000
Balance at beginning of period	**3,019**	**482**
Increase in provision	109	2,655
Amounts utilised	(51)	(40)
Unused amounts reversed	(2,573)	(78)
Balance at end of period	**504**	**3,019**

Note 15.3 Analysis of provision for impaired receivables

Ageing of impaired receivables	**31 Mar 2018** Trade **£000**	**31 Mar 2018** Other **£000**	**31 Mar 2018 Total £000**	**31 Mar 2017 Total £000**
0-30 days	0	0	**0**	**1,535**
31-60 days	0	0	**0**	**3**
61-90 days	0	0	**0**	**129**
91-180 days	6	0	**6**	**779**
Over 180 days	498	0	**498**	**573**
Total	**504**	**0**	**504**	**3,019**

Non-financial asset impaired receivables over 3 months relates to income due from the Compensation Recovery Unit (CRU) in respect of the NHS injury scheme. These debts have been assessed as having a bad debt provision of 22.84% (22.94% in 2016/17). All other debts are reviewed regularly and referred to a debt collector when necessary.

Note 15.4 Ageing of non-impaired receivables past their due date

	31 Mar 2018 Trade **£000**	31 Mar 2018 Other **£000**	**31 Mar 2018 Total £000**	**31 Mar 2017 Total £000**
0-30 days	1,568	0	**1,568**	**773**
31-60 days	16	0	**16**	**63**
61-90 days	371	0	**371**	**250**
91-180 days	0	0	**0**	**127**
Over 180 days	2,344	0	**2,344**	**147**
Total	**4,299**	**0**	**4,299**	**1,360**

68% of trade is with Clinical Commissioning Groups and NHS England, as commissioners for NHS patient care services. As these organisations are funded by government to buy NHS patient care services, no credit scoring of them is considered necessary. The value of trade receivables that are past their due payment date but not impaired is shown above.

Note 16 Cash and cash equivalents

	2017/18	2016/17
	£000	£000
At 1 APRIL	**1,204**	**3,163**
Net change in year	**1,466**	(1,959)
TOTAL at 31 MARCH	**2,670**	**1,204**
Broken down into:		
Cash at commercial banks and in hand	**71**	**58**
Cash with the Government Banking Service	**2,599**	**1,146**
TOTAL	**2,670**	**1,204**

Note 17 Other financial assets

The Trust does not hold other financial assets at the Statement of Financial Position date.

Note 18 Trade and other payables

Note 18.1 Trade and other payables

Current	31 March 2018	31 March 2017
	£000	£000
Trade payables*	3,950	7,094
Capital payables	3,911	2,839
Accruals	4,574	3,505
Social security costs	3,593	3,201
Accrued interest on loans	517	286
Other payables*	4,023	1,683
Total current trade and other payables	**20,568**	**18,608**
Of which payables from NHS and DHSC group bodies:		
Current	985	1,627
Non-current		

*Prior year Trade payables included pension payable which in this year is included under other payables.

Note 18.2 Payables early retirements detail

There were no early retirement costs included in NHS payables.

Note 18.3 Other liabilities

Current (amounts falling due within one year):	31 Mar 2018	31 Mar 2017
	£000	£000
Deferred Income	1,316	1,551
Total other current liabilities	**1,316**	**1,551**

Non- current (amounts falling due after one year):	31 Mar 2018	31 Mar 2017
	£000	£000
Deferred Income	0	0
Total other non- current liabilities	**0**	**0**
Total other liabilities	**1,316**	**1,551**

Note 19 Borrowings

Note 19.1	Total 31 Mar 2018 £000	Total 31 Mar 2017 £000
Current (amounts falling due within one year):		
Loans from the Department of Health	14,944	1,977
Obligations under finance leases	304	30
Total current borrowings	**15,248**	**2,007**
Note 19.2		
Non- current (amounts falling due after one year):		
Loans from the Department of Health	104,484	78,687
Obligations under finance leases	1,055	52
Total non-current borrowings	**105,539**	**78,739**
Total borrowings	**120,787**	**80,746**

Analysis of loans with Department of Health:

The Trust holds eighteen Interim Revenue support loans and four Capital loans outstanding with the Department of Health these are provided in the table below.

Interim Revenue support loans

Period approved	Loan type	Loan amount £000	Interest rate	Loan period	Loan balance £000
2014-15	Interim Revenue support loan	7,400	1.5%	5 years	7,400
2015-16	Interim Revenue support loan	12,100	1.5%	2 years	12,100
2015-16	Interim Revenue support loan	22,400	3.5%	5 years	22,400
2016-17	Interim Revenue support loan	2,029	1.5%	3 years	2,029
2016-17	Interim Revenue support loan	5,544	1.5%	3 years	5,544
2016-17	Interim Revenue support loan	2,127	1.5%	3 years	2,127
2016-17	Interim Revenue support loan	4,520	1.5%	3 years	4,520
2017-18	Interim Revenue support loan	2,491	3.5%	3 years	2,491
2017-18	Interim Revenue support loan	2,889	3.5%	3 years	2,889
2017-18	Interim Revenue support loan	2,974	3.5%	3 years	2,974
2017-18	Interim Revenue support loan	2,270	3.5%	3 years	2,270
2017-18	Interim Revenue support loan	2,135	3.5%	3 years	2,135
2017-18	Interim Revenue support loan	2,354	3.5%	3 years	2,354

2017-18	Interim Revenue support loan	3,059	3.5%	3 years	3,059
2017-18	Interim Revenue support loan	2,169	3.5%	3 years	2,169
2017-18	Interim Revenue support loan	3,498	3.5%	3 years	3,498
2017-18	Interim Revenue support loan	1,734	3.5%	3 years	1,734
2017-18	Interim Revenue support loan	3,370	3.5%	3 years	3,370
		85,063			**85,063**
Capital loans:					
2010-11	NCB Capital loan	20,000	2.73%	15 years	11,120
2015-16	Interim Capital loan	14,800	2.28%	25 years	13,959
2017-18	Interim Capital loan	7,200	0.76%	10 years	7,200
2017-18	Interim Capital loan	2,086	1.10%	10 years	2,086
		44,086			**34,365**
Total loans as at 31 March 2018		**129,149**			**119,428**

Note 20 Finance lease obligations

Note 20.1 Minimum lease payments

	Minimum lease payments	
	31 Mar 2018	**31 Mar 2017**
	£000	**£000**
Gross lease liabilities	**1,432**	**97**
Of which liabilities are due:		
- not later than 1 year	304	36
- later than 1 year but not later than 5 years	1,127	61
- later than 5 years	0	0
Finance charge allocated to future periods	(72)	(15)
Net lease liabilities	**1,359**	**82**
- not later than 1 year	304	30
- later than 1 year but not later than 5 years	1,055	52
- later than 5 years	0	0
	1,359	**82**

Note 20.2 Finance lease receivables

The Trust has no finance leases where it is the lessor.

Note 21 Provisions for liabilities and charges

	Current		Non-current	
	31 Mar 2018 £000	31 Mar 2017 £000	31 Mar 2018 £000	31 Mar 2017 £000
Legal claims	467	89	0	0
Redundancies	0	0	0	0
Injury allowances and other claims	131	244	450	464
Total	**598**	**333**	**450**	**464**

Injury allowances and other provisions

The amount shown against other provisions include permanent injury allowances of £472k payable to former employees of the Trust. With effect from 1 April 2002, trusts are required to account for the full cost of the injury allowance payable to the individual based on their life expectancy. Tables produced by the Governments Actuaries Department provide the estimates of life expectancy.

Provision has been made for one contractual dispute totalling £109k.

Legal claims

The amount shown against legal claims include non-clinical claims made against the Trust. The amounts shown for these provisions are based on advice provided by the NHS Litigation Authority and Trust solicitors. The amounts and timing of estimated settlement will necessarily alter as the cases progress.

In addition to the provision, contingent liabilities for non-clinical negligence claims are given in note 26.

Note 21.1 Movement in provisions

	Total 2017/18 £000	Injury allowances and other claims £000	Other legal claims £000	Total 2016/17 £000
At 1 April	**797**	**708**	**89**	**556**
Change in the discount rate	**9**	0	9	**63**
Arising during the year	**444**	0	444	**293**
Utilised during the year	**(105)**	(79)	(26)	**(65)**
Reversed unused	**(97)**	(57)	(40)	**(56)**
Unwinding of discount	**0**	0	0	**6**
At 31 March	**1,048**	**572**	**476**	**797**
Expected timing of cash flows:				
- within one year	**598**	131	467	**333**
- between one and five years	**450**	450	0	**86**
- after five years	**0**	0	0	**378**
TOTAL	**1,048**	**581**	**467**	**797**

Amount included in provisions of the NHSLA at 31 March 2018 in respect of Clinical Negligence liabilities of the Trust is £161.258m (31 March 2017 £113.510m).

Note 22 Movements in Public Dividend Capital

	2017/18 £000	2016/17 £000
Opening Public Dividend Capital	60,829	60,829
New Public Dividend Capital	300	0
Public Dividend Capital repaid	0	0
Public Dividend Capital at 31 March	**61,129**	**60,829**

Note 23 Movements on reserves

Revaluation Reserve

	2017/18 Property, Plant & Equipment £000	2016/17 Property, Plant & Equipment £000
Opening Balance 1 April	**21,325**	**20,109**
Revaluations	5,747	2,132
Impairments	(203)	(553)
Transfer of the excess of current cost depreciation over historical cost depreciation to the Income and Expenditure Reserve	(445)	(363)
Revaluation Reserve 31 March	**26,424**	**21,325**

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Note 24 Contractual Capital Commitments, Property, Plant and Equipment

The Trust had contractual capital commitments for property, plant and equipment to the value of £3.418m at the 31st March 2018 (£4.295m at 31st March 2017) and £0.911m for intangible software (£0.12 at 31st March 2017).

Note 25 Post Statement of Financial Position Events

The Trust has no known post Statement of Financial Position events that would impact the financial statements

Note 26 Contingencies

The Trust has contingent liabilities detailed below. The Trust's financial liability, if any, cannot be determined until the related claims are resolved. An estimate of the amount involved, inclusive of legal costs, is:

	31 Mar 2018 £000	31 Mar 2017 £000
NHS Litigation Authority legal claims	(110)	(48)
Other claims	(71)	(17)
Gross value of contingent liabilities	**(181)**	**(65)**
Amounts recoverable against liabilities	0	0
Net value of contingent liabilities	**(181)**	**(65)**

The contingent liability relates to those liabilities detailed in Note 21 for which a full provision has not been taken.

Note 27 Related Party Transactions

Note 27.1 Related Party Transactions

	2017/18		2016/17	
	Income £000	Expenditure £000	Income £000	Expenditure £000
Value of transactions with board members	0	0	0	0
Value of transactions with key staff members	0	0	0	0
Value of transactions with other related parties	225,641	41,861	230,557	13,215
Total value of transactions with related parties	**225,641**	**41,861**	**230,557**	**13,215**

Note 27.2 Related Party Balances

	31 Mar 2018		31 Mar 2017	
	Debtor £000	Creditor* £000	Debtor £000	Creditor* £000
Value of balances (other than salary) with board members	0	0	0	0
Value of balances (other than salary) with key staff members	0	0	0	0
Value of balances with other related parties	799	4,061	6,735	3,119
Total value of balances with related parties	**799**	**4,061**	**6,735**	**3,119**

Kettering General Hospital NHS Foundation Trust is a body corporate established by order of the Secretary of State for Health.

The Department of Health is regarded as a related party. During the year Kettering General Hospital NHS Foundation Trust has had a significant number of material transactions with the Department, and with other entities for which the Department is regarded as the parent Department. These entities with material transactions (income or expenditure over £1m) are listed below:

	2017/18		2016/17	
	Income	Expenditure	Income	Expenditure
Organisation	**£000**	**£000**	**£000**	**£000**
NHS bodies				
Department of Health	0	0	1,900	0
NHS England & CCGs	212,815		215,372	
Health Education England	7,510	0	8,063	0
NHS trusts	1,447	3,601	1,096	3,029
Foundation Trusts	1,167	2,145		1,442
Other health bodies	0	7,631	0	8,326
Other Government bodies				
HM Revenue & Customs – Employers costs (NI)	0	13,010	0	11,482
NHS Pensions Agency – Employers cost	0	14,606	0	13,582

Note 27.3 Charitable Funds

The Trust received revenue and capital payments from the hospital charitable fund (registration number 1052467), the corporate trustee for which is Kettering General Hospital NHS Foundation Trust. The audited accounts of the Funds Held on Trust can be obtained from the Finance Director. The Trust has not consolidated the charitable fund with these accounts due to the funds being immaterial (see accounting policy section 1.3). Donated assets are shown in the Property, Plant and Equipment notes.

Note 28 For PFI schemes deemed to be off-statement of financial position

The Trust has no PFI schemes deemed to be off-statement of financial position.

Note 29 Financial Instruments.

Financial risk management

Because of the continuing service provider relationship that the Trust has with Clinical Commissioning Groups (CCGs) and the way CCGs are financed, the Trust is not exposed to the degree of financial risk faced by business entities. Also financial instruments play a much more limited role in creating or changing risk than would be typical of listed companies, to which these standards mainly apply.

The Trust's treasury management operations are carried out by the finance department, within parameters defined formally within the Trust's Standing Financial Instructions and policies agreed by the Board of Directors. Trust treasury activity is subject to review by the Trust's internal auditors. The directors consider that the carrying amounts of financial assets and financial liabilities recorded at amortised cost in the financial statements approximate their fair value.

Currency risk

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

Interest rate risk

100% of the NHS Foundation Trust's financial assets and 100% of its financial liabilities carry nil or fixed rates of interest and therefore it has low exposure to interest rate fluctuations

Credit risk

Because the majority of the Trust's income comes from contracts with other public sector bodies, the Trust has low exposure to credit risk. The maximum exposures as at 31 Mar 2018 are in receivables from customers, as disclosed in the Trade and Other Receivables note. The majority of the Trust's cash balances are held with the Government Banking Service, thereby not subject to any credit risk.

Liquidity risk

The Trust funds its capital expenditure from internally generated resources and DHSC capital loan funding/ PDC. For contracted activity the Trust is paid in 12 monthly instalments through the year, in the main from Clinical Commissioning Groups, which are financed from resources voted annually by Parliament. In the latter part of the year included monthly payments for activity over contracted levels. This has reduced the liquidity risk. Next year the Trust is expecting to draw down support from the DHSC through revenue and capital loans based on discussions with regulators in line with approved limits by Board. The Trust is currently obtaining uncommitted revenue interim support loans on a monthly basis from the Department of Health.

The following are not financial instruments because they arise under legislation rather than under contract:

a. Public Dividend Capital
b. Early retirement liabilities (with the NHS Business Services Authority)
c. Injury benefit liabilities (with the NHS Business Services Authority)

Payments due under the injury cost recovery scheme are not financial instruments as they are not under contract with the Trust.

Note 29.1 Financial assets by category

Assets as per statement of financial position	31 Mar 2018 £000	31 Mar 2017 £000
Loans and receivables		
Trade and other receivables (excluding non-financial assets) – with NHS and DHSC bodies	2,334	4,112
Trade and other receivables (excluding non-financial assets) – with other bodies	1,988	643
Cash and cash equivalents (at bank and in hand)	2,670	1,204
Total	**6,992**	**5,959**

Note 29.2 Financial liabilities by category

Liabilities as per statement of financial position Other financial liabilities	31 Mar 2018 £000	31 Mar 2017 £000
Borrowings excluding finance lease obligations	119,428	80,664
Finance lease obligations	1,359	82
Trade and other payables (excluding non-financial assets) – with NHS and DHSC bodies	1,546	1,913
Trade and other payables (excluding non-financial assets) – with other bodies	13,383	11,574
Provisions under contract	1,048	797
Total	**136,764**	**95,030**

Maturity of Financial liabilities	31 Mar 2018 £000	31 Mar 2017 £000
In one year or less	30,762	15,829
Between one and two years	47,168	16,156
Between two and five years	32,068	48,012
More than five years	26,766	15,033
	136,764	**95,030**

Note 30 Third party assets

The Trust held £20 cash at bank and in hand at 31 March 2018 (£20 at 31 March 2017) that relates to monies held by the Foundation Trust on behalf of patients. This has been excluded from cash at bank and in hand figure reported in the accounts.

	2017/18 £000	2016/17 £000
At 1st April	**0**	**1**
Gross Inflows	13	5
Gross outflows	(13)	(6)
At 31 March	**0**	**0**

Note 31 Losses and special payments

There were 145 cases (118 in 2016/17) of losses and special payments totalling £287,694 (2016/17 £308,686) approved.

	2017/18		2016/17	
	Total number of cases	Total value of cases	Total number of cases	Total value of cases
	Number	£000's	Number	£000's
LOSSES:				
1. Losses of cash due to:				
a. overpayment of salaries etc.	16	7	17	5
b. other cash losses (total value rounds to zero)	2	0	13	0
2. Fruitless payments	1	9	0	0
3. Bad debts and claims abandoned in relation to:				
a. overseas visitors	3	40	9	30
b. other	19	36	10	5
4. Damage to buildings, property etc. (including stores losses) due to:				
a stores losses	3	104	3	216
b. other	0	0	0	0
TOTAL LOSSES	**44**	**196**	**52**	**256**
SPECIAL PAYMENTS:				
5. Compensation under legal obligation	1	12	1	9
6. Extra contractual to contractors	0	0	0	0
7. Ex gratia payments in respect of:				
a. loss of personal effects	20	6	31	8
b. personal injury with advice	27	35	9	33
c. other	40	14	25	2
d. other negligence and injury	13	24	0	0
8. Special severance payments	0	0	0	0
TOTAL SPECIAL PAYMENTS	**101**	**91**	**66**	**52**
TOTAL LOSSES AND SPECIAL PAYMENTS	**145**	**287**	**118**	**308**