Kettering General Hospital
NHS Foundation Trust

Annual Report and Accounts 2018/19

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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 finished my statement to last year's Annual report by stating that "I strongly believe that through its greatest resource, its staff, that KGH is capable of great things." This year's Annual report shows that my belief was well placed.

Over the course of the year 2018/19 I have been proud to be part of an organisation that has identified where it is going – through the development of our short to medium term strategy - and which has committed to a journey to becoming outstanding.

I have seen this commitment to improvement across all areas of the Trust – we work better with our system partners and have addressed our own internal processes as evidenced by the dramatic reductions in the numbers of patients staying in hospital for over 28 days (known as "super stranded" patients) – in April 2018 there were 200 patients waiting and in March 2019 this had reduced to 110 This is not only better for every single person and their families who had been waiting to leave hospital care but also enables us to improve the flow of patient through our hospital. Over the past year we have also seen our A&E waiting times improve – although we still have some way to go to achieve the national performance standards.

2018 saw the 70th anniversary of the NHS and at KGH we used this as an opportunity to celebrate all of the amazing work that takes place in our Trust every day. We held our Annual members Meeting on the evening of July 5th and throughout the day showcased our services and provided the public with an opportunity to visit some of our newly refurbished departments, our new simulation suite used for training and a beautiful internal courtyard garden that has been created for people with dementia and their visitors. A number of our staff were recognised nationally as NHS heroes and these celebrations continued on to our own Annual Staff Awards that I had the pleasure of hosting in November. I am constantly struck by the dedication and commitment of staff from all disciplines and departments to doing their best to provide excellent care.

2018/19 has also been a period of development and consolidation for the Trust Board. We have been joined by Richard Apps as Director of Integrated Governance and Joanna Fawcus replaced Rebecca Brown as Chief Operating Officer. We also appointed a Chief of Digital, Andy Callow, in January and who joins the Trust in April 2019.

We also welcomed two new Non-executive Directors to the Board – Lise Llewellyn who brings with her significant experience from working in Commissioning and public health and Damien Venkatasamy with many years experience in IT. This year also saw the departure of Lizzie Hanna after 3 years of service.

The Board has worked hard to implement recommendations of external reviews of its performance and to ensure it is providing the strategic direction the Trust needs. We have refocused our committee structures and through the creation of Divisional Chiefs of each of our three clinical divisions ensured that clinicians are at the heart of decision making as members of our Executive Group. Our 2018 inspection has reviewed the Board against the domain of "Well Led" and rated KGH as Good – a significant achievement and I am grateful to all of our Board members for their sheer hard work and determination to lead the process of improvement.

We have also seen real improvements in how our staff view working at KGH, more staff than ever took the time to complete the survey (45%) and greater proportions of our staff saying that they are happy with the standard of care, would recommend KGH as a place to work and that care of patients is a top priority.

We continue to be an active member of the Northamptonshire health and Care partnership – particularly in discussions about better collaboration between the two acute Trusts in the County – something I am keen to progress having in December been appointed as Chairman of NGH alongside my role as Chairman of KGH.

I look forward to 2019/20 as being a year of consolidation and further improvement. I am personally committed to ensuring that KGH provides the best possible care to the population that it serves, that we work in partnership with others across health and social care to ensure the services we deliver are joined up and that our staff feel a deserved sense of pride in what they do.

ALAN BURNS
CHAIRMAN

22 May 2019

2 Performance Report

2.1 Overview

2.1.1 Purpose

The purpose of this section of the report is to provide a summary of the clinical, quality and financial performance of the Trust for 2018/19. 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.

2.1.2 Chief Executive 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 2018 to 31st March 2019. The publication of this report coincides with my first anniversary as Chief Executive of Kettering General Hospital and offers an opportunity to reflect on the improvements we have made over the past year and identify those areas of focus for the coming year as we continue on our journey to outstanding. The year started with a review of the Trusts strategic objectives to ensure alignment with our overarching vision of “to provide safe high quality care to our communities”. After a period of intense staff and patient engagement we agreed a number of short to medium term strategic objectives that directly contribute to improving the performance of the Trust and the quality of the care we provide. At the same time we published our Quality Strategy which sets out our Quality Improvement ambitions for the Trust.

As I said last year, ‘no hospital exists as an island state in today’s NHS’, and I have seen significant and genuine progress in collaborative working across Northamptonshire over the last 12 months.

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 our objectives in another difficult year for the NHS. This was highlighted in our latest staff survey results from the Autumn of 2018. These show better engagement with more staff recommending KGH as a place of work and to receive treatment and 89.3% of staff saying that they felt their role makes a difference.

Highlights from the survey results include;

- The best ever response rate amongst our staff (45%)
- Indicators relating to staff engagement and motivation have significantly improved
- Our quality and safety initiatives are reflected in improved scores across all areas
- Of the nine themed areas where it is possible to compare against last year six have improved and five of these have shown statistically significant improvement
- Staff reporting support from their immediate managers and quality of appraisals have improved and the highest rating since 2015

During the year the Trust hosted a successful Dragons Den event where staff pitched for support for their innovative ideas. Five of the successful ideas are now in place and benefitting patients across the Trust and the 6th a patient buggy service will begin operating over the summer.

Between February and March 2019 we were re-inspected by the Care Quality Commission (CQC) – the results of which reflect the progress we have made towards becoming an outstanding organisation.

The CQC also reviewed the Board against the domain of “Well Led” and rated KGH as Good, which is a significant achievement. The Overall rating for the Trust remains Requires Improvement with the CQC identifying both outstanding areas of practice and continued areas of focus for the year ahead.

Highlights from the inspection report are

- Well–Led for the Trust has improved to Good
- Caring remains Good
- No ratings of Inadequate across any service area in any domain
- 14 Must Dos identified vs 39 Must Dos last year

For the first time the Trust received a new rating against its Use of Resources and rated the Trust as Requires Improvement. CQC identified that whilst the Trust has achieved productivity improvements in its clinical services through working with health and social care partners and engaging with national productivity improvement programmes it continues to experience emergency demand pressures, which together with key workforce challenges is contributing to the current financial position.

Following the inspection CQC recommended that the Trust should come out of the Special Measures regime which followed a previous inspection report published in 2017. NHS England and Improvement have supported this recommendation which provides the Trust with a platform to continue our journey to providing outstanding care to our patients.

I am grateful to the Board and all of our staff for their hard work and determination on our continued journey of improvement.

Performance

I am pleased to report that the year has again seen improvements in some of our performance standards with a consistent performance against the diagnostic standard and the delivery of the cancer standards in the context of increased demand and the national picture for cancer waiting times. Significant achievements at the Trust this year have also seen a consistent reduction in the number of Super Stranded patients, a substantial reduction in the backlog of x-ray reports and zero reported 52 week waits in the latter half of the year.

However, the Trust remains challenged in in some performance areas including Referral to Treatment Time (RTT) targets and the maximum waiting of four hours in A&E targets. Despite a disappointing RTT performance the Trust continues to make significant improvements in reducing the numbers of patients waiting over 18 weeks.

Finance

The Trust ended the financial year 2018/19 with a deficit of £28.9m (excluding impairments of £4.7m). This marked an underachievement against the £27.4 deficit plan.

This overall finance picture remained challenging financially, in particular staffing costs in some areas across the Trust and in ensuring safe staffing levels in clinical areas. A national shortage of trained staff available for recruitment has also led to agency costs remaining high. The Trust has also seen a number of unplanned impacts on its income position through under-performance in some clinical areas.

Despite the challenging environment the Trust transformation schemes had delivered £14.6m against a target of £14.5m; areas of under-delivery had been offset by over performance in other areas; there had been a strong clinical commitment and engagement with the cost improvement plan schemes (CIPs).

For 2019-2020, the Board has again set a challenging but achievable financial plan. After a comprehensive financial planning process, the Board has agreed a plan for the year of £25.3m deficit. The efficiency saving required in 19/20 is £10.5m, which is 4.4%.

The year ahead

Among our key challenges in the year ahead that the Trust Board and I will be focusing on, I would like to highlight the following:

- I am particularly excited at the potential of our digital roadmap to make huge inroads into improving patient care – through the introduction of electronic prescribing and electronic patient records for example - that will massively improve our care processes.
- The work we are doing with our system partners through the Health and Care Partnership will help deliver better care outcomes for our patients and has already contributed significantly to reducing the length of time patients stay unnecessarily in hospital.
- The buildings and facilities across the Trust are gradually being improved as funding allows, and these changes are already taking effect – with newly refurbished facilities for our fracture clinic, our minors area in the Accident and Emergency (A&E) department and dermatology clinic at Prospect House. The coming year will also see a transformed outpatients department and work continuing on securing approvals for a new Urgent Care Hub on the main site.
- KGH has been selected as one of fourteen trusts piloting new access measures in urgent and emergency care, to help understand how we can continue to improve patient experience and outcomes.

My congratulations and thanks to all of my colleagues for their hard work in delivering for patients and the community through the year.

2.1.3 Purpose and activities of Kettering General Hospital NHS 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 is organised into four Divisions (3 clinical, 1 corporate). Each clinical division has a Lead (a clinician), a Head of Nursing and a Divisional Director. Divisions are organised as follows:

- 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.

Kettering General Hospital NHS Foundation Trust is a medium sized acute hospital serving a population of approximately 311,000 across North Northamptonshire and South Leicestershire.

The Trust provides general acute, maternity and paediatric services from its main hospital site in Kettering with satellite outpatient facilities in Corby, Irthlingborough (East Northants) and Wellingborough as well as community facilities in Kettering town.

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 Trust's vision is to "***provide safe high quality care to our communities***" and in 2018 after a period of public and staff engagement launched its short to medium term strategy centred around four core strategic objectives:

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

The Trust has effective mechanisms in place to enable collaborative and productive relationships with third party bodies. The Trust co-operates with national and local organisations where there is a duty to do so or where it is in the best interests of the Trust and the local community to do so. Third party bodies include NHS England, NHS Improvement, The Care Quality Commission, members of the Northamptonshire Health & Care Partnership and local Health and Wellbeing Boards and Healthwatch.

2.1.4 History of Kettering General Hospital NHS Foundation Trust

Kettering General Hospital was first opened in 1897 and has grown significantly over the intervening 122 years and now comprises, the original 1890s hospital buildings, 1960s and 70s ward blocks and outpatient facilities (variously refurbished) Treatment Centre opened in 2007 and new Foundation Wing opened in 2012 providing cardiac and intensive care facilities as well as dedicated children's ward and outpatients.

The Trust achieved Foundation Trust status in 2008 and is the only acute Foundation Trust in the County. The southern half of the county is served by Northampton General Hospital NHS Acute Trust. Both Trusts are committed to working collaboratively in future in support of the delivery of the Northamptonshire Health & Care Partnership (STP) in which KGH an active partner.

In recent years the Trust experienced financial and operational difficulties and was rated as Inadequate by the Care Quality Commission in 2017 and placed in Special Measures. This rating was revised to Requires Improvement in February 2018. The Trust has recently been re-inspected – the outcome of which is described above.

2.1.5 Key issues and risks

The Trust has identified through analysis of strategic risk, through the Board Assurance Framework, the top three risks which are Staffing, Infrastructure, and Finance. The Trust Board receives updates against assurances and action plan progress at each public meeting. The most up to date versions can be found on the Trust website at www.kgh.nhs.uk.

2.1.6 Going concern

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

2.2 Performance analysis

2.2.1 Measuring performance

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

An Integrated Governance Report which incorporates a core set of KPIs is reviewed by the Board and Board Committees 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.

2.2.2 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 2018/19 is provided in the table below:

Targets 2018-19	Target/ Plan	Q1	Q2	Q3	Q4
Clostridium difficile year on year reduction – national target 26 for the year (Cumulative)	Max of 25	4	13	16	18
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%	99.3%	98.7%	97.8%	98.6%
62 day wait for first treatment from urgent GP referral to treatment: all cancers	85%	81.9%	88.5%	88.9%	85.7%
62 day wait for first treatment from consultant screening service referral: all cancers	90%	94.7%	94.7%	94.6%	92.3%
Referral to treatment waiting times – Incomplete	95%	80.0%	79.2%	83.2%	86.2%
Maximum waiting time of 4 hours in A&E from arrival to admission, transfer or discharge	95%	84.4%	83.3%	82.6%	81.5
Maximum waiting time of 2 weeks from urgent GP referral to first outpatient appointment for all urgent suspect cancer referrals	93%	95.4%	96.3%	98.1%	98.2%
Two week wait from referral to date first seen – symptomatic breast patients	93%	99.4%	98.0%	98.0%	99.1%
Governance rating					

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

Area	2016-17	2017-18	2018-19	Change
Inpatients	40,016	39,914	TBC	
Outpients	254,590	274,649	TBC	
Day Case	41,224	37,895	TBC	
Accident & Emergency	87,505	87,497	93,334	6.7% increase

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

2.2.3 Performance analysis

Throughout 2018/19 the Trust performance against a range of operational performance standards has been variable. Of particular note is the consistent performance against the diagnostic standard and the delivery of the cancer standards in the context of increased demand and the national picture for cancer waiting times. 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 sub-optimal RTT performance the Trust has made significant improvements in reducing the numbers of patients waiting over 18 weeks.

Our non-elective demand in 2018/19 has been at a consistently higher level to that of the previous year. The Trust has seen very high peak levels of A&E attendances and significant emergency admissions for our elderly medical patients with more complex needs. Despite this the Trust has made significant improvements in its length of stay and discharge numbers working across the whole health system to achieve this. This has meant that for the first time in many years the Trust has been able to maintain its elective care activity and reduce bed pressures over the winter months. Elective activity however was affected due to the overrun of the planned theatre refurbishment at the start of 2018 which impacted our ability to deliver the RTT target.

Diagnostics

The Diagnostic standard known as ‘DM01’ is a national standard and means that 99% of all diagnostic tests relating to physiology, radiology and endoscopy need to be completed within six weeks. From February 2018 we have consistently delivered this target with weekly monitoring in place to actively manage this target and spot early warning signs so capacity can be increased to meet demand if required. The following table details the Trust performance against the 1% diagnostic standard:

DM01 Performance by Quarter for 2017/18 and 2018/19

DM01	2017/2018	2018/2019
Q1	1.32%	0.92%
Q2	1.41%	0.59%
Q3	0.67%	0.51%
Q4	1.41%	0.54%

Referral to Treatment Time (RTT)

The NHS Constitution sets out that (as a minimum) 92% of our patients should wait no longer than 18 weeks from GP referral to treatment (RTT). In 2018/19 our performance has continued to improve with the most progress being seen from December 2018 onwards. We recognise that we have more work to do and our agreed improvement plan for 2019/20 is focussed on sustaining this improvement.

Throughout 2018/19 the Trust has continued to reduce its backlog of patients waiting for treatment. We reduced the number of long wait patients (those waiting over 18 weeks) from 5,052 in March 2018 to 2,909 in March 2019, a 44.4% reduction over the last 12 months. There were also five patients who waited over

the 52 week constitutional standard waiting time. However since September 2018 there have been no further patients who waited over 52 weeks.

Urgent & Emergency Care

We are measured against the urgent and emergency care we provide through a number of clinical indicators. These include the four-hour waiting standard, time-to-triage, time-to-assessment, the number of patients conveyed by ambulance and ambulance handover times. The primary indicator, both locally and nationally, is that at least 95% of patients attending the Emergency Department should be seen, treated and either admitted or discharged within four hours.

We monitor performance against the ED standards on a daily, weekly and monthly basis through robust reporting mechanisms. This allows our clinical and operational teams to assess performance against these standards and to identify key trends, themes and areas for improvement. Urgent and emergency care performance also has a system wide Executive leadership focus at the Urgent & Emergency Care Delivery Board which is chaired by the CEO of KGH. Partners across the system including the CCGs, EMAS and NGH come together to discuss performance and key challenges and to also agree key actions to address these challenges.

Emergency Department (ED) 4-hour performance

The Trust did not achieve the four-hour standard in 2018/19. We acknowledge this overall performance is not where we want it to be for our patients. However there are significant improvements sitting behind this which must be highlighted:

- System collaboration to increase and improve the care options for discharge of those patients who require further care
- Long Stay Wednesday approach and the impact on our stranded and super stranded metric. Super stranded patients (patients staying 21days or more) were reduced from an average of 200 in April 2018 to an average of 110 by March 2019. Stranded patients (staying 7days or more) reduced from an average of 400 in April 2018 to an average of 290 by March 2019
- Emergency length of stay reduced by 0.4 days compared to 2017/18

The ED Senior Leadership Team have an agreed improvement plan and collaborative work across the Trust continues to focus on patient flow and timely access to assessment & interventions our patients need to admit, treat and discharge home within four hours. The two tables below details the Trust's performance for the A&E standard by quarter for 2018/19 and the rise in emergency demand the Trust has faced in 2018/19 compared to 2017/18:

	% withhin 4 hours - Kettering General Hospital			% within 4 hours - Health System		
	Total attendances	Breaches of standard	% within Standard	Total attendances	Breaches of standard	% within Standard
Apr - Jun	22,718	3,544	84.4%	41,293	3,551	91.4%
Jul - Sep	23,201	3,867	83.3%	41,270	3,867	90.6%
Oct - Dec	23,778	4,149	82.6%	42,755	4,150	90.3%
Jan - Mar	23,637	5,669	76.0%	45,446	5,669	87.5%
Total	93,334	17,229	81.5%	170,764	17,237	89.9%

Source: Data Source: Monthly UNIFY SiTREP Returns

	2017/18	**2018/19**	**% Increase**
Attendances	87,497	93,334	6.7%

Cancer Waiting times

There are seven operational standards for the Cancer Waiting Times. These standards monitor the length of time that patients with cancer or suspected cancer wait to be seen and treated in England. In 2018/19 we have consistently delivered the two week wait standards and 31 day standards. For the 62d standard in 2018/19 we failed to deliver in June 2018 but have maintained delivery against this performance since July 2018. We are continuously monitoring all our cancer standards and work closely with all our clinical leads at KGH, our tertiary providers and system partners to look to how we can further improve for our patients and their outcomes.

Developments 18/19

Age UK

A new service has started at KGH provided by Age UK and operates 7 days a week. Easily identifiable, the Support Workers wear a bright yellow polo neck shirt with the Age UK Northamptonshire logo and work across the following services:

- A&E – to avoid hospital admission and help people access social support quickly
- Dementia support on Naseby Wards (A&B), Lamport & Twywell
- Targeted prevention avoiding readmission – facilitating discharge on the day, collecting medication, initial shopping, key safe and supporting the first hour at home

The new service is one of the most comprehensive services provided by Age UK charities at a hospital anywhere in the country and will complement the work done by KGH's own volunteers. The Age UK Northamptonshire team will support the hospital by helping patients with a wide variety of non-clinical tasks ranging from getting cups of tea, filling in forms, and providing activities for dementia patients, to taking people home in Age UK Northamptonshire minibuses and checking they have everything they need.

Integrated Discharge Team

The Integrated Discharge Team (IDT) is made up of professionals from both Health and Social Care who work collaboratively together to ensure safe and timely discharge of patients from KGH. The IDT was agreed, created and commenced in October 2018. This model of working is also being delivered in other NHS organisations across the Northamptonshire footprint. During 2018 the Discharge Team were given additional resources to deliver the corporate vision for patient discharge. The main objective of the team is to provide multidisciplinary expertise and support to staff, patients, families and carers when planning discharge from hospital; aid in enabling the Trust to maximise the utilisation of the bed base; aid in improving patient flow, experience and outcomes.

The aims of the IDT are:

- To provide support and education to the ward staff
- To provide a clear focus on discharge planning
- To provide ward level expertise in discharge planning and process
- To challenge decision making, actions and timescales

Some of the functions of the IDT are:

- Track patients who require supported discharge
- Have heightened focus on stranded and super stranded patients
- Work within the Urgent Care Service to focus on quick turnaround of patients
- To develop existing discharge pathways and transfer of care into community settings by developing key relationships with mental health, nursing and residential homes, district and other nursing services.
- To develop and produce discharge information and literature regarding discharge processes to assist in planning and prevent delays.

The Dementia Garden

This project is completed with an opening planned to coincide with Dementia Awareness Week. The pictures attached show the finished garden which has given a space for patients and relatives away from the hustle and bustle of busy wards. It has enabled families to stay a little longer whilst their relatives sleep, have conversations away from other patients and it has become a sanctuary for patients & families. The Garden has engaged with patients by involving patients in the design, talking to the artist and some patients even managing to get themselves painted in the scenes leaving a legacy to their families. The community engagement in this project has also been critical with the companies involved giving their time, skills and materials. Fundraising events have been well supported with local charities such as the Lions, the Rotary Clubs, Soroptomist International and the local Rugby Club being incredibly generous with their donations. Individuals have jumped out of planes, run half marathons and even purchased specific items in line with the theme. This has been a fantastic achievement and a real resource for patients, families and staff.

Cancer Alliance Projects

To enhance the cancer pathways for our patients the Trust is now offering two new diagnostic services. Firstly to achieve the National Optimal Lung Cancer Pathway the Trust has now purchased the equipment called EBUS which enables us to provide this test in our own hospital, prior to patients requiring treatment at a tertiary centre. Previously access to this test was at another centre so this is now an accessible service for our patients. To support the lung pathway further we are now also able to offer access straight to CT for patients who have an abnormal x-ray. This has been facilitated by recruitment of key staff in Radiology. Capacity in the lung cancer clinics has also been increased to support the patient pathway and ensure timely treatment and referral if required to tertiary centres.

On the Urology cancer pathways the Rapid prostate, mpMRI training has been completed. The Trust in now in a position to complete mpMRI before biopsy and the Surgical Division are developing a Urology one

stop clinic which will further improve the patient's experience. All funding has been allocated to the projects and recruitment is in process for this exciting development to commence.

Long Stay Wednesday

At KGH reducing the number of Super Stranded patients was really important not only improve the flow in the Trust but also to make sure that patients were not remaining in hospital longer than they needed to.

The Long Stay Wednesday Team was established with the support of the Executive team consisting of: the Deputy Chief Operating Officer, Deputy Director of Nursing, Head of Discharge, Head of Therapies, Project Manager and Administrator. The Long Stay Wednesday Team took the weekly long stay patient meeting to the wards and engaged with the ward MDT and provided support on the spot.

Each ward was advised what time the team would be approximately coming over to the ward. This was communicated by email, screen savers and verbally. Super Stranded data was pulled for each ward giving the team a focused list of patients to discuss.

Each patient was discussed with the ward team including the nurse in charge, a therapist and occasionally a consultant or registrar. All information from the review meetings including actions to progress the patient's journey, are recorded electronically and emailed to the ward staff before leaving the ward. The team focused on asking the questions below to ensure each patient had a clear, agreed, plan in the notes that included expected date of discharge and clinical and functional criteria for discharge.

1. Does this person need to be in an acute hospital bed?
2. What is this person waiting for/ what specific action needs to happen next?
3. Which code should we enter for this person?
4. Why not home? Why not today?

There was a significant reduction of super stranded patients at KGH from July 2018 onwards. The number of super stranded patients was reduced by approximately 80 patients and this has been maintained over Christmas, New Year and the Winter Months. There has been significantly improved flow across the Trust with an average of 9 escalation beds being open in 2018/19, in comparison to 19 escalation beds on average open in 2017/18.

The staff on our wards are engaged and utilise the Long stay team to escalate delays, ask for support and share good news stories.

Environmental matters

The UK Government has committed to take action with the Climate Change Act and setting a target to cut carbon emissions by at least 80% by 2050, with a minimum reduction of 26% by 2020 across the UK. The NHS supports this strategy and Kettering General Hospital is committed to the sustainability agenda by way of its Carbon Management Plan.

The Trust recognises 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 continued to implement the elements identified within its Carbon Management Plan to 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.

In the period 2018/19 the Trust has implemented:

- Energy efficient lighting systems using LED technology into refurbishment projects
- Upgraded thermal lagging on steam pipes and high temperature hot water systems
- Optimised water infrastructure by systematically addressing leaking pipework
- Commissioned new ventilation plant with heat recovery systems
- Commenced a programme of updating the building management system for improved thermal comfort controls
- Commenced a programme to improve waste segregation and waste re-cycling rates

Going forward, the Trusts “forward look” estate strategy will be cognisant of the requirement to consider the wider sustainability agenda to reduce its carbon foot print by: -

- Seeking to achieve Building Research Establishment Environmental Assessment Method (BREEAM) excellent rating for planned new builds
- Use of latest technology for improved energy efficiency across the retained estate where programmes of refurbishment are undertaken
- Working with stakeholder partners across Northamptonshire to promote sustainable transport solutions
- Progressing the business case for the new energy centre to replace inefficient temporary heating plant and deploy combined heat and power technology

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.

The NHS Counter Fraud Authority, formerly 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 Counter Fraud Authority guidance.

We do not do business with any external parties that do 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.

Compliance with the Modern Slavery Act 2015

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 on these arrangements as its assurance for supplies obtained through the NHS supply chain.

For supplies obtained outside 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.

SIMON WELDON
CHIEF EXECUTIVE

22 MAY 2019

3 Accountability report

3.1 Directors' report

3.1.1 The Board of Directors

Name		Title	Attendance
Alan Burns		Chairman	9/10
Simon Weldon		Chief Executive Officer	10/10
Richard Apps	(from Sep 2018)	Director of Integrated Governance	3/4
Nicola Briggs		Director of Finance	10/10
Rebecca Brown	(until Jun 2018)	Chief Operating Officer	4/5
Andrew Chilton		Medical Director	7/10
Jenna Davies	(until Jun 2018)	Interim Director of Integrated Governance	5/5
Eileen Doyle	(from Jun 2018)	Interim Chief Operating Officer (until Oct 2018) Interim Deputy Chief Executive (from Nov 2018)	4/5
Joanne Fawcus	(from Oct 2018)	Chief Operating Officer	2/3
Leanne Hackshall		Director of Nursing & Quality	10/10
Mark Smith		Director of Human Resources & Organisational Development	9/10
Janet Gray		Non-Executive Director	10/10
Lizzie Hanna	(until Nov 2018)	Non-Executive Director	5/8
Phil Harris-Bridge		Non-Executive Director Vice Chairman/Senior Independent Director	9/10
Lise Llewellyn	(from July 2018)	Non-Executive Director	4/5
Trevor Shipman		Non-Executive Director	8/10
Damien Venkatasamy	(from July 2018)	Non-Executive Director	5/5
Christopher Welsh		Non-Executive Director	8/10

Attendance = actual/possible attendance at Trust Board

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 Board of Directors remains accountable for all of its functions, even those delegated to individual committees, sub-committees, directors or officers and would therefore expect to receive information about the exercise of delegated functions to enable it is maintain a monitoring role. The Board reserves to itself the powers of: Regulation and Control, Appointment or Dismissal of Committees, Strategy and Business Plans, Budgets, Audit Arrangements and Monitoring. 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 and the Council of Governors are provided with high-quality information appropriate to their respective functions and relevant to the decisions they have to make.

The Board meets regularly for the formal transaction of business, with a session open to public observation and if required 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. From September 2018, following a review of the governance arrangements, the Board met in public on a bi-monthly basis with Board development sessions in each intervening month.

The Board meeting in public receives an integrated performance report which includes information on Quality, Finance, Performance and Workforce. In addition, the Board receives a summary of the key issues, and escalations from each of the Board Committees. The Board also reviews the Board Assurance Framework and the corporate risk registers.

Directors, especially Non-Executive Directors, are able to ensure that they have sufficient information and understanding to enable challenge and to take decisions on an informed basis and shall have access to independent professional advice, at the Trust's expense, where this is judged necessary for the discharge of their responsibilities as Directors.

Directors who have concerns that cannot be resolved about the running of the Trust or any proposed action can ensure that their concerns are recorded in the board minutes.

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 Scheme of Delegation 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 appropriate.

The Council of Governors is responsible generally for representing the public interest, views of the public and Membership and holding the Board to account for its decisions through the Non-Executive Directors. Local forums such as Healthwatch are stakeholder members of the Council of Governors and also attend Public sessions of the Trust Board. The Trust is an active partner in the local community and with other health and social care organisations. The Trust has continued to keep local groups and organisations informed of its plans and continue to provide opportunities for these groups to be involved in the Trust's work and developments.

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 Council of Governors 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 receive the papers for the public sessions of the Board, to support them holding the Board to account.

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. The Trust carries out annual checks against national registers and Board members and their deputies are required to confirm annually that they meet these requirements.

Board of Directors Meetings

There were 10 Board meetings held during 2018/19. This includes 8 scheduled and 2 additional meetings. The additional meetings were held to consider and give final approval to the annual report and the annual plan.

Director’s attendance at Board meetings is included in the table at 2.1.1 above.

Independent Non-Executive Directors

The independence of the Non-Executive Directors is reviewed annually, 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 Chairman holds regular meetings with non-executive directors independently of the Executive Directors.

The Chairman’s other major commitments are as Chair of Northampton General Hospital he was appointed to this position in December 2018 and prior to this had been Chairman of the Princess Alexandra hospital in Harlow. The Trust Board and Council of Governors were informed of the appointment prior to him taking up the position.

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.

Performance Evaluation

The Board recognises that having effective performance reviews 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 focuses on their contribution to the Board and effective governance; with the Chair's performance evaluation and objective setting carried out in a process led by the Senior Independent Director. The results of the performance evaluations are used as the basis for determining individual and collective professional development programmes for non-executive directors relevant to their duties as board members. 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.

A Well led Self-assessment was undertaken in 2018.

Committees of the Board

In addition to the Nominations & Remuneration Committee there are 6 Board Committees. Each of the Committees has delegated authority provided with sufficient resources to enable them to undertake their duties:

Audit Committee

The Audit Committee, comprised of 3 non-executive directors one of whom chairs the Committee, is responsible to the Board of Directors for providing 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 reviews annually the effectiveness of the Trusts 'Freedom to Speak Up' processes. The Audit Committee receives instructions from the Board of Directors on areas where additional assurance is required and formally reports to the Board.

Audit Committee membership 2018/19		
Name	Title	Attendance
Janet Gray	Non-Executive Director	2/2
Lizzie Hanna (until Nov 2018)	Non-Executive Director	3/3
Phil Harris-Bridge	Non-Executive Director	2/2
Lise Llewellyn (from Nov 2018)	Non-Executive Director	1/1
Trevor Shipman (Chairman)	Non-Executive Director	3/4

Significant issues

The Audit Committee met on 23 April 2019 to consider the financial statements for the period 2018/19. The Audit Committee reviewed the financial statements and identified no significant issues.

External Auditors

The Council of Governors approved the appointment of Grant Thornton as external auditors from April 2017 for a period of 3 years with a possibility of extension for a further 2 years.. 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 are

provided in the accounts. The 2018/19 charge shown in the accounts includes VAT and an additional charge relating to 2017/18 for the statutory audit.

The external audit process is subject to annual review by the Trust in terms of competency efficiency and the relationship between the Trust and its auditors. The Audit Committee meets regularly with the external auditor without any Trust Executive Directors, to improve its knowledge of their contribution.

Non-audit work may be performed by the external auditors where the work is clearly audit-related and the external auditors are best placed to do that work. For such assignments the Audit Committee approved protocol is followed which ensures all such work is properly considered. The processes in place ensure auditor objectivity and independence is safeguarded.

Internal Auditors

During the year ended 31 March 2019, the Trust's internal audit and counter fraud function was carried out by TIAA Ltd, an independent business assurance provider delivering services to the public and private sectors.

Quality & Safety Committee

The committee is responsible for overseeing the delivery of the Quality Strategy through:

- Ensuring the objectives underpinning the six Quality Pledges are delivered.
- Ensuring the organisation is striving to provide high quality care to individuals, communities and the population it serves.
- Overseeing the delivery of the Quality Improvement Plan and embedding a culture of continuous improvement.

The Committee receives instructions from the Board of Directors on areas where additional assurance is required and formally reports to the Board.

Performance, Finance & Resources Committee

The Committee is responsible for overseeing and providing assurance that:

- The Trust's transformation agenda is being successfully delivered.
- Investments and capital expenditure are supporting delivery of the overall strategy.
- Operational and financial performance is: in line with agreed plans; driving service improvements; and achieving the financial objectives of the Trust.
- The Estates operational and financial performance is in line with agreed plans

The Committee receives instructions from the Board of Directors on areas where additional assurance is required and formally reports to the Board.

Organisational Development Committee

The committee is responsible for delivering and providing assurance on all aspects of Organisational Development through:

- Delivery of the organisational development strategy through its eight objectives
- Ensuring the organisation is compliant with statutory requirements
- Embedding the CARE values across the organisation

The Committee receives instructions from and escalates items to the Board, seeking their direction and decision making as required.

Charitable Funds Committee

The Committee ensures that spending of charitable funds within its portfolio of responsibility are utilised in accordance with its terms of delegated authority as approved by the Board of Directors.

The KGH Charity Fund has been set up to help improve the lives of patients, their families, visitors and staff at the Kettering General Hospital. By raising funds we aim to enhance and improve patient care and facilities and go the extra mile for local health care.

Digital Hospital Board

The Digital Hospital Board oversees strategic aspects of the Trust's digital, technology and information agenda which includes:

- Executing our Vision for 2020 to deliver digital services that; empower patients, putting them at the centre of their care, enable our passionate staff to provide the best possible services and achieve world class health outcomes, utilise data and information in a collaborative way across the trust and with strategic partners.
- Ensuring that the projects underpinning the five key workstreams in the Digital Roadmap are clinically led and delivered successfully.

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.

Our council of governors are invited to observe both the Board of Director meetings and all Board Committee meetings to improve their understanding of Trust matters and see our Non-Executive Directors in action.

We developed a training programme in response to the needs of our governors and now provide a rolling series of training sessions throughout the year. During 2018 we held a full day of NHS Providers bespoke event on Core Skills for our Council, jointly with Northamptonshire Healthcare Foundation Trust's Council, enabling the opportunity to share thoughts and ideas. We will be hosting a further joint training session in 2019. We have offered our Council of Governors training in finance, strategy, quality, risk, and audit provided by our Executive teams, our auditors and professionals within the Trust. We will continue to respond to the needs and requirements of our governors on an ongoing basis.

The role and responsibilities of the Council of Governors is set out in the Council of Governors Code of Conduct this is included in the Council of Governors Handbook. Each Governor has a copy which is reviewed and updated annually. The Code of Conduct includes the process for removing any member of the Council by reason of attendance at meetings, having a conflict of interest or misconduct in carrying out their duties.

During the last year the Trust has held a number of high profile engagement events which have permitted interaction between our governors and members of the Trust and the wider community. We have also held a series of successful health events across our county with clinicians and nursing teams in attendance to deliver a programme of health lectures to the membership and the public. The programme of events has included cardiology, dermatology, orthopaedics, ophthalmology, a high profile 120 years of KGH event and a fantastic NHS70 celebration. All were well attended by both the public and our governors, with ample opportunity for engagement with refreshments following the events.

Our governors are invited to attend quality assurance site visits on a regular basis, are involved in Trust audits and attend opening events at the Trust providing an opportunity to meet both staff and public. Further opportunities for our governors to engage with members of the public have been made available through Trust talks and presentations given to public forums across the county, including the Kettering Pensioners Parliament and at regular Coffee and Cake events across the constituencies which will continue into 2019/20.

During 2019/20 our Council of Governors will continue to drive engagement across the constituencies and ensure the public interest is represented and the patient voice is heard through our membership and the wider public.

All governors complete an annual declaration of interests a register of which is available on the public website.

Council of Governors

The Council of Governors comprises of 25 members from three specific groups:

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

There were 5 resignations from the Council during 2018/19.

Membership of the Council of Governors 1 April 2018 – 31 March 2019

PUBLIC ELECTED GOVERNORS				
Name	Constituency	Elected	End of Term	Attended
Peter Woolliscroft	Kettering	2 Dec 2017	1 Dec 2020	4/4
Gail Chapman	Kettering	18 Oct 2016	17 Oct 2019	4/4
Mohamed Latif	Kettering	2 Dec 2017	1 Dec 2020	3/4
David Everitt	Corby	2d Dec 2017	1 Dec 2020	2/4
Ray Lilley	Corby	18 Oct 2016	17 Oct 2019	3/4
Anne Royal (resigned)	Corby	2 Dec 2017	11 Dec 2018	1/3
Stuart Lake (resigned)	Wellingborough	2 Dec 2017	12 Oct 2018	2/2
Pat Jackson	Wellingborough	2 Dec 2017	1 Dec 2020	2/4
Graham Lawman	Wellingborough	18 Oct 2016	17 Oct 2019	3/4
Annette Bridgeford	Wellingborough	21 Jan 2019	20 Dec 2020	1/1
Mabel Blades	East Northants	2 Dec 2014	1 Dec 2020	4/4
Reginald Talbot	East Northants	2 Dec 2017	1 Dec 2020	4/4
Eileen Jones	East Northants	18 Oct 2016	17 Oct 2019	3/4

STAFF ELECTED GOVERNORS				
Name	Constituency	Elected	End of term	Attended
Melanie Moore (resigned)	Staff	18 Oct 2016	11 Feb 2019	0/4
Michelle Creighton	Staff	18 Oct 2016	17 Oct 2019	2/4
Andy Frost (resigned)	Staff	2 Dec 2017	14 Jan 2019	1/4
Jennifer McCaffery	Staff	26 April 2018	2 December 2020	2/4
STAKEHOLDER APPOINTED GOVERNORS				
Name	Organisation		End of appointment	Attended
Tansi Harper (resigned)	Corby CCG	February 2014	28 Feb 2019	0/4
Vijay Sharma	University of Leicester	March 2014	March 2020	4/4
Wendy Brackenbury	Local Authority	March 2014	March 2020	1/4
Sonia Bray	Voluntary/ Charitable Sector	April 2015	April 2021	2/4
Sue Watts	Voluntary/ Charitable Sector	March 2015	March 2021	2/4
Dr Andrew Stephen	Voluntary/ Charitable Sector	April 2016	March 2021	3/4
Sheila White	Healthwatch	December 2017	August 2024	2/4
Wendy Patel	Healthwatch	December 2017	August 2024	3/4

Nominated Lead Governor

The Council of Governors elect one of their members to be the Lead Governor. The Lead Governor is a point of contact between NHS Improvement and the other governors, and acts a main point of contact for the Chairman. The Lead Governor until October 2018 was Mr Stuart Lake, Public Governor for Wellingborough, on his retirement the governors elected Professor Peter Woolliscroft Governor for Kettering as lead. Dr Mabel Blades representing East Northamptonshire was Deputy Lead Governor during 2018/19.

Governor Group Meetings

Appointments and Remuneration Committee

The Appointments and Remuneration Committee, is responsible for advising annually on the remuneration of the Chairman and Non-Executive Directors (NEDs); advising on the appointment of 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 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.

During 2018-2019 Governors of the Appointment and Remuneration Group were involved in the appraisals of the Chairman and Non-Executive Directors. The Appointments and Remuneration Group were involved in the recruitment, by open advertisement, of 2 new NEDs during 2018 and 2 during 2019.

The Appointments and Remuneration group met on 4 occasions during 2018/19.

Governor Overview Group

The overview group 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 overview meeting allows Governors to meet regularly with NEDs and assess their performance in each of the key areas of Trust management. The group also focuses on membership and communication.

The Governor Overview Group met on 5 occasions during 2018/19

The Council of Governors: Relationship with the Board of Directors

During 2018/19 there were four Council of Governor meetings which all Non-Executive Directors attended. The Chief Executive and Executive Directors attend Council 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 also take away any key concerns that governors may have and raise these at board committees on behalf of the council.

The Council of Governors take the lead in agreeing with the audit committee the criteria for appointing, re-appointing and removing external auditors.

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. Twice a year the Council of Governors and the Trust Board meet in joint session. 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 newsletters, media releases and any other important information is circulated directly to governors. To ensure our governors are well informed the agenda and reports of all Board of Director meetings are circulated to the full council for information. All governors are invited to attend and observe Board of Directors meetings.

The nominated governors to the Board 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 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.

Should a dispute arise between the Council and the Board of Directors then the disputes resolution procedure set out in Annex 7 of the Trust Constitution will be used. A copy of the Trust's Constitution can be found on the Trust's website www.kgh.nhs.uk.

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 relevant training or 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.

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 NEDs 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 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 31 March 2019 the Trust had 4698 public members, with constituencies as described below:

Constituency	Number of Members 31 March 2019
Kettering	1570
Corby	724
Wellingborough	939
East Northamptonshire	1124
Rest of UK	341

Membership is overseen by the Governors Overview Group which receives regular reports. The Board of Directors further receives an annual 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. 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 2018/19 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. Dr Mabel Blades is the governor membership lead and continues to work to increase public engagement and gain the views of the community the hospital serves.

Trust members receive a copy of the KGH Together magazine three times a year, the aim of which is keeping our members informed with news and updates about the hospital and this will continue going forward. Email newsletters are sent out approximately every month to those members on email.

During 2018/19 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 19 July 2018 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

Director's Biographies

Board of Directors: Non-Executive Directors

- **Alan Burns, Chairman**

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 Northampton General Hospital and previously of the Princess Alexandra Hospital in Harlow. Before that, he 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.

Alan chairs the Trust Board, the Nomination & Remuneration Committee and the Council of Governors.

- **Phil Harris-Bridge, Non-Executive Director**

Phil Harris-Bridge, 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 and Senior Independent Director from December 2017.

Phil is also a member of the Nominations & Remuneration Committee, Performance, Charitable Funds Committee, Finance & Resources Committee (Chair) and sits on the Digital Hospital Board.

- **Janet Gray, Non-Executive Director**

Janet was appointed in October 2014 and re-appointed for a further 3-year term in October 2017 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.

Janet is also a member of the Nominations & Remuneration Committee, Organisational Development Committee (Chair), Charitable Funds Committee (Chair) and the Performance, Finance & Resources Committee.

- **Lizzie Hanna, Non-Executive Director**

Lizzie 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 was a member of Nominations & Remuneration Committee, the Performance Finance & Resources Committee and the Audit Committee; she resigned as a Non-Executive Director in November 2018.

- **Trevor Shipman, Non- Executive Director**

Trevor was appointed in February 2017. Trevor has extensive experience in the NHS and was Finance Director of Central and North West 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 is also a member of the Nominations & Remuneration Committee, Audit Committee (Chair), Charitable Funds Committee and the Organisational Development Committee.

- **Christopher Welsh, Non-Executive Director**

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

Chris is also a member of the Nominations and Remuneration Committee and Quality and Safety Committee (Chair).

- **Lise Llewellyn, Non-Executive Director**

Lise was appointed in June 2018. Lise joined the trust in August 2018, and has worked in both the NHS local government and the charitable sector, with operational and commissioning experience. Her roles have included PCT chief executive, director of public health and trustee of British Red Cross .

Lise is also a member of the Nominations and Remuneration Committee, Quality and Safety Committee and Audit Committee.

- **Damien Venkatasamy, Non-Executive Director**

Damien was appointed in June 2018. Damien has 23 years' experience in the IT service industry. He has lots of experience in delivering services to public sector organisations and wants to use this opportunity to work in the public sector and share his experience of delivering complex and challenging change projects.

Damien is also a member of the Nominations and Remuneration Committee and Performance Finance & Resources Committee.

All Non-Executive Directors are appointed initially for a 3 year term. On review by the Appointment & Remuneration Group of the Council of Governors, 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.

The process for terminating the appointment of the Non-Executive Directors is set out in Annex 6 to the Trust Constitution which can be viewed on the Trusts public website.

Executive Directors

- **Simon Weldon, Chief Executive**

Simon Weldon 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.

- **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.

- **Richard Apps, Director of Integrated Governance**

Richard joined the Trust in July 2018. He has lead responsibility for ensuring effective systems for managing risk and integrating governance across the Trusts 4 divisions. He has a strong academic interest in patient safety and quality improvement having worked at the Universities of Loughborough and Leicester. Most recently Richard worked at NHS Improvement focussing on quality and performance improvement across a range of NHS Trusts.

- **Joanna Fawcus Chief Operating Officer**

Jo joined the Trust in October 2018. Jo started her NHS career as an Information Analyst and then moved into operational management. Jo has worked in many acute providers across the East Midlands and other areas with her most recent role being Deputy Chief Operating Officer at James Paget Hospital in Norfolk. Jo has also completed the Nye Bevan Executive leadership course and is passionate about leadership and engagement to deliver change and sustainable improvement.

- **Eileen Doyle Deputy Chief Executive**

Eileen joined the Trust in June 2018 as Interim Chief Operating Officer from the acute sector where she has over 20 years of operational experience. Eileen was appointed Deputy Chief Executive in November 2018. Her focus is always to support organisations to improve and achieve their quality and performance standards often working in organisations which have undergone significant change or with specific challenges.

3.1.2 Other significant interests held by directors or governors

Information on the interests of the Directors, decision-making staff, and those in other groups identified in the national policy, is published online as required by the '*Managing Conflicts of Interest in the NHS*' guidance. This information is available at all times, proactively published and updated in real-time. The register of interests can be accessed on the Trusts public website

3.1.3 Political donations

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

3.1.4 Better payment practice

The Trust applies standard payment policy terms of 30 days to suppliers of the Trust. However there have been some cash restraints during 2018/19 which has meant that suppliers have , on occasion been paid at up to a week over 30 days. In addition some NHS suppliers and NHS Supply chain were put on longer payment terms. These actions were taken to minimise the impact on the Trusts non Non NHS suppliers but have had a detrimental impact on the Trust's performance against the 95% target for payment of trade invoices.

Detail of the Trust's performance in 2018/19 is shown below with 2017/18 as a comparator.

	2018/19 Number	2018/19 £'000	2017/18 Number	2017/18 £'000
Total Non-NHS invoices paid in the year	69,478	96,040	61,008	87,690
Total Non-NHS invoices paid within target	38,928	51,366	54,996	77,933
Percentage of non NHS trade invoices paid within target	**56%**	**53%**	**90%**	**89%**
Total NHS invoices paid in the year	2,172	9,731	2,041	8,560
Total NHS invoices paid within target	1,053	4,941	1,646	6,589
Percentage of NHS trade invoices paid within target	**48%**	**51%**	**81%**	**77%**

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

Cost allocation and charging

Throughout the year ended 31st March 2019, 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.

3.1.5 NHS Improvement's well-led framework

The Trust was inspected during January - March 2019. This involved an inspection of five core services (Diagnostics, Maternity, Medical Care, Outpatients and Urgent and Emergency Services) and a Well-Led review in March 2019, which looks at how well leaders create an environment that encourages and fosters improvement. The report of the inspection was published in May 2019.

Throughout 2018 the Trust undertook significant work in strengthening and tracking evidence of its Quality Improvement Plan implementation. This included Executive sponsorship and a bi-weekly reporting cycle.

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 regular 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 also continues to be supported by NHS Improvement (NHSI) via the appointment of an Improvement Director.

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

This past year has seen us concentrate upon quality improvement across all that we do. This started with a review of the Trusts strategic objectives to ensure alignment with our overarching vision of "to provide safe high quality care to our communities". After a period of intense staff and patient engagement we agreed a number of short to medium term strategic objectives that directly contribute to improving the quality of care across our Trust. This was further supported by the publication of the Quality Strategy which sets out our Quality Improvement ambitions

The way we report on our quality improvement and outcomes is set out in this years 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 Trust's strategic objectives described in the performance report. This seeks to improve the care that patients receive across Northamptonshire. We are an active member of the Northamptonshire Health and Care Partnership (NHCP), formerly known as the Northamptonshire STP, which consists of key health and care providers in the county. NHCP is not a new organisation but a new way of working in partnership to improve health and care for people living in Northamptonshire. All Partnership organisations remain as separate organisations with their own local responsibilities for the services they provide, but are committed to working together towards the shared NHCP vision for a positive lifetime of health, wellbeing and care in our community. You can find further information about NHCP at www.northamptonshirehcp.co.uk

The Trust also actively engages with the Northamptonshire Health & Well-being Board.

3.1.6 Fees and charges (income generation)

Information on fees and charges, and relevant declarations, are included in the annual accounts, however the Trust receives no net income over £1, from Income Generation Schemes.

For 2018/19 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.

3.1.7 Statement as to disclosure to auditors (s418)

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.

3.1.8 Statement of directors' responsibilities in respect of the accounts

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

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

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

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

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

By order of the Board

..22 May 2019.....Date.....  .....Chief Executive

..22 May 2019…....Date.....  .....Finance Director

3.2 Remuneration report

3.2.1 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 Operating Officer
- Arrangements for the appointment of a new Chief Digital Information Officer
- Arrangements for the appointment of an Interim Deputy Chief Executive
- Approving annual pay increases for Executive Directors

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 £185,000 in remuneration. The CEO's salary was confirmed at the time of appointment following Ministerial approval, no other appointment during 2018/19 required such approval as the salary levels fell below the £149,999 threshold. 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 of the Chair of the Remuneration Committee

As Chair of the Remuneration Committee, Alan Burns, has declared that the major decisions listed above are a true and fair reflection of the matters discussed at the committee during the year 2018/19.

3.2.2 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 Chief Executive and approved 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.

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 Non-Executive Directors a reasonable fee for the services provided in office, having regard to the time commitment, responsibilities of their roles, the overall position of fees in the NHS and 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.

Detail 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, 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. Starting in the 2018-2019 year a 3 year pay deal was negotiated, these arrangements gave staff (in general) a 3% increase in salary levels in the first year.

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.

3.2.3 Annual report on remuneration

Service Contract Obligations

The Executive Directors may have provisions in their service contracts which could give rise to, or impact on, remuneration payments or payments for loss of office not disclosed elsewhere in the remuneration report. The Executive Directors do 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.

Non-Executive Director and Governor expenses

2018/19

	Non Exec Directors	Exec Directors	Governors
Total Number	9	10	25
Total number receiving expenses	4	8	8
Total expenses paid (£)	6,065	5,313	1,290

2017/18

	Non Exec Directors	Exec Directors	Governors
Total Number	8	9	25
Total number receiving expenses	5	9	9
Total expenses paid (£)	5,410	19,557	1,963

Remuneration committee

The Nomination & Remuneration Committee is a Committee of the Board which oversees the process for identification and nomination of senior posts including the Chief Executive. The Committee is chaired by the Trust Chairman. The Committee will annually review the structure, size and composition of the board and make recommendations for changes where appropriate. The remuneration committee has delegated responsibility for setting remuneration for all executive directors, including pension rights and any compensation payments. The Committee will not agree to any full time Executive Director taking on more than one non-executive directorship of an NHS Trust or another organisation of comparable size and complexity.

The Nomination & Remuneration Committee met on three occasions during 2018/19, attendances at each are detailed below:

Members	06/04/18	31/10/18	01/02/19
Alan Burns (Chair)	Yes	Yes	Yes
Janet Gray	Yes	Yes	Yes
Phil Harris-Bridge	Yes	Yes	Yes
Lizzie Hanna (until Nov 18)	Yes	Yes	n/a
Lise Llewellyn (from July 2018)	n/a	Yes	Yes
Trevor Shipman	Yes	Yes	Yes
Damien Venkatasamy (from July 2018)	n/a	Yes	Yes
Christopher Welsh	Yes	Yes	Yes
Non-Members (non-voting, attending for provision of support and advice only)			
Simon Weldon Chief Executive	Yes	Yes	Yes
Mark Smith Director of Human Resources and OD	Yes	Yes	Yes

Disclosures required by Health and Social Care Act and subject to Audit

SALARY AND PENSION ENTITLEMENTS OF SENIOR MANAGERS

REMUNERATION REPORT

Directors							
Financial Year 2018/19				**Salary (bands of £5000)**	**Benefits in kind (travel /lease benefit) (Rounded to the nearest £100)**	**Pension related benefits (Rounded to the nearest £2,500)***	**TOTAL REMUNERATION (Bands of £5,000)**
Name	**Title**	**Start date**	**End date**	**£000**	**£**	**£000**	**£000**
Mr S Weldon	Chief Executive	2 Apr 2018		180-185	100	97.5-100	275-280
Ms J Fawcus	Chief Operating Officer	15 Oct 2018		55-60	0	110-112.5	165-170
Mrs R Brown	Chief Operating Officer	1 Feb 2016	24 June 2018	25-30	200	-	25-30
Miss N Briggs	Director of Finance	1 Dec 2016		125-130	100	30-32.5	155-160
Prof A Chilton**	Medical Director	2 Jun 2010		205-210	200	-	205-210
Ms L Hackshall	Director of Nursing & Quality	1 Oct 2014		110-115	100	-	110-115
Mr M Smith	Director of HR & Org Dev	2 Jun 2014		110-115	-	27.5-30	140-145
Mr R Apps	Director of Governance	18 Jul 2018		55-60	-	55-57.5	110-115
Ms J Davies	Interim Director of Integrated Governance	5 Feb 2018	3 Jun 2018	10-15	-	-	10-15
Mrs E Doyle	Deputy Chief Executive	4 June 2018		145-150	-	47.5-50	195-200

* 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 Prof Chilton includes £105-£110k in respect of clinical duties.

Signed: Mr Simon Weldon– Chief Executive  Date: 22 May 2019

Chairman and Non-Executive Directors						
Financial Year 2018/19				**Salary (bands of £5000)**	**Benefits in kind (travel /lease benefit) (Rounded to the nearest £100)**	**TOTAL REMUNERATION (Bands of £5,000)**
Name	**Title**	**Start date**	**End date**	**£000**	**£**	**£000**
Mr A Burns	Chairman	2 Sep 2017		45-50	100	**45-50**
Mr D Venkatasamy	Non-Executive Director	2 Jul 2018		5-10	0	**5-10**
Mr T Shipman	Non-Executive Director	18 Apr 2017		10-15	0	**10-15**
Mr P Harris-Bridge	Non-Executive Director	1 Sep 2013		10-15	0	**10-15**
Mrs E Hanna	Non-Executive Director	7 Sep 2015	30 Nov 2018	5-10	0	**5-10**
Dr L Llewellyn	Non-Executive Director	1 Jun 2018		5-10	0	**5-10**
Mrs J Gray	Non-Executive Director	27 Oct 2014		10-15	0	**10-15**
Mr C Welsh	Non-Executive Director	1 Feb 2018		10-15	0	**10-15**

Directors							
Financial Year 2017/18				**Salary (bands of £5000)**	**Benefits in kind (travel /lease benefit) (Rounded to the nearest £100)**	**Pension related benefits (Rounded to the nearest £2,500)***	**TOTAL REMUNERATION (Bands of £5,000)**
Name	**Title**	**Start date**	**End date**	**£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
Prof 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 salary for Prof Chilton includes £105-£110k in respect of clinical duties.

Chairman and Non-Executive Directors						
Financial Year 2017/18				**Salary (bands of £5000)**	**Benefits in kind (travel /lease benefit) (Rounded to the nearest £100)**	**TOTAL REMUNERATION (Bands of £5,000)**
Name	**Title**	**Start date**	**End date**	**£000**	**£00**	**£000**
Mr G Foster	Chairman	1st Sep 2013	1st Sep 2017	15-20	0	**15-20**
Mr A Burns	Chairman	2nd Sep 2017		25-30	0	**25-30**
Mr J Hawksfield	Non-Executive Director	13th Dec 2012	30th Jun 2017	0-5	0	**0-5**
Mr S Ramsden	Non-Executive Director	1st Sep 2013	31st Dec 2017	5-10	0	**5-10**
Mr T Shipman	Non-Executive Director	18th Apr 2017		10-15	0	**10-15**
Mr P Harris-Bridge	Non-Executive Director	1st Sep 2013		10-15	0	**10-15**
Mrs E Hanna	Non-Executive Director	7th Sep 2015		10-15	0	**10-15**
Mr A Ball	Non-Executive Director	18th Apr 2017	31st Mar 2018	10-15	0	**10-15**
Mrs J Gray	Non-Executive Director	27th Oct 2014		10-15	0	**10-15**
Mr C Welsh	Non-Executive Director	1st Feb 2018		0-5	0	**0-5**

PENSION BENEFITS

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 (3%), 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. Therefore the Real increase us not the absolute difference between one year and the next.

PENSION BENEFITS TABLE

2018/19 Name	Title	Real increase in pension at age 60 (bands of £2500) £000	Real increase in lump sum at age 60 (bands of £2500 £000	Total accrued pension at age 60 at 31ST March 2019 (bands of £5000) £000	Lump sum at age 60 related to accrued pension at 31st March 2019 (bands of £5000) £000	Cash Equivalent Transfer Value (CETV) at 31st March 2019 £000	Cash Equivalent Transfer Value (CETV) at 31st March 2018 £000	Real Increase in Cash Equivalent Transfer Value * £000
Mr S Weldon	Chief Executive	5-7.5	5-7.5	45-50	105-110	892	706	164
Miss N Briggs	Director of Finance	0-2.5	-	15-20	-	166	116	46
Ms J Fawcus	Chief Operating Officer	0-2.5	2.5-5	25-30	55-60	434	295	60
Mr M Smith	Director of HR & Org Dev.	0-2.5	-	5-10	-	88	55	31
Ms L Hackshall	Director of Nursing & Quality	0-2.5	0-2.5	45-50	140-145	986	854	106
Mr R Apps	Director of Governance	0-2.5	2.5-5	15-20	30-35	220	152	45
Mrs E Doyle	Deputy Chief Executive	2.5-5	0-2.5	10-15	20-25	184	122	48

CPI is 3% in 2018/19.
Please note the CETV figures as at 31st March 2018 have been amended in the table above as a CETV factor error for the 2015 Pension Scheme was identified nationally.

2017/18 Name	Title	Real increase in pension at age 60 (bands of £2500) £000	Real increase in lump sum at age 60 (bands of £2500 £000	Total accrued pension at age 60 at 31ST March 2018 (bands of £5000) £000	Lump sum at age 60 related to accrued pension at 31st March 2018 (bands of £5000) £000	Cash Equivalent Transfer Value (CETV) at 31st March 2018 £000	Cash Equivalent Transfer Value (CETV) at 31st March 2017 £000	Real Increase in Cash Equivalent Transfer Value * £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 Hackshall	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

CPI is 1% in 2017/18

3.2.4 Fair pay multiple

HUTTON REPORT

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:

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

The banded remuneration of the highest paid director in Kettering General Hospital NHS Foundation Trust in the financial year 2018/19 was £205,000-£210,000 (This is the annualised full time equivalent of the payments made in 2018/19). This was 8.06 times the median remuneration of the workforce which was £25,693. 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 was 7.95 times the median remuneration of the workforce which was £26,539.

3.2.5 Payments 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.

3.2.6 Payments to past senior managers

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

3.3 Staff report

3.3.1 Analysis of staff costs

Staff costs			**2018/19**	**2017/18**
	Permanent	**Other**	**Total**	**Total**
	£000	**£000**	**£000**	**£000**
Salaries and wages	123,204	18,543	**141,747**	132,471
Social security costs	13,226	-	**13,226**	12,373
Apprenticeship levy	683	-	**683**	637
Employer's contributions to NHS pensions	15,430	-	**15,430**	14,606
Pension cost - other	13	-	**13**	4
Termination benefits	127	-	**127**	-

Temporary staff	-	14,759	**14,759**	13,388
Total staff costs	**152,683**	**33,302**	**185,985**	**173,479**
Of which				
Costs capitalised as part of assets	511	170	**681**	532

3.3.2 Analysis of average staff numbers

Average number of employees (WTE basis)

			2018/19	2017/18
	Permanent Number	Other Number	Total Number	Total Number
Medical and dental	419	77	**496**	478
Administration and estates	720	56	**776**	732
Healthcare assistants and other support staff	864	138	**1,002**	983
Nursing, midwifery and health visiting staff	1,033	220	**1,253**	1,244
Scientific, therapeutic and technical staff	235	20	**255**	243
Healthcare science staff	187	-	**187**	185
Other	95	1	**96**	89
Total average numbers	**3,553**	**512**	**4,065**	**3,954**
Of which:				
Number of employees (WTE) engaged on capital projects	8	2	**10**	7

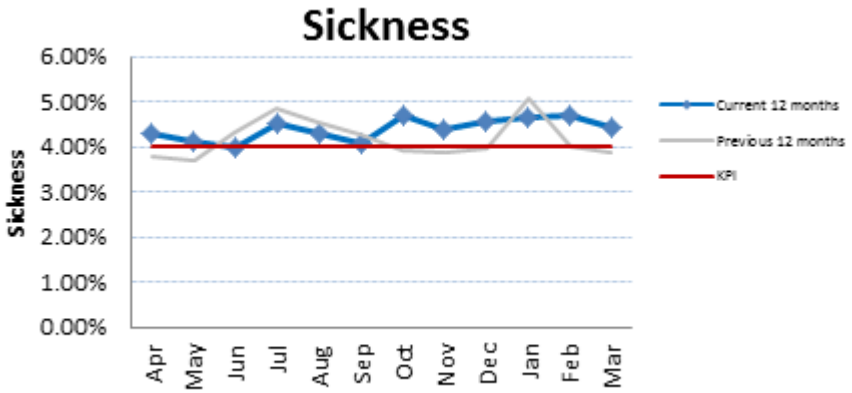
3.3.3 Gender analysis

Staff Type	Female	Male
Exec Directors	3	4
Senior Manager	34	12
All Other Employees	3308	845

3.3.4 Sickness absence data

The Trust has a key performance indicator of sickness absence being 4% or below, absence data is reported on a monthly basis at a divisional and Board basis. The table and chart below show performance over 2018/9

Sickness	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Current 12 months	4.29 %	4.13 %	3.97 %	4.54 %	4.31 %	4.09 %	4.69 %	4.40 %	4.55 %	4.66 %	4.70 %	4.42 %
Previous 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 %



3.3.5 Staff policies and actions applied during the financial year

The Trust takes its diversity and inclusion seriously and aims to provide fair and equitable treatment 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 Equality Act (2010). The latter act consolidates existing equality legislation relating to the protected characteristics of age, disability, gender reassignment, marriage & civil partnerships, pregnancy & maternity, race, religion or belief, sex and sexual orientation. The Trust also works hard to ensure that it carries out its functions in a way that is designed to reduce the inequalities of outcome that can result from socio-economic disadvantage.

The Trust has been successful in becoming a Disability Confident Employer with Committed status. The Disability Confident scheme supports employers to make the most of the talents disabled people can bring to the workplace. The scheme aims to help successfully recruit and retain disabled people and those with health conditions. It was developed by employers and disabled people's representatives to make it rigorous but easily accessible – particularly for smaller businesses. The Trust was awarded the 'Committed' status because we could demonstrate that:

- Our recruitment process is inclusive and accessible
- We communicate and promote vacancies
- We offer an interview to disabled people
- We anticipate and provide reasonable adjustments as required
- We support existing employee who acquires a disability or long term health condition enabling them to stay in work

Mindful Employer Status

The Trust is proud to have the Mindful Employer Status. The Trust has earned this status by increasing awareness about mental health, providing support networks and information and making it healthier to talk about mental health. The Trust is also pro-actively 'mindful' about recruiting people with mental illness. In addition, it has demonstrated that it is willing to enable disclosure of mental ill health to take place without fear of

rejection or prejudice.

We also work with Remploy and Access to Work to provide advice and practical for reasonable adjustments for staff with disabilities mental or physical. In reviewing the Trust Car Park policy, the Trust ensured it provides clearly defined parking areas for staff, visitor and patients disabled badge holders in accordance with the Equality Act 2010.

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.

The Trust also has a number of staff support groups such as (Dis)Ability and LBGT whose role is to improve and support staffs working lives at KGH.

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. The Chief Executive holds regular ‘drop in’ sessions for staff where they can raise any issue with him . Issues raised and their responses are made available to all via the Trust intranet site. The Trust also has a Freedom to Speak Up Guardian, who is available for staff to raise concerns anonymously if they wish about working at the hospital. The Guardian is independent, their role is to ensure these concerns are looked into, action taken if required and a response provided to the staff member.

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. The Trust has also introduced an Employee Assistance Programme available for all staff which provides counselling, financial and legal advice, 24/7, 365 days as year. Staff also have access to physiotherapy, mindfulness and manual handling advice and support. The Trust have an active health and well-being group who meet regularly and develop an annual plan of activity. This year the group have started Metafit classes, as well as continuing to provide yoga, and introduced Step-Jockey for both patients and staff. A number of celebration days such as the NHS70 have taken place including Random Acts of Kindness. During 2018/19 the Trust achieved a take up of the Flu vaccination of over 75%, this was above the previous year’s 65% .

3.3.6 Staff survey results

The survey provides our staff with the opportunity to indicate how they feel about working for the Trust against a number of broad themes by responding to a series of 104 questions usually by indicating whether they agree (or strongly agree) or disagree (or strongly disagree) with specific statements. The staff survey enables KGH to compare itself with other NHS organisations through indication of the best, worst and average score and with itself from previous years.

This year's survey has shown a significant improvement in the Trust's scores – with almost 10% more staff completing the survey than last year (an indicator in itself of engagement.)

Headlines

- ✓ This year's staff survey has the best ever response rate amongst our staff (45%)
- ✓ Indicators relating to staff engagement and motivation have significantly improved
- ✓ Our quality and safety initiatives are reflected in improved scores across all areas
- ✓ Of the nine themed areas where it is possible to compare against last year six have improved and five of these have shown statistically significant improvement
- ✓ Staff reporting support from their immediate managers and quality of appraisals have improved and the highest rating since 2015
- ➢ The survey identified areas for continued focus;
  - ➢ Ensuring staff do not feel discriminated against
  - ➢ Continuing our work in addressing bullying and harassment and particularly between colleagues
  - ➢ Understanding the drivers and further actions that can be taken to improve health and well being
  - ➢ Working with specific service areas to understand why their perceptions of quality of care differ to those of clinical staff

Key points and improvements shown in the 2018 benchmarked results for KGH

- 45% of KGH staff took part in the 2018 NHS Staff Survey (in line with national average) – a significant improvement on last year when 35.5% of staff responded and an almost 20% improvement on three years ago when in 2015, 26.6% of staff took part.
- In comparing the views of staff reflected in this year's survey with those of last year against 9 of the ten themes (one theme is new and therefore unable to compare):

Theme	2017 score	2017 respondents	2018 score	2018 respondents	Statistically significant change?
Equality, diversity & inclusion	**9.1**	1354	**9.0**	1727	Not significant
Health & wellbeing	**5.8**	1370	**5.8**	1736	Not significant
Immediate managers	**6.3**	1375	**6.8**	1745	↑
Morale		0	**6.1**	1721	N/A
Quality of appraisals	**5.0**	1100	**5.6**	1433	↑
Quality of care	**7.2**	1152	**7.5**	1485	↑
Safe environment - Bullying & harassment	**7.7**	1347	**7.8**	1736	Not significant
Safe environment - Violence	**9.5**	1352	**9.5**	1731	Not significant
Safety culture	**6.3**	1362	**6.6**	1729	↑
Staff engagement	**6.7**	1382	**7.0**	1760	↑

Our Top Three Improvements

1 Staff Engagement and Motivation

In questions relating specifically to staff engagement and staff motivation KGH showed improved scores across all three areas and is now above average when compared with other NHS Trusts – 63.1% said they look forward to going to work (NHS average 59.3%) and 77.2% said they were enthusiastic about their job (NHS average 74.8%). Our staff also responded more positively in relation to their ability to contribute to improvements at work with scores across all three areas increased on last year.

2 Quality and Safety Improvements

Staff also reflect the safety improvements made and embedded across the organisation with some dramatic improvements in scores across all six question areas, for example;

- ✓ My organisation takes action to ensure [errors, near misses or incidents] do not happen again – increased by 8% to 69.7%
- ✓ We are given feedback about changes made…… - increased by 8.7% to 57.7%
- ✓ I am confident my organisation would address my concern – increased by 7.7% to 56.8%

However KGH is still either just below or equal to the average score in these specific question areas when benchmarked indicating further work required to build upon the progress that has been made

3 Recommending KGH

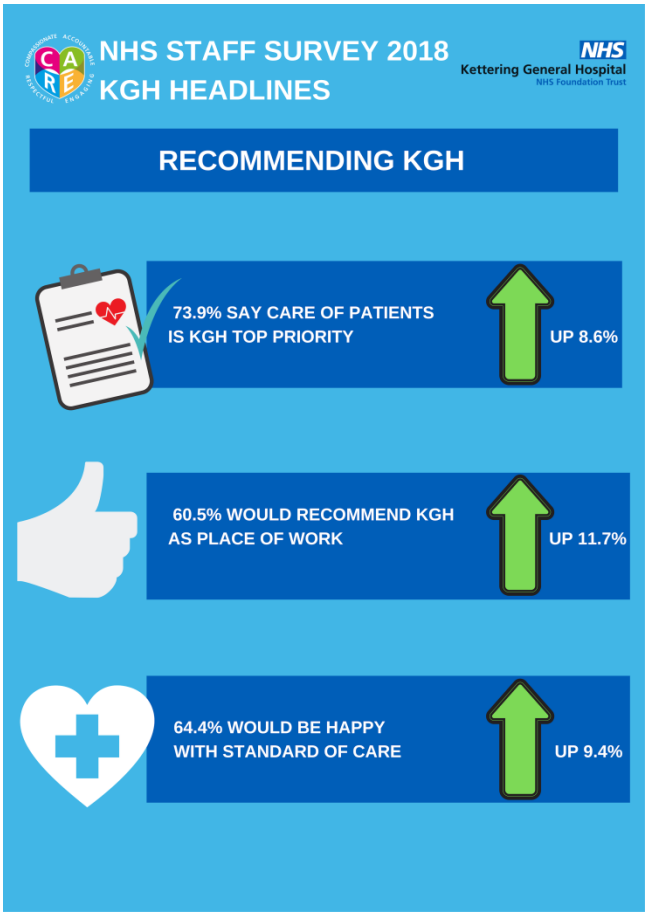
The proportion of staff who would recommend KGH as a place to work or receive treatment has markedly improved

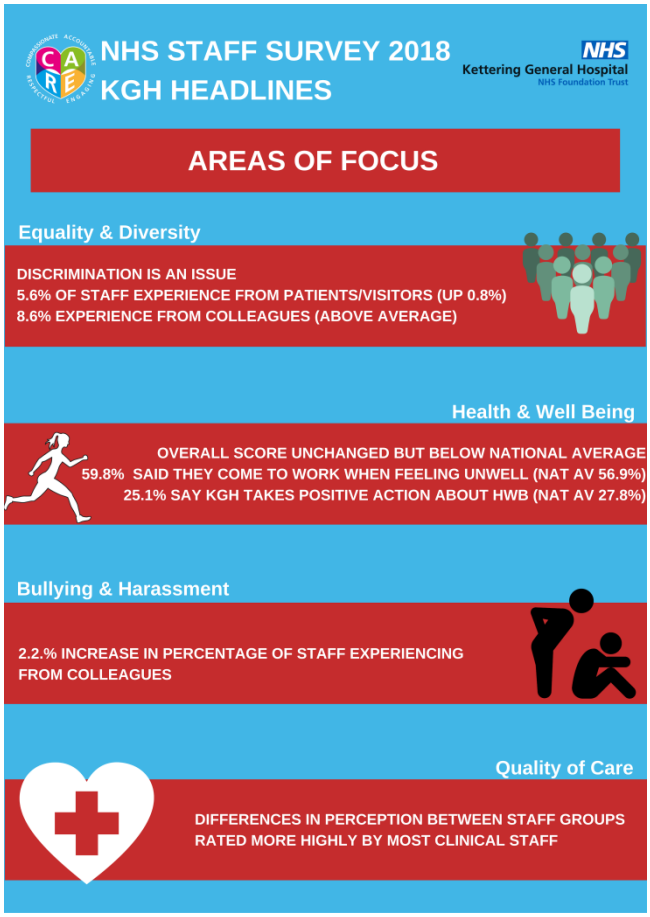
- ✓ 73.9% of respondents agreed that KGH places Care of Patients as its top priority (65.3% last year)
- ✓ 60.5% of staff would recommend KGH as a place of work compared with 48.8% last year
- ✓ 64.4% of staff are happy with the standard of care provided compared with 55% last year

The Trust has significantly engaged with staff this year, learning from last year's results , reviewed and revised the car parking policy , improved recognition and continued to embed the CARE values of the organisation.

The proportion of Staff recommending KGH KGH has increased

There are some key areas we must improve





Next Steps and Actions

An A-Z email was issued to all staff coordinated with the external communications and media release

A detailed key points briefing packs have been developed and circulated to Division and Directorate leads, a presentation has also been given at Leadership brief and Link Listeners in March 2019.

Team briefings will also focus on those areas highlighted by the survey that are of specific interest to individual work groups or Divisions.

This will be supplemented by targeted insight workshops with staff groups looking specifically at the Trust wide areas identified by the survey (building upon work undertaken thus far) i.e.

- Ensuring staff do not feel discriminated against
- Continuing our work in addressing bullying and harassment and particularly between colleagues
- Understanding the further actions that can be taken to improve health and well being

- Working with specific service areas to understand why their perceptions of quality of care differ to those of clinical staff

3.3.7 Trade Union Facility Time

The Trust provides the following Trade Union Facility Time:

- RCN 15 hours per week,
- Unison 1 FTE
- BMA 2 hours per week PA ,
- other ad-hoc time is provided dependant on the exigencies of the service.

3.3.8 Expenditure on consultancy

The Trust only uses external consultancy support when there are skills and capabilities are needed and cannot be sourced internally in a timely manner. This is supported by the appropriate regulatory approval. In 2018/19 total expenditure on consultancy was £1,670k

3.3.9 Off-payroll engagements

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 2019, for more than £245 per Day and that last longer than 6 months:

- **The Trust did not have any off payroll engagements during 2018/19**

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

- **The Trust did not have any off payroll engagements during 2017/18**

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

- **The Trust did not have any off payroll engagements during 2018/19**

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 future key appointments 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.

3.3.10 Exit packages

Reporting of compensation schemes - exit packages 2018/19

Exit package cost band (including any special payment element)	Number of compulsory redundancies Number	Number of other departures agreed Number	Total number of exit packages Number
<£10,000	-	1	**1**
£10,000 - £25,000	-	1	**1**
£25,001 - 50,000	-	-	**-**
£50,001 - £100,000	-	2	**2**
Total number of exit packages by type	**-**	**4**	**4**
Total cost (£)	£0	£165,000	**£165,000**

Reporting of compensation schemes - exit packages 2017/18

There were no compensation scheme exit packages in 2017/18

Exit packages: other (non-compulsory) departure payments

	2018/19		2017/18	
	Payments agreed Number	Total value of agreements £000	Payments agreed Number	Total value of agreements £000
Voluntary redundancies including early retirement contractual costs	2	127	-	-
Contractual payments in lieu of notice	4	38	-	-
Total	**6**	**165**	**-**	**-**

3.4 Disclosures set out in the NHS Foundation Trust Code of Governance

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

3.4.1 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 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. The Single Oversight Framework applied from Quarter 3 of 2016/17.

Segmentation

This segmentation information is the trust's position as at 28th February 2019. Current segmentation information for NHS trusts and foundation trusts is published on the NHS Improvement website.

Finance and use of resources

The finance and use of resources theme is based on the scoring of five measures from '1' to '4', where '1' reflects the strongest performance. These scores are then weighted to give an overall score. Given that finance and use of resources is only one of the five themes feeding into the Single Oversight Framework, the segmentation of the trust disclosed above might not be the same as the overall finance score here.

Area	Metric	2018/19 scores		2017/18 scores	
		Plan	Actual	Plan	Actual
Financial Sustainability	Capital service capacity	4	4	4	4
	Liquidity	3	4	4	4
Financial efficiency	I&E margin	4	4	4	4
Financial controls	Distance from financial plan		4		4
	Agency spend	2	3	2	2
Overall score			**4**		**4**

3.5 Statement of accounting officer's responsibilities

3.5.1 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 regularity of public finances for which they are answerable, and for the keeping of proper accounts, are set out in the NHS Foundation Trust Accounting Officer Memorandum issued by NHS Improvement.

NHS Improvement, in exercise of the powers conferred on Monitor by the NHS Act 2006, has given Accounts Directions which require Kettering General Hospital NHS foundation trust to prepare for each financial year a statement of accounts in the form and on the basis required by those Directions. The accounts are prepared on an accruals basis and must give a true and fair view of the state of affairs of 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
- confirm that the annual report and accounts, taken as a whole, is fair, balanced and understandable and provides the information necessary for patients, regulators and stakeholders to assess the NHS foundation trust's performance, business model and strategy and
- prepare the financial statements on a going concern basis.

The accounting officer is responsible for keeping proper accounting records which disclose with reasonable accuracy at any time the financial position of the NHS foundation trust and to enable him/her to ensure that the accounts comply with requirements outlined in the above mentioned Act. The Accounting Officer is also responsible for safeguarding the assets of the 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.

Signed…… 

Chief Executive Date: 22 May 2019

3.6 Annual governance statement

3.6.1 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.

3.6.2 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 2019 and up to the date of approval of the annual report and accounts.

3.6.3 Capacity to handle risk

Leadership

The Trust Board of Directors, with the support of its committees has a key role in ensuring a robust risk management system is effectively maintained and to develop a culture whereby risk management is "business as usual" at all levels across the organisation. This ensures the best leadership, co-ordination and prioritisation is received, on a strategic and operational basis, of the risk management agenda in relation to clinical, quality, workforce, operational and financial risks. This includes the identification of the full range of risks that are inherent in the delivery of healthcare.

The Board of Directors receives reports and assurance from the Audit, Quality and Safety, Organisational 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) through the Integrated Governance Report.

The Audit Committee assists 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 Internal Auditor's annual work, report and opinion on the effectiveness of the system of internal control.

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 Steering Group, Board Committees and sub-groups 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 Service , Directorate and / or Divisional Risk Registers and escalated to the Corporate Risk Register where a risk is identified as Significant

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

Risk management training has been improved in 2018/19 and forms part of Corporate Induction as well as a core competency training requirement for appropriate staff. Risk assessment and risk register training has been identified as a core subject for all staff at grade 6 and above and is delivered via a number of methods including classroom-based training sessions, one to one sessions and ongoing support is available via the Trust Risk Manager.

Governance and Improvement Managers are 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.

A Risk Management Development Plan commenced and its implementation is monitored by the Risk Management Steering Group and includes embedding the aims and ambitions detailed in the 2019/20 Risk Management Strategy.

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 trust has published an up-to-date register of interests for decision-making staff within the past twelve months, as required by the '*Managing Conflicts of Interest in the NHS*' guidance. This can be viewed online at www.kgh.nhs.uk.

3.6.4 Workforce

The Trust monitor key performance indicators for people issues such as turnover, vacancy numbers on a monthly basis and this is reported to Board through the Organisational Development Committee (ODC) and Integrated Governance Committee (IGC). ODC receives on a bi-monthly basis a safer staffing report which provides detail at ward level, risk management and how issues of concern are being addressed. Twice a month a Workforce Improvement Meeting takes place which reviews roster activity and management as well the recruitment and retention strategies for each division including use of agency and bank. The Trust has an Organisational Development Strategy which used information and findings from the both CQC inspections and the staff survey to develop a workforce plan that was subject to extensive consultation within the Trust in order to secure accuracy and agreement. This plan is regularly reviewed and reported on at ODC. The workforce is a major component of the business planning cycle and operational plan , and the Trust has several related projects to see improvement in the use of job planning, improvements in recruitment and retention of nurses, review of nursing skill mix etc. The Trust were a pilot for the Nurse Associate role an so far have had 3 cohorts commence. We have developed an international nurse recruitment scheme; introduced doctor administrators developed an urgent care Cesar programme and are currently hosting Physician Associates.

3.6.5 Insurance

The Trust has sufficient insurances in place to cover all aspects of the Trusts business including the risk of legal action against the Directors. Insurances in place include membership of the NHS Resolution (formerly NHS Litigation authority) risk pooling schemes.

3.6.6 The risk and control framework

Risk management is recognised as a fundamental part of the Trust's culture, and an integral part of good practice. It is integrated into the Trust's philosophy, practices and business plans. Risk management is the business of everyone in the organisation. The process of risk management begins with the systematic identification of risks throughout the organisation via structured risk assessments. All risks, including those related to the Board Assurance Framework, are detailed on an electronic Trust wide risk register and all staff have access to the risks relevant to their area of work via secure online Dashboards.

Identified risks are documented and then analysed in order to determine their relative importance using a standard risk scoring matrix. Measures to control the risk are identified and implemented to reduce the potential for the risk realising harm or damage. 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. The risk appetite for the Trust is clearly articulated in the Risk Management Strategy in the form of a set of risk appetite statements. The risk tolerance levels linked to the risk appetite are shown as acceptable/tolerable in certain domains or unacceptable, and the grading for each level is mapped against the Risk Matrix.

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. The Board undertook a complete review of the BAF in 2018/19 and the key risks identified include:

- Long term financial sustainability of the Trust at risk due to inefficient or loss making services;
- Long-term organisational strategy at risk without appropriate alignment and engagement with clinical staff;
- Failure to improve staff engagement and morale, which impacts on the staff survey results
- A lack of the required workforce capacity and skill-mix to deliver sustainable, high quality care consistently, seven days a week;
- Delivery of the Digital Strategy;
- Non delivery of the quality strategy impacting on patient and staff experience;
- Suitable hospital and facilities estate impacting on delivery of the long term clinical strategy
- Failure of the system partnership (Northamptonshire Health and Care Partnership) impacting on adult patient care.
- Dilution of patient care during periods of high bed occupancy and activity.

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

Future risks and associated mitigations are identified in a number of ways, including regular 'horizon scanning' as well as through the regular refresh of the organisational risk registers.

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.

19 Serious Incidents were reported in 2018/19. Key themes include, diagnostic incident including delay (including failure to act on test results) and slips, trips and falls. Incidents are included in quarterly reports to the Quality Governance Steering Group which reviews new and closed serious incidents and analyses themes. A thematic analysis of all serious incidents is also completed annually to provide a broader oversight of the data.

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. A well led self-assessment exercise commenced in summer 2018.

Board 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 committees are reviewed at least annually to ensure they remain relevant to the objectives of the Trust. Changes to the terms of reference may be made by the Committee subject to Board approval and following appropriate consultation and agreement.

Escalation of risk issues is through the Divisional Governance structure that allows two-way communication from the Board and its Committees. Trust wide committees/operational groups report to Board via the Quality Governance Steering Group reporting to the Quality and Safety Committee. 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.

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 six sub-groups which are chaired by either the Director of 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 through the Integrated Governance Report, which are overseen by the Director of 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 and an associated Board Committee assigned to test and examine assurance
- 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
- Incident reporting is openly encouraged and staff has access to Lessons Learned themes via Datix Dashboards. Reporters of incidents get automated feedback from incidents identifying any lessons and actions identified.

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.

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.

Carbon Reduction

The Foundation Trust has undertaken risk assessments and has a sustainable development management plan in place which takes account of UK Climate Projections 2018 (UKCP18). The trust ensures that its obligations under the Climate Change Act and the Adaptation Reporting requirements are complied with.

3.6.7 Care Quality Commission

Kettering General Hospital NHS Foundation Trust is registered with the Care Quality Commission and its current registration status is unconditional. There are no conditions on registration.

The Care Quality Commission has not taken enforcement action against Kettering General Hospital NHS Foundation Trust during 2018/19.

The Trust was inspected during January - March 2019. This involved an inspection of five core services (Diagnostics, Maternity, Medical Care, Outpatients and Urgent and Emergency Services) and a Well-Led review in March 2019, which looks at how well leaders create an environment that encourages and fosters improvement. The report of the inspection was published in May 2019.

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

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

The Trusts CQC inspection included an NHS Improvement led Use of Resources assessment, the aim of the assessment is to understand how effectively providers are using their resources to provide high quality, efficient and sustainable care for patients.

The Trust underwent its assessment on the 29th January 2019 and were rated as requires improvement because the Trust is not consistently making best use of its resources to enable it to provide high quality, efficient and sustainable care for patients.

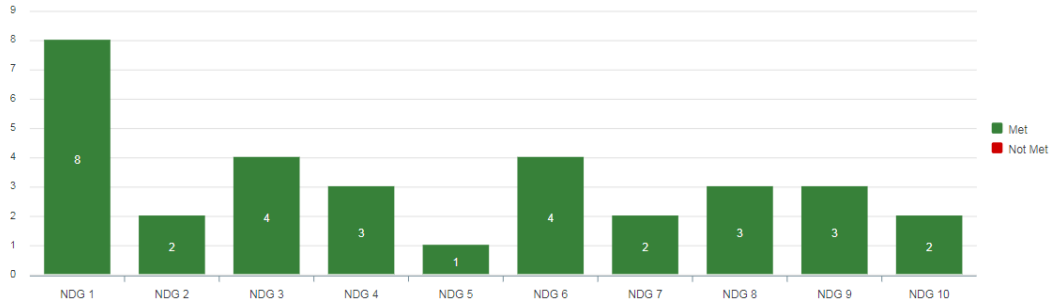
The Trust has achieved productivity improvements in its clinical services through working more with health and social care partners and engaging with national productivity improvement programmes. The Trust however continues to experience emergency demand pressures, which together with key workforce challenges (high vacancy rates and agency spend) is contributing to the deficit financial position.

The Trust Board and Board Committees responsible for Audit and Performance, Finance & Resources regularly review the Trusts economy, efficiency and effectiveness in the use of resources.

3.6.9 Information governance

The Trust uses the Data Security & Protection Toolkit to identify and manage information risks. During the in-year assessment against the Toolkit, the Trust achieved a score of 100% for all mandatory elements.

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 Checklist 'Guidance for Reporting, Managing and Investigating Information Governance and Cyber Security Incidents Requiring Investigation'.



NDG 1 - Personal Confidential Data
NDG 2 - Staff Responsibilities
NDG 3 - Training
NDG 4 - Managing Data Access
NDG 5 - Process Reviews
NDG 6 - Responding to Incidents
NDG 7 - Continuity Planning
NDG 8 - Unsupported Systems
NDG 9 - IT Protection
NDG 10 - Accountable Suppliers

No level 2 incidents were reported to the Information Commissioner during 2018/19.

3.6.10 Annual Quality Report

The directors are required under the Health Act 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 Hospital Foundation Trust's performance over the period covered from 1 April 2018 to 31 March 2019 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.

3.6.11 Review of effectiveness

As Accounting Officer, I have responsibility for reviewing the effectiveness of the system of internal control. My review of the effectiveness of the system of internal control is informed by the work of the internal auditors, clinical audit and the executive managers and clinical leads within the 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 quality report attached to this Annual report and other performance information available to me. My review is also informed by comments made by the external auditors in their management letter and other reports. I have been advised on the implications of the result of my review of the effectiveness of the system of internal control by the board, the audit committee the 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.

3.6.12 Conclusion

There were no significant internal control issues identified during 2018/19.

Signed… 

Chief Executive Date: 22 May 2019

COMPASSIONATE
ACCOUNTABLE
RESPECTFUL
ENGAGING

UNIVERSITY OF LEICESTER
Affiliated Teaching Hospital

NHS
Kettering General Hospital
NHS Foundation Trust

QUALITY REPORT 2018 - 2019

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 2019 (the "Quality Report") and certain performance indicators contained therein against the criteria set out in the 'NHS foundation trust annual reporting manual 2018/19' and additional supporting guidance in the 'Detailed requirements for quality reports 2018/19' (the 'Criteria').

Scope and subject matter

The indicators for the year ended 31 March 2019 subject to the limited assurance engagement consist of the national priority indicators as mandated by NHS Improvement:

- Percentage of patients with a total time in A&E of four hours or less from arrival to admission, transfer or discharge; and
- Maximum waiting time of 62 days from urgent GP referral to first treatment for all cancers.

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 2018/19' 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 2018/19' 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 2018/19'; 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 2018/19' and supporting guidance and the six dimensions of data quality set out in the "Detailed requirements for external assurance for quality reports 2018/19'.

We read the Quality Report and consider whether it addresses the content requirements of the 'NHS foundation trust annual reporting manual 2018/19' 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 2018 to 29 May 2019;
- papers relating to quality reported to the Board over the period 1 April 2018 to 29 May 2019;
- feedback from NHS Nene Clinical Commissioning Group and NHS Corby Clinical Commissioning Group dated 22 May 2019;
- feedback from governors dated 16 May 2019;
- feedback from local Healthwatch Northamptonshire dated 14 May 2019;
- feedback from Northamptonshire County Council Overview and Scrutiny Committee dated 20 May 2019;
- the Trust's complaints report published under regulation 18 of the Local Authority, Social Services and National Health Service Complaints (England) Regulations 2009, dated 20 May 2019;
- the national patient survey dated 13 June 2018;

- the national staff survey dated 26 February 2019;
- the Head of Internal Audit's annual opinion over the Trust's control environment dated 22 May 2019; and
- the Care Quality Commission's inspection report dated 22 May 2019.

We consider the implications for our report if we become aware of any apparent misstatements or material inconsistencies with these 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 2019, 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 2018/19' and supporting guidance to the categories reported in the Quality Report; and
- reading the documents.

A limited assurance engagement is narrower 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 2018/19' 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 and is subject to separate terms and conditions. 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.

Basis for qualified conclusion

The indicator reporting the percentage of patients with a total time in A&E of four hours or less from arrival to admission, transfer or discharge at the end of the reporting period did not meet the six dimensions of data quality in the following respects:

- Completeness: in our testing of 33 A&E attendances the Trust was unable to provide appropriate supporting documentation for three of the attendances which meant that we were unable to confirm whether those patients' arrival and discharge times were being correctly recorded in line with the applicable guidance;
- Accuracy and validity: in our testing of 33 A&E attendances we identified seven instances where the patient's time of discharge was not recorded, which meant that we were unable to confirm whether those patients' discharge times were being correctly recorded in line with the applicable guidance; and
- Accuracy and validity: in our testing of 33 A&E attendances we identified two instances where the discharge time was recorded inconsistently within the Trust's supporting data and systems and in each case these discrepancies meant the cases would have resulted in a 4-hour breach if correctly captured. The errors therefore resulted in both cases being incorrectly recorded in line with the applicable guidance.

Qualified conclusion

Based on the results of our procedures, with the exception of the matter reported in the basis for qualified conclusion paragraph above, nothing has come to our attention that causes us to believe that, for the year ended 31 March 2019:

- 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 2018/19' 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 2018/19'; and
- the indicators in the 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 2018/19' and supporting guidance.

Grant Thornton UK LLP

Grant Thornton UK LLP
Chartered Accountants
Birmingham

29 May 2019

Executive summary

At KGH we want to provide the best possible care.

We aim to be:

C **Compassionate** – we put ourselves in the other person's shoes, introduce ourselves and make them feel comfortable.

A **Accountable** - we deliver what we say we will, when we said we would.

R **Respectful** – we explain things clearly, in simple language, to help us to build trust.

We treat everybody the same.

E **Engaging** – we engage with a purpose, as ambassadors for all things KGH.

NHS Improvement requires all NHS foundation trusts to produce Quality reports as part of their annual reports.

Quality reports help trusts to improve public accountability for the quality of care they provide. The Quality Report is a mandated document which is laid before parliament before being made available to the public on the NHS Choices Website.

Detailed requirements for Quality Reports 2018/19 specifies the content of the Report, including:

- A statement on quality from the Chief Executive (p.12);
- Priorities for improvement for 2019/20 (p.16);
- Statements of assurance from the board (p.22);
- Reporting against core indicators (p.41);
- Performance against the priorities set for 2018/19 (p.61).

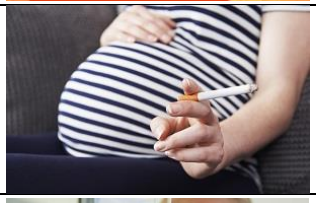
We have to report our progress against the priorities we have selected for this year in next year's Quality Report. We will monitor our progress against the priorities at least quarterly to ensure that we achieve them.

Executive summary

What we will do in 2019/20 to improve

Patient Safety Priorities 2019/20

Greater than 90% compliance with the sepsis bundle
(p.16)



Reduce smoking in pregnancy
(p.16)

Improve the records of cumulative fluid balance for patients receiving intravenous fluids for hydration
(p.18)

Patient Experience Priorities 2019/20

Establish and achieve 95% compliance with the key performance indicators for complaint responsiveness
(p.18)

Deliver six public engagement forums
(p.19)

Involvement of patients in our patient safety lessons learnt forums
(p.19)

Clinical Effectiveness Priorities 2019/20

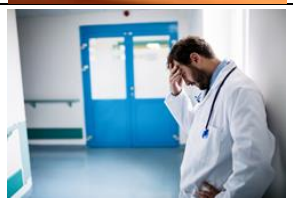
Introduction of e-observations
(p.20)

Ward accreditation to be implemented in all adult wards with plans in place to develop standards for A&E, Outpatients, Maternity and Paediatrics throughout 2019/2020
(p.21)

Progress implementation of ePMA (Electronic Prescribing and Medicines Administration)
(p.21)

Executive summary

What we said we would do to improve in 2018/19

Patient Safety Priorities 2018/19		Did we achieve it?
	Preventing avoidable deterioration (sepsis management) (p.61)	YES
	Safe assessment and response to the needs of mental health patients in A&E (p.64)	ALMOST
	Improve and embed learning from outcomes across the Trust for all staff (p.66)	YES
Patient Experience Priorities 2018/19		**Did we achieve it?**
	Improving how we manage pain relief for our patients (p.67)	NO
	Reducing noise at night for our inpatients (p.68)	ALMOST
	Improving how we communicate with patients about waiting times when referred for treatment (p.69)	YES
Clinical Effectiveness Priorities 2018/19		**Did we achieve it?**
	Increasing the number of mortality reviews (p.71)	ALMOST
	Reducing the number of unexpected term babies being admitted to the neonatal unit with respiratory factors as the primary cause for admission (p.71)	ALMOST
	Improving our compliance with mandatory safeguarding training standards (p.72)	YES

KGH highlights, 2018/19

April 2018

A&E refurbishment

The £450,000 work programme has improved facilities for patients and staff, by adding a private waiting area for children along with additional consulting and treatment rooms.

May 2018

International Nurses Day

The day was an opportunity to remind ourselves of the amazing contribution our nurses, midwives and allied health professionals make, and to celebrate the launch of our new Nursing and Midwifery Framework of Excellence.

June 2018

KGH Obstetrician is an NHS star

Consultant Obstetrician Mrs Adeeba Nishtar was voted as one of the NHS's 'Top 70 Stars' after being nominated by a patient for the care she received during her recent pregnancy.

July 2018

Celebrating NHS long service

KGH Gardener, Ralph, is one of the 122 staff members celebrating his long service this year. He joined the hospital aged 17 in 1959 and has been working at KGH ever since.

August 2018

Cavell star award for Neonatal Unit

The unit, which looks after over 450 ill and premature babies each year, has won a Cavell Star Award after being nominated by a student nurse for its exceptional team working.

September 2018

Main operating theatres refurbishment

£5.5million refurbishment of six main operating theatres.

October 2018

Dragon's Den

KGH Dragons commit £100k to make staff ideas for improvement a reality.

November 2018

Dementia-friendly garden

The garden provides some of our most vulnerable patients with an area which can bring back happy memories.

December 2018

Exciting new simulation training suite

Staff will receive enhanced training in a new, state-of-the-art simulation training suite which simulates medical emergencies.

January 2019

Families rate maternity care highly

KGH scored:
8.9/10 for Labour and Birth
8.8/10 for Staff
7.5/10 for Care in Hospital after birth
in the CQC Maternity Survey.

February 2019

NHS Staff Survey improvements

The survey showed significant improvement in staff views. Compared with last year, five of the nine themed areas showed significant improvements.

March 2019

KGH welcomes new overseas nurses

These are just the latest group of overseas nurses that have taken part in KGH's International Return to Practice programme. In the last 18 months we have enabled 64 nurses to pass their adaptation exams and gain their registration in the UK.

Please note

Hyperlinks have been used throughout this document to facilitate navigation in the electronic format.

If you click on the blue wording or page numbers provided with hyperlinks, you will be taken to the point in the document where there is further information on the subject.

To return to the place in the document where you were prior to accessing the link, use “Alt + ←”.

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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.

Part 1 is a statement on quality from our Chief Executive, Simon Weldon.

In **Part 2** we have provided details of nine specific priorities for quality improvement that we intend to deliver in 2019/20. This year, a centralised system for monitoring our progress against all nine of these priorities will be introduced. This will ensure improvements are on track and inform summary quarterly updates of progress to the Oversight and Scrutiny Committee.

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

Part 3 describes how we performed against the quality priorities set for 2018/19, together with performance against key national priorities in line with the NHS Improvement Single Oversight Framework.

Annex 1 outlines feedback from the Trust's key stakeholders 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, where available.

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

Part 1: Statement on quality from the Chief Executive

Welcome to our Quality Report for 2018/19

The publication of our Quality Report coincides with my first anniversary serving as Chief Executive of Kettering General Hospital and it offers an opportunity to reflect on the improvements we have made over the past year and identify areas of focus for the coming year as we continue on our journey to outstanding.

This past year has seen us concentrate upon quality improvement across all that we do. This started with a review of the Trust's strategic objectives to ensure alignment with our overarching vision "to provide safe high quality care to our communities". After a period of intense staff and patient engagement we agreed a number of short to medium term strategic objectives that directly contribute to improving the quality of care across our Trust. This was further supported by the publication of the Quality Strategy which sets out our Quality Improvement ambitions.

We entered 2018/19 effectively being rated as 'could do better' across many of the indicators used by others to assess quality. I am proud that our staff have risen to the challenge, demonstrating that we really do care about what we do and genuinely wanting to play their part in delivering high quality services. As Chief Executive I am constantly struck by this and have the privilege of meeting staff from across the organisation. The overriding theme at drop-in sessions, staff meetings or ward and department visits is quality improvement – with individuals wanting to share their ideas about how we can do better.

Our 2018 staff survey shows better engagement, with more staff recommending KGH as a place to work and receive treatment

Indeed, our staff survey results – completed by staff in the autumn of 2018 – have shown better engagement with more staff recommending KGH as a place of work and to receive treatment, with 89.3% of staff saying that they felt their role makes a difference. For example; in areas relating directly to quality of care and safety our staff rated us higher than the national average in 2 out of 3 quality questions and scores improved across all six areas relating to safety culture.

This year's Quality Report highlights many of the improvements we have made; for example – a stronger focus on using information and quality audits to identify where we need to focus, a real emphasis on working with, and listening to, our patients and a drive to improve our performance against national

standards that we know make a real difference to the lives of our patients.

A key area of focus for 2019/2020 is to define our approach to Quality Improvement in order that staff better understand and can more confidently engage with quality improvements within either their local wards/departments or in larger scale, cross site programmes.

Within this report you will see the Trust's performance against the Quality Priorities (QP) agreed and set for 2018/19. Using the six pledges of the Quality Strategy I would like to highlight the following achievements:

QP1 – Putting Patients First

- Worked in collaboration with Young Healthwatch to review services for Children and Young People with recommendations to, for example, improve the environment. A short film representing the collaboration, entitled "It's my health – Young Voice", was screened at Cineworld, Northampton on 16 April 2019;
- The Trust installed electronic feedback centres to capture real-time patient experience that wards, departments and individuals can use to improve services;
- Fracture clinic relocated to Frank Radcliffe to provide a dedicated waiting and treatment area.

QP2 – Reducing Avoidable Harm and Mortality

- Our positive infection prevention performance continues with C-Difficile rates well below the ceiling set by Commissioners (18 cases, against a ceiling of 25) and we have had no cases of hospital-associated MRSA for over 3 years and 10 months. The NHSi IP (NHS Improvement, Infection Prevention) expert review in December gave the Trust a green rating for infection prevention and cleaning;
- Trust compliance with the recognition and treatment of Sepsis has improved;
- We successfully, and before time, fully implemented NEWS2, a national early warning score that helps staff identify the deteriorating patient to escalate early.

QP3 – Culture of continuous improvement and safety

- Continued to see improvements in Referral to Treatment Times. By March 2019 86.2% of our patients received treatment within 18 weeks of referral compared with 78.4% in April 2018 (the numbers of patients waiting over 18 weeks has reduced by 44.1% over the past year). We have also significantly reduced and maintained positive performance for the reporting of radiographic images;
- Established a shared learning forum for staff to hear about the progress of others in delivering continuous quality improvement;
- Undertook significant estates work to improve environments for patients and staff.

QP4 – Sustained organisational learning

- Leadership development programmes attended by 17 staff;
- Further development of Learning From Deaths processes to inform and improve patient care.

QP5 – Develop and embed real-time quality data

- Established Ward Accreditation as a programme for identifying compliance with practice standards to inform continuous quality improvement, with the first ward attaining Gold at the end of March;
- Effective use of data has facilitated the Long Stay Wednesday Programme, reducing length of stay and ultimately improving patient experience.

QP6 – Consolidate risk management

- Established access to 'real time' incident reports using this to highlight emerging risks for timely action;
- Developed 'golden threads' between ward/division risk assessments and corporate risk register and board assurance framework for transparency and articulation of risk.

Looking forwards, I am confident that the alignment of our strategic priorities with the quality of care we provide will continue to deliver results.

I am particularly excited at the potential of our digital roadmap to make huge inroads into improving patient care – through the introduction of electronic prescribing and electronic patient records for example - that will massively improve our care processes.

The work we are doing with our system partners through the Health and Care Partnership will help deliver better care outcomes for our patients and has already contributed significantly to reducing the length of time patients stay unnecessarily in hospital.

The buildings and facilities across the Trust are gradually being improved as funding allows. These changes are already taking effect – with newly refurbished facilities for our fracture clinic, our area for treating patients with minor injuries in the Accident and Emergency (A&E) department and dermatology clinic at Prospect House. The coming year will see a transformed outpatient department and work continuing on securing approvals for a new Urgent Care Hub on the main site.

We were pleased to welcome Dr Henrietta Hughes, the National Guardian for Speaking Up, to the Trust in February 2019. This gave us the opportunity to demonstrate the developments to our Freedom to Speak Up process and the improvements we have made to patient safety in response to the issues raised by staff.

And, KGH has been selected as one of fourteen trusts piloting new access measures in urgent and emergency care, to help understand how we can continue to improve patient experience and outcomes.

Earlier this year (February/March 2019) we were re-inspected by the CQC, the outcome of which has just been

reported as 'requires improvement'. The Chief Inspector of Hospitals recommended that following the improvements we have made KGH should come out of special measures. NHS England and NHS Improvement approved this recommendation on 21st May with the result that KGH has exited special measures, noting that all areas inspected have been rated as good or requires improvement. A breakdown of the ratings on page 34 reflects the progress we have made towards becoming an outstanding organisation.

I hope that you will find our Quality Report for 2018/19 informative with regard to our achievements and plans to make further improvements in the year ahead. The specific quality priorities detailed in this Quality Report and summarised here are the result of wide consultation with staff and key stakeholders.

Simon Weldon
Chief Executive

29 May 2019

Patient Safety Priorities

- Greater than 90% compliance with the sepsis bundle;
- Reduce smoking in pregnancy;
- Improve the records of cumulative fluid balance for patients receiving intravenous fluids for hydration.

Patient Experience Priorities

- Establish and achieve 95% compliance with the key performance indicators for complaint responsiveness;
- Deliver six public engagement forums;
- Involvement of patients in our patient safety lessons learnt forums.

Clinical Effectiveness Priorities

- Introduction of e-observations;
- Ward accreditation to be implemented in all adult wards, with plans in place to develop standards for A&E, Outpatients, Maternity and Paediatrics throughout 2019/2020;
- Progress implementation of EPMA (Electronic Prescribing and Medicines Administration).

Part 2: Priorities for improvement and statements of assurance from the board

2.1 Priorities for improvement

Progress made since the publication of the 2017/18 quality account is described in Part 3.

Patient Safety Priorities 2019/20

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

Greater than 90% compliance with the sepsis bundle

Why have we chosen this priority?
From April 2019 the identification and management of sepsis will form part of the NHS Standard Contract within which the standard is 90%. Whilst we acknowledge that this is a challenging target, we have set this as our target for the year ahead.

How will we improve?

- We will promote the prompt recognition and treatment of sepsis through delivering induction and annual mandatory eLearning to clinical staff;
- We will deliver ward level, bite-sized sepsis training in addition to mandatory training to nursing and medical staff;
- We will continue to provide paediatric sepsis simulation training in conjunction with the paediatric team;
- We will reward good practice with sepsis star certificates and challenge poor practice through consultant and ward manager feedback.

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

- We will report our performance against NHS Standard Contract targets;
- We will report on compliance with mandatory training.

How will we report and monitor our progress?

- The Sepsis Working Group meet bi-monthly and will review audits and monitor compliance;
- Minutes of the Sepsis Working Group will be reported to the Patient Safety Advisory Group;
- Audit results will be reported into the Clinical Audit Committee.

Reduce smoking in pregnancy

Why have we chosen this priority?
Every Child has a Healthy Start in Life is one of the four Health and Wellbeing priorities for Northamptonshire. Smoking in pregnancy is a modifiable risk factor for stillbirth, preterm birth, low birth weight and neonatal death. As a Trust with Maternity Services we have the responsibility to understand why the adverse outcome occurred, what action can be taken to prevent this from happening again and how we learn as a wider Health Economy to ensure health

inequalities are prevented. Increasing smoke free pregnancies is a national priority set out in element 1 of the Saving Babies Lives Care Bundle v2 (SBLCBv2) by NHS England. This priority is also referred to in the NHS Long Term Plan. Increasing smoke free pregnancies will contribute to the national target of reducing stillbirths and neonatal deaths by 20% by 2020, and 50% by 2030 in line with Saving Babies Lives.

Northamptonshire has an increased smoking prevalence in pregnancy at around 14%, which is higher than the national average (13% England).

How will we improve?
As a Trust and Maternity Service we are committed to being fully compliant with element 1 of the SBLCBv2:

"Reducing smoking in pregnancy by assessing exposure to carbon monoxide (CO) as appropriate to assist in identifying smokers (or those exposed to CO through other sources) and refer them for support from a trained stop smoking advisor"

We aim to achieve this element by ensuring:

- CO testing will be offered to all pregnant women at the antenatal booking appointment and at the 36 week antenatal appointment, with the outcome recorded;
- Offering additional CO testing to pregnant women as appropriate throughout pregnancy, with the outcome recorded;
- Referring those women with elevated levels (4 ppm or above) for support from a trained stop smoking specialist, based on an opt-out system. The referral pathway will include feedback and follow up processes;
- Ensure all midwives and Maternity Support Workers receive training on the use of the CO monitor and having a brief and meaningful conversation with women about smoking (Very Brief Advice - VBA);
- Work in collaboration with Northampton General Hospital (NGH) through the Northamptonshire Local Maternity System (LMS) to compare outcomes and learn from good practice;
- Ensure that, where it is believed that smoking is a contributing factor to a poor perinatal outcome, trends and themes are examined to determine whether further interventions are required.

How will we measure our improvement and what are our targets?
We plan to fully implement element one of the SBLCBv2 within a 12-month period.

How will we report and monitor our progress?
The SBLCBv2 will be included within the Maternity Safety Plan, in which its progress will be tracked and monitored through the Maternity Directorate Governance Meeting, with bi annual update on the Maternity Safety Plan at the Quality and Safety Committee.

Improve the records of cumulative fluid balance for patients receiving intravenous fluids for hydration

Why have we chosen this priority?
Fluid balance monitoring is a record of a patient's intake and output of fluid. The cumulative fluid balance is the sum total of fluid accumulation over a 24-hour period of time. It can provide a useful biomarker of critical illness and allow prompt intervention to correct any imbalances in fluid intake and output.

Compliance with the protected mealtimes standard for this criterion is approximately 30% currently.

How will we improve?

- We will ensure that all patients receiving intravenous fluids for hydration have their intake and output recorded;
- We will ensure that patients who do not require fluid balance monitoring are not having their intake and output recorded unnecessarily;
- We will improve the accuracy of fluid balance records;
- We will raise awareness of the importance of monitoring the cumulative fluid balance and when to escalate the findings.

How will we measure our improvement and what are our targets?
Going forward, the Nutrition Nurse will audit the fluid balance records of four patients receiving intravenous fluids for hydration from each of the six to eight wards visited each month. This will include the retrospective audit of inpatients during weekends and Bank Holidays to determine whether this has a detrimental impact on the records.

Our target is to demonstrate a progressive and sustained improvement in compliance with the recording of the cumulative fluid balance, with at least 70% compliance by the end of 2019/20.

How will we report and monitor our progress?
The findings of the Ward Accreditation Visits and the Protected Mealtimes standard in relation to this indicator will be included in monthly and quarterly progress reports to the Quality Governance Steering Group. It will also be reported on a monthly basis to the divisional heads of nursing, the matrons and ward sisters and monitored through the divisional governance meetings.

Patient Experience Priorities 2019/20

Establish and achieve 95% compliance with the key performance indicators for complaint responsiveness

Why have we chosen this priority?
This has been chosen as a priority because the Trust recognised the negative impact that past performance has had on the patient experience. Following an independent review of the complaints handling process, to support a timely response and improve patient experience, three key timescales have been agreed according to the complexity of the complaint.

Consequently less complex complaints will receive a response in a shorter timescale than the national recommendation for NHS complaints.

How will we improve?

- Increase the staffing of the complaints team;
- Allocation of one complaints case handler to each of the Trust's three clinical Divisions. This new post will be the point of contact for the complainant and support the Divisional directors in the monitoring of their complaints;
- Identification of a clear escalation route.

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

Compliance with the following targets will be reported on a weekly, monthly and quarterly basis and remedial actions taken prior to the associated breach date, as appropriate:

- 15 working days for single issues;
- 35 working days for moderately complex issues;
- 60 working days for complex issues.

How will we report and monitor our progress?

- Reporting against the above targets will be calculated from the date the complaint was received, or consent has been received, if the complaint has been made on behalf of a patient;
- Progress against improvement targets will be monitored in our monthly dashboard reports to the Quality and Safety Committee, a sub-committee of the Trust Board;
- Quarterly reports also will be provided to the Clinical Commissioning Group and be a component of the Patient Experience and Complaints Annual report to the Trust Board.

Deliver six public engagement forums

Why have we chosen this priority?

Public engagement has been selected as an improvement priority to build on the successful work carried out during 2018. This will provide another platform for the Trust to involve patients and the public in the development of services.

How will we improve?

A programme of events will be scheduled throughout the year according to the issues that would benefit from public input.

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

Each event will be documented and evaluation sought from the attendees at the events.

How will we report and monitor our progress?

Evaluation will be reported to the Patient Experience and Involvement Steering Group at the first meeting following each event. Summarised feedback will be provided to the Quality and Safety Committee.

Involvement of patients in our patient safety lessons learnt forums

Why have we chosen this priority?

Patients provide an invaluable perspective on the services offered by the Trust. As an organisation we want to maximise the potential of this resource by hearing patients' experiences first hand.

Currently patients are invited to share experiences at the public Board on a bi-monthly basis. Involvement in the patient safety lessons learnt forum will provide clinical staff with an opportunity to reflect and learn from the patient experience.

How will we improve?
The Trust aims to increase staff exposure to the perception of patients and to engage with them outside the clinical environment. The patient experience team will endeavour to link patient stories with common themes or topical issues.

How will we measure our improvement and what are our targets?
We will measure our success with this quality priority by the attendance of patients at the meetings. Our target is to share four patient stories per year, ideally delivered by the patient, or with the patient in attendance.

How will we report and monitor our progress?
Quarterly reports will be a standing item on the agenda of the Patient Experience and Involvement Steering Group. The reports will include the attendance of service users, the issues raised by them and consequent actions for improvement.

Clinical Effectiveness Priorities 2019/20

Introduction of e-observations

Why have we chosen this priority?
There are many, well-documented benefits of recording patients' vital signs electronically, included improved patient safety and efficiency. It is one component of a broader initiative to digitalise patient records across KGH.

How will we improve?
The project will bring improvements to:

- Continuity of care;
- Consistent escalation of deteriorating patients;
- Timely specialist input;
- Communication;
- Compliance with audit of early warning score records;
- Mapping of patient position on Medway, with resultant improvements to patient flow;
- Reduction in mortality and morbidity;
- Achievement of the sepsis Commissioning for Quality and Innovation Framework (CQUIN).

How will we measure our improvement and what are our targets?
The contract for the electronic patient record has recently been awarded and a project plan will be proposed by 29 March. In the meantime it is intended that the implementation of e-observations will be complete by the end of November 2019, with full implementation across the Trust.

How will we report and monitor our progress?
Monitoring and reporting plans will be specified in the project plan, for inclusion as soon as available.

Ward accreditation to be implemented in all adult wards with plans in place to develop standards for A&E, Outpatients, Maternity and Paediatrics throughout 2019/2020

Why have we chosen this priority?
Ward Accreditation is a mandatory monitoring and improvement methodology for use within inpatient areas in KGH. This quality improvement tool has 13 priority clinical improvement standards.

How will we improve?
A baseline assessment for all wards was completed in 2018; ten wards were rated Bronze and seven wards rated as Silver. Phase 2 commenced in 2019 and to date all second visits have shown a marked improvement in the rating of the standards.

How will we measure our improvement and what are our targets?
Each standard is measured by two Senior Nurses from an unrelated area of the Trust who undertake a one day quality assessment visit. The target is for all 13 standards to improve from the first assessment.

How will we report and monitor our progress?
The results are reported to the wards by the Deputy Director of Nursing & Quality and an overall progress report is presented and reviewed at the Governor's Meeting, Quality Governance Steering Group and Quality & Safety Committee after each completed assessment phase.

Progress implementation of ePMA (Electronic Prescribing and Medicines Administration)

Why have we chosen this priority?
Prescribing or administering medicines to our patients is our most common therapeutic activity. We want to make sure that our patients are cared for safely when medication is required. ePMA systems will help improve the safety and efficiency of healthcare by aiding the choice, prescribing, administration and supply of medicines. It will help us ensure that our patients receive the right medicines and the right time.

How will we improve?
We will begin implementation of ePMA into inpatient areas across the Trust with roll out to 80% of inpatient areas by the end of March 2020.

How will we measure our improvement and what are our targets?
We will continue to complete monthly Medicines Safety Thermometer audits. ePMA will help us to reduce the percentage of patients missing doses of medicines to <1% and improve documentation of medicines allergies to 100%.

We will measure themes and trends of medication incidents, seeking a reduction in incidents where medications have caused harm by 50%.

How will we report and monitor our progress?
Progress will be monitored by the ePMA Project Board.

2.2 Statements of assurance from the board

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.

2.2.1 Quality of services

During 2018/19 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.

During 2018/19 the Kettering General Hospital NHS Foundation Trust provided and/or subcontracted 22 relevant health services.

The Kettering General Hospital NHS Foundation Trust has reviewed all the data available to them on the quality of care in 22 (i.e. all) of these relevant health services.

Key contracts were 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 reviewed in 2018/19 represents 93% of the total income generated from the provision of relevant health services by the Kettering General Hospital NHS Foundation Trust for 2018/19.

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 them and address the issues raised.

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.

During 2018/19 Kettering General Hospital NHS Foundation Trust subcontracted services to 16 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 & Language Therapy, Dietetics, and Podiatry; Specialist Nursing (including, but not limited to adult and paediatric diabetes Nursing), primary care streaming, Clinical Psychology support for Oncology, and Consultant Medical input into Palliative Care, and Special Needs Dentistry.

The Trust had a contract with Brighterkind Limited for the provision of off-site beds for those patients who are well enough to be transferred pending discharge packages, although this ceased on 04 April 2019.

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

2.2.2 Clinical audit

During 2018/19 49 national clinical audits and five national confidential enquiries covered relevant health services that Kettering General Hospital NHS Foundation Trust provides.

During that period Kettering General Hospital NHS Foundation Trust participated in 94% (46/49) of national clinical audits and 100% (5/5) of national confidential enquiries of the national clinical audits and national confidential enquiries which it was eligible to participate in.

The national clinical audits and national confidential enquiries that Kettering General Hospital NHS Foundation Trust

was eligible to participate in during 2018/19 are included in table 1.

The national clinical audits and national confidential enquiries that Kettering General Hospital NHS Foundation Trust participated in during 2018/19 are identified in table 1.

The national clinical audits and national confidential enquiries that Kettering General Hospital NHS Foundation Trust participated in, and for which data collection was completed during 2018/19 are listed in table 1 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.

Table 1: Participation in national clinical audits and National Confidential Enquiries

Eligible National Clinical Audits	Participated	Number of cases submitted	Participation rate	Comments
Acute Coronary Syndrome or Acute Myocardial Infarction (MINAP)	✓	-	-	Data collection ongoing
Adult Community Acquired Pneumonia	✓	-	-	Data collection ongoing
BAUS Urology Audit - Female Stress Urinary Incontinence	✓	-	-	Awaiting validation of data
BAUS Urology Audit - Nephrectomy	✓	-	-	Data collection ongoing
Cardiac Rhythm Management (CRM)	✓	-	-	Data collection ongoing
Case Mix Programme (CMP)	✓	-	100%	
Elective Surgery (National PROMs Programme)	✓	-	-	Data collection ongoing
Falls and Fragility Fractures Audit Programme (FFFAP)				
a) Inpatient falls	✓	-	-	No eligible cases
b) Hip fracture database	✓	371	100%	
Feverish Children (care in emergency departments)	✓	50	100%	Minimum dataset submitted
Inflammatory Bowel Disease programme / IBD Registry	✗	-	-	Insufficient supporting IT infrastructure and resource
Major Trauma Audit	✓	300	98%	
Mandatory Surveillance of Bloodstream Infections and C. Difficile Infection	✓	-	-	Data collection ongoing

Eligible National Clinical Audits	Participated	Number of cases submitted	Participation rate	Comments
Myocardial Ischaemia National Audit Project (MINAP)	✓	To be confirmed	100%	Data collection ongoing
National Asthma and COPD Audit Programme				
a) COPD Secondary Care	✓	-	-	Ongoing data collection – deadline May 2019
b) Pulmonary Rehabilitation	✓	-	-	Data collection not yet started
c) Adults Asthma	✓	-	-	Data collection ongoing
National Audit of Breast Cancer in Older People	✓	-	-	Data collection ongoing
National Audit of Care at the End of Life (NACEL)	✓	65	81%	
National Audit of Dementia	✓	61	100%	Minimum submission 50 cases
National Audit of Percutaneous Coronary Interventions (PCI)	✓	-	-	Data collection ongoing
National Audit of Seizures and Epilepsies in Children and Young People	✓	-	-	Data collection ongoing
National Bowel Cancer Audit (NBOCA)	✓	-	-	Data collection ongoing
National Cardiac Arrest Audit (NCAA)	✓	-	-	Data collection ongoing
National Clinical Audit for Rheumatoid and Early Inflammatory Arthritis (NCAREIA)	✓	-	-	Data collection ongoing
National Comparative Audit of Major Haemorrhage	✓	4	100%	Data submitted for all eligible patients
National Diabetes Audit - Adults				
a) National Diabetes Core Audit	✗	-	-	IT infrastructure not supported – risk assessment for non-participation completed
b) National Inpatients Diabetes Audit	✓	-	-	Data currently being collected and entered retrospectively

Eligible National Clinical Audits	Participated	Number of cases submitted	Participation rate	Comments
c) National Diabetes Foot care Audit	✓	-	-	Data collection ongoing
d) National Diabetes in Pregnancy Audit	✓	29	100%	
National Emergency Laparotomy Audit (NELA)	✓	-	-	Data collection ongoing
National Heart Failure Audit	✓	297	62%	Data collection ongoing
National Joint Registry (NJR)	✓	-	-	Data collection ongoing
National Lung Cancer Audit (NLCA)	✓	-	-	Data collection ongoing
National Maternity and Perinatal Audit (NMPA)	✓	-	-	Data collection ongoing
National Mortality Case Record Review Programme	✓	-	-	Data collection ongoing
National Neonatal Audit Programme - Neonatal Intensive and Special Care (NNAP)	✓	-	-	Data collection ongoing
National Oesophago-Gastric Cancer (NAOGC)	✓	-	-	Data collection ongoing
National Ophthalmology Audit	✗	-	-	IT infrastructure not embedded for 2018/19. It will be available for 2019/20
National Paediatric Diabetes Audit (NPDA)	✓	-	-	Data collection ongoing
National Prostate Cancer Audit	✓	-	-	Data collection ongoing
Non-invasive ventilation (NIV) - Adults	✓	-	-	Data collection ongoing
Reducing the impact of serious infections (Antimicrobial Resistance and Sepsis)	✓	-	-	Data collection ongoing
Serious Hazards of Transfusion (SHOT): UK National Haemovigilance	✓	8	100%	
Seven Day Hospital Services	✓	173	87%	
Surgical Site Infection Surveillance Service	✓	-	-	Data collection ongoing
Vital Signs in Adults (care in emergency departments)	✓	50	100%	

Eligible National Clinical Audits	Participated	Number of cases submitted	Participation rate	Comments
VTE risk in lower limb immobilisation (care in emergency departments)	✓	43	100%	
Learning Disability Mortality Review Programme (LeDeR)	✓	11	100%	
Eligible National Confidential Enquiries	**Participated**	**Number of cases submitted**	**Participation rate**	**Comments**
Child Health Clinical Outcome Review Programme	✓	-	-	No eligible cases
Medical and Surgical Clinical Outcome Review Programme				
a) Acute Bowel Obstruction	✓	8	100%	
b) Pulmonary Embolism	✓	N/A	-	Organisational questionnaires completed
Maternal, Newborn and Infant Clinical Outcome Review Programme				
a) Perinatal Mortality Review	✓	-	-	Data collection ongoing
b) Surveillance	✓	To be confirmed	100%	Database duplicating some records however all cases uploaded

The reports of nine national clinical audits were reviewed by the provider in 2018/19 and Kettering General Hospital NHS Foundation Trust intends to take the following actions to improve the quality of healthcare provided:

Table 2: Actions in response to recommendations from national clinical audits

Audit	Key Actions
National Lung Cancer Audit published Mar 2018	1. Ensuring data completeness is optimal and uploaded continuously; 2. Discuss with the oncologist and explore the possible reasons for slightly low small cell lung cancer treatment rates; 3. All findings to be reported in the lung cancer multidisciplinary team annual report and discussed at the lung cancer annual business meeting.
National Diabetes Foot Care Audit published Mar 2018	1. Minimum 100 patients per year to be submitted for statistical significance – Perioral Dermatitis Severity index (PODSi) to start data collection for any new ulcers identified within clinics;

Audit	Key Actions
	2. Improve 12-week and 24-week outcomes for persistent ulceration; 3. Increase referrals to rapid access vascular clinic and increase in multi-disciplinary foot care team outpatient activity due to Transformation Investment from NHS England.
National Secondary Care Chronic Obstructive Pulmonary Disease (COPD) Audit published Apr 2018	1. Re-organise the Rocket team to review patients on acute wards; 2. Reviews to be undertaken twice daily; 3. Further educate staff on the COPD Bundle; 4. Add the COPD bundle to the admission pack, this will enable all patients to have the pathway activated if COPD.
Learning Disability Mortality Review Programme published May 2018	1. Policy to be updated to outline automatic structured judgement review for all deaths in patients with a learning disability from 1st April 2018; 2. Amendment to notification system to be made to include Mortality Manager and Assistant.
National Neonatal Audit Programme published Sep 2018	1. To appoint a new admin assistant to maintain high compliance levels; 2. To monitor the ongoing uptake of magnesium sulphate for mothers presenting in preterm labour at <30 weeks; 3. To continue to support breast feeding on the unit and for all new staff to undertake training.
National Emergency Laparotomy Audit published Nov 2018	1. Encourage increased data entry – regular reminders and encouragement to relevant staff; 2. Stimulate the postoperative assessment by a care of elderly specialist to patients over the age of 70; 3. Increase referrals and improvement in communication.
National Heart Failure Audit published Nov 2018	1. Improvement in prescribing levels of key modifying therapies; 2. Ongoing education at ward based level; 3. Heart Failure Study days for medics and GP; 4. Improve accuracy of data entry; 5. Review of post discharge follow-up for cardiology and Heart Failure Nurse Specialist review; 6. Referral to Cardiac Rehab post discharge.
National Bowel Cancer Audit published Dec 2018	1. Continue / maintain the areas where results are very good (case ascertainment, laparoscopic surgical intent and operation, pathology data, length of stay, rectal cancer clearance margin, individual surgeon outcome data); 2. Improve pre-op classification of malignant tumours staging in conjunction with radiology; 3. Improve stoma closure times where possible; 4. Check reason for higher emergency / urgent rate; 5. Audit rectal cancer to measure compliance with guidance

Audit	Key Actions
	on neoadjuvant chemo radiation.
National Audit of Care at the End of Life published Feb 2019	1. Palliative Care to provide seven day, face-to-face services; 2. Survey families and others experience of care; 3. Improve individualised care planning for the dying patient – the expansion of the Palliative Care Nursing service will allow every identified dying patient to receive a Palliative Care assessment to ensure individualised care.

The reports of 134 local clinical audits were reviewed by the provider in 2018/19 and Kettering General Hospital NHS Foundation Trust intends to take the following actions to improve the quality of healthcare provided:

Table 3: Sample of actions in response to recommendations from local clinical audits

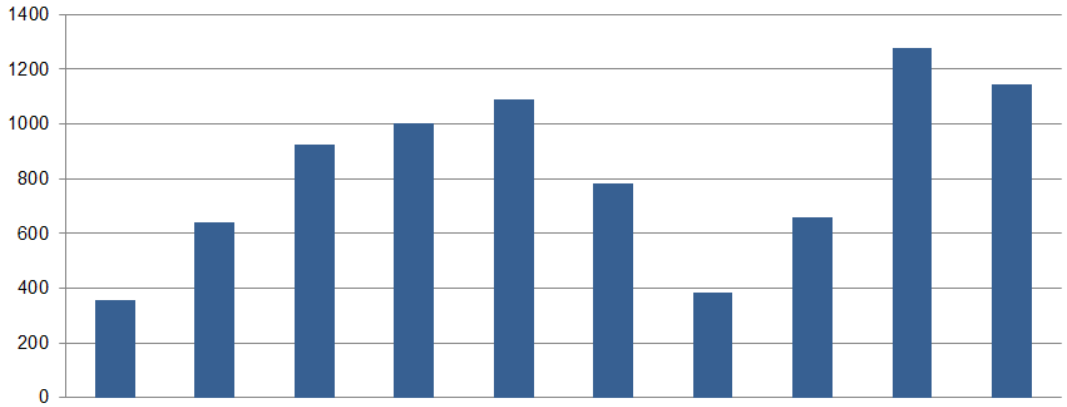
Audit	Key Actions
Breech Presentation and External Cephalic Version (ECV)	1. All women with breech presentation to be offered ECV or contraindication documented; 2. Eligible women who present as breech in labour should be offered ECV; 3. When consenting women for ECV, ensure expectation of procedure is clearly explained in order to minimise abandoned procedures; 4. ECV to be recorded as a procedure on Medway.
Neonatal Hypothermia Audit	1. Use of hats at birth – mothers to be provided with hats for their new born; 2. Monitoring of the room temperature in Delivery Suite and theatre; 3. Liaise with managers to ensure compliance with record keeping.
Management of distal radius fractures – are we compliant with British Orthopaedic Association standards for Trauma & Orthopaedics?	1. Design poster to be put up in plaster room for how to do a full plaster in neutral position with three-point moulding; 2. Design a flow chart to be used by A&E/fracture clinic team in regards to the management of distal radius fractures.
Social history taking in geriatrics	1. Develop a pro forma for A&E containing social history fields; 2. Redesign the admission clerking pro forma to indicate a social history page following history of presenting compliant; 3. Allocate a section for geriatrics with emphasis on social history in initial induction meeting for doctors joining KGH.
Appropriateness of indwelling urinary	1. Restrict use to patients who have clear indications; 2. Alternative methods should be sought before inserting

Audit	Key Actions
catheters on medical wards	catheter (i.e. pre & post-void bladder scan); 3. Review of catheter status regularly on ward rounds; 4. Remove the catheter as soon as it is no longer needed; 5. Development of catheter care sticker, which includes above; 6. Teaching and further education among medical and nursing staff regarding healthcare associated infections, catheter insertion and care.
Are referrals to the Intermediate Care Team for intravenous (IV) antibiotics at home appropriate?	1. Implement a referral process that includes checking blood results and sensitivities before referring for antibiotics at home; 2. Checklist and sticker to be developed and publicised; 3. Discuss ways to record ambulatory care initiated antibiotics in main notes; 4. Implement weekly meetings with KGH care at home to discuss all patients on IV antibiotics on the virtual ward; 5. Implement cellulitis pathway encouraging the use of oral antibiotics for this indication where possible.
Use of non-invasive ventilation (NIV) in acidotic patients	1. Teaching sessions for clinical staff to further educate about the use of NIV on our respiratory wards and acute medical wards; 2. Develop posters to show the pathway and guides for the use of NIV.
Documentation in ITU	1. To raise awareness amongst doctors during induction regarding the importance of completing discharge summary; 2. Consultant of the week/or nurse in charge could check whether weekend discharges had a completed note; 3. During the week, complete easy note as soon as patient has been identified as a potential discharge; 4. Introduce airway sticker for insertion of endotracheal tubes.
Induction of Labour (IOL)	1. To alter the target parameters on the maternity dashboard to represent the National Maternity and Perinatal Audit dataset target; 2. The midwifery matron to address the delays for amniotomy with the delivery suite coordinators where the acuity levels did not warrant delays; 3. To continue to use BirthRate Plus tool on Delivery Suite to accurately record acuity and facilitate ongoing analysis of delays in transfers as the result of Delivery Suite acuity; 4. To encourage midwives and obstetricians to offer outpatient IOL to those who meet criteria; 5. Encourage registrars to consult with their seniors when decisions regarding induction of labour are made as per the established process for booking inductions. This 'fresh eyes' review supports objective consideration of the rationale for induction.

2.2.3 Participation in research

The number of patients receiving relevant health services provided or subcontracted by Kettering General Hospital NHS Foundation Trust in 2018/19 that were recruited during that period to participate in research approved by a research ethics committee 3,563. This consisted of 1146 patients recruited into National Institute of Health Research (NIHR) portfolio studies and 2417 into non-portfolio studies.

KGH Patient recruitment to NIHR Portfolio Studies over the last 10 years



	2009	2010	2011	2012/13	2013/14	2014/15	2015/16	2016/17	2017/18	2018/19
Number of patients	357	641	926	1001	1088	783	384	657	1277	1146

Data source: Internal local audit

2.2.4 CQUIN income

A proportion of Kettering General Hospital NHS Foundation Trust income in 2018/19 was conditional on achieving quality improvement and innovation goals agreed between Kettering General Hospital NHS Foundation Trust and any person or body they entered into a contract, agreement or arrangement with for the provision of relevant health services, through the Commissioning for Quality and Innovation (CQUIN) payment framework.

CQUIN 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 2018/2019 the CQUIN schemes were nationally mandated.

CQUIN Schemes apply to both the Trust contract with its lead commissioner, NHS Corby, and for its specialised services commissioned by NHS England.

The Trust's performance against CQUINs is shown below. Performance for quarters 1, 2 and 3 for 2018/2019 has been assessed by our commissioners. Quarter 4 is pending sign off from our commissioners as at the date of this Quality Report.

Table 4: 2018/19 CQUIN Quarterly Review - Q1, 2 & 3 confirmed, Q4 self-assessment

CCG Indicator	Indicator weighting (%CQUIN scheme available)	Approx. value (£000)	Q1	Q2	Q3	Q4	Outcome
Introduction of health and wellbeing initiatives	33.3% of 0.25% CCG	£157				£63	
Healthy food for NHS staff, visitors and patients	33.3% of 0.25% CCG	£157				£157	
Achieving an uptake of flu vaccinations by frontline clinical staff of 70% (Feb 18)	33.3% of 0.25% CCG	£157				£157	
Reducing the impact of serious infections (Antimicrobial Resistance and Sepsis) [1]	0.25% CCG	£470	£53	£53	£53	£182	
Improving services for people with mental health needs who present to A&E[2]	0.25% CCG	£470	£0	£94	£0	£376	
Offering Advice & Guidance	0.25% CCG	£470	£0	£0	£0	£47	
Preventing ill health by risky behaviours – alcohol and tobacco[3]	0.25% of CCG	£470	£0	£0	£87	£82	
NHS e-referrals – Completed in 2017/18[4]	*0.25% CCG*	*£0*					*£0*
Supporting proactive and safe discharge – suspended in 2017/18	*0.25% CCG*	*£0*					*£0*
NHSE (Specialised and Dental) Indicator							
Medicines Optimisation	1%	£142	£36	£36	£36	£36	
Local neonatal activity and data collection	1%	£142	£36	£36	£36	£36	
Secondary Care Dental	2.50%	£227	£57	£57	£57	£57	
Grand Total		£2,862	£182	£276	£269	£1,193	

Key

Achieved
Partially achieved
Not achieved
No requirement to report

1. The improvements in sepsis management are described on page 61.
2. This CQUIN has had a positive impact on patients that were frequent attenders to A&E. The quality of coding for these patients is now also much improved. Further details of how this CQUIN has had a positive impact are included on page 64.
3. This CQUIN has focused on identifying and influencing inpatients who are increasing or higher risk drinkers by providing brief advice, and to identify and influence inpatients who smoke to make an attempt to stop. Through patient screening, support and collaborative working with Northampton County Council and Substance to Solution, more patients have been encouraged to stop smoking and drink less.
4. The use of the E-referral system and closer working with our local GPs to offer clinical advice and guidance has improved the level of unnecessary attendances to A&E by reducing the number of inappropriate referrals.

Further details of the agreed goals for 2018/19 and for the following 12-month period are available electronically at https://www.england.nhs.uk/nhs-standard-contract/cquin/pres-cquin-17-19/

2.2.5 Care Quality Commission registration

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 2018/19.

The Trust was inspected by the Care Quality Commission on 5th – 7th February and 12th – 14th March 2019. The rating as published on 22nd May 2019 was 'Requires Improvement'. The inspection in March focused on how well led the organisation is and this received a rating of 'Good'. Overall, the services provided by the Trust received 35 ratings of 'Good' and 23 ratings of 'Requires Improvement'. No 'Inadequate' ratings were received. The number of improved ratings across our services total 13, evidencing our journey to outstanding.

The CQC identified 14 areas of improvements that the Trust must take:

Urgent and Emergency Care Services

- Ensure that patients receive initial assessment and observations in a timely manner in line with national standards. Regulation 12 (1)(2)(a)(b);
- Ensure nursing risk assessments and safety checklists are completed. Regulation 12 (2)(a);
- Ensure that waiting children and their families are not waiting to be seen in an adult environment. Regulation 12(2)(d);
- Ensure that pain relief is administered in a timely manner, that pain is re-assessed after receiving pain relief medicines and at regular intervals. Regulation 12 (2) (a).

Medical Care (including Older Peoples' Care)

- All patients initial and review risk assessments are completed and recorded in line with Trust protocols. Regulation 12 (1) (2).
- All patients have a pain assessment and management plan that is regularly reviewed in line with trust protocols. Regulation 12 (1) (2);
- All patients' records are completed with appropriate information to understand their care plans. Ensure all patients have person-centred care plans that are well maintained and reflect appropriately patients' changing needs and treatment. Regulation 12 (1) (2);
- All staff follow the trust infection prevention and control policy regarding hand hygiene procedures. Regulation 12 (1) (2);
- Medicines cancelled on medicine charts are appropriately signed and dated at the time of cancellation. Regulation 12 (1) (2);
- All agency staff have access to systems to report incidents within appropriate timescales in line with trust protocols. Regulation 17 (1) (2);
- All staff complete Mental Capacity Act 2005 and Deprivation of Liberty

Safeguards training. Regulation 18 (1)
- All clinical areas are staffed to ensure safe patient care. Regulation 18 (1);
- There is adequate medical staffing out of hours to ensure patients safety across all clinical areas. Regulation 18 (1).

Trust wide

- All complaints are managed in line with Trust policies. Regulation 16 (1) (2).

Ratings tables

Key to tables

Ratings	Not rated	Inadequate	Requires improvement	Good	Outstanding
Rating change since last inspection	Same	Up one rating	Up two ratings	Down one rating	Down two ratings
Symbol*	→ ←	↑	↑↑	↓	↓↓
Month Year = Date last rating published					

Ratings for the whole trust

Safe	Effective	Caring	Responsive	Well-led	Overall
Requires improvement → ← Feb 2019	Requires improvement → ← Feb 2019	Good → ← Feb 2019	Requires improvement → ← Feb 2019	Good ↑ Feb 2019	Requires improvement → ← Feb 2019

Ratings for Kettering General Hospital

	Safe	Effective	Caring	Responsive	Well-led	Overall
Urgent & emergency services	Requires improvement ↑ Feb 2019	Requires improvement → ← Feb 2019	Good → ← Feb 2019	Requires improvement → ← Feb 2019	Requires improvement ↑ Feb 2019	Requires improvement ↑ Feb 2019
Medical care (including older people's care)	Requires improvement → ← Feb 2019	Requires improvement → ← Feb 2019	Good → ← Feb 2019	Good → ← Feb 2019	Requires improvement → ← Feb 2019	Requires improvement → ← Feb 2019
Surgery	Requires improvement Feb 2018	Good Feb 2018	Good Feb 2018	Requires improvement Feb 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	Good ↑ Feb 2019	Good ↑ Feb 2019	Good → ← Feb 2019	Good ↑ Feb 2019	Good ↑ Feb 2019	Good ↑ Feb 2019
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 2018
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 2019	N/A	Good → ← Feb 2019	Good ↑ Feb 2019	Good → ← Feb 2019	Good → ← Feb 2019
Diagnostic imaging	Good ↑↑ Feb 2019	N/A	Good → ← Feb 2019	Good ↑ Feb 2019	Good ↑↑ Feb 2019	Good ↑ Feb 2019
Overall	Requires improvement → ← Feb 2019	Requires improvement → ← Feb 2019	Good → ← Feb 2019	Requires improvement → ← Feb 2019	Requires improvement → ← Feb 2019	Requires improvement → ← Feb 2019

Requirement Notices

The Trust has received 13 requirement notices that are detailed in the above 'must do' actions. The Regulations are summarised below:

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Maternity and midwifery services Treatment of disease, disorder or injury	Regulation 16 HSCA (RA) Regulations 2014 Receiving and acting on complaints

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing

Actions the Trust will take during 2019/20

The Trust will continue with its governance processes and quality improvement programmes across all services to ensure that the 'must do' actions under the above Regulated Activity is addressed. Progress and any identified risks will be reported to the Board and its nominated committees throughout 2019/20 to ensure the actions are delivered.

2.2.6 Care Quality Commission special reviews and investigations

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

2.2.7 Secondary Uses Service

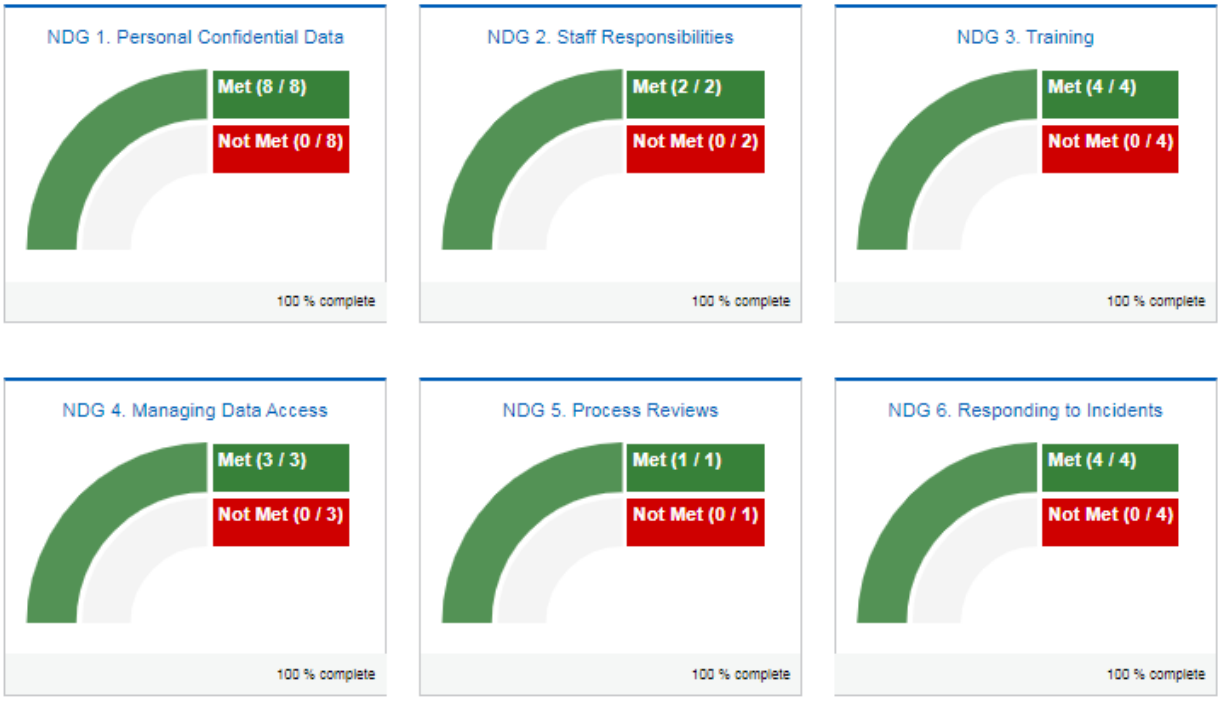
Kettering General Hospital NHS Foundation Trust did not submit records during 2018/19 to the Secondary Uses Service for inclusion in the Hospital Episode Statistics (HES) which are included in the latest published data.

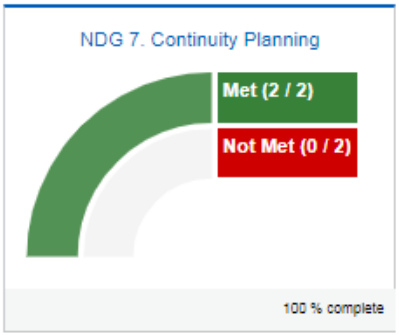
2.2.8 Information Governance

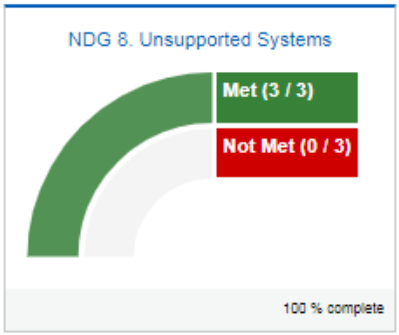
Kettering General Hospital NHS Foundation Trust's Information Governance Assessment Report overall score for 2018/19 was rated as meeting 100 mandatory requirements across 32 standards.

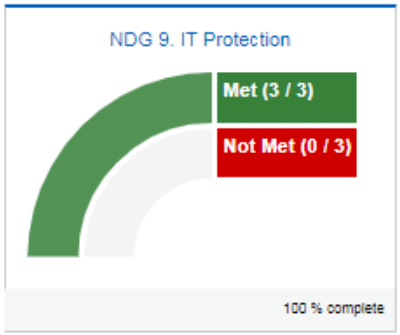
Over the past year there has been development to deliver the wider and changing Information Governance remit, via steps in line with the Data Security and Protection Toolkit (DSPT) whilst the organisation complies with the General Data Protection Regulations. Achievement of these is evidenced through data flow process maps, records of processing activities and compliance with the DSPT mandatory standards.

KGH 2019 Data Security and Protection Toolkit (DSPT)
Compliance with mandatory National Data Guardian's (NDG) Data Security Standards









KGH's Information Governance Assessment Report overall score for 2018/19 rated as meeting 100 mandatory requirements across 32 standards

2.2.9 Payment by Results

Kettering General Hospital NHS Foundation Trust was not subject to the Payment by Results clinical coding audit during 2018/19 by the Audit Commission.

2.2.10 Action taken to improve data quality

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

Having information that is accurate, timely and trusted is key to supporting decision making across the Trust. Over the past few years our approach to providing information has not kept pace with demand or emerging technology improvements, meaning that information provided can be hard to interpret and therefore use to make effective decisions. In order to assist improving our information and data quality the Trust commissioned a number of independent reviews during 2018/19.

Internal Audit assessed whether underlying data for the A&E indicators is accurate, valid, reliable, timely, relevant and complete. To provide this assurance a random sample of patients was tested by completing a review of electronic and manually recorded patient information and real-time physical observations. Discussions and testing verified:

- Accuracy and reasonableness of patient arrival/registration and discharge times;
- The validation process;
- Daily breach validation processes and, if relevant, the reason for breach.

In January 2019 Internal Audit reported that Limited Assurance could be provided due to a number of weaknesses, which included a difference of opinion on

whether the PAS or CAS cards are the prime record. The review indicated that dual recording of certain data takes place, patient records are inconsistent, timing differences between data input are known to occur and retrospective recording of matching times occurs.

Whilst a number of improvements have been made since the report was received, the underlying systems and processes in place across the Trust remained a concern, so in March 2019 the Trust asked KPMG to support us by undertaking a large scale review, known as the Enterprise Data Architecture (EDA) review, which identified the following key areas for attention:

- Increase skills and capacity of the team;
- Revise governance structures;
- Stock-take of the existing reports created;
- Review scale of data quality issues;
- Introduce modern business intelligence and visualisation tools.

Having had time to assess the report, the Trust is now in the process of bringing in some short and medium term assistance to address a number of the highest priority recommendations.

Compounding this situation is the mix of paper and electronic systems in a number of clinical processes. This means there is no single source of data, leading to further potential for errors in reporting and interpretation. The implementation of the Electronic Patient Record (EPR) programme will start to address the reduction in paper, and the streamlining of processes to create a comprehensive electronic record. Implementing the EPR, combined with following up the EDA recommendations, will mean the Trust will be in a better position to have consistency of data sources, able to provide rich information to inform operational and strategic decisions.

2.2.11 Learning from Deaths

During 2018/19 1,214 of Kettering General Hospital NHS Foundation Trust patients died. This comprised the following number of deaths which occurred in each quarter of that reporting period:

- 288 in the first quarter (286 adult in-patient deaths and 2 new born / paediatric deaths);
- 272 in the second quarter (269 adult in-patient deaths and 3 new born / paediatric deaths);
- 303 in the third quarter (299 adult in-patient deaths and 4 new born / paediatric deaths);
- 351 in the fourth quarter (348 adult in-patient deaths and 3 new born / paediatric deaths).

613 mortality case record reviews have been achieved in relation to 1,102 (adult inpatient deaths only) as at 21 April 2019.

The number of deaths in each quarter for which a case record review was carried out was:

- 138 in the first quarter;
- 143 in the second quarter;
- 156 in the third quarter;
- 176 in the fourth quarter (retrospective case record reviews ongoing).

In 2 cases a death was subjected to both a case record review and an investigation.

After the panel discussion, if cases are deemed to be Likert 3 or below, these are escalated to the Serious Incident Review Group (SIRG) for consideration of Internal Investigation or Serious Incident declaration.

One, representing 0.2% of the patient deaths during the reporting period, is judged to be more likely than not to have been due to problems in the care provided to the patient. The one case graded as 'more likely than not to have been due to problems in the care' was subjected to a patient safety investigation that was reported on to the Serious Incident Review Group and any carer or family members of the patient.

In relation to each quarter, this consisted of:

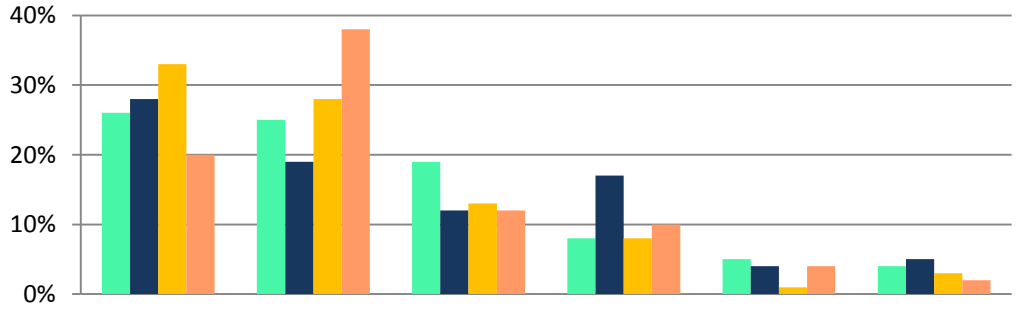
- 0 representing 0% for the first quarter;
- 0 representing 0% for the second quarter;
- 1 representing 0.7% for the third quarter;
- 0 representing 0% for the fourth quarter (retrospective case record reviews ongoing).

These numbers have been estimated using the Trust's local screening pro forma and, where applicable, Structured Judgment Review (SJR) tool. Cases which are identified as having potential problems in healthcare are then escalated to a multi-disciplinary panel discussion.

A summary of the learning themes identified by quarter is detailed below. As reviews for January 2019 are currently ongoing (retrospective case note review) these are not yet available but will be included in the Trust's monthly / quarterly *Learning from Deaths* dashboard which is published on the Kettering General Hospital public website.

613 case record reviews were carried out in relation to 1,102 deaths

Top six quarterly learning themes April – March 2019 (March 2019 reviews ongoing)



	Good care, no learning points	Good care, positive learning point	Improve documentation	Clinical diagnostic issues	Poor communication between teams	Earlier consideration of ceiling of treatment
Quarter 1 2018/19	26%	25%	19%	8%	5%	4%
Quarter 2 2018/19	28%	19%	12%	17%	4%	5%
Quarter 3 2018/19	33%	28%	13%	8%	1%	3%
Quarter 4 2018/19	20%	38%	12%	10%	4%	2%

Data source: local level review

- **Good care, no learning points –** these cases are filed and detailed in the monthly and quarterly Learning from Deaths dashboards;
- **Good care, positive learning point** – these cases are fed back to the specialty mortality and morbidity (M&M) lead as well as any staff named for providing exemplar care / documentation;
- **Improve documentation** – Improve documentation – The Corporate Audit Plan includes the upcoming Trust-wide documentation audit. On completion, the results will be shared via the Patient Safety Advisory Group, and an action plan produced to support improved documentation. Furthermore, the Trust is currently looking at procuring an Electronic Patient Record (EPR) system to provide an electronic solution to improve documentation across the Trust;
- **Clinical diagnostic issues** – these cases relate to results not being acted on in a timely fashion. Specialty M&M meetings are implementing actions around specific cases. Furthermore, there have been improvements made to the Trusts 'Result Reporting' functionality to help highlight specific results which are outside of the 'as expected' range;
- **Poor communication between teams** – these cases has been discussed at various Specialty M&M meetings. This particular learning theme has decreased month on month as a result. Cases identified under this learning theme will continue to be flagged up at M&M meetings;
- **Earlier consideration of ceiling of treatment /** Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) - Specialties requiring refresher training around DNACPR and ceiling of treatment have been identified and ad-hoc sessions are being arranged within the Specialty M&M meetings.

Twenty case record reviews and 0 investigations completed after 01 April 2018 which related to deaths which took place before the start of the reporting period.

Zero, 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 Trust's local screening pro forma and where applicable, SJR tool. Cases which are identified as having potential problems in healthcare are then escalated to a multi-disciplinary panel discussion. After the panel discussion, if cases are deemed to be Likert 3 or below, these are escalated to the Serious Incident Review Group (SIRG) for consideration of Internal Investigation or Serious Incident declaration.

Zero, representing 0% of the patient deaths during 2017/18 are judged to be more likely than not to have been due to problems in the care provided to the patient.

An average of 54% of case record reviews concluded that the care was good

2.3 Reporting against core indicators

2.3.1 Summary Hospital-level Mortality Indicator (SHMI)

(a) The value and banding of the Summary Hospital-level Mortality Indicator ('SHMI') for the Trust for the reporting period

SHMI Oct 2017 to Sep 2018					
Provider name	SHMI value	SHMI banding	Number of spells	Observed deaths	Expected deaths
South Tyneside NHS Foundation Trust	1.27	1	22,401	1,209	953.37
Kettering General Hospital NHS Foundation Trust	1.08	2	51,499	1,757	1,625.1
Homerton University Hospital NHS Foundation Trust	0.69	3	44,661	500	722.81

(b) The percentage of patient deaths with palliative care coded at either diagnosis or specialty level for the Trust for the reporting period.

Crude palliative coding rate for deaths by trust (all non-specialist acute providers) for all admissions Oct 2017 to Sep 2018				
	Provider name	Palliative deaths	Deaths	Palliative coding rate
Lowest rate	South Tyneside NHS Foundation Trust	254	1,777	14.29%
	Kettering General Hospital NHS Foundation Trust	477	1,757	27.15%
Highest rate	Homerton University Hospital NHS Foundation Trust	714	1,199	59.55%

Please note: The Dr Foster report selects the two Trusts with the highest and lowest SHMI to provide a benchmark for comparison of KGH performance nationally.

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

- The above data has been produced by Dr Foster. Dr Foster routinely collects hospital administrative data derived from Hospital Episode Statistics (HES) and analyses the data within the Quality Investigator tool. A report is produced and examines the in-hospital mortality for all inpatient admissions over a 12-month time period.

The Kettering General Hospital NHS Foundation Trust intends to take the following actions to improve this rate and so the quality of its services:

- Continue to monitor this and work closely with the Dr Foster representative for Kettering General Hospital.

2.3.2 Patient-reported outcome measures (PROMS)

Patient Reported Outcome Measures (PROMs) assesses the quality of care delivered to NHS patients from the patient perspective. Currently covering four clinical procedures, PROMs calculate the health gains after surgery using pre and post-operative questionnaires. The health status or health related quality of life at a single point in time is captured through these questionnaires. The information collected is then collated and provides an indication of the outcomes or quality of care delivered to NHS patients.

The procedures measured include;

- Hip Replacements;
- Knee Replacements.

Data was collected on varicose vein and groin hernia procedures in England however, following on from the NHS England Consultation on PROMs, collection of these procedures ceased on 1 October 2017.

Over the page are the last two published findings from the PROMs publication.

Explanatory notes:

Health Gain measures – all patients are asked to complete two general measures, both before and after their surgery	
EQ-5D TM Index includes:	**EQ – Visual Analogue Scale (EQ-VAS)**
• ability to pursue their usual activities; • current experience of anxiety and/or depression, if any; • current experience of pain and discomfort, if any; • mobility, and; • ability to wash and dress themselves (self-care).	Is a single item, 'thermometer'-style measure which asks patients to rate their general health at the time of completion on a linear scale from 0 – 100, with 100 representing the best possible state of health.
Within their post-operative questionnaires, all patients are also asked: • how they would describe the results of their operation (satisfaction), and; • how their problems are now, compared with before the operation (success).	

2016-17 data

HEALTH GAIN Finalised data for April 2016 – March 2017						
Total Knee Replacements						
	Oxford knee score		EQ VAS		EQ-5D Index	
	Health gain	Improved %	Health gain	Improved %	Health gain	Improved %
England	16.392	93.80%	6.892	57.50%	0.323	81.10%
Kettering	19.067	92.40%	18.238	87.10%	0.369	79.80%
Total Hip Replacements						
	Oxford hip score		EQ VAS		EQ-5D Index	
	Health gain	Improved %	Health gain	Improved %	Health gain	Improved %
England	21.382	96.70%	13.137	67.20%	0.437	89.10%
Kettering	22.407	97.80%	17.313	75.90%	0.407	81%

PARTICIPATION RATES Finalised data for April 2016 – March 2017			
Total Knee Replacements			
	Total HES	Total pre-op Qs	Participation rate
England	88671	84097	94.84%
Kettering	261	184	70.50%
Total Hip Replacements			
	Total HES	Total pre-op Qs	Participation rate
England	80443	69328	86.18%
Kettering	210	164	78.10%

2017-18 data

HEALTH GAIN Finalised data for April 2017 – March 2018						
Total Knee Replacements						
	Oxford knee score		EQ VAS		EQ-5D Index	
	Health gain	Improved %	Health gain	Improved %	Health gain	Improved %
England	17.102	94.60%	8.153	59.70%	0.337	82.60%
Kettering	17.702	96.50%	15.594	74.50%	0.317	77%
Total Hip Replacements						
	Oxford hip score		EQ VAS		EQ-5D Index	
	Health gain	Improved %	Health gain	Improved %	Health gain	Improved %
England	22.21	97.20%	13.877	68.30%	0.458	90.00%
Kettering	23.772	97.00%	18.427	72.90%	0.491	85%

PARTICIPATION RATES Finalised data for April 2016 – March 2017			
Total Knee Replacements			
	Total HES	Total pre-op Qs	Participation rate
England	90553	79072	87.32%
Kettering	214	265	123.83%
Total Hip Replacements			
	Total HES	Total pre-op Qs	Participation rate
England	76169	65546	86.05%
Kettering	200	227	113.50%

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

- Following the implementation of Joint School, patients have further education on the procedure they will be undergoing. Therefore, patients have better-informed expectations following surgery and have additional opportunities to ask staff members questions;
- The method for processing the pre-operative questionnaire in-house has changed to improve the accuracy of results. The pre-operative questionnaire is sent immediately after surgery to ensure that the post-operative questionnaire is sent at the correct time. Historically it was sent as soon as it was received. However some patients had their operation the following week, others had to wait a month or, on occasion, longer. This would result in patients receiving questionnaires at varied post-surgery stages, which could impact adversely on the health gain results.

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

- Joint School has been restructured, with four sessions per week with the capacity to discuss the operation process with six patients during each session;
- The PROMs team at Kettering General Hospital have set up a working group to look at ways in which PROMS uptake can be improved, which will in turn help with validity of results.

The Kettering General Hospital NHS Foundation Trust intends to take the following actions to improve this percentage and so the quality of its services, by:

- The PROMS team at Kettering General Hospital will also be looking into potential method to improve PROMS uptake to improve validity of results;
- Historically, focus was directed towards participation rates, however moving forward the Trust will continue to monitor this, but health gain will also be reported and actions put in place to further improve rates wherever possible;

- Further expand Joint School to ensure all patients are able to attend the sessions prior to surgery.

2.3.3 Readmissions

The percentage of patients aged:
(i) 0 to 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.

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 2018/19 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. As a result we are unable to benchmark our performance nationally.

The percentage of patients 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:

	2014/15	2015/16	2016/17	2017/18
0 -15 years	9.0%	9.9%	10.4%	9.2%
16 or over	8.0%	7.4%	8.1%	8.1%

The 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.

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

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

2.3.4 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 Patient Experience and Involvement Steering Group receive assurance on implementation of the strategy and the group has membership from staff, Trust Governors, patient representatives, volunteers and external partners such as Healthwatch / Young Healthwatch Northamptonshire and Northampton Association for the Blind (NAB).

During 2018/19 Young Healthwatch Northamptonshire (YHW) and Kettering General Hospital (KGH) Patient Experience Team have worked together to improve Paediatric services at KGH. Both have a common goal, which is to improve the patient experience. YHW were inspired to improve patient experience because they are potential users of the hospital; therefore they have a vested interest in KGH delivering quality services. Both YHW and KGH believe that patients should have a voice in the services that they use.

YHW's expertise, energy and enthusiasm have been of huge benefit to the Trust. Following the review, YHW members produced a report of their findings. The highlighted areas for improvement informed an action plan to ensure learning was implemented.

In addition to this the Trust took part in The Takeover Challenge. The Takeover Challenge puts children and young people into real-life, decision-making positions in organisations. Children gain a valuable insight and gain experience of a workplace, while organisations benefit from a fresh perspective on their work. Young Healthwatch launched the formal report from their visit in April.

The Takeover Challenge started with YHW attending the Clinical Skills Lab to learn about cannulas and how blood is taken.

Following this they visited the Pathology Department to see what happens to blood and the various processes involved.

Before the report launch YHW finished by visiting Pharmacy where they received a tour of the department and learnt how the medications are managed and processed.

Patient Experience Network National Awards (PENNA)

The collaborative work that has been undertaken between the Trust and YHW was recognised at a national level when the project entitled "It's My Health – Youth Voice" won Patient Experience Team of the Year.

Engaging with the community

Following on from the previous success with the community engagement events,

the Patient Experience Team is designing a portable meeting pod to support with engagement and allow patients and the public to talk in a more private space. This was launched in April 2019.

Examples of positive feedback from NHS Choices during 2018/19:

Breast clinic

"was really nervous ahead of my appointment but needn't have been . I was called in early and there was hardly a wait. Staff are helpful, kind and understanding - all of you from the receptionist to the nurses, the radiographer and consultant and the radiologist - fantastic !! to be treated like an individual amongst all the thousands of patients you must see is amazing . Thank you so much, you should be proud . Well done all. What a great team"

Visited in March 2019. Posted on 12 March 2019

Accident and Emergency

"13 month old baby taken to A&E by ambulance after a seizure when she needed some help with her breathing. Seen by the Paediatric Matron and the ED registrar almost immediately. Received excellent holistic care to help my baby recover. The staff were very efficient and caring. Thank you for all you do."

Visited in October 2018. Posted on 4 October 2018.

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 complainants. Formal complaints are defined as those complainants who wish to receive a response in writing.

During 2018/19 an independent review has been undertaken into the complaints handling process. This review identified and made recommendations on areas for improvement. Whilst the way in which complaints are processed and documented was deemed as good, suggestions have been made to allow further improvements.

These are as follows:

Increase staffing numbers in the complaints team. Each division will be allocated a complaint case handler.

Three tier triage system for new complaints with response time scales based on complexity:

- 15 working days – low complexity
- 35 working days – medium complexity
- 60 working days – high complexity

Lead investigator to produce the draft complaint response.

New key performance indicators:

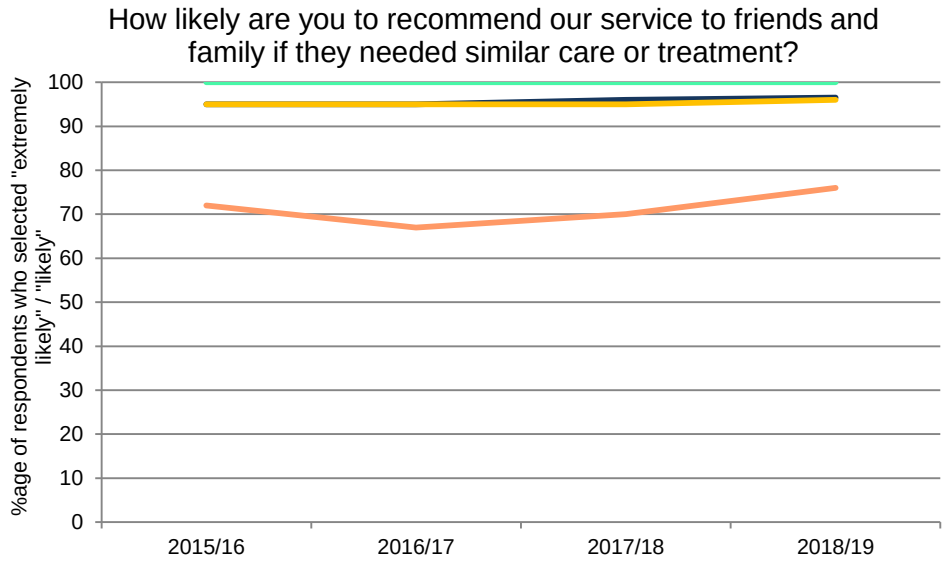
- Acknowledgement of a complaint within 3 working days - **95%**
- Providing a written response to a complaint within timeframes above – **95%**

Dissatisfied complainants not to exceed – **10%**

Change staffing level signatory in line with investigation complexity.

Friends and Family Test Indicator

At the beginning of 2017/18 the Trust changed the metric by which it records the Friends and Family Test (FFT). Previously a Net Promoter Score was used, that measured 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.



Best score nationally	100%	100%	100%	100%
KGH score	95%	95%	96%	96.5%
Average score nationally	95%	95%	95%	96%
Worst score nationally	72%	67%	70%	76%

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

The data is made available for inpatients and patients who have been discharged. (Gateway reference 00931)

The Kettering General Hospital NHS Foundation Trust considers that 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.

KGH Friends and Family survey has scored slightly higher than the national average for a second year

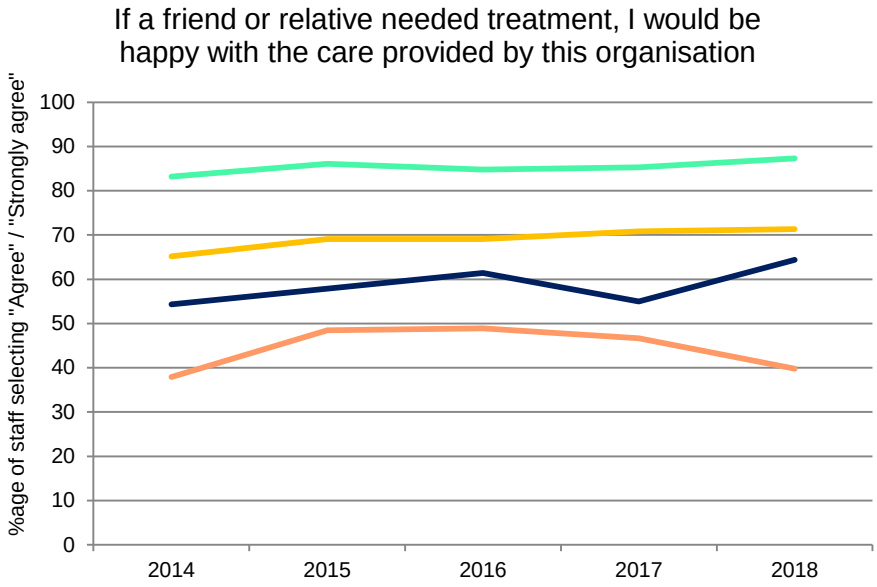
Kettering General Hospital NHS Foundation Trust has taken the following actions to improve this percentage, and so the quality of its services, by:

- Developing an electronic platform to enable feedback to be captured;
- Produced co-designed reporting with staff and patients to make sure results are displayed in a meaningful way;
- Implement feedback kiosks to make feedback accessible;
- Work with volunteers to promote the completion of FFT responses.

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.

2.3.5 The percentage of staff employed by, or under contract to, the Trust who would recommend the Trust as a provider of care to their family or friends

The measurement of staff who would be happy with the standard of care at KGH for their friends and family is tabled below. Please note that the rating has changed from previous years to enable a percentage to be reported. A year on year comparison is provided, which demonstrates the journey and progress that is being made, although it is accepted there is still work to do.



Best score nationally	89.5%	86.1%	84.8%	85.3%	87.3%
KGH score	54.3%	57.9%	61.4%	55.0%	64.4%
Average score nationally	65.4%	69.3%	69.1%	70.8%	71.3%
Worst score nationally	37.9%	45.8%	48.5%	46.4%	39.8%

Data source: 2018 NHS Staff Survey Result

Kettering General Hospital NHS Foundation Trust considers that this data is as described for the following reasons because the data has been reported at a national level and was presented to the Board on the 29th March 2019.

Kettering General Hospital NHS Foundation Trust has taken the following actions to improve this percentage, and so the quality of its services, by improving engagement and embedding the organisational values throughout the organisation and for

them to be meaningful and 'lived'. The Trust also undertook wide consultation on the Trust strategy meaning the priorities were staff led and all have improving care at their centre. The staff survey is a key piece of intelligence with 45% of KGH staff taking part in the 2018 NHS Staff Survey. This marks a significant improvement on last year when 35.5% of staff responded and an almost 20% improvement on three years ago when in 2015 only 26.6% of staff took part. These results validate the actions the Trust has taken to increase staff engagement; this year's score increased in six areas, remained the same in two areas and decreased in only one area. In five of the nine themed areas KGH's improved score was statistically significant;

- (Support from) immediate managers;
- Quality of appraisals;
- Quality of care;
- Safety culture;
- Staff engagement.

2.3.6 The percentage of patients who were admitted to hospital and who were risk-assessed for venous thromboembolism

	Q1	Q2	Q3	Q4	2018/19
Best performance nationally	100%	100%	100%	Not published yet	
Kettering General Hospital	99.3%	99.5%	99.6%	99.6%	99.5%
National average	95.6%	95.5%	95.7%	Not published yet	
Lowest performance nationally	75.8%	68.7%	54.9%	Not published yet	

Data source: NHS Digital

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

- The data is reviewed by the VTE assessment team and is consistent with VTE data collected via the safety thermometer tool.

2.3.7 The rate per 100,000 bed days of cases of C. difficile infection reported within the Trust among patients aged 2 or over during the reporting period

A ceiling was set by our commissioners of no more than 25 cases during 2018/19, a reduction from 26 cases over the previous three years. The data below demonstrates that the Trust figures were well below this ceiling.

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

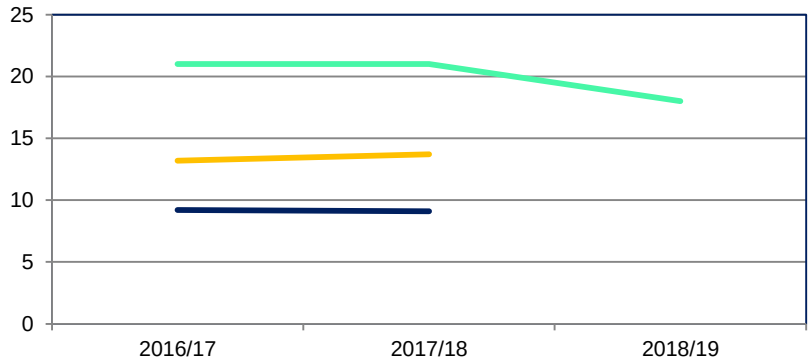
All Clostridium difficile positive specimens are required to be uploaded onto HealthCare Associated Infection Data Capture System (HCAI DCS) which is Public Health England's Data Capture System. This provides an integrated data reporting and analysis system for the mandatory surveillance of Staphylococcus aureus, Escherichia coli, Klebsiella spp., Pseudomonas aeruginosa bacteraemia and Clostridium difficile infections. The system uses patient and specimen detail to assign the specimen according to current acquisition guidelines, e.g. community acquired or hospital acquired. The

numbers are verified by the Trust at the time of uploading, monitored by the Clinical Commissioning Group (CCG) and the microbiology laboratory are also required, as part of the accreditation analysis, to send quarterly reports on numbers of faecal samples tested and number of positives found. These data are then triangulated with the Trust overall numbers accordingly.

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

- Each hospital acquired case has a ward-based root cause analysis (RCA) completed, with support of the Infection Prevention and Control Team. These are validated by the weekly Multi-Disciplinary Team before being sent to the Clinical Commissioning Group;
- Maintaining the ward league table. This details the number of days free from a hospital acquired Clostridium difficile in each area. Visually this acts as a reminder of good practice and provides healthy competition between wards and units. The table comes out with practice reminders, seasonal messages and highlights focusing on areas that require improvement;
- Continued use of the best practice mnemonic SIGHT, as advised by national guidance for when to test and isolate a patient with diarrhoea;
- Incorporation of the Hall Assessment in the stool chart, which sits within the Trust documentation. The assessment allows for actions to be documented, and make decision-making more visual;
- Numbers and RCA themes are monitored through the Infection Prevention and Control Committee and through relevant Divisional Governance meetings.

Cases of C. difficile infection reported among patients aged two or over



KGH number of cases	21	21	18
KGH rate per 100,000 bed days	9.2	9.1	Published Jul 2019
National average rate per 100,000 bed days	13.2	13.7	Published Jul 2019

Data source: HCAI DCS, Public Health England

2.3.8 The number and, where available, rate of patient safety incidents reported within the Trust. Inclusive of the number and percentage of such patient safety incidents that resulted in severe harm or death;

The number and rate (per 1,000 bed days) of patient safety incidents reported										
	Apr 16 – Sep16		Oct 16 – Mar 17		Apr 17 – Sep 17		Oct 17 – Mar 18		Apr 18 – Sep 18	
	#	rate	#	rate	#	rate	#	rate	#	rate
Cluster maximum	11,695	45.6	10,941	42	11,552	45.6	12,401	46.6	12,717	50.7
KGH	3,341	30	2,906	24.9	3,440	30.2	3,854	32.8	3,360	29.3
Cluster average	4,354	32.3	4,402	32.4	4,566	33.8	4,840	34.5	4,874	35.4
Cluster minimum	2,305	21.2	2,554	23.3	2,511	28	2,494	25	2,469	25.4

Number and % of patient safety incidents that resulted in severe harm										
	Apr 16 – Sep16		Oct 16 – Mar 17		Apr 17 – Sep 17		Oct 17 – Mar 18		Apr 18 – Sep 18	
	#	%	#	%	#	%	#	%	#	%
Cluster maximum	75	1.4%	67	2.1%	92	1.5%	78	1.2%	32	0.5%
KGH	21	0.6%	61	2.1%	36	1%	27	0.7%	5	0.1%
Cluster average	20	0.5%	22	0.5%	23	0.5%	21	0.5%	14.7	0.4%
Cluster minimum	2	0.1%	3	0.1%	2	0.1%	2	0.1%	0	0%

Number and % of patient safety incidents that resulted in death										
	Apr 16 – Sep16		Oct 16 – Mar 17		Apr 17 – Sep 17		Oct 17 – Mar 18		Apr 18 – Sep 18	
	#	%	#	%	#	%	#	%	#	%
Cluster maximum	17	0.3%	19	0.3%	29	0.5%	21	0.3%	17	0.5%
KGH	2	0.1%	1	0%	3	0.1%	0	0%	0	0%
Cluster average	5	0.1%	5.3	0.1%	7	0.2%	6	0.18%	5.6	0.2%
Cluster minimum	0	0%	1	0%	0	0%	0	0%	0	0%

Data source: National Reporting and Learning System (NRLS)

2018/19 figures are taken from the latest available NRLS data report for period 01 March 2018 to 30 September 2018. Comparative data are provided for the Midlands and East (Central Midlands) cluster of nine acute (non-specialist) trusts.

A report published by NHS Improvement identifies that there is no evidence of potential under reporting and that our incident reporting rates have not significantly changed, therefore there are currently no further actions for the Trust.

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

6,813 patient safety incidents were captured on Kettering General

Hospital's patient safety incident reporting system, Datix, and were also reported to the NRLS, during the full twelve months of 2018/19. The number of reported incidents is 348 less than 2017/18 and can be attributed to a reduction in patient falls and infrastructure related incidents (bed availability, staffing levels).
The percentage of deaths, deemed to be as a direct result of patient safety and reported to the National Reporting Learning System was nil.

The reduction in severe harm is due to a changed process in reporting of hospital-acquired thrombosis incidents. These were historically reported as severe harm in the first instance, but actual harm is now determined through root cause analysis reporting.

76.6% of incidents reported relate to near misses (where an incident has been averted) and incidents that have incurred no harm.

The Trust actively encourages a culture of open reporting and widespread sharing and learning from incidents to improve patient safety. The safety of our patients is our principal concern and we are relentless in our focus on reducing avoidable harm. We will be open and transparent about our safety work, our incidents and our actions for improvement. We will strive to make the care in our hospitals harm free
Our incident reporting system is monitored to ensure all services in the Trust are able to report incidents.

The Kettering General Hospital NHS Foundation Trust has taken the following actions to improve this number of incidents reported, and so the quality of its services, by:

- Improved awareness at corporate induction and mandatory training on the importance of reporting incidents, including near misses;
- Improved embedded learning from all incidents is in place;
- Governance Managers and Facilitators in place to improve understanding of patient safety embed a learning culture;
- Creation of dashboards in Datix with 'live data' charts to help clinicians better understand their patient safety risks;
- Ward Hot Boards identifying monthly incident trends;
- Lessons Learnt Forums;
- All staff, including bank and agency staff, are encouraged to report incidents as part of their ward local induction;
- Bank staff attend Corporate Induction where the importance of reporting is discussed.

2.3.9 Progress in implementing the priority clinical standards for seven day hospital services

The Seven Day Hospital Services Programme (7DS) was developed to support providers of acute services to deliver consistent care for patients, regardless of the time of day, or day of the week on which they are admitted. Ten 7DS clinical standards were developed, with four of them identified as "priority" standards.

There will be a requirement from June 2019 for organisations to provide both Board level reporting and national reporting on their position twice yearly against the four priority clinical standards. This is achieved by means of a self-assessment against a board assurance template developed by NHS Improvement for consistency of reporting.

Kettering General Hospital NHS Foundation Trust has engaged in the first round of self-assessment and a process has been put in place to ensure ongoing assessment twice a year and board assurance. External assurance will be provided by the Care Quality Commission and Clinical Commissioning Groups.

The initial self-assessment Appendix 1: Priority 7 Day Hospital Services Standards Self-Assessment Autumn/Winter 2018/19 has demonstrated full compliance with three out of the four priority standards. Full compliance with clinical standard 2 remains challenging due to weekend working in Obstetrics and Gynaecology, Cardiology, Paediatrics and General Surgery. Clinical standard 2 requires that:

> *"All emergency admissions must be seen and have a thorough clinical assessment by a suitable consultant as soon as possible but at the latest within 14 hours from the time of admission to hospital."*

Plans to provide the appropriate resource to bridge the gap in delivery of clinical standard 2 have been developed. These include:

- Recruitment of new consultant posts;
- Rota review (capacity and demand match, both for junior doctors and senior consultants);
- County-wide capacity plan;
- Aligning job plans with Seven Day Services;
- Continued reduction of super stranded patients (patients who have been in hospital 7 days or more);
- Seven day service provision is one of the core elements of future clinical sustainability strategy;
- Seven day services are a fundamental requirement for consideration in all new service development business cases.

Additionally, steps have been taken to improve the measurement methodology by:

- Addressing some inconsistencies in recording the time of Decision to Admit;
- Developing formal guidelines/ pathways for admitted patients who do not require consultant review.

The Trust currently not being in a position to demonstrate full compliance with standard 2 is recorded as a risk on the corporate risk register and progress with achieving compliance is monitored.

2.3.10 Freedom to Speak Up

The Trust is committed to establishing an environment where all staff, at whatever level, know that it is safe and acceptable to raise concerns. The Trust values concerns, and sees it as a valuable opportunity to improve services for patients, staff and the public.

We have had a Freedom to Speak up Guardian in the Trust since 2015.
The purpose of this role is to:

- Work as an impartial and independent source of advice to staff, accessible to anyone in the organisation;
- Support a focus on safety and quality;
- Uphold our **CARE** values, learning and proper handling of cases;
- To work alongside key stakeholders to ensure a culture where raising concerns is regarded as 'business as usual';
- Works closely with the Board and stakeholders to improve the culture of speaking up in the NHS.

The Trust's 2018/19 ambition as agreed with the Board and shared widely was to:

- Create a culture of openness and trust;
- Embed processes for raising concerns that are robust, accessible and clear;
- Ensure all concerns raised are taken seriously and acted on;
- Make sure all staff are confident that they are listened to;
- Make sure staff feel recognised and valued for raising a concern;
- Make sure investigations into concerns raised are prompt and fair;
- Ensure staff receive a response about the concern raised, including the action or decision taken;
- Share important lessons and learn from mistakes without the need to apportion blame;
- Ensure there is no detriment to any staff who speak up;
- Engage FTSU Champions to raise awareness in relation to speaking up and assist the FTSU Guardian in listening to concerns.

The FTSU Guardian is supported by a FTSU Officer and a number of FTSU Champions from clinical and non-clinical staff across the Trust.

There are a number of routes by which staff can speak up, including:

Email – there is a secure nhs.net email address for reporting FTSU issues;
Telephone – a dedicated FTSU mobile phone is in place;
Face-to-face meetings with the Guardian and FTSU surgeries are held across the Trust on a weekly basis.

Our FTSU Guardian has direct and open access to our Chief Executive Officer to discuss cases raised and emerging themes. Where required, staff who speak up also have direct access to our Chief Executive Officer.

Key FTSU achievements during 2018/19

NGO case reviews inform our speaking up development plan

Substantial assurance in TIAA audit, December 2018

Appointment of FTSU Champions across the Trust (8 so far)

Engagement from CEO in meeting staff who speak up

Development of 'Tom's Story' as a learning tool from a FTSU case

Feedback from staff that they feel valued and safe when speaking up

Cascade of learning from FTSU outcomes

Development of standards for investigations and timescales

Surgeries access the Trust for FTSU

Joint working with the GMC

Guide for managers promoting an open culture

Quality assurance visits for assurance on improvements

Freedom to Speak-Up Strategy 2018/19

Our Vision: To create a culture where colleagues feel safe to speak up and raise concerns

FREEDOM TO SPEAK UP SAFELY
Together we can make a difference

Aim

Increase the numbers of colleagues indicating they 'feel safe to speak up and challenge the way things are done' and improve the number of colleagues who agree they would 'feel safe about raising concerns about unsafe clinical practice' to be in the top five ranking hospitals in the East Midlands

Strategy	Tactics	Change Idea
Leadership	Managers to take responsibility for reducing the anxiety of colleagues wishing to raise a concern	Top tips; Managers guidance to be developed and circulated
		Training package to be developed for managers
Communication and engagement with colleagues	Colleagues to have a clear understanding of what raising concerns refers to and the process	Colleague leaflet to be distributed setting out why it is important and how to raise concerns
		Recruit FTSU Champions across the Trust and develop network
		Intranet site developed to provide further information and sign posting to support sources
	Reinforce the importance of colleagues feeling safe to speak up through regular communications	Raising concerns to be included in corporate learning and induction
		Monthly staff bulletin article to be published
Openness and transparency	Learning to be shared on a regular basis throughout all levels of the hospital	Six monthly report to board sharing learning from raising concerns
		Learning to be shared via staff bulletin
Policy in line with national guidance	Policy to represent best practice	Full policy review during 2018 following consultation period on implementation of national policy
	Include in pre-performance review checklist process	Review pre-appraisal checklist to ensure the opportunity to raise concerns and how to raise concerns are included

Measurement: % increase in number of staff speaking up
% increase in the national NHS staff survey question agreeing they would feel secure raising concerns about unsafe clinical practice

During 2018/19 we launched a video across the Trust to all staff, emphasising our commitment to speaking up.

During 2019/20 we will launch 'Tom's Story' to embed learning from a speaking up case. Tom's Story is also the result of an initiative from our Chief Executive Officer, emphasising the commitment to an opening and learning culture.

We will also refresh our ambitions for further developments, continue with reporting to the Board and benefit from the time dedicated to Freedom to Speak Up.

Our Senior Independent Director for Speaking up (a Non-Executive Director) continues to support our speaking up culture alongside holding us to account for handling of cases and embedding learning.

During December 2018 the Trust received substantial assurance (the best possible outcome) as a result of an internal audit of the processes in place and the learning from concerns raised.

During 2018/19 more staff spoke up than in any other year, speaking up about patient safety, quality and their working environment, including behaviours. This was welcomed and feedback on investigation outcomes was provided to staff in a way they had chosen. This ranged from face to face meetings with the Guardian or an investigating manager, the Chief Executive or in written format. Feedback is requested from staff up so that we can continue to improve an open culture. During 2018/19 no staff felt there was any detriment to them from speaking up and all reported that they had felt valued for raising a concern.

The Trust was delighted to welcome Dr Henrietta Hughes, the National Guardian for Speaking Up, when she visited on 14 February 2019. From information received from the National Guardian's Office, we have been able to benchmark Kettering General Hospital data against that of other trusts of a similar size.

> "Thank you very much for hosting my visit. It was very clear from the conversations with your colleagues that speaking up is leading to quality improvements."
>
> *Dr Henrietta Hughes*

The following are some examples of improvements that have been made in response to issues raised via the FTSU process during 2018/19:

- Criteria for the transfer of patients requiring oxygen to specific wards strengthened;
- Medical staffing levels across medicine wards improved;
- Equity of annual leave addressed within a team;
- Risk assessment process for patients for whom a bed is not immediately available strengthened;
- Recognition of parking requirements for a disabled member of staff;

- Importance of acting on environmental repairs for staff;
- Improvement to record keeping on nutrition and hydration on wards;
- **CARE** values to be upheld in staff meetings;
- The importance of listening to and communicating with carers/family members and maximising preventative actions to prevent falls;
- Revision of the grievance policy to make it clearer that mediation is an option, with clarification of the next steps if the issue is not resolved;
- Improved communications to staff around the uniform policy.

The NHS Staff Survey results, 2018, demonstrate an improved position on senior managers acting on feedback and that staff feel encouraged to report errors, near misses or incidents.

2.3.11 Consolidated annual report on rota gaps and the plan for improvement to reduce these gaps

The management of the hospital recognises the importance of having fully-staffed rotas to ensure patient safety, staff safety and the well-being and welfare of our staff.

The greatest factor causing gaps in rotas are vacancies. 75-85% of gaps are due to vacancy, with the rest split between sickness, maternity/paternity leave and annual/study leave.

The number of medical staff recruitment (and vacancies) has been increasing. This has been due to difficulties recruiting, retention of staff reduced to Trust Grade doctors being appointed to training grade posts and increase in establishments to meet greater service demands. Not all of these posts being recruited will result in a gap in a rota.

There were challenges in recruiting to junior Trust Grade posts (which are also used to cover training post gaps) from January to July 2018 due to visa restrictions implemented by the Home Office. This saw a reduction in candidates applying and, when offered posts, not being able to start. This was escalated to NHS England by the Director of Human Resources and the Chief Executive. Since July 2018 the visa regulations have been amended and we have seen a large increase in the number of applicants for posts.

The rotas are reviewed to identify gaps and to find bank or agency doctors where possible. The majority of these gaps are filled by bank and agency doctors with 91% of shifts filled, with reviews on a weekly basis in A&E and acute medicine to review the rotas. The medical rota is reviewed twice a week with updates sent out indicating any known gaps. Departmental rota leads in Surgery, Trauma and Orthopaedics, Anaesthetics, Obstetrics and Gynaecology assist the Rota Administrators in identifying and closing gaps.

Where a long term vacancy (over four weeks) is identified, the Trust always tries to book a “long line” bank or agency doctor to cover the gap. At present there are 44 “long line” bank/agency doctors covering gaps on rotas.

The Trust's objective is obviously to fill these gaps and there have been successful recruitment campaigns in high vacancy areas such as medicine, surgery and trauma and orthopaedics. There are also a high number of posts that have been offered which will mean more posts/gaps will be filled and long line bank/agency doctors taken out.

There is an incentive scheme for Trust Doctors of £3,000 to assist (in particular) overseas doctors when first entering the UK with travel, visa and accommodation costs. The Trust also offers all Trust doctors an Educational and Clinical Supervisor, and support with study leave and expenses.

In many specialties rotational posts have been developed to give junior Trust Doctors experience in a range of specialties to improve their experience. This has led to a number of Trust Doctors progressing to training posts.

The Trust is moving to an electronic rostering system for medics. In the next three months additional rota coordinator support needs to be provided within the clinical Divisions to manage the rotas and be supported by the rota administrators.

Part 3: Other information

3.1 Performance against the priorities set for 2018/19

Patient Safety Priorities 2018/19

3.1.1 Preventing avoidable deterioration (sepsis management)

We said we would:

- 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 the National Institute of Health and Care Excellence (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.

What we have achieved:

The timely recognition and management of sepsis remains a Trust and national priority and has been a continued priority for the Trust in 2018/19.

Over the last year the Sepsis Working Group have made the following improvements:

- Updated the paediatric screening tools;
- Updated the adult sepsis screening tool;
- Published a paediatric sepsis guideline;
- Updated the adult sepsis guideline;
- Developed and launched an outpatient pathway;
- Updated the sepsis lanyard cards and distributed them to clinical staff;
- Supported the maternity team to update the Modified Early Obstetric Warning Score (MEOWS) tool to include the latest adult sepsis screening tool;
- Supported the maternity team to develop a community MEOWS tool which includes a sepsis screening and action tool;
- Supported the development and launch of National Early Warning Score 2 (NEWS 2);
- Developed Sepsis E-Learning;
- Ran ongoing paediatric simulation training sessions;
- Delivered additional training and support to key clinical areas;
- Established an audit against NICE Quality Statements 1-4 for new cases of red flag sepsis within the Trust.

A strategy of challenging poor performance and rewarding good practice underpins the sepsis quality improvement work at KGH. Feedback is provided to lead clinicians for most new cases of sepsis. Sepsis star certificates are awarded to staff where good

practice is identified, thanking them for their contribution to the patient's management. This has been a well-received initiative at KGH and staff have often approached the sepsis team expressing a desire to earn a star certificate.

Sepsis management has been internally and externally monitored via the Reducing the Impact of Serious Infections CQUIN. There are four parts to the CQUIN and the sepsis team lead on 2a and 2b, while the antimicrobial team lead on 2c and 2d.

National CQUIN	Indicator	Indicator weighting (% of CQUIN scheme available)
CQUIN 2a	Timely identification of sepsis in emergency departments and acute inpatient settings.	25% of 0.25% (0.0625%)
CQUIN 2b	Timely treatment for sepsis in emergency departments and acute inpatient settings.	25% of 0.25% (0.0625%)
CQUIN 2c	Antibiotic review.	25% of 0.25% (0.0625%)
CQUIN 2d	Reduction in antibiotic consumption per 1,000 admissions and proportion of antibiotic usage (for both in-patients and out-patients) within the Access AWaRe category.	25% of 0.25% (0.0625%)

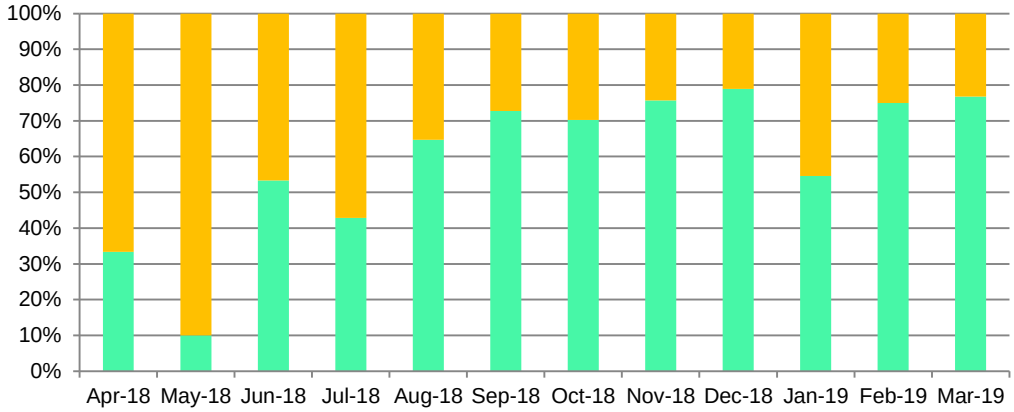
Our overall quarter 4 performance against the CQUIN is:

2a Sepsis screening rates **85%**
2b One-hour antibiotic administration rates for new cases of red flag sepsis **81%**

Recognising that urgent care areas see a high proportion of acutely unwell patients, focused support has been provided to Medical Assessment Unit (MAU) and Clifford wards. Initially this was supported by the East Midlands Patient Safety Collaborative, however their support is now completed. Working with the sisters on both wards, the matron and an urgent care consultant, the Sepsis Nurse Practitioner has been visiting both wards on a regular basis, challenging, teaching and encouraging improvement in the recognition of patients requiring sepsis screening. This has yielded their first sepsis stars.
We developed and published a paediatric sepsis guideline in October 2018 which incorporates the paediatric antibiotic policy for children of different ages with suspected sepsis. The Trust paediatric sepsis lead and the microbiology team are currently in the process of undertaking further work to develop separate paediatric antibiotic guidelines for common infections.

NICE published Quality Statements for sepsis (QS161) in September 2017. KGH has been assessing most new cases of red flag sepsis against statements 1-4 since April 2018. In quarter one, this process was trialled against a selection of inpatient cases, in quarter two A&E cases were also included. Feedback for inpatient cases is provided to senior clinical staff including the patient's consultant and the ward sister praising good elements and highlighting any learning points. Through this process the Trust has seen an overall improvement in the escalation of patients with new red flags for sepsis to a senior clinical decision maker. This is significant for patient safety.

Review of patients screened as red flag sepsis by a senior clinical decision maker



	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19
Total # screened as red flag sepsis	12	10	15	28	34	33	37	37	38	33	44	43
Senior clinician review within 1 hr	4	1	8	12	22	24	26	28	30	18	33	33

We now report our sepsis training compliance figures monthly. At induction all clinical staff receive face to face training and annual competency assessment is achieved by completion of the Trust eLearning programme which was launched in June 2018. As of March 2019, the overall Trust compliance with sepsis mandatory training is 89%.

The A&E department continues to be a strong area of focus for the sepsis working group and A&E staff sit on the sepsis working group. The Sepsis Nurse Practitioner has recently been running bite-sized sepsis training sessions within the A&E department. As part of this 88 staff have received training in addition to their mandatory training. We continually aim to improve completion of the sepsis screening tool and timeliness of antibiotics within the A&E and have embedded the sepsis screening and action tool into the department documentation. The quarter 4 CQUIN audit data for A&E patients is presented below.

2a Sepsis screening rates **87%**
2b One-hour antibiotic administration rates for new cases of red flag sepsis **85%**

Sepsis improvement work and audit is overseen by the Sepsis Working Group, chaired by the Trust Sepsis Lead and Clinical Director of ICU with representation from a number of specialties. The Sepsis Steering Group is chaired by the Sepsis Nurse Practitioner and meets bi-monthly. The Sepsis Steering Group is the forum via which the Working Group update Sepsis Champions (practice improvement facilitators) on current initiatives, provide educational updates and share audit data. Sepsis Champions are expected to feed this back to their clinical areas. To promote attendance the Sepsis Nurse Practitioner issues re-validation slips at meetings and is working with the ward accreditation team to embed having an active sepsis champion into the ward accreditation process. Below is a picture of us playing the Sepsis Star Game (our own invention) during our last meeting in March 2019.

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

We said we would:

- Comply with national guidance from the Royal College of Emergency Medicine (RCEM) 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;
- Improve our documentation.

What we have achieved:

In May 2018 the Mental Health Quality Improvement (MHQI) project was developed with the aim of improving

care to mental health patients who attend the A&E department. Current practice was assessed against the following guidance:

- RCEM *Mental health in the Emergency Department* (tool kit for improving care);
- NCEPOD, 2017 *"Treat as One" Bridging the gap between mental and physical healthcare in general hospitals* (national audit results and recommendations);
- PLAN *Quality Standards for Liaison Psychiatry Service* 5th ED 2017.

This exercise identified four areas in need of improvement. These were:

- Training and education;
- Documentation and assessment;
- Risk and environment; *and*
- Communication between services and service improvement.

Collaborative working with Northamptonshire Hospitals Foundation Trust (NHFT) and Substance to Solutions (Alcohol Liaison Services, S2S) has enabled clearer communications between Trusts and improved the effectiveness of working, allowing timely assessment in line with the PLAN quality standards 2017. It has also allowed for the implementation of a rolling training programme for staff to enhance their mental health/ alcohol dependency knowledge whilst understanding the legislation underpinning practice. A training programme has been introduced which consists of online learning and face-to-face training. It aims to meet the following learning outcomes for staff:

- Awareness of the Acute Liaison Mental Health Service (ALMHS) and the support it offers;
- How the Mental Health Triage Tool informs practice and determines the levels of risk;
- How to refer to ALMHS and S2S (including priority/risk levels);
- Understanding of the legal frameworks that underpin mental health assessment processes;
- Awareness of alternative services that support mental health care provision in the county;
- Understand the more common mental health presentations, including the effects of psychological trauma;
- Development of techniques and strategies to care and communicate with patients presenting with mental health illness;
- Understand the negative stigma of mental illness and how this can impact on the success of care and treatment.

Continued estates work has been undertaken to ensure that the Mental Health room within the A&E department is equipped to the standard set by PLAN 2017.

The Trust has employed a Mental Health Nurse within A&E to help support with the care needs and education of staff. Their role is also to support the implementation and continuous monitoring of the Improving Services for people with mental health needs who present to A&E. The target to reduce the number of attendances to A&E by 20% has been achieved.

Ongoing local audit currently sits at 85% of the use and implementation of the mental health risk assessment tool, based on assessing a patient's level of risk associated with their presentation and behaviours.

A dedicated Mental Health and Alcohol Resource page is now available to all staff on the KGH Intranet (K-Net). This supports sharing of knowledge of conditions, practice and service resources.

Communications from NHFT are three times a day to the Clinical Operations team, showing an overview of current mental health bed states, waiting times to be seen by the service and plans in place for those patients awaiting either placement of further assessment. This has improved the working relationship and between the services and KGH to arrange suitable plan to support and care and wellbeing of patients awaiting further input.

KGH and ALMHS have introduced bi-monthly interface meetings which allow for tracking and monitoring of complaints, incidents and evaluation of improvements made, whilst demonstrating good governance between the services.

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

We said we would:

- Introduce a learning message of the week and share through patient safety huddles and team meetings;
- 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 K-net page for all staff to access;
- Enhance learning messages in our Trust induction training;
- We will invite more multidisciplinary staff to our Patient Safety Lessons Learnt Forum (PSLLF).

What we have achieved:

All staff now have access to the Datix Live Dashboard platform. This allows staff to directly access and review the lessons learned on a daily basis from all patient safety incidents reported, including 'low harm' and 'near miss' incidents.

Learning bulletins for serious incidents are shared across the whole organisation through the nursing Sisters. This ensures that the learning from such incidents is also shared within teams that were not directly connected to the incident. Bulletins are also published on K-Net. Patient Safety and Patient Experience teams are together exploring ways to further enhance K-Net access for all staff to lessons learned from other data sources, such as audit and complaints.

Within Trust induction, emphasis is placed on the importance of learning from all reported incidents and guidance is given as to how to submit a report to Datix to alert a potential patient safety event. Datix reporting within KGH remains at a consistent rate across the year and is actively encouraged. NHSI has identified that any organisation that reports patient safety incidents promptly

is likely to have a positive patient safety culture. We have worked to reduce our NRLS reporting time frame, which was averaging 40 days in 2017/2018, and is now 8 days in 2018/2019.

We have a robust rolling programme across the Trust of quality assurance visits to wards and departments supported by senior clinicians, the governance department and Directors. During these visits discussions with staff are undertaken to test understanding of lessons learned and change initiatives that have arisen from that learning. Quality assurance visit reports are produced and shared, with inclusion of thematic analysis around many areas, including staff knowledge of patient safety issues.

Quarterly patient safety reports are submitted to the Quality Governance Steering Group and Quality and Safety Committee, identifying key themes from outcomes. At year end it is proposed that an annual report of patient safety incidents will be thematically assessed and shared for learning.

We report on compliance with evidence against our learning actions, sharing this both within the Trust and externally with the CCG. Learning assurance is reported by Divisional Governance Managers specific to their divisional specialties.

The audience at the Patient Safety and Lessons Learnt Forum continues to be largely medical, but invitations are extended to the wider multidisciplinary team.

Patient Experience Priorities 2018/19

3.1.4 Improving how we manage pain relief for our patients

We said we would:

- Improve our communication with patients to understand their pain;
- Ensure improved compliance with our observation standards of patients' pain.

What we have achieved:

- A new pain care plan has been devised which forms part of the whole care plan document for patients. This assesses nature, severity, causes of pain as well as any factors that may improve pain. This document will be continually re-evaluated as the patient's condition and pain changes;
- There is a standard on pain that is assessed as part of the ward accreditation process. Patients are asked about their pain management and the effectiveness of the staff and medications to deal with it. We have undertaken teaching sessions as part of ward-based study days, including management of pain pumps and how to appropriately refer patients with pain;
- We are developing a website to include a section on the Acute Pain Team and how we work;
- Produced a policy on the use of Fentanyl in recovery and a Pain policy, both of which are now available on the intranet;
- Exploring the addition of some specific questions regarding pain management to the patient satisfaction questionnaire;

- In the process of developing an Acute Pain module on Helm;
- Data collection to monitor pain management and patient safety following orthopaedic surgery. The results of this are being used to inform the development of the intrathecal opiate policy;
- Exploring the adoption of data programmes which will allow more accurate data collection and analysis of the patients seen by the acute pain team.

Our most recent national inpatient survey results demonstrate an increase in those who have experienced pain. This is demonstrated in the tables below which are taken from the Quality Health reports from to 2017 and 2018 where specific questions have been asked relating to pain.

Were you ever in any pain?

	2017		2018	
	Number of respondents	%	Number of respondents	%
Yes	247	60%	290	61%
No	164	40%	182	39%

Question 41, National CQC Inpatient Survey – *Data Source Quality Health Reports*

Do you think the hospital staff did everything they could to help control your pain?

	2017		2018	
	Number of respondents	%	Number of respondents	%
Yes, definitely	171	68%	192	67%
Yes, to some extent	67	27%	74	26%
No	12	5%	19	7%

Question 42, National CQC Inpatient Survey – *Data Source Quality Health Reports*

These results are due to be published by the CQC in May. This will provide a comparison against national results.

3.1.5 Reducing noise at night for our inpatients

We said we would:

- Launch our campaign on 'Sleep Sound in Hospital';
- Enforce our uniform policy in relation to footwear;
- Continue with our pilot of 'sleep well kits' comprising eye masks and ear plugs;
- Work to ensure soft close bins are in place in all inpatient areas.

What we have achieved:

Our most recent national inpatient survey results demonstrate an overall improvement in the number of those who have reported being affected by noise at night. This is reflected in the scoring out of 10 provided.
However there has been a slight increase in those who have been affected by noise at night from staff. This is demonstrated in the table below, with a comparison with results from 2017.

Were you ever bothered by noise at night from other patients?

	2017		2018	
	Number of respondents	%	Number of respondents	%
Yes	158	38%	150	32%
No	259	62%	314	68%

Question 14, National CQC Inpatient Survey – *Data Source Quality Health Reports*

Were you ever bothered by noise at night from hospital staff?

	2017		2018	
	Number of respondents	%	Number of respondents	%
Yes	75	18%	87	19%
No	341	82%	379	81%

Question 15, National CQC Inpatient Survey – *Data Source Quality Health Reports*

There has been an improvement from those who have experienced noise at night from other patients, however the position on noise from staff has increased by 1%.

The Trust has seen a reduction in the number of negative comments relating to noise received via the Friends and Family Test (FFT). This is reported monthly to wards and departments and is monitored by the Patient Experience and Involvement Steering Group and annually to Trust Board.

Wards are no longer able to order metal bins as they have been removed from the ordering system. As areas are updated and bins are replaced, only plastic, soft-close bins can be ordered. This supports the reduction of noise overall. The Trust has trialled "sleep well" kits but there has been a lack of feedback received from patients.

The Trust will continue to promote the campaign and compliance with wearing soft-soled footwear. Feedback from patients will also be monitored to assess if improvements have been made.

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

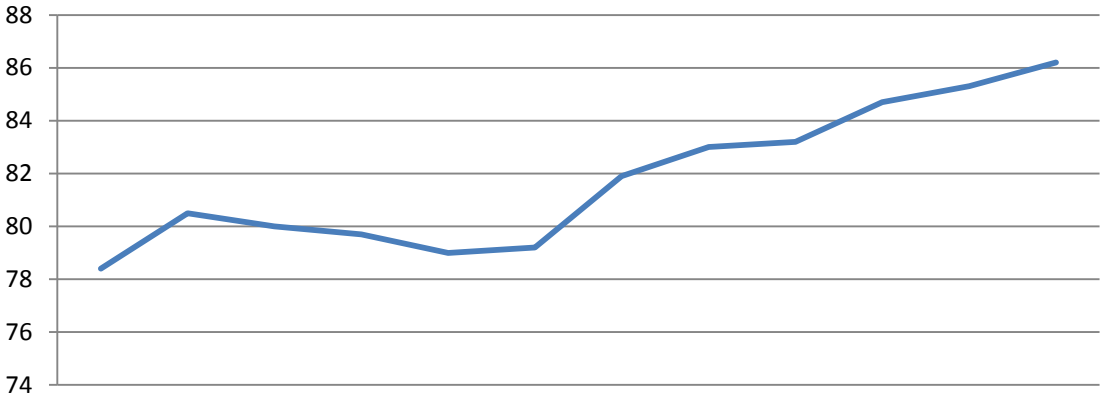
We said we would:

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

What we have achieved:

The Trust has made considerable progress against the RTT standard through 2018/19. In April 2018 Trust RTT performance was at 78.4% but has steadily improved to 86.2% in March 2019. The Trust has an RTT improvement plan that is monitored weekly at the RTT Confirm & Challenge meeting.

Percentage compliance with 18-week RTT standard



	Apr 2018	May 2018	Jun 2018	Jul 2018	Aug 2018	Sep 2018	Oct 2018	Nov 2018	Dec 2018	Jan 2019	Feb 2019	Mar 2019
% performance	78.4	80.5	80	79.7	79	79.2	81.9	83	83.2	84.7	85.3	86.2

The RTT Executive Assurance Group has now been disbanded following the significant progress the organisation has made in tackling the RTT and Radiology backlogs.

A full operational performance report is submitted each month to the Performance, Finance and Resource Committee (PF&R). Deep dives of specialty areas are also presented to PF&R to demonstrate ongoing assurance against agreed plans.

In terms of communication to patients:

- When GPs refer patients via the electronic Referral System (eRS) they can see indicative waiting times for clinics/services;
- When patients log into eRS themselves they can also see the waiting times;
- Appointment letters that are sent to patients ask for patients to let their GP know should their condition improve or worsen;
- Letters also contain links to the Trust website and the Patient Access Policy;
- There is a section of the website about waiting times and details around 18 week rules, as well as information around cancellations and patients who do not attend (DNAs);
- When patients call the appointment centre to cancel an appointment or make enquiries, staff inform them of the Access Policy rules and how long the wait for an appointment is likely to be;
- Each week, all patients who are on the inpatient / day case waiting list who do not have a date are sent a letter apologising for the delay, explain what the process is regarding pre op assessment and giving a contact number for patients to call if they have any queries or concerns.

Clinical Effectiveness Priorities 2018/19

3.1.7 Increasing the number of mortality reviews

We said we would:

- Undertake more than 50% reviews of all patients within the scope of patients;
- Increase the number of multi-disciplinary staff participating in mortality reviews.

What we have achieved:

Central mortality reviews remain at 50% however, a number of Specialties have taken on the responsibility of reviewing all their own deaths and subsequently presenting in their Mortality and Morbidity meetings. Overall, this increases the Trust's reviews above the initial 50% set target.

Additional mortality reviewers have been recruited throughout 2018/19 from a multitude of specialities. Specialty lead nurses (End of Life, Cardiac Resuscitation and Learning Disability) have also been invited and attended panel discussions alongside our pool of Mortality Reviewers. Patient Safety Lessons Learnt Forums and Specialty Mortality and Morbidity meetings have also been extended to senior nursing staff as well as members of the Integrated Governance Team to support with the embedding of learning.

The number of Mortality Reviews will continue to be detailed in the monthly and quarterly Learning from Deaths dashboard (published on the public Kettering General Hospital website).

The Learning from Deaths dashboard is submitted to the Patient Safety Advisory Group (PSAG) and Quality and Safety (Q&S) Committees for approval, as well as Quality Governance Steering Group (QGSG), both monthly and quarterly. Additionally, annual reports summarising the previous financial years' reviews and learning themes / outcomes are presented at the Trust Board (most recently in June 2018).

KGH is also committed to implementing the Medical Examiner model. The Trust has submitted a proposal and business case and it is hoped that this model will be rolled out gradually throughout 2019/20, starting with medical examiner scrutiny of deaths 2 days per week, leading to cover for a 5-day service.

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

We said we would:

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

What we have achieved:

Information from our Avoiding Term Admissions into Neonatal units (ATAiN) database shows that we are making improvement in reducing our overall term admissions to the neonatal unit.

	First admission	37+ weeks gestation	% term admission
2016	283	137	48.4%
2017	305	122	40.0%
2018	282	116	41.1%

Data Source: Avoiding Term Admissions into Neonatal Units

However 'respiratory' as a primary diagnosis for admissions remains our highest contributing factor and we have not improved over the last twelve months.

We have aligned the ATAiN work stream including the reduction respiratory admissions into our overall Maternity Safety Plan and it is reviewed bi-annually at our Maternity Governance Directorate meeting and QGSG. We are working closely with the East Midlands Neonatal Operational Delivery Network (ODN) who regards us as making marked improvement in reducing and reviewing our term admissions. More recently we have compiled an action plan to address outstanding actions which include the implementation of the Newborn Early Warning Trigger and Track (NEWTT) scoring system which enables staff to recognise and escalate the deteriorating neonate – this has been shared with the ODN and Local Maternity System. NEWTT should be fully implemented by May 2019.

We continue to audit in order to address the reduction in respiratory term admissions compliance with the monitoring of room temperatures at delivery and skin-to-skin initiation at birth.

3.1.9 Improving our compliance with mandatory safeguarding training standards

We said we would:

- Ensure that clinical leaders have a plan in place to release staff to attend training;
- Have robust follow up of non-compliance with training.

What we have achieved:

Kettering General Hospital delivers education and training across the Safeguarding Curriculum for adults and children to meet the national guidance and NHS Streamlining agenda.

Safeguarding adults and children level 1 is a required competency for all members of KGH staff in all roles, including volunteers, and is delivered to all staff as part of the Trust induction programme. The competency is renewed 3 yearly via an eLearning package which includes an assessment. The package is updated every 6 months. Group or department face-to-face sessions are offered to facilitate compliance and supportive eLearning is

provided for those who struggle with eLearning and computers.

Evaluation of the package by users is very positive and the assessment has to be passed with 100% to achieve compliance. Outstanding competency requirements are notified by email to prompt completion and managers are informed monthly of their staff compliance.

Safeguarding adults and children level 2 is a competency that is required by all of our patient-facing and handling staff and is renewed 3 yearly. The initial course is also delivered as part of induction for new clinical starters and takes a full day that includes other aspects of safeguarding such as PREVENT (to safeguard vulnerable people from being radicalised to supporting terrorism), Mental Capacity Act, Female Genital Mutilation and Domestic concerns. The course is aligned across the network for consistency and quality and is delivered by our safeguarding leads with review and update yearly.

The participants evaluate the course via survey monkey, with good feedback received. Staff with outstanding competency requirements are emailed to prompt completion and managers are informed monthly of their staff compliance. Non-attendees are emailed and their managers informed of their absence.

Safeguarding children level 3 is a competency required of paediatric registered nurses and more senior staff that are working with children in a decision-making role and directing care investigation and intervention.

At level 3, pre course eLearning is completed, and all candidates have to have completed level 2 as well. It is delivered by means of a 6 hour, face-to-face course, supported by the medical lead for safeguarding and lead practitioners. Renewal of this competency is required every 3 years. There are 4 - 5 sessions a year to support the number of staff requiring this competency. The course is aligned across the network for consistency and quality and is delivered by our safeguarding leads with review and update annually.

Staff may be in their role for a few months before they are able to complete level 3, especially if the paediatric contact is minimal. This adversely impacts on compliance as they remain non-compliant until the next available course. As with the other levels of safeguarding, staff and their manager are reminded by email if they are non-compliant and non-attendance is notified.

Safeguarding training across the profiles level 1 and level 2 has increased and maintained compliance of more than 90% for the past 12 months.

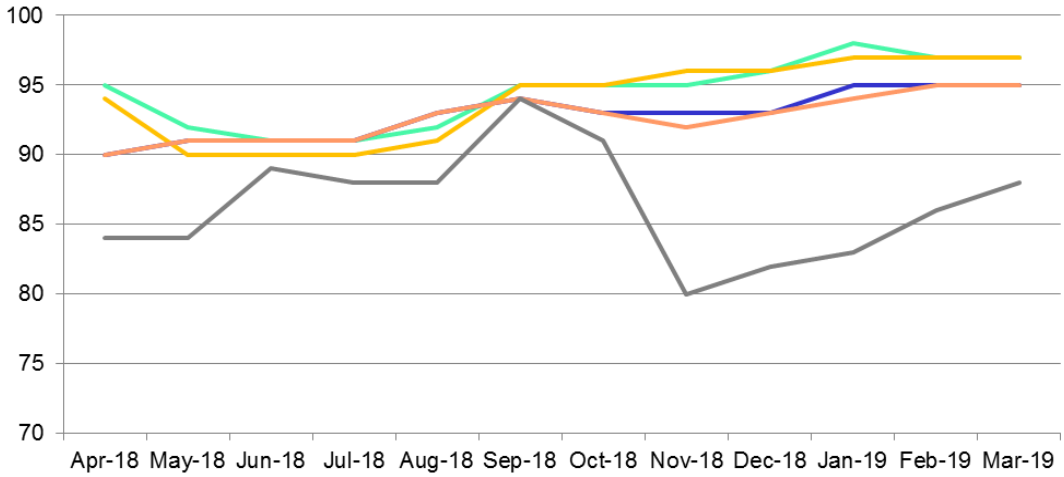
Attendance levels have improved and the eLearning has had a significant impact in maintaining compliance as a refresher for level 1. Individual areas will action plan for their own staff and area when there is a particular area of concern.

Within Obstetrics and Gynaecology the midwives and nursing staff (including Health Care Assistants, Maternity Support Workers, ward clerks etc.) are

booked on to their training well in advance by the Practice Development midwife. This is delivered as part of the midwifery mandatory day by the midwifery safeguarding team and perinatal mental health team. Due to the nature of their work, safeguarding training is never cancelled to support clinical activity.

Similarly, in Paediatrics and Neonates, all staff training requirements are monitored monthly by the ward sister, matron and the paediatric development nurse. Staff are reminded of any upcoming training (alongside self-monitoring of their training needs). Staff either request time to attend updates or complete them as an online module.

Percentage compliance with safeguarding training



Adults - Level 1	95	92	91	91	92	95	95	95	96	98	97	97
Adults - Level 2	90	91	91	91	93	94	93	93	93	95	95	95
Children - Level 1	94	90	90	90	91	95	95	96	96	97	97	97
Children - Level 2	90	91	91	91	93	94	93	92	93	94	95	95
Children - Level 3	84	84	89	88	88	94	91	80	82	83	86	88

3.2 Performance against indicators and performance thresholds

Indicator	Threshold	Weighting	2016-2017				16/17 Total	2017-2018				17/18 Total	2018-2019				18/19 Total
			Q1	Q2	Q3	Q4		Q1	Q2	Q3	Q4		Q1	Q2	Q3	Q4	
Maximum time of 18 weeks from point of referral to treatment in aggregate - admitted						62.4	62.4	56.7	54.9	62.8	62.6	59.2	58	65.4	64.6	59.8	62.0
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	77.8	79.9	78.4	80.6	79.1
Maximum time of 18 weeks from point of referral to treatment in aggregate - patients on an incomplete pathway						62.3	Qtr end census	76	80.6	79.6	77.1	Qtr end census	80	79.2	83.2	86.2	Qtr end census
A&E Maximum waiting time of four hours from arrival to admission/transfer/discharge	95%	1	87.6	87.9	82	75.9	83.4	86.3	85.7	76.7	68.8	79.4	84.4	83.3	82.6	76.0	81.5
All cancers: 62 day wait for first treatment from urgent GP referral for suspected cancer	85%	1	86.3	88.9	86.9	82.6	86.2	89	85.3	85.6	89.3	87.3	81.9	88.5	88.8	86.7	86.7
All cancers: 62 day wait for first treatment from NHS Cancer Screening Service referral	90%	1	88.2	91.3	85.9	90.1	89.1	94.7	93.1	94.9	90.1	93.2	94.7	94.7	94.6	92.5	94.3
All cancers: 31 day wait for second or subsequent treatment comprising surgery	94%	1	100	100	100	97	99.2	100	100	100	100	100	100	100	100	98.3	99.4

0.64% of patients waiting more than the 6 week target for diagnostic procedures at the month end census (target < =1%)

Indicator	Threshold	Weighting	2016-2017				16/17 Total	2017-2018				17/18 Total	2018-2019				18/19 Total
			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	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100
All cancers: 31 day wait for second or subsequent treatment comprising radiotherapy	N/A																
All cancers: 31 day wait from diagnosis to first treatment	96%	1	97.1	98.8	98.8	97.9	98.1	100	99.4	99.7	98.9	99.5	99.3	98.7	97.8	97.9	98.3
Cancer: 2 week wait from referral to date first seen comprising all urgent referrals (cancer suspected)	93%	1	95.9	97.8	97.7	96.8	97.1	96.6	97.4	98.4	95.9	97.1	95.4	96.3	98.1	98.3	97.1
Cancer: 2 week wait from referral to date first seen comprising symptomatic breast patients (cancer not initially suspected)	93%	1	97.4	97.7	96.9	95.3	96.8	93.8	98.2	99	99	97.5	99.4	98	98	99.1	98.6
Clostridium (C.) difficile - meeting the C. Diff objective	16/17 = 26 17/18 = 26 18/19 = 25	1	6	3	4	8	21	9	5	5	2	21	4	9	3	2	18
Certification against compliance with requirements regarding access to healthcare for people with learning disability			Fully achieved					Fully achieved					Fully achieved				

Data Source: National Data Collection Tools (Unify, Open Exeter)

Appendix 1: Priority 7 Day Hospital Services Standards Self-Assessment Autumn/Winter 2018/19

Clinical Standard	Self-assessment of performance		Weekday	Weekend	Overall score
Clinical Standard 2: All emergency admissions must be seen and have a thorough clinical assessment by a suitable consultant as soon as possible but at the latest within 14 hours from the time of admission to hospital.	The areas of challenge relate to weekend working for: Obstetrics & Gynaecology, Paediatrics, General Surgery and Cardiology. A random audit of in scope services was conducted (weekend 28th to 30th December). 38 patients representing the above specialties were audited. Performance O&G 100%, Paediatrics 30% and General Surgery 47%		Yes, the standard is met for over 90% of patients admitted in an emergency	No, the standard is not met for over 90% of patients admitted in an emergency	Standard not met
Clinical Standard 5: Hospital inpatients must have scheduled seven-day access to diagnostic services, typically ultrasound, computerised tomography (CT), magnetic resonance imaging (MRI), echocardiography, endoscopy and microbiology. Consultant-directed diagnostic tests and completed reporting will be available seven days a week: Within 1 hour for critical patients; Within 12 hours for urgent patients; Within 24 hours for non-urgent patients.	Q: Are the following diagnostic tests and reporting always or usually available on site or off site by formal network arrangements for patients admitted as an emergency with critical and urgent clinical needs, in the appropriate timescales?	Microbiology	Yes available on site	Yes available on site	Standard met
		Computerised Tomography (CT)	Yes available on site	Yes available on site	
		Ultrasound	Yes available on site	Yes available off site by formal arrangement	
	This standard is met	Echocardiography	Yes available on site	Yes available on site	
		Magnetic Resonance Imaging (MRI)	Yes available on site	Yes available on site	
		Upper GI endoscopy	Yes available on site	Yes available on site	

Clinical Standard	Self-assessment of performance		Weekday	Weekend	Overall score
Clinical Standard 6: Hospital inpatients must have timely 24 hour access seven days a week to key consultant-directed interventions that meet the relevant specialty guidelines, either on site or through formally agreed networked arrangements with clear written protocols.	Q: Do inpatients have 24-hour access to the following consultant-directed interventions 7 days a week, either on site or via a formal network arrangement?	Critical Care	Yes available on site	Yes available on site	Standard met
		Interventional Radiology	Yes available on site	Yes available off site by formal arrangement	
		Interventional Endoscopy	Yes available on site	Yes available on site	
		Emergency Surgery	Yes available on site	Yes available on site	
	Emergency Renal Replacement therapy - We have formal dialysis capability provided on the ITU. We also are able to provide CVVH. The Renal Replacement pathway is a formal countywide service with the Renal unit based at another Acute provider.	Emergency Renal Replacement Therapy	Yes available off site by formal arrangement	Yes available off site by formal arrangement	
		Urgent Radiotherapy	Yes available off site by formal arrangement	Yes available off site by formal arrangement	
		Stroke Thrombolysis	Yes available off site by formal arrangement	Yes available off site by formal arrangement	
		Percutaneous Coronary Intervention	Yes available on site	Yes available on site	
		Cardiac Pacing	Yes available on site	Yes available on site	

Clinical Standard	Self-assessment of performance	Weekday	Weekend	Overall score
Clinical Standard 8: All patients with high dependency needs should be seen and reviewed by a consultant TWICE DAILY (including all acutely ill patients directly transferred and others who deteriorate). Once a clear pathway of care has been established, patients should be reviewed by a consultant at least ONCE EVERY 24 HOURS, seven days a week, unless it has been determined that this would not affect the patient's care pathway.	This standard is met	Once daily: Yes the standard is met for over 90% of patients admitted in an emergency	Once daily: Yes the standard is met for over 90% of patients admitted in an emergency	Standard met
		Twice daily: Yes the standard is met for over 90% of patients admitted in an emergency	Twice daily: Yes the standard is met for over 90% of patients admitted in an emergency	

Glossary of terms

CVVH

Continuous Veno-Venous Hemofiltration (CVVH) is a temporary treatment for patients with acute renal failure who are unable to tolerate hemodialysis and are unstable. With CVVH, a dialysis catheter is placed in one of the main veins of the body.

Source: MGH

C-Difficile

Clostridium difficile, also known as C. difficile or C. diff, is bacteria that can infect the bowel and cause diarrhoea. The infection most commonly affects people who have recently been treated with antibiotics. It can spread easily to others. Source: NHS Website

Clinical audit

Clinical audit is a way to find out if healthcare is being provided in line with standards and lets care providers and patients know where their service is doing well, and where there could be improvements. Source: NHS England

Commissioning for Quality and Innovation (CQUIN)

The Commissioning for Quality and Innovation (CQUIN) framework supports improvements in the quality of services and the creation of new, improved patterns of care. Source: NHS England

Core Services

Core services are the ones that most trusts provide. They are typically services that people use the most, or in some cases, the ones that may carry the greatest risk.

Source: Care Quality Commission

Data Security and Protection Toolkit (DSPT)

The Data Security and Protection Toolkit is an online self-assessment tool that enables organisations to measure and publish their performance against the National Data Guardian's ten data security standards. It replaces the previous Information Governance toolkit from April 2018. All organisations that have access to NHS patient data and systems must use this toolkit to provide assurance that they are practicing good data security and that personal information is handled correctly. Source: NHS Digital

External Cephalic Version (ECV)

This is an attempt to turn a breech baby into a head-down position by applying pressure on the abdomen. It's a safe procedure, although it can be a bit uncomfortable. Around 50% of breech babies can be turned using ECV, allowing a vaginal birth. Source: NHS Website

Hospital Episode Statistics (HES)

Hospital Episode Statistics is a data warehouse containing details of all admissions, outpatient appointments and A&E attendances at NHS hospitals in England.

Source: NHS Digital

Magnetic Resonance Imaging (MRI)
Magnetic resonance imaging (MRI) is a type of scan that uses strong magnetic fields and radio waves to produce detailed images of the inside of the body. Source: NHS Website

Methicillin Resistant Staphylococcus Aureas (MRSA)
MRSA is a type of bacteria that's resistant to several widely used antibiotics. This means infections with MRSA can be harder to treat than other bacterial infections.
Source: NHS Website

National Confidential Enquiry into Patient Outcome and Deaths (NCEPOD)
NCEPOD's purpose is to assist in maintaining and improving standards of care for adults and children for the benefit of the public by reviewing the management of patients, by undertaking confidential surveys and research, by maintaining and improving the quality of patient care and by publishing and generally making available the results of such activities. Source: NCEPOD

NHS Improvement (NHSI)
NHS Improvement supports foundation trusts and NHS trusts to give patients consistently safe, high quality, compassionate care within local health systems that are financially sustainable. From 01 April, NHS England and NHS Improvement come together to act as a single organisation. Source: NHS Improvement

NHS Standard Contract
The NHS Standard Contract is mandated by NHS England for use by commissioners for all contracts for healthcare services other than primary care. Source: NHS England

National Early Warning Score 2 (NEWS2)
NEWS is a tool developed by the Royal College of Physicians which improves the detection and response to clinical deterioration in adult patients and is a key element of patient safety and improving patient outcomes.
In December 2017, an updated version of NEWS, NEWS2 was published.
Source: NHS England

National Institute of Health and Care Excellence (NICE)
The National Institute for Health and Care Excellence provides national guidance and advice to improve health and social care. Source: NICE

Non-invasive ventilation
Non-invasive ventilation (NIV) refers to the provision of ventilatory support through the patient's upper airway using a mask or similar device. Source: British Thoracic Society

Parts per million (ppm)
One part per million (ppm) denotes one part per 1,000,000 parts Just as per cent means out of a hundred, so parts per million or ppm means out of a million.
Source: Wikipedia

Patient Safety Collaborative

The national patient safety collaboratives (PSC) is the largest safety initiative in the history of the NHS, supporting and encouraging a culture of safety, continuous learning and improvement, across the health and care system. Source: NHS Improvement

Protected Mealtimes

Protected mealtimes are one of ten key characteristics of good nutrition and hydration care. Food and drinks should be provided alone or with assistance in an environment conducive to patients being able to consume their food. Source: NHS England

Royal College of Emergency Medicine

The College works to ensure high quality care by setting and monitoring standards of care, and providing expert guidance and advice on policy to relevant bodies on matters relating to Emergency Medicine. Source: RCEM

Saving Babies Lives Care Bundle v2 (SBLCBv2)

Saving Babies' Lives is designed to tackle stillbirth and early neonatal death. It brings together four elements of care that are recognised as evidence-based and/or best practice:

1. Reducing smoking in pregnancy
2. Risk assessment and surveillance for fetal growth restriction
3. Raising awareness of reduced fetal movement
4. Effective fetal monitoring during labour

The second version of the bundle was published in March 2019. Source: NHS England

SIGHT

SIGHT is a mnemonic protocol to be used when managing suspected potentially infectious diarrhoea:

S Suspect that a case may be infective where there is no clear alternative cause for diarrhoea;

I Isolate the patient and consult with the infection control team (ICT) while determining the cause of the diarrhoea;

G Gloves and aprons must be used for all contacts with the patient and their environment;

H Hand washing with soap and water should be carried out before and after each contact with the patient and the patient's environment;

T Test the stool for toxin, by sending a specimen immediately.

Source: Department of Health and Health Protection Agency

Structured Judgment Review (SJR)

The structured judgement review (SJR) review is based upon the principle that trained clinicians use explicit statements to comment on the quality of healthcare in a way that allows a judgement to be made that is reproducible. Source: Royal College of Physicians

Young Healthwatch Northamptonshire

Young Healthwatch Northamptonshire is a group of young people between the ages of 11 and 24 years old who are keen to make a difference in health and social care and are interested in young people's rights and wellbeing. Their role is to influence better health and wellbeing and improve the quality of services. They report their findings to decision makers to make improvements in services. Source: Young Healthwatch Northamptonshire

Annex 1: Statements from commissioners, local Healthwatch organisations and overview and scrutiny committees

Feedback from our key stakeholders is detailed in the following pages. In finalising the 2018/19 Quality Report, the feedback contained in the following pages has been addressed within the Quality Report as follows:

Governors	
Choice of local quality indicator for audit by our external auditors	In *Detailed requirements for external assurance for quality reports 2018/19*, NHS Improvement strongly recommends that the Summary Hospital-level Mortality Indicator (SHMI) should be selected as the local indicator for 2018/19. The quality indicator requested by the Governors has been included this year and monitoring of compliance will be audited throughout the year. It is, however, not possible to undertake an audit of compliance at this point in time as the data has yet to be collected.
Clinical Commissioning Groups	
CQUIN data requires updating to reflect the year-end position.	Year-end financial values are not available from CCG prior to publishing this report as these have not yet been approved (expected 29 May at the earliest) therefore Q4 self-assessment figures reported.
The CQUIN table provided does not accurately reflect where CQUINs have / have not been achieved.	RAG-rating updated to reflect recommendations made by the CCG CQUIN review panel on 22 May 2019 and reflects year-end position.
It would be helpful to include the impact of CQUINs on patient care.	Some examples have been added to page 32.
Not all indicators include comparator information.	National comparator data have been added to the VTE figures and the NRLS data. Comparator data is not available for the other indicators unless included.
The Seven Day Service section would be strengthened by the inclusion of the plans to become compliant with standard 2.	This has been added to page 55.

Northamptonshire County Council Overview and Scrutiny Committee	
Reference is made to KGH receiving Executive Sponsorship in relation to CQC during 2018/19. The Report would benefit from defining "Executive Sponsorship".	Section 2.2.5, page 33, has been reworded to include the recent CQC visit report which was not available prior to circulation of the draft Quality Report for consultation. However, Executive Sponsorship referred to a member of the Executive team being assigned to support each of the Core Services in meeting the CQC standards.
The Summary Hospital-level Mortality Indicator compares KGH with South Tyneside NHS Foundation Trust and Homerton University Hospital NHS Foundation Trust. Clarification is sought as to why these two trusts are used as comparators and also to include national average figures.	Section 2.3.1, page 41, now includes clarification that the Dr Foster report selects the two Trusts with the highest and lowest SHMI. This provides a benchmark for comparison of KGH performance nationally.
The Chief Executive's statement on quality appears to include an error in the text relating to QP3 (culture of continuous improvement and safety): the same figure is given for March 2018 and March 2019 for the percentage of patients receiving treatment within 18 weeks of referral.	The statement on quality from the CEO on page 13 has been corrected to read: "By March 2019 86.2% of our patients received treatment within 18 weeks of referral compared with 78.4% in April 2018."
The working group emphasises the importance of reducing noise at night for inpatients and expresses support for the 'Sleep Sound in Hospital' campaign.	The Trust will continue to promote the campaign and compliance with wearing soft-soled footwear. Feedback from patients will also be monitored to assess if improvements have been made.

Feedback from Governors

The Council of Governors is made up of Governors who represent the local community and staff and are in the main elected by members of Kettering General Hospital Trust or nominated by various local organisations such as Charities. Thus, the Governors have a key role in being a link with local communities and staff. Governors have opportunities throughout the year to observe, comment on and contribute to the business of the Trust.

The Governors appreciate the opportunity to review and comment on Kettering General Hospital NHS Foundation Trust's 2018-2019 Quality Report. While the report provides complex information, it assists comprehension by the use of colour and tables which are easy to read. Additionally, any abbreviations used are clearly explained. The quality assurance process is clearly detailed throughout the Quality Report and a comparison is shown against standards.

Governors are involved in attending regular meetings which enables updates on what is happening in the hospital. Additionally nominated governors attend Sub-Committees of the Board to observe and comment on discussions. This has demonstrated an increased rigor ensuring that topics are current, that reports are fit for purpose and there is greater emphasis on accountability.

As part of the quality account process, Governors are involved in setting priorities for improvement by audits externally carried out by experts. For the audit for 2019-2020 Governors chose to focus on an audit of hydration which has a marked effect on patient health and well-being. They were disappointed to find that it was not possible to do such an audit until the following years 2020-2021 as data would not be available until then to enable an audit to be carried out. However, they are pleased it will be a future audit topic after the initial work on fluid recording has been undertaken by nursing experts.

The Governors also welcome the progress in implementing various initiatives such as The Seven Day Hospital Services with some clinics being held at weekends. It is pleasing to note that the Trust has a robust Data Security Protection Toolkit in place. Staff are the key resource for the Trust which clearly demonstrates their value with items such as the "Freedom To Speak Up strategy" and the Trust's ambition to create a culture of openness and trust.

Overall the Governors commend the Trust in evidencing improved practice in this Quality Report, and in delivering this wide-reaching service within significant financial and staffing constraints. They also look forward to seeing a continual quality improvement by Kettering General Hospital NHS Foundation Trust.

Feedback from commissioners

NHS Corby Clinical Commissioning Group

NHS Nene Clinical Commissioning Group

Francis Crick House
6 Summerhouse Road
Moulton Park
Northamptonshire
NN3 6BF

TEL: 01604 651100
DDI: 01604 651427
Ref: AD/AJ/HS

22 May 2019

Private & Confidential
Susan Clennett
Associate Director of Quality Governance
Kettering General Hospital NHS Foundation Trust
Rothwell Road
Kettering
NN16 8UZ

By email only: susan.clennett@kgh.nhs.uk

Dear Susan

Kettering General Hospital NHS Foundation Trust Annual Quality Report 2018/19
Northamptonshire Clinical Commissioning Groups Feedback May 2019

The Kettering General Hospital NHS Foundation Trust (KGHFT) annual quality report for 2018/19 has been reviewed by the Northamptonshire Clinical Commissioning Groups (CCGs). It is noted that the report was reviewed whilst in draft format.

Part One
The Quality Report contains a statement summarising the Trust's view of the quality of relevant health services it provided or sub-contracted during 2018/19.

Part Two
Northamptonshire CCGs support the 2018/19 quality priorities as set by KGHFT in relation to improving patient safety, clinical effectiveness and patient experience.

The Quality Report clearly identifies why the Trust has chosen these priorities and the plan to measure improvement and report on progress.

Information on the participation in national clinical audits and confidential enquiries is included with clear examples of actions taken in response to these.

The Trust achievement for the Commissioning for Quality and Innovation (CQUIN) schemes for 2018/19 will need to be updated in the final report to reflect the year-end position. The current table does not accurately reflect where CQUINs have/have not been achieved. It would be helpful to include the impact of implementation of CQUINs on patient care.

Nationally mandated elements are included in the report, however, not all indicators include comparator information for the best and worst trusts and national averages. 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 for 2018/19 and performance against indicators and performance thresholds is included within the report.

Commissioners will continue to work closely with the Trust and support ambitions to sustain high quality standards of care for people who use services.

Yours sincerely

pp
Angela Dempsey
Interim Chief Nurse and Quality Officer
Northamptonshire Clinical Commissioning Groups

Feedback from Healthwatch

healthwatch Northamptonshire

Healthwatch Northamptonshire statement on Kettering General Hospital NHS Foundation Trust (KGH) draft Quality Account 2018/19

Healthwatch Northamptonshire has continued to work with Kettering General Hospital over the past year through our representation on the Patient Engagement Steering Group and through our volunteers regularly visiting the wards using the '15 Steps Challenge' tool to view care through the eyes of patients and carers. Chair of Healthwatch Northamptonshire, Dr David Jones, attends the regular Oversight Group meetings. We are pleased that the joint work between our Young Healthwatch and KGH continues to grow and has gained national recognition from NHS England and through the Patient Experience Network National Awards (PENNA) for the project "It's My Health - Youth Voice".

We welcome the commitment to continuous improvement of quality and safety, and the move towards a centralised system for monitoring improvement. The staff survey results from autumn 2018 are encouraging and indicate positive engagement from staff on KGH's journey towards improvement.

Looking at progress on the priorities set in 2018/19, we are pleased to see that improvements in data quality have resulted in an overall reduction to the length of stay for patients, ultimately improving patient experience. We congratulate the Trust on achieving a 'green rating' in infection prevention and cleaning, and in the learning that has taken place to recognise and treat sepsis. Healthwatch Northamptonshire welcomes the gradual improvement to estates, including to the physical environment in Accident and Emergency for patients with mental health needs. We also note improvements to staffing to assess and support patients with mental health needs and to educate and support staff in this area.

Healthwatch Northamptonshire continues to watch with interest the information collected on re-admissions and we regret that national data is not available for comparison. We hope that the development of the digital roadmap at KGH will yield the anticipated improvements in patient care.

We are pleased that the Trust recognises that listening and acting on feedback, including complaints, is essential to improving quality. We hope that improvements to the way that complaints are handled will lead to more efficient response times, and that targets for the coming year will be met. We look forward to receiving updates via the Patient Experience Group. We also welcome the involvement of patients in learning about patient safety and hope that staff will learn more effectively when they hear from patients first-hand. We recognise the importance of public engagement in involving patients and the public in the development of KGH and will aim to support KGH at events where possible.

Kate Holt, CEO
Connected Together CIC (contract holder of Healthwatch Northamptonshire)

Feedback from Overview and Scrutiny Committee

Kettering General Hospital NHS Foundation Trust – Draft Quality Report 2018/19

Response from the Northamptonshire County Council Overview & Scrutiny Committee

As context for this response it should be noted that Northamptonshire County Council adopted a new model for Overview & Scrutiny (O&S) in September 2018. The new model is based on a single O&S Committee, with a remit that is strongly focused on the following areas:

- Delivery of Northamptonshire County Council's current budget and savings plans
- Development of the Council's future budget proposals
- Major risks to the Council, the local community and the county
- Engagement, alignment and support for the Council's improvement plans

The O&S Committee's remit includes the statutory function for scrutinising the planning and provision of health services in Northamptonshire. However, the prioritisation of the focus areas set out above, as well as the need to bring a newly-constituted Committee into operation, has necessarily minimised the amount of health scrutiny work that the O&S Committee has been able to do in 2018/19.

The O&S Committee formed a working group to consider and respond to local healthcare providers' draft Quality Accounts / Reports for 2018/19. The working group consisted of Councillors Mick Scrimshaw, Wendy Brackenbury, Gill Mercer and Christina Smith-Haynes.

The working group has the following comments on the draft Quality Report:

- The Quality Report uses a clear, readable layout. The working group particularly welcomes the way in which part 2 of the Report sets out priorities for improvement in 2019/20, stating clearly why a priority has been chosen and how improvements will be achieved, measured and reported.
- The priorities for improvement in 2019/20 identified in the Quality Report seem reasonable at the current time.
- The Quality Report acknowledges clearly and honestly that KGH is continuing to progress through a process of improvement, following the 'Requires Improvement' rating by the Care Quality Commission in 2017. However, the working group considers that the Report also reflects the amount of work done by KGH during this period to support improvement.
- The section of the Quality Report concerning Care Quality Commission registration makes reference to KGH receiving Executive Sponsorship during 2018/19 but does not give any further information about what this involved. The working group considers that it would assist the lay reader for the Report to include some information defining Executive Sponsorship.

- The section of the Quality Report concerning performance against the Summary Hospital-level Mortality Indicator for the reporting period compares KGH with South Tyneside NHS Foundation Trust and Homerton University Hospital NHS Foundation Trust. The working group considers that the Report could set out more clearly why these two trusts are used as comparators and that it would also be beneficial to include national average figures.
- The Chief Executive's statement on quality appears to include an error in the text relating to QP3 (culture of continuous improvement and safety): the same figure is given for March 2018 and March 2019 for the percentage of patients receiving treatment within 18 weeks of referral.
- The working group welcomes action being taken to address the learning theme of poor communication between teams in relation to learning from deaths during 2018/19.
- The working group emphasises the importance of reducing noise at night for inpatients and expresses support for the 'Sleep Sound in Hospital' campaign.

The working group welcomes the success of the 'It's My Health – Youth Voice' project in the Patient Experience Network National Awards.

Annex 2: Statement of directors' responsibilities for the quality report

The directors are required under the Health Act 2009 and the National Health Service (Quality Accounts) Regulations to prepare Quality Accounts for each financial year.

NHS Improvement has issued guidance to NHS foundation trust boards on the form and content of annual quality reports (which incorporate the above legal requirements) and on the arrangements that NHS foundation trust boards should put in place to support the data quality for the preparation of the quality report.

In preparing the quality report, directors are required to take steps to satisfy themselves that:

- the content of the quality report meets the requirements set out in the NHS foundation trust annual reporting manual 2018/19 and supporting guidance Detailed requirements for quality reports 2018/19

- the content of the quality report is not inconsistent with internal and external sources of information including:
  - board minutes and papers for the period 01 April 2018 to 29 May 2019
  - papers relating to quality reported to the board over the period 01 April 2018 to 29 May 2019
  - feedback from commissioners dated 22 May 2019
  - feedback from governors dated 16 May 2019
  - feedback from local Healthwatch organisations dated 14 May 2019
  - feedback from overview and scrutiny committee dated 20 May 2019
  - the trust's complaints report published under Regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, dated 20 May 2019
  - the national patient survey 13 June 2018
  - the national staff survey 26 February 2019
  - the Head of Internal Audit's annual opinion of the trust's control environment dated 29 May 2019
  - CQC inspection report dated 22 May 2019

- 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 performance reported in the quality report is robust and reliable, conforms to specified data quality standards and prescribed definitions, is subject to appropriate scrutiny and review
- the quality report has been prepared in accordance with NHS Improvement's annual reporting manual and supporting guidance (which incorporates the quality accounts regulations) as well as the standards to support data quality for the preparation of the quality report.

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

By order of the board.

Simon Weldon
Chief Executive Officer

Alan Burns
Chairman

29 May 2019

Annex 3: Mandatory performance indicator definitions

As recommended in “Detailed requirements for external assurance for quality reports 2018/19”, the detailed definitions of the mandated indicators in the quality report are included here, for ease of reference.

Percentage of incomplete pathways within 18 weeks for patients on incomplete pathways

Source of indicator definition and detailed guidance
The indicator is defined in the technical definitions that accompany *Everyone counts: planning for patients 2014/15-2018/19* at
www.england.nhs.uk/wp-content/uploads/2014/01/ec-tech-def-1415-1819.pdf

Detailed rules and guidance for measuring referral to treatment (RTT) standards are at
https://www.england.nhs.uk/statistics/statistical-work-areas/rtt-waiting-times/rtt-guidance/

Detailed descriptor
EB3: The percentage of incomplete pathways within 18 weeks for patients on incomplete pathways at the end of the period

Numerator
The number of patients on an incomplete pathway at the end of the reporting period who have been waiting no more than 18 weeks

Denominator
The total number of patients on an incomplete pathway at the end of the reporting period

Accountability
Performance is to be sustained at or above the published operational standard. Details of current operational standards are available at:
https://www.england.nhs.uk/wp-content/uploads/2013/12/5yr-strat-plann-guid-wa.pdf
(see Annex B: *NHS Constitution Measures*).

Indicator format
Reported as a percentage

Percentage of patients with a total time in A&E of four hours or less from arrival to admission, transfer or discharge

Source of indicator definition and detailed guidance
The indicator is defined in the technical definitions that accompany *Everyone counts: planning for patients 2014/15 - 2018/19* at
https://www.england.nhs.uk/wp-content/uploads/2013/12/5yr-strat-plann-guid-wa.pdf

Detailed rules and guidance for measuring A&E attendances and emergency admissions are at https://www.england.nhs.uk/statistics/wp-content/uploads/sites/2/2013/03/AE-Attendances-Emergency-Definitions-v2.0-Final.pdf

Numerator
The total number of patients who have a total time in A&E of four hours or less from arrival to admission, transfer or discharge. Calculated as:
(Total number of unplanned A&E attendances) – (Total number of patients who have a total time in A&E over 4 hours from arrival to admission, transfer or discharge)

Denominator
The total number of unplanned A&E attendances

Accountability
Performance is to be sustained at or above the published operational standard. Details of current operational standards are available at:
https://www.england.nhs.uk/wp-content/uploads/2013/12/5yr-strat-plann-guid-wa.pdf
(see Annex B: NHS Constitution measures).

Indicator format
Reported as a percentage

Maximum waiting time of 62 days from urgent GP referral to first treatment for all cancers

Detailed descriptor[1]
PHQ03: Percentage of patients receiving first definitive treatment for cancer within 62 days of an urgent GP referral for suspected cancer

Data definition
All cancer two-month urgent referral to treatment wait

Numerator
Number of patients receiving first definitive treatment for cancer within 62 days following an urgent GP (GDP or GMP) referral for suspected cancer within a given period for all cancers (ICD-10 C00 to C97 and D05)

Denominator
Total number of patients receiving first definitive treatment for cancer following an urgent GP (GDP or GMP) referral for suspected cancer within a given period for all cancers (ICD-10 C00 to C97 and D05)

[1] Cancer referral to treatment period start date is the date the acute provider receives an urgent (two-week wait priority) referral for suspected cancer from a GP and treatment start date is the date first definitive treatment starts if the patient is subsequently diagnosed. For further detail refer to technical guidance at
www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_131880

Accountability
Performance is to be sustained at or above the published operational standard. Details of current operational standards are available at:
www.england.nhs.uk/wp-content/uploads/2013/12/5yr-strat-plann-guid-wa.pdf
(see Annex B: NHS Constitution measures).

Emergency readmissions within 28 days of discharge from hospital[2]

Indicator description
Emergency readmissions within 28 days of discharge from hospital

Indicator construction
Percentage of emergency admissions to a hospital that forms part of the trust occurring within 28 days of the last, previous discharge from a hospital that forms part of the trust

Numerator
The number of finished and unfinished continuous inpatient spells that are emergency admissions within 0 to 27 days (inclusive) of the last, previous discharge from hospital (see denominator), including those where the patient dies, but excluding the following: those with a main specialty on readmission coded under obstetric; and those where the readmitting spell has a diagnosis of cancer (other than benign or in situ) or chemotherapy coded anywhere in the spell.

Denominator
The number of finished continuous inpatient spells within selected medical and surgical specialties, with a discharge date up to 31 March within the year of analysis. Day cases, spells with a discharge coded as death, maternity spells (based on specialty, episode type, diagnosis), and those with mention of a diagnosis of cancer or chemotherapy for cancer anywhere in the spell are excluded. Patients with mention of a diagnosis of cancer or chemotherapy for cancer anywhere in the 365 days before admission are excluded.

Indicator format
Standard percentage

More information
Further information and data can be found as part of the NHS Digital indicator portal.

[2] This definition is adapted from the definition for the 30 days readmissions indicator in the *NHS Outcomes Framework 2013/14: Technical Appendix*. We require trusts to report 28-day emergency readmissions rather than 30 days to be consistent with the mandated indicator requirements of the NHS (Quality Accounts) Amendment Regulations 2012 (S.I. 2012/3081).

Kettering General Hospital NHS Foundation Trust

Annual accounts for the year ended 31 March 2019

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 2019 which comprise the Statement of Comprehensive Income, the Statement of Financial Position, the Statement of Changes in Taxpayers Equity, the Statement of Cash Flows and notes to the financial statements, including a summary of significant accounting policies. The financial reporting framework that has been applied in their preparation is applicable law and International Financial Reporting Standards (IFRSs) as adopted by the European Union, and as interpreted and adapted by the Accounts Directions issued under the National Service Act 2006, the NHS foundation trust annual reporting manual 2018/19 and the Department of Health and Social Care group accounting manual 2018/19.

In our opinion the financial statements:

- give a true and fair view of the financial position of the Trust as at 31 March 2019 and of its expenditure and income for the year then ended;
- have been properly prepared in accordance with International Financial Reporting Standards (IFRSs) as adopted by the European Union, as interpreted and adapted by the Department of Health and Social Care group accounting manual 2018-19; and
- have been prepared in accordance with the requirements of the National Health Service Act 2006.

Basis for opinion

We conducted our audit in accordance with International Standards on Auditing (UK) (ISAs (UK)) and applicable law. 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.

Material uncertainty related to going concern

We draw attention to note 1.2 in the financial statements, which indicates that the Trust recorded an operating deficit of £32 million in 2018/19 in addition to deficits in its previous year's. 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 2019 is £148.5 million, £56.1 million of which will have terms extended in 2019/20. Repayment of loans is not included in the Trust's financial plans for 2019/20. The Trust plans to breakeven in 2019/20 after receiving non-recurrent funding of £25.3 million and, in line with the NHS Long Term plan, is working towards financial sustainability over a 3 to 5 year period. In 2019/20 the Trust requires additional loans of £21 million, £13 million revenue to account for timing of non-recurrent funding in year rather than deficit support as in previous years and £8 million capital to support essential backlog maintenance. At the date of these accounts, some working capital loan support has already been received by the Trust, but further funding is not yet confirmed. These events or conditions, along with the other matters explained in note 1.2, 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

Financial statements audit

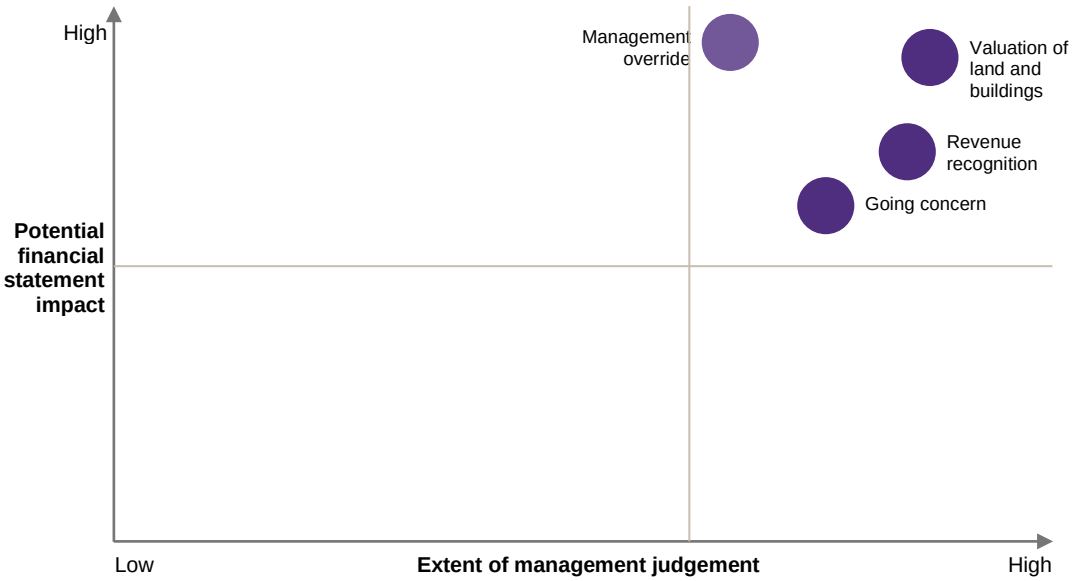
- Overall materiality: £4,900,000, which represents 1.73% of the Trust's gross operating costs (consisting of operating expenses and finance expenses);
- Key audit matters were identified as:
  - Revenue recognition, and
  - Valuation of land and buildings.

Conclusion on the Trust's arrangements for securing economy, efficiency and effectiveness in its use of resources

- We identified one significant risk in respect of the Trust's arrangements for securing economy, efficiency and effectiveness in its use of resources in regards to financial outturn and sustainability (see Report on other legal and regulatory requirements section).

Key audit matters

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.



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.

Key Audit Matter	How the matter was addressed in the audit
Risk 1 – Revenue recognition Trusts are facing significant external pressure to restrain budget overspends and meet externally set financial targets, coupled with increasing patient demand and cost pressures. All the Trust's income from activities is derived from 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 income from activities during the year based on the completion of these activities. This includes the block contract, which is agreed in advance at a fixed price, and patient care income from contract variations. Any patient care activities that are additional to those incorporated in these block contracts with commissioners (contract variations) are subject to verification and agreement by 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. Due to the nature of block contracts we have not identified a significant risk of material misstatement in relation to block contracts. 5.4% of the group's income is recorded as other operating revenues (excluding Education & Training income). The risk around other operating revenues is related to the improper recognition of revenues. Education & Training income is principally derived from contracts that are agreed in advance at a fixed price. We have not identified a significant risk of material misstatement in relation to Education & Training income. We therefore identified the occurrence and accuracy of patient care income from contract variations and other operating revenues, and the existence of associated receivable balances 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; • Agreeing, on a sample basis, income and year end receivables from the group's other operating revenues to supporting evidence; and • agreeing in totality, the Provider Sustainability Fund income received from NHS Improvement, back to supporting documentation. The Trust's accounting policy on income recognition, including contract income, is shown in note 1.5.1 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 and other operating income is in accordance with the Department of Health and Social Care Group Accounting Manual 2018/19 and has been properly applied; and • income from patient activities and other operating income is not materially misstated.
Risk 2 – Valuation of land and buildings The Trust revalues its land and buildings on a 5 yearly basis to ensure that carrying value is not materially different from its current value in use. This represents a significant estimate by management in the financial statements. The Trust engaged [name of] valuer to complete the revaluation in 2018/19. The valuer identified an historical error in the valuation of [name of building] which resulted in the trust processing a £Xm prior period adjustment to reflect the prior years undervaluation of the property. We identified the valuation of land and buildings as a significant risk which was one of the most significant assessed risks of material misstatement.	Our audit work in relation to valuation 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; • verifying that the financial transactions to process the prior period adjustment had been

Key Audit Matter	How the matter was addressed in the audit
	recognised in the financial statements correctly; and • 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 1.8 to the financial statements and related disclosures are included in note 15. **Key observations** We obtained sufficient audit assurance to conclude that: • the basis of the valuation of land and buildings, including the processing of the prior period adjustment, 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.

Our application of materiality

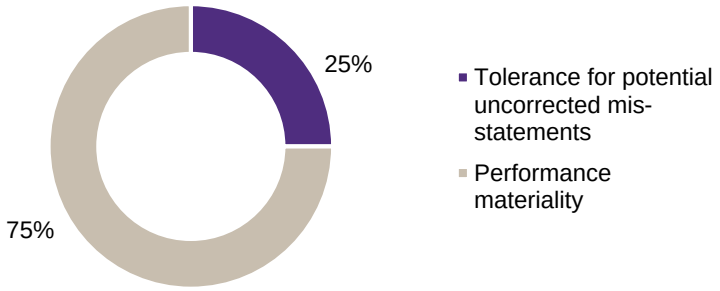
We define materiality as the magnitude of misstatement in the financial statements that makes it probable that the economic decisions of a reasonably knowledgeable person would be changed or influenced. We use materiality in determining the nature, timing and extent of our audit work and in evaluating the results of that work.

Materiality was determined as follows:

Materiality Measure	Trust
Financial statements as a whole	£4,900,000 which is 1.73% 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 the Trust has expended its revenue and other funding. Materiality for the current year is higher than the level we determined for the year ended 31 March 2018 to reflect our understanding of the risks facing the Trust in the current year.
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 and £250,000 to the Cash Equivalent Transfer Value of their pensions due to the public interest in these disclosures and the statutory requirement for these to be made. We also tested the audit fee with no materiality.
Communication of misstatements to the Audit Committee	£300,000 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.

Overall materiality – Trust



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 98.5% 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 92.5% of the Trusts other assets and liabilities.

Other information

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

In connection with our audit of the financial statements, our responsibility is to read the other information and, in doing so, consider whether the other information is materially inconsistent with the financial statements or our knowledge obtained in the audit or otherwise appears to be materially misstated. If we identify such material inconsistencies or apparent material misstatements, we are required to determine whether there is a material misstatement in the financial statements or a material misstatement of the other information. If, based on the work we have performed, we conclude that there is a material misstatement of the 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 35 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

- Audit Committee reporting set out on pages 22 and 23 in accordance with provision C.3.9 of the NHS Foundation Trust Code of Governance – the section describing the work of the Audit Committee does not appropriately address matters communicated by us to the Audit Committee.

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 2018/19 or is misleading or inconsistent with the information of which we are aware from our audit. We are not required to consider whether the Annual Governance Statement addresses all risks and controls or that risks are satisfactorily addressed by internal controls.

We have nothing to report in this regard.

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 2018/19 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.

Matters on which we are required to report by exception

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

- we issue a report in the public interest under Schedule 10 (3) of the National Health Service Act 2006 in the course of, or at the conclusion of the audit; or
- we refer a matter to the regulator under Schedule 10 (6) of the National Health Service Act 2006 because we have reason to believe that the Trust, or a director or officer of the Trust, is about to make, or has made, a decision which involves or would involve the incurring of expenditure that was unlawful, or is about to take, or has begun to take a course of action which, if followed to its conclusion, would be unlawful and likely to cause a loss or deficiency.

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

Responsibilities of the Accounting Officer and Those Charged with Governance for the financial statements

As explained more fully in the Statement of the Chief Executive's responsibilities as the accounting officer set out on pages 54 to 55, 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 2018/19, 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 Accounting Officer has been informed by the relevant national body of the intention to dissolve the Trust without the transfer of the Trust's services to another public sector entity.

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

Auditor's responsibilities for the audit of the financial statements

Our objectives are to obtain reasonable assurance about whether the financial statements as a whole are free from material misstatement, whether due to fraud or error, and to issue an auditor's report that includes our opinion. Reasonable assurance is a high level of assurance, but is not a guarantee that an audit conducted in accordance with ISAs (UK) will always detect a material misstatement when it exists.

Misstatements can arise from fraud or error and are considered material if, individually or in the aggregate, they could reasonably be expected to influence the economic decisions of users taken on the basis of these financial statements.

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

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

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

Under the Code of Audit Practice, we are required to report to you if, in our opinion we have not been able to satisfy ourselves that the Trust has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources for the year ended 31 March 2019**.**

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 2019.

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 £31,666,000 in the year ended 31 March 2019, which represents a significant increase compared to its budgeted deficit of £7,800,000.
- The Trust received loans through an 'uncommitted interim revenue support facility' from (NHS Improvement) totaling £28.4 million in 2018/19.
- Current loans as at 31 March 2019 total £148.5 million with a further £21.0 million planned for 2019/20 providing a total planned loan balance as at March 2019 of £169.5 million.
- The Trust entered into the NHS Improvement 'Control Regime' in 2018/19 and has agreed a control total for 2019/20, forecasting to deliver break-even after receiving non-recurrent funding of £25.3 million. enabling access to the Provider Sustainability Fund (PSF), Financial Recovery Fund (FRF) and marginal rate emergency tariff (MRET) funds.

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.

Significant risks

Under the Code of Audit Practice, we are required to report on how our work addressed the significant risks we identified in forming our conclusion on the adequacy of the Trust's arrangements for securing economy, efficiency and effectiveness in its use of resources. Significant risks are those risks that in our view had the potential to cause us to reach an inappropriate conclusion on the audited body's arrangements. The table below sets out the significant risks we have identified. These significant risks were addressed in the context of our conclusion on the Trust's arrangements as a whole, and in forming our conclusion thereon, and we do not provide a separate opinion on these risks.

Significant risks forming part of our qualified conclusion	How the matter was addressed in the audit
Risk 1 Financial sustainability The Trust originally forecast that it will incur a deficit in 2018/19 of £7.8 million. Primarily due to inefficiencies within the Trust's delivery and the pace of change being driven by the Sustainability and Transformation Plan not providing health economy solutions fast enough, the Trust delivered a £31.577 m deficit in 2018/19. The Trust required financial support primarily via loans from the Department of Health and Social Care (DHSC) of £28.4 million in 2018/19. Total loans from DHSC as at 31 March 2019 equalled £148.5 million. Management anticipate that it could be a number of years before the Trust's income equals or exceeds its expenditure. The Trust will therefore require further cash via revenue loans to pay its expenses in 2019/20. The risk is whether the Trust has adequate arrangements in place to ensure sustainable resource deployment to deliver financial balance.	Our audit work included, but was not restricted to: • discussion with key Senior Officers to understand the arrangements in place to address financial position • evaluation of key Board papers detailing the financial position throughout the financial year, including delivery of cost improvement plans and performance against cash management, • assessment and challenge of key assumptions made by the Trust in their financial forecasts, • review of external documents from agencies such as NHS Improvement and the Care Quality Commission, **Key findings** We have qualified our conclusion in respect of this risk, as set out in the basis of adverse conclusion section of the report.

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 2006 to 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 2019, 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.

Use of our report

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.

M C Stocks

Mark Stocks, Key Audit Partner
for and on behalf of Grant Thornton UK LLP, Local Auditor

The Colmore Building
20 Colmore Circus
Birmingham
B4 6AT

29 May 2019

Foreword to the accounts

Kettering General Hospital NHS Foundation Trust

These accounts, for the year ended 31 March 2019, 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.

Signed 

Name **Simon Weldon**
Job title **Chief Executive**
Date **22 May 2019**

Statement of Comprehensive Income

	Note	2018/19 £000	2017/18 £000 (Restated)
Operating income from patient care activities	3	230,433	217,405
Other operating income	4	21,737	12,904
Operating expenses	6, 8	(280,533)	(262,347)
Operating deficit from continuing operations		**(28,363)**	**(32,038)**
Finance income	11	82	27
Finance expenses	12	(3,357)	(2,420)
PDC dividends payable		-	(271)
Net finance costs		**(3,275)**	**(2,664)**
Other gains / (losses)	13	(28)	21
Deficit for the year from continuing operations		**(31,666)**	**(34,681)**
Deficit for the year		**(31,666)**	**(34,681)**
Other comprehensive income			
Will not be reclassified to income and expenditure:			
Impairments	7	(3,894)	(203)
Revaluations	17	4,288	8,091
Total comprehensive expense for the period		**(31,272)**	**(26,793)**
NHS Improvement Control Total deficit			
Deficit for the period		(31,666)	(34,681)
Remove net impairments not scoring to the Departmental expenditure limit		4,711	807
Remove I&E impact of capital grants and donations		76	310
Adjusted financial performance deficit		**(26,879)**	**(33,564)**

The restatement of 2017/18 relates to a prior period adjustment following the quinquennial valuation of the estate. The only impact is in other comprehensive income not classified to income and expenditure which has shown an increase in Revaluations of £8,461k. Full details are provided in note 36.

In 2017/18 the Trust treated a CQUIN risk reserve as income (£622k), however in the National forms the reserve is included as an adjusting item.

The notes to pages 5 to 40 form part of these accounts

Statement of Financial Position

	Note	31 March 2019 £000	31 March 2018 £000 (Restated)	01 April 2017 £000 (Restated)
Non-current assets				
Intangible assets	14	2,759	1,679	1,383
Property, plant and equipment	15	136,644	134,530	118,283
Receivables	19	1,069	781	786
Total non-current assets		**140,472**	**136,990**	**120,452**
Current assets				
Inventories	18	3,598	3,376	3,880
Receivables	19	7,772	5,755	7,728
Cash and cash equivalents	22	1,342	2,670	1,204
Total current assets		**12,712**	**11,801**	**12,812**
Current liabilities				
Trade and other payables	23	(24,214)	(20,571)	(18,608)
Borrowings	26	(60,180)	(15,248)	(2,007)
Provisions	28	(451)	(598)	(333)
Other liabilities	25	(1,348)	(1,316)	(1,551)
Total current liabilities		**(86,193)**	**(37,733)**	**(22,499)**
Total assets less current liabilities		**66,991**	**111,058**	**110,765**
Non-current liabilities				
Borrowings	26	(89,397)	(105,539)	(78,739)
Provisions	28	(439)	(450)	(464)
Total non-current liabilities		**(89,836)**	**(105,989)**	**(79,203)**
Total assets employed		**(22,845)**	**5,069**	**31,562**
Financed by				
Public dividend capital		64,487	61,129	60,829
Revaluation reserve		34,763	34,885	27,442
Income and expenditure reserve		(122,095)	(90,945)	(56,709)
Total taxpayers' equity		**(22,845)**	**5,069**	**31,562**

A prior year adjustment has been transacted in 2017/18 relating to the valuation of a Trust building. This is explained in note 36. The movement is an increase to Property, plant and equipment and reserves as at 1 April 2017 of £6,117k and a further increase as at 31 March 2018 of £2,344k. There has been no impact on the Statement of Comprehensive Income.

The Trust funds its revenue deficit through borrowings from the DHSC. This has led to an increase in revenue borrowings in the year of £31,251k offset by repayment of capital loans of £2,844k. Previous revenue borrowings from 2015/16 and 2016/17 are repayable in 2019/20 and have moved to current borrowings - see note 26.

The notes on pages 5 to 40 form part of these accounts.

Name
Position Chief Executive
Date **22 May 2019**

Statement of Changes in Equity for the year ended 31 March 2019

	Public dividend capital	Revaluation reserve	Income and expenditure reserve	Total
	£000	£000	£000	£000
Taxpayers' equity at 1 April 2018 - brought forward (restated)	**61,129**	**34,885**	**(90,945)**	**5,069**
Deficit for the year	-	-	(31,666)	**(31,666)**
Other transfers between reserves	-	(516)	516	**-**
Impairments	-	(3,894)	-	**(3,894)**
Revaluations	-	4,288	-	**4,288**
Public dividend capital received	3,358	-	-	**3,358**
Taxpayers' equity at 31 March 2019	**64,487**	**34,763**	**(122,095)**	**(22,845)**

Statement of Changes in Equity for the year ended 31 March 2018

	Public dividend capital	Revaluation reserve	Income and expenditure reserve	Total
	£000	£000	£000	£000
		(Restated)		(Restated)
Taxpayers' equity at 1 April 2017 - brought forward	**60,829**	**21,325**	**(56,709)**	**25,445**
Prior period adjustment	-	6,117	-	**6,117**
Taxpayers' equity at 1 April 2017 - restated	**60,829**	**27,442**	**(56,709)**	**31,562**
Deficit for the year	-	-	(34,681)	**(34,681)**
Other transfers between reserves	-	(445)	445	**-**
Impairments	-	(203)	-	**(203)**
Revaluations	-	8,091	-	**8,091**
Public dividend capital received	300	-	-	**300**
Taxpayers' equity at 31 March 2018	**61,129**	**34,885**	**(90,945)**	**5,069**

The restatement of 2017/18 relates to a prior period adjustment following the quinquennial valuation of the estate.

The revaluation reserve has increased by £6,117k, as at 1 April 2017 and by an additional £2,344k in Revaluations in 2017/18. Full details are provided in note 36.

Information on reserves

Public dividend capital

Public dividend capital (PDC) is a type of public sector equity finance based on the excess of assets over liabilities at the time of establishment of the predecessor NHS organisation. Additional PDC may also be issued to Trusts by the Department of Health and Social Care. A charge, reflecting the cost of capital utilised by the Trust, is payable to the Department of Health as the public dividend capital dividend, however as the Trust has negative net assets, no charge is payable.

Revaluation reserve

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

Income and expenditure reserve

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

Statement of Cash Flows

	Note	2018/19 £000	2017/18 £000
Cash flows from operating activities			
Operating deficit		(28,363)	(32,038)
Non-cash income and expense:			
Depreciation and amortisation	6.1	4,699	5,569
Net impairments	7	4,711	807
Income recognised in respect of capital donations	4	(98)	-
(Increase) / decrease in receivables and other assets		(2,309)	1,930
(Increase) / decrease in inventories		(222)	504
Increase in payables and other liabilities		5,132	425
Increase / (decrease) in provisions		(158)	251
Net cash used in operating activities		**(16,608)**	**(22,552)**
Cash flows from investing activities			
Interest received		77	29
Purchase of intangible assets		(1,047)	(823)
Purchase of property, plant, equipment and investment property		(12,216)	(11,761)
Sales of property, plant, equipment and investment property		85	21
Receipt of cash donations to purchase capital assets		98	-
Net cash used in investing activities		**(13,003)**	**(12,534)**
Cash flows from financing activities			
Public dividend capital received		3,358	300
Movement on loans from the Department of Health and Social Care	26.1	28,407	38,765
Capital element of finance lease rental payments	26.1	(303)	(98)
Interest on loans	26.1	(3,170)	(2,181)
Interest paid on finance lease liabilities	26.1	(18)	(9)
PDC dividend (paid) / refunded		9	(225)
Net cash generated from financing activities		**28,283**	**36,552**
Increase / (decrease) in cash and cash equivalents	**22.1**	**(1,328)**	**1,466**
Cash and cash equivalents at 1 April - brought forward		**2,670**	**1,204**
Cash and cash equivalents at 31 March	22.1	**1,342**	**2,670**

Notes to the Accounts
Note 1 Accounting policies and other information

Note 1.1 Basis of preparation

NHS Improvement, in exercising the statutory functions conferred on Monitor, has directed that the financial statements of the Trust shall meet the accounting requirements of the Department of Health and Social Care Group Accounting Manual (GAM), which shall be agreed with HM Treasury. Consequently, the following financial statements have been prepared in accordance with the GAM 2018/19 issued by the Department of Health and Social Care. The accounting policies contained in the GAM follow International Financial Reporting Standards to the extent that they are meaningful and appropriate to the NHS, as determined by HM Treasury, which is advised by the Financial Reporting Advisory Board. Where the GAM permits a choice of accounting policy, the accounting policy that is judged to be most appropriate to the particular circumstances of the Trust for the purpose of giving a true and fair view has been selected. The particular policies adopted are described below. These have been applied consistently in dealing with items considered material in relation to the accounts

Note 1.1.1 Accounting convention

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

Note 1.2 Going concern
These accounts have been prepared on a going concern basis as assessed by the Board. Non-trading entities in the public sector are assumed to be going concerns where there is a continued provision of a service in the future. The FReM (financial reporting manual) guidance is that the financial statements are 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.

The Board of Directors considered the Trust's going concern position at its meeting of 29th March 2019 and the key areas considered were:
1)The Trust's deficit position of £32m in 2018/19 and its previous years' deficits. Whilst the Trust has a planned breakeven position for 2019/20, the current underlying deficit position presents a material uncertainty relating to the financial stability of the Trust. Taking all matters into consideration, the Directors consider that the services currently provided by the Trust will continue to be provided in the foreseeable future.

2)The Trust has agreed contracts with its local commissioners for 2019/20 with services being commissioned in the same manner as previous years with no discontinued services.
3) The cash support to the Trust required through the extension of £56.12m of loans in 2019/20. The Trust has been advised that the repayment terms for these loans will be reviewed in the year and repayment of the loans is not included in the Trusts plans.

The Trust recorded an operating deficit of £32 million in 2018/19 in addition to deficits in its previous year's. 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 2019 is £148.5 million, £56.1 million of which will have terms extended in 2019/20. Repayment of loans is not included in the Trust's financial plans for 2019/20. The Trust plans to breakeven in 2019/20 after receiving non-recurrent funding of £25.3 million and the Trust, in line with the NHS Long Term plan, is working towards financial sustainability over a 3 to 5 year period. In 2019/20 the Trust requires additional loans of £21 million, £13 million revenue to account for timing of non-recurrent funding in year rather than deficit support as in previous years and £8 million capital to support essential backlog maintenance. At the date of these accounts, some working capital loan support has already been received by the Trust, but further funding is not yet confirmed.

The Board of Directors concluded that there is sufficient evidence that the Trust will continue as a going concern for the foreseeable future and that it was appropriate to prepare the Annual Report and Accounts on a going concern basis.

Note 1.3 Critical judgements in applying accounting policies

The following are the judgements, apart from those involving estimations (see below) that management has made in the process of applying the trust accounting policies and that have the most significant effect on the amounts recognised in the financial statements:

a) Going Concern status - as described in 1.2, the Trust has prepared the accounts on a going concern basis.

b) The Trust has £56.12m of revenue related borrowings repayable in 2019/20. The Trust has made no provision for the repayment of these loans, based on the likelihood that the loan terms will be extended.

c) Income from, and Impairments relating to, the Compensation recovery Unit (CRU) - the income due from the CRU is based on information from that organisation. The Trust is unable to independently validate the outstanding debt and therefore relies upon the CRU, who is responsible for the collection of income on behalf of the Trust, to provide accurate and up to date information to the Trust. For the impairment of receivables the Trust uses the percentage rate provided by the CRU at 21.89% (2017/18 - 22.84%) as an estimation for the impairment. The gross debt included in other receivables is £2.21m with an impairment of £0.48m.

Note 1.3.1 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 quinquennial valuation of the estate was undertaken as at 31 March 2019 by Gerald Eve LLP to provide the value of land and property together with asset lives. 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 IFRS16.This includes the valuation estimates for the prior period adjustment detailed in note 36.

b) Provisions - The Trust has made a provision for legal claims against the Trust. Due to the uncertainty and value of the claims a provision has been made based upon legal advice and internal opinion. The claims are reviewed on a regular basis and estimations revised where necessary. The provision for these claims is shown in Note 28.1 to the accounts.

The Trust also provides for the full cost of permanent injury allowances payable to ex-employees who have been awarded allowances under the NHS Business Services Authority. These allowances are paid throughout the life of the individual unless their circumstances change. The provision is therefore an estimate based on actuarial life expectancies and assumes that payments will be consistent.

Note 1.4 Interests in other entities
The Trust has no interest in other entities (2017/18 - nil).

Note 1.5.1 Revenue from contracts with customers

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

Revenue from NHS contracts

The main source of income for the Trust is contracts with commissioners for health care services. A performance obligation relating to delivery of a spell of health care is generally satisfied over time as healthcare is received and consumed simultaneously by the customer as the Trust performs it. The customer in such a contract is the commissioner, but the customer benefits as services are provided to their patient. Even where a contract could be broken down into separate performance obligations, healthcare generally aligns with paragraph 22(b) of the Standard entailing a delivery of a series of goods or services that are substantially the same and have a similar pattern of transfer. At the year end, the Trust accrues income relating to activity delivered in that year, where a patient care spell is incomplete.

The Trust has agreed its 2018/19 income position with its two lead Commissioners, taking into account partially completed spells and maternity pathway income. Any future invoice challenges or penalties from other Commissioners realting to 2018/19 would not be material to the income reported in these accounts.

Revenue from research contracts

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

NHS injury cost recovery scheme

The 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 Trust recognises the income when it receives notification from the Department of Work and Pension's Compensation Recovery Unit, has completed the NHS2 form and confirmed there are no discrepancies with the treatment. The income is measured at the agreed tariff for the treatments provided to the injured individual, less an allowance for unsuccessful compensation claims and doubtful debts in line with IFRS 9 requirements of measuring expected credit losses over the lifetime of the asset.

Provider Sustainability Fund(PSF)

The PSF enables the Trust to earn income linked to the achievement of financial controls and performance targets. In line with IFRS15, the Trust has accounted for PSF income as a variable consideration. The Trust has accrued income as a contract asset, based on evidence provided by NHSI.

Note 1.5.2 Revenue grants and other contributions to expenditure

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

The value of the benefit received when accessing funds from the Government's apprenticeship service is recognised as income at the point of receipt of the training service. Where these funds are paid directly to an accredited training provider, the corresponding notional expense is also recognised at the point of recognition for the benefit.

Note 1.5.3 Other income
Income from the sale of non-current assets is recognised only when all material conditions of sale have been met, and is measured as the sums due under the sale contract.

Note 1.6 Expenditure on employee benefits

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

Pension costs
NHS Pension Scheme
Past and present employees are covered by the provisions of the NHS Pension Scheme. The scheme is an unfunded, defined benefit scheme that covers NHS employers, general practices and other bodies, allowed under the direction of Secretary of State, in England and Wales. The scheme is not designed in a way that would enable employers to identify their share of the underlying scheme assets and liabilities. Therefore, the scheme is accounted for as though it is a defined contribution scheme.

Employer's pension cost contributions are charged to operating expenses as and when they become due.

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

Note 1.7 Expenditure on other goods and services

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

Note 1.8 Property, plant and equipment
Note 1.8.1 Recognition

Property, plant and equipment is capitalised where:

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

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

Note 1.8.2 Measurement

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

All assets are measured subsequently at valuation. Assets which are held for their service potential and are in use (ie operational assets used to deliver either front line services or back office functions) are measured at their current value in existing use. Assets that were most recently held for their service potential but are surplus with no plan to bring them back into use are measured at fair value where there are no restrictions on sale at the reporting date and where they do not meet the definitions of investment properties or assets held for sale.

Revaluations of property, plant and equipment are performed with sufficient regularity to ensure that carrying values

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

Assets held at depreciated replacement cost have been valued on an alternative site basis where this would meet the location requirements of the services being provided.

Properties in the course of construction for service or administration purposes are carried at cost, less any impairment loss. Cost includes professional fees. Assets are revalued and depreciation commences when the assets are brought into use.

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

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

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

Property, plant and equipment which has been reclassified as 'held for sale' cease to be depreciated upon the reclassification. Assets in the course of construction are not depreciated until the asset is brought into use.

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

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

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

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

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

Note 1.8.3 De-recognition

Assets intended for disposal are reclassified as 'held for sale'. The Trust hold no such assets (2017/18 - nil)

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

Note 1.8.4 Donated assets

Donated property, plant and equipment assets are capitalised at their fair value on receipt. The donation is credited to income at the same time.

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

Note 1.8.5 Useful lives of property, plant and equipment
Useful lives reflect the total life of an asset and not the remaining life of an asset. The range of useful lives are shown

	Min life Years	**Max life Years**
Land	-	-
Buildings, excluding dwellings	11	53
Plant & machinery	5	15
Information technology	8	8
Furniture & fittings	7	10

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

Note 1.9 Intangible assets

Note 1.9.1 Recognition

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

Internally generated intangible assets

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

Expenditure on research is not capitalised.

Expenditure on development is capitalised only where all of the following can be demonstrated:

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

Software

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

Note 1.9.2 Measurement

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

Subsequently intangible assets are measured at current value in existing use. Where no active market exists, intangible assets are valued at the lower of depreciated replacement cost and the value in use where the asset is income generating. Revaluations gains and losses and impairments are treated in the same manner as for property, plant and equipment. An intangible asset which is surplus with no plan to bring it back into use is valued at fair value under IFRS 13, if it does not meet the requirements of IAS 40 of IFRS 5.

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

Amortisation

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

Note 1.9.3 Useful economic life of intangible assets

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

	Min life Years	**Max life Years**
Software licences	8	8

Note 1.10 Inventories
Inventories are valued at the lower of cost and net realisable value. The cost of inventories is measured using the current or weighted average cost method.

Note 1.11 Cash and cash equivalents

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

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

Note 1.12 Carbon Reduction Commitment scheme (CRC)

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.

Note 1.13 Financial assets and financial liabilities

Note 1.13.1 Recognition

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

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

Note 1.13.2 Classification and measurement

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

Financial liabilities in respect of assets acquired through finance leases are recognised and measured in accordance with the accounting policy for leases described below.

Financial assets are classified as subsequently measured at amortised cost.

Financial liabilities classified as subsequently measured at amortised cost.

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

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

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

Impairment of financial assets

For all financial assets measured at amortised cost including lease receivables, contract receivables and contract assets, the Trust recognises an allowance for expected credit losses.

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

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

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

Note 1.13.3 Derecognition

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

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

Note 1.14 Leases

Leases are classified as finance leases when substantially all the risks and rewards of ownership are transferred to the lessee. All other leases are classified as operating leases.

Note 1.14.1 The Trust as lessee

Finance leases

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

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

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

Operating leases

Operating lease payments are recognised as an expense on a straight-line basis over the lease term. Lease incentives are recognised initially 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.

Leases of land and buildings

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

Note 1.14.2 The Trust as lessor

Finance leases

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

Operating leases

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

Note 1.15 Provisions

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

Clinical negligence costs

NHS Resolution operates a risk pooling scheme under which the Trust pays an annual contribution to NHS Resolution, which, in return, settles all clinical negligence claims. Although NHS Resolution is administratively responsible for all clinical negligence cases, the legal liability remains with the Trust. The total value of clinical negligence provisions carried by NHS Resolution on behalf of the Trust is disclosed at note 29 but is not recognised in the Trust's accounts.

Non-clinical risk pooling

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

Note 1.16 Contingencies

Contingent assets (that is, assets arising from past events whose existence will only be confirmed by one or more future events not wholly within the entity's control) are not recognised as assets, but are disclosed in note 29 where an inflow of economic benefits is probable.
Contingent liabilities are not recognised, but are disclosed in note 29, unless the probability of a transfer of economic benefits is remote.

Contingent liabilities are defined as:

• possible obligations arising from past events whose existence will be confirmed only by the occurrence of one or more uncertain future events not wholly within the entity's control; or

• present obligations arising from past events but for which it is not probable that a transfer of economic benefits will arise or for which the amount of the obligation cannot be measured with sufficient reliability.

Note 1.17 Public dividend capital

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

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.

A charge, reflecting the cost of capital utilised by the Trust, is payable as public dividend capital dividend. As the Trust has negative net assets no charge is payable in 2018/19.

Note 1.18 Value added tax

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

Note 1.19 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. However, they are disclosed in a separate note to the accounts in accordance with the requirements of HM Treasury's *FReM*.

Note 1.20 Losses and special payments

Losses and special payments are items that Parliament would not have contemplated when it agreed funds for the health service or passed legislation. By their nature they are items that ideally should not arise. They are therefore subject to special control procedures compared with the generality of payments. They are divided into different categories, which govern the way that individual cases are handled. Losses and special payments are charged to the relevant functional headings in expenditure on an accruals basis, including losses which would have been made good through insurance cover had the Trust not been bearing their own risks (with insurance premiums then being included as normal revenue expenditure).

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

Note 1.21 Early adoption of standards, amendments and interpretations

No new accounting standards or revisions to existing standards have been early adopted in 2018/19.

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

The DHSC GAM does not require the following Standards and Interpretations to be applied in 2018-19. These standards are still subject to HM Treasury FReM adoption, with IFRS16 being for implementation in 2019-20.

- IFRS16 Leases - Application required for accounting periods beginning on or after 1 January 2019, but not yet adopted by the FReM; adoption is not therefore permitted

- IFRS17 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

- IFRIC23 Uncertainty over Income Tax Treatments - Application required for accounting periods beginning on or after 1 January 2019, but not yet adopted by the FReM; adoption is not therefore permitted

Note 2 Operating Segments

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 Divisions are not currently provided on a regular basis to the board of Directors.

Note 3 Operating income from patient care activities

All income from patient care activities relates to contract income recognised in line with accounting policy 1.5.1

Note 3.1 Income from patient care activities (by nature)	2018/19	2017/18
	£000	£000
Acute services		(Restated)
Elective income	36,896	34,554
Non elective income	77,174	76,455
First outpatient income	13,288	12,564
Follow up outpatient income	19,308	18,526
A & E income	12,854	12,044
High cost drugs income from commissioners (excluding pass-through costs)	14,496	14,501
Other NHS clinical income	52,168	46,536
All services		
Private patient income	128	144
Agenda for Change pay award central funding	2,806	-
Other clinical income	1,315	2,081
Total income from activities	**230,433**	**217,405**

Note 3.2 Income from patient care activities (by source)

Income from patient care activities received from:	2018/19	2017/18
	£000	£000
NHS England	32,147	34,789
Clinical commissioning groups	193,807	180,241
Department of Health and Social Care	2,806	44
Other NHS providers	211	1,182
NHS other	94	106
Non-NHS: private patients	128	144
Non-NHS: overseas patients (chargeable to patient)	196	142
Injury cost recovery scheme	906	702
Non NHS: other	138	55
Total income from activities	**230,433**	**217,405**
Of which:		
Related to continuing operations	230,433	217,405
Related to discontinued operations	-	-

The 2017/18 figures have been restated to separate High Cost Drugs Income from commissioners which was previously shown in Other NHS clinical income.

The income from the Department of Health and Social Care relates to central funding provided for the impact of the Agenda for Change pay increases announced during 2018/19 and therefore not included in agreed Commissioner contracts for 2018/19.

Note 3.3 Overseas visitors (relating to patients charged directly by the provider)

	2018/19	2017/18
	£000	£000
Income recognised this year	196	142
Cash payments received in-year	49	39
Amounts added to provision for impairment of receivables	5	10
Amounts written off in-year	56	40

Note 4 Other operating income

	2018/19	2017/18
	£000	£000
Other operating income from contracts with customers:		
Research and development (contract)	496	490
Education and training (excluding notional apprenticeship levy income)	8,057	7,599
Non-patient care services to other bodies	2,126	1,811
Provider sustainability (PSF)	6,972	-
Other contract income	3,181	2,746
Other non-contract operating income		
Receipt of capital grants and donations	98	-
Charitable and other contributions to expenditure	85	29
Rental revenue from operating leases	252	229
Other non-contract income	470	-
Total other operating income	**21,737**	**12,904**
Of which:		
Related to continuing operations	21,737	12,904
Related to discontinued operations	-	-

Other contract income includes income from car parking of £1.87m (2017/18: £1.3m). This increase is due, in part, to the new car park deck which was installed during 2017/18. The Trust incurs expenditure against this income shown in operating expenses.

The Trust did not receive any Provider Sustainability Fund income in 2017/18.

Note 5.1 Additional information on revenue from contracts with customers recognised in the period

	2018/19
	£000
Revenue recognised in the reporting period that was included in within contract liabilities at the previous period end	1,317
Revenue recognised from performance obligations satisfied (or partially satisfied) in previous periods	-

Note 5.2 Transaction price allocated to remaining performance obligations

The Trust has exercised the practical expedients permitted by IFRS 15 paragraph 121 in preparing this disclosure. Revenue from contracts with an expected duration of one year or less and contracts where the Trust recognises revenue directly corresponding to work done to date is not disclosed. The Trust therefore has no Transaction price to be allocated to remaining performance obligations.

Note 5.3 Income from activities arising from commissioner requested services

Under the terms of its provider licence, the Trust is required to analyse the level of income from activities that has arisen from commissioner requested and non-commissioner requested services. Commissioner requested services are defined in the provider license and are services that commissioners believe would need to be protected in the event of provider failure. This information is provided in the table below:

	2018/19	2017/18
	£000	£000
Income from services designated as commissioner requested services	188,067	178,100
Income from services not designated as commissioner requested services	42,366	39,305
Total	**230,433**	**217,405**

Note 6.1 Operating expenses

	2018/19	2017/18
	£000	£000
Purchase of healthcare from NHS and DHSC bodies	3,765	3,979
Purchase of healthcare from non-NHS and non-DHSC bodies	6,040	6,015
Staff and executive Directors costs	183,960	171,743
Remuneration of Non-executive Directors	128	134
Supplies and services - clinical (excluding drugs costs)	21,785	20,799
Supplies and services - general	2,888	2,569
Drug costs (drugs inventory consumed and purchase of non-inventory drugs)	22,200	22,049
Inventories written down	129	104
Consultancy costs	1,670	1,505
Establishment	1,902	1,575
Premises	11,262	10,815
Transport (including patient travel)	589	583
Depreciation on property, plant and equipment	4,569	5,137
Amortisation on intangible assets	130	432
Net impairments	4,711	807
Movement in credit loss allowance: contract receivables / contract assets	118	-
Movement in credit loss allowance: all other receivables and investments	-	(300)
Increase in other provisions	42	347
Change in provisions discount rates	(11)	9
Audit fees payable to the external auditor		
audit services- statutory audit	70	51
other auditor remuneration (external auditor only)	8	7
Internal audit costs	142	150
Clinical negligence	8,690	7,631
Legal fees	108	160
Insurance	331	322
Research and development	549	488
Education and training	1,181	1,197
Rentals under operating leases	1,016	1,473
Redundancy	127	-
Car parking & security	1,106	735
Hospitality	17	8
Losses, ex gratia & special payments	21	143
Other services, eg external payroll	359	488
Other	931	1,192
Total	**280,533**	**262,347**
Of which:		
Related to continuing operations	280,533	262,347
Related to discontinued operations	-	-

The statutory audit fee for 2018/19 includes £19k relating to additional work undertaken during the audit of the 2017/18 accounts.

Note 6.2 Other auditor remuneration

	2018/19	2017/18
	£000	£000
Other auditor remuneration paid to the external auditor:		
1. Audit-related assurance services	8	7
Total	**8**	**7**

Note 6.3 Limitation on auditor's liability

The limitation on auditor's liability for external audit work is £1m (2017/18: £1m).

Note 7 Impairment of assets

	2018/19	2017/18
	£000	£000
Net impairments charged to operating surplus / deficit resulting from:		
Changes in market price	4,711	807
Total net impairments charged to operating surplus / deficit	**4,711**	**807**
Impairments charged to the revaluation reserve	3,894	203
Total net impairments	**8,605**	**1,010**

The change in market price impairment relates to the impact of the quinquennial valuation of the estate undertaken as at 31 March 2019.

Note 8 Employee benefits

	2018/19	2017/18
	Total	Total
	£000	£000
Salaries and wages	141,747	132,471
Social security costs	13,226	12,373
Apprenticeship levy	683	637
Employer's contributions to NHS pensions	15,430	14,606
Pension cost - other	13	4
Termination benefits	127	-
Temporary staff (including agency)	14,759	13,388
Total staff costs	**185,985**	**173,479**
Of which		
Costs capitalised as part of assets	681	532

Employee benefits are included in operating expenses within Research and development, education and training and Staff and Executive Directors costs

Note 8.1 Retirements due to ill-health

During 2018/19 there were 4 early retirements from the Trust agreed on the grounds of ill-health (4 in the year ended 31 March 2018). The estimated additional pension liabilities of these ill-health retirements is £180k (2017/18: £254k).

The cost of these ill-health retirements will be borne by the NHS Business Services Authority - Pensions Division.

Note 9 Pension costs

Past and present employees are covered by the provisions of the two NHS Pension Schemes. Details of the benefits payable and rules of the Schemes can be found on the NHS Pensions website at www.nhsbsa.nhs.uk/pensions. Both are unfunded defined benefit schemes that cover NHS employers, GP practices and other bodies, allowed under the direction of the Secretary of State 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 2019, is based on valuation data as at 31 March 2018, updated to 31 March 2019 with summary global and accounting data. In undertaking this actuarial assessment, the methodology prescribed in IAS19, relevant FReM interpretations, and the discount rate prescribed by HM Treasury have 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 2016. The results of this valuation set the employer contribution rate payable from April 2019. The Department for Health and Social Care has recently laid Scheme Regulations confirming that the employer contribution rate will increase to 20.6% of pensionable pay from this date.

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

National Employment Savings Trust (NEST)

NEST is a Workplace Pension Scheme operated by the Government; it is an alternative pension scheme (to the Superannuation Scheme) which is not NHS specific. It is a defined contribution, off statement of financial position scheme (as it is not exclusively NHS). The number of employees opting in, and the value of contributions, have been negligible. The cost in 2018/19 was £13k (2017/18 £5k).

Note 10 Operating leases

Note 10.1 Kettering General Hospital NHS Foundation Trust as a lessor

This note discloses income generated in operating lease agreements where Kettering General Hospital NHS Foundation Trust is the lessor.

The Trust has four lease arrangements, one relating to a telecommunications mast, the other three relating to franchise operations providing amenities for patients, staff and visitors. These three leases contain a profit share element included in contingent rent.

	2018/19	2017/18
	£000	£000
Operating lease revenue		
Minimum lease receipts	172	156
Contingent rent	80	73
Total	**252**	**229**

	31 March 2019	31 March 2018
	£000	£000
Future minimum lease receipts due:		
- not later than one year;	172	156
- later than one year and not later than five years;	674	622
- later than five years.	186	324
Total	**1,032**	**1,102**

Note 10.2 Kettering General Hospital NHS Foundation Trust as a lessee

This note discloses costs and commitments incurred in operating lease arrangements where Kettering General Hospital NHS Foundation Trust is the lessee.

The Trust has seven land and building lease arrangements relating to services provided from other sites, car parking and office arrangements. In addition the Trust leases equipment including all of the printers for the Trust and several vehicles for departments who work across sites.

	2018/19	2017/18
	£000	£000
Operating lease expense		
Minimum lease payments	1,016	1,473
Total	**1,016**	**1,473**

	31 March 2019	31 March 2018
	£000	£000
Future minimum lease payments due:		
- not later than one year;	1,043	1,457
- later than one year and not later than five years;	2,661	3,218
- later than five years.	2,637	3,151
Total	**6,341**	**7,826**
Future minimum sublease payments to be received	-	-

In 2017/18, the Trust included £446k in operating lease payments relating to the lease car arrangements for individual employees. The lease agreement is between the employee and the lease car company and therefore this has been excluded from 2018/19.

The corresponding entries in future minimum lease payments due not later than one year is £432k and in later than one year and not later than five years is £401k

Note 11 Finance income

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

	2018/19	2017/18
	£000	£000
Interest on bank accounts	81	27
Other finance income	1	-
Total finance income	**82**	**27**

Note 12.1 Finance expenditure

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

	2018/19	2017/18
	£000	£000
Interest expense:		
Loans from the Department of Health and Social Care	3,339	2,411
Finance leases	18	9
Total interest expense	**3,357**	**2,420**
Total finance costs	**3,357**	**2,420**

Note 12.2 The late payment of commercial debts (interest) Act 1998 / Public Contract Regulations 2015

The Trust made no payments of interest under the late payment of commercial debts (interest) Act.

Note 13 Other gains / (losses)

	2018/19	2017/18
	£000	£000
Gains on disposal of assets	18	21
Losses on disposal of assets	(46)	-
Total gains / (losses) on disposal of assets	**(28)**	**21**
Total other gains / (losses)	**(28)**	**21**

Note 14.1 Intangible assets - 2018/19

	Software licences £000	Total £000
Valuation / gross cost at 1 April 2018 - brought forward	**3,583**	**3,583**
Additions	1,210	**1,210**
Valuation / gross cost at 31 March 2019	**4,793**	**4,793**
Amortisation at 1 April 2018 - brought forward	**1,904**	**1,904**
Provided during the year	130	**130**
Amortisation at 31 March 2019	**2,034**	**2,034**
Net book value at 31 March 2019	**2,759**	**2,759**
Net book value at 1 April 2018	**1,679**	**1,679**

Note 14.2 Intangible assets - 2017/18

	Software licences £000	Total £000
Valuation / gross cost at 1 April 2017 - brought forward	**2,855**	**2,855**
Additions	815	**815**
Reclassifications	(87)	**(87)**
Valuation / 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 15.1 Property, plant and equipment - 2018/19

	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 2018 - brought forward - (restated)	**4,950**	**113,111**	**2,036**	**34,165**	**6,606**	**59**	**160,927**
Additions	-	6,954	52	3,286	821	-	**11,113**
Impairments	(317)	(9,225)	-	-	-	-	**(9,542)**
Reversals of impairments	-	937	-	-	-	-	**937**
Revaluations	-	2,358	-	-	(282)	-	**2,076**
Reclassifications	-	2,104	(1,727)	-	(377)	-	**-**
Disposals / derecognition	-	-	-	(1,016)	(60)	-	**(1,076)**
Valuation/gross cost at 31 March 2019	**4,633**	**116,239**	**361**	**36,435**	**6,708**	**59**	**164,435**
Accumulated depreciation at 1 April 2018 - brought forward - (restated)	**-**	**-**	**-**	**22,786**	**3,593**	**18**	**26,397**
Provided during the year	-	1,930	-	2,585	49	5	**4,569**
Revaluations	-	(1,930)	-	-	(282)	-	**(2,212)**
Disposals / derecognition	-	-	-	(903)	(60)	-	**(963)**
Accumulated depreciation at 31 March 2019	**-**	**-**	**-**	**24,468**	**3,300**	**23**	**27,791**
Net book value at 31 March 2019	**4,633**	**116,239**	**361**	**11,967**	**3,408**	**36**	**136,644**
Net book value at 1 April 2018	**4,950**	**113,111**	**2,036**	**11,379**	**3,013**	**41**	**134,530**

During 2018/19, the Trust reviewed and increased the asset lives attributed to IT assets. In addition £377k of network cables were transferred from IT equipment to Buildings as they form part of the infrastructure. This has reduced the level of IT depreciation charged in 2018/19.

Note 15.2 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
		(Restated)					(Restated)
Valuation / gross cost at 1 April 2017 - as previously stated	**4,500**	**95,779**	**13**	**31,541**	**5,355**	**98**	**137,286**
Prior period adjustments	-	6,117	-	-	-	-	**6,117**
Valuation / gross cost at 1 April 2017 - restated	**4,500**	**101,896**	**13**	**31,541**	**5,355**	**98**	**143,403**
Transfers by absorption	-	-	-	-	-	-	**-**
Additions	-	4,921	3,398	4,709	1,183	5	**14,216**
Impairments	-	(1,876)	-	-	-	-	**(1,876)**
Reversals of impairments	-	866	-	-	-	-	**866**
Revaluations	450	5,928	-	-	-	-	**6,378**
Reclassifications	-	1,376	(1,375)	-	86	-	**87**
Transfers to / from assets held for sale	-	-	-	-	-	-	**-**
Disposals / derecognition	-	-	-	(2,085)	(18)	(44)	**(2,147)**
Valuation/gross cost at 31 March 2018	**4,950**	**113,111**	**2,036**	**34,165**	**6,606**	**59**	**160,927**
Accumulated depreciation at 1 April 2017 - as previously stated	**-**	**-**	**-**	**22,341**	**2,721**	**58**	**25,120**
Prior period adjustments	-	-	-	-	-	-	**-**
Accumulated depreciation at 1 April 2017 - restated	**-**	**-**	**-**	**22,341**	**2,721**	**58**	**25,120**
Provided during the year	-	1,713	-	2,530	890	4	**5,137**
Revaluations	-	(1,713)	-	-	-	-	**(1,713)**
Disposals / derecognition	-	-	-	(2,085)	(18)	(44)	**(2,147)**
Accumulated depreciation at 31 March 2018	**-**	**-**	**-**	**22,786**	**3,593**	**18**	**26,397**
Net book value at 31 March 2018	**4,950**	**113,111**	**2,036**	**11,379**	**3,013**	**41**	**134,530**
Net book value at 1 April 2017	**4,500**	**101,896**	**13**	**9,200**	**2,634**	**40**	**118,283**

The restatement of 2017/18 relates to a prior period adjustment following the quinquenniel valuation of the estate.

The revaluation reserve has increased by £6,117k as at 1 April 2017 and by an additional £2,344k in Revaluations in 2017/18, full details are provided in note 36.

Note 15.3 Property, plant and equipment financing - 2018/19

	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 2019							
Owned - purchased	4,633	111,957	348	11,493	3,368	36	**131,835**
Finance leased	-	1,495	-	28	-	-	**1,523**
Owned - donated	-	2,787	13	446	40	-	**3,286**
NBV total at 31 March 2019	**4,633**	**116,239**	**361**	**11,967**	**3,408**	**36**	**136,644**

Note 15.4 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	108,985	2,023	10,825	2,988	41	**129,812**
Finance leased	-	1,444	-	56	-	-	**1,500**
Owned - donated	-	2,682	13	498	25	-	**3,218**
NBV total at 31 March 2018	**4,950**	**113,111**	**2,036**	**11,379**	**3,013**	**41**	**134,530**

Note 16 Donations of property, plant and equipment

The Trust received donations of equipment from the Kettering General Hospital NHSFT General Charitable Fund of 98k (2017/18 - nil)

Note 17 Revaluations of property, plant and equipment

The Trust's land and building assets are valued on the basis explained in Notes 1 to the accounts. Gerald Eve LLP provided an independent valuation of land and building assets (estimated fair value and remaining useful life) as at 31 March 2019.

The implementation of the Royal Institute of Chartered Surveyors guidance on *Depreciated Replacement Cost Method for Valuation for Financial Reporting* issued in November 2018, has reduced the useful lives for the Trusts buildings. This has not affected the Trust's retained deficit for the year but will increase depreciation in 2019/20.

Note 18 Inventories

	2019 £000	2018 £000 (Restated)
Drugs	1,306	1,255
Consumables	2,270	2,099
Energy	22	22
Total inventories	**3,598**	**3,376**
of which:		
Held at fair value less costs to sell	-	-

Inventories recognised in expenses for the year were £32,769k (2017/18: £32,915k). Write-down of inventories recognised as expenses for the year were £129k (2017/18: £104k).

The 31/03/2018 figures have been reclassified to include ward drugs in the Drugs classification (£334k) and Oil stocks into the Energy classification (£22k). Both items had previously been included in Consumables.

Note 19.1 Trade receivables and other receivables

	31 March 2019 £000	31 March 2018 £000 (Restated)
Current		
Contract receivables*	4,352	-
Contract assets*	2,123	-
Trade receivables*	-	2,334
Allowance for impaired contract receivables / assets*	(535)	-
Allowance for other impaired receivables	-	(504)
Prepayments	1,155	1,347
Interest receivable	7	2
PDC dividend receivable	-	9
VAT receivable	208	504
Other receivables*	462	2,063
Total current trade and other receivables	**7,772**	**5,755**
Non-current		
Contract receivables*	1,016	-
Prepayments	53	44
Other receivables*	-	737
Total non-current trade and other receivables	**1,069**	**781**
Of which receivables from NHS and DHSC group bodies:		
Current	4,907	2,306
Non-current	-	-

*Following the application of IFRS 15 from 1 April 2018, the Trust's entitlements to consideration for work performed under contracts with customers are shown seperately as contract receivables and contract assets. This replaces the previous analysis into trade receivables and accrued income. IFRS 15 is applied without restatement therefore the comparative analysis of receivables has not been restated under IFRS 15.

The application of IFRS15 specifically includes CRU income which was previously reported in Other receivables and is now shown in Contract receivables for both current and non current receivables.

The 31/03/2018 figures have been restated to show interest receivable, which was previously reported in Other receivables

Note 19.2 Allowances for credit losses - 2018/19

	Contract receivables and contract assets	All other receivables
	£000	£000
Allowances as at 1 Apr 2018 - brought forward		**504**
Impact of implementing IFRS 9 (and IFRS 15) on 1 April 2018	504	(504)
New allowances arising	123	-
Reversals of allowances	(5)	-
Utilisation of allowances (write offs)	(87)	-
Allowances as at 31 Mar 2019	**535**	**-**

Note 19.3 Allowances for credit losses - 2017/18

IFRS 9 and IFRS 15 are adopted without restatement therefore this analysis is prepared in line with the requirements of IFRS 7 prior to IFRS 9 adoption. As a result it differs in format to the current period disclosure.

	All receivables
	£000
Allowances as at 1 Apr 2017 - brought forward	**3,019**
Increase in provision	109
Amounts utilised	(51)
Unused amounts reversed	(2,573)
Allowances as at 31 Mar 2018	**504**

Note 20 Other assets

The Trust holds no Other Assets (2017/18 - nil)

Note 21 Non-current assets held for sale and assets in disposal groups

The Trust holds no Non - current assets held for sale (2017/18 - nil)

Note 22.1 Cash and cash equivalents movements

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

	2018/19	2017/18
	£000	£000
At 1 April	**2,670**	**1,204**
At start of period for new FTs	**-**	**-**
Net change in year	(1,328)	1,466
Transfer to FT upon authorisation	-	-
At 31 March	**1,342**	**2,670**
Broken down into:		
Cash at commercial banks and in hand	35	71
Cash with the Government Banking Service	1,307	2,599
Total cash and cash equivalents as in SoFP and SoCF	**1,342**	**2,670**

Note 22.2 Third party assets held by the Trust

The Trust held no cash and cash equivalents which relate to monies held by the Trust on behalf of patients or other parties.

Note 23.1 Trade and other payables

	31 March 2019 £000	31 March 2018 £000
Current		
Trade payables	7,910	3,950
Capital payables	2,971	3,911
Accruals	5,634	4,577
Social security costs	3,870	3,593
Accrued interest on loans*	-	517
Other payables	3,829	4,023
Total current trade and other payables	**24,214**	**20,571**
Of which payables from NHS and DHSC group bodies:		
Current	1,930	988
Non-current	-	-

*Following adoption of IFRS 9 on 1 April 2018, loans are measured at amortised cost. Any accrued interest is now included in the carrying value of the loan within note 27 . IFRS 9 is applied without restatement therefore comparatives have not been restated.

Note 23.2 Early retirements in NHS payables above

There were no early retirement costs included in NHS payables (2017/18 - nil)

Note 24 Other financial liabilities

There were no other financial liabilities (2017/18 - nil)

Note 25 Other liabilities

	31 March 2019 £000	31 March 2018 £000
Current		
Deferred income: contract liabilities	1,348	1,316
Total other current liabilities	**1,348**	**1,316**

Note 26 Borrowings

	31 March 2019 £000	31 March 2018 £000
Current		
Loans from the Department of Health and Social Care	59,881	14,944
Obligations under finance leases	299	304
Total current borrowings	**60,180**	**15,248**
Non-current		
Loans from the Department of Health and Social Care	88,640	104,484
Obligations under finance leases	757	1,055
Total non-current borrowings	**89,397**	**105,539**

The Trust funds its revenue deficit through borrowings from the DHSC. This has led to an increase in revenue borrowings in the year of £31,251k offset by repayment of capital loans of £2,844k. Previous revenue borrowings from 2015/16 and 2016/17 are repayable in 2019/20 and have moved to current borrowings.

The Trust has made no provision for the repayment of current revenue loans of £56.12m repayable in 2019/20. NHSi are aware of the situation and the likelihood is that the loan terms will be extended.

Note 26.1 Reconciliation of liabilities arising from financing activities

	Loans from DHSC	Finance leases	Total
	£000	£000	£000
Carrying value at 1 April 2018	**119,428**	**1,359**	**120,787**
Cash movements:			
Financing cash flows - payments and receipts of principal	28,407	(303)	**28,104**
Financing cash flows - payments of interest	(3,170)	(18)	**(3,188)**
Non-cash movements:			
Impact of implementing IFRS 9 on 1 April 2018	517	-	**517**
Application of effective interest rate	3,339	18	**3,357**
Carrying value at 31 March 2019	**148,521**	**1,056**	**149,577**

There are no prior year adjustments arising from the implementation of IFRS 9. However the interest relating to borrowings at 01/04/2018 of £517k is required to be classified as a finacial liability for this note and shown as a non-cash movement above.

Note 27 Finance leases

Note 27.1 Kettering General Hospital NHS Foundation Trust as a lessor

The Trust held no finance leases as a lessor (2017/18 - nil)

Note 27.2 Kettering General Hospital NHS Foundation Trust as a lessee

Obligations under finance leases where Kettering General Hospital NHS Foundation Trust is the lessee.

The Trust holds two finance leases, one for Equipment and one for a Car park deck.

	31 March 2019	31 March 2018
	£000	£000
Gross lease liabilities	**1,110**	**1,431**
of which liabilities are due:		
- not later than one year;	299	304
- later than one year and not later than five years;	811	1,127
Finance charges allocated to future periods	(54)	(72)
Net lease liabilities	**1,056**	**1,359**
of which payable:		
- not later than one year;	299	304
- later than one year and not later than five years;	757	1,055

Note 28.1 Provisions for liabilities and charges analysis

	Pensions: injury benefits*	Legal claims	Other	Total
	£000	£000	£000	£000
At 1 April 2018	**472**	**467**	**109**	**1,048**
Change in the discount rate	(11)	-	-	**(11)**
Arising during the year	21	507	-	**528**
Utilised during the year	(21)	(305)	(102)	**(428)**
Reversed unused	-	(240)	(7)	**(247)**
Unwinding of discount	-	-	-	**-**
At 31 March 2019	**461**	**429**	**-**	**890**
Expected timing of cash flows:				
- not later than one year;	22	429	-	**451**
- later than one year and not later than five years;	89	-	-	**89**
- later than five years.	350	-	-	**350**
Total	**461**	**429**	**-**	**890**

* In 2018/19 the analysis of provisions has been revised to separately identify provisions for injury benefit liabilities. In previous periods, these provisions were included within Other Provisions.

Legal claims

The amount shown against legal claims includes non-clinical claims made against the Trust. The amounts shown for these provisions are based on advice provided by NHS Resolution and the Trusts solicitors. In addition to the provision, contingent liabilities for non clinical negligence claims are given in note 29.

Note 28.2 Clinical negligence liabilities

At 31 March 2019, £181,094k was included in provisions of NHS Resolution in respect of clinical negligence liabilities of Kettering General Hospital NHS Foundation Trust (31 March 2018: £161,258k).

Note 29 Contingent assets and liabilities

	31 March 2019 £000	31 March 2018 £000
Value of contingent liabilities		
NHS Resolution legal claims	(46)	(110)
Other	-	(71)
Gross value of contingent liabilities	**(46)**	**(181)**
Amounts recoverable against liabilities	-	-
Net value of contingent liabilities	**(46)**	**(181)**
Net value of contingent assets	**-**	**-**

The Trust's contingent liabilities relate to NHS Resolution non-clinical claims which have also been provided for in provisions, note 28.1.
The Trust is aware of a Court of Appeal case relating to Employee benefits which could impact on the Trust. As at 31/03/2019, the Trust cannot quantify this contingent liability.

Note 30 Contractual capital commitments

	31 March 2019 £000	31 March 2018 £000
Property, plant and equipment	4,271	3,418
Intangible assets	1,418	911
Total	**5,689**	**4,329**

Note 31 Financial instruments

International Financial Reporting Standard (IFRS) 7 requires disclosure of the role that financial instruments have had during the period in creating or changing the risks an entity faces in undertaking its activities. Financial Instruments play a much more limited role in creating or changing risk within the NHS than would be typical of commercial business entities. The Trust has limited powers to borrow or invest surplus funds. Financial assets and liabilities are generated by day-to-day operational activities rather than being held to change the risks facing the Trust in undertaking its activities.

Note 31.1 Financial risk management

Credit risk

Due to the continuing service provider relationship that the Trust has with local Clinical Commissioning Groups (CCGs) and the way those CCGs are financed, the Trust is not exposed to the same degree of credit risk faced by some entities. Those items in dispute or under query have been assessed and a provision for impairment made, if deemed appropriate. Totals are included in the trade and other receivables in note 20.1.

Liquidity risk

The Trust's net operating costs are incurred mainly in respect of delivering on legally-binding long term contracts with CCGs. CCGs themselves are financed by resources voted annually by Parliament. As noted above, this means that the Trust is not exposed to quite the same level of risk as some other business entities, but as has been evidenced during the year, if the Trust experiences liquidity issues, provided certain criteria can be evidenced, Department of Health and Social Care funding (not categorised as a Financial Instrument) may become eligible for drawdown to ensure the Trust can continue to meet its liabilities as they fall due. As noted in the 'Going Concern' disclosure in note 1, the Board has reasonable expectation that the Trust will have access to adequate resources in the next 12 months.

Market risk

The Trust has borrowed from the government for capital expenditure and revenue support, subject to affordability as confirmed by NHS Improvement. The borrowings are for 1 – 25 years, in line with the life of the associated assets or agreed repayment terms, and interest is charged at a rate fixed for the life of the loan. The Trust therefore has low exposure to interest rate fluctuations.

Foreign 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 and therefore has low exposure to currency rate fluctuations.

Note 31.2 Carrying values of financial assets

IFRS 9 Financial Instruments is applied retrospectively from 1 April 2018 without restatement of comparatives. As such, comparative disclosures have been prepared under IAS 39 and the measurement categories differ to those in the current year analyses.

	Held at amortised cost	Total book value
Carrying values of financial assets as at 31 March 2019 under IFRS 9	**£000**	**£000**
Trade and other receivables excluding non financial assets	7,425	**7,425**
Cash and cash equivalents at bank and in hand	1,342	**1,342**
Total at 31 March 2019	**8,767**	**8,767**

	Loans and receivables	Total book value
Carrying values of financial assets as at 31 March 2018 under IAS 39	**£000**	**£000**
Trade and other receivables excluding non financial assets	4,322	**4,322**
Cash and cash equivalents at bank and in hand	2,670	**2,670**
Total at 31 March 2018	**6,992**	**6,992**

Note 31.3 Carrying value of financial liabilities

IFRS 9 Financial Instruments is applied retrospectively from 1 April 2018 without restatement of comparatives. As such, comparative disclosures have been prepared under IAS 39 and the measurement categories differ to those in the current year analyses.

	Held at amortised cost	Total book value
	£000	£000
Carrying values of financial liabilities as at 31 March 2019 under IFRS 9		
Loans from the Department of Health and Social Care	148,521	**148,521**
Obligations under finance leases	1,056	**1,056**
Trade and other payables excluding non financial liabilities	18,197	**18,197**
Provisions under contract	890	**890**
Total at 31 March 2019	**168,664**	**168,664**

	Other financial liabilities	Total book value
	£000	£000
Carrying values of financial liabilities as at 31 March 2018 under IAS 39		
Loans from the Department of Health and Social Care	119,428	**119,428**
Obligations under finance leases	1,359	**1,359**
Trade and other payables excluding non financial liabilities	14,929	**14,929**
Provisions under contract	1,048	**1,048**
Total at 31 March 2018	**136,764**	**136,764**

Note 31.4 Fair values of financial assets and liabilities

The carrying value of financial assets and liabilities is a reasonable approximation of fair value.

Note 31.5 Maturity of financial liabilities

	31 March 2019	31 March 2018
	£000	£000
In one year or less	78,829	30,762
In more than one year but not more than two years	32,315	47,168
In more than two years but not more than five years	41,028	32,068
In more than five years	16,492	26,766
Total	**168,664**	**136,764**

Note 32 Losses and special payments

	2018/19		2017/18	
	Total number of cases	**Total value of cases**	**Total number of cases**	**Total value of cases**
	Number	**£000**	**Number**	**£000**
Losses				
Cash losses	15	8	18	7
Fruitless payments	-	-	1	9
Bad debts and claims abandoned	21	64	22	76
Stores losses and damage to property	3	130	3	104
Total losses	**39**	**202**	**44**	**196**
Special payments				
Compensation under court order or legally binding arbitration award	-	-	1	12
Ex-gratia payments	84	85	100	79
Total special payments	**84**	**85**	**101**	**91**
Total losses and special payments	**123**	**287**	**145**	**287**
Compensation payments received		-		-

Note 33.1 Initial application of IFRS 9

IFRS 9 Financial Instruments as interpreted and adapted by the GAM has been applied by the Trust from 1 April 2018. The standard is applied retrospectively with the cumulative effect of initial application recognised as an adjustment to reserves on 1 April 2018.

IFRS 9 replaces IAS 39 and introduces a revised approach to classification and measurement of financial assets and financial liabilities, a new forward-looking 'expected loss' impairment model and a revised approach to hedge accounting.

Under IFRS 9, borrowings from the Department of Health and Social Care, which were previously held at historic cost, are measured on an amortised cost basis. Consequently, on 1 April 2018 borrowings increased by £517k, and trade payables correspondingly reduced.

Reassessment of allowances for credit losses under the expected loss model resulted in no change in the carrying value of receivables.

The GAM expands the definition of a contract in the context of financial instruments to include legislation and regulations, except where this gives rise to a tax. Implementation of this adaptation on 1 April 2018 has led to the classifiction of receivables relating to Injury Cost Recovery as a financial asset measured at amortised cost. The carrying value of these receivables at 1 April 2018 was £310k.

Note 33.2 Initial application of IFRS 15

IFRS 15 Revenue from Contracts with Customers as interpreted and adapted by the GAM has been applied by the Trust from 1 April 2018. The standard is applied retrospectively with the cumulative effect of initial application recognised as an adjustment to the income and expenditure reserve on 1 April 2018.

IFRS 15 introduces a new model for the recognition of revenue from contracts with customers replacing the previous standards IAS 11, IAS 18 and related Interpretations. The core principle of IFRS 15 is that an entity recognises revenue when it satisfies performance obligations through the transfer of promised goods or services to customers at an amount that reflects the consideration to which the entity expects to be entitled to in exchange for those goods or services.

As directed by the GAM, the Trust has applied the practical expedient offered in C7A of the standard removing the need to retrospectively restate any contract modifications that occurred before the date of implementation (1 April 2018).

Note 34 Related parties

During the year none of the Trust Board members, members of the key management staff, or parties related to any of them, have undertaken any material transactions with Kettering General Hospital NHS Foundation Trust.

The Department of Health and Social Care is regarded as a related party. During the year the Trust has had a significant number of material transactions with the Department, and with other entities for which the Department is regarded as the parent. These include:

Nene CCG
Corby CCG
NHS England
Northampton General Hospital NHS Trust
Northamptonshire Healthcare NHS Foundation Trust
University Hospitals of Leicester NHS Trust
Cambridgeshire and Peterborough CCG
East Leicester & Rutland CCG
NHS Resolution
NHS Blood & Transplant
Health Education England
NHS Improvement

In addition, the Trust has had a number of material transactions with other government departments and other central and local government bodies. Most of these transactions have been with the NHS Business Services Authority in respect of pension contributions, HMRC in respect of taxation and local councils in relation to business rates.

The Trust has also received revenue payments and capital donations from Kettering General Hospital NHSFT General Charitable Funds whose Corporate Trustee is the Trust Board. An administration charge of £21k (2017/18: £21k) was made by the Trust to the charity.

Note 35 Charitable Funds Consolidation

The Foundation Trust is the Corporate Trustee to Kettering General Hospital NHSFT General Charitable Funds. The Foundation Trust has assessed its relationship to the charitable fund and determined it to be a subsidiary because the Foundation Trust has the power to govern the financial and operating policies of the charitable fund so as to obtain benefits from its activities.

The Trust Board believe that the transactions involving the charitable fund are not material to the Foundation Trust accounts and have chosen not to consolidate the accounts on this basis.

Note 36 Prior period adjustment

Following the quinquennial valuation of the Estate, it was identified that the Foundation Wing showed a material increase in value, discussions with the Valuer and Grant Thornton identified that a prior period adjustment was required, reflecting an error in the carrying value of the building as at 01/04/2017.

The impact of the prior period adjustment is to increase the value of buildings within the Property Plant and equipment asset by £8,461k as at 31/03/2018. The corresponding increase is to the Revaluation Reserve. There has been no impact on the Statement of Comprehensive Income for 2017/18.

	Per Trust published accounts		Adjustments		Restated Accounts	
Period	Property Plant and Equipment £'000	Revaluation reserve £'000	Property Plant and Equipment £'000	Revaluation reserve £'000	Property Plant and Equipment £'000	Revaluation reserve £'000
01/04/2017	95,779	21,325	6,117	6,117	101,896	27,442
31/03/2018	104,650	26,424	2,344	2,344	106,994	28,768
Total increase			8,461	8,461		

Note 37 Events after the reporting date

There have been no events after the reporting date that would impact on the financial statements.