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Northamptonshire Healthcare
NHS Foundation Trust

ANNUAL REPORT & ACCOUNTS 2018/19

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HSJ AWARDS 2018 AGRI
WINNERS
TRUST OF THE YEAR
NORTHAMPTONSHIRE HEALTHCARE NHS FOUNDATION TRUST

Inspected and rated
Outstanding ☆
CareQuality Commission

MAKING A DIFFERENCE FOR YOU, WITH YOU

NORTHAMPTONSHIRE HEALTHCARE NHS FOUNDATION TRUST

Annual Report and Accounts 2018/19

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

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ABOUT THIS REPORT

In this report, you can read what people have to say about our Trust. We have included some of the views of our patients, carers and staff members.

Not all the testimonials you read will be attributed to a name, as sometimes people ask to remain anonymous.

We make it clear whether they are a patient, carer, service user, friend, family member or staff member, and we make it clear that the statement is a testimonial by adding quotation or speech marks.

All of the images you see in this report are of our patients, carers, service users, friends, family members and staff members.

However, photographs that are included near or next to testimonials appear without a name and are not related to the testimonial. Each individual has approved his or her testimonial for publication.

We also include explanations of terms and abbreviations in speech bubbles or balloons, like the one shown below. At the end of our Quality Report, you can also find an Easy Read section, with a summary explanation of our key quality priorities for next year.

We hope that you find this report informative and thank you for taking the time to read it.

WELCOME

FROM THE CHIEF EXECUTIVE

It is my honour to be part of a Trust so dedicated to making a difference to many lives. Our team is committed to putting the person at the centre of what we do, every day of the year.

The past 12 months have been as busy and demanding as ever, with over 100 services, all delivering care in an integrated and compassionate way. This is only possible due to the dedication of colleagues, partners, volunteers and carers to our mission of *making a difference for you, with you*.

This year has seen many significant achievements. Our Care Quality Commission (CQC) Inspection in June and the first Well-led Inspection in July rated the Trust as 'outstanding'. We were also thrilled to be named 'Trust of the Year' at the prestigious HSJ Awards, and earlier in the year we won a HSJ Patient Safety Award for Best Product or Innovation in the Public Sector for our work on body worn cameras. We were chosen to be one of NHS Employers' Diversity and Inclusion Partners, working with NHS Employers and other partners to improve the measurement of diversity, inclusion and equality across the health and social care system.

Indeed, equality and diversity continues to be an important area. We know that creating an environment where everyone's background and life experience is given room to thrive is vital to the achievement of our vision and values. We also reach out to our diverse communities to ensure everyone has equal access to outstanding healthcare. In May 2018, we ran a series of engagement events in our Black, Minority and Ethnic communities to increase awareness of our mental health services. Our goal was to reduce the stigma of mental health problems and encourage people to access services before health problems become serious.

We are always looking for new and more efficient ways of working, and the past year has been no exception. NHS England's *Five Year Forward View*, published in 2014, proposed new care models to fill gaps in health and wellbeing, care and quality, plus finance and efficiency. In response, we are developing care models that encourage partnerships with the wider NHS, social care services, community organisations and education. Our aim is to provide seamless, high-quality support that prevents people 'slipping through the gaps'. This new way of working means we are also addressing pressure points, such as improving support for high-risk patients and working with our district general hospital partners for the benefit of patients, service users and carers.

Another change this year is our approach to staff and resource. It is essential that the whole Trust team works to a high level of productivity and performance, while also focusing on our colleagues development and wellbeing. New ways of evaluating this will help us to drive up our already high standards. As at 31 March 2019, over 90% of our staff had received their annual appraisal. We have invested in training, staff advocacy and open forums. In the national staff survey we have seen a positive trend in the responses, in particular with more colleagues recommending the Trust as a place to work. Following last year's successful implementation of e-Roster, we have now implemented e-Expenses. Work will continue to review rostering in the future to optimise our effective use of resources.

In July 2018, we launched our new staff wellbeing strategy with a focus on supporting colleagues to stay well. The strategy launched with 400 colleagues attending an all-day wellbeing conference, giving them the opportunity to try something new and be inspired.

As always, we have kept a close eye on feedback from our service users. During the last year, 24,816 reviews were submitted through iWantGreatCare. I am pleased to report that 93.67% of reviewers would recommend our services to friends and family. We also achieved a rating of 4.81 out of 5 stars for their overall experience.

We have introduced a number of initiatives to improve patient safety and experience. For example, we have reviewed and updated our falls training and introduced a falls champion role across the whole organisation. We have also reduced the use of restraint in our mental health services. Our CQC 'safe' score has improved from last year, but there is still work to be done and we will continue to do all we can to excel in this important area.

There are always pressures of resource and finance on an NHS Foundation Trust, however by giving focus to our strategic plan, putting patients at the heart of everything we do, and working in a joined-up and respectful way with colleagues, service users and partners, we will continue to improve and evolve. I hope you find the information in this report to be useful.

Angela Hillery

Chief Executive
22 May 2019

PERFORMANCE REPORT

INTRODUCTION

Every day, we deliver physical, mental health and specialty services to people across Northamptonshire and beyond, in the community, at home, work, in schools or in healthcare locations. We offer more than 100 services across the county – as well as some specialist services in bordering and nearby counties – to deliver care together in an integrated way. We work in partnership with other providers, bodies and groups, and are dedicated to *making a difference for you, with you*.

Trust colleagues at our staff wellbeing day

Welcome to our Annual Report and Accounts 2018/19. In this year's report, we share information about us, our strategy, objectives and achievements, as well as our challenges and risks.

SECTION ONE: AN OVERVIEW

We are proud to be a health and wellbeing organisation that is dedicated to making a difference.

We strive to continually innovate and make a difference to our community, and those working for and with our Trust. We share a collective vision to provide outstanding, compassionate care to the people of Northamptonshire and surrounding areas. Together, we listen closely to feedback from our service users and carers to make sure our services are diverse, responsive and are delivered with care and compassion every day.

We are committed to delivering care for our patients in their own homes whenever possible – and provide many services outside of hospitals and in the community.

In this section, we share information about our organisation and its history, its purpose and model, along with our strategies and objectives. We also highlight the risks we faced this year, and review how we performed.

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

Trust colleagues at the HSJ Awards, where we were named Trust of the Year 2018

ABOUT US

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

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

Our governors represent the interests of staff, patients, the public, service users and carers, as well as other local organisations, in the running of our Foundation Trust.

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

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

OUR SERVICE PORTFOLIO

ADULT MENTAL HEALTH AND SPECIALTY SERVICES

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

ADULT SERVICES

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

CHILDREN'S SERVICES

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

OTHER SERVICES

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

OUR HISTORY

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

Today, operating as Northamptonshire Healthcare NHS Foundation Trust, more than 4,800 staff contribute to providing dedicated outstanding healthcare for our community, making contact with patients on more than 1.7 million occasions in 2018/19 alone.

OUR COMMUNITY

According to the Office of National Statistics' population projections (accessed February 2019), Northamptonshire's current population of 752,200 people is set to rise by 7% over the next 10 years. Of this population, 25% are aged 0-19, 57% are aged 20-64 and 18% are over 65 years old.

Based on public health data from Northamptonshire County Council, one in every 100 adults are dependent on alcohol, 66% are overweight, and 16% smoke. They also report that just under 36% of adults are physically inactive and life expectancy for women is lower than the national average, at 83 years.

OUR DRIVERS

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

The NHS is also continuing to drive Sustainability and Transformation Partnerships, in order to integrate funding and services at a local level.

In response, we have been developing new care models locally that foster partnerships with the wider NHS, local government (including social care and housing), the voluntary and community sectors and higher education.

Following the announcement of an extra £20.5 billion funding for the NHS by 2023/24, the national team published the NHS Long Term Plan in January 2019 to 'make sure the NHS is fit for the future'. Developed in partnership with frontline health and care staff, patients and their families, the plan makes a renewed commitment that mental health services will grow faster than the overall NHS budget. This will enable further service expansion and faster access to community and crisis mental health services for both adults and particularly children and young people.

Over the next five years all parts of the country will be asked to increase the capacity and responsiveness of community and intermediate care services to those who are clinically judged to benefit most.

Northamptonshire
Health and Care Partnership

WHAT IS NORTHAMPTONSHIRE HEALTH AND CARE PARTNERSHIP (NHCP)?

Formerly known as the Northamptonshire STP, NHCP consists of key health and care providers in the county.

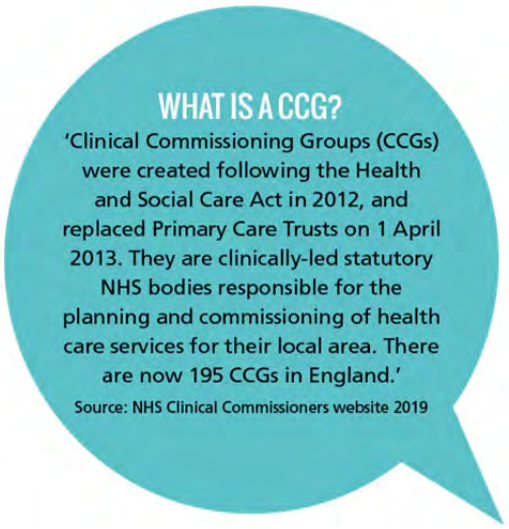
'NHCP is not a new organisation but a new way of working in partnership to improve health and care for people living in Northamptonshire. All partnership organisations remain as separate organisations with their own local responsibilities for the services they provide, but are committed to working together towards the shared NHCP vision for a positive lifetime of health, wellbeing and care in our community.'

Source: Northamptonshire County Council website 2019

These developments are aligned to the Northamptonshire Health and Care Partnership (NHCP), which brings commissioners and providers across Northamptonshire's health and social care economy together around a shared mission 'empowering positive futures; choose well, stay well, live well'. The partnership is striving for 'a positive lifetime of health, wellbeing and care in our community', which it has broken down into four ambitions:

1. We want a positive lifetime of health, wellbeing and care
2. We want better standards of care
3. We want better collaborative working
4. We want better management of our resources.

With this work at both national and local levels, and our local community's demographic growth, the Trust is planning for increased demand on its services, an increase in focus on improvements to the most health deprived areas and a continued focus on services for frail, older and long-term users of health services. Partnerships within and outside the healthcare sector remain important for the Trust.



OUR LOCAL COMMISSIONERS

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

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

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

- Improving primary and community service support for patients with high risks, so they are less likely to need urgent care
- Unifying how our district general hospital services work together so patients will get the best outcomes if they need these services
- Introducing more ways to support patients' health and wellbeing in our community
- Improving access to GPs, primary and community care – which will mean we have less pressured emergency and urgent and care services.

OUR LOCAL CONTEXT

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

Key providers operating in Northamptonshire include:

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

HOW THIS AFFECTS US

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

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

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

OUR VISION AND STRATEGY

Our strategic and organisational objectives are designed to keep safe, quality care at the foundation of all we do every day.

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

Our 2018 CQC rating of 'outstanding' was a significant milestone on the journey to achieving our vision.

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

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

OUR MISSION

Our mission is *making a difference for you, with you* and was chosen by our own staff and stakeholders.

It means that in everything we do and through every service we provide, we want to make a difference in people's lives – for those we care for, those we work with and those who work for us. Everyone is part of our team.

OUR STRATEGIC PLANS

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

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

ADULT AND CHILDREN'S SERVICES

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

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

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

Universal Children's Services

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

Specialist Ambulatory Services

- To work in partnership with colleagues in primary and secondary care, ensuring that individuals are treated as close to home as possible, and in line with the Five Year Forward View
- To maximise the treatment available within NHFT
- To work with commissioners to ensure contracts are retained and developed to meet the needs of the public
- To develop roles and responsibilities to ensure opportunities are maximised and service users receive high quality care by appropriately trained teams.

Safeguarding

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

Children's and Adolescent's Mental Health Services

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

Specialist Children's Services

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

Community Nursing

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

Adult Therapies, Podiatry and Specialist Nursing

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

Specialist Palliative Care and Community Inpatients

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

MENTAL HEALTH, LEARNING DISABILITY AND SPECIALTY SERVICES

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

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

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

Learning Disability Services

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

Specialty Services

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

Mental Health Inpatient Services

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

Mental Health Community Services

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

Crisis Pathway Services

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

Older Adult Services

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

Celebrating 70 years of the NHS

SUMMARY OF CURRENT ORGANISATIONAL RISKS

The Board of Directors review the Trust's Organisational Risk Register (ORR) at each meeting held in public. The Organisational Risk Register Board reports (which are available on our website) describe the ORR risks referenced in the table below in more detail.

Current risk levels given the existing set of controls

Consequence					
5		2383 Care delivery	3948 EU exit 3739 Partnership appetite 3746 Staff engagement & leadership 3750 Unable to sustain & influence 2833 VTE 2761 Acute Outflows 2386 Safeguarding 2385 Workforce capability 3744 Staff wellbeing 3911 Workforce supply & capacity	3735 Partnership delivery	3870 Financial performance
4		2384 Regulatory non-compliance	3738 Partnership compliance/performance 3582 System wide intermediate care 3742 Innovation BAU 3743 Failed innovation 2387 Poor practice	3581 System leadership 3736 Partners impact income 3740 Innovation capacity 3745 Diverse & inclusive workforce 3425 17/19 Integration & BCF 3757 Service capacity 2972 PPM NHSPS properties	3748 Ability to achieve
3		2563 Clinical audit	3214 GDPR	3751 Commercial finance benefits 2562 EPPR 3741 Innovation ROI 2771 Medical staffing levels 3926 Falsified Medicines Directive	3871 Operations disruption
2		2860 Regulatory non-compliance IAPT			
1					
	1	2	3	4	5
	Likelihood				

OUR BIGGEST RISKS

The significant risks in relation to the Trust's strategic objectives are described in the Trust-wide organisational risk register. During 2018/19, the most significant risks included:

- Financial performance not meeting plan due to internal and external risks crystallising and mitigations being insufficient
- Lack of expertise and good systems inhibiting our ability to achieve
- Partnership failing to deliver achieved patient benefits
- Workforce supply and capacity insufficient to meet contractual demand and deliver high quality of care
- Workforce capability insufficient to meet contractual demand and deliver high quality of care.

These risks will carry forward into 2019/20. The Trust has put in place controls and action plans to mitigate these risks and these are described in the organisational risk register, including effective financial governance arrangements, oversight and scrutiny of partnerships by the Strategic Partnership Forum and robust safe staffing and recruitment processes.

PERFORMANCE AGAINST TARGETS

In 2018/19 we achieved seven out of the 10 statutory targets at fourth quarter. Performance for the year is summarised in the following table. Unless indicated otherwise, Trust performance against indicators is based on data collected by the Trust and held on trust IT systems.

Indicator	2017/18 year performance	2018/19 Target	2018/19 Performance - Q1	2018/19 Performance - Q2	2018/19 Performance - Q3	2018/19 Performance - Q4	Overall 2018/19 Year Performance
Early Intervention in Psychosis (EIP) within 2 weeks	93.62%	53%	100.00%	97.00%	87.50%	93.80%	94.87%
Cardio-metabolic assessment (a) Inpatients	60% (Q4)	90%	79.0%	92.0%	84.0%	92.0%	not applicable
(b) EIP	79.6% (Q4)	90%	89.1%	89.8%	88.9%	88.8%	not applicable
c) Community Mental Health (people on CPA)	51.3% (Q4)	65%	50.5%	49.3%	51.6%	47.6%	not applicable
Improving Access to Psychological Therapies (IAPT) - (a) Recovery	43.92%	50%	47.90%	44.50%	52.85%	51.20%	48.84%
IAPT - (b).i 6 weeks referral	75.77%	75%	93.50%	95.40%	96.63%	97.30%	95.54%
IAPT - (b).ii 18 weeks referral	99.08%	95%	99.40%	99.80%	99.93%	99.90%	99.73%
CPA 7 days	97.93%	95%	99.19%	98.60%	97.63%	98.60%	98.50%
Admissions to Adult patients < 16 years old	0	0	0	0	0	0	0
Inappropriate OOA placements for Adult MH	4940	0	992	423	130	346	1891 (157.6 per month)

CONCLUSION

Although the Trust operates in an ever-changing social, health and economic landscape, it has performed well in 2018/19.

It is vital that we continue to put improvement and adaptability on our agenda to remain an effective and agile organisation for our population. It is one of the reasons that we continue to review and adapt our strategy and plans, as well as explore new and different services and pathways.

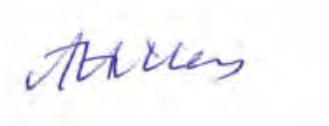
Our risks continue to be in maintaining strong financial performance, workforce supply and the pressures of increased demand. This is why we scrutinise our financial performance and recruitment programmes, as well as our safe staffing monitoring and reporting.

Our financial performance
2018/19 was a challenging year from a financial perspective, however the Trust continued to perform well and met its financial targets. We exceeded our control total by reducing agency costs, increasing permanent staff and significantly reducing pressures from Mental Health Acute Outflow costs. This means that the Trust received its entire core Provider Sustainability Funding (PSF) and became eligible to receive Incentive and Bonus PSF funding.

Our quality performance
In June 2018, the Care Quality Commission (CQC) inspected the Trust and rated us as 'outstanding' overall, compared to our previous overall rating published in 2017 of 'good'. We also received the 'outstanding' rating in the 'caring' and 'well-led' domains. I am proud of this achievement, and want to acknowledge and thank everyone who contributed to delivering this overall position.

Our regulatory performance
In 2018/19, we achieved seven out of the ten statutory targets at fourth quarter. Performance for the year is summarised in the table on the previous page.

Overall for the 2018/19 year we improved against all relevant indicators for Early Intervention in Psychosis (EIP), Cardio-metabolic assessments, Improving Access to Psychological Therapies (IAPT) recovery and referral, Care Programme Approach (CPA), admissions to adult patients and Out of Area (OOA) placements for adult mental health compared to 2017/18.



Angela Hillery
Chief Executive

22 May 2019

SECTION TWO: PERFORMANCE ANALYSIS

OUR PERFORMANCE

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

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

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

We also use external benchmarking available to us, in particular NHSI Model Hospital comparisons and are a member of the NHS Benchmarking Network.

MEASURING OUR PERFORMANCE
We measure our performance in the following areas:

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

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

ANTI-BRIBERY

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

STAFF PERFORMANCE, RESOURCE AND PRODUCTIVITY

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

We measure our staff productivity, resource and performance in the following ways.

Staff performance
This year, appraisals have increased. Our internal records show that, as at 31 March 2019, over 90% of staff received an appraisal this year.

We also invested in job-related training, staff advocacy and open forums, as well as in pulse surveys, to help us further understand how we can positively impact performance and encourage the involvement and motivation of staff.

Staff resource and productivity
In 2018/19, following the successful implementation of e-Roster, we implemented e-Expenses. Work continues to improve and review rostering across the organisation to ensure best practice and the continued efficient use of substantive staff, which reduces agency spend.

ENVIRONMENTAL MATTERS

Our Sustainable Development Management Plan (SDMP), approved by our Board of Directors, has been designed to clarify our objectives on environmental matters, sustainable development and climate change. Sustainable development and carbon management are corporate responsibilities that we take very seriously.

Our SDMP provides clear governance for an assurance process that considers all legal requirements, while taking into account the demands of providing high quality healthcare.

The NHFT Sustainable Development Management Plan was reviewed in 2017 and the current plan is scheduled to run until 2020.

The Plan sets out the Trust's vision for sustainability and establishes a plan of actions for how the Trust can become a more sustainable provider of healthcare services.

Based on the right mix of social, economic and environmental factors that are fundamental to creating a sustainable health service, our SDMP will also help our organisation to meet its carbon reduction commitments and make essential efficiency savings.

Our SDMP helps us to:

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

The latest carbon footprint (2017/18) shows a 24.79% decrease in direct carbon emissions compared with the 2011/12 baseline. Emissions from electricity, gas and water have decreased considerably. There have been issues with collecting accurate water data, which are being investigated, and waste has a slight increase of 5.50%.

In 2018, we were recognised with the Investors in the Environment (iiE) Level Accreditation certificate. An acknowledgement of our commitment to reducing our environmental impact and the continual improvement of environmental performance, the accreditation shows we have made good progress with our carbon footprint reduction.

We have completed the Sustainable Development Unit's (SDU) Sustainable Development Assessment Tool (SDAT) for the second consecutive year and increased our score to 69%, up from 67% in 2017/18. The Trust was one of the first in the country to complete the full SDAT as per the Organisational Summary published by the SDU.

The SDU organisational summary tracks performance of NHS trusts across 16 different sustainability metrics. This data has been used to benchmark NHFT against the 11 other community and mental health trusts. The Trust is on par with the highest achievers in eight of the 16 areas. Progress has been made on three of the remaining eight areas over the last 12 months, and this will be reflected when the new Organisational Summary is published by the SDU.

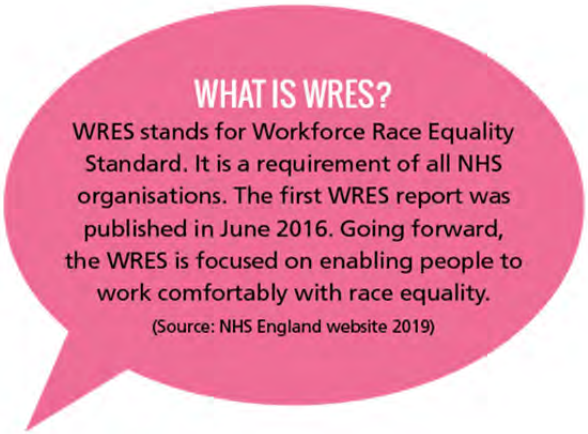
EQUALITY, DIVERSITY AND INCLUSION

We value diversity and being inclusive in everything we do. It is also important as it helps us to future proof our organisation as an employer and a service provider. We have a large, diverse workforce and patient population.

We recognise that promoting human rights, equality, diversity and inclusion (EDI) – while tackling inequality, discrimination and harassment – is central to the achievement of our vision and core values.

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

We use the national performance tool for equality, the NHS Equality Delivery System 2 (EDS2). Designed to help NHS organisations understand how equality can drive improvements and strengthen the accountability of services to patients and the public, we are focused on addressing inequalities and delivering positive outcomes for all groups protected under the Equality Act 2010.



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

Our EDI work this year
In May 2018, together with our community stakeholders and partner organisations across Northamptonshire, we ran a series of community engagement events. These provided awareness of mental health services that reduce stigma and build effective and lasting partnerships with our Black, Minority and Ethnic (BME) communities, so that people will access services before mental health crises develop.

This year, staff members attended public and bespoke events hosted by community groups to share improvements made to mental health services and information, which include the Changing Minds IAPT service and Crisis Cafes. We reached over 500 people in Northamptonshire through this work.

Community engagement remains a priority. This year, we appointed an Equality and Engagement Manager to work with our trained BME service users and carers to progress the community engagement programme.

VOLUNTEER NETWORK

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

This year, we had a bank of 120 consistent volunteers, with an average of 25 new enquiries each month. Over the last year, 108 new volunteers were recruited, and many gave approximately half a day of their time a week, for a total of six months. Others have remained, making a longer commitment.

We value all our volunteers and thank them for the positive contributions they make to the Trust each and every day. This year, Voluntary Impact Northamptonshire (VIN) continued to provide volunteer management to the Trust. VIN was contracted by the Trust to help us find volunteers and match people with suitable volunteering opportunities in our organisation.

They also give us assurance that the appropriate processes are in place to recruit and manage volunteers. VIN continued to provide volunteer management to the Trust and will continue to do so until at least March 2022.

In 2017/18, VIN established processes and procedures for the Trust's volunteering opportunities, and our Volunteering Development Officer (VDO) conducted project work to explore these development opportunities. Last year, we also recruited a Volunteer Coordinator, who supports our VDO with the coordination of volunteers and administration. As well as continuing volunteer management for new and existing volunteers and staff in 2018/19, the Volunteer Manager and Volunteer Coordinator have been working towards the nationally recognised 'Investing in Volunteers' accreditation'. Once we have achieved this, we will be the only Trust in the county to have the accreditation, and one of a handful of NHS Trusts in England.

QUALITY PERFORMANCE, ASSURANCE AND IMPROVEMENT

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

Patient safety

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

Patient experience

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

Clinical effectiveness

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

PATIENT SAFETY, EXPERIENCE AND FEEDBACK

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

- Performance data
- Internal and external quality benchmarking
- Our response to incidents, complaints and Patient Advice and Liaison Service (PALS) concerns
- Feedback, including compliments, PALS and iWantGreatCare
- Information from our key stakeholders, such as commissioners, Healthwatch and the voluntary sector
- Through our patient involvement work stream and patient experience groups.

During the year, we had a total of 24,816 reviews through our systematic feedback system iWantGreatCare.

93.67% of reviewers would recommend our services to friends and family, and they awarded us a rating of 4.81 out of 5 stars for their overall experience.

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

- Reviewed and updated the organisations falls training and policy
- Increased Trust staff compliance with level 1 and 2 falls training to over 90%
- Introduced the falls champion role across the organisation
- Developed a patient safety communication strategy, which has included the development of a lessons learned section on the Staff Room
- Implemented a new process for reviewing and signing off the clinically based National Patient Safety Alerts
- Undertook a review of suicide and self-harm prevention training
- Reviewed and strengthened our strategy to reduce restraint practice within the mental health services
- Improved triangulation of information and data to identify trends and themes.

IWANTGREATCARE RESULTS

Reviews
24,816

Recommend the service to friends and family
93.67%

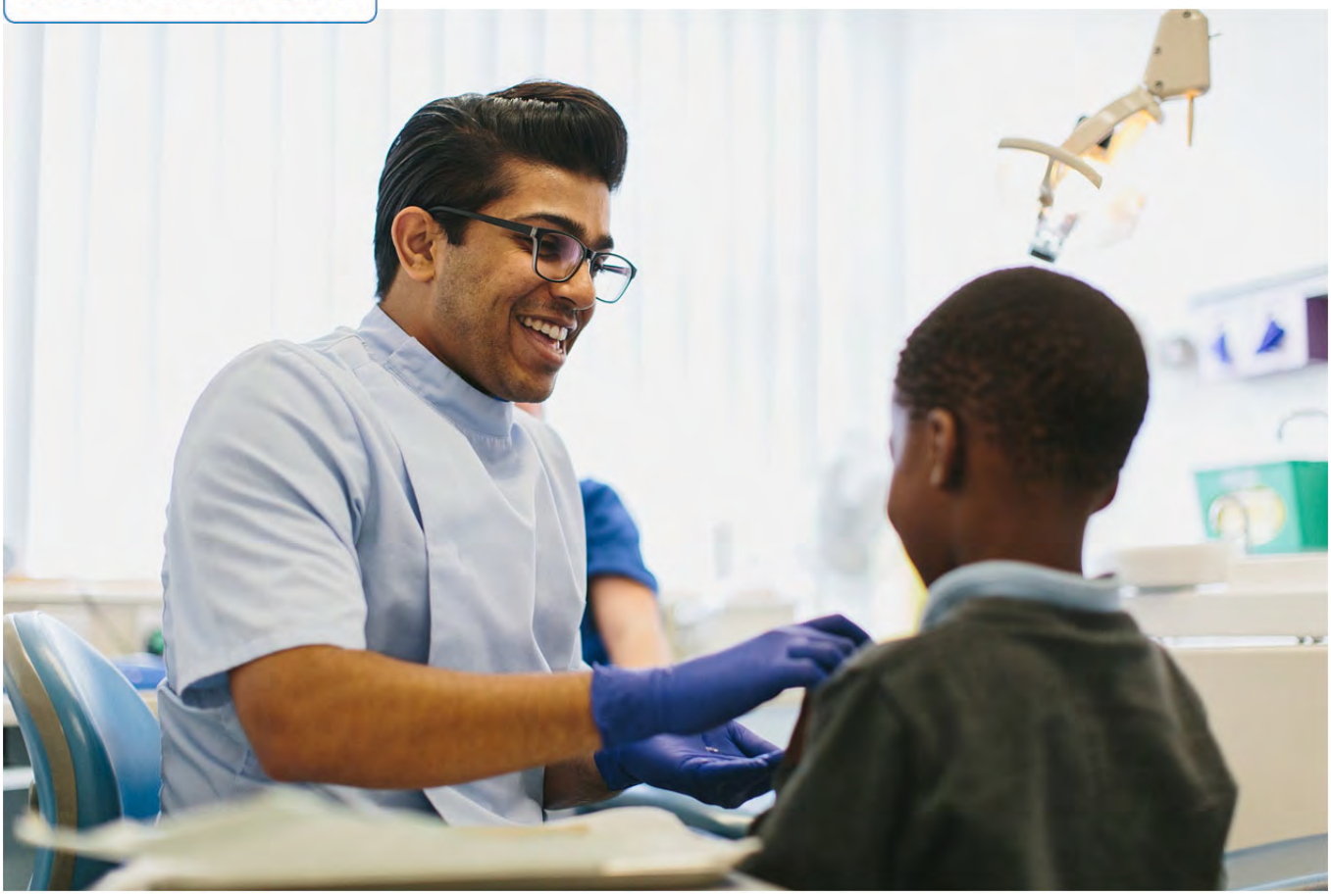
Average rating across all services
4.81

Carers rating for feeling supported
4.79

Carer reviews
4,860

Reviews responded to
1,142

iWantGreatCare



HEALTH AND SAFETY

The health, safety and risk committee provides an overarching view of health, safety and welfare and assurance that non-clinical risks are managed effectively on behalf of the organisation. Key health and safety developments during 2018/19 included:

- Improvements to the lone working/risk escalation process
- Continued development of estates statutory compliance reporting
- Formalisation of building manager role.

FINANCIAL TARGETS, PLAN AND PERFORMANCE

This year's financial plan was established in the context of a continuingly difficult national economic position, along with a challenging local health and social care economy. In response, our annual plan showed a surplus position in 2018/19 – this met the agreed control total and maintained an overall 'use of resources' risk rating of '1'.

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

In 2018/19, the Trust received income of £216.6 million, incurred expenditure of £212.5 million, and owned and operated £100.7 million of assets in order to provide a comprehensive range of mental health, community healthcare and sexual health services for the local population. Our key financial targets in the 2018/19 plan and performance against these are shown in the table below.

FINANCIAL TARGET	FINANCIAL TARGET	ACTUAL	VARIANCE
Control total Surplus/(deficit)	£1.6 million	£4.1 million	£2.5million
Provider Sustainability Fund	£1.610 million	£3.687 million	£2.077 million
Cost improvements (savings)	£7.0 million	£7.0 million	£nil
Net current assets	£9.4 million	£16.1million	£6.7 million
Agency Costs	£8.96 million	£6.388 million	£2.572 million
Use of resources rating	1	1	

The Trust has a strong record of planning and delivering a good 'use of resources' rating. We performed in line with our plan and main financial targets for the year. This meant we achieved additional provider sustainability funding to further boost our financial position.

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

The major financial risks to the Trust in 2019/20 will be the achievement of its financial strategy, including savings target of £3.28 million, and the impact of the continuation of planned structural and organisational change in local health and social care services.

The risk associated with the savings target is managed through the development of detailed savings plans, with clinical and service managers and an established performance management process that enables review and action planning on a routine basis, including at Trust Board level.

Risk associated with structural and organisational change is managed through joint planning and ongoing engagement with the Trust's main commissioners and developing risk-sharing arrangements.

OUR YEAR IN BRIEF

The Trust operates in a complex and changing community, and while we manage competing priorities and challenges, we made significant progress and had many developments this year.

Our achievements this year include:

- Following the routine Care Quality Commission (CQC) inspection in June 2018 and the first well-led inspection in July, the Trust was rated as 'outstanding' thanks to our dedicated and compassionate staff. Of the ratings within the five CQC domains, the Trust received 'good' for 'safe', 'effective' and 'responsive' and 'outstanding' for 'caring' and 'well-led'
- The Trust was named 'Trust of the Year' at the prestigious HSJ Awards, a testament to the hard work of the whole team
- Our Community hospital at Danetre was accredited for the quality care they provide to their patients as they approach the end of their lives with the Gold Standards Framework (GSF) Quality Hallmark Award
- All Adult Mental Health In-patient units at Berrywood Hospital were awarded Acute Inpatient Mental Health Services (AIMS) accreditation for dedication to providing high quality patient care
- Investors in the Environment awarded the Trust the Green Award 2018. Along with continued positive general progress, our carbon emissions reduced by 24% across the organisation
- We were chosen to be one of NHS Employers' Diversity and Inclusion Partners, to work with NHS Employers and other partners to support system-wide efforts to improve the robust measurement of diversity, inclusion and equality across the health and social care system
- The Trust and Local Government Shared Services (LGSS) were shortlisted for a prestigious HSJ Value Award in the category 'Improving the value of NHS Support Services' for their work to remove costs from IT services, while improving quality
- We won the prestigious HSJ Patient Safety Award for Best Product or Innovation in the Public Sector. Our pilot for the use of body worn cameras on mental health wards was shortlisted in the 'Product or Innovation – Public' category
- The Royal College of Nursing Institute shortlisted the Trust for two awards this year. Rebecca Goadsby, who now works as a Mental Health Nurse on Bay Ward at Berrywood Hospital, was shortlisted for the Andrew Parker Student Nurse Award, and our body worn camera project was shortlisted in the 'Mental Health Nursing' category
- We were shortlisted for an Employee Wellbeing Award in the 'Leadership and Culture' category
- Our Volunteer Services were nominated for a 2018 Changemaker Award in the category of 'Community Changemaker of the Year'
- Our communications team was shortlisted for the 'Comms2point0 Awards' Team of the Year, and Dionne Mayhew, Head of Communications, was shortlisted for the Lifetime Achievement of the Year
- Our Trust website was shortlisted for website of the year at the Public Sector Communications Awards 2018
- Our Equality and Inclusion Manager Diana Belfon was nominated for the Most Inspiring Individual of the Year Award 2019 at the National Centre for Diversity Grand Awards
- The Trust's podiatry service was shortlisted for a Northampton General Hospital Best Care Award
- Linda Clifford and Sue Rayment received the honour Queen's Nurse, Elizabeth Gonzalez Malaga, Specialty Registrar in Special Care Dentistry, and Remi Popoola, Senior Physiotherapist at Danetre Hospital, Daventry, were appointed Clinical Fellows within the Clinical Senate for 12 months, and Dr Shahid Latif and Dr Imran Malik were awarded Fellowships by the Royal College of Psychiatrists.

Quality Awards winners Helen Hough and Rowena Rogers with NHFT Chief Executive Angela Hillery

Events we held this year

- The Trust held a mentor learning conference in June 2018, which was well received
- We held a Leadership Matters event focused on health and wellbeing in July with over 400 staff in attendance
- Also in July, we held a health expo in Northampton town centre for our Black, Minority and Ethnic (BME) community
- We attended the Midlands and East Mental Health Workforce Conference in September and gave presentations on workforce supply and culture and leadership
- We held a volunteer celebration event with 35 of our volunteers, and some of our staff
- In October, the Trust held its annual Black History Month event
- Our Chief Executive was a guest speaker at the Northamptonshire Patient, Service User, Carer & Public Networking event hosted by the East Midlands Academic Science Network and Patient and Public Involvement Senate, on the topic of 'empowering positive futures'
- As part of the National Guardian Office's Speaking Up Month during October, our Freedom to Speak Up guardian Matt Asbrey and our Chief Executive attended a reception in the Members' Dining Room at the House of Commons
- In November, the Trust held its annual Quality Awards ceremony. Over 250 attended the celebration, recognising those who are delivering quality care
- Also in November, we held our first ever 'unconference'. A conference without an agenda, designed to give staff the opportunity to talk about the scheme, ideas and issues that mattered to them

- In February 2019, we hosted an Open Day at Berrywood Hospital as part of NHS Improvement's Moving to Good and Beyond programme

- Also in February, we held the first of its kind conference in Northamptonshire on Black, Minority and Ethnic (BME) communities accessing mental health care. It brought together experts in the equality and mental health industry to talk about challenges faced by BME people with mental health problems, and how organisations can support them with improved service access.

The Trust's 11th Nurse AHP Conference held in May 2019

Local developments this year

- In April 2018, the name of Northamptonshire County Council's Children, Families and Education directorate changed to Children First Northamptonshire. This change was a key part of the Council's Children's Services Transformation Programme which is funded by the DfE (Department for Education)
- In May, Northamptonshire Sustainability and Transformation Partnership became known as the Northamptonshire Health and Care Partnership (NHCP). This change signified the aim to work collaboratively to deliver the transformation needed

- The **3Sixty Care** partnership collaborated with Age UK to offer elderly and frail patients extended health and social care navigation and support. The collaborative working helps to enhance the medical support offered by practices to address the social issues associated with health, as well as contributing to the development of patient care plans, which is especially beneficial in the case of ongoing chronic disease management

- In June, we welcomed the custody healthcare service – a new, five-year contract between Northamptonshire Police, the Trust and the Northamptonshire Police and Crime Commissioner to provide full-time healthcare to detainees in the custody facilities in Kettering and Northampton
- Northamptonshire County Council, Corby CCG and Nene CCG consulted on a draft Northamptonshire All Age Autism Strategy, to explore how different local organisations in Northamptonshire work together to support autistic people of all ages in a much better way throughout their lives
- We were awarded the continuing contract for the Falls Service, commissioned by Northamptonshire County Council, until 31 March 2021
- NHS England awarded the Trust funding of almost £300,000 towards access of Individual Placement and Support (IPS) Services by 2020/21, as part of the Five Year Forward View in Mental Health. This makes a difference to the long-term employment of service users with severe and enduring mental health issues
- We won the tender contract for four years, to provide the county's integrated sexual health services and HIV services on behalf of Northamptonshire County Council and NHS England. We have the option to extend the contract for a further two years.

National developments this year

- January 2019 has marked a significant phase for the NHS with the launch of the NHS 10 Year Plan. The plan sets out a series of ambitions to ensure the NHS remains fit for its future over the next 10 years. This includes how the NHS will support people to take more control over their own health and the care they receive, how the NHS will tackle prevention and health inequalities, how it will continue to back its workforce and encourage and support the very best people to come and work for the NHS, how it can make best use of digital technology and innovation, and how all of this will be done while getting the best value out of taxpayers' investment in the NHS
- The NHS united schools and colleges to set up new Mental Health Support Teams to support a population of more than 470,000 children in 25 trailblazer areas across England. The teams will be based in and near schools and colleges in 25 areas, supporting up to 8,000 children and young people
- In May, NHS England and NHS Improvement announced some key steps that they are taking to bring the organisations closer together, including increased integration and alignment of national programmes and activities, and integration of NHS England and NHS Improvement regional teams
- In June, NHS England confirmed that new and expectant mums will be able to access specialist perinatal mental health community services in every part of the country by April 2019. Northamptonshire was named as one of 35 new sites announced in community perinatal mental health service expansion
- Also in June, NHS Improvement and the National Guardian's Office published guidance for boards on Freedom to Speak Up, setting out expectations of trust boards for ensuring a culture that is responsive to feedback and focused on learning and continual improvement

- The Prime Minister Theresa May announced a new funding settlement for the NHS, giving the service real-terms growth of more than 3% for the next five years (this will equate to £20.5 billion more revenue in real terms compared with 2018/19)
- NHS Improvement published 'Learning Disability Improvement Standards for NHS Trusts'. The standards, the first of their kind aimed solely at NHS Trusts, are intended to help the NHS measure the quality of service we provide to people with learning disabilities, autism or both.

These standards provide a necessary benchmark against which all NHS trusts will be able to measure the level and quality of their services

- Also mid-year, NHS England launched a multi-million pound advertising campaign to recruit thousands of new members of staff to the NHS, with a specific focus on nurses. The recruitment drive will highlight the vast range of opportunities available in the health service, including mental health, learning disability and community and general practice nurses.

ANALYSIS OF OUR PERFORMANCE THIS YEAR

PERFORMANCE HIGHLIGHTS	PERFORMANCE CHALLENGES
• The Care Quality Commission (CQC) rated the Trust 'outstanding' overall and 'outstanding' in the 'caring' and 'well-led' domains in August 2018. • We were named HSJ Trust of the Year. • The Trust was awarded the HSJ Patient Safety Award for Best Product or Innovation in the Public Sector for our development and use of body worn cameras. • We were recognised with AIMS accreditations for the continued success of our in-patient mental health teams. • There were continued developments in our quality priority to manage falls across the Trust. These included updated policies, updated training, training compliance, bespoke patient advice leaflets, and an increase in the numbers of falls champions. • We focused on our staff experience (for example, with a wellbeing event in July 2018) and have observed very positive staff survey results and over 90% compliance with supervision and appraisal for staff. • In our staff survey results, our staff engagement score was 7.5 for engagement, where the national average was 7.0. • We were ranked seventh of all trusts nationally and were the best scoring trust in five of the 10 national themes and scored better compared to trust of our type in all themes than last year. • Our top five ranking scores (where we scored more favourably compared to trusts of a similar type) were: 1. Effective use of patient/service user feedback 2. Organisation's action on health and wellbeing of staff 3. Senior managers involving staff in important decisions 4. The extent to which the organisation values the work of staff 5. Staff recommendation of the organisation as a place to work • We continue to analyse patient feedback using iWGC and have been rated 4.81 out of five stars overall across services by patients, service users, carers, family members and friends. • We were recommended by 93.67% of the 24,816 respondents.	• The CQC determined that we 'require improvement' in 'safe' for acute wards for adults of working age and psychiatric intensive care units, being 'responsive' in community mental health services for people with learning disabilities or autism, mental health crisis services and health-based places of safety, wards for people with learning disabilities or autism. • In our staff survey results, our bottom five ranking scores (where we scored less favourably compared to trusts of a similar type) were: 1. Percentage of staff working extra hours 2. Percentage of staff / colleagues reporting most recent experience of physical violence at work 3. Percentage of staff experiencing harassment, bullying or abuse from a colleague 4. Percentage of staff / colleagues putting themselves under pressure to come to work when not feeling well 5. Percentage of staff / colleagues witnessing errors, near misses, or incidents that could have hurt patients / service users *For our financial highlights and challenges, please see our summary of **financial targets, plan and performance** on page 36.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ACCOUNTABILITY REPORT

INTRODUCTION

Including and engaging our community is vital to continuing to provide outstanding care to our patients, service users, families and carers. It is also critical that we communicate and engage with our staff and wider Trust community effectively. This is how we capture and use feedback, create improvements and develop our services in a practical and assured way.

Providing safe, compassionate care also depends on how effectively we govern and review our processes, progress and opportunities to develop. In this report, we share how we govern our Trust, and engage with all our stakeholders and the community.

BOARD OF DIRECTORS

Our 'outstanding' rating from the Care Quality Commission (CQC) was encouraged by our culture of involvement, collaboration and engagement. Our Board of Directors lead this culture and ensure that we are efficiently and effectively balancing safety and quality, with the right governance. Their specialist skills, knowledge and experience are critical to our organisation's delivery of this standard of care.

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

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

We are required by the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 to ensure that our directors are fit and proper for their roles. To fulfill this responsibility, the Trust has undertaken appropriate Fit and Proper Persons checks for all directors during 2018/19.

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

The directors are responsible for preparing the Annual Report and Accounts, and consider the Annual Report and Accounts 2018/19 as a whole is fair, balanced, understandable and provides the necessary information.

OUR DIRECTORS

Directors with voting rights

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

Crishni Waring, Chair

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

Crishni has more than 20 years of experience in business, change and HR management. She has a very diverse industry background including healthcare, business services, retail, public sector, logistics and distribution. Crishni set up a consultancy business in 2010 providing consulting and interim management services to clients in public and private sectors. She is currently also the Chair of Warwickshire Wildlife Trust, a charity with a mission to protect local wildlife and wild places.

Angela Hillery, Chief Executive

Angela has worked within the NHS for over 30 years and has held a variety of leadership positions during this time, including Director of Operations.

In 2017 and 2018 Angela was listed in the HSJ Top 50 rated CEO's and in 2015 was a finalist for 'Chief Executive of the Year' at the HSJ Awards. Angela's ethos is in her commitment to upholding values and developing compassionate cultures for those we care for and work with. Co-production and involvement with patients, service users and carers is a priority at NHFT with many notable projects underway, including the 'Moving Ahead' project to deliver equalities in mental health services for BME communities.

In 2018, the Trust achieved an overall rating of Outstanding from the CQC and also won the 2018 HSJ Trust of the Year Award. Angela has a clinical background as a Speech and Language therapist and has served on the National Management Board of the Royal College of Speech and Language Therapy and held a partner role with the Health Professional Council.

In August 2017, Angela took on the lead role for the Northamptonshire Sustainability and Transformation Plan in Northamptonshire. Angela is passionate about parity of esteem for Mental Health Services and has family experiences that drive her commitment to continual improvements.

Moira Ingham, Non-Executive Director

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

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

Richard Wheeler, Finance Director

Richard is a Chartered Accountant with 14 years of NHS experience, starting in 2005 as Head of Finance at the Leicestershire, Northamptonshire and Rutland Strategic Health Authority. He was then appointed Deputy Director of Finance at Oxford University Hospitals and prior to joining the Trust was Director of Finance for East Midlands Ambulance Service (EMAS).

Richard has a maths degree and was awarded Healthcare Finance Managers Association (HFMA) Deputy Finance Director of the Year in December 2012. He was Finance Lead for the Northamptonshire Health and Care Partnership (previously known as STP or Sustainability and Transformation Partnership) from July 2017 to December 2018.

Bev Messinger, Non Executive Director (until 31 December 2018)

With over 30 years of public service experience in local government, across seven local authorities, including Northamptonshire County Council, Bev has held diverse roles in the voluntary sector.

These included director at a charity for the long-term unemployed, chair of the Coventry Citizens Advice Bureau and trustee of a national charity for people with learning difficulties and disabilities. Bev is also a Fellow of the Chartered Institute of Personnel and Development and is Chief Executive at the Institution of Occupational Safety and Health.

Prof Alex O'Neill-Kerr, Medical Director

Alex has been medical director for the Trust since 2003 and has 25 years' experience as a general adult consultant psychiatrist. He is a Fellow of the Royal College of Psychiatrists and a Fellow of the College of Psychiatry of South Africa.

Alex is a visiting Professor in Neuromodulation at the University of Northampton, and the clinical lead for the Northamptonshire Centre for Neuromodulation based at Berrywood Hospital providing electroconvulsive therapy (ECT) and nurse administered ECT, repetitive transcranial magnetic stimulation (rTMS), theta burst treatment (TBS), transcranial Direct Current Stimulation (tDCS) and Ketamine infusion.

Scott Adams, Non-Executive Director

Scott is Director of Strategy and Business Development for NHS Professionals, having moved to this new role during 2018/19.

Prior to this he was Director of Integrated Health and Social Care within the Major and Public Sector of British Telecom where he had responsibility for the definition and investment prioritisation of major and public sector growth strategy.

Scott has 20 years' experience working at senior managerial and Director level in British Telecom. He has vast experience of delivering transformational growth programmes and holds a Master's degree in Business Administration.

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

From a nursing career spanning over 35 years, with many years in senior leadership roles, five years as Director of Nursing, AHPs and Quality and experience in social care, Julie leads by example.

Julie regularly spends time with clinical services to ensure she understands patient and carer needs, and staff challenges. Julie is passionate about safe, quality care and has ensured that this has remained at the foundation of her strategic planning. She has a leadership role as the joint Nurse in the Northamptonshire Health Care Partnership and holds a Master's degree in Managing Partnerships in Health and Social Care.

Alastair Watson, Non-Executive Director

Alastair is currently Investment Director at Innisfree, a leading infrastructure investment group. He has over 20 years of project finance and infrastructure experience and has worked in both the public and private sectors for businesses that range from start-ups to large multi-national corporates.

Alastair has worked in roles covering audit, financial advisory, equity and debt investment and he currently sits as a magistrate on the Leicestershire and Rutland bench. Alastair is a Fellow of the Institute of Chartered Accountants in England and Wales.

Melanie Hall, Non-Executive Director

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

Having worked as a partner with the NHS for much of her career, Melanie has a wealth of experience in business and service transformation, and an excellent understanding of the challenges and broad strategic direction of the NHS. Melanie also brings knowledge and high standards of quality assurance and governance levels with regards to Care Quality Commission standards and audits. She is currently Chair of Pathology First, an NHS-Synlab joint venture serving trusts in Essex with Pathology Services.

Maria Wogan, Non-executive Director (from 1 November 2018)

Maria has held senior positions in national and local health organisations and local government and has over 15 years of board level experience working in the NHS as a commissioner, provider and regulator.

Maria has a Master's degree in Public and Social Administration and is a qualified Chartered Secretary. Maria has extensive experience in corporate governance, planning and strategy, and has a track record in delivering significant transformation programmes, managing people, budgets and projects. Most recently, Maria was the Executive Lead for System Redesign in the Bedfordshire, Luton and MK Sustainability and Transformation Partnership. Maria is a Member of the Inspiring Futures Through Learning Multi-Academy Trust and Chair of Arts for Health MK.

Nicky McLeod, Non-executive Director (from 1 January 2019)

Nicky started her career by training as a General Nurse in London and went on to work in the pharmaceutical industry for 11 years in sales and marketing roles.

Following this, Nicky worked in direct healthcare with Cygnet Health Care, an Independent Mental Health Care provider. After over 10 years of experience, she became the Chief Operating Officer for a national organisation with 22 hospitals, and held a school governor role for five years. Nicky has a focus and a passion for organisational culture based on values and extensive experience in in-patient specialist mental health services.

DIRECTORS IN ATTENDANCE
Without voting rights

Chris Oakes, Director of Human Resources and Organisational Development

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

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

Sandra Mellors, Chief Operating Officer

Sandra's healthcare experience spans a 30-year career in the NHS, 22 of those as a physiotherapist, before moving into managerial roles. Previously an Associate Director of Adult, Primary and Urgent Care at Tower Hamlets PCT, General Manager of Borough and Specialist Services at Bart's and London NHS Trust, Sandra joined the Trust in 2012 as Locality Manager for Kettering.

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

David Williams, Director of Business Development

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

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

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

Our directors' specific terms of reference

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

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

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

To further develop good governance practices, we responded to the report by developing and implementing an action plan which was regularly revisited to ensure that all actions identified were incorporated into 'business as usual' for either the Board of Directors or its committees.

During 2018/2019, the Care Quality Commission (CQC) rated the Trust overall as 'outstanding' following an inspection visit. This included a rating of 'outstanding' for the 'caring' and 'well-led' domains.

At its July 2018 meeting, the Board of Directors agreed to the proposal to extend the external review timescale from three to five years. NHS Improvement had indicated there was a potential need at a national level for the rationale and timing of development reviews to be re-evaluated given the recent introduction of CQC annual well-led inspections. Having reflected on this feedback, the Board concluded that extending the external review timescale from three to five years was a sensible approach as it would allow time for a definitive view to be gained from NHS Improvement on the future of development reviews. As a result, the development review will take place during 2020/21. This has been agreed and confirmed by NHS Improvement in January 2019, following the Performance Review Meeting held in October 2018.

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

In keeping with our ongoing improvement commitment, a number of Board development days and workshops (some externally facilitated, and others managed within the Trust) were held during the year. Topics included:

- Board preparation for the CQC inspection visit
- Diversity including unconscious bias
- Resilient leadership
- Freedom to Speak Up self-review
- Development of understanding of and reflection on the national policy agenda and the latest position/developments in the 'system leadership' agenda
- Thinking through our future strategy
- Digital technologies and transformation: future opportunities for NHFT
- Integrated community services
- Our DIGBQ strategy *(Develop, Innovate, Grow, Build, Quality)*
- Developing workforce safeguards
- Courageous conversations.

Role modelling leadership
A joint Board of Directors and Council of Governors annual event took place in August 2018 and was well-attended by both governors and directors. The event focused on how the Board and Council visibly model the Trust's leadership behaviours and included how ways of working can be strengthened to reinforce these behaviours. The event was externally facilitated and included input on leadership and culture, and their link with improved patient outcomes. The event was followed by positive feedback from attendees.

OUR BOARD MEETINGS

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

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

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

CHAIR	Crishni Waring
DEPUTY CHAIR	Bev Messinger (until 31 December 2018) Moira Ingham (interim from 1 January 2019)
SENIOR INDEPENDENT DIRECTOR	Moira Ingham* *NOTE – Annual leave commitments meant Bev Messinger covered the Senior Independent Director role for the period 15 October 2018 to 22 November 2018 inclusive.
CHIEF EXECUTIVE	Angela Hillery

OUR NON-EXECUTIVE DIRECTORS

Our non-executive directors bring independent judgement, experience and expertise from outside the Trust and apply this for the benefit of our organisation, its stakeholders and the wider community. There are no relationships or circumstances that are likely to affect, or appear to affect, any director's independent judgement. For these reasons, the Board of Directors considers all non-executive directors to be independent. Our Council of Governors is responsible for non-executive director appointment and termination, with the normal appointment term being three years. Non-executive directors are eligible for reappointment, though usually only for one further period of three years.

ATTENDANCE AT BOARD OF DIRECTORS' MEETINGS

1 April 2018 to 31 March 2019

DATE	Crishni Waring	Scott Adams	Melanie Hall	Moira Ingham	Nicky McLeod (from 1 Jan 2019)	Bev Messinger (until 31 Dec 2018)	Alastair Watson	Maria Wogan (from 1 Nov 2018)	Angela Hillery	Prof Alex O'Neill-Kerr	Julie Shepherd	Richard Wheeler
23 May 2018 (Board/ ISA 260 meeting)	√	√	√	A		A	√		√	A	√	√
25 May 2018 (extra-ordinary meeting)	√	√	A	A		A	√		A	√	√	√
31 May 2018	√	√	√	√		A	√		√	A	√	√
26 Jul 2018	√	√	√	√		√	√		√	√	√	√
27 Sept 2018	√	A	√	√		√	√		√	A	√	√
29 Nov 2018	√	√	√	√		√	A	√	√	√ *	√	√
31 Jan 2019	√	√	√	√	√		√	√	√	√	√	√
28 Mar 2019	√	A	A	√	√		√	√	√	√	√	√

* denotes absent from the meeting held in public but present for the private session
A denotes apologies for absence
√ denotes present
Orange shading denotes not in post at the time of the meeting/no longer a Board member

NOMINATIONS AND REMUNERATION COMMITTEE

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

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

The Nominations and Remuneration Committee have not appointed any substantive executive director members of the Board during the past year.

Nomination functions of the committee are:

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

Remuneration functions of the committee are:

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

ATTENDANCE AT NOMINATIONS AND REMUNERATION COMMITTEE

DATE	Crishni Waring	Scott Adams	Melanie Hall	Moira Ingham	Nicky McLeod	Bev Messinger	Maria Wogan	Alastair Watson
31 May 2018	√	√	√	√		A		√
26 July 2018	√	√	√	√		√		√
29 November 2018	√	√	A	√		√	√	A
31 January 2019	√	√	√	√	√		√	√

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

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AUDIT COMMITTEE

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

The specific terms of reference of the Audit Committee cover:
1. Integrated governance, risk management and internal control
2. Internal audit
3. External audit
4. Relationship with the Council of Governors
5. Other assurance functions
6. Counter fraud
7. Management
8. Financial reporting
9. Whistleblowing.

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

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

OUR AUDITORS

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

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

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

External audit
In conjunction with the Finance, Planning and Performance Governor sub-group of the Council of Governors, a process for the appointment of the Trust's External Auditors from 1 November 2017 was agreed. The sub-group was given delegated authority to undertake the process at the July 2017 Council of Governors' meeting. Members of this sub-group formed the Governor Audit Working Group.

This group met in September 2017 and discussed the tenders received and the scoring, raising points of clarification where needed.

This group, working alongside the Board's Audit Committee, made a recommendation to the September 2017 Council of Governors meeting based on this discussion. This recommendation was approved and KPMG were re-appointed as the Trust's External Auditors for a further four-year period from 1 November 2017.

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

The value of the external audit plan for 2018/19, as approved by the Audit Committee in March 2019, equates to £50,000 for the annual audit and opinion, which included the new accounting standards and Agresso upgrade and £9,642 for the quality accounts opinion excluding value added tax. The external audit plan equates to audit services only. The Audit Committee agreed a policy for the engagement of external auditors for non-audit work in December 2012. Any non-audit services are commissioned in accordance with this policy. It outlines threats to audit independence that theoretically exist and the mitigations that will be applied to ensure that auditor objectivity and independence is appropriately safeguarded.

During 2018/19, the Trust commissioned non-audit services from KPMG to provide training and education on the issue of pensions tax. This work was originally commissioned through the Board of Directors' Nominations and Remuneration Committee, however the workshop session was extended to the wider Board of Directors. Including the cost of preparation for this work, KPMG's fee equated to £2,500 excluding value added tax.

Reporting on auditing
The Audit Committee meets regularly to review audit reports and provide assurance to the Board. While preparing and reviewing the annual accounts 2018/19, the Audit Committee considered accounting policies, accounting estimates and material judgements and the main changes as listed in the DH Group Accounting Manual (GAM) 2018/19.

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

Valuation of property, plant and equipment
Each year the Trust is required to review the valuation of its property, plant and equipment in line with accounting standards. A formal valuation is required to be carried out every five years. The latest valuation has an effective valuation date of 31 March 2019.

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

A formal valuation was carried out in 2018/19. The results of the valuation of the Foundation Trust's property, plant and equipment are included in the accounts section of this report.

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

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

The arrangements that have been considered for joint venture accounting for 2018/19 are listed below.

ARRANGEMENT	DESCRIPTION
First for Wellbeing (FfW)	• Community Interest Company limited by guarantee. • The Trust 'owns' a £38 guarantee along with Northamptonshire County Council (£51) and University of Northampton (£11).
3SixtyCare Ltd	• Company limited by shares. • Shareholding is on a 50:50 basis with the GPs, and the total shareholding changing is in line with patient lists.
rTMS Memorandum of Understanding with Smart TMS	• Memorandum of understanding signed during 2016/17 and remains in place. Joint Venture agreement ended on 24 April 2018.
Northampton GP and Community Alliance Limited Liability Partnership	• Company registered with Companies House July 2018. There was no trading activity during 2018/19.

Accounting estimates and judgements
Included in note 1.4 of the accounting policies are those areas of critical accounting judgements and key sources of estimation likely to be included in the draft accounts for 2018/19. Given the short timescale available for producing the accounts it is inevitable that estimates and judgements will be necessary.

The likely areas of estimate and judgement are:

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

Going concern assessment
In preparing accounts in accordance with the GAM, the Trust must consider whether the going concern assumption is appropriate. The Audit Committee discussed this at its meeting in March 2019 and concluded that, subject to clarification of the guidance in the FT Annual Reporting Manual and the Department of Health Group Accounting Manual, that the accounts should be prepared on a going concern basis.

The basis of this planning assumption is:

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

ATTENDANCE AT AUDIT COMMITTEE MEETINGS

1 April 2018 to 31 March 2019

DATE	Alastair Watson	Scott Adams	Melanie Hall	Nicky McLeod
26 April 2018	√	√	√	
21 June 2018	√	A	√	
13 September 2018	√	√	√	
13 December 2018	√	√	A	
14 March 2019	√	A	√	√

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

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CHARITABLE SUPPORT

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

They provide support to Cynthia Spencer Hospice, Cransley Hospice, and other causes and projects across the Trust.

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

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

This year, we received the following grants:

- Cynthia Spencer £688,888
- Cransley Hospice £587,361
- Mental health and community services £105,000.

Northamptonshire Health Charitable Fund contributed towards the following activities and equipment in 2018/19:

1. Provision of new equipment for the Children's Community Dental Health Service
2. Purchase of a number of items of equipment for Danetre hospital
3. Patient amenities and activities, including supporting the award-winning allotment project
4. Support for a number of small research projects
5. Sponsorship of the Trust's staff awards evening.

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

DISCLOSURES

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

The Better Payment Practice Code requires the Trust to aim to pay all undisputed invoices by the due date or within 30 days of receipt of good or a valid invoice, whichever is later. The Trust's payment performance against this code is shown in the Notes to the Accounts. The income received by the Trust, other than from the provision of goods and services for the purpose of the health service in England relates to rental income from non-NHS tenants of Trust properties, income generation from Communicare (occupational health services) and income from catering. This is deemed insignificant in value and therefore had no material impact on the Trust meeting its principal obligations. There are no known events after the reporting period that impact on the financial statements for 2018/19. The Trust is a partner of First for Wellbeing, a community interest company, which came into operation on 1 April 2016 and is in the process of being dissolved.

OUR QUALITY GOVERNANCE

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

Improving the governance of quality

Looking ahead, in 2019/20, the Trust will be continuing to ensure that our governance arrangements are robust and streamlined, using an evaluation of our current framework, systems and processes.

This strengthening of core quality and governance meetings has meant that issues can be resolved at a tactical level, and assurance can be provided to the Quality and Governance Committee in a more succinct and measured way.

The Trust uses a robust self-assessment process, which is based on the CQC's key lines of enquiry, and is supported by a 'confirm and challenge' system.

This is how clinical senior leaders establish the validity of the self-assessment methodology.
In addition, the annual audit plan identifies key areas of patient care that are to be reviewed in line with internal and external requirements.

This provides the organisation with baseline and performance data for clinical activities such as record keeping and nutritional screening. These systems identify where improvements could be made, which is monitored locally by clinical leads and the quality team.

We make sure that data relating to patient safety and our core quality indicators is brought together on an internal dashboard. This provides clear indication to managers and team leaders where there are any potential issues, concerns or areas of good practice across their area. The function provides a platform for action planning where improvement is required. This data is routinely interrogated as part of the internal triangulation process.

Going forward, the Trust intends to refine the quality dashboard to meet its needs, the needs of individual services and those of our external partners.

PATIENT CARE AND FEEDBACK

We are continuously striving to improve outcomes for patients and their carers, and developing our services to meet the needs of our community. We were delighted to receive an 'outstanding' rating from the CQC in 2018, with a 'good' rating for 'safety' and 'outstanding' for 'well-led' and 'caring'.

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

A systematic quality governance process supports quality improvement in the Trust. This is continuously reviewed to ensure that it is fit for purpose and provides quality assurance that is central to patient care. Next year, there will be a continued focus on quality improvement at all levels across the organisation with the roll out of training across all clinical and non-clinical staffing groups.

iWantGreatCare (iWGC)

The head of patient experience, iWGC manager, and head of quality surveillance work closely together to ensure that these varying forms of feedback are triangulated and inform other quality improvement and assurance processes.

These include serious incident investigations and lessons learned as well as service reviews. We gain assurance from services through our management reporting structure, governance meetings and patient experience groups.

Reviews, comments and responses through iWGC are also published on the iWGC public website. The Trust uses iWGC to continuously collect feedback from patients and carers in all services, including prisons. All comments are publicly available through the iWGC website with the exception of prisons, some sensitive services and where the respondent has expressly requested that the feedback is not publicly displayed.

Friends and Family Test

Responses can be given in a variety of formats and respondents are asked to comment on a variety of patient experience measures. There is also room for free text. The numerical data is integrated with our performance reporting system, while free text comments are used to improve services through our patient experience and governance groups. Service managers respond to comments with details of actions taken.

Staff feedback

Our staff survey is also used to improve quality and drive service development. During the year, the Trust focused on driving a robust and interactive leadership framework that included training, reverse mentoring opportunities, senior leadership team meetings and Leadership Matters events. Staff wellbeing support has also been prioritised with the launch of a new wellbeing policy and initiatives.

In July 2018, over 400 staff took part in the organisation's first wellbeing conference. At the conference, staff were offered the opportunity to try new activities (for example, clubbercize and mindfulness) to support health and resilience.

At the Trust's staff wellbeing conference

QUALITY MONITORING

Internal reviews and audit plans
Quality and improvements are monitored and measured using a number of indicators, as part of our robust internal review process. Our annual audit plan identifies key areas of patient care, which are reviewed in line with internal and external requirements.

This provides the organisation with baseline and performance data for clinical activities such as the National Early Warning Score (NEWS). These systems also identify where improvements could be made, which are then monitored locally by clinical leads. Information is reported directly to the Quality Forum, and outputs are channeled to the Quality and Governance Committee as required.

Quality improvement is routinely identified from national initiatives and from best practice guidance such as The National Institute for Health and Care Excellence (NICE). Directorate leads map this guidance against each service based on relevance and suitability. When new implementation measures are recommended, our deputy medical directors work together with services to develop the improvement plan and monitor progress.

Patient safety and quality dashboard

We bring data relating to patient safety and our core quality indicators together on one service line dashboard. This dashboard features patient safety measures, for example the number of complaints, falls, and serious incident reviews, as well as quality indicators such as clinical supervision activity, self-assessment outcome and staffing levels.

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

Quality Forum, Quality and Governance Committee

Data is routinely interrogated as part of the internal triangulation process prior to the Quality Forum, the directorate quality meetings and as part of our internal quality summit process.

Externally, the Trust works closely with commissioners to develop and maintain quality driven services that are responsive to the needs of the local population.

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

Services and performance against targets

Measuring our performance against targets requires focus on service user and patient needs, service development and the effectiveness of care delivery. Our transformation programmes are linked to these key factors and rely on patient, carer and staff feedback to understand our progress. This year, we responded positively to the requirements of the local and national quality schedules. Our Commissioning for Quality and Innovation (CQUIN) indicators supported developments in Accident and Emergency care for mental health service users, wellbeing for staff and service users via our flu vaccination programme, and changes to our café menus and snack bars.

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

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

As our community's healthcare needs grow, we are continually reviewing our performance of these healthcare targets, and recognise areas that are challenging to us, such as waiting times. In 2019/20, further work will be undertaken to refine and develop the quality dashboards across the clinical services. This will support teams with defining the areas of need and good practice.

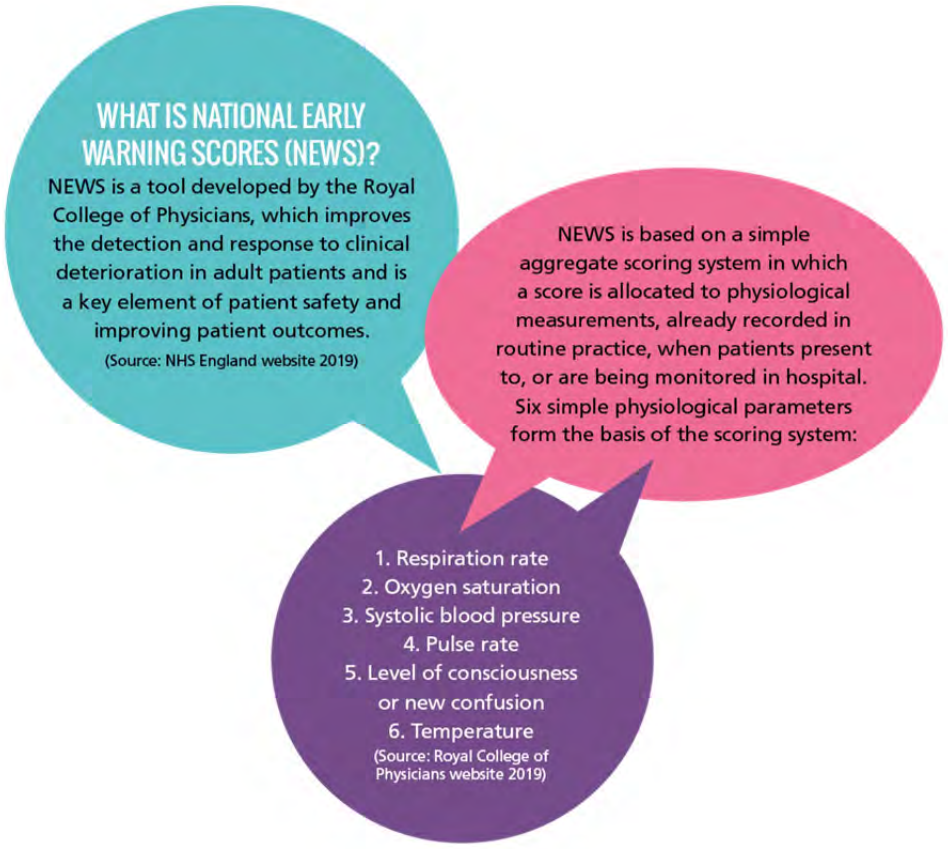
This year's NHFT apprentices

Sign up to safety

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

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

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



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

Monitoring arrangements for complaints processes are in place, and information about complaints is held centrally. In order to further improve the complaints process, peer reviewing has been successfully introduced to ensure objectivity in the way investigations are completed. This involves our service users and carers, who use a pre-agreed proforma to review the process and the investigation pathway. The outcomes are then fed back to the CRC for evaluation. We have a robust complaints policy that is reviewed a minimum of once every two years.

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

Improvements in patient and carer information

Patient and carer information continue to evolve. We ensure that we include language and accessibility information on all our leaflets, so that staff, patients and carers are aware that we can provide the required information in a number of different languages and fonts. PALS and complaints information is available across the Trust in a variety of formats. In addition, the Trust produces leaflets with information about the services that we offer.

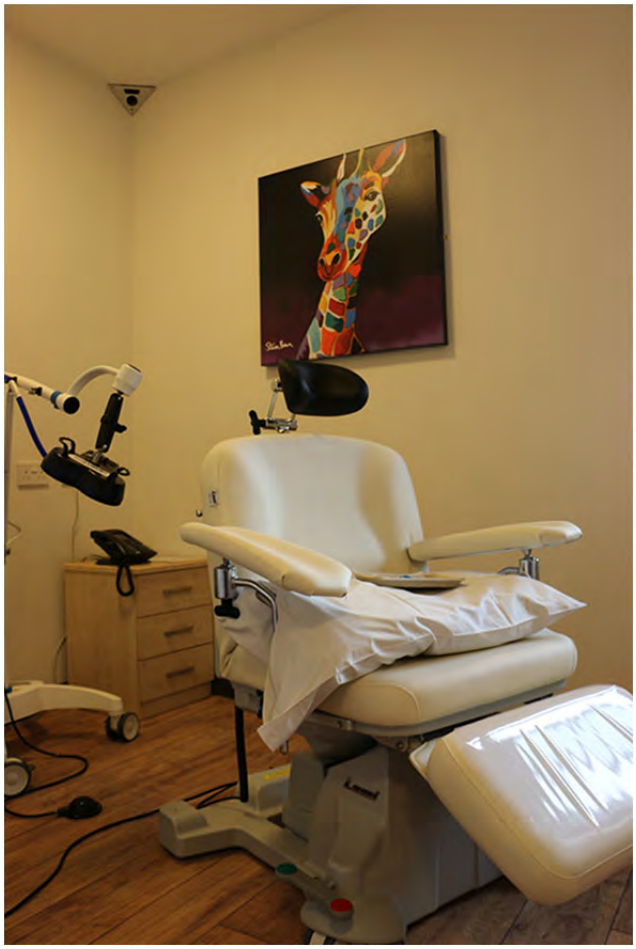
Patient and carer information has also improved through technology. An example of this is the Trust's Twitter account, which is widely used to promote wellbeing and publicise events. The Health Visiting Service and School Nurses have their own social media accounts, which has been popular with families across Northamptonshire.

Stakeholder relations

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

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

Using quality data and information to understand local needs has allowed us to identify gaps in service and link safe, quality-driven transformation to effective care. Working with local commissioning groups for the Commissioning for Quality and Innovation (CQUIN) development has enabled us to pilot new healthcare initiatives, which will feed into any future planning and decision-making for care priorities.



An rTMS suite

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

We continue to look for ways to partner for the development and delivery of services that enhance the physical, emotional, social and economic wellbeing of the county's population.

In addition, services linked to third sector organisations such as Marie Curie continue to be run in partnership with our palliative pathways. Our positive relationship with mental health charity provider Mind has supported an increased capacity to run county-wide crisis cafes for our mental health service users.

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

EQUALITY

We are proud of our work in Equality, Diversity and Inclusion (EDI). A number of significant improvements have demonstrated that we are reaching our vision to be a leading provider of outstanding compassionate care. We believe that by publishing our equality information, we demonstrate our transparency about the progress we are making on equality. This enables us to be more accountable to our patients, local communities and staff.

In line with our duties as an employer and provider of NHS services, we also have an equality and inclusion policy that provides a framework to ensure compliance with the Equality Act 2010 and Human Rights Act 1998. We have fully complied with the Public Sector Equality Duty (PSED) by publishing our gender pay gap, our annual Equality Information Report and our Equality Objectives.

We published our Annual Equality Information Report in January 2019, which reports how we have met our duties under the Equality Act 2010, including an analysis of our workforce and service data.

BME, LGBTQ+, Disability and Working Carers

We have four active and vibrant staff networks and allies: Black Minority and Ethnic (BME), Lesbian Gay Bi-sexual Transgender Questioning (LGBTQ+), Disability and Working Carers.

Each continues to grow and develop and have a dedicated Board member sponsor in the Trust. They remain a core asset in terms of our staff stakeholder groups and features with our governance frameworks, reporting to the Diversity Network Group.

Award nomination for equality and diversity

We were shortlisted for the Inclusive Workplace Award for the Global Equality and Diversity Awards 2018, for work undertaken for staff engagement. On 5 June 2018, we held a staff network celebration event. The agenda for the event included a key speaker from Northamptonshire Carers, who promoted the benefits of Northamptonshire Carers and the support that they offer, a speaker from the local LGBTQ+ community, who shared his own powerful story, and a speaker from DisabledGo.

The DisabledGo speaker was able to provide essential and detailed information to enable greater choice and independence for anyone with access requirements, and share how an ageing population and dementia can have an impact on equality issues.

The '*Living Our Pride Values: A Focus on Equality'* booklet was produced and shared, which outlines our commitment to ensure that people are treated equally and fairly at work, during care, or out in the community.

The booklet was commended by Yvonne Coghill CBE, who was at this time Director of WRES (Workforce Race Equality Standard) Implementation for NHS England, and was launched at the staff celebration event.

Accessible Information Standard (AIS)

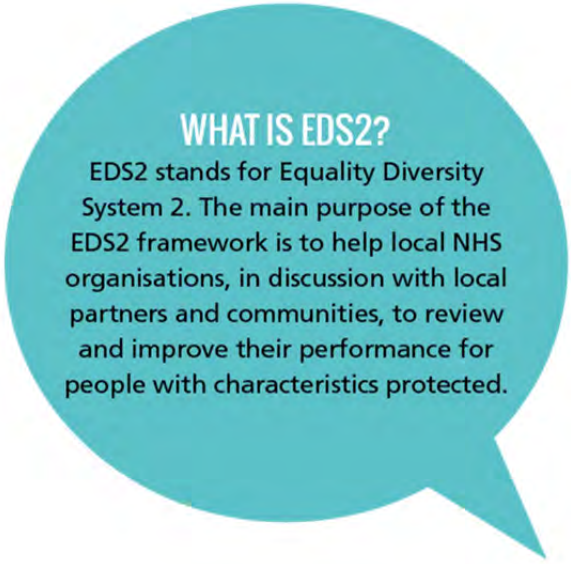
We are working hard to ensure that we are compliant with NHS England's Accessible Information Standard (AIS) and have implemented the standard through SystmOne (and our patient clinical records), and all bespoke patient recording systems (except for one due to the sensitivity of the information provided). We are committed to annually review our performance for AIS.

Our Equality Analysis

Our framework is robust, with organisational policies and procedures that are assured through our Trust Policy Board and monitored by the Equality and Inclusion team. All Trust projects are managed through our Project Management Office (PMO), specifically our Cost Improvement Programmes (CIPs). These are reviewed by the Director of Nursing, AHPs and Quality and Medical Director, who provide overview and scrutiny to ensure compliance with the 'due regard' element of the Equality Act 2010.

As an example of best practice, this year, the Equality and Inclusion team, Equality Network members and estates management worked together on the equality analysis for the development of the Car Parking Strategy. This enabled the Trust to ensure that as significant changes were implemented, appropriate provisions were considered to safeguard our protected groups, in order to ensure no disproportionate impact on our staff and service users. Further work will continue to ensure all new corporate strategies undergo equality analysis as part of their development.

We are currently working with local NHS organisations and the CCG to design a collaborative equality analysis template, to help streamline the equality analysis process for Northamptonshire's health economy. This will ensure that we have a consistent approach when there are changes to policies, programmes and services, as well as any relevant strategies or initiatives.



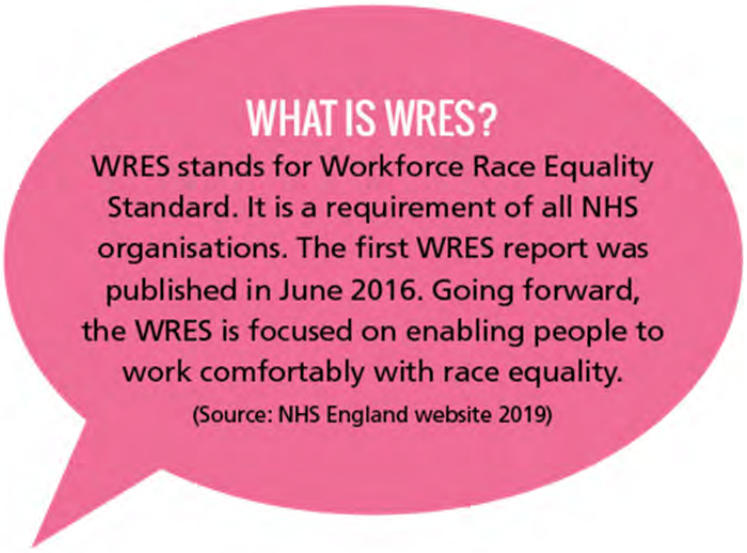
EDS2

This year, the Trust reviewed its Adult Mental Health Inpatient services using the EDS2 framework. The service was internally graded by self-assessment and produced an evidence document. Following the self-assessment, we worked with a group of service users, carers and patients involved to form an external grading panel.

While the Trust graded itself as 'developing' (amber) in the majority of the areas, the external grading panel upgraded us to 'achieving' (green) for six of the 18 outcomes. Some of the agreed areas to focus on included:

- Developing a leaflet for patients and carers on discharge to include information about the Recovery College. The leaflet has been co-produced with services users and carers.
- A welcome pack available in 'easy read' format, with information about complaints and PALS.
- More information about spiritual guidance and support. This has been included in the patient welcome pack.

Following a vigorous application to become a partner of the NHS Employee Diversity and Inclusion programme, we were chosen to take part in May 2018. We committed to working with NHS Employers and the other partners to support system-wide efforts to improve the robust measurement of diversity, inclusion and equality across the health and social care system. This programme will include specific focus on areas such as the WRES, WDES, the Sexual Orientation Monitoring standard and the whole area of gender pay gap reporting and its associated issues.



In addition to implementing the WRES and publishing our results, we participated in the NHS WRES Experts Programme, which commenced in March 2018. Programme participants include professionals across the NHS who advocate, oversee and champion the implementation of the WRES.

The Trust will continue to support the national NHS initiatives to promote race equality and implement best practice.

In addition, an analysis of our staff survey results from groups with protected characteristics highlighted several areas that the Trust will be focusing on. We must continue to work with our staff networks and local community to address discrimination and improve patient experience and outcomes for all.

The Trust is committed to ensuring that we provide appropriate and responsive services across our diverse population and workforce.

STATEMENT OF DISCLOSURE

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

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

REGISTERS OF INTERESTS

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

REMUNERATION REPORT

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

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

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

The Nominations and Remuneration Committee agree the reward policy for executive directors. Payments in 2018/19 were made in line with this policy, which reflected the impact of public sector pay restraint on other staff within the Trust, market data, affordability, corporate and individual performance.

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

Corporate, strategic and individual performance objectives will again be agreed for 2019/20.

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

Angela Hillery

Chief Executive
22 May 2019

SALARIES AND ALLOWANCES 1 APRIL 2018 -31 MARCH 2019 Summary

Name and title	2018/19			
	Salary (bands of £5,000)	Performance pay and bonuses (bands of £5,000)	Clinical Excellence Awards (bands of £5,000)	Total (bands of £5,000)
Angela Hillery, Chief Executive*	160-165	5-10	0	170-175
Prof Alex O'Neill-Kerr, Medical Director *	145-150	0-5	35-40	185-190
Julie Shepherd, Director of Nursing, AHPs and Quality*	110-115	0-5	0	115-120
Chris Oakes, Director of Human Resources and Organisational Development	110-115	0-5	0	115-120
Sandra Mellors, Chief Operating Officer	110-115	0-5	0	115-120
David Williams, Director of Business Development (from November 2017)	110-115	0-5	0	110-115
Richard Wheeler, Finance Director*	125-130	0-5	0	130-135

* Denotes Voting right

Performance-related bonuses are awarded solely at the discretion of the Nominations and Remuneration Committee.

In 2018/19 seven awards were made for significant contributions above and beyond those expected of Directors.

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

Expenses

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

	2018/2019			2017/2018		
	Number			Number		
	Total	Receiving expenses	Expenses £'00	Total	Receiving expenses	Expenses £'00
Directors	7	7	113	7	7	99
Non-Executive Directors	9	6	65	7	5	45
Governors	46	13	35	37	16	51
Total	62	26	213	51	28	195

SALARIES AND ALLOWANCES 1 APRIL 2018 -31 MARCH 2019

Name and title	Salary (bands of £5,000)	Taxable Benefits to the nearest £100*	Performance pay and bonuses (bands of £5,000)	Long-term performance pay and bonuses (bands of £5,000)	All pension-related benefits (bands of £2,500)	Total (bands of £5,000)
Crishni Waring, Chair*	40-45	0	0	0	0	40-45
Melanie Hall, Non Executive Director* (from 1 January 2018)	10-15	0	0	0	0	10-15
Scott Adams, Non Executive Director* (from 8 May 2017)	10-15	0	0	0	0	10-15
Bev Messinger, Non Executive Director* (until 31 Dec 2018)	10-15	0	0	0	0	10-15
Moira Ingham, Non Executive Director*	10-15	0	0	0	0	10-15
Alastair Watson, Non Executive Director*	10-15	0	0	0	0	10-15
Nicola McLeod, Non Executive Director (from 1 Jan 2019)	0-5	0	0	0	0	0-5
Maria Wogan, Non Executive Director (from 1 Nov 2018)	5-10	0	0	0	0	5-10
Angela Hillery, Chief Executive*	160-165	0	5-10	0	0-2.5	175-180
Prof Alex O'Neill-Kerr, Medical Director *	185-190	0	0-5	0	0-2.5	185-190
Julie Shepherd, Director of Nursing, AHPs and Quality*	110-115	0	0-5	0	0-2.5	115-120
Chris Oakes, Director of Human Resources and Organisational Development	110-115	0	0-5	0	0	115-120
Sandra Mellors, Chief Operating Officer	110-115	0	0-5	0	0-2.5	115-120
David Williams, Director of Business Development (from November 2017)	110-115	0	0-5	0	20-22.5	130-135
Richard Wheeler, Finance Director*	125-130	0	0-5	0	72.5-75	205-210

* Denotes Voting right

No Benefits in Kind were paid during 2018/19

Performance-related bonuses are awarded solely at the discretion of the Nominations and Remuneration Committee. In 2018/19 seven awards were made for significant contributions above and beyond those expected of Directors.

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

SALARIES AND ALLOWANCES 1 APRIL 2017 -31 MARCH 2018

Name and title	Salary (bands of £5,000)	Expense payments (taxable) to the nearest £100*	Performance pay and bonuses (bands of £5,000)	Long-term performance pay and bonuses (bands of £5,000)	All pension-related benefits (bands of £2,500)	Total (bands of £5,000)
Crishni Waring, Chair*	40-45	0	0	0	0	40-45
Melanie Hall, Non Executive Director* (from 1 January 2018)	0-5	0	0	0	0	0-5
Paul Clark, Non Executive Director* (until 31 March 2018)	10-15	0	0	0	0	10-15
Scott Adams, Non Executive Director* (from 8 May 2017)	10-15	0	0	0	0	10-15
Bev Messinger, Non Executive Director* (until 31 December 2018)	10-15	0	0	0	0	10-15
Moira Ingham, Non Executive Director*	10-15	0	0	0	0	10-15
Alastair Watson, Non Executive Director*	10-15	0	0	0	0	10-15
Angela Hillery, Chief Executive*	160-165	0	5-10	0	25-27.5	195-200
Prof Alex O'Neill-Kerr, Medical Director *	180-185	0	0-5	0	12.5-15	200-205
Julie Shepherd, Director of Nursing, AHPs and Quality*	110-115	0	0-5	0	160-162.5	270-275
Chris Oakes, Director of Human Resources and Organisational Development	110-115	0	0-5	0	0	115-120
Sandra Mellors, Chief Operating Officer	110-115	0	0	0	45-47.5	155-160
David Williams, Director of Business Development (from November 2017)	45-50	0	0	0	157.5-160	200-205
Richard Wheeler, Finance Director*	125-130	0	0-5	0	22.5-25	150-155

* Denotes Voting right

No Benefits in Kind were paid during 2017/18

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

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

PENSION BENEFITS

Name and title	Real increase in pension at pension age	Real increase in pension lump sum at pension age	Total accrued pension at pension age at 31 March 2019	Lump sum at age 60 related to accrued pension at 31 March 2019	Cash Equivalent Transfer Value at 1 April 2018	Real Increase in Cash Equivalent Transfer Value	Cash Equivalent Transfer Value at 31 March 2019	Employers Contribution to Stakeholder Pension
	(bands of £2,500) £000	(bands of £2,500) £000	(bands of £5,000) £000	(bands of £5000) £000	£000	£000	£000	To nearest £100
Angela Hillery, Chief Executive	0-2.5	0	65-70	160-165	1,112	142	1,287	0
Prof Alex O'Neill-Kerr, Medical Director	0	0	35-40	110-115	818	72	914	0
Julie Shepherd, Director of Nursing AHP and Quality	0	0	50-55	155-160	1,018	106	1,154	0
Sandra Mellors, Chief Operating Officer	0-2.5	0-2.5	30-35	100-105	728	78	828	0
David Williams, Director of Business Development (from November 2017)	0-2.5	0	20-25	35-40	269	62	339	0
Richard Wheeler, Finance Director	2.5-5	5-7.5	40-45	100-105	652	153	825	0

As Non-Executive Directors do not receive pensionable remuneration, there will be no entries in respect of pensions for Non-Executive Directors.
As Chris Oakes is not in the pension scheme there are no entries in this table

A Cash Equivalent Transfer Value (CETV) is the actuarially assessed capital value of the pension scheme benefits accrued by a member at a particular point in time. The benefits valued are the member's accrued benefits and any contingent spouse's pension payable from the scheme. A CETV is a payment made by a pension scheme, or arrangement to secure pension benefits in another pension scheme or arrangement when the member leaves a scheme and chooses to transfer the benefits accrued in their former scheme. The pension figures shown relate to the benefits that the individual has accrued as a consequence of their total membership of the pension scheme, not just their service in a senior capacity to which the disclosure applies. The CETV figures, and from 2004-05 the other pension details, include the value of any pension benefits in another scheme or arrangement which the individual has transferred to the NHS pension scheme. They also include any additional pension benefit accrued to the member as a result of their purchasing additional years of pension service in the scheme at their own cost. CETVs are calculated within the guidelines and framework prescribed by the Institute and Faculty of Actuaries.

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

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

The mid point banded remuneration of the highest-paid director in Northamptonshire Healthcare NHS Foundation Trust in the financial year 2018-2019 was £187,500 (2017-2018, £188,750).

This was 6.7 times (2017-2018, 7.1) the median remuneration of the workforce,
(2017-2018, £26,565).

In 2018-2019 no employee received remuneration in excess of the highest paid director. Remuneration ranged from £17,460 to £189,060 (2017-2018 £15,404 to £187,680)

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

	2018/2019 Total £	2017/2018 Total £
Band of highest paid director's total (£000s)	187.5	187.5
Trust median remuneration	28,050	26,565
Ratio	6.7	7.1

In 2018/2019 the median employee was a band 6 this was also the case in 2017/18. The actual rate for the band 6 has increased due to the new agenda for change rates which came into effect during 2018/19.

OUR STAFF

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

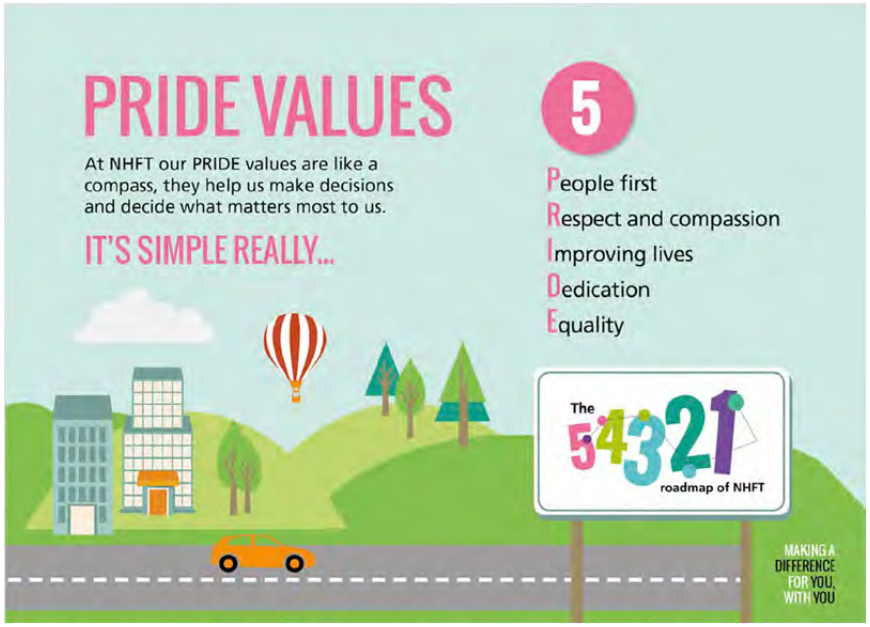
Every year, the Human Resources and Organisational Development Team put a workforce plan in place to make sure we effectively and efficiently allocate people and resources. We adopt a multi-faceted approach and often include reviews of service needs, analysis of key people and management data. We also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

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

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

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

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



NUMBER OF EMPLOYEES

The table below displays the average number of employees (whole time equivalent basis). Our 2017/18 data has been revised to ensure it is consistent with our annual accounts data.

	Total 2018/19	Permanent	Other	Total 2017/18	Permanent	Other
	Number	Number	Number	Number	Number	Number
				Restated	Restated	
Medical and dental	107	70	37	77	69	8
Ambulance staff	0	0	0	0	0	0
Administration and estates	838	718	120	753	669	84
Healthcare assistants and other support staff	894	691	203	848	662	186
Nursing, midwifery and health visiting staff	1,379	1,123	256	1,277	1,072	205
Nursing, midwifery and health visiting learners	0	0	0	3	3	0
Scientific, therapeutic and technical staff	499	475	24	459	440	19
Healthcare science staff	0	0	0	0	0	0
Social care staff	0	0	0	1	0	1
Other	0	0	0	0	0	0
Total average numbers	3,717	3,077	640	3,419	2,916	503
Of which:						
Number of employees (WTE) engaged on capital projects	6	6	0	7	4	3

STAFF SICKNESS ABSENCE

	2018/19	2017/18
	Number	Number
Total days lost	34,937	32,797
Total staff years	3,157	2,984
Average working days lost (per WTE)	11	11

STAFF IN POST

STAFF IN POST

As at 31 March 2019

Female executive directors	Male executive directors
3	4

Senior managers	33
Senior managers band 8A and above	95
Of the above female senior managers	68
Of the above male senior managers	27

Total staff 2016/17*	Total staff 2017/18*	Total staff 2018/19*	Female staff	Male staff	Bank staff	Permanent staff
4,545	5,076	4,885	4,103	782	1,021	3,720

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

Staff at the Trust's Learning and Development workshop

EXIT PACKAGES

EXIT PACKAGES

	Number of compulsory redundancies	Number of other departures agreed	Total number of exit packages	Number of compulsory redundancies	Number of other departures agreed	Total number of exit packages
	2018/19	2018/19	2018/19	2017/18	2017/18	2017/18
Exit package cost band (including any special payment element)						
<£10,000	0	0	0	4	0	4
£10,000 - £25,000	2	2	4	3	0	3
£25,001 - 50,000	0	0	0	1	0	1
£50,001 - £100,000	1	0	1	1	0	1
£100,001 - £150,000	0	0	0	0	0	0
£150,001 - £200,000	0	0	0	0	0	0
>£200,000	0	0	0	0	0	0
Total number of exit packages by type	3	2	5	9	0	9
Total resource cost £000	107	35	142	200	0	200

The compulsory redundancies relate to implementation of the required efficiency programme and have paid in accordance with Agenda for Change.

Exit costs in this note are accounted in full in the year of departure. Where the Foundation Trust has agreed early retirements, the additional costs are met by the Foundation Trust and not by the NHS Pensions Scheme. Ill-health retirement costs are met by the NHS Pensions Scheme and not included in the table.

	Agreements	Total value of agreements	Agreements	Total value of agreements
	Number	£000	Number	£000
	2018/19	2018/19	2017/18	2017/18
Exit packages: other (non-compulsory) departure payment				
Voluntary redundancies including early retirement contractual costs	0	0	0	0
Mutually agreed resignations (MARS) contractual costs	0	0	0	0
Early retirements in the efficiency of the service contractual costs	0	0	0	0
Contractual payments in lieu of notice	2	35	0	0
Exit payments following employment tribunals or court orders	0	0	0	0
Non-contractual payments requiring HMT approval (special severance payments	0	0	0	0
Total	2	35	0	0
of which:				
non-contractual payments requiring HMT approval made to individuals where the payment value was more than 12 months' of their annual salary	0	0	0	0

There were no no-contractual payments to individuals where the payment value was more than 12 months of their salary.

TERMINATION BENEFITS

During 2018/19 contracts were terminated for 5 staff (9 in 2017/18) at a cost of £142k (£200k in 2017/18).

EMPLOYEE BENEFITS

There are no other employee benefits.

RECRUITMENT

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

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

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

We recognise underrepresented groups at times need to overcome additional barriers to enter work. We are a level 2 Disability Confident Employer with a commitment to employing, retaining and developing disabled people in our workforce. This means we guarantee interviews for disabled persons if they meet the minimum criteria. In the coming year, we will be supporting colleagues from protected groups with career development workshops to enhance diversity at all levels in the Trust.

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

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

To promote good practice throughout the recruitment process, these procedures cover all stages of recruitment – from the point a vacancy first arises through to appointment. Over the year we have increased our recruitment activity, being proactive in our approach by utilising a targeted approach and open days for our traditionally hard to fill vacancies. We have improved the candidate experience of joining our Trust, streamlining processes and ensuring new colleagues are equipped to work on their first day.

ABSENCE MANAGEMENT

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

This year, we launched our new staff wellbeing strategy. We recognise that staff can only deliver compassionate care if they are cared for themselves. The new approach was launched at the 'Your Health, Your Wellbeing' event attended by over 400 staff.

As part of the new wellbeing strategy, we redesigned our approach to absence management. A new policy was implemented, with input from staff members and managers who had experienced the previous policy and was agreed in partnership with our Trade Unions. The new policy introduced a 'Wellbeing Wheel' to help staff reflect on their health, highlight the support available from the Trust and develop an action plan. We also introduced a 'Back to Work Map' to support staff return to work after long-term sickness.

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

TRAINING AND DEVELOPMENT

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

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

STAFF ENGAGEMENT

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

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

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

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

Examples of our actions include:

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

Our established staff networks – that we work in partnership with – help us to develop our equality practice. They are an important source of feedback and ideas for the Trust. Our networks include our staff disability and allies network, Black Minority and Ethnic (BME) staff development network and Lesbian, Gay, Bi-sexual,Transgender and Questioning (LGBTQ+) and allies network and our newly formed Working Carers Network.

FRAUD

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

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

UK MODERN SLAVERY ACT 2015

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

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

As part of the inter-agency Northamptonshire Safeguarding Adults and Children's Boards, we are committed to safeguarding training for all our staff at the appropriate level. All staff are mandated to complete level 1 training with clinical staff required to complete level 2 and if applicable level 3.

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

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

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

OCCUPATIONAL HEALTH AND WELLBEING

We are fully committed to supporting the health and wellbeing of our employees. It is our aim to ensure that our staff are aware of the existing services that are available to them, and to develop new services to help improve their lives.

The Occupational Health and Wellbeing team provides an extensive range of services, which are available to all staff. The number of fitness tests, annual health checks and cholesterol tests continue to increase, and we are now providing fitness classes at all of the larger main sites. In 2018, 387 members of staff participated in these wellbeing activities.

Wellbeing event
In July, we held a Leadership Matters event to celebrate staff wellbeing and launch the Trust's wellbeing strategy, in conjunction with celebrating 70 years of the NHS. More than 400 members of staff were in attendance and came from across all services. There were two keynote speakers: Vanessa King from Action for Happiness delivered a presentation on the 10 key steps to happier living, and Sally Gunnell, OBE spoke about her journey towards reaching her goal of becoming an Olympic gold medallist. Both key speakers promoted the importance of wellbeing for the self, resilience and positive thoughts. A number of taster activities were available for staff to engage in on the day, including 'Clubbercise', salsa, pilates, 'Move it or Lose it', Tai Chi and walking groups, as well as sessions addressing resilience, self-compassion, mindfulness, menopause and sleep. The event was hailed as a great success by attendees.

Psychological wellbeing services
Following the demands on psychological services, we have employed two counsellors to provide a service available five days a week. We have also increased counselling availability – it is now available at three sites, allowing more staff to attend more easily. With this increase, we are also able to offer cognitive behavioural therapy (CBT) and mindfulness courses. In November 2018, we successfully interviewed for the post of Wellbeing Psychologist. This new post will implement a range of psychological interventions for individuals and staff groups within the Trust.

Menopausal support
This year we developed a menopause-focused mindfulness booklet and began to provide support sessions for staff.

Pastoral care
The Trust's chaplaincy service provides help and support to staff, as well as to service users and their families. Over the last year, the chaplaincy service has seen a number of staff for bereavement counselling and emotional support when dealing with crisis situations.

Mental health first aiders
To date, over 80 members of staff have received their mental health first aid training, with more training going ahead throughout the year.

Seasonal flu vaccination programme
The 2018/19 seasonal flu vaccination programme was a great success, with 78.4% of front line staff receiving the vaccination.

Physiotherapy
The in-house physiotherapy service continues to provide treatment for musculoskeletal problems. Symptoms affecting the back, knees and shoulders are the main causes for referrals. Staff were triaged and/or seen within an average of five working days.

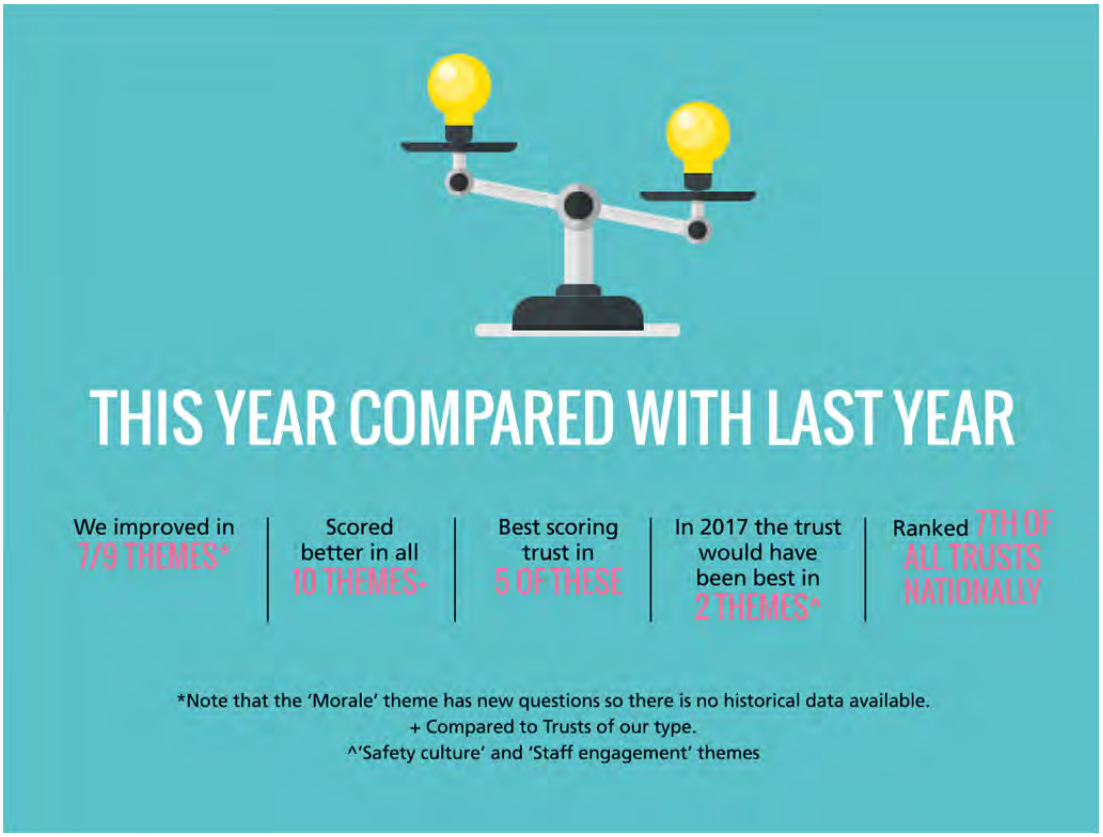
TRADE UNION FACILITY TIME

The Trade Union (Facility Time Publication Requirements) Regulations 2017 came into force on 1 April 2017. These regulations place a legislative requirement on the Trust to collate and publish, on an annual basis, a range of data on the amount and cost of facility time within their organisation. The Trust data published in line with the Cabinet Office guidance is listed below:

- 6 employees (whole time equivalent or WTE) were relevant union officials with paid facilities time during the period April 2018 to March 2019
- 5 of these employees spent between 1 and 50% of their working hours on facility time
- 1 of these employees spent between 51 and 99% of their working hours on facility time
- £83,012 of the Trust's total pay bill (£146,792,000) was spent on paying employees who were relevant union officials for facility time during the period April 2018 to March 2019
- This equates to 0.06% of the total pay bill spent on facility time
- 100% of time was spent on paid trade union activities.

STAFF SURVEY

Our Trust took part in the annual NHS staff survey 2018, which was open for all Trust staff to complete in late 2018. Official results from NHS England were released in early February 2019. This Staff Survey section also appears later in our Quality Report as it is published as a separate report.



Our 2018 response rate

2017/18 (PREVIOUS YEAR)	2018/19 (CURRENT YEAR)		TRUST IMPROVEMENT/ DETERIORATION
Our Trust	Our Trust	Benchmarking group (trust type) average	
48.4%	51.0%	45%	+2.6%

The '32 Key Findings' previously used in the National Staff Survey have been replaced with 10 themes to provide a summary of different areas of staff experience. These themes are scored on a 0-10 scale, with 10 being the best possible score for each theme.

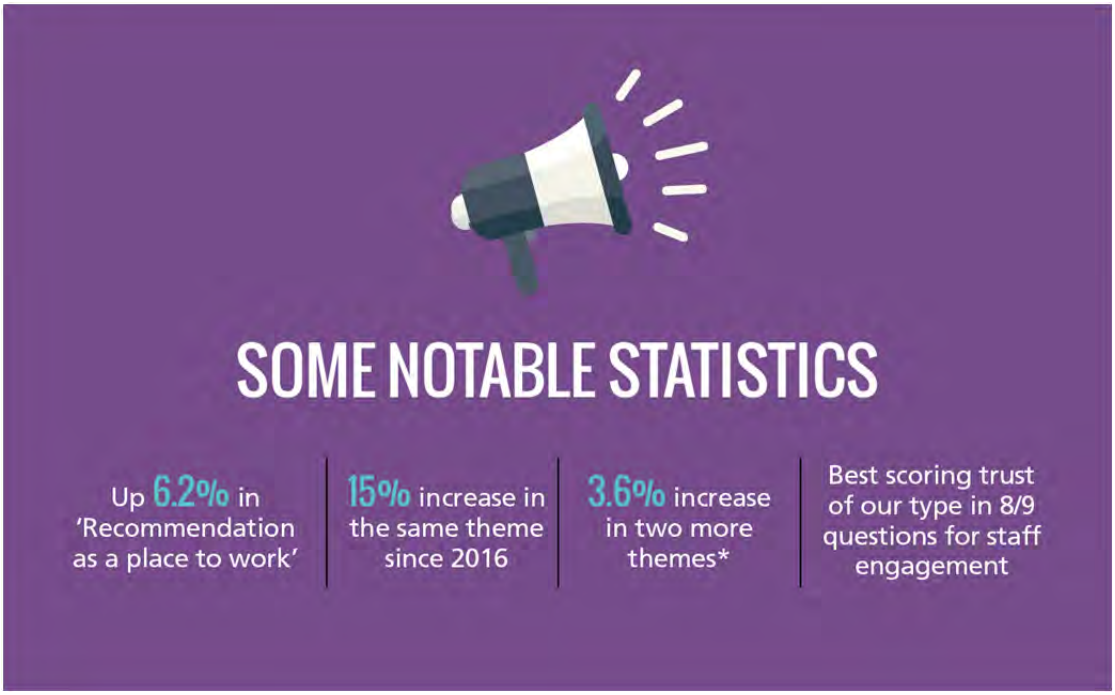
The Trust is benchmarked against 30 other trusts of our type: combined mental health/learning disability and community trusts. The Trust's results are detailed below:

Theme	2017	2018	Best	Average
Equality, diversity and inclusion	9.2	9.3	9.4	9.2
Health and wellbeing	6.4	6.6	6.6	6.1
Immediate managers	7.1	7.3	7.4	7.2
Morale	n/a	6.7	6.7	6.2
Quality of appraisals	5.9	6.0	6.0	5.5
Quality of care	7.6	7.7	7.7	7.4
Safe environment - Bullying & harassment	8.4	8.4	8.6	8.2
Safe environment - Violence	9.5	9.5	9.7	9.5
Safety culture	7.1	7.3	7.4	6.8
Staff engagement	7.3	7.5	7.5	7.0

Top five ranking scores

(Areas where we scored more favourably compared to trusts of a similar type)

1. Effective use of patient/service user feedback
2. Organisation's action on health and wellbeing of staff
3. Senior managers involving staff in important decisions
4. The extent to which the organisation values the work of staff
5. Staff recommendation of the organisation as a place to work



*The two themes that improved were 'Care as the top priority' and 'Recommendation as a place for care'

Research shows these are the primary drivers for staff engagement, and ultimately improved patient experience and outcomes. They can also be seen as exceptional improvements and bring the Trust's target of 80% recommendation as a place to work and receive care within reach. Nationally, the Trust achieved the second highest score for the theme of 'health and wellbeing' across all Trusts.

Although the number of staff working extra hours remains above average compared to similar trusts, this has improved in 2018 with 2.2% fewer staff working unpaid additional hours. Again, with staff engagement and health and wellbeing themes improving, our staff remain dedicated to our patients and service users and "going the extra mile" to make a difference.

Bottom five ranking scores

(Areas where we scored less favourably compared to trusts of a similar type)

1. **Percentage of staff working extra hours**
2. **Percentage of staff / colleagues reporting most recent experience of physical violence at work**
3. **Percentage of staff experiencing harassment, bullying or abuse from a colleague**
4. **Percentage of staff / colleagues putting themselves under pressure to come to work when not feeling well**
5. **Percentage of staff / colleagues witnessing errors, near misses, or incidents that could have hurt patients / service users**

The deterioration in witnessing or errors, near misses or incidents and experiencing harassment, bullying or abuse is reflected nationally. The survey also shows that 97.8% of staff reported their most recent error, near miss or incident. The survey also showed a 3.5% increase in staff reporting their most recent experience of harassment, bullying or abuse and is now better than average for Trusts of our type. The reporting of physical violence at work will be an area of focus for the Trust throughout 2019.

Signing the Trust's staff charter

FUTURE PRIORITIES AND TARGETS

Our two-year Staff Engagement Plan 'Let's talk' was launched following the National Staff Survey 2017 results. Linked to our mission 'Making a difference for you, with you', the Trust will continue to focus on:

- Listening to and involving you
- Supporting our managers
- Helping you to speak up
- Developing our employer promise
- Supporting your health and wellbeing
- Ending bullying and harassment
- Equality for all.

Following the results of the 2018 survey, the Trust has also identified four areas for development and improvement through 2019:

1. Increase the reporting of incidents of physical violence
2. Better involvement from managers when making decisions that affect staff and their work
3. Address staff working longer hours which is impacting on health and wellbeing
4. Develop a new approach to end bullying and harassment that focuses on intervening early to avoid the continuation of inappropriate behaviours.

ANNUAL REPORT DISCLOSURES

For all off-payroll engagements as of 31 March 2019, for more than £245 per day and that last longer than six months.

Number of existing engagements as of 31 March 2019	17
Of which:	
Number that have existed for less than one year at time of reporting	14
Number that have existed for between one and two years at time of reporting	1
Number that have existed for between two and three years at time of reporting	1
Number that have existed for between three and four years at time of reporting	1
Number that have existed for four or more years at time of reporting	0

For all new off-payroll engagements, or those that reached six months in duration, between 1 April 2018 and 31 March 2019, for more than £245 per day and that last longer than six months.

Number of new engagements, or those that reached six months in duration, between 1 April 2017 and 31 March 2018	9
Of which:	
Number assessed as within the scope of IR35	9*
Number assessed as not within the scope of IR35	0
Of which:	
Number engaged directly (via PSC contracted to trust) and are on the Trust's payroll	0
Number of engagements reassessed for consistency/assurance purposes during the year	0
Number of engagements that saw a change to IR35 status following the consistency review	0

*All engagements noted here concern agency staff and so the payroll deductions are made by the agency engaging the worker following an IR35 assessment and direction by the Trust.
In addition to the assessments above, 15 workers were directly engaged via their Personal Service Company with deductions made via the Trust's payroll in 2018-19 where a reassessment of IR35 indicated they were inside the scope.

For any off-payroll engagements of board members, and/or, senior officials with significant financial responsibility, between 1 April 2018 and 31 March 2019.

Number of off-payroll engagements of Board members, and/or senior officials with significant financial responsibility, during the financial year	0
Number of individuals that have been deemed 'board members and/or senior officials with significant financial responsibility' during the financial year. This figure must include both off-payroll and on-payroll engagements.	82

GOVERNANCE

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

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

WHO CAN BE A GOVERNOR?

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

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

We welcome the views of everyone and actively encourage input in a number of ways. The public has access to forums such as the Board of Directors' meeting. Our annual public and members' meeting was held on 20th September 2018 and was held jointly with the Council of Governors Annual General meeting. Members are invited to these meetings as a further opportunity to share their views with the Board of Directors. A register of governors' interests is updated annually and is available from the Northamptonshire Healthcare NHS Foundation Trust office.

How we engaged our members this year

1. Initial communications
All new members receive a welcome letter and introductory information.

2. Ongoing communications
We continue to issue regular bulletins and reports from the chair. These include governor and organisational updates, and a membership survey is in development, and due to be sent out in 2019/20. An e-newsletter is sent out every 6-8 weeks to members (called Editions).

3. Involvement planning
Members in East Northamptonshire were asked to complete a survey about place-based planning in February 2019.

4. Website members' area
We maintain a dedicated place to find information and updates. This includes information about governor elections.

5. Promotional materials
These help to encourage member recruitment of staff, service users and local carers. For example, the Trust services send out membership application forms to our service areas and staff inductions promote the benefits of membership to new employees.

6. Events
The focus in 2018/19 has been to attend and invite members to both internal and external events. Events attended include freshers' fairs, a careers fair, and library events. One library event in 2018/19 was a health and wellbeing event that members were invited to in March 2019. These events are used to promote membership, volunteering and involvement, and offer members of the public to the opportunity to discuss our services.

OUR MEMBERSHIP STRATEGY

Historically, the Trust has had separate strategies on membership, volunteering and involvement. A number of workshops on membership and involvement have been held in 2017/18 and 2018/19, working towards integrating the current, separate strategies. These workshops had representatives attend from the Council of Governors, involvement team, and volunteering and communication teams.

Merging the three strategies builds on the work that helped secure our CQC 'outstanding' rating, and represents good governance. By joining the strategies together, we expect cross-promotion of involvement, which should positively impact our engagement with service users, staff and members of the public.

A draft Patient and Public Involvement strategy was presented to and discussed with various stakeholders and forums for feedback during 2018/19. It encompasses membership/governors, involvement, volunteering and co-production. These forums included the Governors' Membership and Governance sub group, Patient Experience Steering Group, Quality Forum and Quality and Governance Committee. The strategy was welcomed and endorsed by the Council of Governors and the Board of Directors at their respective meetings in March 2019.

Further work will be undertaken on the specific work plans of the elements of the strategy. Through the Governors' Membership and Governance sub group a lot of work has been undertaken on how to better engage with members. Trust staff and governors have given increased priority to attending events to promote NHFT, membership, volunteering and involvement. This has included freshers' fairs, Christmas markets, volunteer fairs and Trust- held events.

There is also significant focus being given to identifying the best ways to engage with members, and the Trust is considering more targeted communications to members, with the possibility of holding more localised events. Promoting the role of the Governor is also being encouraged. This work will continue into 2019/20.

We aim to make membership, volunteer and involvement engagement a central part of how we gain an even better understanding of our patients, service users, families, carers, staff and community. We have 12,400 members and their input directly contributes to the development of the Trust.

Our ultimate aim is to increase our members' sense of engagement with the Trust.

Our membership recruitment programme has been ongoing since 2007. This is in accordance with the Health and Social Care Act 2012 section 153 (2) (2), which requires Trust membership to be representative of the people we serve.

To properly ensure that our membership is a true representation of the population we serve, we commissioned information from membership engagement services in June 2018. Our membership base was found to have no significant outliers, though there were areas with potential for improvement.

Non-executive directors routinely attend the Council of Governors Membership and Governance sub group, at which regular reports on membership are presented and discussed.

OUR MEMBERSHIP TARGETS

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

In 2018/19 the 'target' was to maintain the same number of members as in 2017/18 and this had been achieved.

The Council of Governors' Membership and Governance sub-group agreed the 2019/20 'target' will be to maintain the 2018/19 membership numbers.

The Trust has successfully achieved the membership target to maintain the 2017/18 member levels for 2018/19 – there are approximately 150 (net) new members.

The Trust's membership has increased by 8% in the last five years.

MEMBERSHIP AT YEAR-END

	MARCH 2015	MARCH 2016	MARCH 2017	MARCH 2018	MARCH 2019
Public members	7508	7963	8111	8299	8450
Patient and carer members	2343	2354	2344	2359	2376
Staff members	1684	1574	1557	1637	1624
Total members	11535	11891	12012	12295	12450

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

Foundation Trust Office
Front Block
St Mary's Hospital
London Road
Kettering NN15 7PW
Phone: 01536 452257
Email: foundationtrust@nhft.nhs.uk
Web: www.nhft.nhs.uk/governors

REGISTERS OF INTERESTS

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

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COUNCIL OF GOVERNORS

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

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

New and existing governors remain in post until one of the following situations occurs:

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

The Council of Governors appoints a lead governor from its membership. The Council of Governors reviewed the Lead Governor role description in May 2018 and endorsed the addition of a Deputy Lead Governor within its constitution. The Membership and Governance sub group was given delegated authority to agree the final version of the role description which they agreed in June 2018. From 2 July 2018 Tony Locock, Adult Service User Governor was appointed Lead Governor and from 16 July 2018, Tremaine Richard-Noel, Younger Service User Governor was appointed Deputy Lead Governor. Governors contribute in various ways through committees and sub groups. They appoint or remove the chair and non-executive directors, as well as hold responsibility for their remuneration. They also appoint or remove the external auditor.

The roles of our committees and sub groups

In March 2018, the Council of Governors discussed and endorsed new proposals in which they made changes to their sub group structure. As part of this review, the Council of Governors agreed to form a new sub group (from 1 April 2018), which amalgamated elements of the two previous sub groups (patient, safety and experience and staff and resources). The terms of reference had been agreed at the March 2018 Council of Governors meeting. The Corporate Assessment Group was also removed as part of this review.

- Nominations and remuneration committee

In May 2018 the Council of Governors reviewed the membership of this committee. A change was agreed to remove the specific requirements for four elected and two partner governors, and instead was changed to six governors. This committee appoints, removes and re- appoints the chair and nonexecutive directors and determines their terms and conditions. A key focus of the committee's work in 2018/19 was to lead the process for the appointment of the two new non-executive directors. Maria Wogan was appointed from 1 November 2018 and replaced the post vacated by Paul Clark on 31 March 2018. Nicky McLeod was appointed from 1 January 2019 and replaced Bev Messinger (who left on 31 December 2018).

The Council of Governors, at their September and November 2018 meetings, successfully made two appointments. This followed a recruitment process led by the Nominations and Remuneration Committee, which included long listing, shortlisting and a final panel interview. A stakeholder group comprising executive and non-executive directors, as well as governors, formed part of this recruitment and selection process. An executive search company was appointed by the Nominations and Remuneration Committee under delegated authority from the Council of Governors to support this recruitment process.

The Nominations and Remuneration Committee also supported appointing Moira Ingham as Deputy Chair from 1 January 2019 to 31 March 2019. This was approved at the November 2018 Council of Governors meeting. The Council of Governors at its March 2019 meeting then subsequently extended this to 31 July 2019 while work was undertaken on the role description and process of appointment for the Deputy Chair.

o Membership and governance sub group

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

o Finance, planning and performance sub group

Providing views on forward plans, this sub group also examines financial and non-financial performance in specific areas, dictated by a defined work plan. This sub group (as agreed at the March 2018 Council of Governors meeting) also absorbed the 'resources' element of the previous Staff and Resources sub group (such as estates and IM&T).

o Patient and Staff sub group

This sub group aims to study and seek assurance on the quality of specific services of the Trust, in respect of patient and staff experience.

o Chair's sub group

Comprising the chair of the Council of Governors and the chairs of each committee and sub group, as well as task and finish groups, this sub group plans and discusses agendas for the Council of Governors meetings. This sub group also now reviews the Board of Directors minutes and agendas (which had previously been undertaken by the Corporate Assessment Group). The Board of Directors minutes and agendas are also shared with the wider council.

In February 2019, the Membership and Governance sub group also agreed to form a Task and Finish group to review the Council of Governors governance arrangements.

Governor training and development

The Membership and Governance sub group monitors ongoing governor training. In 2018/19, we made significant progress with identifying and meeting the training and development needs of governors. Governors have previously agreed to undertake mandatory training, which aligns them with the Skills for Health programme that all our staff must also follow. Governors have accessed a range of other training and development opportunities, some of which are NHS-wide and some of which are developed and delivered internally. In January 2019, governors attended a joint training session with governors from Kettering General NHS Foundation Trust. NHS Providers facilitated this session.

How we involve our governors

Directors attend the Council of Governors main meeting and non-executive directors also attend the sub group meetings. This allows them to listen and respond to views and questions from governors.

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

The Council of Governors also features partner organisations. These organisations will sometimes carry out their own engagement activities within the local community. Governors will announce any conflicts of interest or make declarations of interest where appropriate.

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

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

Contribution to our annual plan
The Council of Governors and the Finance Planning and Performance sub group have contributed views to the development of the Trust's refreshed 2019/20 operational plan. At the March 2019 Council of Governors' meeting, governors discussed future national and local plans, referencing the NHS 10-year plan, NHFT's Operational Plan 2019/20 and the East Northants Place Based Plan. Governors and members were also engaged through a series of events in the process to refresh the Trust's Strategic Plan 2018/19 to 2022/23, with discussions also taking place at Council of Governors meetings in January 2018 and March 2018.

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

GOVERNORS

We held six meetings of the Council of Governors during 2018/19.

Governor attendance at meetings during the year
The following governors were in post from 1st April to 23rd April 2018, however no Council of Governors meetings were held during this time:

- Priscilla Brown (Carer Governor)
- Alan Devenish (Carer Governor)
- Gail Sutherland (Public Governor, Northampton)
- Hummad Anwar (Adult Service User Governor)
- Brian Lawrence (Older Service User Governor)
- Joe Sims (Public Governor, Kettering and Corby)
- Nick Mann (Staff Governor, Doctors and Dentists)
- Suzanne Johnson (Staff Governor, Non Clinical)
- Tony Bagot-Webb (Public Governor, Daventry and South Northamptonshire)

CONSTITUENCY	CLASS	NAME	NUMBER OF MEETINGS ATTENDED (SIX MEETINGS)
Public	Corby and Kettering	Chris Davison (from 24 Apr 2018)	6 of 6
	Corby and Kettering	Richard Dobson	5 of 6
	Corby and Kettering	Paul Joy	3 of 6
	Northampton	Des Savage	4 of 6
	Northampton	Howard Wood (from 7 Nov 2018)	2 of 3
	Northampton	Janet Lomax (until 14 Aug 2018) Saher Anwar (from 7 Nov 2018)	1 of 2 1 of 3
	Wellingborough and East Northants	John Walker	6 of 6
	Wellingborough and East Northants	Janet Hathaway	5 of 6
	Wellingborough and East Northants	Jon Collins (until 19 July 2018) David Robinson (from 19 Dec 2018)	0 of 2 2 of 2
	Daventry and South Northants	Carol Phillips (from 24 Apr 2018)	5 of 6
	Daventry and South Northants	Simon Leibling (until 6 Jul 2018) Gary Telford (from 19 Dec 2018)	0 of 1 1 of 2
Patients and carers	Daventry and South Northants	Michael Darling	6 of 6
	Rest of England	Colin Cohen (from 24 Apr 2018)	5 of 5
	Adult service user	Kevin Boyce	2 of 6
	Adult service user	Colin Russell (until August 2018)	2 of 2
	Adult service user	Beverley Sturdgess	2 of 6
	Adult service user	Jane Petch (from 7 Nov 2018)	2 of 3
	Adult service user	Alan Clark	3 of 6
	Adult service user	Tony Locock	5 of 6
	Younger service user	Tremaine Richard-Noel	5 of 6

CONSTITUENCY	CLASS	NAME	NUMBER OF MEETINGS ATTENDED (SIX MEETINGS)
	Older service user	Margaret Horne (from 24 Apr 2018)	4 of 6
	Carer	Sandra Wright	2 of 6
	Carer	Sandra Bemrose	1 of 6
Staff	Registered nurses	Cazz Broxton (from 24 Apr 2018)	3 of 6
	Non clinical	Samantha Benfield (from 19 Dec 2018)	1 of 2
	Other clinical	Kirsty Harris (from 24 Apr 2018)	3 of 6
	Doctors and dentists	Shahid Hussain (from 24 Apr 2018)	5 of 6
	Unregistered nurses	Stuart Fitzgerald	3 of 6
Partners	Borough and District councils	Rosemary Herring	4 of 6
	Northamptonshire County Council	Christina Smith-Haynes	4 of 6
	Northamptonshire Rights and Equality Council	Joe O'Neill (until 30 Jan 2019) Martin Sawyer (from 31 Jan 2019)	0 of 5 0 of 1
	Older people – Age UK Northamptonshire	Sue Watts	3 of 6
	The University of Northampton	John Turnbull	5 of 6

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

DIRECTOR ATTENDANCE AT COUNCIL OF GOVERNOR MEETINGS

NAME OF DIRECTOR	TITLE	NUMBER OF MEETINGS ATTENDED (SIX MEETINGS)
Crishni Waring	Chair	6 of 6
Scott Adams	Non-executive director	6 of 6
Alastair Watson	Non-executive director	5 of 6
Bev Messinger (until 31 Dec 2018)	Non-executive director	3 of 4
Moira Ingham	Non-executive director	5 of 6
Maria Wogan (from 1 Nov 2018)	Non-executive director	3 of 3
Nicky Mcleod (from 1 Jan 2019)	Non-executive director	2 of 2
Melanie Hall	Non-executive director	6 of 6
Angela Hillery	Chief executive	4 of 6
Prof. Alex O'Neill-Kerr	Medical director	3 of 6
Richard Wheeler	Finance director	6 of 6
Julie Shepherd	Director of nursing, AHPs and quality	4 of 6
Sandra Mellors	Chief operating officer	6 of 6
Chris Oakes	Director of human resources and organisational development	3 of 6
David Williams	Director of Business Development	5 of 6

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

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

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NHS IMPROVEMENT'S SINGLE OVERSIGHT FRAMEWORK

AREA	METRIC	2018/19 Q1 SCORE	2018/19 Q2 SCORE	2018/19 Q3 SCORE	2018/19 Q4 SCORE
Financial sustainability	Capital service capacity	2	2	2	2
	Liquidity	1	1	1	1
Financial efficiency	I&E margin	2	2	2	1
Financial controls	Distance from financial plan	1	1	2	1
	Agency spend	1	1	1	1
Overall scoring		1	1	1	1

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

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

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

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

The Trust is currently placed within segment 1 under the Single Oversight Framework. The CQC carried out a comprehensive assessment of our services in June/July 2018 and rated the Trust overall as 'Outstanding'. This was an improvement on the last inspection in 2017 when the Trust was rated 'Good'. This segmentation information is the Trust's position at 31 March 2019. Current segmentation information for NHS Trusts and Foundation Trusts is published on the NHS Improvement website. Under the Single Oversight Framework, the Trust's overall finance and use of resources risk rating score is 1. The finance and use of resources theme is based on the scoring of five measures from 1 to 4 where 1 reflects the strongest performance. These scores are then weighted to give an overall score.

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ANNUAL GOVERNANCE STATEMENT

Scope of responsibility

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

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 Northamptonshire Healthcare NHS Foundation Trust, to evaluate the likelihood of those risks being realised and the impact should they be realised, and to manage them efficiently, effectively and economically. The system of internal control has been in place in Northamptonshire Healthcare NHS Foundation Trust for the year ended 31 March 2019 and up to the date of approval of the annual report and accounts.

Capacity to handle risk

The Quality and Governance committee and the Performance Committee have delegated responsibility as part of the organisation's risk management strategy on behalf of the Trust's Board of Directors. This ensures the best leadership, coordination and prioritisation is received, on a strategic and operational basis, of the risk management agenda in relation to clinical, quality, workforce, operational and financial risks. This includes the identification of the full range of risks that are inherent in the delivery of healthcare.

The health, safety and risk committee provides an overarching view of health, safety and welfare and assurance that non-clinical risks are managed effectively on behalf of the organisation. Key health and safety developments during 2018/19 were improvements to the lone working/risk escalation process, continued development of estates statutory compliance reporting and formalisation of building manager role.

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

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

The risk and control framework

As part of their routine 2018/19 audit plan, the Trust's internal auditors reviewed the effectiveness of the risk management arrangements at Executive Team, Board of Directors and Committee levels and how the Organisational Risk Register was being used in practice. The auditors' report, to which they assigned a low risk classification, was a source of positive assurance for the Trust; the report's overview stated: "It was clear from our observations that the Trust has a risk culture, and that all directors, both executive and non-executive, have a good understanding of the Trust's risks and how they are being managed. The Trust has a learning culture, and improvement in risk management arrangements is no exception."

The significant risks in relation to the Trust's strategic objectives are described in the Trust-wide organisational risk register.

During 2018/19, the most significant risks included:

- Financial performance does not meet plan due to internal and external risks crystallising and mitigations being insufficient
- Lack of expertise and good systems inhibits our ability to achieve
- Partnership fails to deliver achieved patient benefits
- Workforce supply and capacity insufficient to meet contractual demand and deliver high quality of care
- Workforce capability insufficient to meet contractual demand and deliver high quality of care.

These risks will carry forward into 2019/20. The Trust has put in place controls and action plans to mitigate these risks and these are described in the organisational risk register, including effective financial governance arrangements, oversight and scrutiny of partnerships by the Strategic Partnership Forum and robust safe staffing and recruitment processes.
The Board also agreed during 2018/19 to reflect in the Organisational Risk Register the risk of disruption to services and of a detrimental impact on patient safety as a result of a European Union (EU) Exit. Mitigations in place to manage this risk include the establishment of a project group, which meets regularly to ensure the Trust responds appropriately to national guidance and to oversee local contingency plans.

Emergency preparedness, risk and resilience (EPRR) remains on the organisational risk register as the Trust's EPRR arrangements continue to develop. During 2017/18, the Trust moved from 'substantial' to 'fully compliant' with EPRR Core Standard. This fully compliant rating was maintained in 2018/19.

The Trust's internal audit programme supports the organisation in continuously strengthening its governance processes. Our internal auditors have carried out a review of the controls and processes in place for reporting on admissions avoidance and their report includes one 'high risk' finding. The Trust is responding to this finding including addressing the identified risk.

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

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

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

1. The effectiveness of governance structures

- Continued work has been undertaken to further improve Board processes including content and format of papers, agenda planning and assurance reporting. Specifically, a new template has been developed for Board papers with input from both executive and non-executive colleagues, refreshed work plans have been introduced for the Board and all committees and a revised assurance report based on a format used by another Trust has been introduced. Board Governance training workshops continue to be delivered to senior leaders across the Trust. Parts of these workshops have focussed on the development of the requisite report writing skills.
- In August 2018 the Board of Directors and Council of Governors held a joint workshop. The theme of the 2017 joint workshop centred on the Board's and Council's respective roles in relation to leadership and governance. The specific focus of that session was on the governance aspect.

For the 2018 event, the session focussed on the leadership element and reflected on NHFT's leadership behaviours. The session considered how the Board and Council 'live' and visibly model these behaviours both collectively (in Board and Council settings) and individually as Board directors and governors. It also identified how the Board and Council could further strengthen ways of working which reinforced the commitment to these leadership behaviours.

- NHS Improvement expects foundation trusts to carry out an external review of their governance arrangements every three years. In 2015/16, we engaged Ernst and Young LLP (EY) to undertake an external well-led governance review following a tender process. To further develop good governance practices in future, we responded to the report by developing and implementing an action plan. At its July 2018 meeting the Board of Directors agreed to the proposal to extend the external review timescale from three to five years. NHS Improvement had indicated there was a potential need at a national level for the rationale and timing of development reviews to be re-evaluated given the recent introduction of CQC annual well-led inspections. Having reflected on this feedback, the Board concluded that extending the external review timescale from three to five years was a sensible approach since it would thereby allow time for a definitive view to be gained from NHS Improvement on the future of development reviews. The development review would, therefore, take place during 2020/21. This had been agreed and confirmed by NHS Improvement in January 2019, following the Performance Review Meeting held in October 2018.
- In November 2018, NHSI published a report 'Learning from Development Reviews of Leadership and Governance Using the Well-Led Framework'. The report, which set out learning from the 40 plus reviews already undertaken, was considered by the Executive Board in March 2019. The Executive Board benchmarked and self-assessed the Trust's own position against the report's findings and concluded that the self-assessment analysis provided positive assurance in terms of the Trust's position as measured against the NHSI report findings. The self-assessment report was also received at the April 2019 Quality and Governance and Performance Committee meetings for further information and assurance purposes.
- Our Board of Directors and committees routinely review their performance against specific criteria at every meeting. Individual Board committees have either reviewed their performance against their terms of reference or have plans to review this in the near future.
- Representatives from the Council of Governors attend Board of Directors' meetings, at which governors are given the opportunity to raise questions and comments at appropriate points on agenda items being discussed by the Board. Reports from Council of Governors' meetings are regularly presented at Board of directors' meetings thereby facilitating discussion and information sharing between these two forums.
- The Trust has robust information governance and data quality policies in place, accessible to all staff, which cover issues such as data security and systems' data quality. The Trust also has a Board-appointed Senior Information Risk Owner and Caldicott Guardian.
- The Trust's constitution is regularly reviewed and updated to reflect legislative changes or organisational requirements with appropriate advice obtained from the Trust's legal advisors. The Council of Governors, in conjunction with the Board of Directors, reviewed aspects of the FT Constitution. Only one change was made in 2018/19, which related to appointment procedure of the Lead/Deputy Governor and the addition of a Deputy Lead Governor role.

- In November 2018 the Strategic Executive Board received a report, which provided positive assurance on compliance against the new UK Code of Governance (which came into force on 1st January 2019) and detailed analysis/benchmarking against the NHS Providers Governance survey results (which also provided further positive assurance).
- In preparing the Annual Governance Statement, there are no material inconsistencies identified between this Statement, the existing Corporate Governance Statement, Quality Report, Annual Report and reports arising from the CQC.

2. The responsibilities of directors and committees:

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

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

- These are clearly defined within the overall governance structures of the Trust and within the terms of reference of the Board committees. Reports and minutes from board committees are included in the public and private sessions of the Board of Directors' meetings respectively.
- The Trust's governance pack, which provides a comprehensive picture of the overall governance structures operating within the organisation, is regularly updated to ensure it continuously reflects current practices.
  During 2018/19 it has been agreed that changes to the top-level governance structure will be reported, through a standing item agenda, at the Trust's Audit Committee.
- The structure and arrangements of executive team meetings were reviewed and strengthened during 2017/18 with the new format being introduced from April 2018. In November 2018, the Strategic Executive Board again further reviewed these arrangements and it was agreed the effectiveness of the new executive governance structure was working effectively in line with the original vision with some areas for further development identified.
- Management of risk is allocated to two committees of the Board of Directors: the Performance Committee and Quality and Governance Committee, with the Board taking an overarching responsibility for risk (including ensuring effective exchange between the two committees). In 2018/19 the Quality and Governance Committee introduced the practice of 'deep diving' into red-rated risks as a regular item at its meeting to further strengthen insight and scrutiny of key organisational risks.
- The Audit Committee's terms of reference also include risk management responsibilities. The Committee reviews the establishment and maintenance of an effective system of integrated governance, risk management and internal control across the whole of the organisation's activities (both clinical and non-clinical), which supports the achievement of the organisation's objectives.

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

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

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

- The Trust has well-established performance management systems in place with respect to our quality, operational and financial obligations, with appropriate links to the organisational risk register processes. The Board of directors routinely receives and scrutinises performance reports at its meetings with ongoing development of a Trust-wide integrated Performance Dashboard. The Performance Committee and Quality and Governance committee have key responsibilities within the overall performance management framework and quality strategy of the Trust.
- The Board takes leadership of the Trust's planning processes (both operational and strategic) and receives and reviews regular progress reports on delivery. Board sessions are held as part of the overall planning process, to which deputy directors (operational and clinical) are regularly invited. As part of its Board Development programme the Board discussed and reviewed its Strategy at its February 2019 session. The Trust has applied the principles of the NHS Foundation Trust Code of Governance on a 'comply or explain' basis. The NHS Foundation Trust Code of Governance, most recently revised in July 2014, is based on the principles of the UK Corporate Governance Code issued in 2012. The Trust is required to comply with its Foundation Trust Constitution, and governance processes are designed to underpin this requirement.

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

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

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

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

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

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

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

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

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

- A 'freedom to speak up' guardian and policy are in place and awareness of this is promoted within the Trust, with clear reporting lines established within the Trust's governance structures.

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

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

- Covers all the organisation's main activities.

- Identifies the Trust's strategic focus.

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

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

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

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

The organisational risk register describes the risks to achieving the organisation's strategic objectives. They are drawn from operational indicators of risk and from horizon-scanning discussions about external risks to achieving the strategic objectives. The organisational risk register is updated regularly through the year. Any gaps in controls that are identified are subject to the implementation of an action plan and assurances within the organisational risk register. The Performance Committee and Quality and Governance Committee continually review the organisational risk register, and assurance of the process and management of risks is reported to the Board of directors in public session. The Trust has a robust risk assessment and risk register process in place to identify both clinical and non-clinical risks at local, directorate/service and organisational levels. Those risks that cannot be eliminated or managed at a local or directorate/service level, and are assessed to be a significant risk, are escalated to the organisational risk register. The Trust uses DatixWeb, a risk management information system incorporating the use of dashboards for real-time reporting and escalation of identified risks.

The Trust has a robust approach to ensure that short, medium and long-term workforce strategies and staffing systems are in place which assures the Board that staffing processes are safe, sustainable and effective.

The Trust identified its key workforce objectives by engaging senior leaders from across the Trust; they are part of the Trust's strategic objectives.

Trust committees including the Trust Board, Performance Committee, Quality & Governance Committee, Transformation Committee and Executive Board receive the key workforce strategies, plans and initiatives. They monitor delivery via Key Performance Indicators displayed on a range of appropriate integrated dashboards to ensure effective progress.

The Safer Staffing Board oversees the Trust's adherence to the National Quality Board 2016 guidance and the NHSI 'Developing Workforce Safeguards' 2018 guidance. It reviews and monitors staffing risks, mitigating actions and quality impact assessments to inform the assurance reports that are provided to Trust Board and Quality and Governance Committee.

The Quality and Governance Committee and Trust Board receive monthly and six monthly Safe Staffing Reports in respect to all Inpatient Staffing Levels and other key services. The reporting process/frequency has been reviewed

and from April 2019, reporting on staffing systems including establishment levels and identified risks for all clinical services will take place on a six-monthly basis. This will be in addition to the current monthly inpatient safer staffing reporting process.

An integrated WorkForce Assurance dashboard has been developed at Trust and service level to support the assurance process.

NHFT uses a range of workforce-planning methods:

1. Professional judgement method – multi-disciplinary teams (MDTs) of lead clinicians and managers consider workforce requirements together with the Safe Care Leads and Human Resources and Organisational Development Team. Using their professional judgement, MDTs will review the current performance standards, financial performance, patient feedback and commissioning intentions and consider the benefits/risks of alternative skill–mixes as part of this approach.
2. Workload quality method – the Trust uses evidence-based tools to calculate staffing levels based on a variety of inputs, including the Keith Hurst (2016) Acuity and Dependency Tool, staffing requirements tool (Professional Judgment Tool, Keith Hurst 2015), to ensure that the nursing establishment supports the staffing level and skill mix for each ward. Whilst more common in ward-based services, the Trust is developing its own staffing models for some community-based services.
3. Triangulation of the above with quality, patient feedback, workforce and workflow metrics.
4. Benchmarking internally and externally (where information is available and applicable).

The Trust has a range of dashboards that provide data required for triangulation. NHFT is developing its dashboards in line with NHS Improvement 'best practice' recommendations. All service managers have access to appropriate dashboard(s), which ensures operational leads are fully aware of their current quality performance. The Trust's Board and its committees receive triangulated data in a number of key documents including Safer Staffing, various reports related to Patient Safety e.g. Serious Incident, Learning from Deaths etc. and Workforce and Financial reports. The Trust utilises the information in a number of ways to:

- assure the Board that the systems and processes are working to identify risk or good practice/outcome;
- challenge the data and request further information;
- identify internally driven, focussed pieces of quality work;
- review dashboards;
- formulate ideas for change or for new ways of working;
- review the Organisational Risk Register;
- identify new quality indicators aligned to transformational programmes; and
- promote quality across the organisation utilising key messages/themes.

The Trust uses triangulated data to drive quality improvement initiatives across the organisation and to enhance service productivity, where appropriate.

The Trust has a structured approach through its governance to ensure that changes that impact on staffing levels/skills mix etc. are subject to robust quality impact assessments.

The Trust is required to be registered with either or both the Care Quality Commission (CQC) and Ofsted for delivery of our services. The Trust achieved registration for all of our services with the CQC from 1 April 2010, and Ofsted from 1 August 2013, without any conditions of registration. The CQC have undertaken Mental Health Act inspections across appropriate services within the organisation in 2018/19. Ofsted have also undertaken inspections in 2018/19 with positive outcomes being demonstrated and where needed actions being undertaken. The CQC did not take any enforcement actions against the Trust during 2018/19, nor has the organisation been required to participate in any special reviews or investigation by the CQC during the year.

Under its routine inspection programme, the CQC inspected the Trust in June and July 2018 and published its report in August 2018. The Trust achieved an overall rating of 'Outstanding' in this inspection, with a rating of 'Outstanding' in the Caring and Well-Led domains. Prior to this, the CQC reviewed the organisation in January 2017 and published its

resultant report in March 2017, which gave the organisation an overall rating of 'Good'. The Trust took forward the learning from the CQC inspection in 2018 and has delivered against the action plan reporting both to Trust Board and the Quality and Governance Committee.

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

The information gained from the internal assessment is reviewed and services are supported to develop solutions to any identified gaps or share good practice where this has been highlighted. Patients, service users, carers and visitors are encouraged to report any issue of concern, or suggest areas for improvement using iWantGreatCare, leaflets, comment cards (positioned in patient areas), and through discharge patient surveys. Our robust involvement pathway includes gathering feedback from external stakeholders as well as using patients' and carers' views. This process enables these groups to feedback and scrutinise the Trust's activity ensuring that the patient and carer view is incorporated into our systems.

The organisation has a number of patient experience groups, where patients and carers are members. These oversee and monitor involvement and patient experience activity in the Trust. Our patient advice and liaison service (PALS) provides central reporting of low level concerns and issues raised by patients, General Practitioners (GPs) and the public. It is also fully integrated with the complaints management process. These and other patient experience issues are considered at the pathway patient experience groups, which are reported via the quality and governance process. Additionally the Trust has implemented iWantGreatCare, which has successfully generated unprecedented levels of feedback from our service users, carers and relatives.

Our Council of Governors has been in place from 1 May 2009, which has strengthened arrangements for the involvement and accountability of patients, carers, staff, partners and the public. The Council of Governors also has a sub-group structure in place, whose remits include finance, planning and performance, patient and staff, and membership and governance. These sub-groups help support the Trust's scrutiny and assurance processes.

The Council of Governors' Chairs sub group reviews papers discussed at Trust Board of directors' meetings held in public, as well as the agenda and minutes of the Board of Directors' meetings held in private session. The Board papers, agendas and minutes are also shared with the wider Council of Governors. Revisions to the Council of Governors sub group structure were implemented from April 2018 and as part of this process Council sub groups were more closely aligned with Trust Board Committees. A review of the changes to the sub group structure/Council of Governors meeting arrangements is currently on-going.

In 2018/19 the Council of Governors received presentations, and had the opportunity to comment on the Trust's staff survey results, risk management, organisational risk register, primary, community and social care and mental health transformation. The Council of Governors is an important piece of the overall governance jigsaw of the Trust. At its March 2019 meeting, the Council of Governors endorsed a new Patient and Public Involvement Strategy which brought together in a more coordinated way the Trust's involvement, membership and volunteering activities to further strengthen our work in this area.

The foundation trust has published an up-to-date register of interests for decision-making staff within the past 12 months, as required by the 'Managing Conflicts of Interest in the NHS' guidance.

As an employer with staff entitled to membership of the NHS Pension Scheme, control measures are in place to ensure all employer obligations contained within the Scheme regulations are complied with. This includes ensuring that deductions from salary, employer's contributions and payments into the Scheme are in accordance with the Scheme rules, and that member Pension Scheme records are accurately updated in accordance with the timescales detailed in the Regulations

Control measures are in place to ensure that all the organisation's obligations under equality, diversity and human rights legislation are complied with. Compliance is reported on an annual basis in the published *Equality Information Report as required by the Public Sector Equality Duty (PSED)*. Regular progress reports are taken to the Board of Directors and the Quality and Governance Committee.

The Equality, Inclusion and Human Right Assurance Board (EIAB), chaired by the Director of Nursing, AHPs and Quality with a non-Executive Director as a member of the committee. The committee provides the Trust with overarching assurance of compliance with the Equality Act 2010; Public Sector Equality Duty and gender pay reporting and has a clear focus on Patient Experience. Service users and carers, governors and community representatives are included in the membership. This EIAB oversees a number of sub-committees and groups which strengthen the Trust's governance around Equality, Diversity and Inclusion. The Diversity Network Leads (DNL) meeting takes place on a quarterly basis and is co-chaired by the Chief Executive and BME Staff network chair and supported by the Director of Human Resources and Organisational Development. The DNL oversees work undertaken to improve the staff experience and leads on work streams that develops an inclusive workplace culture. Our four Staff Networks (BAME, Disability; LGBTQ+ and Carers Networks) report into the DNL and the networks are recognised as a key stakeholder group within the Trust decision-making and consultative processes.

The Trust undertakes relevant and proportionate Equality Analysis (*due regar*d) to consider the impact of our policies, functions and actions in relation to groups protected under the Equality Act 2010. Equality Analysis are embedded in our policy development frameworks and ratified through the Trust Policy Board. In addition, the same process is applied to organisational change, service redesign and cost improvement programmes managed through the Project Management Office (PMO). Equality Analysis is embedded into the PMO function, Equality and Inclusion Manager provides the scrutiny for each work stream and final approval is given by the Director of Nursing, AHPs and Quality and the Medical Director.

The organisation implements all NHS England (NHSE) equality and diversity standards and requirements. The Trust uses the NHS Equality Delivery System (EDS2), Accessible Information Standard, and the NHS Workforce Race and Disability Equality Standards to improve patient and staff experience. For each regulation, performance is monitored by the EIAB and reported to commissioners and NHSE, as required and published in our annual *Equality Information Report*.

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.

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

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

For an indication of economy and efficiency in the organisation, the Trust used benchmarking information from 1 April 2018 to 31 March 2019. Detailed work is being undertaken as part of the cost improvement planning process for 2019/20 and in support of on-going efficiency improvement via the Transformation Committee, this includes engagement with key senior managers (e.g. specific workshop held in December 2018). This work will enable the Trust to understand why costs of some of its individual services appear to be high and to identify opportunities to improve economy and effectiveness through our productivity and/ or cost improvement programmes. The Trust is a member of the NHS Benchmarking Network and has participated in benchmarking exercises during 2018/19.

The Trust complies with reference costs reporting to provide a comparative analysis of our costs in line with national guidance. From 2019/20 there is a mandated requirement for

Mental Health providers to move towards a patient level information and costing system (PLICS) and we are taking advice as an integrated community and mental health provider on our requirements.

Separately, we have developed an Indicative Activity Plan and Price Activity Matrix process as a requirement from our Clinical Commissioning Group (CCG) and to support our own understanding of activity pressures and variation in cost between services. This provides a price for units of activity such as per contact and bed day, allowing the Trust and commissioners to support understanding and potential for CCG investment and trust efficiency.

Information governance

During the period 1 April 2018 to 31 March 2019 the Trust has continued to improve its information governance framework. The management of information governance risks has been reviewed through monitoring information assets, information flows and information governance incidents via our information governance team. This activity supports the application and monitoring of compliance against the requirements of the Data Security and Protection toolkit. Achievement against this is monitored through the Information Management and Technology (IM&T) Programme Board. The Trust has exceeded the minimum standard for the Data Security and Protection Toolkit and has established a framework to oversee information governance compliance within the organisation. The IM&T Programme Board receives reports on all key information governance issues. *The information governance team received 520 incidents between 1 April 2018 and 31 March 2019.* This figure includes any medical records incidents as well as the reported loss of smartcards. This figure also includes 51 incidents that relate to other organisations that have been logged by Trust staff on the Trust reporting system. There were four serious incidents reported to the Information Commissioner's Office via the information governance incident national reporting tool. The incidents related breaches of confidentiality. The incidents have been reviewed by the Information Commissioner's Office who have determined that the Trust has taken appropriate action and no fines or penalties have been levied towards the Trust.

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

The quality team works with operational managers and deputy directors to monitor progress in delivering our core quality initiatives inclusive of Commissioning for Quality and Innovation (CQUIN), the quality schedule and the quality account. Quality initiatives within the Trust continue to be reinforced by our quality framework, which is continually being reviewed and updated. The organisation has established arrangements via the Quality Forum for the regular review of service performance and monthly monitoring of a range of quality and effectiveness indicators. Additional processes are in place to support innovation, inclusive of quality improvements in efficiency and cost effectiveness.

The key document for quality measurement and reporting is the quality account, of which a quarterly update of the quality indicators is delivered to the Quality and Governance Committee. The quality priorities identified in the account are sourced from a review of risks, innovation and internal discussion; these are then widely consulted upon to ensure they are appropriate. The account, once in draft format, will be reviewed in a number of forums, and will be audited against the national guidance by the organisation's external audit team. In addition, the organisation has a dashboard, subject to continuous development, which allows pathways to receive detailed information relating to their services in line with all aspects of quality and safety.

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

Statutory reporting on elective wait times is required for only two Trust services, with wait lists and access times fully monitored and triangulated. Data quality is assured via existing automated processes to identify the incorrect patient demographics (correct NHS numbers, Postcodes, GP registration etc.) and prevent duplicates in data. This also includes prevention of impossible errors (gender and age patient treatments are appropriately aligned) at patient level reporting for each service, for the reporting of both access times for patients seen and wait times for patients still waiting to be seen, through the organisation's established performance framework meetings. Internally, performance in this area is measured against an 18-week expectation with action planning required as standard for areas of under attainment. Risks to data quality in this area are managed through weekly communication between the performance team and clinical service leads and dashboard reporting. An overarching Data Quality Oversight Group is in the pipeline for 2019/20 to pull together the Clinical Support/Information Governance/Performance Team facilitation of the health record alongside operational input into strengthening data availability and across the Trust.

The Quality and Governance Committee, on behalf of the Board of Directors, receives assurance on issues of patient safety, patient experience and patient outcomes and promotes the involvement of service users, carers and the public. In addition to this, thematic reviews of service areas or indicators of concern are commissioned by and shared with the Quality and Governance committee as they arise. Through these reviews and regular reporting, we have a clear understanding on where we need to focus to improve clinical practice and effectiveness and reduce the incidents of harm. In addition to this, the Trust's Board of Directors receives reports and presentations on issues impacting on quality, including:

- Patient stories
- Serious incidents, GP concerns and complaints, IWantGreat Care patient feedback
- Safer staffing
- Safeguarding
- Agency usage
- Organisational risk registers.

Policy development is integral to quality and safe patient care; it underpins clinical practice and is used as a positive framework to meet the required standards.

Policies are informed by current evidence, which is referenced; each document is updated at least every three years following a full consultation, and are readily available to all staff to access and utilise.

Clinical quality issues, particularly relating to best practice and national guidance, are scrutinised and discussed at the quality forum. Representatives from all relevant profession groups attend this forum to ensure clinical quality is reviewed. The forum also evaluates (as needed) impact assessments on the quality of care when there are changes in services, either as a result of the cost improvement programme or because of service redesign. The forum receives papers from a variety of internal groups and quality focussed committees (including pathway specific ones). Its role is to scrutinise quality activity and report to the Quality and Governance Committee.

Review of effectiveness

As Accounting Officer, I have responsibility for reviewing the effectiveness of the system of internal control. My review of the effectiveness of the system of internal control is informed by the work of the internal auditors, clinical audit and the executive managers and clinical leads within the 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 reports. I have been advised on the implications of the result of my review of the effectiveness of the system of internal control by the Board, the Audit Committee the Quality and Governance Committee and the

Performance Committee, and a plan to address weaknesses and ensure continuous improvement of the system is in place.

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

- Routine reporting on incidents to the board of directors
- PALS, GP concerns and iWantGreatCare feedback and complaints reports
- Patient stories at Board meetings
- Delivering and monitoring safe staffing reports to the Board of Directors and the Quality and Governance committee
- The Trust's assurance structure and reporting for statutory body registration requirements
- Internal audit assessment of the Trust's risk management structure processes
- Patient-led assessment of the care environment (PLACE) scores
- Board development days
- The work of the Audit Committee, the Quality and Governance Committee, the Performance Committee, the SI Review Committee and Complaints Review Committee
- Internal and external audit reports
- Reports from regulators
- The work of the local counter-fraud specialist
- Operational service directorates presenting at the Trust Board and its committees
- Trust responses to external inquiries and reports
- Directorate and service performance reviews

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

- The Trust Board receives reports from the Quality and Governance Committee, the Performance Committee, the Audit Committee and the Council of Governors' in public session. These reports highlight issues of assurance and concern for the Board of Directors. In addition, the Board of Directors receives minutes of Board committees in private session. The Audit Committee has oversight of corporate governance arrangements and receives appropriate external assurance.
- The Audit Committee ensures the establishment and maintenance of an effective system of internal control and risk management.
- All managers have the responsibility for developing and implementing the risk management strategy and policy through the line management of individual directorates. The risk management strategy is annually reviewed at the Board.
- The Performance Committee assures effective control on financial and performance matters.
- The internal auditors verify that a suitable and effective system of risk management and internal control is in place on an annual basis. They have direct access to the Chair of the Audit Committee to raise any issues of concern.

Conclusion

My review confirms that the Trust has a generally sound system of internal controls that supports the achievement of our policies, aims and objectives and that any control issues have been addressed. No significant internal control issues have been identified. The Trust is committed to the continuous improvement of processes of internal control and assurance and as such may introduce additional controls within the forthcoming financial year (2019/20), as the Trust's Board of Directors deems necessary.

Angela Hillery

Chief executive

22 May 2019

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QUALITY REPORT 2018/19

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QUALITY REPORT

PART ONE

INTRODUCTION

As a leading healthcare provider, safety and quality are critical to our service delivery. In this Quality Report, we share our approach to the services we provide at our sites located across the county, and the services we provide in the community. This includes physical health, mental health and specialty services.

What is a Quality Report?

Quality Reports are produced by providers of NHS healthcare services and contain information about the quality of the services they provide. These reports are published annually by every NHS healthcare provider and are made available to the public. They are both retrospective and forward-looking. All NHS healthcare providers must produce a publicly available Quality Report, as set out in the vision for the National Quality Framework, 'High Quality Care for All', published by the Department of Health in 2008.

What are the aims of the Quality Report?

1. To enable patients and their carers to make well informed choices about their providers of healthcare
2. To enable the public to hold providers to account for the quality of the services they deliver
3. To engage the leaders of an organisation in their quality improvement agenda.

Who reads the Quality Report?

Our audiences are wide-ranging, and include people who use our services and their carers, staff, commissioners and regulating bodies. We produce our report for anyone who wants to know more about the quality of our services, and how we plan to maintain and improve this. For this reason, we provide explanations of terms and abbreviations in speech mark designs like the one on the right.

What information can be found in the Quality Account?
We share how we measure and review our performance, as well as set priorities for improvements for the year ahead to be clear about the quality of our services. Like all NHS healthcare providers, we measure the quality of our services by looking at:

- Patient safety
- The effectiveness of treatments that patients receive
- How patients experienced the care provided.

In this report, you will also be able to read what people have to say about our Trust. Not all the testimonials you read will be attributed to a name, as sometimes people ask to remain anonymous. We make it clear whether they are a staff member, patient, carer, service user or friend or family member, and we make it clear the statement is a testimonial by adding quotation marks. Some photographs that are included appear without a name and may not be related to the testimonial.

However, each individual has approved every photo and quote for publication.

The content required in this Quality Report is identified in the Quality Account Toolkit, a document produced by the Department of Health. It provides a set of nationally mandated statements, which allow readers to make comparisons between organisations.

The Toolkit for 2010/11 stated that every Quality Account must include:

- A statement from the board (or equivalent) of your organisation summarising the quality of NHS services provided
- The organisation's priorities for quality improvement for the coming financial year
- A review of the quality of services in the organisation.

We hope you find what we share in our Quality Report for 2018/19 worthwhile and informative.

STATEMENT OF QUALITY

From Angela Hillery, Chief Executive

From the CQC rating the Trust as 'outstanding' to patient, service user, carer, friends, family and staff feedback, we have been recognised in many ways for our quality of care this year.

Every day, our staff are focused on our mission *making a difference, for you, with you*. Their care and compassion for our patients, service users, families and carers can be seen in our CQC scores.

As well as being rated 'outstanding' overall, we were also rated 'outstanding' in the 'caring' and 'well-led' domains. We have also improved in the 'safe' domain with a 'good' rating. Of course, there is always more work to do, and like everyone at the Trust, I am passionate about improving our quality of care in every way we can. You can learn more about this in our plans and priorities for the year to come, later in this report.

You can also read how our staff engagement has improved once again this year. As part of the annual national NHS staff survey, staff were asked a range of questions about all aspects of their life and work at our Trust.

This year, we scored better in all 10 themes, and were ranked seventh of all trusts nationally. We were also the best scoring trust of our type in eight out of nine questions for staff engagement. Even with these positive ratings, like every year, we will continue to work on areas for improvement and to monitor our progress carefully.

By working in partnership with organisations and involving our patients, service users, carers, friends and family, as well as staff, we stay connected to our community. Through this involvement, we strengthen our ability to deliver outstanding care. This is why this year we continued to engage in public events and seek feedback in a number of ways.

From 'iWantGreatCare' feedback forms to staff wellbeing events, we have kept involvement at the heart of our care. This year's events included a health expo for our Black, Minority and Ethnic (BME) community, an AHP conference and a staff network celebration event with key speakers from Northamptonshire Carers, DisabledGo and our Lesbian, Gay, Bisexual Transgender and Questioning (LGBTQ+) community.

Like last year, our iWantGreatCare feedback score for recommendation to friends and family is high – this year we were rated just under 94%. From over 24,900 reviews, our average rating was 4.81 out of 5 stars for great care. We are particularly proud of our rating of 4.79 by carers for feeling supported by the Trust.

I want to take this opportunity to thank each and every patient, service user, carer, friend and family member for your valuable feedback and involvement. Thank you also to every staff member for your continued dedication to making a difference.

If you have any questions or comments about this report, I would be happy to hear from you.

Angela Hillery
Chief Executive
22 May 2019

STATEMENT OF QUALITY

From Julie Shepherd, Director of Nursing, AHPs and Quality

Our commitment to *making a difference, with you, for you* comes from our staff's dedication and compassion to our patients and service users.

This continued dedication is evident in how we involve our patients, service users, carers, family and friends, and staff. We invite everyone who comes into contact with our services to share their experience with us, and encourage participation in research and innovation, staff recruitment, volunteering and sharing views on our strategy. From this involvement in shaping our priorities, determining our focus and future care, we continually improve our standards of quality services.

This year, our commitment to improvements in quality and care for our patients and service users has resulted in accreditations and strong ratings, positive survey results, and awards and recognition.

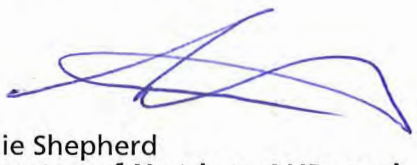
In addition to the CQC rating the Trust 'outstanding' overall and in the 'caring' and 'well-led' domains, we were named 'Trust of the Year' at the prestigious HSJ Awards and were awarded the HSJ Patient Safety Award for Best Product or Innovation in the Public Sector for our development and use of body worn cameras.

We were also recognised with Acute Inpatient Mental Health Services (AIMS) accreditations for these inpatient wards at Berrywood Hospital, thanks to the continued success of our in-patient mental health teams, along with many other accreditations that can be found later in this Quality Report. You can also read more about our awards and achievements in this Quality Report, as well as in our wider Annual Report and Accounts.

Like involvement, equality and diversity is essential to better shaping and providing our services to meet the different needs of our community. It also helps us to learn lessons when we need to, and supports our values of people first, respect and compassion, improving lives, dedication and equality. Our staff networks support this and include Black Minority and Ethnic (BME), Lesbian Gay Bi-sexual Transgender Questioning LGBTQ+), and Disability and Working Carers. This year, our commitment to equality and diversity was recognised with an award nomination for the Global Equality and Diversity award for work undertaken in staff engagement.

Over the past year, our staff have shown a continued commitment to our quality priorities. One example of this was our sharing patient safety experiences so that we could all learn from incidents to reduce harm to patients. By giving focus to this we reduced the number of serious incidents from 32 (2017/18) to 24 (2018/19), which is a drop of 25%. In this report, we share our progress against our other priorities from this year, as well as our priorities for the year ahead.

I hope you find this report to be interesting and informative. As ever, I welcome feedback, particularly from our stakeholders, partners, service users, carers and their families

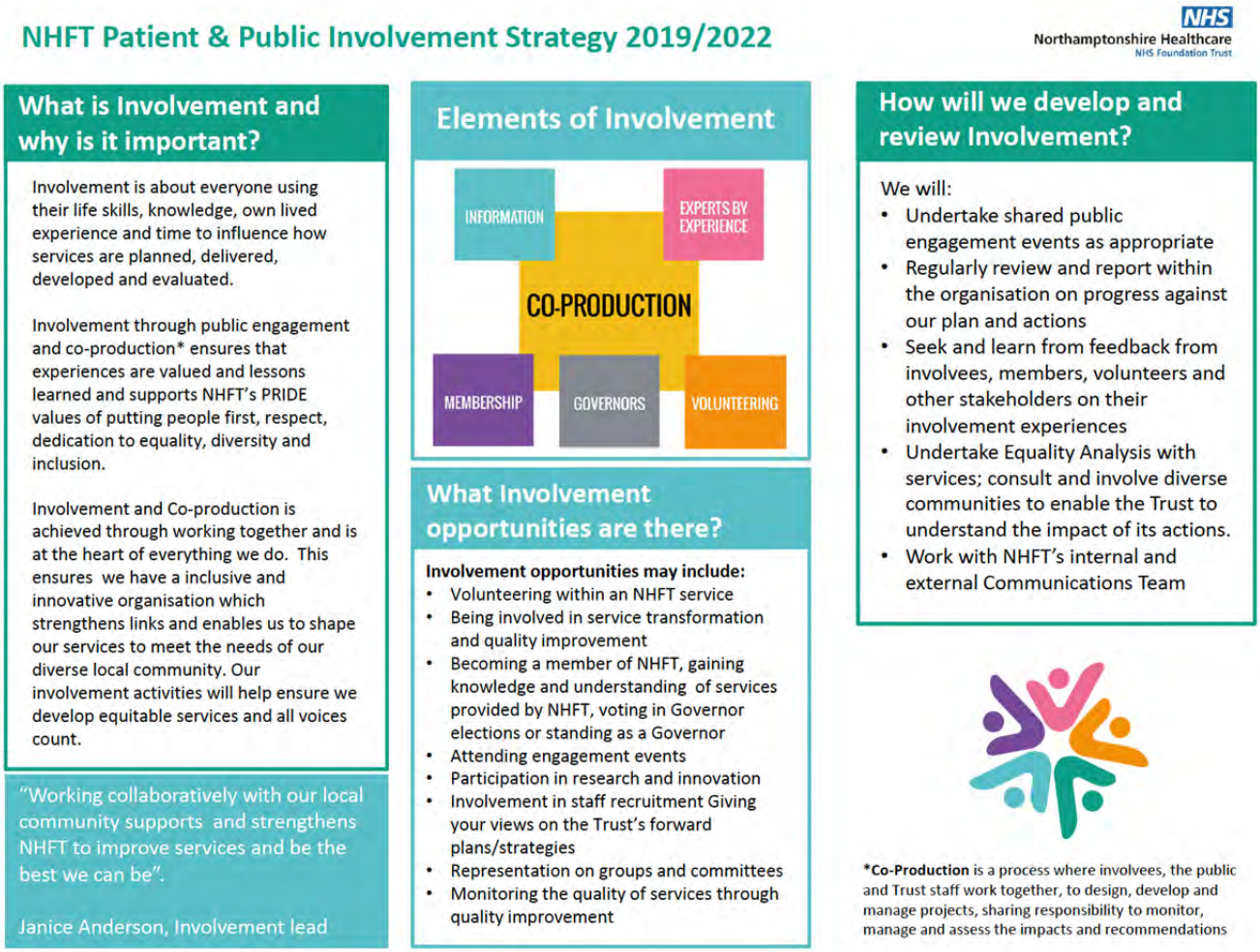


Julie Shepherd
Director of Nursing, AHPs and Quality

22 May 2019

INVOLVEMENT: AT THE HEART OF QUALITY

Our patients, service users, carers and families are at the heart of our approach to quality. They each play an integral part in helping us to develop services, transform clinical pathways and support the organisation.



A PATIENT'S STORY

"The last few years have been the hardest of my life, and I feel as though I've been under any and all services. At one point, I remember learning the word 'institutionalised', which resonated with me. I'd lost my own voice, and just wanted to make other people happy. I met with Ellie, and quickly I realised I was falling into that habit. It was really frustrating.

I wanted to be honest but it was so hard to find or explain how I really felt about my experience under mental health services. Ellie stayed with me throughout, and this really surprised me as I thought she would give up.

We tried lots of different activities and found that by doing art, I would start talking openly about my own experiences. I remember that feeling like the weight of the world was off of my shoulders. That was nearly two years ago.

I feel a completely different person to who I was then. I feel like my voice came back. I've been on interview panels, gone to different groups, and even met with the police to discuss my experiences of being in crisis.

All the way through this, I have been supported by Ellie and the other people who are involved. I've now started to do a health and social care course at college, which has given me a reason to wake up in the morning. I want to work in mental health eventually and so having this experience has not only been good for me, but good for my future career."

PART TWO

OUR PRIORITIES 2019/20

In this section, we share our quality priorities for the year ahead. As with our priorities for this year (see Part Three), for the coming year we have set objectives and measure our work in three main areas: patient safety, patient experience and clinical effectiveness. Our priorities or indicators are not covered by a national definition unless indicated otherwise.

Following initial discussion and a comprehensive review of internal quality data, risks and future innovation, we developed our priorities in collaboration with our staff, carers and patients.

We consulted a wide range of audiences, including members of the Northamptonshire Healthcare NHS Foundation Trust's quality team, our Patient Experience Group (including patients and carers), governors, Quality Report meeting members, the Quality Forum, the executive team, the Nursing Advisory Committee, the Allied Healthcare Professional Advisory Committee, colleagues from training and our staff group networks. The Trust Board and the Quality and Governance Committee have agreed the priorities for improvement.

Our priorities will support the Trust as we continue to make sure that safe, quality care is at the heart of all we do. This coming year, our priorities for improvement are:

1. Strengthening our local induction programme for clinical staff
2. Implementing NEWS 2 across the relevant services

WHAT IS NEWS 2?

NEWS2 is the latest version of the National Early Warning Score (NEWS), first produced in 2012 and updated in December 2017, which advocates a system to standardise the assessment and response to acute illness.

(Source: NHS England website, March 2019)

3. Improving equality service user data
4. Reducing the number of prone restraints used within Mental Health Inpatient Services, in line with our reduction strategy
5. Increasing our compliance with the number of relevant venous thromboembolism (VTE) assessments completed.

WHAT IS VTE?

Venous thromboembolism (VTE) is a condition in which a blood clot forms most often in the deep veins of the leg, groin or arm (known as deep vein thrombosis, DVT) and travels in the circulation, lodging in the lungs (known as pulmonary embolism, PE).

Source: worldthrombosisday.org (March 2019)

OUR PRIORITIES THIS YEAR

The tables below list our priorities for improvement in 2019/20, and specify which Care Quality Commission (CQC) domain(s) they belong to. We describe what the priorities mean, and why we chose them, as well as how we aim to achieve them, and how we will measure them. This then informs what we report on in our Quality Report next year, and communicates how we will review our performance.

Priority for improvement

We will strengthen and monitor the percentage of appropriate staff who undertake local induction.

CQC domains: well-led and safe

What this means

This indicator was chosen because we recognise that an effective and consistent induction process will enable new staff to begin their employment in a positive and supportive environment, and promote long-term staff retention.

A comprehensive local induction will ensure that new staff are provided with the information, support and learning necessary to operate effectively in their new role and to quickly integrate effectively.

How we will do it

We will achieve this by:

<u>In quarter one</u>

- Reviewing the current local induction processes in place for clinical staff, including the relevant policy (HRp025) and current recording and reporting processes, linking with the probationary process (HRp 037) and the recording of local induction
- Establishing the percentage of appropriate staff who have received a local induction, using this data as a benchmark set target for compliance for achievement by fourth quarter 2019/20
- Review and identify the appropriate staff group 'cohort' for this priority
- Auditing local induction checklists currently used (against best practice and local policy requirements).

<u>In quarter two</u>

- Reviewing results and updating checklists, policies and procedures. Undertake a consultation and pilot of new checklist
- Disseminate new practice and polices across the Trust
- Develop a communication plan and

How it will be measured

1. Our audit process and working party
2. Reporting each quarter to the Quality and Governance Committee. Data collection, benchmarking against the baseline and an agreed cohort.

commence roll out in line with its timeframes. <u>In quarter three</u> • Implement communication plan as per timescales • Collect and review the percentage of staff who have undertaken local induction in quarters 1 and 2. <u>In quarter four</u> • Report yearly uptake of local induction against baseline measurement.	

Priority for improvement

We will implement National Early Warning Score (NEWS) 2 across the relevant services. (Prior to the implementation of NEWS2, the Trust used NEWS in relevant services. This had a patient safety target of 90%, excluding clinical exceptions. This target continues as an expectation.)

CQC domain: safe

What this means

This priority was chosen because we recognise the importance of ensuring there is early detection, timeliness and competency associated with the clinical response when treating people with acute illness.

NEWS was initially developed to improve the detection of and response to clinical deterioration in patients with acute illness. The original NEWS was released in 2012 and has been widely implemented across the UK. It was created to standardise the process of recording, scoring and responding to changes in routinely measured physiological parameters in acutely ill patients.

The NEWS chart has been updated in 2017. The revised National Early Warning Score 2 (NEWS2), published by the Royal College of Physicians in December 2017, has changed the following:

- The recording of physiological parameters has been reordered to align with the Resuscitation Council (UK) ABCDE sequence
- The ranges for the boundaries of each parameter score are now shown on the chart
- The chart has a dedicated section (SpO2 Scale 2) for use with patients with hypercapnic (increased amounts of CO2 in the blood) and respiratory failure (usually due to COPD), who have clinically recommended oxygen saturation of 88–92%
- The section of the chart for recording the rate of (L/min) and method/device for supplemental oxygen delivery has been improved
- The importance of considering serious sepsis in patients with known or suspected infection, or at risk of infection, is emphasised – a NEW score of 5 or more is the key trigger threshold for urgent clinical review and action
- The addition of 'new confusion' (which includes disorientation, delirium or any new alteration to mentation) to the AVPU score, which becomes ACVPU (where C represents confusion)
- The chart has a new colour scheme, reflecting the fact that the original red–amber–green colours were not ideal for staff with red/green colour blindness.

How we will do it	How it will be measured
We will achieve this by: <u>In quarter one</u> • Identifying relevant clinical areas for NEWS 2 roll out • Making NEWS 2 training available to all appropriate staff (in line with national time frames) and ensure that NEWS 2 paperwork has been introduced to all relevant clinical areas • Reviewing internal record keeping and existing NEWS audit tools, adapting these for NEWS 2 delivery. <u>In quarter two</u> • Commencing the monthly audit of NEWS2 compliance • Reviewing audit results for NEWS 2 compliance and developing an action plan to address identified needs. <u>In quarter three</u> • Reviewing and updating existing policies • Monthly auditing focused around the correct completion of NEWS 2 forms • Reviewing compliance against the desired outcomes of the quarter 2 action plan, making any required changes based on audit findings. <u>In quarter four</u> • Monthly auditing focused on the correct completion of NEWS 2 forms • Reviewing progress against the priority targets for 2019/20, including compliance with NEWS 2 completion.	Relevant clinical areas will audit NEWS2 monthly. We will measure this by: • Monthly audits of completion of NEWS2 in relevant clinical areas • Quarterly reporting to Quality Forum • Quarterly reporting to Quality and Governance Committee.

Priority for improvement

We will increase five of the protected characteristic category baselines by either 10 or 20% (services using SystmOne clinical record recording). The improvement difference is summarised below:

- Disability 10%
- Ethnicity 10%
- Marital status 20%
- Sexual orientation 10%
- Belief 20%

CQC domains: safe and effective

What this means

We chose this priority because we want quality information and data to help drive our equality, diversity and inclusion (EDI) work forward, and improve patient experience and outcomes. We identified that by improving data quality across our single patient profile we can provide better patient care, safety and patient experience and outcomes using the protected characteristics. Our focus will be on data completeness in patient records for: sexual orientation, religion, ethnicity and marital status.

How we will do it

We will achieve this by:

<u>In quarter one</u>

- Obtaining a baseline of SystmOne recorded service user demographic information across Trust-wide services
- Developing a plan (training/ communication) with the aim to increase staff understanding of the importance of recording the profile data
- Devising patient questionnaires for mental health and community in-patients to establish: whether they are being asked for their demographic data on admission
- Collecting questionnaire responses
- Reporting progress to the Equality and Inclusion Assurance Board each quarter (2019/20).

<u>In quarter two</u>

- Analysing questionnaire data
- Following review of the data, a co-produced workshop with patients and staff will capture ways to improve collecting demographic data
- Reporting results to directorate management meetings
- Developing an action plan with the patients and clinical teams/directorates to address any gaps in data identified.

<u>In quarter three</u>

- Collecting and analysing responses from service users on the collection of demographic information

How it will be measured

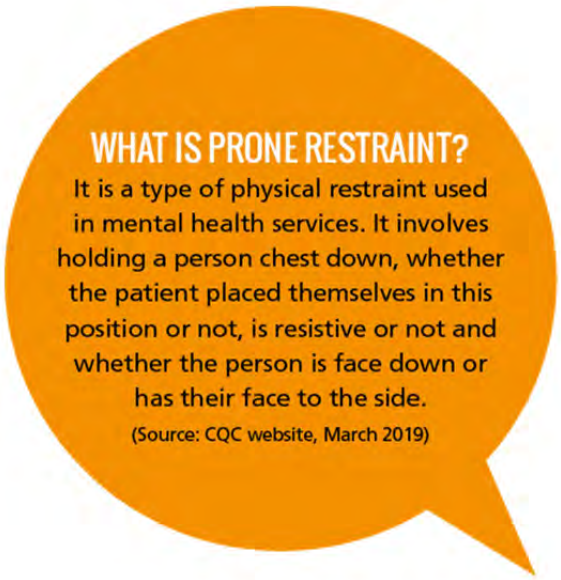
- We will measure the improvements by monitoring the equality dashboard from the Trust's business data systems, reporting on a monthly basis, checking for data completeness for the protected characteristics
- We will use the data from the patient's questionnaire to understand the challenges of why the data is not being asked and reported
- Service user profile data figures will be discussed at the directorate management meetings on a monthly basis, and reported on a quarterly basis to the Equality and Inclusion Assurance Board (the minutes will be provided to the Quality Forum for assurance)
- If required improvements are not being made, a report will be provided to the Quality and Governance Committee
- Reporting progress and data in the annual Equality Information Report
- Equality and Inclusion Assurance Board (EIAB) minutes.

• Producing a summary report on the key findings of the survey to be discussed at Equality and Inclusion Assurance Board (EIAB) • Working with clinical teams, clinical systems, quality improvement leads, head of quality surveillance and performance to develop a work plan to improve data quality for patient information • Sharing the quarterly report with the EIAB. <u>In quarter four</u> • Reviewing annual performance regarding improving the data collected for each protected characteristics to be reported in the annual Equality Information Report • Presenting the Annual Report to EIAB and sharing any key results reported to the Trust as part of compliance with our legal duty to publish of Equality Information.	

Priority for improvement

We will reduce the numbers of prone restraints used within Mental Health Inpatient Services in line with our reduction strategy.

CQC domain: safe



What this means

This indicator was chosen because our CQC inspection report this year identified that we need to review the number of prone restraints in accordance with the Mental Health Act Code of Practice. This review, in conjunction with the results of a national freedom of information request, indicated that the majority of prone restraints occurred both at NHFT and nationally, either as part of a procedure to exit seclusion or to administer Innovative Medicines Initiative (IMI) medication.

In March, the Trust purchased 20 Safety Pod devices that will enable staff to exit seclusion without using the prone position. Although the pods are not suitable for use in every seclusion exit, they will provide an alternative on many occasions. The Prevention and Management of Violence and Aggression (PMVA) team have included the use of the pods on training courses and are attending ward team days in order to offer bespoke, in situation training.

Following an extensive and rigorous analysis of the training system conducted by the Trust, the PMVA Team, in conjunction with our accrediting organisation, has reviewed and modified the course content. This system utilises a 'core skills approach', which provides staff with numerous alternatives to the use of the prone position.

How we will do it

We will achieve this by:

<u>In quarter one</u>

- Obtaining data from SMART reporting 2017-19 to be used as the baseline. The system is already designed to enable reporting. Changes to the mental health services dataset (MHSDS) came into effect from 1 April 2019. In light of this, the current data collection system in place is being reviewed to ensure we meet the additional requirements

How it will be measured

- Regular audits of restraint
- Staff training records
- The PMVA group will monitor the data from SMART
- Regular reports will be provided to Mental Health Act Scrutiny and the Quality Forum
- A thematic review, supported by research and development, to ensure new procedures do not have a negative impact on patients and staff.

• Comparison of rates of prone for the same reporting period for the previous two years • Data will continue to be reported to PMVA, Mental Health Act Scrutiny and Trust Board across all four quarters • Delivering training to staff on the wards, as part of team training days, bespoke sessions within the PMVA department and on scheduled PMVA training courses and on courses • Bespoke safety pod training provision will initially be focussed on the ward reporting the highest use of prone restraint and all staff on that ward, therefore in first quarter all substantive staff will be trained by the end of April 2019 • Ensuring that 30% of permanent staff, based on wards with seclusion pods available are trained. <u>In quarter two</u> • By the end of Q2 80% of substantive staff based on wards using pods will be trained in their use. <u>In quarter three</u> • Reviewing of feedback from staff and service users regarding safety and efficacy of pod use. Audit of numbers of prone restraints carried out • Achieving a 20% reduction in prone restraints compared to the equivalent six months in 2018 • Training 100% of substantive staff working on wards in using safety pods. <u>In quarter four</u> • Reviewing numbers of prone and feedback from pod training and the use of pods • Identifying future priorities for action and reviewing published data from other trusts to understand any impact the new reporting requirements have had on the rates of prone elsewhere.	

Priority for improvement

We will increase our compliance with the number of appropriate VTE assessments completed, based on an agreed baseline of 95% (including clinical exceptions).

CQC domain: safe

What this means

We chose this priority because VTE is a leading cause of death and disability worldwide that can be easily prevented.

Hospital-acquired venous thromboembolism (VTE), also known as hospital-acquired or hospital-associated thrombosis (HAT), covers all VTE that occurs in hospital and within 90 days after a hospital admission. It is a common and potentially preventable problem. VTE most frequently occurs in the deep veins of the legs or pelvis (a deep vein thrombosis [DVT]). If it dislodges and travels to the lungs, it is called a pulmonary embolism, which in some cases can be fatal.

VTE risk assessment can prevent deaths in hospital by implementing VTE prophylaxis where necessary. It includes mechanical methods (such as anti-embolism stockings and intermittent pneumatic compression devices), and pharmacological treatments (such as heparin and other anticoagulant drugs).

How we will do it

We will achieve this by:

<u>In quarter one</u>

- Confirming wards that need to undertake VTE assessment of their patients based on NICE guidance
- Obtaining a baseline for all services and identifying a projection for improvements
- Conducting weekly audits to identify progress against trajectory to identify any issues and inform implementation of action plan
- Reviewing SystmOne template
- Working with the Performance Team to ensure that data reported on Trust electronic data system is accurate
- SystmOne training to be provided with an algorithm for VTE completion in the patient's notes
- Developing and rolling out of a communication plan to ensure all relevant staff understand their roles and responsibilities for VTE
- All doctors to be given an 'Admission Assessment Criteria' to ensure they do not miss off

How it will be measured

- SystmOne VTE risk assessment template modified and implemented
- Monthly data will be obtained from the Trust electronic data system and shared with all wards
- Monthly report produced for the executive board
- The VTE working group will meet regularly to monitor progress
- Each identified ward will have one VTE champion
- Regular reporting to Quality Forum and Quality and Governance Committee.

important parts of the admission process • Exploring the possibility of including VTE risk assessment on the clerking page on SystemOne • VTE to be added to ward round checklist, to ensure regular review of risk • VTE assessment awareness training to be developed/ reviewed for nurses and HCAs • Ensuring that VTE is included as part of the junior doctor's induction • Implementing VTE champions across wards • Reviewing monthly audit results, developing an action plan to address non-delivery of patient safety target • Undertake data quality assurance. <u>In quarter two, three and four</u> • Scrutinising of monthly audit results and review compliance against the desired outcomes of the action plan, making any required changes based on audit findings.	

A FAMILY MEMBER'S STORY

"Several years ago I was in a lonely and exhausted place. A family member had become very unwell and we were about to be launched into a whirlwind of mental health hospitals, diagnosis and difficult emotions.

It's fair to say that it has taken until now for me to come to terms with those events, but that being given the opportunity to become involved in NHFT services and to speak out about lived experiences and the impact upon families and carers has been a massive part of my acceptance, understanding, and own recovery. Hopefully my experiences will help staff and other carers and service users to bring about positive changes for those needing mental health support in this Trust.

From feeling hopeless, with no control over what was happening to our family and totally lacking in confidence, I have been supported by the Involvement Team, and by the great leadership and staff within NHFT to use my experience in so many ways.

I have had the opportunity to interview future staff and to be part of many co-produced projects, such as the Warren crisis house, a new Care Programme Approach (CPA) initiative, staff training, co-designing new hospital welcome packs for carers and co-chairing service user and carer experience groups. This has been alongside bringing service user and carers' voices and needs into suicide prevention, crisis care, hospital and community services and even pharmacy and police services.

Being involved and valued, and not just being listened to but actually heard, and seeing services change and develop in response to our service user and carers' needs has been amazing. It has changed my life for the better and also given me confidence and hope for the future of my loved one and for all those who deserve to receive excellent care at every stage of their recovery."

OUR STATEMENTS OF ASSURANCE

To provide reassurance of the quality of services, NHS healthcare providers provide a series of statements in Quality Reports regarding audits of services, income, registration and records, information governance, clinical coding and patient deaths. Our Board of Directors endorse the below statements of assurance.

OUR SERVICES

During 2018/19, the Trust provided and/or sub-contracted 143 relevant health services (these are services we deliver within the Trust). 113 of these services were fully contracted service lines and 30 were sub-contracted services under service level agreement.

We have reviewed all the data available to us on the quality of care in 143 of these relevant health services.

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 Trust for the year.

OUR AUDITS

During 2018/19, seven national clinical audits and two national confidential enquiries covered relevant health services that Northamptonshire Healthcare NHS Foundation Trust provides. During that period, we participated in 100% of the national clinical audits and 100% of the national confidential enquiries in which we were eligible to participate in by the audit commission.

2018/19 audits
The national clinical audits and national confidential enquiries that Northamptonshire Healthcare NHS Foundation Trust were eligible to participate in during 2018/19 were as follows:

- Falls and Fragility Fracture Audit
- National Audit of Care at the End of Life
- National Audit of Intermediate Care
- National Clinical Audit of Psychosis.

Data collected at audits in 2018/19

- Prescribing Observatory for Mental Health (POMH)
- Mental Health Clinical Outcome Review Programme – National Confidential Enquiry into Suicide & Homicide by People with Mental Illness
- Learning Disability Mortality Review Group.

Following a discussion at the Trust, it was agreed that as our Psychological Services are already fully integrated into teams that we could not accurately participate in the National Audit of Anxiety & Depression. The audit was designed for stand alone psychological services.

We also supported our colleagues in the acute sector by participating in the following audits:

- National Diabetes Audit – Adult (National Diabetes foot care Audit – NHS Digital)
- Sentinel Stroke National Audit Programme (SSNAP).

The national clinical audits and national confidential enquiries that Northamptonshire Healthcare NHS Foundation Trust participated in, and for which data collection was completed during 2018/19, are listed below. Accompanying this is 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.

Title	% of eligible sample
Falls and Fragility Fracture Audit	100% of eligible sample
National Audit of Care at the End of Life	100% of eligible sample
National Audit of Intermediate Care	100% of eligible sample
National Clinical Audit of Psychosis	100% of eligible sample
National Diabetes Audit – Adult: National Diabetes Foot Care Audit (NHS Digital)	This was a data capture exercise only
Prescribing Observatory for Mental Health (POMH) Assessment of side effects of depot and LAI antipsychotic medication Monitoring of patients prescribed Lithium Rapid Tranquilisation Prescribing Clozapine	 100% of eligible sample 100% of eligible sample 100% of eligible sample 100% of eligible sample
Sentinel Stroke National Audit Programme (SSNAP)	100% of eligible sample
Mental Health Clinical Outcome Review Programme – National Confidential Enquiry into Suicide & Homicide by People with Mental Illness	This was a data capture exercise only
Learning Disability Mortality Review Group	100% of eligible sample

Our actions as a result of national audits in 2018/19
We reviewed the reports from seven national clinical audits in 2018/19 and intend to take the following actions to improve the quality of care provided.

Falls and Fragility Fracture Audit

- Data collection began January 2019. It is anticipated that the number of eligible participants from the Trust will be small
- The Trust will develop an action plan, as required, when the report is received. Some local learning has already been identified around post falls actions
- Falls information has been re-circulated, and further training has been offered to the wards. A falls champion for each ward has been identified.

National Audit of Care at the End of Life

- The Trust report was received February 2019
- We will standardise documentation for patients at the end of life using a standard operating procedure
- We will write documentation requirements for community beds patients who are at the end of life.

National Audit of Intermediate Care (NAIC)

Bed-based (community beds)

- We will reduce the number of patients needing to be returned to an acute hospital from Corby Community Hospital. This involves actions to:
    - Identify times that patients were transferred back to acute hospitals
    - Work with Kettering General Hospital (KGH) to identify appropriate patients to be transitioned to Corby
    - Continue to reach into KGH Integrated Discharge Team (IDT) to assist with education
    - Undertake a quarterly audit of patients being discharged back to KGH, escalating issues as required.

- We will ensure the number of patients receiving harm-free care and treatment of a urine infection with a catheter is equivalent to, or better than, the national norm
- We will reduce the number of medication incidents that cause harm in line with, or better than, the national norm. This involves actions to:
    - Review NAIC definition of harm-free care so we can focus target areas
    - Review information submitted to NAIC to ensure it excluded stroke and end of life patients
    - Identify specific areas that require improvement in quality
    - Make an action plan for improvement and audit to ensure improvement is delivered.

Home-based (ICT)

- We will ensure that the number of patients receiving harm-free care and treatment of a urine infection with a catheter is equivalent to, or better than, the national norm
- We will reduce the percentage of patients with harm from a fall in care and reduce the prevalence of pressure ulcers (percentage) in line with, or better than, the

national norm. This involves actions to:
    - Review NAIC definition of harm-free care so we can focus target areas.
    - Review information submitted to NAIC to ensure it excluded stroke and end of life patients.
    - Identify specific areas that require improvement in quality.
    - Make an action plan for improvement and audit to ensure improvement is delivered.
- We will standardise assessments used across services to reduce duplication and enable better evaluation of outcomes. This involves actions to:
    - Review assessment tools used.
    - Review the Sunderland Score.

<u>National Clinical Audit of Psychosis (2018/19)</u>

- Data has been collected. The report is due later in 2019.

<u>National Clinical Audit of Psychosis (2017/18)</u>

NHFT were identified as being a national outlier for one standard, this gave the organisation an 'alert' status for the following:

Standard 6: Daily dose exceeding the upper limit of the dose range recommended by the BNF.

The following actions have therefore been undertaken:

- All cases have been reviewed by the Deputy Medical Director for mental health, who supports the clinical decision making and rationale
- The patients and consultant are aware of and understand the risks
- The risk is being managed correctly.

<u>Prescribing Observatory in Mental Health</u>

- The report for the assessment of the side effects of depot and long acting injectable antipsychotic medication has been received. Meetings with lead clinicians have been scheduled to develop an action plan. A lead clinician has been assigned to ensure the directorate owns the action plan.

<u>Monitoring of patients prescribed Lithium</u>

- Data collection is currently underway. We will develop an action plan, as required, when we receive the report.

<u>Rapid tranquilisation</u>

- The report has been received. Meetings with lead clinicians have been scheduled to develop an action plan. A lead clinician has been assigned to ensure the directorate owns the action plan.

<u>Prescribing Clozapine</u>

- The report was received in March 2019. An action plan is being developed. A lead clinician has been assigned to ensure the directorate owns the action plan.

<u>Mental Health Clinical Outcome Review Programme – National Confidential Enquiry into Suicide & Homicide by People with Mental Illness</u>

- Created a dedicated role for STORM training, arranged update of trainers and delivered a comprehensive rolling training package
- Wrote and submitted zero ambition plan for NHS England – awaiting feedback (this was

initially presented and approved at Trust Board)
- Supported development of "Commonsense Confidentiality" leaflet to support involvement of family/friends in planning of care
- Delivered a number of half day briefing sessions on work of Suicide Prevention group and suicide prevention more broadly
- Supported development of suicide prevention course through recovery college
- Continued participation in countywide suicide prevention group, with plans to launch public-facing multi-agency campaign later in year.

<u>Learning Disability (LD) Mortality Review (LeDeR) Group</u>

- We continue to engage with the group and have reviewed the annual LeDeR report
- Newsletters published by the LeDeR programme, for example in relation to managing constipation, were shared with LD teams.

Our actions as a result of local audits in 2018/19

We reviewed 84 local clinical audit reports in 2018/19 and are taking the following actions to improve the quality of healthcare provided.

Chlamydia and Gonorrhoea partner notification at Northamptonshire Integrated Sexual Health and HIV Service (NISHH)

- We will continue to follow the British Association for Sexual Health and HIV (BASHH) guidelines on management of Chlamydia and Gonorrhoea.
- We will use clear documentation on the Partner Notification template the last sexual intercourse (LSI) date with the contact(s).

Audit of number of treatments provided for patients with Low Back Pain (LBP) verus guidelines recommended by their Keele Start Back Score

- Low score patients treatment sessions will be reduced by offering a four-week group programme instead of the current six weeks
- High score patients may benefit from a more local service providing 1:1 Chronic Back Pain/ Chronic Lower Back Pain (CBT/CLBP).

Evaluation of pathways through Child and Adolescent Mental Health Services (CAMHS) following the introduction of a new service model

- Standardised training in the assessment and use of Children's Global Assessment Scale (CGAS) should be provided for the whole of CAMHS and CGAS scores recorded as standard for all clinicians assessing a child or young person at a transition point in their care or in crisis situations.

Compliance of progesterone only pill protocol

- We will remind staff of the importance of recording missed fields
- We will amend electronic patient record template to provide reminders for all non-compliant fields (for example, late/missed pill advice, further medical advice).

Fluoride provision in Special Care Dentistry

- Staff will continue to use templates already in place
- Staff will be reminded how to claim correctly and for what.
- We will change the disease risk on template to include caries or periodontal disease
- We will amend prescription forms to identify by R4 number instead of NHS number.

Investigations for congenital cytomegalovirus (cCMV) among children with sensorineural hearing loss

- We will undertake identification of newborns with cCMV infection before 21 days of age
- We will undertake treatment of severe cCMV infection before 28 days of age

- We will undertake appropriate investigations for diagnosis of cCMV infection
- We will refer to relevant specialties after the diagnosis of cCMV infection.

Fatigue management

- Patients indicated an increased quality in life following the fatigue management course and most indicated that they would like to attend further fatigue management events. The course will be offered as an ongoing event.

Impact of use of sticker in medical notes

- We will continue to use stickers in both acute Trusts. The colour of the border will be changed to be more visible.

Referring into nutrition and dietetic service for community outpatients and home visits

- We will continue consistent practice across the county
- We will re-design the triaging process for consistency and need for senior staff input
- We will better understand if the pathways provide sufficient guidance by determining the number of patients being referred back into the service
- We will provide further training for administration staff
- We will identify the percentage of patients referred in with nutrition support opting into the service
- We will review the feasibility of having nutritional guidance/templates and direct referral to service within GP systems.

Audit of Attention Deficit Hyperactivity Disorder (ADHD) management within Community Paediatrics

- We will establish the feasibility of developing a SystmOne template for medication reviews
- We will increase awareness of requirement to document blood pressure centile chart and add heart rate (HR) nomogram to SystmOne's template
- We will raise ADHD follow up time as a concern within the Trust
- We will add rating scales to routine follow up.

Compliance of emergency hormonal contraception protocol

- We will remind staff of the importance of recording missed fields
- We will amend electronic patient record templates to provide reminders for all non-compliant fields.

Community beds monthly falls audit

- On a monthly basis, Falls Champions will continue to provide the data about falls leaflets, lying and standing blood pressure and fear of falling until this is fully ingrained into practice – i.e. with results of 90% or more for each area
- The Falls Lead will continue to attend operational meetings and local staff meetings as requested to discuss and offer feedback
- Each unit will discuss their results with other units to share ideas around best practice. Areas that score highly can discuss how they achieved their results with areas that have lower scores.

Antimicrobials point prevalence study, May 2018 and November 2018

- Results were fed back to the Infection, Prevention and Control Assurance meeting in February 2019 and a strategy will be developed to improve urinary tract infection prescribing.

Opioid prescription in Cynthia Spencer Hospice

- Every patient will be given an information leaflet in their admission folder about the effects of strong opioid medication
- We will incorporate pre-written laxatives in drug cards.

Intrauterine device (IUD)/Intrauterine System (IUS) protocol adherence audit

- The current pre-IUD insertion leaflet will be updated to include details of the risks of insertion to aid the consent taking process
- The IUD insertion template in Lilie will be updated to make documentation of pregnancy exclusion prior to insertion clearer.

Re-audit of monitoring of patients for post injection syndrome following Olanzapine long acting injection

- Staff will be reminded of the importance and need for scanning completed monitoring forms into the clinical record as evidence that this monitoring has occurred
- An agreement on where to save the forms in the clinical record and the name of these files should made to ensure they can be easily located
- Staff will be reminded of the use of the new form, which was redesigned to simplify the monitoring record sheet to include only vital information.
- Staff will be reminded that all parts of the form need to be completed.

Audit of compliance with the Policy for Rapid Tranquilisation (RT) in all inpatient wards

- The nursing team will be reminded that all RT incidents are recorded on Datix and documented on patients' SystmOne notes (our policy states that this should be done by the nurse in charge of the shift)
- Nurses must be made aware that on completing a Datix entry for RT they must state what time the doctor was contacted and what time they attended the ward
- We will remind doctors of the requirement in the policy to attend the ward in person as soon as possible. During out-of-hours the expectation is that this should ideally be within 30 minutes of being called
- We will raise awareness of the findings of this report organisationally and present findings at Medicines Management Committee, Adult Governance Meetings, Clinical Audit and Effectiveness Committee and local meetings, as appropriate
- We will explore the feasibility of incorporating an RT record into the Restraint and Seclusion template on SystmOne (at developmental stage)
- We will complete a quarterly RT surveillance
- We will re-audit on a monthly basis to ascertain if improvements have been effective.

Audit of compliance with the policy for primary thromboprophylaxis at St Mary's and Berrywood Adult Mental Health Inpatient Wards, Hospices and the Community Hospital Inpatient Wards

- We will review newly updated NICE Guidelines
- We will raise awareness of the findings of this report organisationally and present findings at Medicines Management Committee, Adult Governance Meetings, Clinical Audit and Effectiveness Committee and local meetings as appropriate
- We will increase awareness of how to use venous thromboembolism (VTE) assessment tool on SystmOne
- We will publish audit findings and best practice via a targeted learning bulletin
- We will include this in the junior doctor's induction
- We will re-audit in 12 months to ascertain if improvements have been effective.

Audit of medicine reconciliation record forms at St Mary's and Berrywood Adult Mental Health Inpatient Wards, Palliative Care Inpatient Wards and the Community Hospital Inpatient Wards

- We will improve doctors' awareness of completion of medicines reconciliation
- We will publish audit findings and best practice via a targeted learning bulletin
- We will raise awareness of the findings of this report organisationally and present findings at Medicines Management Committee, Adult Governance Meetings, Clinical Audit and Effectiveness Committee and local meetings as appropriate
- We will raise awareness of correct allergy documentation on medication charts and publish audit findings and best practice via a targeted learning bulletin
- We will re-audit in 12 months to ascertain if improvements have been effective.

Annual audit of storage and record keeping within NHFT unit bases in relation to use of FP10 Prescription Forms in accordance with Policy MMP005 (prescriber not named on FP10 Prescription Forms)

- We will raise awareness of the findings of this report organisationally and present findings at the Medicines Management Committee
- We will locate pads recorded on the pharmacy database as not collected
- We will keep track of uncollected pads on the database and add records to the database when uncollected pads have been destroyed, and we will complete quarterly checks
- Where reported on the audit questionnaire that details are not current, we request team managers and team leaders to email the Pharmacy Team Administrator with a request to change details on prescription pads. We will update details on pads and destroy old pads as appropriate

- We will inform individual teams of audit findings and best practice via targeted emails. Team managers and leaders are to improve teams' awareness of requirements for completion of FP10 records by devising an FP10 process and ensuring the nominated person and deputy are identified (if not done so already)
- We will provide support as appropriate to the team manager and leader of each unit to review audit results of each unit to:
    - Trace missing pads and prescriptions as far as possible
    - Submit Datix reports for pads and prescriptions that cannot be accounted for.
- We will ask teams to monitor record keeping on at least a monthly basis and provide assurance to the pharmacy on a quarterly basis that policy is being adhered to and to escalate as necessary
- We will re-audit in 12 months to ascertain if improvements have been effective
- We will review the value of record-keeping paperwork after next year's audit of Datix reports for pads and prescriptions that cannot be accounted for.

<u>Prescribing standards audit</u>

- We will produce an updated learning bulletin on allergy documentation to improve the quality of allergy recording
- We will raise awareness of how to cancel prescriptions
- We will raise awareness of the findings of this report organisationally and present findings at Medicines Management Committee, Adult Governance Meetings, Clinical Audit and Effectiveness Committee and local meetings, as appropriate
- We will re-audit in 12 months to ascertain if improvements have been effective.

<u>Baseline audit to assess the compliance of UCAT (South) with recommended physical health monitoring for patients who were commenced or had their antipsychotic changed whilst under their care</u>

- Patients that have commenced treatment, or have had their antipsychotic changed or increased by a UCAT medic now requires physical health monitoring. This should be part of their management plan and needs to be done either at the physical health clinic at Campbell House or via their GP
- The request for physical health monitoring should be documented clearly in a patient's case notes. If the patient refuses to have blood tests and an ECG, then this should be documented in their case notes and the patient should be offered another physical health monitoring in line with recommended guidelines
- If bloods are requested by the GP, then Trust staff will complete a physical health monitoring form

- We will undertake a nurse-led clinic in secondary care to recommended physical heath monitoring at recommended periods while patients are on antipsychotic medication. Early identification of cardiovascular and diabetes risk factors is a feasible option.

<u>An audit of Flumazenil usage in the Trust's Salaried Primary Care Dental Service (SPCDS)</u>

- We will share feedback at peer-review meetings and at the Senior Clinician and Management Group
- We will re-audit annually.

<u>Bi-annual service evaluation of staff communication</u>

- We will provide results of the audit at Senior Clinician and Management Group (SCAM)
- Local discussions will take place at team meetings relating to how we can manage National Safety Standards for Invasive Procedures (NatSSIPs)
- We will revise our toolkit.

<u>National Early Warning Scores (NEWS) – Mental Health & Adult & Child (quarters 1-4)</u>

- We will ensure continual improvement NEWS audits will remain on a monthly basis
- We will implement NEWS2 in all relevant clinical areas
- Ward Managers and Modern Matrons will continue to feed back to all clinical staff to ensure:
    - Those areas that have not achieved 90% will have further training, either online or face-to-face to improve concordance with standards. This will be provided by the Clinical Skills Team
    - The Quality Team have aligned with the Adult and Child pathway and are currently implementing a new audit tool
    - The Clinical Quality Facilitator (CQF) has been visiting ward areas and discussing NEWS with staff and managers, as well as providing up-to-date audit data for wards to work from
    - The CQF provides the Directorate Management Team (DMT) with regular updates on progress of outliers
    - Areas that have access to a Registered General Nurse (RGN) will share these results and complete an action plan.

<u>Nutritional Assessments (MUST) – Mental Health & Adult & Child Q1, Q2, Q3, Q4</u>

- Feedback will be offered by the Clinical Quality Facilitators to ward managers
- Staff to identify where a patient has refused to engage in MUST scoring.

<u>Overview of Electronic and Paper Record Keeping Audit – Mental Health & Adult & Child (quarters 1-4)</u>

- Our teams will improve compliance for areas that are RAG rated as amber by developing team action plans
- All teams will develop a Qualitative Record Keeping Audit
- We will feed back results through pathway meetings.

Transitions from Children's and Young Person's Mental Health Service to Adult Mental Health – AMHS Transitions

- We developed and implemented workshops to enable young people to meet with young adults who had been through the transitions process
- We developed a process so that SystmOne flags all young people from 17 years and six months of age
- We developed a transition to primary care Standard Operating Procedure (SOP).

Supporting people to die in Preferred Place of Death (PPD)

- We adopted the East Midlands End of Life Education Standards
- A training needs assessment has been undertaken using a questionnaire. It explores current opinions of specialist palliative care (SPC) Workforce and Non Malignant Nurse Specialist Workforce, in regards to experience and need for training in SPC and non-malignant, long term conditions
- The End of Life Care Practice Development Team (NHFT) secured funding from Health Education England East Midlands (HEEM) to develop and deliver an end of life care course for preceptor nurses
- The Trust's Practice Development Team have delivered 10 one-day workshops to 86 learners on the use of syringe drivers.

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OUR INCOME

A proportion of the Trust's income in 2018/19 was conditional, based on achieving quality improvement and innovation goals. These goals were agreed between the Trust and the person or body who entered into a contract, agreement or arrangement for the provision of relevant health services, through the Commissioning for Quality and Innovation Income (CQUIN) payment framework. Further details of the agreed goals and for the following 12-month period are available electronically at www.nhft.nhs.uk.

The total monetary income in 2018/19 that was conditional on achieving quality improvement and innovation goals was £3,290,777. Of this, £3,080.385 was from Nene and Corby CCGs.

The CQUIN target is not equally weighted across each quarter. However, achievement against the monetary income that was available at the end of quarter 3 was 86.2%. At the time of publishing, quarter 4 achievement was still to be confirmed by CCG and NHS England.

The total monetary income in 2017/18 that was conditional on achieving quality improvement and innovation goals was £3,341,502. Of this, £3,127,811 was from Nene and Corby CCGs. Achievement against the cumulative CQUIN target at the end of quarter 4 was 87%.

A number of patient-centred successes were noted as part of the CQUIN evaluation process. These outcomes will have a positive and lasting effect for the service users and their carers.

For example, we are continuing to work with our acute colleagues to ensure that people who have attended A&E multiple times in the last year are able to meet with specialist mental health staff for assessment, review and care planning.

This continues to reduce their attendance at A&E and improve the quality of their lives. The Trust continues working to ensure that service users are supported to reduce their tobacco and alcohol intake.

Staff have been trained to offer interventions around smoking and alcohol and various means of communication have been used to raise awareness, inform and educate staff on the importance of screening, intervening and documenting care around tobacco and alcohol consumption.

The Estates and Catering teams continue to review their food supplies in line with the CQUIN requirements.

As a result, the café's offering has changed and healthier products are now more accessible to patients, service users, staff and carers.

NHFT vaccinated 78% of our frontline staff with the flu vaccine. Clinics were offered at various places around the Trust and at different times, including out of hours, to enable staff to attend easily. Flu vaccination clinics were also available at conferences organised by NHFT. Incentives to encourage staff to have a flu vaccine included participation in a weekly prize draw.

The Trust continues to ensure that staff's wellbeing is ensured by offering annual health checks, fitness classes, fitness testing, access to a staff physiotherapist service, sleep and stress webinars, a staff psychological support service and counselling service.

A significant improvement has been achieved in ensuring that service users with a severe mental illness have their physical health monitored and are offered interventions where necessary.

OUR CQC RATINGS

The CQC carried out a comprehensive assessment of our services in June and July 2018. In August 2018, we were very proud to receive an overall 'outstanding' rating from the CQC. This was an improvement on the last inspection in 2017, when we received the rating 'good'. We are proud that we continue to be rated outstanding for 'caring' and we are outstanding for 'well-led'.

	Safe	Effective	Caring	Responsive	Well led	Overall
Acute wards for adults of working age and psychiatric intensive care units	Requires improvement	Good	Good	Good	Good	Good
Child and adolescent mental health wards	Good	Outstanding ☆	Outstanding ☆	Good	Outstanding ☆	Outstanding ☆
Community dental services	Good	Outstanding ☆	Good	Good	Outstanding ☆	Outstanding ☆
Community health inpatient services	Good	Good	Outstanding ☆	Good	Outstanding ☆	Outstanding ☆
Community health services for adults	Good	Good	Good	Good	Good	Good
Community health services for children, young people and families	Good	Good	Good	Good	Good	Good
Community mental health services for people with learning disabilities or autism	Good	Good	Outstanding ☆	Requires improvement	Good	Good
Community-based mental health services for adults of working age	Good	Good	Good	Good	Good	Good
Community-based mental health services for older people	Good	Good	Outstanding ☆	Outstanding ☆	Outstanding ☆	Outstanding ☆
Forensic inpatient/secure wards	Good	Good	Good	Good	Good	Good

	Safe	Effective	Caring	Responsive	Well led	Overall
Long stay/rehabilitation mental health wards for working age adults	Good	Good	Good	Good	Good	Good
Mental health crisis services and health-based places of safety	Requires improvement	Good	Good	Outstanding ☆	Good	Good
Specialist community mental health services for children and young people	Good	Good	Good	Good	Good	Good
Substance misuse services	Good	Good	Outstanding ☆	Outstanding ☆	Good	Outstanding ☆
Wards for older people with mental health problems	Good	Good	Outstanding ☆	Good	Good	Good
Wards for people with learning disabilities or autism	Requires improvement	Good	Good	Good	Good	Good
End of life care	Good	Good	Outstanding ☆	Good	Good	Good

Our results clearly indicate the dedication and hard work of our staff.
Our patients, service users and carers are, and have always been, our highest priority. We are delighted that we were rated as 'outstanding' overall, and in the 'caring' and 'well-led' domains. In the 'safe' domain, our rating has moved from 'requires improvement' to 'good'.

The CQC recognised that our team were helpful and empathetic, and that our service users and carers were respected and valued as individuals. They noted that the Trust had worked hard to produce a strong, visible and person-centred culture. Staff were seen to be highly motivated and delivered kind and compassionate care, which respected the individual choices of patients and protected their dignity. Additionally, staff recognised and respected the individual needs of patients, including cultural, social and religious beliefs. The CQC stated that they were struck by how well staff treated patients and carers. Staff were identified as being discreet, respectful and responsive in all their interactions.

We also know that we continue to have work to do – and that our journey does not end here. In particular, we continue to focus on the 'safe' domain, and improving the safety of the services we provide.

These were the CQC's findings:

- They were particularly impressed by the strength and depth of leadership at the Trust. The Trust board and senior leadership team displayed integrity on an ongoing basis
- The Trust had a senior leadership team in place with the appropriate range of skills, knowledge and experience to perform its role. There had been no recent changes to the executive team. Executive board members were capable, open and responsive to feedback and striving for improvement throughout the organisation
- Non-executive and executive directors were clear about their areas of responsibility.

- The Trust used the organisational risk register as its board assurance framework to support good governance
- Individual directorates were held to account by the board on finance, performance and quality. Business portfolios were well defined and owned by an executive director
- The Trust's leadership team had a comprehensive knowledge of current priorities and challenges across all sectors and took action to address them
- The Trust had a clear vision and set of values with quality and sustainability as the top priorities. The Trust values were: people first, respect and compassion, improving lives, dedication and equality, known by the acronym PRIDE. Values were embedded within Trust processes, for example, staff appraisals, recruitment and staff awards, which were aligned to values. The CQC noted that the Trust's vision and values were embedded at board level and informed how the senior leadership team operated
- They were impressed by the extent that the values of the Trust have been embraced by everyone, and were shown and modelled by all the staff they met. Staff challenged behaviours in each other when necessary
- The Trust ensured patients, families and carers had the opportunities to be active partners in their care. Staff across the organisation worked in partnership with patients and those close to them in an integrated approach
- Patients could give feedback on the service they received in a number of ways, for example, via 'I want great care' feedback forms. The Trust shared this information with teams. The wards held regular meetings with full patient involvement
- Staff held patients at the centre of everything they did. Trust values were found to be embedded in staff behaviours with patients across all services. Staff and patients co-produced projects and they saw many examples where patients were at the centre of the Trust's activities
- The Trust involved patients in decisions about the service. Some patients were working with the Involvement team at the Trust. Patients were involved in changes to service provision and planning of new services
- Staff always communicated with patients sensitively and compassionately so that they understood their care and treatment. They used a range of methods of communication including using signers, easy read leaflets, and they sought support from carers and families where appropriate
- Staff had excellent links with other services to enhance the care of their patients. Staff consistently signposted patients to an extensive range of other services such as third sector organisations, carers groups, Alzheimer's society, Age Concern, Mind and the Citizens Advice Bureau
- Staff knew how to raise concerns about disrespectful, discriminatory or abusive behaviour or attitudes without fear of the consequences, and knew this would be acted upon. The CQC noted that they saw evidence that staff were increasingly raising concerns openly and incidents of anonymous contacts to the Freedom to Speak Up Guardian had reduced. This evidenced that open and transparent culture was fully embedded

- The inspectors were also impressed by the Trust's attitude towards innovation and service improvements. The delivery of innovative and evidence-based high quality care was central to all aspects of the running of the service. There was a true sense of desire to drive service improvement for the benefit of patients, carers, and the wider system, evident throughout the inspection
- The Trust had robust systems and processes for managing patient safety. Staff recognised when incidents occurred and reported them appropriately.

Additionally, the CQC identified that the Trust responded in a very positive way to the improvements they asked them to make following the inspection in January 2017.

Following the inspection, we developed an action plan to meet the requirements of the CQC inspection. This plan has been actively managed and scrutinised by the Quality Forum and Quality and Governance Committee, with the Board's oversight.

As part of our relationship monitoring arrangements, the CQC inspection team have advised that they are satisfied with our methods for addressing our actions. Below is an overview of our approach to managing the required actions:

- Focusing on project managing activity building on previous good practice
- Establishing the process and ensuring staff are clear on their responsibility
- Achieving clarity on our priority areas by focusing on the Safe domain
- Maintaining a future focus to ensure we have a resilient plan to maintain our rating
- Establishing agreed governance assurance process to monitor delivery of actions.

The full service reports and overall Trust report can be found on the CQC's website.

NHFT CQC SERVICE LEVEL RATINGS TABLES 2018

Ratings for the whole trust

Safe	Effective	Caring	Responsive	Well-led	Overall
Good ↑ Aug 2018	Good →← Aug 2018	Outstanding →← Aug 2018	Good →← Aug 2018	Outstanding ↑ Aug 2018	Outstanding ↑ Aug 2018

The rating for well-led is based on our inspection at trust level, taking into account what we found in individual services. Ratings for other key questions are from combining ratings for services and using our professional judgement.

Ratings for community health services

	Safe	Effective	Caring	Responsive	Well-led	Overall
Community health services for adults	Good ↑ Aug 2018	Good →← Aug 2018	Good →← Aug 2018	Good →← Aug 2018	Good →← Aug 2018	Good →← Aug 2018
Community health services for children and young people	Good Mar 2017	Good Mar 2017	Good Mar 2017	Good Mar 2017	Good Mar 2017	Good Mar 2017
Community health inpatient services	Good ↑ Aug 2018	Good ↑ Aug 2018	Outstanding ↑ Aug 2018	Good →← Aug 2018	Outstanding ↑ Aug 2018	Outstanding ↑↑ Aug 2018
Community end of life care	Good Mar 2017	Good Mar 2017	Outstanding Mar 2017	Good Mar 2017	Good Mar 2017	Good Mar 2017
Community dental services	Good Mar 2017	Outstanding Mar 2017	Good Mar 2017	Good Mar 2017	Outstanding Mar 2017	Outstanding Mar 2017
Overall*	Good ↑ Aug 2018	Good →← Aug 2018	Outstanding ↑ Aug 2018	Good →← Aug 2018	Outstanding ↑ Aug 2018	Outstanding ↑ Aug 2018

*Overall ratings for community health services are from combining ratings for services. Our decisions on overall ratings take into account the relative size of services. We use our professional judgement to reach fair and balanced ratings.

Ratings for mental health services

	Safe	Effective	Caring	Responsive	Well-led	Overall
Acute wards for adults of working age and psychiatric intensive care units	Requires improvement →← Aug 2018	Good →← Aug 2018	Good →← Aug 2018	Good →← Aug 2018	Good →← Aug 2018	Good →← Aug 2018
Long-stay or rehabilitation mental health wards for working age adults	Good Mar 2017	Good Mar 2017	Good Mar 2017	Good Mar 2017	Good Mar 2017	Good Mar 2017
Forensic inpatient or secure wards	Good Mar 2017	Good Mar 2017	Good Mar 2017	Good Mar 2017	Good Mar 2017	Good Mar 2017
Child and adolescent mental health wards	Good Mar 2017	Outstanding Mar 2017	Outstanding Mar 2017	Good Mar 2017	Outstanding Mar 2017	Outstanding Mar 2017
Wards for older people with mental health problems	Good Mar 2017	Good Mar 2017	Outstanding Mar 2017	Good Mar 2017	Good Mar 2017	Good Mar 2017
Community-based mental health services for adults of working age	Good ↑ Aug 2018	Good →← Aug 2018	Good →← Aug 2018	Good →← Aug 2018	Good →← Aug 2018	Good →← Aug 2018
Mental health crisis services and health-based places of safety	Requires improvement →← Aug 2018	Good →← Aug 2018	Good →← Aug 2018	Outstanding ↑ Aug 2018	Good →← Aug 2018	Good →← Aug 2018
Specialist community mental health services for children and young people	Good Mar 2017	Good Mar 2017	Good Mar 2017	Good Mar 2017	Good Mar 2017	Good Mar 2017
Community-based mental health services for older people	Good →← Aug 2018	Good ↑ Aug 2018	Outstanding ↑ Aug 2018	Outstanding ↑ Aug 2018	Outstanding ↑↑ Aug 2018	Outstanding ↑↑ Aug 2018
Community mental health services for people with a learning disability or autism	Good Mar 2017	Good Mar 2017	Outstanding Mar 2017	Requires improvement Mar 2017	Good Mar 2017	Good Mar 2017
Overall	Good ↑ Aug 2018	Good →← Aug 2018	Outstanding →← Aug 2018	Good →← Aug 2018	Good →← Aug 2018	Good →← Aug 2018

Overall ratings for mental health services are from combining ratings for services. Our decisions on overall ratings take into account the relative size of services. We use our professional judgement to reach fair and balanced ratings.

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

OUR REGISTRATION STATUS

The Trust is required to register with the Care Quality Commission (CQC). We confirm that all our services are registered and we have no conditions of registration. The CQC has not taken any enforcement action against the Trust during 2018/19.

In 2018/19 we participated in a special review by the Care Quality Commission called Opening the Door to Change. The CQC was asked to undertake this review by the Secretary of State for Health and Social Care. The CQC, alongside NHS Improvements, was asked to look at issues in NHS trusts that contribute to Never Events taking place.

The review sought to answer four questions:

1. How do trusts regard existing guidance to prevent Never Events?
2. How effectively do trusts use safety guidance?
3. How do other system partners support the implementation of safety guidance?
4. What can we learn from other industries?

Our staff were interviewed as part of this process and their views were fed into the Opening the Door Report and its recommendations.

The outcomes from this report were aimed at national bodies and groups (for example, the National Patient Safety Alert Committee and NHS Improvement), rather than Trust and NHS providers. As a result, the Trust has not taken any specific action to address the recommendations.

The Trust was part of a CQC System Review for the county of Northamptonshire.

This review was carried out following a request from the Secretaries of State for Health and Social care, and for Housing, Communities and Local Government to undertake a programme of 20 targeted reviews of local authority areas. The purpose of the review is to understand how people move through the health and social care system with a focus on the interfaces between services.

A countywide action plan has been produced following the review and all organisations have representation in the system project group, which is ensuring all actions are implemented.

WHAT ARE NEVER EVENTS?

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

In 2018/19, the Trust instigated a Serious Incident investigation into a Never Event linked to the medication Methotrexate. This incident occurred within a prison healthcare setting, there was no harm to the patient, learning was identified and shared within other NHFT prison healthcare teams.

SERIOUS INCIDENTS (SIs)

Total SIs declared by the trust in 2018/19	Incidents entered onto STEIS* (This number includes the 23 SIs declared to the left)	STEIS downgrades requested*	SIs declared in Adult Mental Health and Learning Disabilities Specialty Services	SIs declared in Adult and Children's Services
23	48	21	10	13

Never event declared by the trust in 2018/19

1

* STEIS is the national system on which SI investigations are logged. In addition to SIs some Commissioners insist upon certain types of incidents being logged on STEIS prior to being declared an SI. A downgrade request is submitted to Commissioners when an initial review has been completed and it has been determined that an SI investigation is not indicated. There are also instances whereby a Commissioner refuses a downgrade or insists upon an SI being declared.

The following explains how we managed Serious Incidents (SIs) this year, and our learnings to take forward into next year.

- All incidents likely to require further investigation, prior to going through the Internal Assurance Meeting (IAM) process, are reviewed at directorate team meetings of the Adult & Children's directorate and the Adult Mental Health, Learning Disabilities and Specialty Services directorate.
- The IAM meeting reviews and evaluates incidents against local policies and the NHS England SI Framework, and considers what level of further investigation is required. Attendees include service managers, medics, experienced clinical leaders and subject matter experts.
- As standard and where appropriate, patients, service users and carers are offered the chance to participate in the investigation of incidents in which they are involved. This contributes to the terms of reference prior to the investigation, and includes engagement in a debrief with the investigator following the report's completion.
- This approach is also applied to concise investigations (previously known as clinical reviews), which are investigations of incidents that do not meet the criteria for a serious incident investigation, but meet the criteria for internal review.
- A large project has recently been completed that enables the Patient Safety Team to monitor and manage individual actions recommended following an investigation.
- Prior to this, action plans were only reviewed after all the actions were completed. This information is now live on Datix and is being shared with Operational teams to further strengthen this process.

- **Training to support managing SIs:** Together with our three dedicated serious incident investigators, we continue to develop the investigation process, extraction of learning and quality of investigation reports.
- Root Cause Analysis training is available to appropriate staff via an external provider. The Trust is currently developing its own training with the support of patients with specialist knowledge and experience of this area. The training will incorporate recent Human Factors work.

A PARENT'S STORY

"As a parent of a child with both physical and mental health challenges, I often find myself feeling incredibly alone and exhausted. Alone as I am desperately trying to link in all the different professionals, and exhausted from the frustration of how some systems operate. I started working within participation after my daughter started, as I was hopeful that I might be able to help.

As a whole, I had found CAMHS to be responsive and helpful, but I still felt that I could be helpful in development. Since starting with participation in CAMHS, I have been a member of interview panels and attended parent involvement groups. I love going to groups, and meeting other people who can relate to my experience.

I appreciate that Ellie is always available for 1:1s and check ins, particularly if there is something that I feel passionate about sharing (for me, social media is an area of interest). We then see if we can build a project from this. I sometimes feel like Ellie is busy, but I know she will always get back to me.

Being involved has really opened my eyes to all the different work going on, and I've genuinely enjoyed participating with different staff, parents and other professionals. It's done me a great service in not only improving my awareness, but giving this whole experience a silver lining. It's an incredible feeling to know that my experience and my child's experience is being so valued and heard."

OUR RECORDS

NHS Number and General Medical Practice Code Validity

The Trust submitted records during 2018/19 for the Secondary Uses Service. These are included in the latest published data for Hospital Episode Statistics.

The percentage of records in the published data that included the patient's valid NHS number was:
99.6% for admitted patient care
99.9% for outpatient care

The percentage of records in the published data that included the patient's valid General Medical Practice Code was:
99.7% for admitted patient care
99.7% for outpatient care

OUR INFORMATION GOVERNANCE

The Trust is required to complete the NHS Digital Information Governance Toolkit annually. National toolkit reporting requirements have changed for 2018/19 and trusts are required to complete the new Data Security and Protection Toolkit. This toolkit is a self-assessment tool that requires organisations to provide assurance against the ten National Data Guardian Standards. The toolkit sets organisations 149 information governance and security requirements to be met across the 10 standards. Our overall score for this new 2018/19 toolkit submission is 96.6%.

OUR CLINICAL CODING AUDIT

A Terminology and Classifications Delivery Service approved auditor undertook the Clinical Coding Audit of ICD-10 in line with the Data Security and Protection Toolkit requirements using the suggested audit sample size of 50 episodes. These episodes contained a total of 292 individual codes with a 98% accuracy for primary diagnoses and 98.35% for secondary diagnosis. These results should not be extrapolated further than the actual sample audited.

OUR LEARNING FROM DEATHS

During 2018/19, 244 deaths were reported on Datix. As we are not an Acute Trust, the National Quality Board's guidance directs us, as a community or mental health Trust, to focus upon a cohort from within our inpatient areas. It should therefore be noted that of these 244 deaths, 24 occurred within this cohort.

The following number of deaths occurred in each quarter of the reporting period:

- 58 in the first quarter
- 60 in the second quarter
- 66 in the third quarter
- 60 in the fourth quarter.

By 31 March, 30 case record reviews or investigations had been carried out; an additional 6 deaths outside of scope were also reviewed.

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

- 9 in the first quarter
- 7 in the second quarter
- 3 in the third quarter
- 11 in the fourth quarter.

Of the 30 deaths in scope, 2 (0.8% of the 244) are judged more likely than not to have been due to problems in patient care, as follows:

- For the first quarter 0 representing 0%
- For the second quarter 1 representing 0.4%
- For the third quarter 1 representing 0.4%
- For the fourth quarter 0 representing 0%.

These numbers have been estimated using the evaluated outcome of a formal root cause analysis investigation or the Learning From Deaths Structured Judgement Review Tool.

Key learning and actions from deaths following review/investigation:

- The Urgent Care and Assessment Team (UCAT) should review the skill mix and involvement of assistant psychologists in telescreening service users to determine whether their skills and competencies are best utilised in a different way, such as providing specific interventions for Primary Care Liaison (PCL) clients. This will enable other qualified staff to concentrate on tele-screening service users referred to UCAT.
- The Business Intelligence Unit of the Trust should generate from SystmOne, the electronic patient record system, a report showing the deaths of service users with an open referral to a mental health team, with 'death' cited as reason for discharge, or with a date of death already entered on the service user's record. This will facilitate timely reporting of deaths and ensure that initial Duty of Candour and Being Open conversations are promptly carried out in line with policy.
- All urgent referrals to UCAT should be telescreened, before a decision is made as to whether the referral can be downgraded. The decision to downgrade should only be made following agreement by all relevant parties involved, including the referrer.
- All operational teams within Improving Access to Psychological Therapies (IAPT) to deliver a clinical skills session on effectively communicating to patients the step up process and their available support once they are placed on the Step 3 waiting list.
- Explore opportunities for technological solutions to alert services on different clinical systems (for example, IAPTus and SystmOne) that a service user is being seen by another healthcare professional.
- Education and guidance should be provided to GPs regarding what constitutes an urgent referral. This should include the level of information required in the referral to support the screening process.
- A review has been undertaken in skill mixes to divert Assistant Psychologists from screening duties to focus on providing specific interventions for PCLW clients. This will enable other qualified staff to concentrate on tele-screening service users referred to UCAT.
- A statement has been sent to remind the team of their responsibilities in relation to Adult Community Mental Health Services operating policy and a random audit of 20 urgent referrals within 6 month period, North and South of county will be undertaken; to evidence that patients are being contacted in line with the policy.
- Clinical skills sessions will be instigated and led by an IAPT Senior Step 2 worker/Step 3 therapist for each operational team.

- With performance analyst support, we will explore if SystmOne and IAPTus can communicate to one another if a service user is under more than one service. If this is not possible, we will consider a week-daily report of IAPT service users who also open to other mental health teams on SystmOne.
- Additional education and guidance for referring into services and the level of urgency will be fed back to GPs via appropriate forums, including Protected Learning Time (PLT) and Local Medical Committee.
- Specific action plans relating to investigations of deaths are monitored by the Patient Safety Team and the Directorate Management Teams. Action plans for these deaths in this reporting period are yet to be fully concluded.
- The Patient Safety Team will implement a process for impact assessments of actions relating to reviews or investigations during 2019/20.
- Actions reported during 2018/19, relating to carer and family engagement in care and during investigations has received positive feedback from Patient Experience Groups and the 'Common Sense Confidentiality' guide was developed to support carers, families and staff if a patient declined consent to share information. Actions taken to develop this guide, alongside Duty of Candour training refresh and piloting 'Difficult conversation' workshops has led to increased awareness of the need to include families and carers in care.
- There were no case record reviews and one investigation completed during 2018/19 that relates to a death that occurred in 2017/18. This number has been estimated using Datix, the Trust's incident reporting system and evaluated outcome of a formal root cause analysis investigation. One death representing 0.3% of the patient deaths during 2017/18 was judged to be more likely than not to have been due to problems in the care provided to the patient.

OUR DATA QUALITY

The Trust's data quality is assured by an automated process that identifies the incorrect patient demographics, including NHS numbers, postcodes, and GP registration, and prevents duplicates. It also prevents impossible errors at patient level reporting for each service so that gender and age patient treatments are appropriately aligned. This makes sure that the reporting of access times for patients seen, and wait times for patients still waiting to be seen, are recorded through our established performance framework meetings.

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

Risks to data quality in this area are managed through weekly communication between the performance team and clinical service leads, and dashboard reporting. In 2019/20, the Trust is planning a Data Quality Oversight Group to collaboratively facilitate health records with operational input to strengthen data availability and integrity. This would include the clinical support, information governance and performance team.

Our assurance processes work from Board to Ward. At Board level, we have an Integrated our Performance Dashboard, which allows the Board to scrutinise performance and triangulate data quality.

This has worked very effectively and has been supplemented by similar dashboards at a Directorate level that are monitored and acted on by divisional management teams. Additionally, a workforce-focused dashboard has also been implemented. These supplement and work alongside our SMART web-based reporting tool, which provides information to all staff.

Every staff member has a responsibility for ensuring data quality. This accountability is included in all new job descriptions, in accordance with the requirements of the Data Security and Protection toolkit (DSPT). Targeted training complements this, and is available to assist staff and user forums for our core clinical system. Data quality issues are raised and managed at a monthly Performance, Information and Data Quality Group Meeting, which is held with senior operations staff and the performance and informatics teams.

Routine data quality outcomes modules are established and implemented to ensure improvement plan measures effectiveness. The data quality team runs Mental Health Services Data Sets and Community Information Data Sets to improve performance. In accordance with the DSPT, the Trust undertakes an annual programme of data quality monitoring and audit. Service managers support the implementation of action plans based on the recommendations for change arising from the findings of monitoring and audit activities. The data quality team also carries out audits of compliance with established procedures on a six-monthly basis on a targeted basis. The existing NHFT Data Quality Policy will be reviewed and ratified by January 2020.

REPORTING AGAINST CORE INDICATORS

This table shows how we have performed against key core indicators set by NHS Improvement. NHS Digital makes data available from outside the Trust for the following relevant indicators. Unless indicated otherwise, Trust performance against indicators is based on data collected by the Trust and held on Trust IT systems.

Indicator	Trust score 2016/17	Trust score 2017/18	Trust score 2018/19	National average score	Ft highest score 2018/19	Ft lowest score 2018/19	Non ft highest score 2018/19	Non ft lowest score 2018/19
Care Programme Approach (CPA) 7 days^	97.7%	97.93%	98.50%	95.7%	100%	83.5%	100%	87.8%
Admissions to acute wards*	96.4%	96.67%	96.51%	98.12%	100%	88.2%	100%	90.9%
Readmissions to hospital within 28 days discharge (i) 0 to 15	2.94%	3.51%	TBC May	10.00%	13.6%	0% (5.74%)	14.94%	0% (3.75%)
(ii) 16 or over	7.09%	5.35%	TBC	11.45%	17.2%	0% (4.88%)	17.72%	0% (3.35%)
Patient experience Community Mental Health services' indicator score**	87%	86%	6.6				7.7 (all trusts)	5.9 (all trusts)
Patient safety incidents - number	1963	2,822	3173	3,381	9,204	16	5,188	1,330
Patient safety incidents - rate	35.83	54.24	57.5		114.3	24.9	96.6	26.2
Patient safety incidents - severe harm/death number	7	14	6	36.7	239	1	88	0
Patient safety incidents - severe harm/death rate	0.36%	0.5%	0.2%	1.2%	3.7%	0.2%	2.8%	0.0%

Data is 2017/18 benchmarking - to be updated for 2018/19 in mid May 2019.
^ The Trust has further improved performance since last year.
*The Trust has maintained performance above target for the gatekeeping of acute mental health admissions.
**This is new methodology. Our maintained performance reflects our iWGC reports and service evaluations.

This is the data made available to the Trust by the Health and Social Care Information Centre with regard to the number and, where available, rate of patient safety incidents reported within the Trust during the reporting period, and the number and percentage of such patient safety incidents that resulted in severe harm or death.

2018/19 data provided is as published by the National Reporting and Learning System (NRLS) March 2019 for the period 1 April 2018 to 30 September 2018. The available data set that allows benchmarking of this information provides a rate per 1,000 bed days. As a mental health and community trust, our rate will show inflation, as it does not take into consideration community contacts. This will be an issue for all mental health and community trusts.

STATEMENTS OF ASSURANCE FOR SELECTED CORE INDICATORS

Indicator	Trust Score	NHFT considers that this data is described for the following reasons:	NHFT has taken the following actions to improve our score, and so the quality of its services, by:
The data made available to the National Health Service Trust or NHS Foundation Trust with regard to the percentage of patients on Care Programme Approach who were followed up within seven days after discharge from psychiatric inpatient care during the reporting period.	98.50%	The Trust has further improved performance since last year.	The alert system implemented in 2016/17 from wards to community services continues to ensure all patients are prepared for discharge and follow-up arrangements are fully in place. The wards continue to ensure correct contact details for the service user are available to community services.
The data made available to the National Health Service Trust or NHS Foundation Trust with regard to the percentage of admissions to acute wards for which the Crisis Resolution Home Treatment Team acted as a gatekeeper during the reporting period.	96.51%	The Trust has maintained performance above target for the gatekeeping of acute mental health admissions.	The continued deployment and development of the acute mental health liaison service, alongside improved reporting mechanisms continue to ensure performance is maintained above target.
Patient experience of community mental health services indicator score with regard to a patient's experience of contact with either a health or social care worker.	6.6	NB: there is a new methodology for this indicator. Maintained performance reflects our iWGC reports and service evaluations. Data is taken from the Community Mental Health Survey.	Continuing development and implementation of co-produced recovery groups, who review the production of care planning and delivery of care. This ensures our service users and carers are an integral part of our service planning and delivery both on an individual and strategic level.

The data made available to the National Health Service Trust or NHS Foundation Trust with regard to the number and, where available, rate of patient safety incidents reported within the Trust during the reporting period, and the number and percentage of such patient safety incidents that resulted in severe harm or death.	3,173 57.5 6 0.2%	These scores reflect that the Trust continues to make reporting of (and learning from) incidents a priority. 2018/19 data provided is as published by NRLS March 2019 for the period 1 April 2018 to 30 September 2018. The available data set that allows benchmarking of this information provides a rate per 1,000 bed days. As a mental health and community trust, our rate will show inflation, as it does not take into consideration community contacts. This will be an issue for all mental health and community trusts.	The Trust has invested resource into simplifying the incident data capture process and review and sign off processes encouraging the reporting of incidents and improving its accuracy to support learning.

ACCREDITATION SCHEMES

The following services have undertaken the following accreditation schemes during 2018/19. Participation in these schemes demonstrates that staff members are actively engaged in quality improvement and take pride in the quality of care they deliver.

SCHEME		SERVICE	ACCREDITATION STATUS
Care Quality Commission (CQC) grading			In 2018 we were thrilled to receive a rating of 'outstanding' from the CQC.
Acute Inpatient Menta Health Services (AIMS)		All adult inpatient wards at Berrywood Hospital, and the Forest Centre, St Mary's Hospital	We are AIMS accredited.
Workplace Wellbeing Charter			This accreditation demonstrates our commitment to the health and wellbeing of our workforce. These standards reflect best practice and are endorsed nationally by Public Health England.
Living Wage Employer			The real Living Wage is based on the cost of living and is voluntarily paid by 3,500 UK employers who believe a fair day's work deserves a fair day's pay. NHFT is proud to have been accredited as a Living Wage employer.
Northamptonshire Carers Association – Level Three Accreditation			We are very proud to have reached the highest level of this scheme set up by Northamptonshire Carers to encourage employers to provide better opportunities for carers.
Armed Forces Covenant Employer Recognition Scheme - Silver			We are proud to be supportive of those who serve in the armed forces, including veterans, reservists, cadets and forces families.
Investors in the Environment, Green Award 2018			The national accreditation scheme looks at our environmental management plan to make sure we are reducing our core emissions, including gas, electricity and waste, by 2% per year. The Trust has done exceptionally well by managing to reduce carbon emissions by 24%.
Disability Confident Employer			The Trust is an accredited disability confident employer under the government scheme, which works with employers to remove barriers, increase understanding and ensure that disabled people have the opportunities to fulfil their potential and realise their aspirations.
Gold Standards Framework (GSF) (Leads to the GSF Hallmark Award in End of Life Care)		Danetre Hospital (Community Beds)	GSF accreditation at Care Homes standard.
Accreditation for Inpatient Mental Health Services (AIMS)	AIMS - WA (Working Age Units)	Mental Health In-patients (working age)	**Cove: AIMS peer review** 11th September 2017 (awaiting report) Cove Ward, Berrywood – Aims Accreditation 25 Aug 2018 to 6 Mar 2021 **Bay AIMS peer review** 21 Sept 2017 (awaiting report) Bay Ward, Berrywood – Aims Accreditation 6 Mar 2018 to 6 Sept 2019 **Harbour AIMS Peer review** 20 Sept 2017 (awaiting report) Harbour Ward, Berrywood – Aims Accreditation 29 May 2018 to 6 Sept 2020 **Kingfisher AIMS Peer review** 12 Oct 2017 (awaiting report) Further evidence required to support and deferred till 29 Jan 2019. Awaiting report from the further submission. **Avocet AIMS Peer review** 27 Jun 2017 (awaiting report) 30 Oct 2018- further evidence required to support and deferred till 29 Jan 2019. Awaiting report from the further submission. **Sandpiper AIMS Peer review** 21 Jun 2017 (awaiting report) 5 Nov 2018 accredited.

SCHEME		SERVICE	ACCREDITATION STATUS
	AIMS - PICU (Psychiatric Intensive Care Units)	Intensive Care Unit – Mental Health	Marina Accredited Marina Ward, Berrywood – Aims Accreditation 5 Sept 2017
	AIMS - OP (Wards for Older People)	Older People's Mental Health In-patient Service	Orchard & Spinney wards (The Forest Centre) Accredited Sept 2016 The Forest Centre Accredited and has re-accreditation visit due in May 2019 Brookview and Riverside (Berrywood Hospital) Accredited February 2015 At the time of publishing, Brookview and Riverside are awaiting the outcome of their reassessment accreditation visit
	AIMS - Rehab (Rehabilitation wards)	In-patient Rehabilitation Mental Health	Meadowbank Accredited June 2017 Meadowbank, Berrywood – Aims Accreditation 23 May 2017 to 22 May 2020
	Quality Network for Inpatient CAMHS (QNIC)	CAMHS Inpatient Services	The Burrows Accredited May 2015 A peer review was held in January 2018 and a full will be conducted 2 May 2019 The Sett QNIC Peer review 11 Jan 2018 (awaiting report) The Sett was QNIC accredited in November 2018 until April 2021
	Quality Network for Forensic Mental Health Services (QNFMH)	In-patient Mental health – low secure	Wheatfield Peer review 2 February 2018 Wheatfield, Berrywood had a full inspection 20 Feb 2017and a peer review was held 30 April 2018.
ECT Accreditation Scheme (ECTAS)		The Treatment Centre	Accredited Accreditation is scheduled for 20 Jun 2019.
rTMS		Quayside	Has received RCN accreditation for training events.
Eat out, Eat well Accreditation Scheme		The Trust's hospital cafes	Berrywood Silver accreditation Cynthia Spencer Gold accreditation Danetre Gold accreditation Isebrook Gold accreditation St. Mary's Gold accreditation
Wellbeing charter			Accredited November 2017
Investors in the Environment			Green Award 2018 For reducing our carbon emissions by 24%. [(This is the reduction against the baseline measured in 2010)]
Gold Standards Framework - Hospital End of Life Care (Leads to the GSF Hallmark Award in End of Life Care)		Danetre In-patient Ward, Danetre Hospital (Community Beds)	GSF accreditation at Hospital Standard - awarded September 2018. Danetre had previously achieved Care Homes Standard before the Hospital Standard was available.

PATIENT AND FAMILY LIAISON

A dedicated Patient and Family Liaison Lead (P&FLL) joined the Trust in September 2017.
Their role is to support patients, service users and their families or carers during serious incident investigation or concise investigation process or Structured Judgement Review.

During investigations the P&FLL will:

- Remain independent from the investigation
- Make contact with the patient, service user, carer or family
- Aim to attend the first meeting with the patient/family and the investigator to eliminate the need to discuss potentially upsetting circumstances more than once
- Provide appropriate support until conclusion of the Investigation or Coroner's Inquest, whichever is the latter.

Support provided by the P&FLL may be in person, via phone or email, and includes:

- Signposting to other organisations, such as support organisations and service provision (e.g. Northamptonshire Carers, The Compassionate Friends, SANEline, The Lowdown, SOBS, Cruse, volunteer drivers, befriending) and information on access to medical records
- A booklet of relevant support organisations
- Individual or separate support, depending on need, for the patient, family or carers
- Passing any questions or information raised by the patient, family or carers to the investigator
- Being present at feedback of the investigation to explain terminology and be a listening ear for concerns or feedback
- Sharing relaxation techniques and mindfulness courses, as directed by the Head of Psychological Therapies.

A close working relationship has been developed with the local Coroner's Office and they are aware of all cases supported by the P&FLL.

How the P&FLL works with the Coroner's Office:

- The Coroner can ask the P&FLL to help families return key paperwork in a timely way
- Patients, families and carers are supported before and during the Inquest. This can include discussing what the inquest may be like, what to expect, the room, how it will run, getting there and parking
- The P&FLL attends the Inquest to support the family and introduce them to any NHFT staff present
- The P&FLL keeps a record of all contact with patients and families and any key discussion points.

If the Trust is undertaking a Structured Judgement Review (SJR) under the Learning From Deaths criteria, the P&FLL will:

- Write to the family to make them aware of the (not for cause) review and ask them to express any concerns
- Report any issues to the reviewer

- Raise any patient or family concerns that arise after the SJR, through the PALS/ Complaints process.

The P&FLL monitors the Trust's compliance with the initial notification element of the Duty of Candour process. The P&FLL will:

- Carry out the work on Datix
- Cover incidents documented on Datix as moderate harm and above
- Ensure that an initial conversation is carried out with the patient or their next of kin by the most appropriate person
- Make a record of that conversation on Datix and SystmOne
- Prompt the team to have that conversation if it has not been carried out. This is particularly important where it is not clear if the incident will lead to a Serious Incident Investigation or Concise Investigation
  – the aim is to ensure that contact from an investigator is not the first time the patient or family has heard from the Trust
- Monitor compliance for incidents that do not meet the threshold for Duty of Candour.

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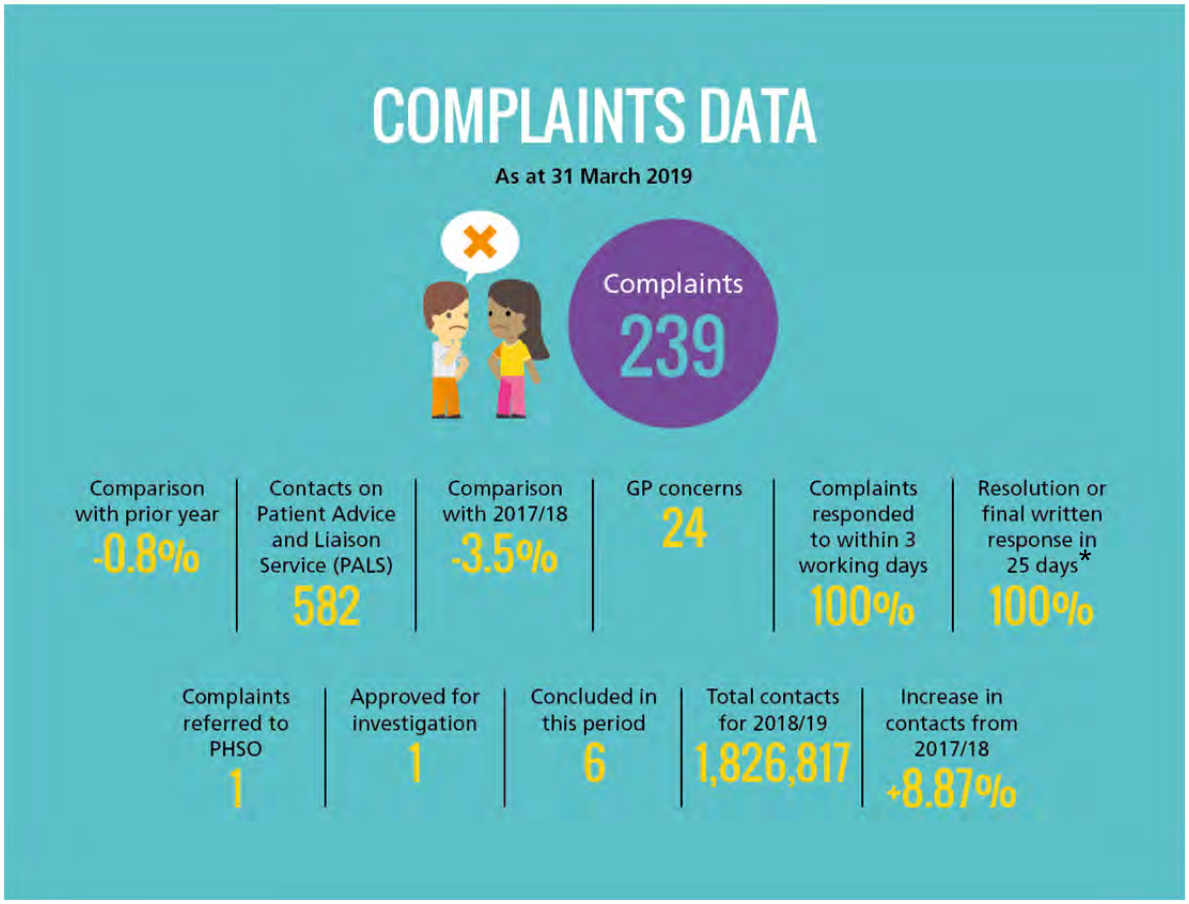


**In a number of cases, the timeframe may need to be negotiated with the complainant so a full and detailed analysis of their complaint can be undertaken.*

We continue to review systems and processes to ensure that learning and improvements from complaints and concerns are part of our core activity and robust action is taken to put things right when required. We also continue to extend our partnership working with other trusts in order to undertake joint investigations and share learning.

We have a good working relationship with the Parliamentary and Health Service Ombudsman (PHSO) and Care Quality Commission (CQC).

Our peer review process is now run as a highly successful forum bringing together staff, service users and carers. This identifies learning and develops a high quality complaints management process.

In addition to managing queries from patients and carers, the Complaints and PALS Team continue to appropriately manage queries received from MPs and GPs. The team also ensures that detailed themed reports are provided to the Complaints Review Committee (CRC) on a quarterly basis and closely monitors complaints on an annual basis.

A PATIENT'S STORY

"Coming to CAMHS was overall a good experience. Everyone I met was friendly and seemed like they wanted to help me. At times I felt like I waited too long for help, but when I did get the help it was just what I needed. Towards the end of my time with my therapist, she told me about participation and getting involved with the service. Then I met with Ellie (participation worker) and we spoke about my experience with CAMHS, and how we might use my experience to help other people. I really liked this.

I've found Ellie to be supportive, and I always feel like she is on my side. I like how she makes me feel like I can be completely honest. We have 1:1 meetings where we talk about how I'm feeling, which is great as it means we have trust in each other for our work. It also means that I feel comfortable telling Ellie if things are too much, or if an activity isn't for me.

I recommend participation to anyone who is interested, it has helped me to improve my confidence and makes me feel really good.

It's good to know that my voice is going to change things for other young people, and it has made me really interested in working in mental health for a career.

I've met new people, and learnt about other people's experiences. I mostly go to groups, do 1:1 projects about endings and discharge, and am hoping to be a part of interview panels after I have attended training in April 2019. I'm really excited about what is to come, and am really grateful for the experience CAMHS have given me."

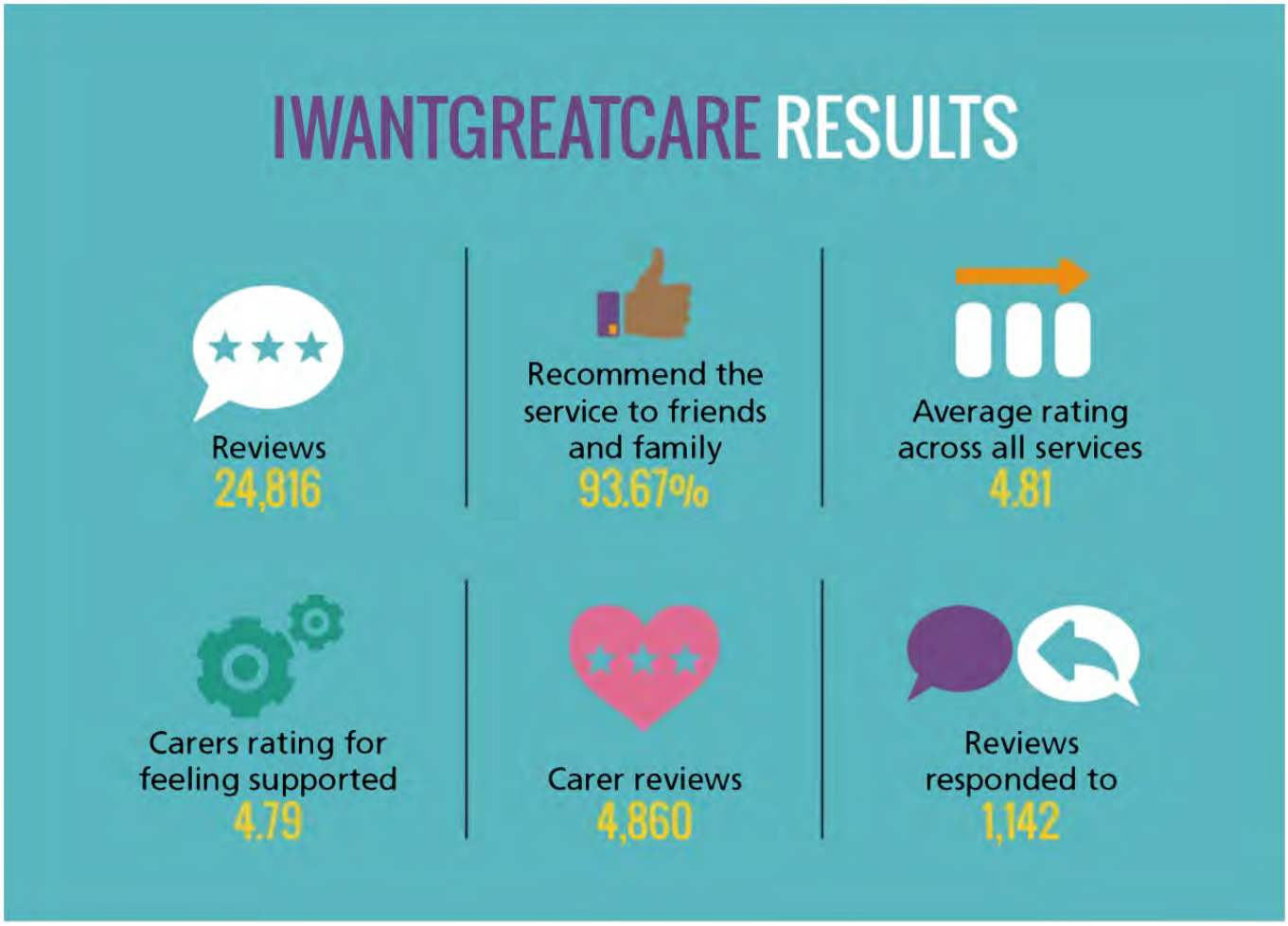
iWANTGREATCARE

Central to quality is the gathering and use of patient (and carer) feedback to improve patient experience and quality of care through the constant review and improvement of services.

Feedback is gathered from complaints, incidents, PALS contacts, compliments and letters of appreciation and, more systematically, through iWantGreatCare (IWGC).

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

Assurance from services is gained through the service management reporting structure, governance meetings and patient experience groups. Responses are required for those reviews which contain a negative aspect or suggestion for improvement (typically 5% of total). Reviews, comments and responses through iWGC are published on the iWGC public website.



IWANTGREATCARE RESULTS

Month/year	Total number of reviews	Likely to recommend	Kindness and compassion of staff	Info. About care and treatment	Involvement	Dignity and respect	Ave. 5 Star rating
April	2266	92.8%	4.88	4.74	4.77	4.88	4.79
May	2319	93.23%	4.91	4.78	4.81	4.92	4.81
June	1991	93.17%	4.91	4.77	4.80	4.90	4.80
July	2107	92.93%	4.88	4.75	4.76	4.87	4.78
August	2237	94.68%	4.90	4.75	4.76	4.89	4.81
Sep	2042	94.03%	4.90	4.78	4.79	4.90	4.80
Oct	2298	93.39%	4.92	4.78	4.80	4.91	4.81
Nov	2248	93.86%	4.90	4.77	4.79	4.89	4.81
Dec	1356	93.58%	4.92	4.80	4.81	4.92	4.82
Jan	1926	94.70%	4.92	4.79	4.81	4.91	4.83
Feb	2093	93.93%	4.93	4.77	4.79	4.89	4.83
March	2047	94.04%	4.91	4.79	4.81	4.92	4.81
FULL YEAR	24,816	93.67%	4.90	4.77	4.79	4.90	4.81

iWantGreatCare

PART THREE

OUR PRIORITIES 2018/19

Our Board of Directors endorses the below statements of assurance regarding our progress against the priorities we set ourselves this year (2018/19). As with our priorities for the coming year (see Part Two of this report, where you can read about our performance metrics for 2019/20), we set objectives and measure our work against these in three main areas: patient safety, patient experience and clinical effectiveness. Our indicators are not covered by a national definition unless indicated otherwise.

PATIENT SAFETY

What we said	What we did
1. Our priority was to reduce the level of risk associated with self-harm incidents. **CQC domain: safe** Our objective for this priority was to understand themes and complexities around self-harm incidents, to learn lessons and improve service user outcomes.	• The number of self-harm incidents in 2018/19 reported is 1,458 compared to 1,529 during 2017/18. This is a slight decrease over the past 12 months • There has been a reduction in the number of severe incidents and deaths as a result of self-harm during 2018/19 (28 compared to 32 in 2017/18) • NHFT has employed a Personality Disorder Lead to support patients who self-harm and to work with staff to develop their knowledge base and skills especially in relation to planning effective care • A sensory space is being developed to ensure there is a calming area for patients to utilise for wellbeing purposes • The STORM (Skills based Training on Risk Management) training has been reviewed and a lead appointed for a year to drive the education and embed the practices into clinical practice and SystmOne • Supported development of "Common sense Confidentiality" leaflet to support involvement of family/friends in planning of care

	• Delivered a number of half-day briefing sessions on work of Suicide Prevention group and suicide prevention more broadly • Supported development of suicide prevention course through the Recovery College • Continued participation in countywide suicide prevention group, with plans to launch public-facing multi-agency campaign later in year.
How we monitored it • Serious incident investigations relating to self-harm incidents were identified and reviewed collectively to identify any trends or commonality • Self-harm incidents continued to be reported on the Trust's Datix system and reviewed in line with our policy.	**How we measured it** • Six-monthly thematic reports (if relevant) with actions to address issues • Improvements in the level of risk reported in incidents around self-harm were measured via Datix reporting.

What we said	What we did
2. To embed the mortality and morbidity process across the organisation. **CQC domain: safe** Our objective for this priority was to implement a Learning from Deaths process in line with the national guidance.	• The Learning Disabilities Mortality Review (LeDeR) programme is now active in the county The Trust is rolling out the Learning From Deaths scope to include all deaths that are suspected to be due to suicide; not just those within the original Learning From Deaths scope • This ensures that we can extract learning from all deaths that are due to suspected suicide to inform our own Suicide Prevention Strategy and strengthen shared learning with the Countywide Suicide Prevention Strategy Group led by the Local Authority. The countywide group includes stakeholders from the Local Authority, police, ambulance and GPs • The Learning From Deaths policy is being reviewed to incorporate the most recent national guidance (Royal College of Psychiatrists, 2019) • The Royal College of Psychiatrists have trialled and now published a Mortality Review Tool. This tool is being adapted to meet the Trust's requirements and expectations on what we want to achieve from reviewing deaths. It is expected the Mortality Review Tool will be used in place of the current Structured Judgement Review Tool and will be adapted to fit the needs of all our services • Trust board reporting continues in line with requirements. The Mortality Lead evaluates all the routes. The Trust currently reviews death as part of the Quality element of the DIGBQ strategy Cases that do not meet the Serious Incident or Clinical Review criteria are being forwarded to relevant Medical Leads for consideration of being discussed as part of the wider Mortality and Morbidity agenda • We participated in the CCG Learning Disability Mortality Review Committee, this process supports the countywide implementation of the LeDeR programme • Members of the Patient Safety Team attend the committee • We hold morbidity and mortality (M&M) meetings within the pathways as well as participating in the countywide morbidity and mortality meetings. Learning From Deaths reviews are shared within these meetings and at M&M presentation events.

How we monitored it	How we measured it
• Morbidity and mortality meetings will take place in all clinical directorates quarterly. Our morbidity and mortality steering group will oversee these • Reviews will be considered collectively to identify any trends or commonality.	• Evidence of sharing and implementation of learning • Staff trained: During the course of 2018/19 the Patient Safety Team attended a number of Team days, Prison Healthcare Away Day and the Countywide Adult Safeguarding Board to present sessions on Trust's approach to deaths on Datix, Learning From Deaths and how this links with the M&M agenda. Training in completion of Mortality Reviews for medical staff was delivered at a Consultant Away day • NHFT attended the regional Mazars group until they were concluded. However, in 2018/19 NHFT continued to meet bi-annually with the other trusts that attended and liaised virtually to discuss learning from deaths implementation • NHFT participates in a countywide Mortality and Morbidity meeting. This is attended by both Acute Trusts and Commisioners. The Countywide group meets bi-annually to present the learnings from reviews or investigations • Feedback from the regular quarterly M&M review meetings across all clinical directorates • Steering group to receive formal updates against action plan.

What we said

3. To increase the levels of reporting associated with falls, ensuring that all relevant patients and service users in inpatients and community settings have a falls risk assessment completed, and that those identified at risk have a falls plan implemented.

CQC domains: safe, effective and caring

- Our falls are a major concern for patient safety and a marker of care quality
- Nationally, a significant number of falls result in death or severe or moderate injury, at an estimated cost of £15 million per annum for immediate healthcare treatment alone
- Locally in the Trust there was a slight increase in the number of falls reported on Datix from 294 (2015/16) to 382 for the same period in 2016/17

This included an increase in falls classified as:

- Low harm from 115 (2015/6) to 132 (2016/17)
- Moderate harm from 18 (2015/16) to 20 (2016/17)
- Severe harm from 2 (2015/16) to 3 (2016/17).

What we did

- The number of falls champions has increased from 50 to 78 during 2018/19 covering 38 different clinical areas (including palliative care, community beds, elderly and adult inpatient mental health, ICT, learning disabilities, district nursing and prisons)
- Falls prevention training at Levels 1 and 2 has been in place and offered since May 2017. Training figures show an increase in staff undergoing training. At the end of quarter 4, 94% of all relevant staff have completed Level 1 training (compared to 84.91% in 2017/18) and 96% of all relevant staff have completed Level 2 training (compared to 79.62% in 2017/18)
- The number of falls reported on datix has increased from 483 (2017/18) to 651 in 2018/19. However, the vast majority are near miss/no harm incidents. The details included:

o Near miss/no harm – 347 reported Datix incidents (2017/18) to 468 in 2018/19

o Low harm – 117 reported Datix incidents (2017/18) to 145 in 2018/19

o Moderate harm – 18 reported Datix incidents (2017/18) to 36 in 2018/19

- Severe harm – 1 Datix incident (2017/18) to 2 in 2018/19
- Quarterly thematic reviews are carried out, however investigation of the majority of falls shows that nothing could have been done differently to prevent the fall from happening. Areas that could be improved included:
    - o Changing a client's home environment
    - o Putting in place a falls alarm
- Learnings from these incidents have been disseminated within the Trust. There have been **no** areas of concern identified through the Falls Lead review and IAM process
- There continues to be a decrease in falls Datixes that identify that something could have been done differently to prevent the fall, and a decrease in further actions needed following the fall

	• 100% of relevant patients/service users who had an inpatient fall reported on Datix had a falls risk assessment and care plan or equivalent in place therefore reducing risk of falls and harm to the patient • Falls Development Lead appointed permanently and in post from May 2018 • Development within falls prevention documentation within Systmone, the electronic patient record system, has taken place, making it easier for staff to use, helping to ensure all falls risk factors are adequately assessed • Falls Champions study days take place regularly • An easy read falls leaflet has been developed • The Trust continues to implement the Standing up for Ourselves – Reducing Falls and Promoting Bone Health – A Strategic Commissioning Framework for Northamptonshire (2015-2020), which focusses on making falls prevention everyone's business • All clinical staff are familiar with post falls guidance and this is readily available in inpatient settings • Ongoing regular local meetings occur for staff in high falls risk areas to discuss falls occurrences and recommendations – Falls Champions lead these meetings • Ongoing Regular Falls Champions meetings to support and embed good practice regarding falls prevention and post falls guidance are in place.
How we monitored it • The number of staff who have undergone training • Quarterly reporting on number of falls and completion of risk falls assessment and, if necessary, falls care plans • Falls Champions in place throughout the inpatient units • Updated process for reporting on Datix to ease reporting and identification of falls.	**How we measured it** • Training records • Increase in the number of falls risk assessments completed and falls care plans where required • Quarterly thematic reports (if relevant) with actions to address issues, quarterly • Number of Falls Champions in place.

PATIENT EXPERIENCE

What we said

1. To collaboratively develop a recovery college model within the organisation.

CQC domains: effective, responsive and safe

Embedding a recovery-based approach will play a central role in achieving positive patient reported outcomes and improving patient experience.

This could lead to improved clinical outcomes, reduced lengths of stay and fewer readmissions

What we did

- A full recovery college prospectus has been in place since Q2 2017/18
- In 2018/19 the prospectus has been update and published, in conjunction with the University of Northampton
- Funding to support the Recovery College during 2019/20 has been agreed. As part of this funding, targets will be developed in Q1 for 2019/20
- The Recovery College delivers 40 classes of 24 courses during the term including: Artistic Practices and Mindfulness, Comedy and Recovery, Smoking Reduction Techniques for Better Physical and Mental Health, Men's Suicide Reduction, Collaborative care planning, co-production and Living with Emotions
- The college has peer roles in strategic and college process development
- Recruitment for trainers continues to take place, 2 Peer Trainers have been recruited and are available to deliver the courses
- During 2018/19, the number of people who have attended these courses is 355 people across 16 different classes (compared with 76 people in 2017/18)
- Outcome measures and student evaluation have resulted in the following changes:
    - Reviewing of powerpoint presentation slides after comments that they were too busy
    - Addition of more group exercises to sessions
    - Purchase of new audit speakers after comments around sound
    - Increasing the font size on slides
- 96% of attendees rated the value of the recovery course as good to excellent.

How we monitored it	How we measured it
• Evidence of engagement of staff and patients in developing the Recovery College • Minutes of planning groups • Course prospectus developed • Outcome measures in place • Trainers recruited • Course attendance.	• Number of trainers recruited • Number of sessions offered • Percentage of patients attending sessions • Outcome measures showing review of courses and changes made where necessary • As the Recovery College model develops throughout the year we will be able to set targets for subsequent years.

What we said

2. Increase the numbers of service users and carers involved in staff recruitment.

CQC domains: well-led

- We recognise that service users and carers should play a key role in the recruitment of clinical staff
- It is paramount that staff are appointed who have values and beliefs aligned to the needs of our service users and carers
- Including more service users and carers who would like to be part of the ongoing development of the Trust means increased likelihood of their needs being met.

What we did

- In 2018/19 65 service users volunteered to be involved in staff recruitment, compared to 38 in 2017/18, an increase of 71% (19 service users were involved in 2016/17). We have amended our figures from the 2017/18 Quality Account as our reporting was an inaccurate reflection of the situation within the Trust
- The number of service users and carers who have been a member of a recruitment panel has increased by 29% to 195 in 2018/19 from 151 in 2017/18 (66 service users and carers were a member of a recruitment panel in 2016/17)
- Following the work of the pathway Patient Experience Groups and dedicated recruitment days, where staff have met involvees, the operational services work closely with their own service users and carers/parents to identify the role they would like to be involved in. This is because the central patient Involvement team only have recruitment data for service users who claim an expense or who have signed up centrally to be involved
- The Recruitment & Selection Procedure (HRp026) confirms the Trust's commitment to include service user and carer involvement in the selection and recruitment of all senior management, senior practitioner, consultant and staff grade psychiatrists appointments and other staff where deemed appropriate
- To further improve involvement in the recruitment process, a small group of involvees took part in training, to support the shortlisting of candidates using TRAC.

How we monitored it

- A database listing service users and carers willing to be involved in staff recruitment
- The patient Involvement team will monitor how many service users and carers are requested to support with interview activity
- Course attendance.

How we measured it

- 10% increase in number of service users and carers willing to be involved in staff recruitment (to be reported six-monthly)
- Increase by 15% number of service users and carers who have been a member of a recruitment panel compared to 2017/18
- Six-monthly evaluation of post interview feedback and evidence of tailoring of processes where found to be necessary.

What we said

3. Using IWantGreatCare (iWGC), and other sources of feedback to learn from and respond to patients and carers.

CQC domains: effective and responsive

This was a priority for 2016/17 and continues to be vital to our drive to listen and use experience to shape care delivery and service design.

What we did

- Quarterly reports are produced for services, directorates and the Trust
- iWGC (FFT) feedback is a standing agenda item on team and management meetings in line with Quality Framework and in response to feedback. Changes are discussed at patient experience groups
- The Steering Patient Experience Group monitors issues raised through iWGC
- There have been 1,306 reviews with a negative aspect or suggestion for improvement (6% of total responses) compared with 845 in 2017/18 and (754 in 2016/17)
- 87.5% (1142) of these reviews have been responded to compared with 75% in 2017/18 and (35% in 2016/17. This is an increase in response during 2018/19 of 12.5%)
- Triangulation of feedback (PALS, complaints, compliments and iWantGreatCare) is being strengthened to provide a more informed view of what works well and areas for improvement. This, coupled with enhancements to performance and quality dashboards, will provide more focussed and analytical reports for, amongst others, the Complaints Review Committee, Patient Experience Groups, Quality Forum and senior leadership meetings
- Triangulating information – The safe care leads continue to triangulate information arising from the staffing lower fill rate exception report, with complaints, iWGC and serious incidents, to identify potential quality risks
- iWGC data available earlier in this document.

How we monitored it

The iWGC and patient experience teams will monitor the embedded feedback process and any required actions.

How we measured it

- Quarterly reports outlining number of feedback reports required and received via iWGC
- 10% increase in the number of responses required within timescale based upon 2017/18 baseline (75%)
- Evidence in board and committee reports that the Trust is triangulating iWGC feedback with other source of information, for example complaints, serious incidents, and safe staffing.

CLINICAL EFFECTIVENESS

What we said

1. To work collaboratively internally to share our patient safety experiences and outcomes in order to improve learning from incidents, complaints and compliments, and reduce harm.

CQC domain: safe

This was a quality priority for 2016/17. Further work was required to ensure that learning is embedded effectively within the organisation. Learning from patient safety experiences will continue to be at the heart of quality improvement.

What we did

- The number of serious incidents has reduced from 32 (2017/18) to 24 (2018/19) and (37 in 2016/17). This is an overall drop during 2018/19 of 25%
- The lessons learnt exchange has been reviewed to strengthen how it shares lessons learnt across the Trust
- Safeguarding – The learning lessons exchange meeting has agreed that they will review recommendations and actions arising from multi-agency serious case reviews and safeguarding adult reviews. The reports are currently shared on The Staff Room intranet for wider sharing
- Triangulating information – The safe care leads continue to triangulate information arising from the staffing lower fill rate exception report, with complaints, iWGC and serious incidents. Themes identified include appropriate escalation for short staffing. Ad-hoc reviews are undertaken as necessary. Information relation to escalation is on The Staff Room intranet
- Lesson learnt from Serious incidents is reported to the public Trust board
- The Datix codes for complaints and PALS have also been revised to ensure that the codes are streamlined. The iWGC manager has themed iWGC responses using the same category codes as PALS and complaints to provide a triangulated report which was presented to Patient Experience Group and is due to be considered at the Complaints Review Committee in January for inclusion within the Board reports

	• Communicating with Carers – a task and finish group was formed to review the importance of the 'voice of the carer' and suggested the development and sharing of a common-sense confidentiality guide, incorporating the Royal College of Nursing guidance and NHFT carers' charter. This has now been published and shared • Carers' Web design – a co-produced group of carers and staff members met to review our website, using other Trust web pages to identify good practice. Changes have been identified and were drafted and discussed at the Patient Experience Steering Group. It is envisaged that updates on the website will commence in 2019/20 • NHFT is an active participant in the countywide patient safety group, sharing incidents and investigations to support the wider learning agenda • The Trust has a range of dashboards that provide data required for triangulation. All service managers have access to patient safety data which ensures operational leads are fully aware of their current quality performance and risks.
How we monitored it • We will monitor our lessons learnt activity and platforms, and identify outcomes from these that have contributed to our internal safety agenda • National and local circulation of risks, safety concerns and best practices will continue to be shared with staff groups via numerous mechanisms.	**How we measured it** • A six-monthly report outlining an evaluation of the ways that staff members learn and share information, for example webinars, patient and carer stories, medicine bulletins, conferences, governance meetings, and Patient Experience Groups • The number of investigations that have a joint focus will provide evidence of the need to share information and jointly plan for patient safety across the health system.

What we said	What we did
2. Develop the skills and competence of all newly qualified band 5 nursing staff and allied health professionals. **CQC domains: well-led and safe** To ensure that newly qualified staff are supported and engaged quickly to develop their skills base and quality care.	• Newly qualified nurses are supported in their preceptorship within their clinical teams, which supports individual local clinical development and transition into their new professional roles • Supporting the clinical infrastructure, from April 2018 onwards. The Professional Practice Education and Training Team has supported the recruitment and deployment of practice development nurses in Service Teams to work with the individuals local preceptorship and competency development of students and newly qualified nurses • We have identified 12 areas that employ newly qualified nurses and will have access to practice development nurses. Four practice development posts are currently filled. The other eight are in various stages of the recruitment process • Newly qualified nurses are also supported in their professional development through a corporate programme of preceptorship. This includes up to eight days of supportive workshops and training days • The corporate preceptorship is continually updated each year based on feedback from preceptees and service managers: o Sessions from April 2018 and November 2018 o Exploring the Professional Role and Accountability o The Professional Role and Record Keeping – Healthcare Records on Trial o Personal Growth and Development o Understanding Professional Boundaries o Supervision and Wellbeing o Safer Staffing and Re-validation o Sage & Thyme – Problem Solving and Communication Model o My Appraisal – The apprisee o Supporting and Supervising Student Preparation o Equality and Diversity – Unconscious Bias o Service User and Carer Involvement Workshop Co-produced and Delivered with Service Users and Carers. • Feedback on the course has indicated that all of the attendees have found the course useful in contributing to their role development. Feedback has contributed to recommendations for changes going forward

	• Newly qualified nurses are being prepared to support learners during as part of the preceptorship period • In conjunction with clinical practice, the pre and post-registration team are developing practice development posts and facilitating preparation sessions for preceptors. Access to resources for clinical skills training have been sourced, which supports timely access to training staff during the preceptorship period • A number of new elements were added to the Preceptorship course during 2018/19. This included: Sage and Thyme, Exploring Professional Boundaries, Supervision and Wellbeing and Governance – perceptions of risk and managing risks • April 2018/19: following feedback from previous cohorts, a clinical supervision and wellbing workshop is now delivered face-to-face during the corporate programme.
How we monitored it • This will be carried out via the preceptorship programme • A report will be produced twice a year that will include: o Attendance data o Evaluations o Successful completion o Identified clinical competences o Online supervision package. • Mentorship qualification (at the end of the programme).	**How we measured it** • A report is prepared and forwarded to the quality monitoring team on a six-monthly basis • Individual evaluations of workshops and training days have shown us what preceptees value in their development • Each preceptee is provided with a portfolio, where the preceptorship is signed off and validated as completed by the Service Manager and through appraisal. A record of completion is then added to the Trust training records on completion of both the clinical and corporate programme • Development of clinical competencies are identified and verified as achieved by preceptor or practice development nurses in service teams • April 2018-April 2019: 58 newly qualified nurses have been supported through a preceptorship programme (17 were supported in 2017/18). The Professional Practice Education and Training Team currently holds records of completion • On completion of the preceptorship programme for staff from April 2018/19, they will be retrospectively be added to the Electronic Staff Record • A six-monthly report outlining progress and uptake of preceptorship programme • All newly quality nurses are identified, and have taken part in and successfully completed the programme.

What we said	What we did
3. To increase the reporting associated with completed physical examinations within the mental health services. **CQC domains: effective and safe** Improved physical healthcare for people with severe mental illness.	• All relevant staff have been trained to deliver physical health checks. The training programme is available to all clinical staff and covers processes for assessing, documenting and acting on cardio metabolic risk factors. The training is available as E-Learning via the Electronic Staff Records, as formal training sessions, training sessions within block training, train the trainer sessions and on the job training within the staff member's area of work • Clear pathways for intervention and signposting have been developed, updated and disseminated to all staff via e-brief statement and pathways poster • Work to improve the functionality of the Physical Health template has been implemented and is continuously updated to ensure ease of recording • Auditing of the inpatient records has occurred quarterly with the results being fed back to the ward areas with clear actions when required. The audits have shown an increase in compliance from 60% in 2017/18 to 92% in 2018/19 • Work continues to raise awareness of the need for physical health checks with all staff • Training continues to be delivered to junior doctors • EIP: 89% of patients have physical healthcare measurements recorded during 2018/19 compared to 62% in 2017/18 • Community Mental Health: 50% of patients have physical healthcare measurements recorded in 2018/19 compared to 41% in 2017/18.

How we monitored it	How we measured it
Quarterly reporting for the following: • Outlining number of staff who have had physical health training • Progress with access to ICE system • Results of audit around physical examinations with action plan.	Inpatients and EIP: • 90% of patients have physical healthcare measurements recorded. Community Mental Health Services: • 2017/18 – 65% of patients have physical health measurements recorded • 2018/19 – 75% have physical health measurements recorded.

Local Indicator Audit

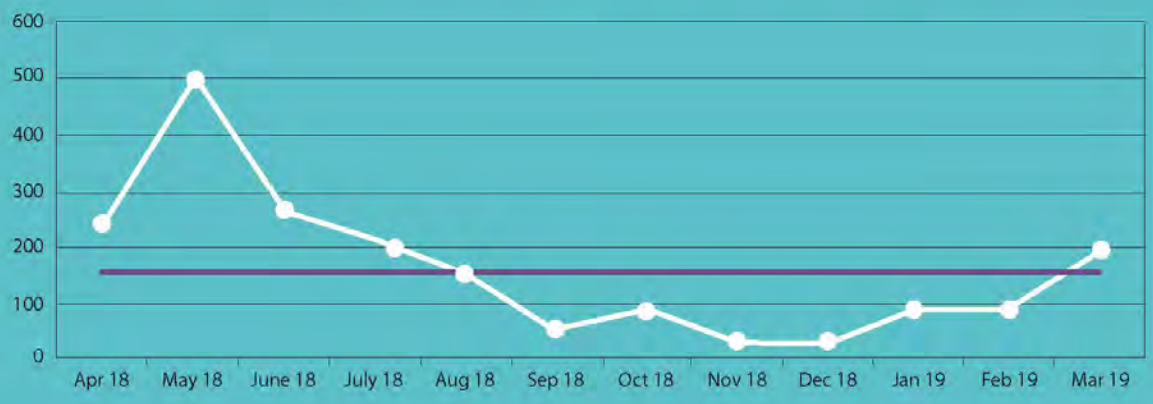
Each year our external auditors are asked by our governors to review one indicator within the Quality Report as part of their testing of their limited assurance work reported in this report. This year the local indicator was the percentage of relevant staff who attend falls training.

PERFORMANCE AGAINST TARGETS

In 2018/19 we achieved seven out of the 10 statutory targets at fourth quarter. Performance for the year is summarised in the following table. Unless indicated otherwise, Trust performance against indicators is based on data collected by the Trust and held on trust IT systems.

Indicator	2017/18 year performance	2018/19 Target	2018/19 Performance - Q1	2018/19 Performance - Q2	2018/19 Performance - Q3	2018/19 Performance - Q4	Overall 2018/19 Year Performance
Early Intervention in Psychosis (EIP) within 2 weeks	93.62%	53%	86.67%	86.67%	73.33%	94.12%	85.84%
Cardio-metabolic assessment (a) Inpatients	60% (Q4)	90%	79.0%	92.0%	84.0%	92.0%	not applicable
(b) EIP	79.6% (Q4)	90%	89.1%	89.8%	88.9%	88.8%	not applicable
c) Community Mental Health (people on CPA)	51.3% (Q4)	65%	50.5%	49.3%	51.6%	47.6%	not applicable
Improving Access to Psychological Therapies (IAPT) - (a) Recovery	43.92%	50%	47.90%	44.50%	52.85%	51.20%	48.84%
IAPT - (b).i 6 weeks referral	75.77%	75%	93.50%	95.40%	96.63%	97.30%	95.54%
IAPT - (b).ii 18 weeks referral	99.08%	95%	99.40%	99.80%	99.93%	99.90%	99.73%
CPA 7 days	97.93%	95%	99.19%	98.60%	97.63%	98.60%	98.50%
Admissions to Adult patients < 16 years old	0	0	0	0	0	0	0
Inappropriate OOA placements for Adult MH	4940	0	992	423	130	346	1891 (157.6 per month)

	Apr 18	May 18	June 18	July 18	Aug 18	Sep 18	Oct 18	Nov 18	Dec 18	Jan 19	Feb 19	Mar 19	Monthly average
Inappropriate OOA placements for Adult MH	239	485	268	210	152	61	88	27	15	78	81	187	157.6



A STAFF MEMBER'S STORY

"It all started some months ago – in fact it was at NHFT's wellbeing conference held in July 2018. I always knew that I was overweight and my physical health wasn't great, always feeling tired, painful joints and generally avoiding any physical exercise. Despite knowing this and being aware of the overall impact my life choices were having on me and ultimately my family I never acted upon this I just put it to one side and continued doing what I was doing. That was until the 18 July 2018 whilst attending the wellbeing conference two of my colleagues attended a stall being run by First for Wellbeing where they were carrying out health checks. I don't know what it was but something made me go to the stand and have a health check – which confirmed which I already knew – I was morbidly obese and had very high blood pressure. As a result of this I was advised to seek medical advice from my GP and have by blood pressure monitored at regular intervals. As I was considered morbidly obese I met the criteria to be sponsored to attend a slimming group of my choice for 12 weeks.

Within a couple weeks my paperwork to join Slimming World came through the post and within a week I attended my first session at my local slimming world group. To say I was nervous was a complete understatement. I felt so embarrassed for being so overweight and didn't know what to expect. When I walked through the doors I was greeted with friendly smiles and soon put at ease.

Gayle the slimming world consultant explained everything to me – I wasn't judged by anyone and could see and hear how supportive the group was to each other and shared their own slimming world journeys. As a group we are all really supportive of each other, giving encouragement and sharing ideas whether this is during group or within Facebook chats outside of the group to support each other, and chivvy each other along through the highs and lows.

After my first session I went home and studied the information that I was given and started planning my week ahead, what food would I be eating and what types of exercise would I engage in. I soon realised that Slimming World is about making choices in food optimising and enjoying the food I like, whilst making the right choices which I'll be able to sustain long term. Within my first week I lost 11lb in weight and was absolutely shocked how easy it was to follow a plan and how great I felt. Since joining slimming world 39 weeks ago I've continued to lose weight and have lost 7st in total. I am 8lb away from my target weight and am really enjoying the benefits of being a healthy me – I have lots more energy, enjoy trying new foods and generally feeling better all round.

I haven't lost the weight through diet alone I have been active in lots of ways, going to the gym, aqua zumba, boot camp, running and doing Park Run.

In March 2019 – I was awarded my slimming world's groups Greatest Loser 2019 – this was a fantastic achievement and wouldn't have been achieved without all the support from family, friends, work colleagues and the support from my slimming world group – THANK YOU!"

OUR STAFF AND CULTURE

Safe, quality care depends on openness and transparency, a culture of innovation driven by engagement and the structure of a safe working environment. In this section, we share our approach to our staff, culture and care.

DUTY OF CANDOUR

The CQC document, "Regulation 20: Duty of Candour" states that our responsibilities under Duty of Candour are triggered by the occurrence of a notifiable Patient Safety Incident that, "in the reasonable opinion of a healthcare professional, could result in, or appears to have resulted in:

(a) the death of the service user, where the death relates directly to the incident rather than to the natural course of the service user's illness or underlying condition, or
(b) severe harm, moderate harm or prolonged psychological harm to the service user."

A Patient Safety Incident, broadly speaking, is an act, omission or deviation from expected practice, or an issue with a current system or process that is likely to cause harm if not remedied.

Under the guidance and our contract, when our responsibilities are triggered there are two main aspects to what is required of us. These are initial notification and an update/outcome in relation to further action. At the Trust, this is achieved by performing three steps when completing Duty of Candour:

1. Initial notification

This is normally undertaken by the team/practitioner involved in the patient's care. They are the most appropriate and able person to explain what has occurred and the next steps. This should be done "as soon as is reasonably practicable". This would normally be completed in person, or via telephone if there is an appropriate reason. The notification includes providing an account of the incident, offering an apology and advising what further inquiries into the incident will be undertaken.

2. Update

Advise the relevant person on appropriate further enquiries. This would likely be undertaken by the local practitioner or manager. However, if the enquiries to be made were in the form of an investigation (for a Serious Incident, SI, or Concise Investigation, CI), then the investigator would arrange to meet the patient/family (with the Trust's Patient and Family Liaison Lead) to provide support. They would also seek input into the focus of the investigation by highlighting any concerns or queries regarding care.

3. Feedback

Once the completed report is signed off, the investigator arranges to feed back the findings of the report and answer any queries. This must be done within 10 working days (as per the contract). If the relevant person cannot be contacted or declines to speak to a representative of the Trust, a written record is to be kept of attempts to contact or speak to that person.

When an incident occurs, it is not always immediately clear as to whether or not the harm has been caused as a result of a Patient Safety Incident – particularly for self-harm and suicide incidents. For example, if a community patient is suspected of completing suicide, but all care and interventions provided are in accordance with policy and best practice (assuming there is no issue with the process itself), then no Patient Safety Incident has occurred. This may not be confirmed until the completion of the investigation.

'Being Open' is similar to Duty of Candour

Staff make contact with the patient and relevant family who are involved in care to advise them of an incident and that a review of care will be undertaken. All incidents reported on Datix are reviewed proportionately, from a local review of the Datix up to a Serious Incident Investigation.

This requirement is outlined in NHFT policy and overseen, from a Trustwide perspective, by the Patient and Family Liaison Lead. In the interests of being open and honest, we promote a culture of transparency that facilitates informing patients and families following any incident, regardless of whether or not it is classified as a Patient Safety Incident. This is supported by our Duty of Candour policy, training and the structure of Datix. When an incident is reported, the reporter completes relevant details of conversations with the patient/family, whether or not the incident falls under Duty of Candour. Since August 2018, we also capture 'Being Open' conversations. These two categories of conversations are monitored by the P&FLL via Datix Dashboards. Prompts are given to ensure conversations are held. Aside from some cases of self-harm, a high proportion of conversations are taking place with patients and families, while the need for prompting by the P&FLL is one incident per week or fewer.

5,445 of 8,126

This was the number of incidents (non-death incidents) where we have spoken with the patients following an incident regardless of the level of harm. Following an investigation where no 'Notifiable Patient Safety Incident' has occurred, Being Open is still performed. Where Duty of Candour is undertaken following a Patient Safety Incident, this process is monitored and compliance audited. This ensures we meet our obligation under Regulation 20.

During 2018/19 there have been no confirmed Duty of Candour breaches. Work undertaken in the area of Duty of Candour and Being Open strengthens the culture and practice already in place at the Trust. This includes, but is not limited to, a complete revision of Duty of Candour e-learning, which is now more comprehensive, and over 40 policy update sessions. All health professionals, those working with patients and those handling patient identifiable data, undertake Duty of Candour training annually. Updated Duty of Candour e-learning went live on 1 August 2018 and as of 5 March 2019 more than 90% of staff who were required to undertake this training have successfully completed it.

FREEDOM TO SPEAK UP

The Gosport Independent Panel Report has been internally reviewed and actions have been identified which the Trust have systematically been working through. Organisationally, the nursing and midwifery processes for fitness to practice have been strengthened, Freedom to Speak Up Champions trained (these roles are in addition to the Guardian) and supervision processes reviewed in order to support timely escalation of concerns.

The Trust's Chief Executive is the lead Director for Freedom to Speak Up, which signals to staff the importance the organisation places on raising and resolving issues. Medication safety and incidents are reviewed within the Medication Safety Group, and the palliative medicine department uses a pain management process to support the needs of the patient and carer. The Trust has also co-produced a common sense confidentiality booklet (partly in response to the Gosport outcome) and is in the processes of developing a carer page on its public website.

During 2018/19, the Trust has taken several actions in order to support a positive speaking up culture.

Freedom to Speak Up Champions

In July 2018, the Trust delivered the National Guardian Office's (NGO) foundation training to 11 staff from our Trust, and other Trusts in our region. This was the first regional training session delivered in the country and was attended by new Freedom to Speak Up champions in the Trust and Moira Ingham (non-executive lead for Freedom to Speak Up).

Diana Belfon, BME Staff Network Chair, was the first Champion in the Trust, taking on this voluntary role in December 2017.

Since having a BME Champion, concerns from our BME staff have increased by 420%, demonstrating the value of having Champions supporting our vulnerable groups. The Champions are in place to support staff in vulnerable groups in speaking up, with representatives for apprentices, non-registered staff, students, junior doctors and each of the Trust's four staff networks. The Trust now has 19 Champions spread across the organisation to support staff to speak up.

National Guardian visit

On Tuesday 24 July, Dr Henrietta Hughes (National Freedom to Speak Up Guardian) visited the Trust, meeting the Chair, Chief Executive, Non-Executive Lead for Freedom to Speak Up and the Trust's guardian. Henrietta was shown around Berrywood hospital by Andres Patino and visited a few of the wards before meeting some of the Trust's new Champions and a number of staff who have spoken up whilst working for NHFT.

Dr Hughes commented positively on the work we have done and how we have embedded speaking up as part of our strategy and our work on equality, as well as its inclusion in our staff engagement plan; Let's Talk.

Care Quality Commission (CQC) inspection

Freedom to Speak Up was included as part of the Trust's CQC inspection under the 'well-led' domain. Anonymous activity is reported to Trust Board and Quality and Governance Committee. As part of the process, the Trust's Freedom to Speak Up Guardian was interviewed about the support for the role, how the Trust responds to concerns raised by workers and evidence of a positive speaking up culture in the Trust.

The final report included the following reference to Freedom to Speak Up:

"Staff knew how to raise concerns about disrespectful, discriminatory or abusive behaviour or attitudes without fear of the consequences, and they knew this would be acted upon.

We saw evidence that staff were increasingly raising concerns openly and incidents of anonymous contacts to the Freedom to Speak Up Guardian had reduced. This evidenced that an open and transparent culture was fully embedded."

CONCERNS RAISED BY STAFF THROUGH FREEDOM TO SPEAK UP

Time	Concerns raised through Freedom to Speak Up	Concerns raised anonymously	Concerns relating to patient safety	Concerns relating to bullying/ harassment
2018-19 - Q1	28	1	13	5
2018-19 – Q2	32	3	10	5
2018-19 – Q3	36	4	8	9
2018-19 – Q4	39	2	16	4

STAFF ENGAGEMENT

Looking ahead to 2019/20, the Trust continues to deliver the Freedom to Speak Up strategy, which forms part of the Trust's Let's Talk staff engagement plan. This will be linked to the 5-4-3-2-1 campaign under: '1 – Making a difference for you with you'. In order to give the organisation time to plan and deliver on key objectives, this will be a two-year plan designed to achieve significant improvements by National Staff Survey (NSS) 2020, with NSS 2019 being used as a benchmark.

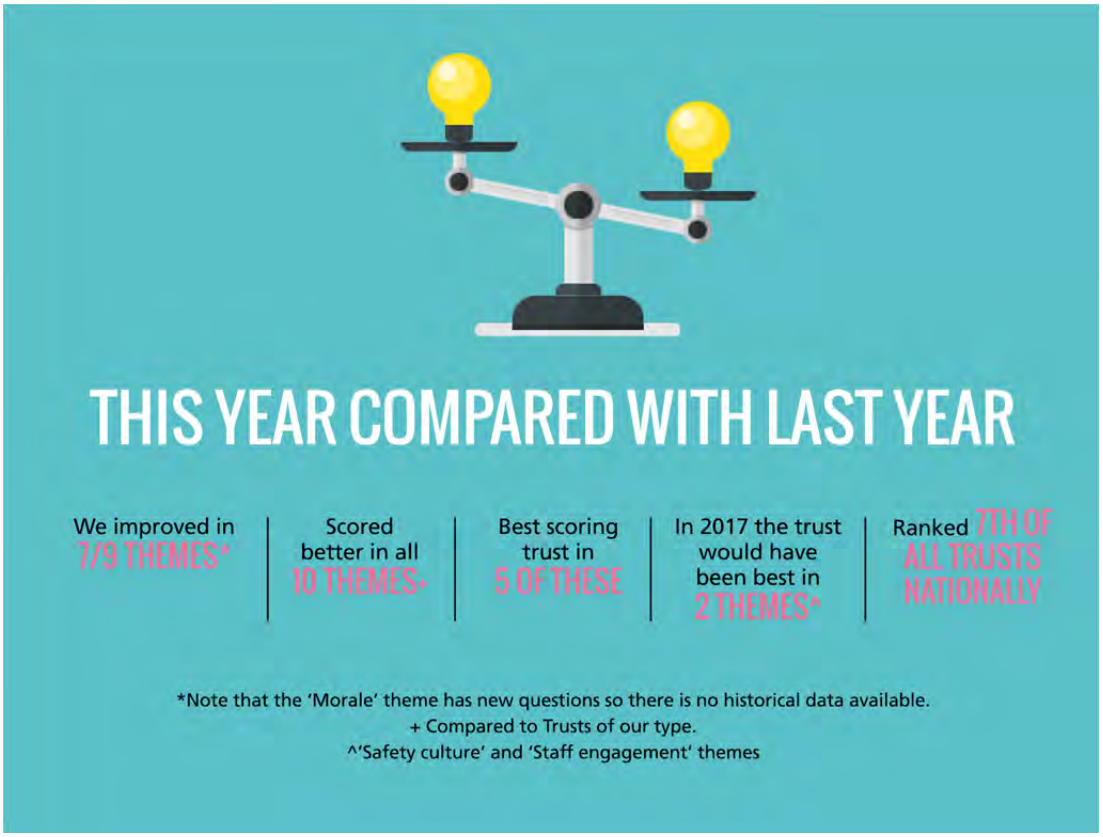
Actions include support and training for managers in dealing with speaking up concerns, further expansion of the speaking up Champions network and establishing a case review process in order to effectively embed learning from speaking up in the organisation.

Staff engagement is a central part of the NSS and consists of questions about motivation, involvement and advocacy. Engagement is critical to our organisation – there is clear evidence that highly engaged staff deliver better care, and patients and service user outcomes are higher. There are also indirect benefits to the organisation, including higher levels of retention of staff and reduced levels of sickness and absence.

A summary of the Trust's and each locality's results will be produced and shared with all staff through our internal communication channels. There will be a dedicated page on our intranet, The Staff Room, with results and resources available to demonstrate the openness and transparency of our approach.

STAFF SURVEY

Our Trust took part in the annual NHS staff survey 2018, which was open for all Trust staff to complete in late 2018. Official results from NHS England were released in early February 2019. This Staff Survey section appears in our Accountability Report. We also publish it in this Quality Report because we publish it separately.



Our 2018 response rate

2017/18 (PREVIOUS YEAR)	2018/19 (CURRENT YEAR)		TRUST IMPROVEMENT/ DETERIORATION
Our Trust	Our Trust	Benchmarking group (trust type) average	
48.4%	51.0%	45%	+2.6%

The '32 Key Findings' previously used in the National Staff Survey have been replaced with 10 themes to provide a summary of different areas of staff experience. These themes are scored on a 0-10 scale, with 10 being the best possible score for each theme.

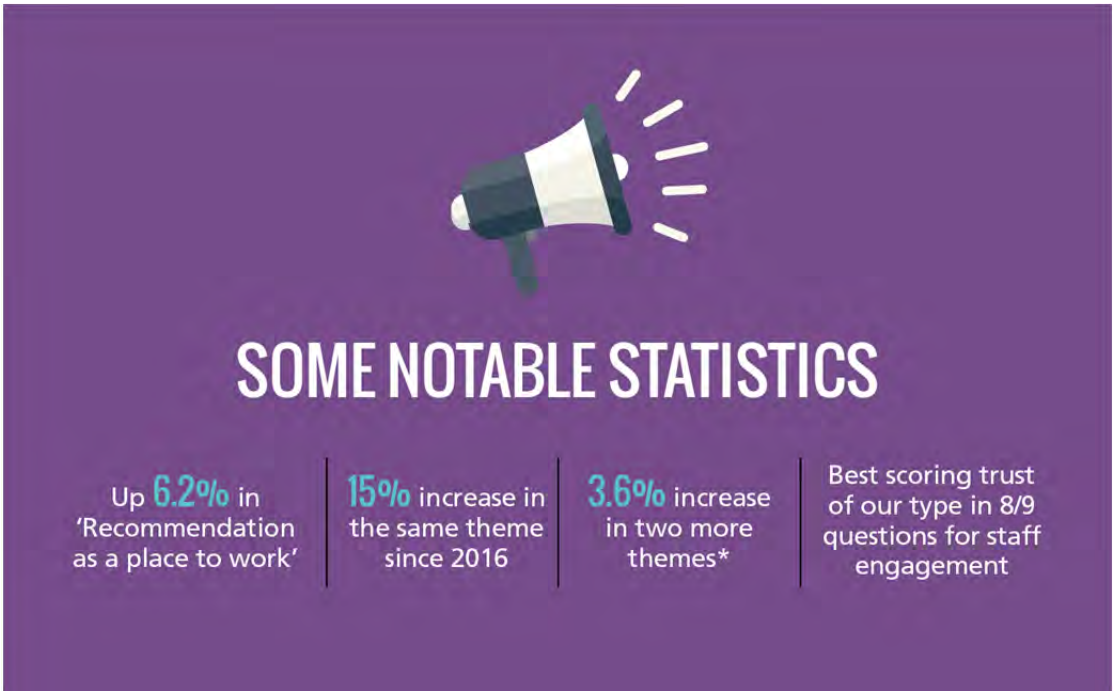
The Trust is benchmarked against 30 other trusts of our type: combined mental health/learning disability and community trusts. The Trust's results are detailed below:

Theme	2017	2018	Best	Average
Equality, diversity and inclusion	9.2	9.3	9.4	9.2
Health and wellbeing	6.4	6.6	6.6	6.1
Immediate managers	7.1	7.3	7.4	7.2
Morale	n/a	6.7	6.7	6.2
Quality of appraisals	5.9	6.0	6.0	5.5
Quality of care	7.6	7.7	7.7	7.4
Safe environment - Bullying & harassment	8.4	8.4	8.6	8.2
Safe environment - Violence	9.5	9.5	9.7	9.5
Safety culture	7.1	7.3	7.4	6.8
Staff engagement	7.3	7.5	7.5	7.0

Top five ranking scores

(Areas where we scored more favourably compared to trusts of a similar type)

1. Effective use of patient/service user feedback
2. Organisation's action on health and wellbeing of staff
3. Senior managers involving staff in important decisions
4. The extent to which the organisation values the work of staff
5. Staff recommendation of the organisation as a place to work



*The two themes that improved were 'Care as the top priority' and 'Recommendation as a place for care'

Research shows these are the primary drivers for staff engagement, and ultimately improved patient experience and outcomes. They can also be seen as exceptional improvements and bring the Trust's target of 80% recommendation as a place to work and receive care within reach. Nationally, the Trust achieved the second highest score for the theme of 'health and wellbeing' across all Trusts.

Although the number of staff working extra hours remains above average compared to similar trusts, this has improved in 2018 with 2.2% fewer staff working unpaid additional hours.

Again, with staff engagement and health and wellbeing themes improving, our staff remain dedicated to our patients and service users and "going the extra mile" to make a difference.

Bottom five ranking scores
(Areas where we scored less favourably compared to trusts of a similar type)

1. **Percentage of staff working extra hours**
2. **Percentage of staff / colleagues reporting most recent experience of physical violence at work**
3. **Percentage of staff experiencing harassment, bullying or abuse from a colleague**
4. **Percentage of staff / colleagues putting themselves under pressure to come to work when not feeling well**
5. **Percentage of staff / colleagues witnessing errors, near misses, or incidents that could have hurt patients / service users**

The deterioration in witnessing or errors, near misses or incidents and experiencing harassment, bullying or abuse is reflected nationally. The survey also shows that 97.8% of staff reported their most recent error, near miss or incident. The survey also showed a 3.5% increase in staff reporting their most recent experience of harassment, bullying or abuse and is now better than average for Trusts of our type. The reporting of physical violence at work will be an area of focus for the Trust throughout 2019.

OUR FUTURE PRIORITIES AND TARGETS

Our two-year Staff Engagement Plan 'Let's talk' was launched following the National Staff Survey 2017 results. Linked to our mission 'Making a difference for you, with you', the Trust will continue to focus on:

- Listening to and involving you
- Supporting our managers
- Helping you to speak up
- Developing our employer promise
- Supporting your health and wellbeing
- Ending bullying and harassment
- Equality for all.

Following the results of the 2018 survey, the Trust has also identified four areas for development and improvement through 2019:

1. Increase the reporting of incidents of physical violence
2. Better involvement from managers when making decisions that affect staff and their work
3. Address staff working longer hours which is impacting on health and wellbeing
4. Develop a new approach to end bullying and harassment that focuses on intervening early to avoid the continuation of inappropriate behaviours.

SAFE WORKING HOURS
FOR DOCTORS AND DENTISTS IN TRAINING

We are committed to ensuring that all our junior doctors and dentists in training are fully supported. The Trust has appointed a consultant to the role of Guardian of Safe Working Hours (GOSWH) to act as Champion for safe working hours and to actively monitor compliance with the Terms and Conditions of Service for Doctors & Dentists in Training (England) 2016 within the new contract.

NHFT currently has 30 doctors in training posts. During the 2018/19 financial year we have consistently had unfilled posts, this has meant that the Trust had the equivalent of 2 WTE vacancies/quarter. Clearly these vacancies put pressure on the system.

The vacancies have arisen due to Health Education England being unable to recruit to training posts. This should be seen against a significant shortage of junior doctors at all grades and in all specialties, meaning vacancies are common place nationally. There has been a year on year fall on doctors going into a third year of postgraduate training and hence CT doctors in particular are lower in availability.

In addition, as an organisation, we are particularly vulnerable to medical vacancies, as our rotas are mostly staffed by psychiatry and general practice trainees, two specialties with particularly pronounced recruitment difficulties. At a national level, steps have been taken to address this.

This has included offering pay enhancements to junior doctors to encourage them to apply for these posts. Clearly, while this is welcomed, it will take time to deliver an increase in the availability of qualified psychiatric doctors. Therefore, there is likely to be a continued shortfall in the medium term.

In all cases, the vacancies were subject to several recruitment rounds. In addition, sourcing via agencies, even with escalated rates, has proved unsuccessful with the exception of out of hours on call cover, which the Trust does successfully cover.

The Trust regularly holds junior doctor forums. There has been minimal feedback from junior doctors to indicate any major adverse impacts on working hours. There have been a small number of exceptions raised relating to not being able to take breaks and working over but these are not systemic issues.

The 2018/19 cohort of junior doctors has been understanding about the national situation. A continuation of this situation cannot be relied upon and as such the Trust is proactively looking at alternative approaches to improve our recruitment success rate and is exploring new roles to provide additional support to the multi-disciplinary teams when vacancies do arise. Two physicians associates have been appointed within the 2018/19 financial year to support the in hours junior doctor workload/rotas. This is an approach being taken by a number of NHS organisations.

APPROACH AND SYSTEMS FOR INNOVATION

The Trust has 'To Innovate' as a strategic theme with 5 key objectives:

1. Develop a culture for innovation
2. Build capability and capacity
3. Find out 'what works'
4. Develop collaborations
5. Ensure stakeholder engagement.

This makes innovation a visible, core Trust function that is everybody's responsibility.

The number of participants recruited to NIHR portfolio research by Northamptonshire Healthcare NHS Foundation Trust in 2018/19 was 582.

The Innovation Pathway outlines processes and support for innovation. Supporting culture, capability and capacity development are:

- The Innovation Space on the intranet
- Ideas Champions
- 5 Special Research and Innovation Groups (SpRInGs).

Ideas can be progressed by anyone through the monthly Ideas Forum, from initial concept through to ideation and feasibility. The forum offers peer support, expert/governance review and links to the many regional partners supporting this agenda.

Where appropriate, ideas are supported with implementation and evaluation/research advice to ascertain impact on patients, staff and return on investment.

The number of projects being supported is growing, and these are captured on a central database. Several ideas have now progressed to become research projects. The Innovation Pathway will next focus on:

- Ensuring successful communication and socialisation of the strategy
- Implementation, monitoring impact and sustainability of practice.

The ambition is to work with partners to ensure adoption and diffusion of innovation across the health economy and region.

A Framework for the Management and Governance of the Innovation Pathway ensures that we consistently manage issues of clinical safety and project governance in a way that protects both patients and staff. This works in partnership with the Quality Improvement and audit agenda within the Trust.

A CARER'S STORY

"Over the past 18 years it has been difficult to make and take time for myself, or to acknowledge that I am a carer, not a 'usual' mum and how shattered I am. It's difficult to juggle work and home life. When my son needs me during work hours I want to respond but I also want to give 100% to my job – I feel torn because I can't do both at the same time. Sometimes I feel incredibly proud of my career and all I've achieved but equally I feel guilty that I should be putting that effort into caring for my son. Have I got the balance right?

It is challenging to enjoy the pleasantries of working life without forward planning – i.e. going for impromptu drinks after work, or attending training that finishes later than I am able to commit to. It is incredibly hard sometimes having to care 24/7 at work and at home, but massively rewarding at the same time.

I have sometimes felt like a liability in my job role which drives me to work harder. I have felt despondent at times, thinking that I wasn't a good option as an employee because I couldn't work full time or need flexibility, and I have been made to feel that I wasn't committed to my job.

Working Carers Staff Network have been awesome in making me realise that working carers are valued, supported, understood and protected. I had no idea about the carers passport before and now have one in place.

Now I am vocal about being a working carer, the staff network and the importance of supporting all carers – my son is my number one priority. Northamptonshire Carers are amazing, a member of their team visited and spent time with me, it was nice to feel understood and that I was important enough to be looked after too. She advised on my son and encouraged me to look after my wellbeing – I was given treats, a massage and a weekend away. I can't thank them enough. I now feel able to take time to care for myself and not feel guilty about it.

It's important for employers to value and understand working carers because we work hard! We are committed. We need work to keep us sane! We are flexible. I love my job. I was once asked why I work as most people in my position wouldn't. The simple answer is that I love my job, I'm committed and passionate and strive to give our service users the best possible care (that sounds so corny but that's what drives me)."

Gemma, Carer

HOW OUR QUALITY ACCOUNT WAS PREPARED

Many people, and health and wellbeing bodies were involved in developing our Quality Report and agreeing priorities for the next year. These included:

- Allied Healthcare Professional Advisory Committee
- Healthwatch
- Clinical Commissioning Group
- Northampton County Council
- Education and Training Team
- Nursing Advisory Committee
- Governor sub-group
- Patient Involvement Team, including patients, service users and carers
- Patient Experience Group
- Quality Forum
- Quality Team
- The Trust's non-executive directors
- The Trust's executive team
- The Quality and Governance Committee
- The Trust Board.

Themes identified in complaints and serious incidents were also used to help identify priorities for improvement during the next year.

OUR QUALITY CARE PRIORITIES

AN EASY READ VERSION:

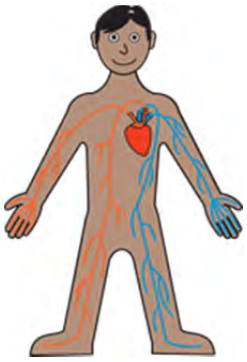
These are things we will do to make your care better next year:

- Strengthen our local induction programme for clinical staff
- Find better ways to make sure our staff know their jobs well

- Implement NEWS 2 across the relevant services
- Make sure we always check how to help people who are very ill

- Improve equality service user data
- Find better ways to keep records of the different types of people we care for

- Reduce the number of prone restraints used within Mental Health Inpatient Services, in line with our reduction strategy
- Find better ways to look after people who become upset while in our mental health care



- Increase our compliance with the number of relevant venous thromboembolism (VTE) assessments completed
- Make sure we look after people by checking if they have problems with their veins.

ANNEX 1

STATEMENTS FROM STAKEHOLDERS

NHS Improvement's Annual Reporting Manual determines the Trust's mandatory obligations for items to be included in the Annual Report. We welcome suggestions from our key stakeholders regarding content and incorporate these suggestions where it is appropriate to do so. Clinical Commissioning Groups, Healthwatch and the Overview and Scrutiny Committee (OSC) were all invited to comment on our Quality Report and we welcome their responses.

We include the feedback from our stakeholders exactly as it is received. Where we were able to make adjustments to the Quality Report we did so. We will continue to work with our stakeholder partners to provide further assurance that we deliver patient-centred, quality services.

Healthwatch Northamptonshire statement on Northamptonshire Healthcare NHS Foundation Trust (NHFT) draft Quality Account 2018/19

Healthwatch Northamptonshire has continued to work closely with NHFT over the past year through our representation on a number of NHFT groups and committees, including the Patient Experience Steering Group (where we are able to share feedback we have received from the public), the Mental Health Patient Experience Group, the Serious Incident Review Committee and the Moving Ahead project, including the Community Engagement steering group.

The feedback we receive from members of the public relating to services provided by NHFT is varied and as such it is difficult to identify common themes. However, we pass on issues raised with us and thank NHFT for valuing this feedback and looking into these issues where appropriate.

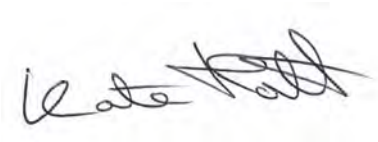
Healthwatch Northamptonshire welcomes the commitment from NHFT to learning from complaints and making improvements based on the feedback from patients and carers. We are pleased to see a slight decline in the number of complaints received in the previous year, and the rate of 100% responded to within 3 working days is impressive.

We congratulate NHFT for the achievement of 'Outstanding' status from the Care Quality Commission (CQC) following the inspection in July 2018. The Trust's continued commitment to patient and carer involvement, co-production and partnership across the organisation has no doubt contributed to the CQC's recognition of outstanding care. The staff survey results from 2018 are encouraging and indicate positive engagement from staff to ensure the Trust maintains high standards.

We note the progress on priorities set for 2018/19, in particular the commitment to learning from deaths. We welcome the appointment of the Patient and Family Liaison Lead, who provides support to patients, families and carers at crucial times such as investigations and inquests. We also appreciate this appointment's role in ensuring the Trust complies with the Duty of Candour.

Healthwatch Northamptonshire will watch with interest the Trust's priorities for the coming year, including improvements in collecting service user data, monitoring the physical health of service users with severe mental illness and the reduction of prone restraint in mental health inpatient services.

We will continue to work with NHFT to support, challenge and assist them in ensuring high quality, innovative and patient-centred care.



Kate Holt

CEO

Connected Together CIC (contract holder of Healthwatch Northamptonshire)

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 651252
Ref: AD/GOK/HS

16 May 2019

Private & Confidential
Julie Shepherd
Director of Nursing
Northamptonshire Healthcare NHS Foundation Trust
1st Floor, Carey Block
St Mary's Hospital
77 London Road
Kettering NN15 7PW

By email only: julie.shepherd@nhft.nhs.uk

Dear Julie

Northamptonshire Healthcare NHS Foundation Trust Annual Quality Account 2018/19

The Northamptonshire Healthcare NHS Foundation Trust (NHFT) annual quality account for 2018/19 has been reviewed by Northamptonshire Clinical Commissioning Groups.

It is noted that the report was reviewed whilst in draft format and, therefore, without a statement of quality or information regarding sub-contracted services. The trust should update the final report to reflect the actual achievement of the CQUIN full year end position.

Nationally mandated elements are included in the report together with internal and external assurance mechanisms for quality being used.

The annual quality account has sought and included the views of patients.

The trust should be congratulated on the overall 'Outstanding' rating of the Care Quality Commission inspection report undertaken in January 2018.

Northamptonshire Clinical Commissioning Groups look forward to continuing to work closely with the Trust in 2019/20.

Yours sincerely

Angela Dempsey
Interim Chief Nurse and Quality Officer
Northamptonshire Clinical Commissioning Groups

cc: Gabriella O'Keeffe, Head of Quality Transformation, Northamptonshire CCGs

Northamptonshire Healthcare 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 content flows well.
- The working group welcomes the 'Outstanding' rating achieved by NHFT in 2018. The working group considers that the Quality Report demonstrates that NHFT also remains focussed on maintaining and further improving its effectiveness even from its existing strong position.
- The working group considers that NHFT may have the least well-known role and functions of all of the major healthcare providers operating in Northamptonshire. It could therefore be beneficial for the Quality Account to include as part of its opening a clear, headline-level summary of the services that NHFT delivers. This would provide additional context for NHFT's performance in 2018/19 and its improvement priorities for 2019/20. The working group considers that this would assist the lay reader to see how the practically-focussed improvement priorities for 2019/20 chosen by NHFT link through to its overall vision and will support the effective delivery of services in areas such as mental health.
- On a very practical level the working group would have found it easier to consider the draft Quality Report if it had included page numbers.

ANNEX 2

STATEMENTS OF DIRECTORS' RESPONSIBILITIES

The directors are required under the Health Act 2009 and the National Health Service (Quality Accounts) Regulations to prepare Quality Accounts for each financial year. NHS Improvement has issued guidance to NHS foundation trust boards on the form and content of annual Quality Reports (which incorporate the above legal requirements) and on the arrangements that NHS foundation trust boards should put in place to support the data quality for the preparation of the Quality Report.

In preparing the Quality Report, directors are required to take steps to satisfy themselves that:

- The content of the quality report meets the requirements set out in the NHS foundation trust annual reporting manual 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 April 2018 to March 2019
    - Papers relating to quality reported to the board over the period April 2018 to March 2019
    - Feedback from commissioners dated 16 May 2019
    - Feedback from governors at the Governor Patient & Staff sub group 15 March 2019
    - Feedback from Healthwatch Northamptonshire dated 15 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 31 May 2018
    - The latest national patient survey dated March 2019
    - The latest national staff survey published by NHS England 26 February 2019
    - The Head of Internal Audit's annual opinion of the Trust's control environment dated 22 May 2019
    - The CQC inspection report dated 16 August 2018
    - Feedback from the Complaints and Patient Advice and Liaison Service on 31 May 2018
- The Quality Report presents a balanced picture of the Trust's performance over the period covered
- The performance information reported in the Quality Report is reliable and accurate
- There are proper internal controls over the collection and reporting of the measures of performance included in the Quality Report, and these controls are subject to review to confirm that they are working effectively in practice
- The data underpinning the measures of performance reported in the Quality Report is robust and reliable, conforms to specified data quality standards and prescribed definitions and 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

Crishni Waring

Chair

22 May 2019

Angela Hillery

Chief Executive

22 May 2019

KPMG

INDEPENDENT AUDITOR'S REPORT TO THE COUNCIL OF GOVERNORS OF NORTHAMPTONSHIRE HEALTHCARE NHS FOUNDATION TRUST ON THE QUALITY REPORT

We have been engaged by the Council of Governors of Northamptonshire Healthcare NHS Foundation Trust to perform an independent assurance engagement in respect of Northamptonshire Healthcare NHS Foundation Trust's Quality Report for the year ended 31 March 2019 (the 'Quality Report') and certain performance indicators contained therein.

Scope and subject matter

The indicators for the year ended 31 March 2019 subject to limited assurance consist of the following two national priority indicators:

- early intervention in psychosis (EIP): people experiencing a first episode of psychosis treated with a National Institute for Health and Care Excellence (NICE)-approved care package within two weeks of referral
- inappropriate out-of-area placements for adult mental health services

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

Respective responsibilities of the directors and auditors

The directors are responsible for the content and the preparation of the Quality Report in accordance with the criteria set out in the *NHS Foundation Trust Annual Reporting Manual* issued by NHS Improvement.

Our responsibility is to form a conclusion, based on limited assurance procedures, on whether anything has come to our attention that causes us to believe that:

- the Quality Report is not prepared in all material respects in line with the criteria set out in the *NHS Foundation Trust Annual Reporting Manual* and supporting guidance;
- the Quality Report is not consistent in all material respects with the sources specified in the *Detailed requirements for quality reports for foundation trusts 2018/19* ('the Guidance'); and
- the indicators in the Quality Report identified as having been the subject of limited assurance in the Quality Report are not reasonably stated in all material respects in accordance with the NHS Foundation Trust Annual Reporting Manual and the six dimensions of data quality set out in the Guidance.

We read the Quality Report and consider whether it addresses the content requirements of the NHS Foundation Trust Annual Reporting Manual and consider the implications for our report if we become aware of any material omissions.

We read the other information contained in the Quality Report and consider whether it is materially inconsistent with:

- Board minutes and papers for the period April 2018 to May 2019;
- papers relating to quality reported to the board over the period April 2018 to May 2019;
- feedback from commissioners, dated 16 May 2019;
- feedback from governors, dated 15 March 2019;
- feedback from local Healthwatch organisations, dated 15 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;
- the latest national patient survey, dated March 2019;

- the latest national staff survey, dated February 2019;
- Care Quality Commission Inspection, dated 16 August 2018;
- the 2018/19 Head of Internal Audit's annual opinion over the trust's control environment, dated 22 May 2019; and
- any other information included in our review.

We consider the implications for our report if we become aware of any apparent misstatements or material inconsistencies with those documents (collectively, the 'documents'). Our responsibilities do not extend to any other information.

We are in compliance with the applicable independence and competency requirements of the Institute of Chartered Accountants in England and Wales (ICAEW) Code of Ethics. Our team comprised assurance practitioners and relevant subject matter experts.

This report, including the conclusion, has been prepared solely for the Council of Governors of Northamptonshire Healthcare NHS Foundation Trust as a body, to assist the Council of Governors in reporting the NHS Foundation Trust's quality agenda, performance and activities. We permit the disclosure of this report within the Annual Report for the year ended 31 March 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 indicator. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the Council of Governors as a body and Northamptonshire Healthcare NHS Foundation Trust for our work or this report, except where terms are expressly agreed and with our prior consent in writing.

Assurance work performed

We conducted this limited assurance engagement in accordance with International Standard on Assurance Engagements 3000 (Revised) – 'Assurance Engagements other than Audits or Reviews of Historical Financial Information', issued by the International Auditing and Assurance Standards Board ('ISAE 3000'). Our limited assurance procedures included:

- evaluating the design and implementation of the key processes and controls for managing and reporting the indicator;
- making enquiries of management;
- testing key management controls;
- limited testing, on a selective basis, of the data used to calculate the indicator back to supporting documentation;
- comparing the content requirements of the NHS Foundation Trust Annual Reporting Manual to the categories reported in the Quality Report; and
- reading the documents.

A limited assurance engagement is smaller in scope than a reasonable assurance engagement. The nature, timing and extent of procedures for gathering sufficient appropriate evidence are deliberately limited relative to a reasonable assurance engagement.

Limitations

Non-financial performance information is subject to more inherent limitations than financial information, given the characteristics of the subject matter and the methods used for determining such information.

The absence of a significant body of established practice on which to draw allows for the selection of different, but acceptable measurement techniques which can result in materially different measurements and can affect comparability. The precision of different measurement techniques may also vary. Furthermore, the nature and methods used to determine such information, as well as the measurement criteria and the precision of these criteria, may change

over time. It is important to read the quality report in the context of the criteria set out in the *NHS Foundation Trust Annual Reporting Manual* and supporting guidance.

The scope of our assurance work has not included governance over quality or the non-mandated indicator, which was determined locally by Northamptonshire Healthcare NHS Foundation Trust.

Conclusion

Based on the results of our procedures, nothing has come to our attention that causes us to believe that, for the year ended 31 March 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 and supporting guidance;
- the Quality Report is not consistent in all material respects with the sources specified in the Guidance; and
- the indicators in the Quality Report subject to limited assurance have not been reasonably stated in all material respects in accordance with the NHS Foundation Trust Annual Reporting Manual and the six dimensions of data quality set out in the Guidance.

Andrew Bostock
Partner
KPMG LLP
Chartered Accountants
One Snowhill
Snow Hill Queensway
Birningham
B4 6GH

28 May 2018

FINANCE REPORT

INTRODUCTION

NHS Improvement, the sector regulator for health services in England, in exercise of powers conferred on it by paragraphs 24 and 25 of Schedule 7 of the National Health Service Act 2006, directs that the keeping of accounts and the annual report of each NHS Foundation Trust shall be in the form as laid down in the annual reporting guidance for NHS Foundation Trusts within the NHS Foundation Trust Annual Reporting Manual, known as the FT ARM, that is in force for the relevant financial period. The accounts have been prepared in accordance with paragraphs 24 and 25 of Schedule 7 to the National Health Service Act 2006 as laid down in the FT ARM.

These accounts cover the financial year 2018/19 and provide figures for 2017/18 for comparison where required. After making enquiries, the directors have a reasonable expectation that the Trust has adequate resources to continue in operational existence for the foreseeable future. For this reason, we continue to adopt the going concern basis in preparing our accounts. These pages include the following financial statements and information:

Statement of comprehensive income (SoCI)

Statement of financial position

Statement of changes in taxpayers' equity

Statement of cash flows

Notes to the accounts

Accounting policies for pensions and other retirement benefits are set out in the notes to the accounts and details of senior managers' remuneration can be found in the remuneration report.

Angela Hillery

Chief Executive
22 May 2019

STATEMENT OF RESPONSIBILITIES

Statement of the chief executive's responsibilities as the accounting officer of Northamptonshire Healthcare NHS Foundation Trust

The NHS Act 2006 states that the chief executive is the accounting officer of the NHS foundation trust. The relevant responsibilities of the accounting officer, including their responsibility for the propriety and regularity of public finances for which they are answerable, and for the keeping of proper accounts, are set out in the NHS Foundation Trust accounting officer Memorandum issued by NHS Improvement.

NHS Improvement, in exercise of the powers conferred on Monitor by the NHS Act 2006, has given Accounts Directions which require Northamptonshire Healthcare NHS Foundation Trust to prepare for each financial year a statement of accounts in the form and on the basis required by those Directions. The accounts are prepared on an accruals basis and must give a true and fair view of the state of affairs of Northamptonshire Healthcare NHS Foundation Trust and of its income and expenditure, total recognised gains and losses and cash flows for the financial year.

In preparing the accounts, the accounting officer is required to comply with the requirements of the Department of Health Group Accounting Manual and in particular to:

- Observe the Accounts Direction issued by NHS Improvement, including the relevant accounting and disclosure requirements, and apply suitable accounting policies on a consistent basis
- Make judgements and estimates on a reasonable basis
- State whether applicable accounting standards as set out in the NHS Foundation Trust Annual Reporting Manual (and the Department of Health Group Accounting Manual) have been followed, and disclose and explain any material departures in the financial statements
- Ensure that the use of public funds complies with the relevant legislation, delegated authorities and guidance and
- Prepare the financial statements on a going concern basis.

The accounting officer is responsible for keeping proper accounting records, which disclose with reasonable accuracy at any time the financial position of the Northamptonshire Healthcare NHS Foundation Trust and to enable them to ensure that the accounts comply with requirements outlined in the above-mentioned Act. The accounting officer is also responsible for safeguarding the assets of the Northamptonshire Healthcare NHS Foundation Trust and hence for taking reasonable steps for the prevention and detection of fraud and other irregularities.

To the best of my knowledge and belief, I have properly discharged the responsibilities set out in the NHS Foundation Trust Accounting Officer Memorandum.

Angela Hillery
Chief Executive
22 May 2019

Northamptonshire Healthcare NHS Foundation Trust has complied with the cost allocation and charging requirements set out in HM Treasury and Office of Public Sector Information guidance. The directors consider the annual report and accounts, taken as a whole, to be fair, balanced and understandable and provides the information necessary for patients, regulators and stakeholders to assess the Trust's performance, business model and strategy.

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FINANCIAL STATEMENTS

STATEMENT OF COMPREHENSIVE INCOME FOR THE PERIOD ENDED 31 MARCH 2019	NOTE	2018/2019 £000	2017/2018 £000
Operating revenue			
Revenue from patient care activities	4	201,878	186,736
Other operating revenue	5	14,551	12,171
Operating expenses, of which:	6	**(208,093)**	**(187,077)**
Employee benefits	8	(146,792)	(136,346)
Other operating expenses	6	(61,301)	(50,731)
Net operating surplus/(deficit)		**8,336**	**11,830**
Financing			
Finance income	12	227	92
Finance cost - financial liabilities	14	(2,594)	(2,710)
Public dividend expense		(1,838)	(1,429)
Net finance costs		(4,205)	(4,047)
Gains/(losses) on disposal of assets	13	(7)	110
Share of profit/(loss) of associates/ joint ventures	19	0	(148)
Gain/(loss) on transfer by absorption	9	0	0
Retained surplus/(deficit) for the period*		**4,124**	**7,745**
Other comprehensive income			
Impairments and reversals taken to revaluation reserve	43	(810)	(93)
Gains on revaluations	15/16	2,942	11,248
Remeasurements of defined benefit pension scheme (liability)/assets	9	0	0
Net gain/(loss) on other reserves		0	0
Net gain/(loss) on available for sale financial assets		0	0
Asset disposals		0	0
Other reserve movements	9	0	0
Reclassification adjustments:			
- Transfers from donated and government grant reserves		0	0
- On disposal of available for sale financial assets		0	0
Total comprehensive income for the period		**6,256**	**18,900**

Note*

Includes Provider Sustainability Funding (was previously Sustainability Transformation Funding) of	**3,687**	**4,243**
Retained surplus/(loss) excluding Provider Sustainability Funding	**437**	**3,502**

The notes that follow form part of these accounts.

STATEMENT OF FINANCIAL POSITION AS AT 31 MARCH 2019

	NOTE	31 March 2019 £000	31 March 2018 £000
Non-current assets			
Property, plant and equipment	15	115,531	111,007
Intangible assets	16	2,725	2,287
Investment in associate	19	0	0
Other investments	20	76	76
Other financial assets	23	0	0
Total non-current assets		118,332	113,370
Current assets			
Inventories	21	84	85
Trade and other receivables	22	10,702	11,636
Other financial assets	23	0	0
Other current assets	24	0	0
Cash and cash equivalents	25	42,837	37,541
Non-current assets held for sale	15	250	0
Total current assets		53,873	49,262
Total assets		172,205	162,632
Current liabilities			
Trade and other payables	26	(27,072)	(23,748)
Other liabilities	28	(3,719)	(2,488)
Borrowings	27	(987)	(1,005)
Other financial liabilities	33	0	0
Provisions	34	(5,948)	(6,467)
Total current liabilities		(37,726)	(33,708)
Net current assets/(liabilities)		16,147	15,554
Total assets less current liabilities		134,479	128,924
Non-current liabilities			
Borrowings	27	(33,042)	(34,029)
Trade and other payables	26	(217)	(237)
Provisions	34	(438)	(453)
Other liabilities	28	0	0
Total assets employed		100,782	94,205
Financed by taxpayers' equity			
Public dividend capital	SoCITE	37,576	37,255
Retained earnings	SoCITE	34,454	30,330
Revaluation reserve	43	28,752	26,620
Total taxpayers' equity		100,782	94,205

These financial statements were approved by 'those charged with governance' on behalf of the board of directors on 22 May 2019 and signed on its behalf by:

Angela Hillery, Chief Executive

STATEMENT OF CHANGES IN TAXPAYERS' EQUITY

	Public dividend capital (PDC)	Retained earnings	Revaluation reserve	Donated asset reserve	Gov't grant reserve	Pension reserve	Total
	£000	£000	£000	£000	£000	£000	£000
Taxpayers equity at 1 April 2018	**37,255**	**30,330**	**26,620**	**0**	**0**	**0**	**94,205**
Retained surplus/(deficit) for the period	0	4,124	0	**0**	**0**	**0**	**4,124**
Transfers between reserves	0	0	0	**0**	**0**	**0**	**0**
Impairments and reversals	0	0	(810)	**0**	**0**	**0**	**(810)**
Net gain/(loss) on revaluation of property, plant, equipment	0	0	2,942	**0**	**0**	**0**	**2,942**
Asset disposals	0	0	0	**0**	**0**	**0**	**0**
Remeasurement of defined net benefit pension scheme asset/liability	0	0	0	**0**	**0**	**0**	**0**
Other reserve movements	0	0	0	**0**	**0**	**0**	**0**
Originating capital for Trust establishment in period	0	0	0			**0**	**0**
New PDC received	321	0	0	**0**	**0**	**0**	**321**
Balance at 31 March 2019	**37,576**	**34,454**	**28,752**	**0**	**0**	**0**	**100,782**
Taxpayers equity at 1 April 2017	**37,255**	**22,585**	**15,465**	**0**	**0**	**0**	**75,305**
Retained surplus/(deficit) for the period	0	7,745	0	0	0	0	7,745
Transfers between reserves	0	0	0	0	0	0	0
Impairments and reversals	0	0	(93)	0	0	0	(93)
Net gain/(loss) on revaluation of property, plant, equipment	0	0	11,248	0	0	0	11,248
Asset disposals	0	0	0	0	0	0	0
Remeasurement of defined net benefit pension scheme asset/liability	0	0	0	0	0	0	0
Other reserve movements	0	0	0	0	0	0	0
New PDC received	0	0	0	0	0	0	0
Balance at 31 March 2018	**37,255**	**30,330**	**26,620**	**0**	**0**	**0**	**94,205**

STATEMENT OF CASH FLOWS FOR THE PERIOD ENDED 31 MARCH 2019

	NOTE	31 March 2019 £000	31 March 2018 £000
Cash flows from operating activities			
Operating surplus/(deficit)	SoCI	8,336	11,830
Depreciation and amortisation	15/16	5,041	4,800
Impairments and (reversals)	17	(459)	(1,754)
Pension liability	9	0	0
(Increase)/decrease in inventories	21	1	42
(Increase)/decrease in trade and other receivables	22	865	(3,966)
(Increase)/decrease in other current assets	24	0	0
Increase/(decrease) in trade and other payables	26	2,404	(1,423)
Increase/(decrease) in other liabilities	28	1,231	2,276
Increase/(decrease) in provisions	34	(545)	(571)
Other movements in operating cash flows		0	0
Net cash inflow/(outflow) from operating activities		**16,874**	**11,234**
Cash flows from investing activities			
Interest received	12	227	92
Purchase of property, plant and equipment	15	(6,071)	(3,321)
Sale of property, plant and equipment	15	0	198
Purchase of intangible assets	16	(888)	(959)
Purchase of other investments	20	0	0
Sale of other financial assets	20	0	3
Net cash inflow/(outflow) from investing activities		**(6,732)**	**(3,987)**
Net cash inflow/(outflow) before financing		**10,142**	**7,247**
Cash flows from financing activities			
Public dividend capital received		321	0
Capital element of PFI obligations	32	(1,001)	(1,298)
Capital element of finance lease payments	29	(4)	(5)
Interest paid	14	0	0
Interest element of PFI obligations	32	(2,581)	(2,695)
Interest element of finance lease payments	29	(2)	(2)
PDC dividends paid		(1,579)	(1,142)
Cash flows from other financing activities		0	0
Net cash inflow/(outflow) from financing		**(4,846)**	**(5,142)**
Net increase/(decrease) in cash and cash equivalents		**5,296**	**2,105**
Cash and cash equivalents (and bank overdrafts) at the beginning of the period		37,541	35,436
Cash and cash equivalents (and bank overdrafts) at the end of the financial period	25	**42,837**	**37,541**

NOTES TO THE ACCOUNTS

1.0 Accounting policies and other information

NHS Improvement, in exercising the statutory functions conferred on Monitor, has directed that the financial statements of NHS foundation trusts shall meet the accounting requirements of the *Department of Health and Social Care Group Accounting Manual (GAM)* which shall be agreed with HM Treasury. Consequently, the following financial statements have been prepared in accordance with the GAM 2018/19 issued by the Department of Health and Social Care. The accounting policies contained in the GAM follow International Financial Reporting Standards (IFRS) to the extent that they are meaningful and appropriate to the NHS, as determined by HM Treasury, which is advised by the Financial Reporting Advisory Board. Where the GAM permits a choice of accounting policy, the accounting policy that is judged to be most appropriate to the particular circumstances of the NHS foundation trust for the purpose of giving a true and fair view has been selected. The particular polices adopted are described below. The accounting policies have been applied consistently in dealing with items considered material in relation to the accounts.

1.1 Going Concern

This Annual Report and Accounts have been prepared on a going concern basis. Non-trading bodies in the public sector are assumed to be going concerns where the continued provision of a service in the future is anticipated, as evidenced by inclusion of financial provision for that service in published documents.

1.2 Accounting convention

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

1.3 Consolidation

1.3.1 Subsidiaries

Entities over which the foundation trust has the power to exercise control are classified as subsidiaries and consolidated. The foundation trust has control when it has the ability to affect the variable returns from the other entity through its power to direct activities. The income, expenses, assets, liabilities, equity and reserves of the subsidiary are consolidated in full into the appropriate financial statement lines. The capital and reserves attributable to non-controlling interests are included as a separate item in the Statement of Financial Position. Appropriate adjustments are made on consolidation where the subsidiary's accounting policies are not aligned with the foundation trust or where the subsidiary's accounting date is not coterminous. Subsidiaries that are classified as held for sale are measured at the lower of their carrying amount or 'fair value less selling costs'.
The foundation trust has charitable funds that are managed alongside those from Northampton General Hospital NHS Trust (NGH). The charity responsible for managing the funds attained independent status in 1 April 2016 and as such the power to govern the financial and operating policies of the funds sits with them.

As the value of the charitable funds is not considered to be material to the foundation trust's accounts and the funds are managed on its behalf by the independent charity, they have not been consolidated in these accounts. The foundation trust has not accounted for any subsidiaries in the financial statements for this period.

1.3.2 Associates

Entities over which the foundation trust has the power to exercise a significant influence so as to obtain economic or other benefits are classified as associates and are recognised in these financial statements using the equity method. Per IAS 28 Investments in Associates and Joint Ventures, significant influence is considered to be a holding of 20% or more of the voting rights in an entity. The investment is initially recognised at cost. It is increased or decreased later to reflect the foundation trust's share of the entity's profit or loss or other gains and losses (e.g. revaluation gains on the entity's property, plant and equipment) following acquisition. It is also reduced when any distribution e.g. share dividends are received by the foundation trust from the associate. Associates that are classified as 'held for sale' are measured at the lower of their carrying amount or 'fair value less selling costs'. The foundation trust has accounted for its investment in First for Wellbeing as an associate as it holds 38% of the voting rights. The investment in First for Wellbeing is accounted for using the equity method.

1.3.3 Joint arrangements

Arrangements over which the foundation trust has joint control with one or more other entities are classified as joint arrangements. A joint arrangement is either a joint operation or a joint venture.

A joint venture is a joint arrangement whereby the parties that have joint control of the arrangement have rights to the net assets of the arrangement. Joint ventures are recognised as an investment and accounted for using the equity method.

The Trust has not accounted for any joint ventures in the financial statements for this period.

A joint operation exists where the parties that have joint control have rights to the assets and obligations for the liabilities relating to the arrangement. Where the foundation trust is a joint operator it recognises its share of assets, liabilities, income and expenses in its own accounts. The foundation trust has not accounted for any joint operations in the financial statements for this period.

1.3.4 Other investments

Investment in associates and joint ventures that are not considered to be material are accounted for as non-current financial assets. The foundation trust has accounted for its investment in 3Sixty Care Ltd as a financial asset and has recognised the fair value of the shareholding within Other Investments. The foundation trust is deemed to have significant influence over the entity by way of the 50% shareholding but the share of profit and net assets of the entity are not considered to be material.

1.4 Critical accounting judgements and key sources of estimation uncertainty

In the application of the foundation trust's accounting policies, management is required to make various judgments, estimates and assumptions. These are regularly reviewed.

1.4.1 Critical judgements in applying accounting polices

The following are the judgments, apart from those involving estimations (see below) that management has made in the process of applying the foundation trust's accounting policies and that have the most significant effect on the amounts recognised in the financial statements.

1.4.1.1 Depreciation of property, plant and equipment

Judgments are required to give useful lives and residual values to property, plant and equipment. Key sources of those values are based on regular studies of actual asset lives and the intended use for those assets. Changes in technology or the condition of the asset may mean that the actual life or remaining value is different to the estimate. Where the foundation trust decides that the useful life of property, plant and equipment should be shortened or residual value reduced, it depreciates the net book value in excess of the residual value over the revised remaining useful life, as a result increasing depreciation expense. Any change in an asset's life or residual value is shown in the foundation trust's financial statements when the change in estimate is decided.

1.4.1.2 Impairment of property, plant and equipment and intangible assets

The identification of impairment indicators and the deciding of the recoverable amount for assets need good judgment concerning the identification and proof of impairment indicators. Key sources on impairment indicators are found externally and internally.
External sources of information may be:

1. During the period, an asset's market value has declined a lot more than would be expected during normal use over time
2. Significant changes in technology and regulatory environments and
3. Significant dips in the economy.

Internal sources of information may be:

4. Out of date or physical damage
5. Not able to perform to the expected level now or in the future and
6. Large changes in the use of its assets or the strategy for its overall use.

The foundation trust decides any impairment by comparing the carrying values of assets to their net realisable value. Net realisable value represents fair value as assessed through valuation on a modern equivalent assets basis.

1.4.1.3 Revenue recognition

Revenue, which does not include discounts, represents the amount due for services provided to customers and is accounted for on an accrual basis to match revenue with the provision of service. Revenue is recognised monthly as services are provided. Where services are invoiced in advance, revenue is deferred and recognised when the service is delivered. Revenue for unbilled services is accrued. Judgment is required in how these principles are applied and the specific guidance for foundation trust revenues.

1.4.1.4 Fair value estimation

The fair value of financial instruments that are not traded in an active market is agreed by using valuation techniques. The foundation trust uses a variety of methods and makes assumptions that are based on the market conditions at each statement of financial position date.
In the application of the foundation trust's accounting policies, management is required to make judgments, estimates and assumptions about the carrying amounts of assets and liabilities that are not obvious from other sources. The estimates and associated assumptions are based on historical experience and other helpful factors. Actual results may differ from those estimates and the estimates and underlying assumptions are continually reviewed.

Revisions to accounting estimates are recognised in the period they affect, when the estimate is revised. That may be only one period or in the period of the revision and future periods.

The nominal value less estimated credit adjustments of trade receivables and payables are assumed to approximate their fair values. The fair value of financial liabilities for disclosure purposes is estimated by discounting the future contractual cash flows at the current market interest rate that is available to the foundation trust for similar financial instruments. The following are the critical judgments, apart from those involving estimations (see below) that management has made in the process of applying the foundation trust's accounting policies and that have the largest effect on the amounts included in the financial statements.

1.4.2 Key sources of estimation uncertainty

The following are assumptions about the future and other major sources of estimation uncertainty that have a significant risk of resulting in a material adjustment to the carrying amounts of assets and liabilities within the next financial year.

1.4.2.1 Provisions

The identification of impairment indicators and the deciding of the recoverable amount for assets need good judgment concerning the identification and proof of impairment indicators. Key sources on impairment indicators are found externally and internally.

1.5 Transfers of functions

As public sector bodies are deemed to operate under common control, business reconfigurations within the DHSC group are outside the scope of IFRS 3 Business Combinations.
Where functions transfer between two public sector bodies, the GAM requires the application of 'absorption accounting'.

Absorption accounting requires that entities account for their transactions in the period in which they took place. Where assets and liabilities transfer, the gain or loss resulting is recognised in the Statement of Comprehensive Income, and is disclosed separately from operating costs.

1.6 Pooled budgets

The foundation trust has not entered into any pooled budgets in the financial year.

1.7 Operating segments

Income and expenditure are analysed in the Operating Segments note and are reported in line with management information used within the foundation trust.

1.8 Revenue

The main source of revenue for the foundation trust is contracts with commissioners in respect of healthcare services. Revenue in respect of services provided is recognised when, and to the extent that, performance occurs, and is measured at the fair value of the consideration receivable. At the year end, the foundation trust accrues income relating to activity delivered in that year. Where a patient spell (where applicable) is incomplete at the year end, revenue relating to the partially completed spell is accrued and agreed with the commissioner.

Where income is received for a specific activity that is to be delivered in the following financial year, that income is deferred.

The foundation trust receives income under the NHS Injury Cost Recovery Scheme, designed to reclaim the cost of treating injured individuals to whom personal injury compensation has subsequently been paid, for instance by an insurer. The foundation trust recognises the income when it receives notification from the Department of Work and Pensions' Compensation Recovery Unit that the individual has logged a compensation claim. The income is measured at the agreed tariff for the treatments provided to the injured individual, less a provision for unsuccessful compensation claims and doubtful debts.
Income from the sale of non-current assets is recognised only when all material conditions of sale have been met, and is measured as the sums due under the sale contract.
Revenue in respect of services provided is recognised when, and to the extent that, performance occurs, and is measured at the fair value of the consideration receivable.
Where income is for a specific activity that is to be delivered in the following year, that income is deferred.

1.9 Expenditure on employee benefits

1.9.1 Short-term employee benefits
Salaries, wages and employment-related payments are recognised in the period in which the service is received from employees, including non-consolidated performance pay earned by not yet paid. The cost of leave entitlement earned but not taken by employees at the end of the period is recognised in the financial statements to the extent that employees are allowed to carry forward leave into the following period.

1.9.2. Retirement benefit costs

1.9.2.1 NHS Pension Scheme

Past and present employees are covered by the NHS Pension Schemes. These scheme are unfunded, defined benefit schemes that covers NHS employers, general practices and other bodies, allowed under the direction of Secretary of State, in England and Wales. The schemes are not designed to be run in a way that would enable NHS bodies to identify their share of the underlying scheme assets and liabilities. Therefore, the schemes are accounted for as though they were defined contribution schemes: the cost to the foundation trust or participating in a scheme is taken as equal to the contributions payable to the scheme for the accounting period.

For early retirements other than those due to ill health the additional pension liabilities are not funded by the scheme. The full amount of the liability for the additional costs is charged to expenditure at the time the foundation trust commits itself to the retirement, regardless of the method of payment. The schemes are subject to a full actuarial valuation every four years and an accounting valuation every year.

1.9.2.2 National Employment Savings Trust (NEST)

The Pensions Act 2008 requires the foundation trust to automatically enrol all eligible staff into a workplace pension scheme.
If staff meet the eligibility criteria for the NHS Pension scheme they will be automatically enrolled into it. If staff are eligible under auto enrolment law but do not meet the eligibility criteria for the NHS Pension scheme they will be automatically enrolled into the NEST scheme, which is the foundation trust's designated alternate scheme. NEST is a defined contribution pension scheme and details of the contributions paid by the Trust on behalf of employees are shown in note 9.2 to the accounts.

1.10 Other expenses

Other operating expenses are recognised when, and to the extent that, the goods or services have been received. They are measured at the fair value of the consideration payable.

1.10.1 Value Added Tax (VAT)

Most of the activities of the foundation trust are outside the scope of VAT. Irrecoverable VAT is charged to the relevant expenditure category or included in the capitalised purchase cost of non-current assets. Where output tax is charged or input VAT is recoverable, the amounts are stated net of VAT.

1.11 Corporation Tax

NHS foundation trusts must pay corporation tax if they are delivering large scale commercial activities that are not part of core health care delivery, like running a commercial laundry. The majority of the foundation trust's income is core health care and so corporation tax was not payable by the Trust in 2018/2019.

1.12 Property, plant and equipment

1.12.1 Recognition

Property, plant and equipment is capitalised where:

- It is used for delivering services or for administrative purposes
- It is probable that future economic benefits will flow to, or service potential be provided to the foundation trust

- It is expected to be used for more than one financial year
- The cost of the item can be measured reliably, and either
- The item has a cost of at least £5,000 or
- Collectively, a number of items have a cost of at least £5,000 and individually have a cost of more than £250,where the assets are functionally interdependent, had broadly simultanous purchase dates, are expected to have simultaneous disposal dates and are under single managerial control or
- Items are part of the initial equipping and setting-up cost of a new building, ward or unit, whatever their individual or group cost.

Leased assets valued at the start of the lease at less than £5,000 will not be capitalised and will be expensed through the Statement of Comprehensive Income. Where a large asset, for example a building, includes a number of parts with significantly different asset lives, the components are treated as separate assets and depreciated over their individual useful economic lives.

1.12.2 Measurement
1.12.2.1 Valuation
All property, plant and equipment assets are measured to begin with at cost, representing the cost directly attributable to acquiring or constructing the asset and bringing it to the location and condition necessary for it to be capable of operating in the manner intended by management.

Assets that are held for their service potential and are in use are measured subsequently at their current value in existing use. Assets that are most recently held for their service potential but are surplus are measured at fair value where there are no restrictions preventing access to the market at the reporting date. An item of property, plant and equipment which is surplus with no plan to bring it back into use is valued at fair value under IFRS 13 fair value measurement, if it does not meet the requirements of IAS 40 investment property or IFRS 5 non-current assets held for sale. Revaluations or property, plant and equipment are performed with sufficient regularity to ensure that carrying amounts are not materially different from those that would be determined at the end of the reporting period.

Current values in use are determined as follows:

Land and non-specialised buildings – market value for existing use

Specialised buildings – depreciated replacement cost, modern equivalent asset basis.

Valuation services are provided to the Trust by District Valuer Services, Valuation Office Agency (VOA) and a full five year valuation was undertaken as at 31 March 2019. District Valuer Services (DVS) is the specialist property arm of the Valuation Office Agency (VOA), who provide independent, impartial, valuation and professional property advice across the entire public sector.

Properties in the course of construction for service or administration purposes are carried at cost, less any impairment loss. Cost includes professional fees and, where capitalised in accordance with IAS 23, borrowing costs. Assets are revalued and depreciation commences when they are brought into use.

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

An increase arising on revaluation is taken to the revaluation reserve except where it reverses an impairment for the same asset previously recognised in expenditure, in which case it is credited to expenditure to the extent of the decrease previously charged there. A revaluation decrease that does not result from a loss of economic value or service potential is recognised as an impairment charged to the revaluation reserve to the extent that there is a balance on the reserve for the asset, and thereafter to expenditure. Gains and losses recognised in the revaluation reserve are reported as other comprehensive income in the Statement of Comprehensive Income.

1.12.2.2 Subsequent expenditure
Where subsequent expenditure enhances an asset beyond its original specification, the directly attributable cost is capitalised.

Where subsequent expenditure restores the asset to its original specification, the expenditure is capitalised and any existing carrying value of the item replaced is written-out and charged to operating expenses.

1.12.2.3 De-recognition
Assets intended for disposal are reclassified as Held for Sale once all of the following criteria are met:

- The asset is available for immediate sale in its present condition subject only to terms which are normal for such sales
- The sale must be highly probable i.e.:
  - Management are committed to a plan to sell the asset
  - An active programme has begun to find a buyer and complete the sale
  - The asset is being actively marketed at a reasonable price
  - The sale is expected to be completed within 12 months of the date of classification as Held for Sale and
  - The actions needed to complete the plan indicate it will go ahead without major changes

Following reclassification, the assets are measured at the lower of their existing carrying amount and their fair value minus the selling costs. Depreciation stops being charged and the assets are not revalued, except where the fair value minus selling costs becomes less than the carrying amount. Assets are de-recognised when all material sale contract conditions have been met.

Property, plant and equipment which is to be scrapped or demolished does not qualify for recognition as Held for Sale and instead is retained as an operational asset and the asset's economic life is adjusted. The asset is de-recognised when scrapping or demolition takes place.

1.13 Investment properties

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

1.14 Intangible assets

1.14.1 Recognition
Intangible assets are non-monetary assets without physical substance, which are capable of sale separately from the rest of the foundation trust's business or which arise from contractual or other legal rights. They are recognised only when it is probable that future economic benefits will flow to, or service potential be provided to, the foundation trust; where the cost of the asset can be measured reliably; and where the cost is at least £5,000.
Software that is integral to the operating of hardware, e.g. an operating system, is capitalised as part of the relevant item of property, plant and equipment. Software that is not integral to the operation of hardware, e.g. application software, is capitalised as an intangible asset.
Internally generated goodwill, brands, mastheads, publishing titles, customer lists and similar items are not capitalised as intangible assets. Expenditure on research is not capitalised: it is recognised as an operating expense in the period in which it is incurred.
Internally generated assets are recognised if, and only if, all of the following have been demonstrated:

- The technical feasibility of completing the intangible asset so that it will be available for use
- The intention to complete the intangible asset and use it
- The ability to sell or use the intangible asset
- How the intangible asset will generate probable future economic benefits or service potential, e.g. the presence of a market for it or its output, or where it is to be used for internal use, the usefulness of the asset
- The availability of adequate financial, technical and other resources to complete the intangible asset and sell or use it, and
- The ability to measure reliably the expenditure attributable to the intangible asset during its development.

1.14.2 Measurement
Intangible assets acquired separately are recognised initially at cost. The amount initially recognised for internally-generated intangible assets is the sum of the expenditure incurred when the criteria for recognition are initially met. Where no internally-generated intangible asset can be recognised, the expenditure is recognised in the period in which it is incurred.

Following initial recognition, intangible assets are carried at current value in exiting use by reference to an active market, or, where no market exists, at the lower of amortised replacement cost (modern equivalent assets basis) and value in use where the asset is income generating. Internally-developed software is held at historic cost to reflect the opposing effects of increases in development costs and technological advances. Revaluation gains and losses and impairments are treated in the same manner as for property, plant and equipment.

1.15 Depreciation, amortisation and impairments

Freehold land is considered to have an endless life and is not depreciated. Assets under construction or development, and assets held for sale are not depreciated/amortised. Otherwise, depreciation or amortisation is charged to write off the costs or valuation of property, plant and equipment and intangible assets, less any residual value, on a straight line basis over their estimated useful economic lives. The estimated useful life of an asset is the period over which the foundation trust expects to obtain economic benefit or service potential from the asset. This is specific to the foundation trust and may be shorted than the physical life of the asset itself. Estimated useful lives and residual values are reviewed each year end, with the effect of any changes recognised on a prospective basis. The foundation trust has decided the useful economic lives for each category of asset to be:

- Buildings
  determined by working with an External Valuer
- Plant and machinery
  5-15 years
- Medical and other equipment
  5-15 years
- Transport equipment
  7 years
- Information technology
  5-10 years
- Mainframe IT equipment
  8 years
- Fixtures and fittings
  5-10 years
- Software
  by reference to the licencing agreement.

Assets held under finance leases are depreciated over the shorter of the lease term and the useful economic lives, unless the foundation trust expects to acquire the asset at the end of the lease term, in which case the asset is depreciated in the same manner as for owned assets. Property, plant and equipment that have been reclassified as Held for Sale stop being depreciated when they are reclassified. Assets being built and residual interests in off-Statement of Financial Position PFI contract assets are not depreciated, until the asset is brought into use or reverts to the Trust, respectively.

At each financial year end, the foundation trust checks whether there is any indication that its property plant and equipment or intangible assets have suffered an impairment loss. If there is indication of such an impairment, the recoverable amount of the asset is estimated to determine whether there has been a loss and, if so, its amount. Intangible assets not yet available for use are tested for impairment annually at the financial year end.

Impairment losses that arise from a clear consumption of economic benefit are taken to expenditure. Where an impairment loss subsequently reverses, the carrying amount of the asset is increased to the revised estimate of the recoverable amount but capped at the amount that would have been determined had there been no initial impairment loss. The reversal of the impairment loss is credited to expenditure.

1.16 Donated assets

Donated non-current assets are capitalised at current value in existing use, if they will be held for service potential, or otherwise at fair value on receipt, with a matching credit to income. They are valued, depreciated and impaired as described above for purchased assets. Gains and losses on revaluations, impairments and sales are treated in the same way as for purchased assets. Deferred income is recognised only where conditions attached to the donation preclude immediate recognition of the gain.

1.17 Government grant funded assets

Government grant funded assets are capitalised at current value in existing use, if they will be held for their service potential, or otherwise at fair value on receipt, with a matching credit to income. Deferred income is recognised only where conditions attached to the grant preclude immediate recognition of the gain.

1.18 Leases

Leases are classified as finance leases when substantially all the risks and rewards of ownership are transferred to the lessee. All other leases are classified as operating leases.

1.18.1 The foundation trust as lessee

Property, plant and equipment held under finance leases are initially recognised, at the inception of the lease, at fair value or, if lower, at the present value of the minimum lease payments, with a matching liability for the lease obligation to the lessor. Lease payments are apportioned between finance charges and reduction of the lease obligation to achieve a constant rate of interest on the remaining balance of the liability. Finance charges are recognised in the Statement of Comprehensive Income. The lease liability is de-recognised when the liability is discharged, cancelled or expires. Operating lease payments are recognised as an expense on a straight-line basis over the lease term. Lease incentives are recognised initially as a liability and subsequently as a reduction of rentals on a straight line basis over the lease term. Contingent rentals are recognised as an expense in the period on which they are incurred. Where a lease is for land and buildings, the land and building components are separated and individually assessed as to whether they are operating or finance leases.

1.18.2 The foundation trust as lessor

Amounts due from lessee under finance leases are recorded as receivables at the amount of the foundation trust's net investment in the leases. Finance lease income is allocated to accounting periods to reflect a constant periodic rate of return on the foundation trust's net investment outstanding in respect of the leases.

Rental income from operating leases is recognised on a straight-line basis over the term of the lease. Initial direct costs incurred in negotiating and arranging an operating lease are added to the carrying value of the leased asset and recognised as an expense on a straight-line basis over the lease term.

1.19 Private Finance Initiative (PFI) transactions

PFI transactions that meet the IFRIC 12 definition of a service concession, as interpreted in HM Treasury's FReM, are accounted for as on-Statement of Financial Position by the foundation trust. In accordance with IAS17, the underlying assets are recognised as property, plant and equipment, together with an equivalent finance lease liability.

The annual unitary payment is separated into the following component parts, using appropriate estimation techniques where necessary:

- Payment for the fair value or services received
- Repayment of the finance lease liability, including finance costs, and
- Payment for the replacement of components of the asset during the contract 'lifecycle replacement'.

1.19.1 Services received

The cost of services received in the year is recorded under the relevant headings within 'operating expenses'.

1.19.2 PFI assets, liabilities and finance costs

The PFI assets are recognised as property, plant and equipment when they come in to use.

The assets are measured initially atfair value or, if lower, at present value of the minimum lease payments, in accordance with the principles of IAS17. Subsequently, the assets are measured at current value in existing use. A PFI liability is recognised at the same time as the PFI assets are recognised. It is measured initially at the same amount as the initial value of the assets and is subsequently measured as a finance lease liability in accordance with IAS 17.

An annual finance cost is calculated by applying the implicit interest rate in the lease to the opening lease liability for the period, and is charged to 'Finance Cost' within the Statement of Comprehensive Income.

The element of the annual unitary payment that is allocated as a finance lease rental is applied to meet the annual finance cost and to repay the lease liability over the contract term.

The element of the annual unitary payment increase due to cumulative indexation is treated as contingent rent and is expenses as incurred.

1.19.3 Lifecycle replacement

Components of the asset replaced by the operator during the contract ('lifecycle replacement') are capitalised where they meet the foundation trust's criteria for capital expenditure. They are capitalised at the time they are provided by the operator, and are measured initially at cost.

The element of the annual unitary payment allocated to lifecycle replacement is pre-determined for each year of the contract from the operator's planned programme of lifecycle replacement. Where the lifecycle component is provided earlier or later than expected, a short-term accrual or prepayment is recognised respectively.

Where the fair value of the lifecycle component is less than the amount determined in the contract, the difference is recognised as an expense when the replacement is provided.

If the fair value is greater than the amount determined in the contract, the difference is treated as a 'free' asset and a deferred income balance is recognised.

The deferred income is released to operating income over the shorted of the remaining contract period or the useful economic life of the replacement component. Any material changes in asset values will be identified through the five yearly revaluations of property, plant and equipment.

1.19.4 Assets contributed by the foundation trust to the operator for use in the scheme
Assets contributed for use in the scheme continue to be recognised as items of property, plant and equipment in the foundation trust's Statement of Financial position.

1.19.5 Other assets contributed by the foundation trust to the operator
Other assets contributed ,e.g. cash payments, surplus property, etc. by the foundation trust to the operator before the asset is brought into use, where these are intended to defray the operator's capital costs, are recognised initially as prepayments during the construction phase of the contract. When the asset is made available to the foundation trust, the prepayment is treated as an initial payment towards the finance lease liability and is set against the carrying value of the liability.

1.20 Inventories
Inventories are valued at the lower of cost and net realisable value using the first in, first out (FIFO) method. This is considered to be a reasonable approximation to fair value.

1.21 Cash and cash equivalents
Cash is cash in hand and deposits with any financial institution repayable without penalty on notice of not more than 24 hours. Cash equivalents are investments that mature in three months or less from the date of acquisition and that are readily convertible to known amounts of cash with insignificant risk of change in value. In the Statement of Cash Flows, cash and cash equivalents are shown net of bank overdrafts that are repayable on demand and that form an integral part of the foundation trust's cash management. Cash, bank and overdraft balances are recorded at current values.

1.22 Provisions

Provisions are recognised when the foundation trust has a present legal or constructive obligation as a result of a past event, it is probable that the foundation trust will be required to settle the obligation, and a reliable estimate can be made of the obligation. The amount recognised as a provision is the best estimate of the expenditure required to settle the obligation at the end of the reporting period, taking into account the risks and uncertainties. Where a provision is measured using the cash flows estimated to settle the obligation, its carrying amount is the present value of those cash flows using HM Treasury's discount rates.

The receivable is recognised as an asset if it is virtually certain that some or all of the economic benefits needed to settle a provision will be recovered from a third party and the amount of the receivable can be measured reliably.

Early retirement provisions are discounted using the rates set out in the PES (2018) 12 Revised Discount Rates for General Provisions, Post-Employment Benefits and Financial Instruments.

Present obligations arising under onerous contracts are recognised and measured as a provision. An onerous contract is one where the Trust has a contract where the unavoidable costs of meeting the obligations under the contract exceed the economic benefits expected to be received under it.

1.23 Clinical negligence costs

The NHS Litigation Authority (NHSLA) operates a risk pooling scheme under which the foundation tryst pays an annual contribution to the NHSLA, which in turn settles all clinical negligence claims. The contribution is charged to expenditure. Although the NHSLA is administratively responsible for all clinical negligence cases, the legal liability remains with the foundation trust.

The total value of clinical negligence provisions carried by the NHSLA on behalf of the foundation trust is disclosed at note 34 but is not recognised in the foundation trust's accounts.

1.24 Non-clinical risk pooling

The foundation trust takes part in the Property Expenses Scheme and the Liabilities to Third Parties Scheme. Both are risk pooling schemes where the foundation trust pays an annual contribution to the NHSLA and in return receives assistance with the costs of claims arising. The annual membership contributions, and any excesses payable in respect of particular claims, are charged to operating expenses as and when they become due.

1.25 Carbon Reduction Commitment scheme (CRC)

The CRC scheme is a mandatory cap and trade scheme for non-transport CO2 emissions. The foundation trust is registered with the CRC scheme, and is therefore required to surrender to the Government an allowance for every tonne of CO2 it emits during the financial year. A liability and related expense is recognised in respect of this obligation as CO2 emissions are made.

The carrying amount of the liability at the financial year end will therefore reflect the CO2 emissions that have been made during that financial year, less the allowances (if any) surrendered voluntarily during the financial year in respect of that financial year.

The liability will be measured at the amount expected to be incurred in settling the obligation. This will be the cost of the number of allowances required to settle the obligation.

Allowances acquired under the scheme are recognised as intangible assets.

1.26 Contingencies

A contingent liability is:

- A possible obligation that arises from past events and whose existence will be confirmed only by the occurrence, or non-occurrence of one or more uncertain future events not wholly within the control of the foundation trust, or
- A present obligation that is not recognised because it is not probable that a payment will be required to settle the obligation or the amount of the obligation cannot be measured sufficiently reliably.

A contingent liability is disclosed unless the possibility of a payment is remote.

A contingent asset is a possible asset that arises from past events and whose existence will be confirmed by the occurrence or non-occurrence of one or more uncertain future events not wholly within the control of the foundation trust. A contingent assets is disclosed where an inflow of economic benefits is probable.

Where the time value of money is material, contingent liabilities and contingent assets are disclosed at their present value.

1.27 Financial assets

Financial assets are recognised when the foundation trust becomes party to the financial instrument contract or, in the case of trade receivables, when the goods or services have been delivered. Financial assets are derecognised when the contractual rights have expired or the asset has been transferred.

Financial assets are initially recognised at fair value. Fair value is determined by reference to quoted market prices where possible, otherwise by valuation techniques. The effective interest rate is the rate that exactly discounts estimated future cash receipts through the expected life of the financial asset, to the initial fair value of the financial asset.

Financial assets are classified into the following categories: financial assets at fair value through profit and loss, held to maturity investments, available for sale financial assets, and loans and receivables. The classification depends on the nature and purpose of the financial assets and is determined at the time of initial recognition.

1.27.1 Financial assets at fair value through profit and loss

Financial assets at fair value through profit and loss are held for trading. A financial asset is classified in this category if it has been acquired principally for the purpose of selling in the short-term. Derivatives are also categorised as held for trading unless they are designated as hedges.

Embedded derivatives that have different risks and characteristics to their host contracts, and contracts with embedded derivatives whose separate value cannot be ascertained, are treated as financial assets at fair value through profit and loss. They are held at fair value, with any resultant gain or loss recognised in calculating the foundation trust's surplus or deficit for the year. The net gain or loss incorporates any interest earned on the financial asset.

1.27.2 Held to maturity investments
Held to maturity investments are non-derivative financial assets with fixed or determinable payments and fixed maturity, and where there is a positive intention and ability to hold to maturity. After initial recognition, they are held at amortised cost using the effective interest method, less any impairment. Interest is recognised using the effective interest method.

1.27.3 Loans and receivables
Loans and receivables are non-derivative financial assets with fixed or determinable payments that are not quoted in an active market. After initial recognition, they are measured at amortised cost using the effective interest method, less any impairment. Interest is recognised using the effective interest method.

1.27.4 Available for sale financial assets
Available for sale financial assets are non-derivative financial assets that are designated as available for sale or that do not fall within any of the other three financial asset classifications. They are measured at fair value with changes in value, other than impairment losses, taken to Other Comprehensive Income. Accumulated gains or losses are recycled to the Statement of Comprehensive Income on de-recognition.

1.27.5 Impairment
At the end of the reporting period, the foundation trust assesses whether any financial assets, other than those held at 'fair value through profit and loss', are impaired. Financial assets are impaired and impairment losses recognised if there is objective evidence of impairment as a result of one or more events that occurred after the initial recognition of the asset and that have an impact on the estimated future cash flows of the asset.

For financial assets carried at amortised cost, the amount of the impairment loss is measured as the difference between the asset's carrying amount and the present value of the revised future cash flows discounted at the asset's original effective interest rate. The loss is recognised in expenditure. If, in a subsequent period, the amount of the impairment loss decreases and the decrease can be related objectively to an event occurring after the impairment was recognised, the previously recognised impairment loss is reversed through expenditure to the extent that the carrying amount of the receivable at the date of the impairment is reversed does not exceed what the amortised cost would have been had the impairment not been recognised.

1.28 Financial liabilities

Financial liabilities are recognised when the foundation trust becomes party to the contractual provisions of the financial instrument or, in the case of trade payables, when the goods or services have been received. Financial liabilities are de-recognised when the liability has been discharged – that is, the liability has been paid or has expired.

Loans from the Department of Health and Social Care are recognised at historic cost. Otherwise, financial liabilities are initially recognised at fair value.

1.28.1 Financial guarantee contract liabilities

Financial guarantee contract liabilities are subsequently measured at the higher of:

- the amount of the obligation under the contract, as determined in accordance with IAS 37 Provisions, Contingent Liabilities and Contingent Assets, and
- the premium received (or imputed) for entering into the guarantee less cumulative amortisation.

1.28.2 Financial liabilities at fair value through profit and loss

Embedded derivatives that have different risks and characteristics to their host contracts, and contracts with embedded derivatives whose separate value cannot be ascertained, are treated as financial liabilities at fair value through profit and loss.

They are held at fair value, with any resultant gain or loss recognised in the foundation trust's surplus/deficit. The net gain or loss incorporates any interest payable on the financial liability.

1.28.3 Other financial liabilities

After initial recognition, all other financial liabilities are measured at amortised cost using the effective interest method, except for loans from Department of Health and Social Care, which are carried at historic cost. The effective interest rate is the rate that exactly discounts estimated future cash payments through the life of the asset, to the net carrying amount of the financial liability. Interest is recognised using the effective interest method.

1.29 Public dividend capital

Public dividend capital (PDC) is a type of public sector equity finance, which represents the Department of Health and Social Care's investment in the foundation trust. HM Treasury has determined that, being issued under statutory authority rather than under contract, PDC is not a financial instrument within the meaning of IAS 32.

At any time, the Secretary of State can issue new PDC to, and require repayments of PDC from, the foundation trust. PDC is recorded at the value received. An annual charge, reflecting the cost of capital utilised by the foundation trust, is payable to the Department of Health and Social care as PDC dividend. The charge is calculated at the real rate set by the Secretary of State with the consent of HM Treasury (currently 3.5%) on the average relevant net assets of the foundation trust. Relevant net assets are calculated as the value of all assets less all liabilities, except for:

- donated assets (including lottery funded assets)

- average daily cash balances held with the Government Banking Services (GBS) and National Loans Fund (NLF) deposits, excluding cash balances held in GBS accounts that relate to a short-term working capital facility, and
- any PDC dividend balance receivable or payable.

The average relevant net assets is calculated as a simple average of opening and closing relevant net assets.

Under the requirements laid down by the Department of Health and Social Care, the dividend for the year is calculated on the actual average relevant net assets as set out in the 'pre-audit' version of the annual accounts. The dividend thus calculated is not revised should any adjustment to net assets occur following the audit of the annual accounts. The PDC dividend calculation is based upon the foundation trust's group accounts, i.e. including subsidiaries, but excluding consolidated charitable funds if applicable.

1.30 Foreign currencies

The foundation trust's functional currency and presentational currency is pounds sterling, and figures are presented in thousands of pounds unless expressly stated otherwise. Transactions denominated in a foreign currency are translated into sterling at the spot exchange rate on the date of the transaction. At the end of the reporting period, monetary items denominated in foreign currencies are retranslated at the spot exchange rate on 31 March.

Exchange gains and losses on monetary items (arising on settlement of the transaction or on retranslation at the Statement of Financial Position date) are recognised in the Statement of Comprehensive Income in the period in which they arise.

1.31 Third party assets

Assets belonging to third parties (such as money held on behalf of patients) are not recognised in the accounts since the foundation trust has no beneficial interest in them. Details of third party assets are given in note 39 to the accounts.

1.32 Losses and special payments

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

Losses and special payments are charged to the relevant functional headings in expenditure on an accrual basis, including losses which would have been made good through insurance cover had the foundation trust not been bearing their own risks (with insurance premiums then being included as normal revenue expenditure).

1.33 Gifts

Gifts are items that are voluntarily disclosed, with no preconditions and without the expectation of any return.

Gifts include all transactions economically equivalent to free and unremunerated transfers, such as the loan of an asset for its expected useful life, and the sale or lease of assets at below market value.

1.34 Accounting standards and amendments issued but not yet adopted

The DHSC GAM does not require the following Standards and Interpretations to be applied in 2018/19. These standards are still subject to HM Treasury FReM adoption, with IFRS 16 expected for implementation in 2020/2021.

- IFRS 14 Regulatory Deferral Accounts, Not EU-endorsed, applies to first time adopters of IFRS after 1 January 2016, therefore not applicable to DH group bodies.
- IFRS 16 leases – application required for accounting periods beginning on or after 1 January 2019, but not yet adopted by the FReM: early adoption is not therefore permitted
- IFRS 17 insurance contracts – application required for accounting periods beginning on or after 1 January 2021 but not yet adopted by the FReM; early adoption is not therefore permitted
- IFRIC 23 uncertainty over income tax treatments – application required for accounting periods beginning on or after 1 January 2019.

1.35 Accounting standards issued that have been adopted early

There are no accounting standards issued that have been adopted early for this financial period.

2. OPERATING SEGMENTS

The Foundation Trust operates under only one material segment which is healthcare and income is almost totally for the supply of services.

Management information is produced on a monthly basis to enable the chief operating decision maker to make informed decisions on the allocation of resources.

Under IFRS 8, reporting segments para 13, the quantitative threshold is 10% or more of combined revenue in determining a segment.

Non-patient care income is 6.7% (6.1% in 2017/2018) and therefore disclosure is not required.

3. INCOME GENERATION ACTIVITIES

The Foundation Trust undertakes income generation activities with an aim of achieving profit, which is then used in patient care.

The Foundation Trust does not have any income generation activities whose full cost exceeds £1 million in a full year or is otherwise material. Income from the sale of goods is immaterial.

4. REVENUE FROM PATIENT CARE ACTIVITIES

4.1 OPERATING INCOME BY SOURCE

	31 March 2019	31 March 2018
	£000	£000
NHS		
NHS trusts	1,926	1,041
CCGs	146,349	127,184
NHS England	31,875	30,144
Foundation trusts	1,461	1,372
Department of Health and Social Care	2,042	0
NHS other	0	0
Non-NHS		
Overseas patients (non-reciprocal)	0	0
Local authorities (healthcare services)	17,387	26,306
Private Patients	72	67
Other	766	622
Total	**201,878**	**186,736**

During 2018/19 the commissioning arrangements for some services were transferred from Northamptonshire County Council (shown in the table above as part of Local authorities) to Nene & Corby CCG (CCGs).

4.2 OPERATING INCOME BY NATURE	31 March 2019	31 March 2018
	£000	£000
Mental health trusts		
Block contract income	92,974	66,435
Other clinical income from mandatory services	1,151	1,637
Community trusts (any trusts providing community services)		
Income from CCGs and NHS England	93,400	89,879
Income not from CCGs and NHS England	12,239	28,719
All trusts		
Private patient income	72	66
AfC pay award central funding	2,042	0
Other clinical income	0	0
Total income from activities	**201,878**	**186,736**

All income from activities has been deemed to have arisen from commissioner requested services.

4.3 PRIVATE PATIENT INCOME	31 March 2019	31 March 2018
	£000	£000
Private patient income	72	66
Total patient related income	201,878	186,736
Proportion (as percentage)	0%	0%

4.4 INCOME FROM OVERSEAS VISITORS (RELATING TO PATIENTS CHARGED DIRECTLY BY THE FOUNDATION TRUST)

The Foundation Trust did not receive any income from overseas visitors in 2018/2019 (2017/2018 £nil).

5.OTHER OPERATING INCOME	31 March 2019	31 March 2018
	£000	£000
Research and development	490	408
Education and training	3,788	2,958
Education and training - notional income from apprenticeship fund	114	0
Charitable and other contributions to expenditure	1,301	1,308
Non-patient care services to other bodies	648	563
Rental revenue from operating leases	113	143
Income in respect of staff where accounted on a gross basis	842	795
Provider Sustainability Fund/Sustainability and Transformation Fund income	3,687	4,243
Other revenue*	3,568	1,753
	14,551	**12,171**
*** Other revenue includes:**		**Restated**
Canteen income	383	289
IT recharges	65	216
Estates recharges	375	462
Northamptonshire Health and Care Partnership	1,810	269
Miscellaneous	935	517
	3,568	**1,753**

6. OPERATING EXPENSES

	31 March 2019	31 March 2018
	£000	£000
Purchase of healthcare from non-NHS and non-DHSC bodies	4,148	4,517
Staff and executive directors costs	144,940	134,452
Non-executive directors	123	119
Supplies and services – clinical (excluding drugs costs)	16,832	12,938
Supplies and services - general	2,431	2,101
Drugs costs	6,718	6,844
Consultancy*	1,077	188
Establishment	1,760	2,026
Premises - business rates collected by local authorities	761	691
Premises - other	5,598	5,439
Transport (business travel only)	2,858	2,764
Transport - other (including patient travel)	1,100	626
Depreciation	4,273	4,209
Amortisation	768	591
Impairments net of (reversals)	(459)	(1,754)
Increase/(decrease) in impairment of receivables	53	(736)
Audit fees payable to the external auditor:		
Audit services - statutory audit	44	44
Other auditor remuneration (payable to external auditor only)	12	10
Internal audit - non-staff	128	75
Clinical negligence - amounts payable to NHS Resolution	320	257
Legal fees	398	203
Insurance	44	70
Research and development - staff costs	387	410
Research and development - non-staff	0	0
Education and training - staff costs	571	534
Education and training - non-staff	948	1,045
Education and training - notional, funded from apprenticeship fund	114	0
Operating lease expenditure (net)	5,003	4,189
Early retirements - staff costs	0	0
Early retirements - non-staff	0	0
Redundancy costs - staff costs	531	730
Redundancy costs - non-staff	0	0
Charges to operating expenditure for on-SoFP IFRIC 12 schemes	1,645	1,448
Car parking and security	57	26
Hospitality	0	0
Other losses and special payments - staff costs	0	0
Other losses and special payments - non-staff	20	17
Grossing up consortium arrangements	0	0
Other services (e.g. external payroll)	4,149	3,747
Other	741	(743)
Total operating expenditure	**208,093**	**187,077**
Of which:		
Related to continuing operations	208,093	187,077
Related to discontinued operations	0	0

* Includes £569k of costs relating to Northamptonshire Health and Care Partnership

6.1 OTHER AUDIT REMUNERATION (PAID TO THE EXTERNAL AUDITOR)

	31 March 2019	31 March 2018
	£000	£000
Audit-related assurance services	10	10
Taxation compliance services	0	0
All taxation advisory services not falling within the line above	0	0
Internal audit services	0	0
All assurance services not falling within the lines above	0	0
Corporate finance transaction services not falling within the lines above	0	0
All other non-audit services not falling within the lines above	2	0
Total	**12**	**10**

6.2 LIMITATION ON AUDITOR'S LIABILITY

	31 March 2019	31 March 2018
	£000	£000
Limitation on auditor's liability	**1,000**	**1,000**

7. OPERATING LEASES

7.1 AS LESSEE

The significant lease arrangements where the Foundation Trust is the lessee relate to lease of buildings and office equipment (photocopiers) over various lease periods.

Renewal and any restrictions imposed by the lease arrangement will be as per the individual lease agreements held by the relevant managers within the Foundation Trust.

Limited purchase options are available as per the lease contracts.

	31 March 2019	31 March 2018
	£000	£000
Payments recognised as an expense		
Minimum lease payments	5,003	4,189
Contingent rents	0	0
Less: sub-lease payments received	0	0
Total	**5,003**	**4,189**

	31 March 2019	31 March 2018
	£000	£000
Total future minimum lease payments payable:		
Not later than one year	4,766	4,814
Between one and five years	656	479
After five years	0	13
Total	**5,422**	**5,306**

No future sub-lease payments are expected to be received.

7.2 AS LESSOR

The leasing arrangements where the Foundation Trust is lessor relate to leasing of vacant areas of buildings where the Foundation Trust is the owner or the main occupier.

	31 March 2019	31 March 2018
	£000	£000
Rental Revenue		
Minimum lease receipts	113	143
Contingent rent	0	0
Other	0	0
Total rental revenue	**113**	**143**

	31 March 2019	31 March 2018
	£000	£000
Total future minimum lease receipts receivable:		
Not later than one year	103	134
Between one and five years	121	182
After five years	0	0
Total	**224**	**316**

8. EMPLOYEE COSTS

	31 March 2019	31 March 2018
	£000	£000
Salaries and wages	113,237	103,750
Social security costs	11,783	10,751
Employer contributions to NHS Pension Scheme	14,270	13,108
Apprenticeship levy	559	512
Other pension costs	24	11
Other post-employment benefits	0	0
Other employment benefits	0	0
Termination benefits (on an accruals basis)	531	730
Agency/contract staff	6,388	7,484
Total gross staff costs	146,792	136,346
Less income where netted off expenditure	0	0
Total staff costs	**146,792**	**136,346**
	31 March 2019	**31 March 2018**
Of the total above:	**£000**	**£000**
Employee benefits charged to capital	363	220
Employee benefits charged to revenue	146,429	136,126
Total	**146,792**	**136,346**

9. PENSION COSTS

9.1 NHS PENSION SCHEME

Past and present employees are covered by the provisions of the two NHS Pensions Schemes. Details of the benefits payable and rules of the Schemes can be found on the NHS Pensions website at www.nhsbsa.nhs.uk/pensions. Both are unfunded defined benefit schemes that cover NHS employers, GP practices and other bodies, allowed under the direction of the Secretary of State, in England and Wales. They are not designed to be run in a way that would enable NHS bodies to identify their share of the underlying scheme assets and liabilities. Therefore, each scheme is accounted for as if it were a defined contribution scheme: the cost to the NHS body of participating in each scheme is taken as equal to the contributions payable to the scheme for the accounting period.

In order that the defined benefit obligations recognised in the financial statements do not differ materially from those that would be determined at the reporting date by a formal actuarial valuation, the FReM requires that "the period between formal valuations shall be four years, with approximate assessments in intervening years". An outline of these follows:

a) Accounting valuation

A valuation of scheme liability is carried out annually by the scheme actuary (currently the Government Actuary's Department) as at the end of the reporting period. This utilises an actuarial assessment for the previous accounting period in conjunction with updated membership and financial data for the current reporting period, and are accepted as providing suitably robust figures for financial reporting purposes. The valuation of the scheme liability at 31 March 2019, is based on the validation data as at 31 March 2018, updated to 31 March 2019 with summary global member and accounting data. In undertaking this actuarial assessment, the methodology prescribed in IAS19, relevant FReM interpretations, and the discount rate prescribed by HM Treasury have been used.

The latest assessment of the liabilities of the scheme is contained in the scheme actuary report, which forms part of the annual NHS Pension Scheme Accounts. These accounts can be viewed on the NHS Pensions website and are published annually. Copies can also be obtained from The Stationery Office.

b) Full actuarial (funding) valuation

The purpose of this valuation is to assess the level of liability in respect of the benefits due under the schemes (taking into account recent demographic experience), and to recommend contribution rates payable by employees and employers.

The latest actuarial valuation undertaken for the NHS Pension Scheme was completed as at 31 March 2016. The results of this valuation set the employer contribution rate payable from April 2019. The Department of Health and Social Care have 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 was also expected to test the cost of the Scheme relative to the employer cost cap set following the 2012 valuation. Following a judgment from the Court of Appeal in December 2018 Government announced a pause to that part of the valuation process pending conclusion of the continuing legal process.

9.2 NATIONAL EMPLOYEE SAVINGS TRUST PENSION SCHEME (NEST)

Employees of the Foundation Trust may also be members of the NEST scheme. Under the Pensions Act 2008, the Foundation Trust had a responsibility from 1 August 2013 to have a pension scheme available for all staff meeting the criteria to be enrolled under the legislation. In some cases staff may not be eligible to join the NHS Pension Scheme and so the Foundation Trust has set up the NEST scheme as an alternative.

Contributions paid by the Foundation Trust on behalf of employees was £24k in 2018/19 (£11k in 2017/18), and is shown within operating expenses.

10 RETIREMENTS DUE TO ILL-HEALTH

In the period to 31 March 2019 there was 1 early retirement (2 in the period ending 31 March 2018) from the Foundation Trust agreed on the grounds of ill-health.

The estimated additional pension liabilities of these ill-health retirements will be £140k (£105k in the period to 31 March 2018)

The cost of these ill-health retirements will be borne by the NHS Business Services Authority - Pensions Division.

11. PAYMENT PERFORMANCE

11.1 BETTER PAYMENT PRACTICE CODE

	Number	£000
2018/2019		
Total non-NHS trade invoices paid in the period	**36,234**	**99,687**
Total non-NHS trade invoices paid within target	**32,216**	**93,388**
Percentage of non-NHS trade invoices paid within target	**89%**	**94%**
Total NHS trade invoices paid in the period	**844**	**8,922**
Total NHS trade invoices paid within target	**679**	**7,817**
Percentage of NHS trade invoices paid within target	**80%**	**88%**
2017/2018		
Total non-NHS trade invoices paid in the period	34,490	93,507
Total non-NHS trade invoices paid within target	32,309	89,722
Percentage of non-NHS trade invoices paid within target	**94%**	**96%**
Total NHS trade invoices paid in the period	757	6,831
Total NHS trade invoices paid within target	705	6,638
Percentage of NHS trade invoices paid within target	**93%**	**97%**

The Better Payment Practice Code requires the Foundation Trust to aim to pay all undisputed invoices by the due date or within 30 days of receipt of goods or a valid invoice, whichever is later.

11.2 THE LATE PAYMENT OF COMMERCIAL DEBTS (INTEREST) ACT 1998

	31 March 2019 £000	31 March 2018 £000
Amounts included in finance costs from claims made under this legislation	0	0
Compensation paid to cover debt recovery costs	0	0
Total	**0**	**0**

12. FINANCE INCOME

	31 March 2019 £000	31 March 2018 £000
PFI finance lease revenue:		
- planned	0	0
- contingent	0	0
Other finance lease revenue	0	0
Interest revenue:		
- Bank accounts	227	92
- Other	0	0
Total	**227**	**92**

13. OTHER GAINS AND LOSSES

	31 March 2019 £000	31 March 2018 £000
Gain/(loss) on disposal of property, plant and equipment	(7)	110
Total	**(7)**	**110**

The loss on disposal does not relate to land and buildings assets used in the provision of commissioner requested services.

14. FINANCE COST - INTEREST EXPENSE

	31 March 2019 £000	31 March 2018 £000
Interest on obligations under finance leases	2	2
Interest on obligations under PFI contracts:		
- main finance cost	1,787	1,851
- contingent finance cost	794	844
Interest on late payment of commercial debt	0	0
Other interest expense	0	0
Total interest expense	**2,583**	**2,697**
Unwinding of discount on provisions	11	13
Total interest expense	**2,594**	**2,710**

15. PROPERTY, PLANT AND EQUIPMENT

15.1 PROPERTY, PLANT AND EQUIPMENT 2018/19

	Land	Buildings excluding dwellings	Dwellings	AUC*	Plant and machinery	Transport equipment	IT	Furniture and fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Cost/valuation at 1 April 2018	15,355	91,505	1,680	278	1,124	56	16,997	2,390	129,385
Additions purchased	0	2,296	0	257	97	0	3,550	263	**6,463**
Additions leased	0	0	0	0	0	0	0	0	**0**
Impairments charged to operating expenses	0	(187)	0	0	0	0	0	0	**(187)**
Impairments charged to the revaluation reserve	0	(810)	0	0	0	0	0	0	**(810)**
Reversal of impairments credited to operating expenditure	0	646	0	0	0	0	0	0	**646**
Reclassifications	0	278	0	(278)	0	0	0	0	**0**
Revaluations	0	(5,510)	(65)	0	0	0	0	0	**(5,575)**
Transfer to disposal group as held for sale	(70)	(180)	0	0	0	0	0	0	**(250)**
Disposals/derecognition	0	0	0	0	(10)	0	(4,337)	(7)	**(4,354)**
Cost/valuation at 31 March 2019	15,285	88,038	1,615	257	1,211	56	16,210	2,646	125,318
Depreciation at 1 April 2018	0	7,414	65	0	315	37	9,340	1,207	18,378
Charged during the period	0	2,271	22	0	137	5	1,616	222	4,273
Revaluations	0	(8,430)	(87)	0	0	0	0	0	**(8,517)**
Disposals/derecognition	0	0	0	0	(3)	0	(4,337)	(7)	**(4,347)**
Depreciation at 31 March 2019	0	1,255	0	0	449	42	6,619	1,422	9,787
Net book value									
Purchased	15,285	86,783	1,615	257	762	14	9,591	1,224	115,531
Donated	0	0	0	0	0	0	0	0	**0**
Government granted	0	0	0	0	0	0	0	0	**0**
Net book value total at 31 March 2019	15,285	86,783	1,615	257	762	14	9,591	1,224	115,531
Asset financing									
Owned	15,285	29,742	1,615	257	762	0	9,591	1,224	**58,476**
Finance leased	0	0	0	0	0	14	0	0	**14**
On-SoFP PFI contract	0	57,041	0	0	0	0	0	0	**57,041**
Net book value total at 31 March 2019	15,285	86,783	1,615	257	762	14	9,591	1,224	115,531

* = Assets under construction

15. PROPERTY, PLANT AND EQUIPMENT

15.1 PROPERTY, PLANT AND EQUIPMENT 2017/18

	Land	Buildings excluding dwellings	Dwellings	AUC*	Plant and machinery	Transport equipment	IT	Furniture and fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Cost/valuation at 1 April 2017	15,340	77,391	1,658	922	772	56	15,189	2,022	113,350
Additions purchased	0	1,195	0	268	464	0	2,669	552	**5,148**
Additions leased	0	0	0	0	0	0	0	0	**0**
Impairments charged to operating expenses	0	(65)	0	(1)	0	0	0	0	**(66)**
Impairments charged to the revaluation reserve	0	(93)	0	0	0	0	0	0	**(93)**
Reversal of impairments credited to operating expenditure	0	1,820	0	0	0	0	0	0	**1,820**
Reclassifications	0	137	0	(911)	0	0	774	0	**0**
Revaluation/indexation gains	15	11,211	22	0	0	0	0	0	**11,248**
Transfer to disposal group as held for sale	0	0	0	0	0	0	0	0	**0**
Disposals/derecognition	0	(91)	0	0	(112)	0	(1,635)	(184)	**(2,022)**
Cost/valuation at 31 March 2018	15,355	91,505	1,680	278	1,124	56	16,997	2,390	129,385
Depreciation at 1 April 2017	0	5,562	43	0	337	32	9,022	1,107	16,103
Charged during the period	0	1,911	22	0	81	5	1,951	239	**4,209**
Transfer to disposal group as held for sale	0	0	0	0	0	0	0	0	**0**
Disposals/derecognition	0	(59)	0	0	(103)	0	(1,633)	(139)	**(1,934)**
Depreciation at 31 March 2018	0	7,414	65	0	315	37	9,340	1,207	18,378
Net book value									
Purchased	15,355	84,091	1,615	278	809	19	7,657	1,183	**111,007**
Donated	0	0	0	0	0	0	0	0	**0**
Government granted	0	0	0	0	0	0	0	0	**0**
Net book value total at 31 March 2018	15,355	84,091	1,615	278	809	19	7,657	1,183	111,007
Asset financing									
Owned	15,355	28,670	1,615	278	809	0	7,657	1,183	**55,567**
Finance leased	0	0	0	0	0	19	0	0	**19**
On-SoFP PFI contract	0	55,421	0	0	0	0	0	0	**55,421**
Net book value total at 31 March 2018	15,355	84,091	1,615	278	809	19	7,657	1,183	111,007

* = Assets under construction

15. PROPERTY, PLANT AND EQUIPMENT (CONT.)

There are no donated assets in year.

The effective date of revaluation of property, plant and equipment is 31 March 2019. The revaluation is based on a District Valuer Services valuation by a MRICS qualified surveyor, on a modern equivalent asset basis.

Asset lives for each class of asset held are as follows and represent the range of component parts that make up each asset:	Min. life (Years)	Max. life (Years)
Buildings excluding dwellings	1	72
Dwellings	30	90
Plant and machinery	5	10
Transport equipment	5	5
Information technology	2	10
Furniture and fittings	3	10
Software licences (purchased)	2	10
Development Expenditure (internally generated)	5	5
Websites (Internally generated)	5	5

At 31 March 2019, of the total non-current asset values, £300k (£370k at 31 March 2018) related to land valued at open market value and £925k (£1,105k at 31 March 2018) related to buildings valued at open market value.

There is no compensation from third parties for assets impaired, lost or given up and therefore nil is included in the income statement.

The gross carrying amount of fully depreciated tangible assets still in use is £4,332k (£6,732k at 31 March 2018).

15.3 PROPERTIES LEASED TO THIRD PARTIES BY THE FOUNDATION TRUST

Asset	Gross cost £'000	Accumulated depreciation £'000	Depreciation in year £'000	Revaluation in year £'000	Total £'000
399 Cottingham Road	250	0	0	0	250
39 Billing Road	675	0	0	0	675
Total	**925**	**0**	**0**	**0**	**925**

There are £nil (£nil in 2018/19) of impairments recognised and £nil (£nil in 2017/18) of impairments reversed for these assets.

15.4 NON-CURRENT ASSETS HELD FOR SALE

	Property, plant and equipment £000	Land £000	Total £000
Net book value at 1 April 2018	**0**	**0**	**0**
Plus assets classified as held for sale in the year	180	70	250
Less assets sold in the year	0	0	0
Less impairments of assets held for sale	0	0	0
Plus reversal of impairment of assets held for sale	0	0	0
Net book value at 31 March 2019	**180**	**70**	**250**
Net book value at 1 April 2017	**0**	**0**	**0**
Plus assets classified as held for sale in the year	0	0	0
Less assets sold in the year	0	0	0
Plus reversal of impairment of assets held for sale	0	0	0
Net book value at 31 March 2018	**0**	**0**	**0**

16.INTANGIBLE ASSETS

2018/19	Software licences purchased	Development expenditure	AUC	Website	Total
	£000	£0	£000	£000	£000
Cost or valuation at 1 April 2018	3,307	0	0	241	3,548
Additions purchased/internally generated	800	289	0	117	1,206
Reversals of impairments	0		0	0	0
Reclassifications	0	0	0	0	0
Disposals	0	0	0	0	0
Cost/valuation at 31 March 2019	**4,107**	**289**	**0**	**358**	**4,754**
Amortisation at 1 April 2018	1,240	0	0	21	1,261
Disposals	0	0	0	0	0
Charged during the period	732	0	0	36	768
Amortisation at 31 March 2019	**1,972**	**0**	**0**	**57**	**2,029**
Analysis of net book value total at 31 March 2019					
Purchased	2,135	289	0	301	2,725
Finance leased	0	0	0	0	0
Net book value total at 31 March 2019	**2,135**	**289**	**0**	**301**	**2,725**
2017/18	£000	£0	£000	£000	£000
Cost or valuation at 1 April 2017	2,081	0	137	0	2,218
Additions purchased	1,330	0	0	104	1,434
Reclassifications	0	0	(137)	137	0
Disposals	(104)				(104)
Cost/valuation at 31 March 2018	**3,307**	**0**	**0**	**241**	**3,548**
Amortisation at 1 April 2017	774	0	0	0	774
Disposals	(104)	0	0	0	(104)
Charged during the period	570	0	0	21	591
Amortisation at 31 March 2018	**1,240**	**0**	**0**	**21**	**1,261**
Analysis of net book value total at 31 March 2018					
Purchased	2,067	0	0	220	2,287
Finance leased	0	0	0	0	0
Net book value total at 31 March 2018	**2,067**	**0**	**0**	**220**	**2,287**

16.INTANGIBLE ASSETS (CONT.)

The intangible assets within these financial statements relate to externally procured software, website and development expenditure. In line with the valuation policy for tangible IT assets, intangible assets have not been revalued. The current values are considered to be fair in that they are the result of the application of amortisation on a straight line basis. The carrying amount of the intangible assets at cost is £2,725k (£2,287k at 31 March 2018). There are no intangible assets which have indefinite lives and the finite lives of the intangible assets are between nil and ten years. There are no intangible assets acquired by government grant. The value of intangible assets still in use, which have been fully amortised is £101k (£101k at 31 March 2018). There are no intangible assets controlled by the Foundation Trust that are not recognised as assets because they did not meet the recognition criteria of IAS 38.

17. IMPAIRMENTS

An impairment review was carried out at the end of the financial period and an impairment of £997k (£159k in the 12 months to 31 March 2018) on land and buildings has been recognised.

The year end review of values in conjunction with the district valuer also identified an increase in land and building assets that had previously been impaired of £646k (£1,820k in the 12 months to 31 March 2018).

The net impact on the SoCI is a reversal of impairment of £459k (£1,754k in the 12 months to 31 March 2018).

No impairments were recognised prior to the disposal of assets during the year (2017/2018 £nil).

The overall revaluation impact was to increase the value of the Foundation Trust's estate by £2,591k (increase of £12,908k in the 12 months to 31 March 2018) with a £2,133k increase (£11,155k increase in the 12 months to 31 March 2018) to revaluation reserves.

17.1 IMPAIRMENT OF ASSETS

	31 March 2019	31 March 2018
	£000	£000
Impairments/(reversals) charged to operating surplus/deficit		
Loss or damage from normal operations	0	0
Over specification of assets	0	0
Abandonment of assets in the course of construction	0	0
Changes in market price	(459)	(1,754)
Total impairments/(reversals) charged to operating surplus	**(459)**	**(1,754)**
Impairments charged to the revaluation reserve	810	93
Total impairments	**351**	**(1,661)**

18. CAPITAL COMMITMENTS

Contracted capital commitments not otherwise included in these financial statements	31 March 2019	31 March 2018
	£000	£000
Property, plant and equipment	0	0
Intangible assets	0	0
Total	**0**	**0**

19. INVESTMENTS IN ASSOCIATES

	31 March 2019	31 March 2018
	£000	£000
Carrying value at 1 April	**0**	**148**
Share of profit/(loss)	0	(148)
Carrying value at 31 March	**0**	**0**

The Foundation Trust holds a 38% share of voting rights in First for Wellbeing which is a community interest company limited by guarantee. First for Wellbeing, which started trading during 2016/17, is a joint venture between the Foundation Trust, Northamptonshire County Council and the University of Northampton. The full extent of the Foundation Trust's guarantee is £38.

During 2018/19, First for Wellbeing has ceased trading, with services transferred to Northamptonshire County Council. The Board of Directors have approved a member's voluntary liquidation of the company, which is not yet complete.

The investment has been accounted for on an equity basis with a carrying value of nil.

20. OTHER INVESTMENTS

	31 March 2019	31 March 2018
	£000	£000
Carrying value at 1 April	**76**	**79**
Acquisitions in year	0	0
Disposals	0	(3)
Carrying value at 31 March	**76**	**76**

In 2016/17 the Foundation Trust purchased shares in 3Sixty Care Ltd which is a Multispecialty Community Provider; the Foundation Trust's share constitutes 50% of the voting rights.

3Sixty Care Ltd, whose trading name is the 3Sixty Care Partnership, has been formed with partners in the 3Sixty Care GP Federation (covering Corby, East Northants, Wellingborough and surrounding areas).

The investment has been accounted for at fair value and the carrying value of the investment is considered to be supported by the net assets.

There is not considered to be an active market for the investment in 3Sixty Care Ltd.

During 2018/19, the Foundation Trust has entered into a limited liability partnership with General Practice Alliance Limited, which is a GP federation based in Northampton, to form Northampton GP and Community Alliance Limited Liability Partnership. The partnership has not traded during the year.

21. INVENTORIES

21.1 INVENTORIES

	31 March 2019	31 March 2018
	£000	£000
Consumables	66	61
Other	18	24
Total	**84**	**85**

21.2 INVENTORIES RECOGNISED IN EXPENSES

	31 March 2019	31 March 2018
	£000	£000
Inventories recognised as an expense in the period	(898)	(796)
Write-down of inventories recognised as an expense	0	0
Reversal of any write-downs of inventories resulting in a reduction of recognised expenses	0	0
Total	**(898)**	**(796)**

22.TRADE AND OTHER RECEIVABLES

	31 March 2019	31 March 2018
	£000	£000
Current		
Contract receivables (IFRS 15) invoiced*	6,801	0
Contract receivables (IFRS 15) not yet invoiced*	3,134	0
Contract assets (IFRS 15)	0	0
Trade receivables - revenue	0	10,461
Provision for impared contract assets	(35)	0
Provision for the impairment of receivables	(73)	(99)
Deposits and advances	1	1
Prepayments	637	611
PDC receivable	0	69
VAT receivable	136	520
Other receivables - revenue	101	73
Total	10,702	11,636
Of which receivable from NHS and DHSC group bodies:	8,677	9,169
Non-current		
Total	0	0

*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 separately 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 majority of trade is with CCGs as commissioners for NHS patient care services.
As CCGs are funded by government to buy NHS patient care services, no credit scoring of them is considered necessary.

22.1 AGEING OF RECEIVABLES

	31/03/19	31 March 2018
	£000	£000
Ageing of impaired receivables		
0 - 30 days	6	4
30 - 60 days	6	0
60 - 90 days	0	5
90 - 180 days	15	9
180 - 360 days	81	81
Total	108	99

Ageing of non-impaired receivables		
0 - 30 days	5,728	3,686
30 - 60 days	134	201
60 - 90 days	96	179
90 - 180 days	87	156
180 - 360 days	727	891
Total	6,772	5,113

22.2 PROVISION FOR IMPAIRMENT OF RECEIVABLES

	##############	31 March 2018
	£000	£000
Balance at start of period	99	2,408
Increase in provision	41	77
Amounts utilised	0	(1,573)
Unused amounts recovered	(32)	(813)
Balance at end of period	108	99

Receivables impaired relate to trade receivables which have been examined on a case by case basis in terms of their potential recovery.

23. OTHER FINANCIAL ASSETS

There are no other financial assets.

24. OTHER CURRENT ASSETS

There are no other current assets.

25. CASH AND CASH EQUIVALENTS

	31 March 2019	31 March 2018
	£000	£000
Balance at 1 April	37,541	35,436
Net change in period	5,296	2,105
Balance at 31 March	**42,837**	**37,541**

Made up of:		
Cash with Government Banking Service	42,797	37,473
Commercial banks and cash in hand	40	68
Current investments	0	0
Cash and cash equivalents as in SoFP	**42,837**	**37,541**
Bank overdraft	0	0
Cash and cash equivalents as in SoCF	**42,837**	**37,541**

26. TRADE AND OTHER PAYABLES

	31 March 2019	31 March 2018
Current	£000	£000
Trade payables - revenue	1,848	3,048
Other trade payables - capital	4,092	3,362
Social security costs	1,661	1,521
Other taxes payable	1,126	1,070
Other payables	1,983	1,800
Accruals	16,172	12,947
PDC dividend creditor	190	0
Total current trade and other payables	**27,072**	**23,748**

Non-current		
Other trade payables - capital	217	237
Total non-current trade and other payables	**217**	**237**

26.1 EARLY RETIREMENTS IN NHS PAYABLES

There are no early retirements in NHS payables.

27. BORROWINGS

	31 March 2019	31 March 2018
Current	**£000**	**£000**
Finance lease liabilities	5	4
Obligations under PFI, LIFT or other service concession	982	1,001
Total current borrowings	**987**	**1,005**

Non-current		
Finance lease liabilities	5	10
Obligations under PFI, LIFT or other service concession	33,037	34,019
Total non-current borrowings	**33,042**	**34,029**

Finance lease liabilities relate to commitments on vehicles which have been capitalised. Expected dates of settlement are consistent with lease termination dates which range between one and five years.

Date of settlement for the Welland PFI scheme is 2035 (30 years from date of completion of construction).

Date of settlement for the Berrywood PFI scheme is 2037 (30 years from date of completion of construction).

28. OTHER LIABILITIES

	31 March 2019	31 March 2018
Current	**£000**	**£000**
Deferred income	3,719	2,488
Total current other liabilities	**3,719**	**2,488**

There are no non-current liabilities.

29. FINANCE LEASE OBLIGATIONS

The Foundation Trust leased vehicles with leasing companies, there are no purchasing options at the end of lease and there are no favourable terms of renewal.

No contingent rent is payable.

	Minimum lease payments	
	31 March 2019	31 March 2018
Amounts payable under finance leases:	**£000**	**£000**
Gross lease liabilities of which liabilities are:	**14**	**21**
Within one year	7	7
Between one and five years	7	14
After five years	0	0
Less future finance charges	(4)	(7)
Net lease liabilities of which liabilities are due:	**10**	**14**
Within one year	5	4
Between one and five years	5	10
After five years	0	0
Total amounts payable under finance leases	**10**	**14**

30. FINANCE LEASE RECEIVABLES, I.E. AS LESSOR

There are no finance lease receivables and there is no finance lease rental revenue.

31. FINANCE LEASE COMMITMENTS

Finance leases above £5,000 are capitalised.

	31/03/19	31 March 2018
Total obligations for finance leases due:	**£000**	**£000**
Gross finance leases of which liabilities are due:	14	21
Not later than one year	7	7
Later than one year, not later than five years	7	14
Later than five years	0	0
Gross Finance Lease liabilities	**14**	**21**
Finance charges allocated to future periods	(4)	(7)
Net Finance Leases of which liabilities are due:	**10**	**14**
Not later than one year	5	4
Later than one year, not later than five years	5	10
Later than five years	0	0
Net Finance Liabilities	**10**	**14**

32. PRIVATE FINANCE INITIATIVE CONTRACTS

32.1 PFI SCHEMES OFF-STATEMENT OF FINANCIAL POSITION

There are no off-Statement of Financial Position PFI schemes.

32.2 PFI SCHEMES ON-STATEMENT OF FINANCIAL POSITION

There are two PFI schemes:

- the Welland scheme in Kettering, which opened in December 2005 and comprises two treatment wards and an assessment ward. The term of the agreement is 30 years from the date of the handover of the asset, which is December 2035.

- the Berrywood scheme in Northampton, which opened in December 2008 and comprises four assessment wards, an ICU, elderly beds, low secure beds and rehab beds. The term of the agreement is 30 years from the commencement of construction of the asset, which is the end of October 2037.

Under IFRIC 12, the PFI assets are treated as assets of the Foundation Trust; as the substance of the contract is that the Foundation Trust has a finance lease and payments comprise two elements – imputed finance lease charges and service charges. Details of the imputed finance lease charges are shown on the next page.

At the end of the contract period the facilities and equipment will be handed back to the Foundation Trust in a specified condition, at no cost. If this condition is not met then the operator may be required to compensate the Foundation Trust, under the terms of the agreement. No renewal options are noted.

The contracts may be terminated by either party if specified default conditions are met. There are voluntary termination options within the contracts, although there is a financial penalty if these are exercised. No changes to the contractual arrangements have occurred during 2018/19.

32.2 PFI SCHEMES ON-STATEMENT OF FINANCIAL POSITION (CONT.)

Total obligations for on-Statement of Financial Position PFI contracts due:	31 March 2019	31 March 2018
	£000	£000
Gross PFI liabilities of which liabilities are due:	**52,748**	**55,537**
Not later than one year	2,720	2,788
Later than one year, not later than five years	12,387	11,953
Later than five years	37,641	40,796
Gross PFI liabilities	**52,748**	**55,537**
Finance charges allocated to future periods	(18,729)	(20,517)
Net PFI liabilities of which liabilities are due:	**34,019**	**35,020**
Not later than one year	982	1,001
Later than one year, not later than five years	6,097	5,374
Later than five years	26,940	28,645
Net PFI liabilities	**34,019**	**35,020**

	31 March 2019	31 March 2018
	£000	£000
Total future payments committed in respect of PFI, LIFT or other service concession arrangements of which liabilities are due:	**81,978**	**84,568**
Not later than one year	5,591	5,534
Later than one year, not later than five years	20,917	20,702
Later than five years	55,470	58,332

The PFI contracts set the required performance standard, including availability, and set out the associated penalty deductions for unavailability.

There are no other obligations to acquire or build items of property, plant and equipment other than the equipment replacement specified in the lifecycle values within the unitary charge.

There are no other rights and obligations noted in the contracts.

32.3 CHARGES TO EXPENDITURE

The total charged in the period to expenditure in respect of the service element of on-Statement of Financial Position PFI contracts was £1,645k (£1,448k 2017/18).

	31 March 2019	31 March 2018
Commitments in respect of the service element:	**£000**	**£000**
Not later than one year	1,269	1,214
Later than one year, not later than five years	5,332	5,291
Later than five years	22,138	23,864
Total	28,739	30,369

32.4 AMOUNTS PAYABLE TO SERVICE CONCESSION OPERATOR

	31 March 2019	31 March 2018
Analysis of amounts paid to service concession operator:	**£000**	**£000**
Interest charge	1,787	1,851
Repayment of finance lease liability	1,001	1,298
Service element	1,645	1,448
Capital lifecycle maintenance	966	509
Contingent rent	794	844
Total	6,193	5,950

33. OTHER FINANCIAL LIABILITIES

The Foundation Trust has pledged £38 as a guarantee on formation of First for Wellbeing, a community interest company limited by guarantee. The value of the guarantee is not deemed to be material to either entity.

34. PROVISIONS

	31 March 2019	31 March 2018
Current	**£000**	**£000**
Pensions relating to other staff	26	26
Legal claims	53	56
Other	5,869	6,385
Total	5,948	6,467
Non-current		
Pensions relating to other staff	408	423
Other	30	30
Total	438	453

Legal claims are as advised by NHS Resolution who administer claims on behalf of the Foundation Trust and outstanding claims are expected to clear by 31 March 2020.

Pension provisions relate to staff who have retired early on ill health grounds from the NHS Pensions Scheme. They are calculated in accordance with Department of Health and Social Care guidance. There is no uncertainty with regard to timing or values.

Other includes:
- £3,357k (£3,283k at 31 March 2018) service change/reprovision costs that are based on calculated entitlements and are expected to materialise by the end of 2019/2020.
- £30k (£30k at 31 March 2018) for dilapidation works expected at the end of property leases

£2,130k (£2,336k at 31 March 2018) is included in the provisions of NHS Resolution in respect of clinical negligence liabilities of the Foundation Trust.

34. PROVISIONS (CONT.)

	Pensions relating to other staff	Legal claims	Other	Total
	£000	£000	£000	£000
At 1 April 2018	449	56	6,415	6,920
Arising during the period	0	66	5,869	5,935
Used during the period	(26)	(53)	(108)	(187)
Reversed unused	0	(16)	(6,277)	(6,293)
Unwinding of discount	11	0	0	11
At 31 March 2019	434	53	5,899	6,386
Expected timing of cash flows:				
Not later than one year	26	53	5,869	5,948
Later than one year and not later than five years	104	0	0	104
Later than five years	304	0	30	334
At 31 March 2019	434	53	5,899	6,386

At 1 April 2017	462	93	6,923	7,478
Arising during the period	0	28	4,577	4,605
Used during the period	(26)	(29)	(115)	(170)
Reversed unused	0	(36)	(4,970)	(5,006)
Unwinding of discount	13	0	0	13
At 31 March 2018	449	56	6,415	6,920
Expected timing of cash flows:				
Not later than one year	26	56	6,385	6,467
Later than one year and not later than five years	104	0	0	104
Later than five years	319	0	30	349
At 31 March 2018	449	56	6,415	6,920

35. CONTINGENCIES

35.1 CONTINGENT LIABILITIES

The Foundation Trust has contingent liabilities arising from claims being assessed by the NHS Litigation Authority of £40.1k at 31 March 2019 (£22k at 31 March 2018).

The Foundation Trust has contingent liabilities of £1.3 million arising from the sale of land in 2010 at the former Princess Marina Hospital.

35.2 CONTINGENT ASSETS

There are no contingent assets.

36. FINANCIAL INSTRUMENTS

IFRS 9 Financial Instruments is applied retrospectively from 1 April 2018 wihout reststement of comparatives.
As such comparative disclosures have been prepared under IAS 39 and the measurement categories differ to those in the current year analyses.

36.1 FINANCIAL ASSETS

Carrying values of Fianancial assets as at 31 March 2019 under IFRS 9	Held at amortised cost	Total Book Value
	£000	£000
Receivables	9,928	9,928
Cash and cash equivalents	42,837	42,837

Non-current assets held for sale	0	0
Other financial assets	0	0
Other investments	76	76
Total at 31 March 2019	**52,841**	**52,841**

Carrying values of financial assets as at 31 March under IAS 39	Loans and receivables	Total book value
	£000	£000
Receivables	10,363	10,363
Cash and cash equivalents	37,541	37,541
Other financial assets	0	0
Other investments	76	76
Total at 31 March 2018	**47,980**	**47,980**

36.2 FINANCIAL LIABILITIES

Carrying values of financial liabilities as at 31 March 2019 under IFRS 9	Held at amortised cost	Total book value
	£000	£000
Obligations under finance leases	10	10
Obligations under PFI contracts	34,019	34,019
Payables	22,337	22,337
Provisions under contract	83	83
Other financial liabilities	0	0
Total at 31 March 2019	**56,449**	**56,449**

Carrying values of financial liabilities as at 31 March 2018 under IAS 39	Other financial liabilities	Total book value
	£000	£000
Obligations under finance leases	14	14
Obligations under PFI contracts	35,020	35,020
Payables	19,594	19,594
Provisions under contract	85	85
Other financial liabilities	0	0
Total at 31 March 2018	**54,713**	**54,713**

36.3 MATURITY OF FINANCIAL LIABILITIES

	31 March 2019	31 March 2018
	£000	£000
In one year or less	23,160	20,417
In more than one year but not more than two years	1,357	1,223
In more than two years but not more than five years	4,962	4,398
In more than five years	26,970	28,675
	56,449	54,713

36.4 FAIR VALUE OF FINANCIAL ASSETS

	£000	£000
	Book value	Fair value
Non current trade and other receivable excluding non-financial liabilities	0	0
Other investments	76	76
Other	0	0
Total	76	76

36.5 FAIR VALUE OF FINANCIAL LIABILITIES

	£000	£000
	Book value	Fair value
Non current trade and other payables excluding non-financial liabilities	217	217
Provisions under contract	83	83
Loans	0	0
Other	0	0
Total	300	300

36.5 FINANCIAL RISK MANAGEMENT

Financial reporting standard IFRS7 requires disclosure of the role that financial instruments have had during the period in creating or changing the risks a body faces in undertaking its activities. Because of the continuing service provider relationship that the Foundation Trust has with Clinical Commissioning Groups (CCGs) and the way those CCGs are financed, the Foundation Trust is not exposed to the degree of financial risk faced by private sector entities. Also, financial instruments play a much more limited role in creating or changing risk than would be typical of listed companies, to which the financial reporting standards mainly apply. The Foundation Trust has limited powers to borrow or invest surplus funds and financial assets and liabilities are generated by day-to-day operational activities rather than being held to change the risks facing the Foundation Trust in undertaking its activities.

The Foundation Trust's treasury management operations are carried out by the finance department.

Currency risk

The Foundation Trust is principally a domestic organisation with the majority of transactions, assets and liabilities being in the UK and sterling based. The Foundation Trust has no overseas operations. The Foundation Trust therefore has low exposure to currency rate fluctuations.

Interest rate risk

The Foundation Trust is free to borrow from commercial or public sector sources for capital expenditure, subject to limits set by NHSI, the independent regulator, and as specified in their terms of authorisation. Therefore, it has a relatively low exposure to interest rate fluctuations.

Credit risk

Because the majority of the Foundation Trust's income comes from contracts with other public sector bodies, the Foundation Trust has low exposure to credit risk. The maximum exposures as at 31 March 2019 are in receivables from customers, as disclosed in the trade and other receivables note.

Liquidity risk

The majority of the Foundation Trust's operating costs are incurred under contracts with CCGs and NHS England, which are financed from resources voted annually by Parliament. The Foundation Trust funds its capital expenditure from internally generated cash from operations and asset sales. The Foundation Trust is not, therefore, exposed to significant liquidity risks.

37. EVENTS AFTER THE REPORTING PERIOD

There are no known events after the reporting period that impact on the financial statements for 2018/19.

38. RELATED PARTY TRANSACTIONS

During the period none of the Foundation Trust board of directors or members of the key management staff, or parties related to any of them, has undertaken any material transactions with Northamptonshire Healthcare NHS Foundation Trust.

During the year Northamptonshire Healthcare NHS Foundation Trust has had a significant number of material transactions with related parties, as detailed below:

	Receipts from related party	Payments to related party	Amounts due from related party	Amounts owed to related party
2018/2019	£000	£000	£000	£000
Board of directors	0	0	0	0
Key staff members	0	0	0	0
Department of Health and Social Care	2,153	0	41	0
Nene CCG	129,493	732	3,211	3,251
Corby CCG	15,026	76	14	6
Northampton General NHS Trust	1,593	1,471	17	160
Kettering General NHS Foundation Trust	1,390	877	260	162
NHS England	35,592	4	3,434	840
Other NHS bodies	9,673	7,598	1,700	527
Charitable funds	0	0	12	0
Northamptonshire County Council	16,383	4,905	565	4,300
NHS Pensions Agency	0	14,270	0	1,971
First for Wellbeing CIC	145	0	0	0
3Sixty Care	347	465	43	116
General Practice Alliance	12	15	0	0
Other	1,179	13,602	381	3,198
Total	212,986	44,015	9,678	14,531

2017/2018	£000	£000	£000	£000
Board of directors	0	0	0	0
Key staff members	0	0	0	0
Department of Health and Social Care	22	0	0	0
Nene CCG	110,952	680	3,158	2,269
Corby CCG	13,226	17	0	49
Northampton General NHS Trust	1,476	1,454	41	117
Kettering General NHS Foundation Trust	1,577	791	491	13
NHS England	34,402	0	4,277	185
Other NHS bodies	6,494	8,605	980	2,041
Charitable funds	0	0	5	0
Northamptonshire County Council	25,601	4,370	138	2,834
NHS Pensions Agency	0	13,108	0	1,799
First for Wellbeing CIC	329	0	91	0
3Sixty Care	147	0	42	149
General Practice Alliance	0	0	0	0
Other	1,222	12,557	705	3,141
Total	195,448	41,582	9,928	12,597

First for Wellbeing is a community interest company limited by guarantee in which the Foundation Trust holds 38% of the voting rights.

3Sixty Care is a company limited by shares in which the Foundation Trust holds a 50% shareholding.

General Practice Alliance is a GP Federation which has formed a partnership with the Foundation Trust.

39. THIRD PARTY ASSETS

The Foundation Trust held £5k (£6k at 31 March 2018) cash and cash equivalents at 31 March 2019 which relates to monies held by the NHS Foundation Foundation Trust on behalf of patients. This has been excluded from the cash and cash equivalents figure reported in the accounts.

40. INTRA-GOVERNMENT AND OTHER BALANCES

	Current receivables	Non-current receivables	Current payables	Non-current payables
	£000	£000	£000	£000
Balances with Department of Health and Social Care	41	0	0	0
Balances with Public Health England	3	0	0	0
Balances with NHS England and CCGs	7,563	0	743	0
Balances with Health Education England	437	0	0	0
Balances with NHS Trusts	169	0	255	0
Balances with other FTs	429	0	234	0
Balances with Special Health Authorities	10	0	3	0
Balances with NDPBs	1	0	0	0
Balances with Other DH bodies	24	0	169	0
Balances with Local Government	810	0	4,444	0
Other WGA Bodies	136	0	5,023	0
Intra-government balances	**9,623**	**0**	**10,871**	**0**
Balances with bodies external to government	1,079		16,201	217
At 31 March 2019	**10,702**	**0**	**27,072**	**217**
Balances with Department of Health and Social Care	0	0	0	0
Balances with Public Health England	1	0	3	0
Balances with NHS England and CCGs	8,244	0	2,503	0
Balances with Health Education England	58	0	546	0
Balances with NHS Trusts	158	0	160	0
Balances with other FTs	528	0	114	0
Balances with Special Health Authorities	7	0	0	0
Balances with NDPBs	95	0	95	0
Balances with Other DH bodies	10	0	1,348	0
Balances with Local Government	260	0	2,976	0
Other WGA Bodies	520	0	4,703	0
Intra-government balances	**9,881**	**0**	**12,448**	**0**
Balances with bodies external to government	1,755		11,300	237
At 31 March 2018	**11,636**	**0**	**23,748**	**237**

41. LOSSES AND SPECIAL PAYMENTS

	31 March 2019	31 March 2019	31 March 2018	31 March 2018
Losses	**Number**	**£000**	**Number**	**£000**
Losses of cash	0	0	12	9
Bad debts and claims abandoned	0	0	2	0
Total losses	**0**	**0**	**14**	**9**

Special Payments				
Compensation payments	16	71	7	103
Ex-gratia payments	12	2	4	1
Extra contractual payments to contractors	0	0	0	0
Other employment payments	9	12	1	0
Total special payments	**37**	**85**	**12**	**104**

Total losses and special payments	**37**	**85**	**26**	**113**

Losses and special payments are accounted for on an accruals basis excluding provisions for future losses.

42. OTHER FINANCIAL COMMITMENTS

The Foundation Trust has not entered into any non-cancellable contracts which are not leases, PFI contracts or other service concession arrangements.

43. REVALUATION RESERVE

	Revaluation reserve: property, plant and equipment	Revaluation reserve: assets held for sale	Total revaluation reserve
	£000	£000	£000
At 1 April 2018	**26,620**	**0**	**26,620**
Impairments	(810)	0	(810)
Revaluations	2,942	0	2,942
Disposals	0	0	0
Transfer of the excess of current cost depreciation over historical cost depreciation to the Income and Expenditure Reserve	0	0	0
Other reserve movements	(194)	194	0
Movements on other reserves	0	0	0
Revaluation reserve at 31 March 2019	**28,558**	**194**	**28,752**

At 1 April 2017	**15,465**	**0**	**15,465**
Impairments	(93)	0	(93)
Revaluations	11,248	0	11,248
Disposals	0	0	0
Transfer of the excess of current cost depreciation over historical cost depreciation to the Income and Expenditure Reserve	0	0	0
Other reserve movements	0	0	0
Movements on other reserves	0	0	0
Revaluation reserve at 31 March 2018	**26,620**	**0**	**26,620**

Independent auditor's report

to the Council of Governors of Northamptonshire Healthcare NHS Foundation Trust only

Opinions and conclusions arising from our audit

Our opinion is unmodified

We have audited the financial statements of Northamptonshire Healthcare NHS Foundation Trust ("the Trust") for the year ended 31 March 2019 which comprise the Statement of Comprehensive Income, Statement of Financial Position, the Statement of Changes in Taxpayers Equity and the related notes, including the accounting policies in note 1.

In our opinion:

— the financial statements give a true and fair view of the state of the Trust's affairs as at 31 March 2019 and of its income and expenditure for the year then ended; and

— the Trust's financial statements have been properly prepared in accordance with the Accounts Direction issued under paragraphs 24 and 25 of Schedule 7 of the National Health Service Act 2006, the NHS Foundation Trust Annual Reporting Manual 2017/18 and the Department of Health and Social Care Group Accounting Manual 2018/19.

Basis for opinion

We conducted our audit in accordance with International Standards on Auditing (UK) ("ISAs (UK)") and applicable law. Our responsibilities are described below. We have fulfilled our ethical responsibilities under, and are independent of the Trust in accordance with, UK ethical requirements including the FRC Ethical Standard. We believe that the audit evidence we have obtained is a sufficient and appropriate basis for our opinion.

Overview		
Materiality: Financial statements as a whole	£3.5 million (2017/18: £3.5 million) 2% (2017/18: 2%) of income from operations	
Risks of material misstatement		**vs 2017/18**
Recurring risks	Valuation of Land and Buildings	◀▶
	Recognition of NHS and non NHS income and receivables	◀▶
	New: Accrued expenditure recognition	▲

2. Key audit matters: our assessment of risks of material misstatement

Key audit matters are those matters that, in our professional judgment, were of most significance in the audit of the financial statements and include the most significant assessed risks of material misstatement (whether or not due to fraud) identified by us, including those which had the greatest effect on: the overall audit strategy; the allocation of resources in the audit; and directing the efforts of the engagement team.

We summarise below the key audit matters, in decreasing order of audit significance, in arriving at our audit opinion above, together with our key audit procedures to address those matters and our findings from those procedures in order that the Trust's governors as a body may better understand the process by which we arrived at our audit opinion. These matters were addressed, and our results are based on procedures undertaken, in the context of, and solely for the purpose of, our audit of the financial statements as a whole, and in forming our opinion thereon , and consequently are incidental to that opinion, and we do not provide a separate opinion on these matters.

	The risk	Our response
Recognition of NHS and non-NHS income Income: (£208,093 million; 2017/18: £187,077 million) *Refer to page 61 (Audit Committee Report), page 233 (accounting policy) and page 248 (financial disclosures).*	**Accounting Application** Of the Trust's reported total income, £178,224 million (2017/18, £157,328 million) came from Clinical Commissioning Groups (CCG) and NHS England. The remaining was sourced from local authorities and other counterparties and carried a greater risk in terms of pricing and recoverability. In 2018/19 the Trust has received sustainability funding from NHS Improvement. This is received subject to achieving defined financial and operational targets on a quarterly basis. The Trust was allocated £3.687 million of provider sustainability funding. An agreement of balances exercise is undertaken between NHS bodies to agree the value of transactions during the year and the amounts owed at the year end. 'Mismatch' reports are available setting out discrepancies between the submitted balances from each party in transactions and variances over £300,000 are required to be reported to the National Audit Office to inform the audit of the Department of Health and Social Care consolidated accounts. The Trust reported total income of £14,551 million (2017/18: £12,171 million) from other activities, primarily education and training, research and development, or other activities. The risk in regard to both types of income is that is incorrectly recognised as revenue.	Our procedures included: — **Test of detail**: • Within the listing of contracts held by the Trust, we have agreed for the five largest commissioners of Trust activity that signed contracts were in place. We investigated contract variations and reconciled accounting entries to the original contract; • We assessed the outcome of the agreement of balances exercise with CCGs and other NHS providers. Where there were any mismatches we have sought explanations for variances greater than £300,000. We have observed whether the Trust is in formal dispute in relation to any material income balances and have examined the supporting correspondence; • We have performed testing of a sample of income received before and after 31st March 2019 to support the completeness assertion over income balances recorded in the financial statements and confirming that income has been recorded in the correct accounting period; • We tested material other income balances by agreeing a sample of income transactions through to supporting documentation; and — **Accounting Analysis**: We assessed the estimation basis upon which provisions for debt have been made. Our findings: We found the decisions made by the Trust in regard to the recognition of income to be balanced.

	The risk	Our response
Valuation of land and buildings (£103.323 million; 2017/18: £106.860 million) *Refer to page 61 (Audit Committee Report), page 234 (accounting policy) and page 256 (financial disclosures).*	**Subjective Valuation** Land and buildings are initially recognised at cost. Non-specialised property assets in operational use are subsequently recognised at existing value in use (EUV). Specialised assets(such as hospitals) where a market value is not readily ascertainable, are subsequently recognised at the depreciated replacement cost (DRC) of a modern equivalent asset that has the same service potential as the existing property (MEAV). There is significant judgement involved in determining the appropriate basis for each asset according to the degree of specialisation, as well as over the assumptions made in arriving at the valuation. The most significant part of the Trust's asset base is land and buildings. Hospitals are usually valued as specialised assets as there is not an active market for their sale. The Department of Health and Social Care's Group Accounting Manual requires that specialised assets are valued at Depreciated Replacement Cost on a modern equivalent asset basis. When considering the cost to build a replacement asset the Trust may consider whether the asset would be built to the same specification or in the same location. Valuation is completed by an external expert, the District Valuer, engaged by the Trust, using construction indices. Therefore accurate records of the current estate are required. Full valuations are completed every five years, with interim desktop valuations completed in interim periods. Valuations are inherently judgmental, therefore our work focused on whether the valuer's methodology, assumptions and underlying data, are appropriate and correctly applied. In 2018/19, the Trust undertook a full revaluation of its land and buildings by its external valuer at the 31 March 2019 resulting in a £3.5 million decrease in the value of the land and buildings. The risk in regard to the valuation of PPE recognised in the financial statements is that it is based on incorrect information or that judgements made are not balanced. The effect of these matters is that, as part of our risk assessment, we determined that the valuation of land and buildings has a high degree of estimation uncertainty, with a potential range of reasonable outcomes greater than our materiality for the financial statements as a whole.	Our procedures included: — **Assessing valuer's credentials:** We assessed the expertise of the valuer, who performed the valuation for the Trust. We reviewed the instructions provided to the valuer and assessed their independence and objectivity to the terms under which they were engaged by management; — **Methodology choice:** Using our expert valuer we have assessed whether the underlying approach and methodology used in preparing the valuation was appropriate and permissible within The Department of Health and Social Care Group Accounting Manual 2018/19 (GAM); — **Assessing transparency:** We considered the adequacy of the Trust's disclosures in respect of land and buildings, with particular focus on the PFI scheme disclosures due to the material nature of these assets; — **Test of details:** • We agreed the valuations provided by the valuer as a result of the valuation to entries recorded within the Fixed Asset Register; • We considered managements assessment of any need for an impairment across its asset base either due to loss of value or reduction in future benefits that would be achieved; and • We considered the accuracy of the data provided to the valuer and undertook testing to ensure both its completeness and accuracy, including reviewing changes in floor area measurements. Our findings: We found the judgements made in regard to the valuation of land and buildings to be balanced.

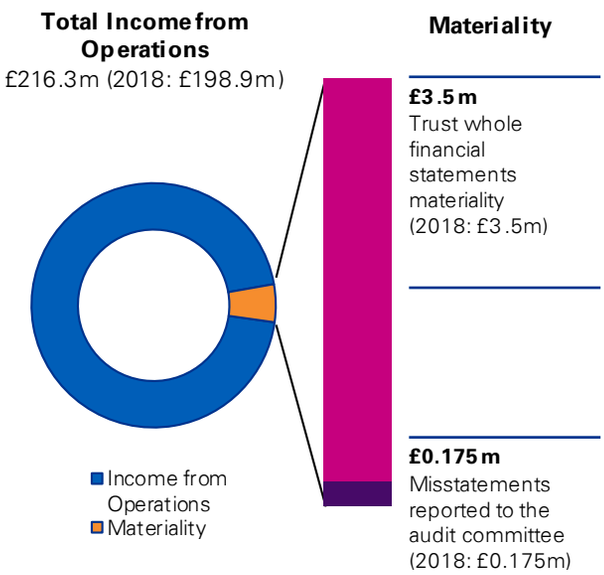
	The risk	Our response
Accrued expenditure recognition Trade and other payables (£27m; 2017/18: £13.7m) *Refer to page 61 (Audit Committee Report), page 234 (accounting policy) and page 250 and 261 (financial disclosures).*	**Effects of irregularities** As most public bodies are net spending bodies, then the risk of material misstatement due to fraud related to expenditure recognition may be greater than the risk of fraud related to revenue recognition. There is a risk that the Trust may manipulate expenditure to meet externally set targets and we had regard to this when planning and performing our audit procedures. This risk does not apply to all expenditure in the period. The incentives for fraudulent expenditure recognition relate to achieving financial targets and the key risks relate to the manipulation of creditors and accrued non-pay expenditure at year-end, as well as the completeness of the recognition of provisions or the inappropriate release of existing provisions.	Our procedures included: **Tests of detail:** — We inspected all material items of expenditure in the March and April 2019 bank statements and cashbooks to agree these have been accounted for correctly; — We considered year-end processes to assess that expenditure has been reflected in the correct period; — We performed a year-on-year comparison of accruals to evaluate the completeness of the accruals balance, as well as agreeing a sample to supporting documentation; — We vouched a sample of creditor balances to supporting documentation and to agree the correct treatment as a payable at year-end; and — We inspected confirmations of balances provided by the Department of Health and Social Care as part of the Agreement of Balances exercise and compared the relevant payables recorded in the Trust's financial statements to the receivables balances recorded within the accounts of Commissioners or other providers. Where applicable we investigated variances and reviewed relevant correspondence to assess the reasonableness of the Trust's approach to recognising expenditure to Commissioners or other Providers. **Our findings** We found the resulting estimates made by the Trust in relation to expenditure to be balanced.

3. Our application of materiality

Materiality for the Trust financial statements as a whole was set at £3.5 million (2017/18: £3.5 million), determined with reference to a benchmark of operating income (of which it represents approximately 2%). We consider operating income to be more stable than a surplus- or deficit-related benchmark.

We agreed to report to the Audit Committee any corrected and uncorrected identified misstatements exceeding £0.175 million (2017/18: £0.175 million), in addition to other identified misstatements that warranted reporting on qualitative grounds.

Our audit of the Trust was undertaken to the materiality level specified above and was largely performed at the Trust's headquarters in Kettering.



4. We have nothing to report on going concern

The Accounting Officer has prepared the financial statements on the going concern basis as they have not been informed by the relevant national body of the intention to dissolve the Trust without the transfer of its services to another public sector entity. They have also concluded that there are no material uncertainties that could have cast significant doubt over their ability to continue as a going concern for at least a year from the date of approval of the financial statements ("the going concern period").

Our responsibility is to conclude on the appropriateness of the Accounting Officer's conclusions and, had there been a material uncertainty related to going concern, to make reference to that in this audit report. However, as we cannot predict all future events or conditions and as subsequent events may result in outcomes that are inconsistent with judgements that were reasonable at the time they were made, the absence of reference to a material uncertainty in this auditor's report is not a guarantee that the Trust will continue in operation.

In our evaluation of the Accounting Officer's conclusions, we considered the inherent risks to the Trust's business model, including the impact of Brexit, and analysed how those risks might affect the Trust's financial resources or ability to continue operations over the going concern period. We evaluated those risks and concluded that they were not significant enough to require us to perform additional audit procedures.

Based on this work, we are required to report to you if we have anything material to add or draw attention to in relation to the Accounting Officers statement in Note 1 to the financial statements on the use of the going concern basis of accounting with no material uncertainties that may cast significant doubt over the Trust's use of that basis for a period of at least twelve months from the date of approval of the financial statements.

We have nothing to report in these respects, and we did not identify going concern as a key audit matter.

5. We have nothing to report on the other information in the Annual Report

The directors are responsible for the other information presented in the Annual Report together with the financial statements. Our opinion on the financial statements does not cover the other information and, accordingly, we do not express an audit opinion or, except as explicitly stated below, any form of assurance conclusion thereon.

Our responsibility is to read the other information and, in doing so, consider whether, based on our financial statements audit work, the information therein is materially misstated or inconsistent with the financial statements or our audit knowledge. Based solely on that work we have not identified material misstatements in the other information.

In our opinion the other information included in the Annual Report for the financial year is consistent with the financial statements

Remuneration report

In our opinion the part of the remuneration report to be audited has been properly prepared in accordance with the NHS Foundation Trust Annual Reporting Manual 2018/19.

Corporate governance disclosures

We are required to report to you if:

— we have identified material inconsistencies between the knowledge we acquired during our financial statements audit and the directors' statement that they consider that the annual report and financial statements taken as a whole is fair, balanced and understandable and provides the information necessary for stakeholders to assess the Trust's position and performance, business model and strategy; or

— the section of the annual report describing the work of the Audit Committee does not appropriately address matters communicated by us to the Audit Committee; or

— the Annual Governance Statement does not reflect the disclosure requirements set out in the NHS Foundation Trust Annual Reporting Manual 2018/19, is misleading or is not consistent with our knowledge of the Trust and other information of which we are aware from our audit of the financial statements.

We have nothing to report in these respects.

KPMG

6. Respective responsibilities

Accounting Officer's responsibilities

As explained more fully in the statement set out on page 223, the Accounting Officer is responsible for the preparation of financial statements that give a true and fair view. They are also responsible for: such internal control as they determine is necessary to enable the preparation of financial statements that are free from material misstatement, whether due to fraud or error; assessing the Trust's ability to continue as a going concern, disclosing, as applicable, matters related to going concern; and using the going concern basis of accounting unless they have been informed by the relevant national body of the intention to dissolve the Trust without the transfer of its services to another public sector entity

Auditor's responsibilities

Our objectives are to obtain reasonable assurance about whether the financial statements as a whole are free from material misstatement, whether due to fraud or error, and to issue our opinion in an auditor's report. Reasonable assurance is a high level of assurance, but does not guarantee that an audit conducted in accordance with ISAs (UK) will always detect a material misstatement when it exists. Misstatements can arise from fraud or error and are considered material if, individually or in aggregate, they could reasonably be expected to influence the economic decisions of users taken on the basis of the financial statements.

A fuller description of our responsibilities is provided on the FRC's website at www.frc.org.uk/auditorsresponsibilities

REPORT ON OTHER LEGAL AND REGULATORY MATTERS

We have nothing to report on the statutory reporting matters

We are required by Schedule 2 to the Code of Audit Practice issued by the Comptroller and Auditor General ('the Code of Audit Practice') to report to you if:

— any reports to the regulator have been made under Schedule 10(6) of the National Health Service Act 2006.

— any matters have been reported in the public interest under Schedule 10(3) of the National Health Service Act 2006 in the course of, or at the end of the audit.

We have nothing to report in these respects.

We have nothing to report in respect of our work on the Trust's arrangements for securing economy, efficiency and effectiveness in the use of resources

Under the Code of Audit Practice we are required to report to you if the Trust has not made proper arrangement for securing economy, efficiency and effectiveness in the use of resources.

We have nothing to report in this respect.

Respective responsibilities in respect of our review of arrangements for securing economy, efficiency and effectiveness in the use of resources

The Trust is responsible for putting in place proper arrangements for securing economy, efficiency and effectiveness in the use of resources

Under Section 62(1) and Schedule 10 paragraph 1(d), of the National Health Service Act 2006 we have a duty to satisfy ourselves that the Trust has made proper arrangements for securing economy, efficiency and effectiveness in the use of resources .

We are not required to consider, nor have we considered, whether all aspects of the Trust's arrangements for securing economy, efficiency and effectiveness in the use of resources are operating effectively.

We have undertaken our review in accordance with the Code of Audit Practice, having regard to the specified criterion issued by the Comptroller and Auditor General (C&AG) in November 2017, as to whether the Trust had proper arrangements to ensure it took properly informed decisions and deployed resources to achieve planned and sustainable outcomes for taxpayers and local people. We planned our work in accordance with the Code of Audit Practice and related guidance. Based on our risk assessment, we undertook such work as we considered necessary.

Report on our review of the adequacy of arrangements for securing economy, efficiency and effectiveness in the use of resources

We are required by guidance issued by the C&AG under Paragraph 9 of Schedule 6 to the Local Audit and Accountability Act 2014 to report on how our work addressed any identified significant risks to our conclusion on the adequacy of the Trust's arrangements for securing economy, efficiency and effectiveness in the use of resources. The 'risk' in this case is the risk that we could come to an incorrect conclusion in respect of the Trust's arrangements, rather than the risk of the arrangements themselves being inadequate.

We carry out a risk assessment to determine the nature and extent of further work that may be required. Our risk assessment includes consideration of the significance of business and operational risks facing the Trust, insofar as they relate to 'proper arrangements'. This includes sector and organisation level risks and draws on relevant cost and performance information as appropriate, as well as the results of reviews by inspectorates, review agencies and other relevant bodies.

The significant risks identified during our risk assessment are set out overleaf together with the findings from the work we carried out on each area.

Significant Risk	Description	Work carried out and judgements
Working with partners and other third parties	**Governance arrangements over partnership working** The Trust is involved in partnership working and continues to develop and expand this. The Trust has a subsidiary, 3Sixty Care Ltd formed with partners over the 3Sixty Care GP Federation. Secondly, the Trust set up a Community Interest Company (First for Wellbeing) in 2016/17 which ceased trading during the period. The risk is that there are inadequate governance arrangements in place to cover these partnership agreements.	Our work included: **Governance and reporting arrangements:** We reviewed the current governance arrangements in place and the reporting structure to the Board. We reviewed the training mechanism in place to ensure key members of staff involved in partnerships are aware of their duties in response to Governance. We reviewed the governance framework over the STP in light of the changes during the year. **Our findings on this risk area:** We consider the arrangements in place for working with partners and other third parties to be adequate.
Sustainable resource deployment	**Financial sustainability and CIPs** The Trust had a CIP target of £6.8m for 2018/19. At the year end the Trust achieved a total of £5.1m of recurrent schemes however was successful in achieving the planned outturn position overall. These targets were challenging in the difficult financial environment within the NHS and as such represent a direct risk to the sustainable resource deployment by the Trust. As at 31 March 2019, the Trust has a new CIP target of £3.3m to meet in 2019/20.	Our work included: - **Cost Improvement Plans**: We reviewed the Trust's CIP schemes and the split between recurrent and non recurrent achievement. - **Underlying Surplus/Deficit:** We reviewed the Trust's underlying position and reported performance compared to the initial planned surplus. - **Financial Sustainability:** We reviewed the 2019/20 plan and the sensitivity of the assumptions through reviewing the 2018/19 outturn to the planned surplus of £4.124m. **Our findings on this risk area:** We consider the arrangements in place for sustainable resource deployment to be adequate.

THE PURPOSE OF OUR AUDIT WORK AND TO WHOM WE OWE OUR RESPONSIBILITIES

This report is made solely to the Council of Governors of the Trust, as a body, in accordance with Schedule 10 of the National Health Service Act 2006 and the terms of our engagement by the Trust. Our audit work has been undertaken so that we might state to the Council of Governors of the Trust, as a body, those matters we are required to state to them in an auditor's report, and the further matters we are required to state to them in accordance with the terms agreed with the Trust, and for no other purpose. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the Council of Governors of the Trust, as a body, for our audit work, for this report, or for the opinions we have formed.

CERTIFICATE OF COMPLETION OF THE AUDIT

We certify that we have completed the audit of the accounts of Northamptonshire Healthcare NHS Foundation Trust in accordance with the requirements of Schedule 10 of the National Health Service Act 2006 and the Code of Audit Practice issued by the National Audit Office.

Andrew Bostock for and on behalf of KPMG LLP
Chartered Accountants and Statutory Auditor
One Snowhill
Snowhill Queensway
Birmingham
B4 6GH

28 May 2018

KPMG

Now you can follow our progress, find out more about our services, read reports from our meetings, keep up-to-date on our news and send us your comments and views.

Visit our website at www.nhft.nhs.uk

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