UNIVERSITY OF LEICESTER
Affiliated Teaching Hospital

NHS
Kettering General Hospital
NHS Foundation Trust

Kettering General Hospital
NHS Foundation Trust

Annual Report & Accounts

2019/20

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Kettering General Hospital
NHS Foundation Trust

Annual Report & Accounts

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

Welcome

to the Kettering General Hospitals' Annual Report and Accounts 2019/20.

Contents

This time last year, I expressed how proud I was to be part of an organisation that had identified where it was going and had committed to a journey to becoming outstanding. Now, in welcoming you to our 2019/20 Annual Report, I'm delighted to update you on our progress as an organisation.

The year started well as, thanks to the dedication and tireless efforts of our staff, we moved out of special measures in May 2019. Having agreed a short to medium term strategy during 2018, in November 2019 we agreed a clinical sustainability strategy to support us on a path to a successful future, ensuring that we deliver safe, high quality care to our communities. The strategy is about finding ambitious but practical ways to reimagine our purpose, to reinvigorate and strengthen our acute services, and to plan a future where we deliver holistic, high quality care beyond the boundaries of our hospital.

Statement from the Chairman

1

A centre piece of the strategy is a drive for greater collaboration with our partners within the local care system, and particularly Northampton General Hospital, the county's other provider of 'acute' hospital services. In December 2019, both hospitals agreed to move towards a group management model to strengthen health services in Northamptonshire. This included the appointment of a Group Chief Executive Officer, and I'm delighted to confirm the appointment of the Trust's own Chief Executive, Simon Weldon, to the position. Simon will formally take up the post later on 1 July 2020, and will be turning our commitments to greater collaboration, at pace, and closer joint working between senior management teams and clinical services, into reality.

Our strategy is about transforming services for patients, and making sure they have access to the right care when they need it most. Delivering safe, high quality care in an efficient way and in the right setting is our core aim.

We've said for years that several parts of our current hospital estate just won't enable us to achieve this, particularly our A&E Department, identified by the CQC as one of the most cramped and unsuitable they'd ever visited. With the support of our local MPs, we continued to lobby hard for improvements during the year and, I'm pleased to say, our persistence has paid off, as our bid for £46 million funding towards an Urgent Care Hub was approved by the Government in October 2019.

We have also been able to progress plans to improve our site through the Government's Health Infrastructure Plan (HIP2), having been one of a number of hospitals allowed to bid for a share of £100m of 'seed' funding to develop outline and full business cases for investment. We've already started on the planning and preparation work to design a set of buildings that can deliver the highest standards of modern medical care to our local population for the next 30 years, with a view to completing a Strategic Outline Case (SOC), by the end of 2020. The HIP2 and Urgent Care Hub programmes will be running in parallel to ensure we build the right facilities in the right place – look out for public engagement events and workshops as we move through the planning and design phases, to ensure we are listening to our local patients and public about what they need from a new facility.

2019/20 has been another period of development and consolidation for the Trust Board, as we appointed Mark Smith to the position of Joint Chief People Officer with Northampton General Hospital as part of our drive for closer collaboration. We also welcomed Polly Grimmett to the Board as Director of Strategy, with responsibility to oversee the major investment programmes, HIP2 and the Urgent Care Hub.

We welcomed two new Non-Executive Directors to the Board – Alice Cooper, who brings experience a variety of senior roles in the areas of Risk, Information, Strategy and Planning and Liisa Janov, a Finance Director at Jaguar Land Rover. We look forward to utilising their skills and experience from different sectors to drive our improvement journey. This year also saw the departure of Phil Harris-Bridge after six years of distinguished service; Trevor Shipman has succeeded Phil as the Trust's Vice-Chairman and Senior Independent Director.

The Trust has an active and engaged Council of Governors, whose role is to represent the interests of our members and communities, and to hold the Board to account for performance. Many of our Governors are elected by the members and, following elections in 2019, we welcomed David Harland, Pam Marray and Angela Mason as public governors and Bev Bone and Jayne Chambers to represent our staff. I'd like to thank the Governors whose terms of office expired during the year, and express my condolences following the sad death of David Everitt, who served on the Council as a Public Governor for Corby between 2014/19.

As I write, the Trust is coping with the peak of the Coronavirus pandemic; I'm very grateful to our staff for their efforts to reconfigure the hospital to maximise critical care capacity and look after our patients in the most challenging of circumstances, and also to the generosity of local individuals and businesses for their kind donations. Whilst our efforts have rightly been focussed on responding to this horrible virus, we won't lose sight of our 'business as usual' care responsibilities, and how our strategic development plans are necessary to ensure a healthy and sustainable future.

Alan Burns
Chairman
17 June 2020

Performance Report

2

2.1 OVERVIEW

2.1.1 Purpose

The purpose of this section of the report is to provide a summary of the clinical, quality and financial performance of the Trust for 2019/20. It gives a summary of the organisation, its purpose, key risks and performance over the year. Detailed information that supports this summary is included throughout the document and is referenced as appropriate. It opens with a statement from our Chief Executive.

2.1.2 Chief Executive Statement

On behalf of the Board, I am pleased to introduce this annual report on the Trust's performance in the year from 1st April 2019 to 31st March 2020. The publication of this report coincides with my second anniversary as Chief Executive of Kettering General Hospital and offers an opportunity to reflect on our continuing journey to improve the services we offer to patients and how we care for our staff.

Of course the end of the period covered by the Annual Report has been dominated by COVID-19. Undoubtedly, it will dominate the year ahead: it is unprecedented and will change the way in which the NHS works. It is too early to offer definitive comment on what has happened and it would be unwise to do so: the full judgement on how the Trust responded will only become clear with time. However, I would like to make three initial comments here.

First, it is clear that our local community has faced and continues to deal with a great tragedy. There have been significant excess deaths as a consequence of COVID-19 and every one of these deaths is an irreplaceable loss to the families involved. I know that the thoughts of the whole hospital community are with our local community.

Secondly, the response of our staff has been extraordinary. In every way, they have risen to the challenge and been able to respond to the needs of our patients. I know that some of them have been affected by COVID-19 and continue to live with the aftermath of the illness. I pay tribute here again to our team, to the families and friends that have supported them and again extend our thanks for what they have all done and continue to do.

Thirdly, the response of our local community has been equally extraordinary. The hospital has been the recipient of so much kindness and support, it is difficult to single out any one individual or group. The donations have not just been of food, welcome though those have been, but also of people reaching out to tell us in so many ways how much the NHS has meant to them.

Beyond COVID-19, the Trust continued to make significant progress this year.

In May 2019 we came out of special measures after a Care Quality Commission (CQC) report found we had made significant improvements and had progressed to the point where all clinical services inspected were rated as either good or requires improvement. The Trust was also rated good for the Well-Led domain. This was a huge achievement and reflects the work of many staff. The Trust was also well supported by partners and regional colleagues and I would like to take this opportunity to thank them here. I would also like to note in particular the support and guidance we received from our Improvement Director, Sue Holden.

Despite the evident improvements that have been made, there is more still to do and I know staff are ambitious to go further. A key area of focus for 2020/21 is to define our approach to Continuous Quality Improvement. We will develop a supportive working environment in order that staff better understand and can more confidently engage with quality improvements within either their local wards / departments or in larger scale, cross-site programmes. This will enable all staff to have the opportunity to suggest ideas for quality improvement at any time; provide the right level of Quality, Service Improvement and Redesign (QSIR) training, in house, to help everyone to feel confident to improve quality; and to provide support for the delivery of quality improvement ideas. I was delighted that Dr Rabia Imitiaz, Deputy Medical Director, accepted the challenge of leading this work.

We have good evidence that staff are hungry to take on the improvement challenge. As Chief Executive I have the privilege of meeting staff from across the organisation. The overriding theme at drop-in sessions, staff meetings or ward and department visits is quality improvement – with individuals wanting to share their ideas about how we can do better; however, the most visible demonstration of the desire to innovate for the benefit of patients came in February 2020 when Dragon's Den came back to KGH.

Just like the BBC programme, staff worked in groups to develop pitches for a share of a £100,000. Just like in the programme, they had to make pitches to our local Dragons and then answer any questions the Dragons cared to ask. We saw some great ideas on the evening, including the recruitment and training of 30 new Pastoral Care Volunteers to support vulnerable patients in A&E at weekends, artwork and redecoration to make our older person's wards more interesting and calming for dementia patients, and the purchase of laparoscopic simulators to enable junior doctors to practice the techniques of camera-guided procedures and improve their skills and confidence before undertaking procedures for real. I look forward to seeing these and other ideas come to fruition during the year to come. I would also like to thank all of our Dragons for their enthusiasm and commitment – they really put our pitchers through their paces!

A further area of significant progress this year has been on the hospital estate. In October 2019, we received a visit from Health Minister Edward Argar who visited our Emergency Department, Middleton Assessment Unit and Maternity Unit to see some of the challenges the old estate presents the NHS with. I also received a letter from Secretary of State for Health, Matt Hancock, which confirmed we are on a list of 21 Trusts to receive 'seed' funding to prepare business cases for capital investment. This is excellent news and will present us with a very important opportunity to present our case for investment as part of the Government's Health Infrastructure Plan (HIP2). We were also delighted to receive funding of almost £46 million towards the construction of a new Urgent Care Hub, and have commenced a programme to oversee the preparation and submission and outline and full business cases to ensure this much-needed facility progresses with haste.

In February 2020, we were delighted to welcome the Prime Minister Boris Johnson to Kettering General Hospital on 27-28 February, so that he could see a busy NHS hospital at work for himself. The PM was with us for several hours and met a large number of staff of all grades including cleaners, porters, reception staff, doctors, nurses and other specialists – and also had the opportunity to speak to lots of patients. He wanted to see the health service as it really was and see the pressures our staff were under for himself and, with more than 90 patients in our A&E when he arrived; he was certainly able to do this. The Prime Minister enjoyed his visit to KGH and described our teams as NHS heroes, subsequently writing in a national newspaper, "On Thursday night in Kettering I saw this country's greatest assets in the fight against sickness of any kind - the staff of the NHS."

Obviously, this progress is more than welcome and is a hugely positive statement about the future of the hospital. It is also the start of a journey and one that will doubtless dominate this and other reports in the years ahead. All of us in the hospital know that this is a once in a lifetime opportunity and we are determined to make the most of it. We know too that this is a gift to the community of Kettering and we will involve them in our journey at every stage: it is their hospital.

Finally, I would like to pay tribute to all those who have supported us to get this far. I would particularly like to thank our local MP, Philip Hollobone and his colleagues, Peter Bone and Tom Pursglove. Their indefatigable support for this work has been invaluable and I'm sure their support will continue to be needed in the years ahead.

Quality of care is at the heart of all we do. It is not enough simply to serve our patients: we must know that we do it well. We have made many quality improvements this year; for example, a stronger focus on using information and quality audits to identify where we need to focus, a real emphasis on working with, and listening to, our patients and a drive to improve our performance against national standards

that we know make a real difference to the lives of our patients. However, here, I would like to touch on three aspects of quality that may not be immediately obvious but nonetheless are key areas of work that help us deliver the excellent quality of care that our patients deserve.

Firstly, I'm pleased to report that the Trust exceeded its target for 80% of staff to receive the 'flu vaccination this year. This was thanks in no small part to Ned's story, and to the inspirational campaigning of Ned's parents, Nikki Shaw and Dan Rowe, to promote the importance of flu vaccination. Nikki and Dan tragically lost one of their two identical twin baby sons to flu last year, and were determined to do something to help people to understand just how dangerous flu can be and why it is so vital that as many people as possible are vaccinated. With this in mind, they worked with us to produce a short film called Ned's Story in memory of their son who died aged eight weeks. Ned's Story was used within the hospital to encourage a very high uptake of staff 'flu vaccination to protect patients, staff and everyone who visits the hospital. In addition, we supported Nikki and Dan's campaign to encourage flu vaccination through local media and social media. Their message reached more than 241,000 people via the KGH Facebook page alone.

Secondly, I am particularly pleased with the progress of our digital roadmap. Through the introduction of electronic observation recording our staff can identify our most acutely unwell patients at ward and Trust level. Since we went live in October 2019, 304,000 observations have been recorded. In association with this, CareFlow Connect provides a secure means of communication between clinicians, and has enabled 24,490 electronic handovers to support continuity of care since December 2019. Developing this work further and at even greater pace will be a key priority in the year ahead.

Thirdly, this year's staff survey has the best ever response rate of 51% - an increase on last year's response rate of 45% and above the national average score of 47.5%. As a Board, we know that how our staff feel about working at KGH directly impacts the care that they provide, so this survey really matters. Between September and November last year, 2,099 KGH staff took part in the survey. Overall staff opinions of the organisation are stable with seven of the 11 themed areas returning the same overall score as last year. Of the other four remaining themed area scores two were slightly improved – equality and diversity 9.1/10 up from 9/10 and health and wellbeing up to 5.9/10 from 5.8/10. Two areas had slightly lower scores than last time staff environment/violence 9.4/10 down from 9.5/10 and team working down from 6.7/10 to 6.6/10. We'll be preparing and implementing detailed action plans to respond to the feedback received, though this has been delayed by the onset of the Coronavirus pandemic, which has required us to prioritise immediate staff support measures.

In April 2020, I was proud to have been appointed to the position of Group Chief Executive of Kettering General Hospital and Northampton General Hospital, and am looking forward to taking forward work to build a successful and sustainable partnership that will make the make the most of our people to deliver clinical excellence.

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

Performance Summary

Complaints

The effective handling of, and learning from, complaints is an ongoing area of focus and, during the course of the year, we've closed all outstanding complaints which had been open for over six months and reduced the average response time from 92 days to 57 days. We have consistently struggled to meet our performance standards to respond to complaints within agreed timeframes, and have put in place a number of measures to improve this, including holding monthly complaints peer review panels, process mapping to eliminate variation within the divisions with complaints handling, a thematic review of complaints being undertaken to identify organisational themes and lessons, patient experience strategy review and improved procedure for the corporate handling of care complaints.

Diagnostics

The Diagnostic standard known as 'DM01', is a national standard and means that 99% of all diagnostic tests relating to physiology, radiology and endoscopy need to be completed within six weeks. From February 2018 we consistently delivered this target with weekly monitoring in place to actively manage this target and spot early warning signs so capacity can be increased to meet demand if required. The cancellation of all routine diagnostic work in March 2020 due to the impact of Covid-19 resulted in the Trust failing DM01 for the first time since February 2018.

Referral to Treatment Time (RTT)

The NHS Constitution sets out that (as a minimum) 92% of our patients should wait no longer than 18 weeks from GP referral to treatment (RTT). In 2019/20 our performance continued to improve but again the impact of Covid-19 caused a deterioration in performance in March 2020. We reported just one wait of over 52 weeks which after investigation was the result of an administrative error. The impact of Covid-19 and how we plan for the restart of routine work will be a significant focus during 2020/21.

Urgent & Emergency Care

KGH was asked to be a field test site for the clinical review of national urgent and emergency care access standards. This pilot commenced on 22nd May 2019 and we are now in Phase 2 of the pilot. As a field testing site KGH is not required to report against the 4-hour standard. We do however continue to report and monitor our performance against the national ambulance handover standards. During 2019/20 performance against the 60min handover time significantly deteriorated. The KGH Emergency Department is a very confined and logistically challenged environment with the teams involved constantly seeking ways of moving patients through the department safely; mobilising staff to different areas as demand dictates. The department therefore struggles with high conveyance numbers and in particular when they arrive in batches. Performance however did start to improve during February 2020 and has continued to improve in March.

Cancer Waiting times

There are seven operational standards for the Cancer Waiting Times. These standards monitor the length of time that patients with cancer or suspected cancer wait to be seen and treated in England. In 2019/20 we have consistently delivered the two week wait standards (with the exception in June 2019 of the Symptomatic Breast standard) and the 31 day standards (with the exception of July 2019 31d diagnosis to treatment standard). For the 62d standard in 2019/20 we have consistently delivered this standard. We are continuously monitoring all our cancer standards and work closely with all our clinical leads at KGH, our tertiary providers and system partners to look to how we can further improve for our patients and their outcomes.

Stranded & Super Stranded

The number of 'stranded' and 'super-stranded' patients staying for long periods in hospital has continued to cause concern through the year. In March 2020 the Trust worked closely with system partners as part of the preparation for Covid-19 to identify safe and suitable capacity for all patients who required placement and continuing care. This resulted in a significant decrease in those patients who were classed as stranded & super stranded. The challenge moving forward into 2020/21 will be to ensure that our pandemic recovery plan allows us to establish these newer, lower, numbers as the new norm.

Finance

The Trust ended this financial year with a deficit of £12.3m (2018/19 £31.7m). This position was reached after accounting for £18.2m of additional income in the form of Performance, Sustainability Funding (PSF), Financial Sustainability Funding (FRF) and Marginal Rate Emergency Threshold income.

The Trust's deficit position, prior to this additional income, was £31.4m, which is £6.2m adverse to the planned deficit of £25.2m.

The additional income was received as a result of the Trust delivering the Q1, Q2 and Q3 planned financial position. The final Trust deficit position was in line with the revised forecast submitted to NHSI at Month 10.

The Trust financial performance remained challenging, with the need to ensure safe staffing levels in clinical areas, resulting in higher costs in some of those areas. A national shortage of trained staff available for recruitment has also led to agency costs remaining high. In order to mitigate continued pay overspends the Trust has invested in international nurse recruitment and trainee nurse development programmes to reduce future nursing vacancy levels.

High levels of stranded and super stranded patients also contributed to the increase in pay and non-pay expenditure within 2019/20. The Trust has focused on various methods such as long stay Wednesday and Home for Christmas in order to improve this position. Same Day Emergency Care has also been successfully implemented in order to support with discharges.

Despite the challenging environment the Trust transformation schemes had delivered £10.8m against a target of £10.5m; Over performance is largely due to income maximisation, procurement savings and corporate cost reduction schemes.

The improved system working and focus on maximising benefits to the system saw all partners reach a year end settlement enabling KGH to deliver its Q3 PSF/ FRF and to support all partners to either reach or move closer to their control totals. This system working and open book approach will see us move to a process of understanding costs of service/ pathways across the system and a block contract type approach to future contracts between system partners.

COVID 19 impacted activity in March 2020, and is expected to do so into 2020/21, therefore a separate national contract has been agreed with the independent sector to manage cancer and urgent activity. The COVID 19 revenue expenditure and lost income totalled £2.7m in 2019/20, and was covered by central funding to be received in cash terms in May 2020.

Capital expenditure for 2019/20 is £12.4m compared to a plan of £14.2m (excluding COVID 19 capital expenditure). £0.3m of capital COVID expenditure was incurred within 2019/20.

2.1.3 Purpose and activities of Kettering General Hospital NHS Foundation Trust

Business model and environment

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

As a Foundation Trust, our local communities have more influence over our decision-making; by becoming members and electing our Governors, our local communities can be part of the decision-making process for our strategy and how we deliver services. We are accountable to our local communities through our Members and Governors; our commissioners through contracts; Parliament (in that we lay our annual report and accounts before Parliament); the Care Quality Commission (through the legal requirement to register and meet the associated standards for the quality of care we provide); and NHS Improvement through the NHS Provider Licence.

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

Our local system

We are part of the Northamptonshire Sustainability and Transformation Partnership (STP), now known as the Northamptonshire Health and Care Partnership (NHCP), with Northampton General Hospital NHS Trust, Northamptonshire Healthcare NHS Foundation Trust, Northamptonshire County Council (soon to be split into two organisations, covering the north and south of the county), Corby and Nene Clinical Commissioning Groups, General Practice federations and alliances, and Voluntary Impact Northamptonshire. The system is already facing a financial deficit which, without greater collaboration, will grow over the next five years.

Organisational structure

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

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

The Trust is organised into four Divisions (3 clinical, 1 corporate). Each clinical division has a Lead (a clinician), a Head of Nursing and a Divisional Director. Divisions are organised as follows:

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

Kettering General Hospital NHS Foundation Trust is a medium sized acute hospital serving a population of approximately 330,000 across North Northamptonshire and South Leicestershire. Our local population will continue to grow and age over the next five years. This means that, if we take no action to deliver care differently, the number of patients we see in all these settings will increase significantly, with the greatest increase in the over-80 population. These demographic changes are an important factor in the development of our clinical strategy, in which we have sought to address these challenges with practical and creative solutions based on partnership working across our local system.

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

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

Strategy and Partnerships

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

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

During 2018-19, the Director of Strategy and Transformation and Medical Director led work to develop a long term strategy to deliver our strategic objectives, whilst also developing collaborative arrangements with Northampton General Hospital (NGH) to enable the two acute health providers in the county to work more closely together to achieve benefits for patients and serve the current and future health needs of a growing population.

The strategy was agreed in November 2019 following extensive clinical and partner engagement, providing a roadmap to sustainability and outstanding services based around a commitment to transform services, balance of 'quick wins' and long term system-wide transformation, whilst carefully considering the impact on our people and partners. The roadmap describes our journey from a model of predominantly standalone delivery to a position from which we can provide sustainable core acute services to our local community, in partnership with NGH, and integrate with other organisations to provide joined-up care through a system that supports people to stay well.

The strategy identifies a number of priority areas for action to support practical implementation during its first year. Using broad headings, we are empowering our clinical and support divisions to determine how they want to turn their strategies into reality, with arrangements in place to provide regular assurance around progress to our Board, Governors, partners and communities.

2.1.4 History of Kettering General Hospital NHS Foundation Trust

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

During 2019/20, we were pleased to be awarded capital funding of £45.786 million to build a new Urgent Care Hub to replace existing facilities which are no longer fit for purpose, and to be included in the second round of government Health Infrastructure funding, providing 'seed' capital to develop business cases for site redevelopment options.

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

In recent years the Trust experienced financial and operational difficulties and was rated as Inadequate by the Care Quality Commission in 2017 and placed in Special Measures. This rating was revised to Requires Improvement in February 2018. The Trust has recently been re-inspected and exited Special Measures in 2019.

2.1.5 Key issues and risks

The Trust recognises that balancing high quality care alongside long term financial and clinical sustainability gives rise to significant and challenging strategic risks. The Board Assurance Framework (BAF) brings together in one place all of the relevant information on the risks to the Trust's strategic objectives and ensures there is clarity about the risks that may impact on the Trust's ability to deliver its strategic objectives together with any gaps in control or assurance.

Our BAF is discussed at every board meeting and is reviewed by sub-committees on a monthly basis to ensure that controls and assurances are sufficient and that mitigation plans are being implemented and are taking effect.

2.1.6 Going concern

After making enquiries, the directors have a reasonable expectation that the NHS foundation trust has adequate resources to continue in operational existence for the foreseeable future. For this reason, the Trust will continue to adopt the going concern basis in preparing the accounts. The Board of Directors agreed the Trust's Going Concern Assessment at its meeting on 29 May 2020.

2.2 PERFORMANCE ANALYSIS

Following extensive redesign in 2018, the Trust has developed and embedded its Integrated Governance Report, submitted to Board Committees each month and brought into a single exception report to the Board. During 2019/20, we introduced Statistical Process Control exception reporting, using longitudinal data and statistical theory to inform judgement and provide greater assurance and trend analysis.

The Trust has also embedded its Board Assurance Framework and Corporate Risk Register, allowing for the alignment and escalation of risks from ward through Directorate and Divisional risk registers up to the corporate risk register with the Risk Management Steering Group and Quality and Safety Committee maintaining governance oversight and a reporting line to the Board. All 129 risk registers, identified from ward to board, were in place by 31 December 2019.

Assurance and escalation of the Trust's performance on quality, risk, operational performance and finance is achieved through management action and accountabilities through the Executive Team; during 2019/20, quarterly Performance Review Meetings were relaunched, chaired by the Chief Operating Officer and enabling the Trust's frontline divisions to be held to account for performance.

Links to the Integrated Governance Reports, considered by the Board of Directors during the year, are available on our public website: *www.kgh.nhs.uk/board-of-directors-and-board-meetings.*

Further information about our work and achievements during the year is available in our 'KGH Together' magazine, available here: *www.kgh.nhs.uk/about-us-kgh-together-magazine.*

“The hospital has been the recipient of so much kindness and support...”

Highlights

2019

APRIL

KGH's Rheumatology Team

The KGH Rheumatology Team is one of the top performing Trusts nationally in the early diagnosis and management of inflammatory arthritis. The audit was overseen by the Healthcare Quality Improvement Partnership.

MAY

KGH Out of Special Measures

On 22 May 2019 KGH came out of special measures after a Care Quality Commission (CQC) report found it had made significant improvements and had progressed to the point where all areas inspected have been rated as either good or requires improvement.

JUNE

Waiting times reduced

KGH has launched a new procedure to help speed up the diagnosis of lung cancer and serious infections using an ultrasonic bronchoscopy system.

JULY

New patient buggy up and running

KGH has launched its new electric buggy service which will enable less able patients to be driven by registered hospital volunteers to and from the hospital set pick up points.

AUGUST

New cardiac echo simulator

A new £45,000 state-of-the-art Cardiac Echo Ultrasound Simulator has been kindly gifted to KGH from a grateful Desborough couple and will provide a vital practice in detecting heart problems.

SEPTEMBER

KGH Flu Campaign launched

A couple who lost one of their identical twin baby sons to flu campaigned with KGH for people to be vaccinated to prevent such tragedies happening to other families.

OCTOBER

Urgent Care Hub

KGH's case for an Urgent Care Hub and for major investment in the hospital was highlighted to a Government Health Minister.

DECEMBER

Cardiac Physiologist graduated

A cardiac physiologist from KGH has graduated with the highest score in the UK for one exam and scored in the top 1% in the world for another.

NOVEMBER

NHS Rainbow Badge Scheme launched

KGH launched the Rainbow Badge scheme for staff who wish to demonstrate to members of the LGBTQ community that they are respected during their time at the hospital.

2020

JANUARY

Leaders in Safeguarding Quality Mark

KGH is the first trust in the country to receive a nationally recognised accreditation for high standards in the way it works to protect children and adults from abuse and neglect.

FEBRUARY

KGH Dragon's Den

Staff used a variety of innovative approaches to impress the Dragons including dance routines and acting out a mini play in a bid to improve patient care at KGH.

MARCH

First step to become carbon neutral

KGH has taken delivery of its first electric vehicle as it moves towards a target of becoming carbon neutral by 2050.

Simon Weldon
Chief Executive
17 June 2020

Accountability Report

3

3.1 DIRECTORS' REPORT

3.1.1 The Board of Directors

Name	Title	Attendance
Alan Burns	Chairman	4/6
Simon Weldon	Chief Executive Officer	6/6
Richard Apps	Director of Integrated Governance	6/6
Nicci Briggs	Director of Finance	6/6
Andy Callow	Chief Digital and Information Officer	6/6
Andrew Chilton	Medical Director	6/6
Eileen Doyle (until Aug 2019)	Interim Chief Operating Officer (until Oct 2018) Interim Deputy Chief Executive (from Nov 2018)	2/2
Jo Fawcus	Chief Operating Officer	6/6
Polly Grimmett (from Dec 2019)	Director of Strategy	2/2
Leanne Hackshall	Director of Nursing & Quality	6/6
Mark Smith	Director of Human Resources & Organisational Development Chief People Officer (from 1 September 2019)	5/6
Alice Cooper (from April 2019)	Non-Executive Director	5/6
Janet Gray	Non-Executive Director	6/6
Phil Harris-Bridge (until Sep 2019)	Non-Executive Director Vice Chairman /Senior Independent Director	3/3
Liisa Janov (from Oct 2019)	Non-Executive Director	3/3
Lise Llewellyn	Non-Executive Director	6/6
Trevor Shipman	Non-Executive Director/Vice Chairman /Senior Independent Director*	6/6
Damien Venkatasamy	Non-Executive Director	5/6
Chris Welsh	Non-Executive Director	5/6

Attendance = actual/possible attendance at Board of Directors meetings. *From October 2019

Note: Disclosures required by Health and Social Care Act which have been subject to Audit are marked as such.

The Board of Directors and Council of Governors

High-level overview

Under the structure set out in the National Health Service Act 2006, and the Trust Constitution, the Board of Directors is ultimately responsible for the operation of the Trust, and for exercising its powers. The Board of Directors remains accountable for all of its functions, even those delegated to individual committees, sub-committees, directors or officers and would therefore expect to receive information about the exercise of delegated functions to enable it to maintain a monitoring role. The Board reserves to itself the powers of: Regulation and Control, Appointment or Dismissal of Committees, Strategy and Business Plans, Budgets, Audit Arrangements and Monitoring. The Council of Governors has a limited set of specified decisions that the Act has reserved to it, including the appointment of Non-Executive Directors and external Auditors, and which the Board cannot undertake; together with some other decisions where they must be consulted prior to the Board taking a decision. The Board and the Council of Governors are provided with high-quality information appropriate to their respective functions and relevant to the decisions they have to make.

The Board meets regularly for the formal transaction of business, with a session open to public observation and if required a further limited session in private. The regular agenda allows the Board to review financial and operational performance; consider the risk environment affecting the Trust, both internal and external; and receive assurance and escalated items from the detailed work undertaken by Board Committees. The Board also regularly considers the development of strategy, including external changes and challenges. The Board meets in public on a bi-monthly basis with Board development sessions in each intervening month to provide dedicated time to focus in depth on matters relating to strategy, culture and operations.

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

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

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

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

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

Council meets on a scheduled basis of four meetings in each year, with additional meetings being held if required to deal with urgent business. Each Council of Governors meeting is open to the public to observe, except where specific business needs to be considered in private. Governors receive papers for the public sessions of the Board and Committees, with Nominated Governors appointed to each Committee to support them to hold the Board to account.

Fit and proper person test

Requirements are included in the eligibility criteria for Directors regarding the need to meet the "fit and proper" persons test described in the provider licence. The Trust carries out annual checks against national registers and Board members and their deputies are required to confirm annually that they meet these requirements.

Board of Directors Meetings

There were six formal Board meetings held during 2019/20. Directors' attendance at Board meetings is included in the table at Section 3.1.1 on page 13.

Independent Non-Executive Directors

The independence of the Non-Executive Directors is reviewed annually, having regard to the criteria in the Code of Governance, to identify any factors that might indicate that a Non-Executive Director was no longer independent. Having considered those matters, the Board considers that all of the Non-Executive Directors

are independent of the management of the Trust. No matters have been identified that might indicate that a Non-Executive Director was not independent from Trust Management.

The Chairman holds regular meetings with non-executive directors independently of the Executive Directors, and carries out an annual appraisal, the outcomes of which are reported to the Council of Governors for approval.

The Chairman is also Chair of Northampton General Hospital, having been appointed to this position in December 2018. The Trust Board and Council of Governors were informed of the appointment prior to him taking up the position.

Completeness, balance and appropriateness of the Board

Details of the skills, expertise and experience of the individual Directors can be found in the biography section, in the staff report from page 22.

Performance Evaluation

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

Individual Directors are subject to performance evaluation through the appraisal process. For Executive Directors, the process is applied in the same way as for all other employees, with objectives being set at the start of the year, progress being reviewed, and the appraisal at the end of the year. Recognising their position as Directors and members of a unitary Board, the objectives and appraisal include an element reflecting their contribution to the Board, both in their direct area of responsibility and across the general responsibilities of the Board as a whole. The Non-Executive Directors are subject to a similar process, which focuses on their contribution to the Board and effective governance; with the Chair's performance evaluation and objective setting carried out in a process led by the Senior Independent Director. The results of the performance evaluations are used as the basis for determining individual and collective professional development programmes for non-executive directors relevant to their duties as board members. The outcomes of the process are reported to the Nomination and Remuneration Committee in respect of Executive Directors, and the Council of Governors (via the Council's Appointments and Remuneration Group) in respect of the Non-Executive Directors.

The Board undertook a comprehensive self-assessment against the CQC's Well-Led framework in 2019, and has also participated in a development programme, which is due to conclude in Summer 2020.

Committees of the Board

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

Audit Committee

The Audit Committee, comprised of 3 non-executive directors, one of whom chairs the Committee, is responsible to the Board of Directors for providing an independent view of financial and corporate governance and risk management. The committee is responsible for the relationship with the Trust's auditors.

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

Audit Committee membership 2019/20

Name	Title	Attendance
Alice Cooper (from July 2019)	Non-Executive Director	3/3
Lise Llewellyn	Non-Executive Director	4/5
Trevor Shipman (Chairman)	Non-Executive Director	5/5

Significant issues

The Audit Committee met on 27 April 2020 to consider the financial statements for the period 2019/20. The Audit Committee reviewed the financial statements and identified no significant issues.

External Auditors

The Council of Governors approved the re-appointment of Grant Thornton as external auditors from April 2020 for a period of four years, finishing with the external audit of the 2023/24 annual accounts. As a result of the additional scrutiny and detailed level of audit required to meet the FRC guidelines, the Trust incurred higher costs of £74,500 for 2019/20 to reflect the additional days required by Grant Thornton, representing an increase of £22,500.

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

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

Internal Auditors

During the year ended 31 March 2020, the Trust's internal audit and counter fraud function was carried out by TIAA Ltd, an independent business assurance provider delivering services to the public and private sectors.

Quality & Safety Committee

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

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

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

Performance, Finance & Resources Committee

The Committee is responsible for overseeing and providing assurance that:

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

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

Organisational Development Committee

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

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

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

Charitable Funds Committee

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

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

Digital Hospital Committee

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

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

Strategic Development Committee

This Committee was established by the Board of Directors in November 2019 to oversee the modernisation of the Trust's estate to ensure that it is a key enabler to deliver clinical service ambitions; specifically, the Committee is leading work to progress the provision of a new Urgent Care Hub and wider hospital redevelopment programme, linked to the Health Infrastructure Programme (HIP2). It is chaired by the Trust Chair.

*Compassionate, Accountable, Respectful, Engaging

Council of Governors and Membership

Overview

The Council of Governors is made up of individuals who represent the local community and staff or are nominated by various local organisations such as Charities. In this challenging time they maintain a key role in being a link with local people and staff. Throughout the year Governors have contributed to the business of the Trust.

The Governors applaud the planned close working with Northampton General Hospital including the roles of the established Chief People Officer and the recently appointed Group Chief Executive Officer which enables closer working practices to benefit patient care. As part of the quality account process, Governors are involved in setting priorities for external audits and for 2020-21 requested an audit on fluid balance; this audit was deferred due to reduced external audit requirements as a result of COVID-19; however, work to sustain improved performance and reporting against this measure continued during the year, and will be incorporated into the Internal Audit Plan for 2020-21.

Role and Responsibilities of the Council

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

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

We deliver an annual training programme in response to the needs of our new and continuing governors. During 2019-2020, including core skills workshops run by NHS Providers and in-house briefings on key topics such as changes to performance reporting and transformation agenda. We will continue to respond to the needs and requirements of our governors on an ongoing basis.

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

Our governors engage within the hospital and the wider community in a number of ways, for example being invited to observe clinical quality visits and be represented on project groups taking forward key initiatives such as the Patient Record Review. During 2020/21 our Council of Governors will continue to drive engagement across the constituencies and ensure the public interest is represented and the patient voice is heard through our membership and the wider public.

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

Council of Governors

At 31 March 2020, the Council of Governors comprised 18 members from three specific groups:

- 11 public governors
- 3 staff governors
- 4 stakeholder governors

Membership of the Council of Governors 1 April 2019 – 31 March 2020

Public Elected Governors

Name	Constituency	Elected	End of Term	Attended
Peter Woolliscroft	Kettering	2 Dec 2017	1 Dec 2020	4/4
Gail Chapman	Kettering	18 Oct 2016 18 Oct 2019	17 Oct 2019 17 Oct 2022	4/4
Mohamed Latif	Kettering	2 Dec 2017	1 Dec 2020	1/4
David Everitt (deceased)	Corby	2 Dec 2017	-	1/1
Ray Lilley	Corby	18 Oct 2016	17 Oct 2019	0/2
Pat Jackson	Wellingborough	2 Dec 2017	1 Dec 2020	4/4
Graham Lawman	Wellingborough	18 Oct 2016 17 Oct 2019	17 Oct 2019 17 Oct 2022	2/4
Annette Bridgeford	Wellingborough	21 Jan 2019	20 Dec 2020	2/4
Mabel Blades	East Northants	2 Dec 2014	1 Dec 2020	4/4
Reg Talbot	East Northants	2 Dec 2017	1 Dec 2020	4/4
David Harland	Corby	18 Oct 2019	18 Oct 2022	2/2
Pam Marray	Corby	18 Oct 2019	17 Oct 2022	2/2
Angela Mason	East Northants	18 Oct 2019	17 Oct 2022	2/2

Staff Elected Governors

Name	Constituency	Elected	End of Term	Attended
Jayne Chambers	Staff	18 Oct 2019	17 Oct 2022	2/2
Bev Bone	Staff	18 Oct 2019	17 Oct 2022	1/2
Michelle Creighton	Staff	18 Oct 2016	17 Oct 2019	0/2
Jennifer McCaffery	Staff	26 April 2018	2 December 2020	2/4

Stakeholder Appointed Governors

Name	Organisation		End of Appointment	Attended
Vijay Sharma	University of Leicester	March 2014	March 2020 (resigned)	1/4
Wendy Brackenbury	Local Authority	March 2014	March 2023	1/4
Sue Watts	Voluntary / Charitable Sector	March 2015	March 2024	1/4
Dr Andrew Stephen	Voluntary / Charitable Sector	April 2016	March 2025	2/4
Sheila White / Wendy Patel	Healthwatch	December 2017	August 2024	4/4

Nominated Lead Governor

The Council of Governors appoints one of its members to be the Lead Governor. The Lead Governor is a point of contact between NHS Improvement and the other governors, and acts a main point of contact for the Chairman. Professor Peter Woolliscroft was appointed to the position in November 2018 to service a two-year term.

Governor Group Meetings

Appointments and Remuneration Group

The Appointments and Remuneration Group, is responsible for advising annually on the remuneration of the Chairman and Non-Executive Directors (NEDs); advising on the appointment of NEDs and the Chairman; receiving performance/appraisal information relating to the Chairman/NEDs to assist in considering re-appointments to the role.

Members of the group will be provided with the views of the Board on the appointment of any non-executive director taking into consideration the skills and experience required to compliment the board as whole. Governors are involved in the interview process together with current non-executive directors, the chairman and the director of HR and any other appropriate person.

The Appointments and Remuneration group met twice during 2019/20 to carry out the appraisals of, and agree revised remuneration levels for, the Chairman and Non-Executive Directors, and recommend the reappointment of Trevor Shipman to a second term of office as a Non -Executive Director.

Governor Overview Group

The overview group receives information on all aspects of performance, finance, quality and safety, audit, workforce and any other relevant trust issues or matters of importance. The overview meeting allows Governors to meet regularly with NEDs and assess their performance in each of the key areas of Trust management. The group also focuses on membership, communication and training

The Governor Overview Group met on six occasions during 2019/20.

The Council of Governors: Relationship with the Board of Directors

Non-Executive Directors attend Council of Governors meeting to provide feedback from Board Committees.

In addition, bi-annual joint meetings of the Board and Council took place in May and November 2019 to consider matters of common interest on key issues such as the Trust's CQC Inspection Outcomes, Clinical Sustainability Strategy and Group Model Collaboration proposals with Northampton General Hospital.

The Chief Executive and Executive Directors attend Council meetings where necessary to provide information or updates on aspects of strategy, key developments in the Trust, finances, national initiatives or any areas of concern or interest that governors may have. Our Non-Executive Directors also take away any key concerns that governors may have and raise these at board committees on behalf of the council.

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

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

Governors are provided with information to enable them to carry out their duties and keep fully informed about Trust matters. All CEO newsletters, media releases and any other important information is circulated directly to governors. To ensure our governors are well informed, the agenda and reports of all Board of Director meetings are circulated to the full council for information. All governors are invited to attend and observe Board of Directors meetings.

The nominated governors to Board Committees may raise any comments, concerns or queries from the Council in advance, and have the opportunity to meet with committee chairs to discuss these matters to gain assurances on behalf of the Council.

Members of the Board of Directors have provided training sessions for governors to ensure they are up to date with the trust plans, understand the key challenges, and are actively engaged in the development of the strategy and operational plans of the trust – examples during 2019/20 during Statistical Process Control, performance management, transformation and the Trust's digital journey.

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

Keeping our Governors Informed

We provide a training and induction programme that runs through the year on all key aspects of NHS business including finance, audit, quality, statutory duties, patient experience and any other relevant training required or requested. Governors are requested to complete a skills audit each year. All governors can attend the 'Governwell' Training courses run by NHS Providers and any other relevant training or conferences that take place across the UK.

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

Keeping the Directors aware of Governor and Member views

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

Membership

The Trust has two categories of membership:

- Public members
- Staff Members

All staff who have been employed for a 12 month period by the Trust automatically become members of the KGH Foundation Trust and are eligible to vote in elections. The majority of the KGH Foundation Trust members are drawn from Kettering, Corby, East Northamptonshire, Wellingborough, East Leicestershire and Northampton, these being the principal areas that the hospital serves.

As at 31 March 2020 the Trust had 4,622 public members, with constituencies as described below:

Constituency	Number of Members 31 March 2020
Kettering	1,814
Corby	693
Wellingborough	1,084
East Northamptonshire	687
Rest of UK	344

Dr Mabel Blades is the governor membership lead and continues to work to increase public engagement and gain the views of the community the hospital serves.

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

Our Annual Members Meeting was held in 19 July 2019 and attracted a good public response. Members enjoyed viewing the large number of stands showcasing the Trust's services. The Annual Members meeting gave members of the public an opportunity to ask questions of the Executive Team and speak to Governors who took the opportunity to engage with the membership. The Lead Governor gave members an overview of the work governors had undertaken during the year and invited input from the members on the trust's plans.

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

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

Contacting Governors

Members can contact Governors via:

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

Telephone: *01536 491019*

Email: *kghcouncil.members@nhs.net*

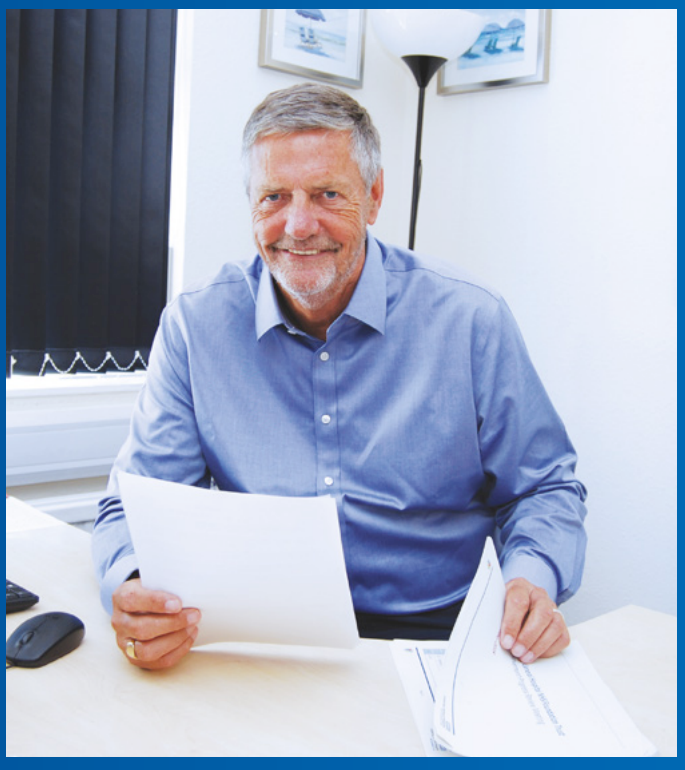
















Directors' Biographies

BOARD OF DIRECTORS

Non-Executive Directors

Alan Burns
Chairman

Alan has worked in the NHS for 43 years in a variety of senior roles and has also run his own consultancy business supporting leadership and improving performance through coaching. Alan is also the Chairman of Northampton General Hospital and previously of the Princess Alexandra Hospital in Harlow. Before that, he spent 24 years as a Chief Executive of a number of Strategic Health Authorities. Alan has been involved in national work on public sector reform and research and development and was Vice Chairman of the NHS Confederation.

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

Trevor Shipman
Vice-Chairman, Non-Executive Director and Senior Independent Director

Trevor was appointed in February 2017, and reappointed for a second term in 2020. Trevor lives in Northamptonshire and has extensive experience in the NHS and was Finance Director of Central and North West London NHS Foundation Trust. He is a member of the Association of Certified Chartered Accountants and brings a wealth of experience in audit and finance to the Board.

Trevor was appointed as the Trust's Vice-Chair and Senior Independent Director in October 2019, chairs the Audit Committee and is a member of the Charitable Funds, Remuneration and Nomination, Organisational Development and Strategic Development Committees.

Alice Cooper
Non-Executive Director

Alice was appointed in April 2019. After studying Psychology, Alice started her professional career at KPMG, qualifying as a Chartered Accountant and later joining the specialist Financial Services Audit team. She later moved to working directly for a large Building Society Group, holding a variety of senior roles in the areas of Risk, Information, Strategy and Planning.

Having always enjoyed the people development side of her work, more recently, Alice trained as an Executive and Career Coach, and now combines this freelance role with her other responsibilities, including her non-executive director role.

Alice was born in Kettering and has lived in the area for much of her life. Outside of work and looking after a young family, she is a keen singer, and is also active in children and families work in her local church.

Alice chairs the Digital Hospital Committee and is a Member of the Remuneration and Nomination, Charitable Funds and Audit Committees.

Janet Gray
Non-Executive Director

Janet was appointed in October 2014 and re-appointed for a further 3-year term in October 2017 Janet is CEO of the Academy for Healthcare science, a UK-wide organisation which brings together the entire Healthcare Science Profession to improve patient care and advance and promote the Healthcare science workforce. Janet has a long career in healthcare, building on her work as a clinician, in Nursing and Midwifery, to move into teaching and later management. She has a wide portfolio of experience in executive, Chief executive and non-executive roles in public, private and third sector organisations.

Janet chairs the Organisational Development Committee and Charitable Funds Committee and is a member of the Remuneration and Nomination Committee.

Liisa Janov
Non-Executive Director

Liisa joined the Board as a Non-Executive Director in October 2019. Liisa is a Finance Director at Jaguar Land Rover, a company she joined 17 years ago. During her career as an operational finance partner she gained experience of the automotive sector and led innovation in a rapidly changing environment. She finds creative, practical solutions that release value and improve performance. Liisa believes her experience of improving profitability through transformation will help her support KGH on the journey to outstanding.

Liisa is a member of the Remuneration and Nomination, Organisational Development and Performance, Finance and Resources Committees.

Professor Chris Welsh
Non-Executive Director

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

Chris chairs the Quality and Safety Committee and is a member of the Remuneration and Nomination Committee.

Dr Lise Llewellyn
Non-Executive Director

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

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

Damien Venkatasamy
Non-Executive Director

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

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

Terms of Office

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

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

Executive Directors

Simon Weldon
Chief Executive

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

Simon was appointed as Group Chief Executive of Kettering General Hospital NHS Foundation Trust and Northampton General Hospital Trust in April 2020.

Professor Andrew Chilton
Medical Director

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

Andy Callow
Chief Digital and Information Officer

Andy became Digital Chief Information Officer with the Trust in April 2019 and brings a wealth of digital experience to the role from a career spanning the public and private sectors.

Andy was previously Programme Director for the innovative NHS App at NHS Digital and took the app from inception to availability in the app stores in a little over 12 months. Prior to that he was the Head of Technology Delivery for the national NHS website NHS. UK, which receives around 40 million visits each month.

Andy has also held senior positions in the public and private sector, including five years as Head of Information and ICT for Children's Services at Derbyshire County Council and over three years as a Director for EMPSN (East Midlands Public Sector Network), a network and application services company covering all of the East Midlands.

Nicola Briggs
Director of Finance

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

Polly Grimmett
Director of Strategy

Polly joined the Trust in 2017, and has responsibility for leading the Strategic Development of the Trust. This includes being the executive lead for the redesign and rebuild of the site, including leading the work to rebuild a new Urgent Care facility for the hospital. The role also includes developing the Trust's relationships with other partners, to ensure patients in North Northamptonshire receive an integrated approach to all there care needs and remain as well as possible.

Polly spent much of her career in operational management roles in different acute providers, and also worked in commissioning and community services. Most recently she was part of the merger team at North West Anglia Foundation Trust and led the redevelopment of the Stamford hospital site.

Leanne Hackshall
Director of Nursing & Quality

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

Mark Smith
Chief People Officer

Mark joined the Trust in June 2014 in this key role, with lead responsibility for developing a highly skilled, trained and well-led workforce. Mark has the responsibility for creating systems and processes that engage all staff in living the values of the organisation. Mark has held a number of roles in Human Resources within the NHS since 2004 and prior to this, held roles within the private sector. Mark was appointed as Chief People Officer for KGH and Northampton General Hospital in September 2019, as part of the emerging collaboration initiative between the two organisations.

Richard Apps
Director of Integrated Governance

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

Joanna Fawcus
Chief Operating Officer

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

3.1.2 Other significant interests held by directors or governors

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

3.1.3 Political donations

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

3.1.4 Better payment practice

The Trust applies standard payment policy terms of 30 days to suppliers of the Trust; however, there were some cash restraints during 2018/19 which meant that some supplier invoices paid in April 2019 were over 30 days and this has had a detrimental effect on the 2019/20 performance. Whilst there have been some minimal cash restraints in 2019/20, these have impacted on NHS suppliers only.

Detail of the Trust's performance in 2019/20 is shown below with 2018/19 as a comparator.

	Month 1- 12 2019/20 Number	Month 1- 12 2019/20 £'000	2018/19 Number	2018/19 £'000
Total Non-NHS invoices paid in the year	74,140	105,935	69,478	96,040
Total Non-NHS invoices paid within target	53,502	70,662	38,928	51,366
Percentage of non NHS trade invoices paid within target	**72%**	**67%**	**56%**	**53%**
Total NHS invoices paid in the year	2,475	10,103	2,172	9,731
Total NHS invoices paid within target	1,634	6,895	1,053	4,941
Percentage of NHS trade invoices paid within target	**66%**	**68%**	**48%**	**51%**

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

Cost allocation and charging

Throughout the year ended 31 March 2020, and at all subsequent times until the approval of this annual report by the Audit Committee, the Trust has been compliant with the guidance on cost allocation and charging that has been issued for the NHS by Her Majesty's Treasury.

3.1.5 NHS Improvement's well-led framework

The Trust was inspected during January - March 2019, and again in February 2020.The first inspection involved an inspection of five core services (Diagnostics, Maternity, Medical Care, Outpatients and Urgent and Emergency Services) and a Well-Led review in March 2019, which looked at how well leaders created an environment that encourages and fosters improvement. The report of the inspection was published in May 2019. An unannounced visit to the Emergency Department took place in February 2020, leading to focused improvement work, by reducing overcrowding in the ED and creating effective patient flow through the Trust.

Throughout 2019 the Trust undertook significant work in strengthening and tracking evidence of its Quality Improvement Plan implementation. This included Executive sponsorship and a bi-weekly reporting cycle.

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

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

Our collaborative working across the local health economy is described in the Trust's strategic objectives, outlined in the performance report. This seeks to improve the care that patients receive across Northamptonshire. We are an active member of the Northamptonshire Health and Care Partnership (NHCP), formerly known as the Northamptonshire STP, which consists of key health and care providers in the county. NHCP is not a new organisation but a new way of working in partnership to improve health and care for people living in Northamptonshire. All Partnership organisations remain as separate organisations with their own local responsibilities for the services they provide, but are committed to working together towards the shared NHCP vision for a positive lifetime of health, wellbeing and care in our community.

You can find further information about NHCP at *www.northamptonshirehcp.co.uk.*

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

3.1.5.1 Fees and charges (income generation) (Has been subject to audit)

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

For 2019/20 income from the provision of goods and services for the purposes of the health service in England was greater than income from the provision of goods and services for any other purposes. Income from other sources has supported the provision and development of health services.

Information and disclosures related to the income from the provision of goods and services are included in the annual accounts. See note 3 on page 75 of the final accounts for a breakdown on income sources.

Simon Weldon
Chief Executive
17 June 2020

REMUNERATION REPORT

3.1.6 Annual statement on remuneration

Major decisions on Senior Managers' remuneration

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

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

- Chief Executive and Executive Director Annual Performance and Salary Review
- Deputy Chief Executive Extension of Contract (to August 2019)
- Appointment of Chief People Officer (Joint with Northampton General Hospital)
- Appointment of Director of Strategy
- Creation of Group Chief Executive Post

Substantial changes made to Senior Managers' remuneration

The Nomination and Remuneration Committee, at its meeting in June 2019, approved annual pay increases for very senior managers, as recommended by NHS Improvement. At the same meeting, the Committee approved a proposal to move the Director of Integrated Governance onto 'Very Senior Manager' terms and conditions.

During the year, no Director received more than £200,000 in remuneration. The CEO's salary was confirmed at the time of appointment following Ministerial approval, no other appointment during 2019/20 required such approval as the salary levels fell below the £149,999 threshold. In respect of the Medical Director, the Committee has had regard to the level of remuneration that would be payable for a full-time Consultant of equivalent experience, recognising that the Medical Director also has additional responsibilities as a Director.

Statement of the Chair of the Remuneration Committee

The Chair of the Remuneration Committee, Alan Burns, has declared that the major decisions listed above are a true and fair reflection of the matters discussed at the committee during 2019/20.

3.1.7 Senior managers' remuneration policy

For the purpose of the accounts and remuneration report, the Chief Executive has agreed the definition of a "senior manager" to be Directors only, those on Very Senior Manager (VSM) Terms and Conditions.

The Trust does not have performance-related salaries and the terms and conditions of contracts for its Executive Directors are subject to the normal terms and conditions of other NHS staff The Chief Executive's proposed salary increase, agreed by the Remuneration and Nomination Committee, in June 2019, was amended into a Performance Related Pay payment of £12,925, in accordance with advice received from NHS England/Improvement. The rationale behind the payment was recognition of the work the Chief Executive had undertaken to meet and enhance his performance objectives, and particularly in supporting taking the Trust out of CQC Special Measures and progressing the acute Trust position within the Integrated Care System. The Chief Executive also has an earn-back clause within with his contract, under which 10% of salary can be removed if objectives (as agreed with the Trust Chair) are not achieved. The Directors are not entitled to receive any benefit under share options or money and assets under long term incentive schemes. In addition no advances, credits or guarantees have been made on behalf of any of the Directors.

Policy on remunerating Executive Directors

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

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

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

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

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

Full details of remuneration are provided in the Annual Remuneration Report on page 30.

Policy on remunerating Non-Executive Directors

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

Detail of Non-Executive remuneration is provided in the annual remuneration report on page 30.

The Council of Governors approved increases to the annual remuneration of the Trust Chair and Non-Executive Directors in December 2019, as follows:

- Trust Chair: £45k to £48k;
- Trust Vice-Chair, Audit Committee Chair and Senior Independent Director: £13,795 to £16,500, and
- Non-Executive Directors: £11,125 to £12,500.

Service contract obligations

Service contracts are explained in the annual remuneration report on page 30.

Policy of payment on loss of office

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

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

Statement of consideration of employment conditions elsewhere in the foundation trust

In setting the remuneration of Executive Directors, the Nomination and Remuneration Committee takes into account a number of factors, including the national settlements in respect of other employees in the Trust. These are largely identified through the Agenda for Change and medical contract arrangements, negotiated between NHS Employers and the staff trade unions. Starting in the 2018-2019 year a 3 year pay deal was negotiated, these arrangements gave staff (in general) a 3% increase in salary levels in the first year.

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

Policy on diversity and inclusion used by the Remuneration and Nomination Committee

The Trust's recruitment and selection policies are incorporated into executive director recruitment processes to ensure an inclusive approach to attract the right candidate from the broadest cross-section of the available talent.

3.1.8 Annual report on remuneration

Service Contract Obligations

The Executive Directors may have provisions in their service contracts which could give rise to, or impact on, remuneration payments or payments for loss of office not disclosed elsewhere in the remuneration report. The Executive Directors do have provisions in their service contracts that reflect the relevant provisions in the Agenda for Change provisions to provide for payments based on salary and length of service. Reckonable salary is capped at £80,000 and payments are based on one month's salary for each completed year of service, up to 24 months' payment. The maximum total payable is £160,000.

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

Non-Executive Director and Governor expenses

2019/20

	Non Exec Directors	Exec Directors	Governors
Total Number at 31/3/20	8	9	18
Total number receiving expenses	6	8	9
Total expenses paid (£)	**9,858**	**7,975**	**1,232**

2018/19

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

Nomination and Remuneration committee

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

The Nomination & Remuneration Committee met on four occasions during 2019/20, attendances at each are detailed below:

	28/06/19	30/09/19	29/11/19	20/12/19
Alan Burns	Yes	Yes	Yes	Yes
Alice Cooper	No	Yes	Yes	Yes
Janet Gray	Yes	Yes	Yes	Yes
Phil Harris-Bridge	Yes	Yes	-	-
Liisa Janov	-	-	Yes	Yes
Lise Llewellyn	No	Yes	Yes	Yes
Trevor Shipman	Yes	No	Yes	Yes
Damien Venkatasamy	No	Yes	Yes	No
Chris Welsh	No	Yes	Yes	Yes

Remuneration Report

Salary and Pension entitlements of senior managers (Has been subject to audit)

Executive Directors (Voting And Non-Voting)

Financial Year 2019/20				Salary (bands of £5,000)	Expense payments (taxable) (to nearest £100)	Performance pay and bonuses (bands of £5,000)	All pension -related benefits (bands of £2,500)*	TOTAL REMUNERATION (bands of £5,000)
Name	Title	Start date	End date	£000	£	£000	£000	£000
Mr S Weldon	Chief Executive	2 Apr 2018		185-190	200	10-15	27.5-30	225-230
Ms J Fawcus	Chief Operating Officer	15 Oct 2018		120-125	300		110-112.5	230-235
Miss N Briggs	Director of Finance	1 Dec 2016		140-145	-		42.5-45	185-190
Prof A Chilton**	Medical Director	2 Jun 2010		225-230	100		-	225-230
Ms L Hackshall	Director of Nursing	1 Oct 2014		120-125	100		137.5-140	260-265
Mr M Smith***	Chief people Officer	2 Jun 2014		90-95	100		32.5-35	120-125
Mr R Apps	Director of Governance	18 Jul 2018		100-105	100		80-82.5	180-185
Mrs E Doyle	Deputy Chief Executive	4 June 2018	22 Jul 2019	95-100	-		30-32.5	125-130
Mr A Callow	Chief Digital & Information Officer	8 April 2019		110-115	-		170-172.5	280-285
Ms Polly Grimmett	Director of Strategy	20 Dec 2019		25-30	300		65-67.5	90-95

Notes

* The pension related benefits figures are the differences in estimated benefits comparing the start to the end of the year for a Director's pension entitlements including any lump sum and adjustments for inflation. This figure is calculated using the HMRC formula derived from S229 of the Finance Act 2004.

**The salary for Professor Chilton includes £115-£120k in respect of clinical duties.

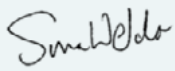
*** Mark Smith was appointed as joint Chief People Officer for Northampton General Hospital NHST (NGH) and Kettering General Hospital NHSFT from 1 September 2019. His remuneration above has been reduced to reflect the charges made to NGH. His total salary for the year was in the range £130,000-£135,000.

Expense payments are taxable reimbursements relating to travel claims.

Directors have no non-cash benefits.

No provisions for the recovery of sums paid to directors or for withholding the payment of sums to senior managers were required during the year.

Mr Simon Weldon
Chief Executive
17 June 2020



Chairman and Non-Executive Directors

Financial Year 2019/20				Salary (bands of £5,000)	Expense payments (taxable) (to nearest £100)	TOTAL REMUNERATION (bands of £5,000)
Name	Title	Start date	End date	£000	£	£000
Mr A Burns	Chairman	2 Sep 2017		45-50	-	45-50
Mr D Venkatasamy	Non-Executive Director	2 Jul 2018		10-15	-	10-15
Mr T Shipman	Non-Executive Director	18 Apr 2017		15-20	100	15-20
Mr P Harris-Bridge	Non-Executive Director	1 Sep 2013	30 Sep 2019	5-10	-	5-10
Ms A Cooper	Non-Executive Director	5 April 2019		10-15	100	10-15
Dr L Llewellyn	Non-Executive Director	1 Jun 2018		10-15	-	10-15
Mrs J Gray	Non-Executive Director	27 Oct 2014		10-15	-	10-15
Ms L Janov	Non-Executive Director	1 Oct 2019		5-10	-	5-10
Mr C Welsh	Non-Executive Director	1 Feb 2018		10-15	-	10-15

Executive Directors (Voting and Non-Voting)

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

* The pension related benefits figures are the differences in estimated benefits comparing the start to the end of the year for a Director's pension entitlements including any lump sum and adjustments for inflation. This figure is calculated using the HMRC formula derived from S229 of the Finance Act 2004.

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

Chairman and Non-Executive Directors

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

Pension Benefits

A Cash Equivalent Transfer Value (CETV) is the actuarially assessed capital value of the pension scheme benefits accrued by a member at a particular point in time. The benefits valued are the member's accrued benefits and any contingent spouse's pension payable from the scheme. A CETV is a payment made by a pension scheme, or arrangement to secure pension benefits in another pension scheme or arrangement when the member leaves a scheme and chooses to transfer the benefits accrued in their former scheme. The pension figures shown relate to the benefits that the individual has accrued as a consequence of their total membership of the pension scheme, not just their service in a senior capacity to which the disclosure applies. The CETV figures and other pension details include the value of any pension benefits in another scheme or arrangement which the individual has transferred to the NHS pension scheme. They also include any additional pension benefit accrued to the member as a result of their purchasing additional years of pension service in the scheme at their own cost. CETVs are calculated within the guidelines and framework prescribed by the Institute and Faculty of Actuaries. There will be no CETV for employees aged 60 or above.

Real Increase in CETV – This reflects the increase in CETV effectively funded by the employer. It takes account of the increase in accrued pension due to inflation (2.4%), 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. Consequently, the Real increase us not the absolute difference between one year and the next.

Pension Benefits (Has been subject to audit)

2019/20		Real increase in pension at pension age (bands of £2500)	Real increase in lump sum at pension age (bands of £2500)	Total accrued pension at pension age at 31/03/20 (bands of £5000)	Lump sum at pension age related to accrued pension at 31/03/20 (bands of £5000)	Cash Equivalent Transfer Value (CETV) at 31/03/20	Cash Equivalent Transfer Value (CETV) at 31/03/19	Real Increase in Cash Equivalent Transfer Value *
Name	**Title**	**£000**	**£000**	**£000**	**£000**	**£000**	**£000**	**£000**
Mr S Weldon	Chief Executive	0-2.5	-	50-55	105-110	964	891	31
Miss N Briggs	Director of Finance	2.5-5	-	20-25	-	197	166	19
Ms J Fawcus	Chief Operating Officer	5-7.5	10-12.5	30-35	70-75	551	434	89
Mr M Smith	Chief People Officer	0-2.5	-	10-15	-	109	88	12
Ms L Hackshall	Director of Nursing and Quality	5-7.5	20-22.5	55-60	165-170	1181	986	153
Mr R Apps	Director of Governance	2.5-5	5-7.5	15-20	35-40	293	220	53
Mrs E Doyle	Deputy Chief Executive	0-2.5	-	10-15	20-25	214	184	3
Mr A Callow	Chief Digital and Information Officer	7.5-10	-	5-10	-	110	-	92
Ms P Grimmett	Director of Strategy	0-2.5	0-2.5	20-25	40-45	327	265	12

CPI is 2.4% in 2019/20.

S Weldon, N Briggs, M Smith and E Doyle all left the NHS pension scheme during the year. M Smith left the pension scheme prior to his recharge to NGH. There are no additional benefits that become receivable by the individual in the event that they retire early.

Pension Benefits (Has been subject to audit)

2018/19		Real increase in pension at age 60 (bands of £2500)	Real increase in lump sum at age 60 (bands of £2500)	Total accrued pension at age 60 at 31/03/19 (bands of £5000)	Lump sum at age 60 related to accrued pension at 31/03/19 (bands of £5000)	Cash Equivalent Transfer Value (CETV) at 31/03/19	Cash Equivalent Transfer Value (CETV) at 31/03/18	Real Increase in Cash Equivalent Transfer Value *
Name	**Title**	**£000**	**£000**	**£000**	**£000**	**£000**	**£000**	**£000**
Mr S Weldon	Chief Executive	5-7.5	5-7.5	45-50	105-110	892	706	164
Miss N Briggs	Director of Finance	0-2.5	-	15-20	-	166	116	46
Ms J Fawcus	Chief Operating Officer	0-2.5	2.5-5	25-30	55-60	434	295	60
Mr M Smith	Director of HR & Org Dev.	0-2.5	-	5-10	-	88	55	31
Ms L Hackshall	Director of Nursing & Quality	0-2.5	0-2.5	45-50	140-145	986	854	106
Mr R Apps	Director of Governance	0-2.5	2.5-5	15-20	30-35	220	152	45
Mrs E Doyle	Deputy Chief Executive	2.5-5	0-2.5	10-15	20-25	184	122	48

CPI was 3% in 2018/19.

3.1.9 Fair pay multiple (Has been subject to audit)

Hutton Report

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

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

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

Permanent staff - the full time equivalent basic contracted pay plus enhancements, overtime, shift allowances etc.

Bank staff – as for permanent staff but excludes bank staff who already have a permanent post and only includes bank staff paid in March.

Agency staff – the average cost of agency staff less commission who worked during the year multiplied by the Whole Time Equivalent number of staff that worked in the year.

The banded remuneration of the highest paid director in Kettering General Hospital NHS Foundation Trust in the financial year 2019/20 was £225,000-£230,000 (This is the annualised full time equivalent of the payments made in 2019/20). This was 8.48 times the median remuneration of the workforce which was £26,966. The banded remuneration of the highest paid director in Kettering General Hospital NHS Foundation Trust in the financial year 2018/19 was £205,000-£210,000. This was 8.06 times the median remuneration of the workforce which was £25,693. Staff remuneration was in the range of £7,626 to £210,128.

3.1.10 Payments for loss of office (Has been subject to audit)

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

3.1.11 Payments to past senior managers (Has been subject to audit)

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

3.2 STAFF REPORT

3.2.1 Analysis of staff costs (Has been subject to audit)

Staff costs

	Permanent £000	Other £000	2019/20 Total £000	2018/19 Total £000
Salaries and wages	134,497	19,084	**153,581**	141,780
Social security costs	14,410	-	**14,410**	13,226
Apprenticeship levy	747	-	**747**	683
Employer's contributions to NHS pensions	24,098	-	**24,098**	15,430
Pension cost – other	22	-	**22**	13
Termination benefits	697	-	**697**	127
Temporary staff	-	16,110	**16,110**	14,759
Total gross staff costs	**174,471**	**35,194**	**209,665**	**186,018**
Recoveries in respect of seconded staff	(151)	-	**(151)**	(33)
Total Staff Costs	**174,320**	**35,194**	**209,514**	**185,985**
Of which:				
Costs capitalised as part of assets	1,170	333	**1,503**	681

3.2.2 Analysis of average staff numbers (Has been subject to audit)

Average number of employees (WTE basis)

	Permanent Number	Other Number	2019/20 Total Number	2018/19 Total Number
Medical and dental	446	76	**522**	496
Administration and estates	778	56	**834**	776
Healthcare assistants and other support staff	936	142	**1,078**	1,002
Nursing, midwifery and health visiting staff	1,054	227	**1,281**	1,253
Scientific, therapeutic and technical staff	259	18	**277**	255
Healthcare science staff	180	-	**180**	187
Other	107	1	**108**	96
Total average numbers	**3,760**	**520**	**4,280**	**4,065**
Of which:				
Number of employees (WTE) engaged on capital projects	20	3	**23**	10

3.2.3 Gender analysis

Staff Type	Female	Male
Exec Directors	3	5
Senior Manager	40	20
All Other Employees	3523	940

Senior Managers by Gender

Band	Female	Male	Grand Total
XN09	13	5	18
XN10	6	6	12
XN11	4	2	6
XN12	2	3	5
XR09	6	3	9
XR10	6	1	7
XR11	1		1
YM53	1		1
YM72	1		1
Grand Total	**40**	**20**	**60**

3.2.4 Sickness absence data

Sickness absence data will be available on the NHS Digital website: *www.digital.nhs.uk/data-and-information/publications/statistical/nhs-sickness-absence-rates*.

3.2.5 Staff policies and actions applied during the financial year

The Trust takes its diversity and inclusion seriously and aims to provide fair and equitable treatment and value diversity in its staff, patients and visitors. In doing so, it aims to ensure that its actions and working practices comply with both the spirit and intention of the Human Rights Act (1998) and the Equality Act (2010). The latter act consolidated previous equality legislation relating to the protected characteristics of age, disability, gender reassignment, marriage & civil partnerships, pregnancy & maternity, race, religion or belief, sex and sexual orientation. The Trust also works hard to ensure that it carries out its functions in a way that is designed to reduce the inequalities of outcome that can result from socio-economic disadvantage.

Equality & Diversity

disability confident COMMITTED

The Trust has retained its Disability Confident Employer with Committed status. The Disability Confident scheme supports employers to make the most of the talents disabled people can bring to the workplace. The scheme aims to help successfully recruit and retain disabled people and those with health conditions. It was developed by employers and disabled people's representatives to make it rigorous but easily accessible – particularly for smaller businesses.

The Trust was awarded the 'Committed' status because we could demonstrate that:

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

Mindful Employer Status

MINDFUL EMPLOYER

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

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

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

The associated staff member policies capture aspects from the commencement of employment, identifying relevant statutory and mandatory training, and ensuring development to support career progression. Our policies also establish minimum expectations in relation to conduct, behaviour and performance, as well as supportive approaches to allow staff members to raise matters of concern in a safe and protected way.

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

The Trust maintains an excellent relationship with staff side representatives through established employee and management consultation and negotiating forums (Joint Staff Consultation and Negotiating Committee, Local Negotiating Committee and Junior Doctors forum). These forums continue to provide invaluable feedback to Trust management on matters of concern to employees and allows for consultation on any proposed changes. The Chief Executive holds regular 'drop in' sessions for staff where they can raise any issues. Issues raised and their responses are made available to all via the Trust intranet site. The Trust also has a Freedom to Speak Up Guardian, who is available for staff to raise concerns anonymously if they wish about working at the hospital. The Guardian is independent, their role is to ensure these concerns are looked into, action taken if required and a response provided to the staff member.

Information on health and safety performance and occupational health (AS)

The Trust continues to maintain the Department of Health and Social Care's principle of improving the working lives of staff and supports the NHS agenda of maintaining healthy work environment for all staff. Our Occupational Health service delivers health awareness and offers health surveillance programmes for staff. The Trust has also introduced an Employee Assistance Programme available for all staff which provides counselling, financial and legal advice, 24/7, 365 days as year. Staff also have access to physiotherapy, mindfulness and manual handling advice and support. A number of celebration days and Random Acts of Kindness have taken place throughout the year. During 2019/20 the Trust achieved a take up of the Flu vaccination of over 80%, this was above the previous year's 75%.

3.2.6 Staff survey results

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

Survey Details:	Mode	Type	2019 NHS Staff Survey
	Mixed	Census	

Benchmarked against:

ACUTE TRUSTS

2019 benchmarking group details:

259,296	47%	85
Completed Questionaires	Median Response Rate	Organisations in Group

The Trust undertook wide consultation on the Trust strategy meaning the priorities were staff led and all have improving care at their centre. The staff survey is a key piece of intelligence with 51% of KGH staff taking part in the 2019 NHS Staff Survey.

This marks a continued improvement on last year 2018 at 45% and 35.5% in 2017

The result varied as follows, none of which were statistically significant.

Theme	Change since last year		Compared to national average	
Equality, Diversity, Inclusion	^	+0.1	^	+0.1
Health & Well Being	^	+0.1	–	0.0
Support from Immediate managers	–	0.0	–	0.0
Quality of Appraisals	–	0.0	–	0.0
Quality of Care	–	0.0	–	0.0
Bullying & Harassment	–	0.0	v	-0.1
Violence	v	-0.1	–	0.0
Safety Culture	–	0.0	v	-0.1
Staff Engagement	–	0.0	–	0.0

Next Steps and Actions

We were due to start the review of actions in March 2020. This has been paused whilst the trust provides operational support to COVID-19 as part of which we have introduced the Listening Into Action App in order to get direct feedback from staff and put it into action.

3.2.7 Trade Union Facility Time

The Trust provides the following Trade Union Facility Time:

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

3.2.8 Expenditure on consultancy

The Trust only uses external consultancy support when there are skills and capabilities are needed and cannot be sourced internally in a timely manner. This is supported by the appropriate regulatory approval. In 2019/20 total expenditure on consultancy was £806k, compared to £1,670k in 2018/19.

3.2.9 Off-payroll engagements

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

Disclosure requirements are set out in Annex 6 of chapter on page 76 of the *Foundation Trust Reporting Manual 2019-20.*

The Trust did not have any off payroll engagements during 2019/20.

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

3.2.10 Exit packages (Has been subject to audit)

2019/20	No. of compulsory redundancies	No. of other departures agreed number	Cost of other departures agreed £	Total number of exit packages	Total Cost of Exit Packages £
Band					
£10,000-£25,000	-	1	16,707	1	16,707
£25,001-£50,000	-	1	35,421	1	35,421
£50,001-£100,000	-	1	98,598	1	98,598
£100,001-£150,000	-	3	414,547	3	414,547
£150,001-£200,000	-	1	160,663	1	160,663
Total	-	7	725,936	7	725,936

2018/19	No. of compulsory redundancies	No. of other departures agreed number	Cost of other departures agreed £	Total number of exit packages	Total cost of exit packages £
Band					
<£10,000	-	1	7,103	1	7,103
£10,000-£25,000	-	1	10,546	1	10,546
£50,001-£100,000	-	2	147,621	2	147,621
Total	-	4	165,270	4	165,270

Exit packages (non-compulsory) departure payments

	2019/20 (2018/19)	
	Payments agreed	Total value £000
Voluntary redundancies, including early retirement contractual costs	- (2)	- (127)
Mutually agreed resignations contractual costs	6(0)	647 (0)
Contractual payments in lieu of notice	5 (4)	79 (38)
Total	11 (6)	726 (165)
Of which Non-contractual payments requiring HMT approval made to individuals where the payment value was more than 12 months' of their annual salary	-	-

Note: As a single exit package can be made up of several components, each of which can be counted separately in this Note, the total number above will not necessarily match the total numbers in the compensation scheme note, which will be the number of individuals.

3.3 DISCLOSURES SET OUT IN THE NHS FOUNDATION TRUST CODE OF GOVERNANCE

Kettering General Hospital NHS Foundation Trust has applied the principles of the NHS Foundation Trust Code of Governance on a comply or explain basis. The NHS Foundation Trust Code of Governance, most recently revised in July 2014, is based on the principles of the UK Corporate Governance Code issued in 2012. The Trust's 2019/20 disclosures are set out in the Annual Governance Statement (see page 42).

3.3.1 NHS Oversight Framework

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

- Quality of care
- Finance and use of resources
- Operational performance
- Strategic change
- Leadership and improvement capability (well-led)

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

Segmentation

This segmentation information is the trust's position as at 31 March 2020. Current segmentation information for NHS trusts and foundation trusts is published on the NHS Improvement website.

Finance and use of resources

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

		2019/20 scores		2018/19 scores	
Area	**Metric**	**Plan**	**Actual**	**Plan**	**Actual**
Financial stability	Capital service capacity	4	4	4	4
	Liquidity	4	4	3	4
Financial efficiency	I & E margin	2	4	4	4
Financial controls	Distance from financial plan		4		4
	Agency spend	1	3	2	3
Overall score			4		4

3.4 STATEMENT OF ACCOUNTING OFFICER'S RESPONSIBILITIES

3.4.1 Statement of the chief executive's responsibilities as the accounting officer of Kettering General Hospital NHS Foundation Trust

The NHS Act 2006 states that the chief executive is the accounting officer of the NHS foundation trust. The relevant responsibilities of the accounting officer, including their responsibility for the propriety and regularity of public finances for which they are answerable, and for the keeping of proper accounts, are set out in the NHS Foundation Trust Accounting Officer Memorandum issued by NHS Improvement.

NHS Improvement, in exercise of the powers conferred on Monitor by the NHS Act 2006, has given Accounts Directions which require Kettering General Hospital NHS Foundation Trust to prepare for each financial year a statement of accounts in the form and on the basis required by those Directions. The accounts are prepared on an accruals basis and must give a true and fair view of the state of affairs of Kettering General Hospital NHS foundation trust and of its income and expenditure, other items of comprehensive income and cash flows for the financial year.

In preparing the accounts and overseeing the use of public funds, the Accounting Officer is required to comply with the requirements of the Department of Health Group Accounting Manual and in particular to:

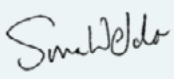
- observe the Accounts Direction issued by NHS Improvement, including the relevant accounting and disclosure requirements, and apply suitable accounting policies on a consistent basis
- make judgements and estimates on a reasonable basis
- state whether applicable accounting standards as set out in the NHS Foundation Trust Annual Reporting Manual (and the Department of Health Group Accounting Manual) have been followed, and disclose and explain any material departures in the financial statements
- ensure that the use of public funds complies with the relevant legislation, delegated authorities and guidance
- confirm that the annual report and accounts, taken as a whole, is fair, balanced and understandable and provides the information necessary for patients, regulators and stakeholders to assess the NHS foundation trust's performance, business model and strategy and
- prepare the financial statements on a going concern basis and disclose any material uncertainties over going concern.

The accounting officer is responsible for keeping proper accounting records which disclose with reasonable accuracy at any time the financial position of the NHS foundation trust and to enable 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 NHS foundation trust and hence for taking reasonable steps for the prevention and detection of fraud and other irregularities.

As far as I am aware, there is no relevant audit information of which the NHS foundation trust's auditors are unaware and I have taken all the steps that I ought to have taken to make myself aware of any relevant audit information and to establish that the NHS foundation trust's auditors are aware of that information.

To the best of my knowledge and belief, I have properly discharged the responsibilities set out in the NHS Foundation Trust Accounting Officer Memorandum.

Mr Simon Weldon
Chief Executive
17 June 2020



3.5 ANNUAL GOVERNANCE STATEMENT

3.5.1 Scope of responsibility

As Accounting Officer, I have responsibility for maintaining a sound system of internal control that supports the achievement of the NHS foundation trust's policies, aims and objectives, whilst safeguarding the public funds and departmental assets for which I am personally responsible, in accordance with the responsibilities assigned to me. I am also responsible for ensuring that the NHS foundation trust is administered prudently and economically and that resources are applied efficiently and effectively. I also acknowledge my responsibilities as set out in the NHS Foundation Trust Accounting Officer Memorandum.

3.5.2 The purpose of the system of internal control

The system of internal control is designed to manage risk to a reasonable level rather than to eliminate all risk of failure to achieve policies, aims and objectives; it can therefore only provide reasonable and not absolute assurance of effectiveness. The system of internal control is based on an ongoing process designed to identify and prioritise the risks to the achievement of the policies, aims and objectives of Kettering General Hospital NHS Foundation Trust, to evaluate the likelihood of those risks being realised and the impact should they be realised, and to manage them efficiently, effectively and economically. The system of internal control has been in place in Kettering General Hospital NHS Foundation Trust for the year ended 31 March 2020 and up to the date of approval of the annual report and accounts.

Trust Governance

The governance of the Trust is led by the Board of Directors, with the Council of Governors exercising a representative function and performing some specific functions that Parliament has reserved to it. Regulators have set out required standards of governance, linking across both the Care Quality Commission and NHS Improvement, through the Well-Led process and the related Key Lines of Enquiry (KLOE) for CQC inspection processes. Current policy is for all provider trusts to have their governance inspected (through the "Are they well-led?" strand) on an annual basis. A well led self-assessment exercise took place in Autumn 2019.

Board committees have responsibilities in respect of monitoring and leading on aspects of risk management across the Trust in accordance with their terms of reference. The terms of reference of the committees are reviewed at least annually to ensure they remain relevant to the objectives of the Trust. Changes to the terms of reference may be made by the Committee subject to Board approval and following appropriate consultation and agreement.

3.5.3 Capacity to handle risk

Leadership

The Trust Board of Directors, with the support of its sub-committees, is responsible for establishing the principal strategic and corporate objectives and for driving the organisation forward to achieve these. It is also responsible for ensuring that there are robust and effective systems in place to identify and manage the risks associated with the achievement of these objectives and to develop a culture whereby risk management is "business as usual" at all levels across the organisation.

The Board of Directors receives reports and assurance from the Audit, Digital Hospital, Quality and Safety, Organisational Development and Performance, Finance and Resources Committee meetings and discusses and notes progress with risk management actions as necessary.

The Board, in exercising its responsibility, also considers key indicators capable of showing improvements in risk management and/or providing early warning of risk (e.g. incident and complaints statistics, progress in compliance with registration requirements of Care Quality Commission) through the Integrated Governance Reports.

The Audit Committee, on behalf of the Board, provides the Board with an independent and objective review of risk management in the Trust and performs an annual review of the effectiveness of the risk management activities (both clinical and non-clinical).

The Director of Integrated Governance has delegated responsibility to lead the Trust's risk management and governance processes. All Executive Directors have responsibility for the delivery of a robust risk management and governance process in both their functional and corporate roles.

Managing risk in the organisation is carried out through:

- The Board Assurance Framework, which is a top-down approach and undertaken collectively by the Risk Management Steering Group, Board Committees and sub-groups and the Board, involving scoping, reviewing and managing the risk to the corporate objectives of the Trust.
- Operational Risk, which is a bottom-up approach undertaken by the staff and managers of all services, by which, risks are logged onto the Service, Directorate and / or Divisional Risk Registers and escalated to the Corporate Risk Register where a risk is identified as Significant.

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

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

Ambition 5 of the Risk Management strategy sets out to support the Trust Board in being able to receive and provide assurance that the trust has a clear line of sight of all risks across the organisation. This has been evidenced in the ward to board ('Golden Thread') review of each BAF risk presented by Executive leads and Risk Management Steering Group.

Public stakeholders' involvement in managing risks is specified within detailed risk controls and actions within the Board Assurance Framework, which is submitted to bi-monthly public Board of Directors and is available to view here: *www.kgh.nhs.uk/board-of-directors-and-board-meetings*.

Training

Focus has continued in relation to the roll-out of training in respect to risk management and risk registers to ensure consistency and standardisation of its application and process. Risk management training forms part of Corporate Induction as well as a core competency training requirement for all staff at band 6 and above, but is also accessible to staff of all grades. This is delivered via a number of methods including classroom-based training sessions, one to one sessions and ongoing support is available via the Trust Risk Manager.

Governance and Improvement Managers are in place to support divisions and directorates in areas such as risk management, patient safety, health and safety, and quality improvement. This expertise will support in the effective management of operational, corporate and strategic risks.

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

3.5.4 Workforce

The Trust monitor key performance indicators for people issues such as turnover, vacancy numbers on a monthly basis and this is reported to Board through the Organisational Development Committee (ODC) and Integrated Governance Committee (IGC). ODC receives on a bi-monthly basis a safer staffing report which provides detail at ward level, risk management and how issues of concern are being addressed. Twice a month a Workforce Improvement Meeting takes place which reviews roster activity and management as well the recruitment and retention strategies for each division including use of agency and bank. The Trust has an Organisational Development Strategy which used information and findings from the both CQC inspections and the staff survey to develop a workforce plan that was subject to extensive consultation within the Trust in order to secure accuracy and agreement. This plan is regularly reviewed and reported on at ODC. The workforce is a major component of the business planning cycle and operational plan, and the Trust has several related projects to see improvement in the use of job planning, improvements in recruitment and retention of nurses, review of nursing skill mix etc. The Trust were a pilot for the Nurse Associate role and so far have had 3 cohorts commence. We carried out a successful international nurse recruitment scheme during 2019/20, employing over 100 staff, and have put in place a package of additional measures to support staff coping with the COVID-19 pandemic, including relaxations on parking restrictions, making food and accommodation available and access to support for mental health issues.

3.5.5 Insurance

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

3.5.6 The risk and control framework

Risk management is recognised as a fundamental part of the Trust's culture and is the business of everyone in the organisation. The Board of Directors is committed to the leadership of the risk management and governance functions in the Trust. Each Executive Director has responsibility for some aspect of risk management and governance; this also includes Non-Executive Directors chairing Board Committees, for example, Audit Committee.

The Risk Management Strategy sets out the strategic direction, structures and processes for the identification, evaluation and control of risk, as well as the system of internal control. The Strategy has been developed to support the delivery of the Trust's Strategic Aims and Objectives. Its priorities are to ensure all strategic risks are managed in line with the Board's risk appetite and to ensure that risks that could prevent objectives being achieved are proactively identified, quantified and managed to an acceptable level and in doing so provide a robust risk management framework with appropriate reporting arrangements and individual responsibilities clearly identified.

The process of risk management begins with the systematic identification of risks throughout the organisation via structured risk assessments. The Trust uses an integrated approach to the identification and management of risk identified through a variety of mechanisms, both reactive and proactive. Pro-active identification may arise from local risk assessments, impact assessments and 'horizon scanning' of published reports on healthcare subjects. Re-active identification can be flagged as a result of a serious incident, a trend in incidents or complaints or as a result of an audit, either internal or external.

Identified risks are recorded on Datix; the Trusts integrated risk management system and analysed to determine their relative importance using a standard risk scoring matrix. This is then utilised to populate the relevant division, directorate or ward risk registers via our online system. Responsibility for the management and control of a particular risk rests with the division, directorate or ward concerned.

Strategic risks are identified within the Board Assurance Framework and assurance that the risks are appropriately managed is sought from both external and internal sources as appropriate.

At 31 March 2020, there were nine risks tracked through the BAF:

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

The main 'themed' three areas identified as the greatest risks to the Trust are:

Staffing

By "staffing" we mean the potential impact on patient care resulting from any combination of insufficient staff numbers, competence, staff experience and staff engagement with, and delivery of, the Trusts quality priorities

Infrastructure

by "Infrastructure" we mean the ability for both the hospital estate and Information Technology to enable and facilitate high quality care for our patients

Finance

by "Finances" we mean the Trusts ability to provide sustainable services through efficiency improvements and delivery of improved financial performance

Board committees have responsibilities in respect of monitoring and leading on aspects of risk management across the Trust in accordance with their terms of reference. A deep dive review of each BAF risk is held on a rotational basis at every Board committee meeting and is a standing agenda item.

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

Publication of registers of interest.

The Trust has published on its website an up-to-date register of interests, including gifts and hospitality, for decision-making staff (defined at the Trust as Consultants and staff on Agenda for Change Band 8D and above) within the past 12 months, as required by the Managing Conflicts of Interest in the NHS guidance.

Serious Incidents (SI)

Serious Incidents can have a significant impact upon service users and staff. Ensuring that all serious incidents are reported in a timely manner via the national Strategic Executive Information System (STEIS), provides assurance that the Trust is effectively identifying, declaring and promptly investigating such incidents for the purposes of learning; so that patient safety can be improved. All 'moderate' harm and above incidents reported on Datix are reviewed by the Patient Safety Team and presented to the Serious Incident Review Group (SIRG) for determination of level of investigation required. The Trust has a robust process, overseen by the Integrated Governance Team, for ensuring that identified actions and learning themes are monitored and implemented following a serious incident investigation.

30 Serious Incidents were reported in 2019/2020. The most common categories of SI's reported were diagnostic incidents (including delay and failure to act on test results) and slips/trips/falls. These themes are consistent with the previous year. Incidents are included in quarterly reports to the Quality Governance Steering Group, which reviews new and closed serious incidents and analyses emerging themes and trends. A monthly report, detailing all new serious incidents reported, is also presented to the Quality and Safety Committee. A thematic analysis of all serious incidents is completed annually to provide a broader oversight of the data and comparison against previous years.

NHS Foundation Trust Code of Governance

Kettering General Hospital NHS Foundation Trust has applied the principles of the NHS Foundation Trust Code of Governance on a comply or explain basis. The NHS Foundation Trust Code of Governance, most recently revised in July 2014, is based on the principles of the UK Corporate Governance Code, issued in 2012. The Code of Governance is available to view here: *www.gov.uk/government/publications/nhs-foundation-trusts-code-of-governance.*

Issue	Code of Governance Reference	Disclosure
Board and Council of Governors	A.1.1	As set out in Directors' Report
Board, Nomination Committee, Audit Committee, Remuneration Committee	A.1.2	As set out in Directors' Report
Council of Governors	A.5.3	As set out in Directors' Report
Board	B.1.1	As set out in Directors' Report
Board	B.1.4	As set out in Directors' Report
Nomination Committee	B.2.10	As set out in Directors' Report
Chair / Council of Governors	B.3.1	As set out in Directors' Report
Council of Governors	B.5.6	As set out in Directors' Report
Board	B.6.1	As set out in Directors' Report
Board	B.6.2	The Trust engaged the services of the ODD Company to undertake a Board Development programme during 2019/20
Board	C.1.1	As set out in Directors' Report
Board	C.2.1	As set out in Annual Governance Statement
Audit Committee / control environment	C.2.2	As set out in Annual Governance Statement
Audit Committee / Council of Governors	C.3.5	Recommendation accepted by Council of Governors in March 2020
Audit Committee	C.3.9	As set out in Directors' Report and Annual Governance Statement
Board / Remuneration Committee	D.1.3	As set out in Directors' Report
Board	E.1.5	As set out in Directors' Report
Board / Membership	E.1.6	As set out in Directors' Report
Membership	E.1.4	As set out in Directors' Report

Risk management embedded into daily practice

Risk management is embedded within the Trust by various means, including:

- Appropriately skilled members of the Board of Directors provide rigorous challenge to the quality governance processes through receipt of reports relating to quality governance.
- Risk Management Strategy and Risk Assessment and Risk Register Policy, which is available to all staff through our internet and intranet sites;
- Effective use of divisional, directorate and ward risk registers, the corporate risk register and the board assurance framework; oversight at Division Governance meetings of division risks;
- Board and sub-board committee oversight of principal risks to the organisation's strategic aims. Each sub-committee of the Board has the relevant strategic risks on the BAF allocated to them for intelligence and assurance;
- Compliance with the mechanisms for the reporting of all accidents and incidents using our online incident reporting system and an open and accountable reporting culture whereby staff are encouraged to identify and report risk issues;
- All serious incidents are actively managed and monitored to ensure compliance with action plans and being open, and progress is monitored by the Quality Governance Steering Group.
- Outcomes from complaints, incidents and claims are used to mitigate future risks and these outcomes are also aggregated to identify Trust-wide risks;
- Risk management training and education for staff, including induction training, statutory and mandatory training. The requirement for risk management training is identified in our training needs analysis, which details the type and level of training required by staff group and work area. A central record of all such training activity is maintained;
- All staff have access to Lessons Learned themes via Datix Dashboards. Reporters of incidents get automated feedback from incidents identifying any lessons and actions identified.
- Enhanced risk management processes overseen by the Risk Management Steering group;
- 'Freedom to Speak Up' guardian in place for staff to raise concerns, which is promoted within the Trust.

COVID-19

The Trust has reviewed its governance framework to ensure the flexibility with which to respond to the COVID-19 pandemic, enabling remote decision-making by the Board and Committees, putting in

place an operational command structure with decision and change logs and temporarily amending Standing Financial Instructions.

A Trust-wide risk assessment on the preparedness and management of COVID 19 was presented to the Executive Group and Trust Board in March 2020, considering impacts on Demand and Capacity, Infection Prevention & Control, Procurement and Supplies and Workforce. Additionally, each Division and Corporate Service has been asked to consider any emerging risks to the delivery of their services as a result of COVID-19. Over 100 risks have been identified, which will be robustly monitoring within the Trust's control framework during 2020/21.

Whilst responding to the pandemic has led to changes in how the trust's control environment is applied, due to the speed and robustness of the Trust's preparedness, this is not considered to constitute a significant internal control issue.

Pension Controls

As an employer with staff entitled to membership of the NHS Pension Scheme, control measures are in place to ensure all employer obligations contained within the Scheme regulations are complied with. This includes ensuring that deductions from salary, employer's contributions and payments into the Scheme are in accordance with the Scheme rules, and that member Pension Scheme records are accurately updated in accordance with the timescales detailed in the Regulations. The Trust Board adopted an Alternative Pension Policy in September 2019, based on NHS Employers guidance and offering eligibility to individuals leaving the NHS Pension Scheme to receive alternative awards equivalent to 12% of their base salaries.

Equality, diversity and human rights

Control measures are in place to ensure that all the organisation's obligations under equality, diversity and human rights legislation are complied with - the Staffing Report sets out more information in Section 3.2.5 on page 37.

Carbon Reduction

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

Social, community, anti-bribery, and human rights

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

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

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

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

Anti-bribery policy

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

Our zero-tolerance approach to bribery, and commitment to the Bribery Act 2010, is set out in further detail within the Counter Fraud and Anti-Bribery Policy, and across a range of other Trust policies and procedural documentation. All staff and volunteers, Non-Executive Directors, Governors and other relevant parties are responsible for familiarising themselves with the requirements of this and for complying with these at all times.

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

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

Compliance with the Modern Slavery Act 2015

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

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

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

3.5.7 Care Quality Commission

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

The Care Quality Commission has not taken enforcement action against Kettering General Hospital NHS Foundation Trust during 2019/20.

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

improvement. The report of the inspection was published in May 2019, rating the Trust as Good for Caring and Well-Led and Requires Improvement for Safe, Effective and Responsive.

In addition the Trust underwent an unannounced inspection of our Emergency Department in February 2020. The report is yet to be published. The Trust also received the Routine Provider Information Request (RPIR) on the 11th February 2020, this information request normally precedes an inspection, usually within the next three months; however, due to COVID-19, this is now likely to be delayed until Autumn 2020.

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

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

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

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

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

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

3.5.9 Information governance

The Trust uses the Data Security & Protection Toolkit to identify and manage information risks, which is usually submitted annually to NHS Digital at the end of the financial year. Within this are 116 mandatory assertions which can only be marked complete when all of their components have been achieved. At present we have currently completed and evidenced 92 of the 116 mandatory components.

The remaining 24 components are all in progress and were expected to be completed by the 31 March 2020 deadline, with some technical security elements also being coordinated with the 3rd party providers of these functions. NHS Digital have recently extended the deadline for toolkit completion nationally to 31 of September in recognition of reallocation of resources required for the coronavirus pandemic. Until this time they have confirmed that our previous year's DSPT assessment of All Standards Met is valid. Work will recommence on the outstanding components during the summer when the demands on the IG and IT teams from the COVID response have fallen.

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

Due in part to an increased focus on IG breaches throughout the Trust four incidents were discovered that were externally reportable to the Information Commissioners Office (ICO) in the past year. However on all occasions the ICO was satisfied with our investigation and response so they deemed it necessary to take no further action against the Trust.

3.5.10 Annual Quality Report

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

The Quality Report presents a balanced picture of Kettering General Hospital Foundation Trust's performance over the period covered from 1 April 2018 to 31 March 2019 and indicates that there are appropriate controls in place to ensure the accuracy of data.

These controls include:

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

- Key individuals involved in producing the report are recruited on the basis that they have the appropriate skills and knowledge to deliver their responsibilities
- All indicators included within the Quality Report are reported on a regular basis.
- The Quality Report will be approved by the Quality and Safety Committee; it will describe how we have engaged with a wide range of stakeholders in our activity to improve the quality of care provided.

3.5.11 Internal Audit Opinion

The Head of Internal Audit is satisfied that, for the areas reviewed during the year, Trust has reasonable and effective risk management, control and governance processes in place. Not having completed all of the planned work due to the global Covid-19 pandemic has not impacted on the overall assessment.

This opinion is based solely on the matters that came to the attention of TIAA during the course of the internal audit reviews carried out during the year and is not an opinion on all elements of the risk management, control and governance processes or the ongoing financial viability or the Trust's ability to meet financial obligations which must be obtained from its various sources of assurance.

3.5.12 Review of effectiveness

As Accounting Officer, I have responsibility for reviewing the effectiveness of the system of internal control. My review of the effectiveness of the system of internal control is informed by the work of the internal auditors, clinical audit and the executive managers and clinical leads within the Kettering General Hospital NHS Foundation Trust who have responsibility for the development and maintenance of the internal control framework. I have drawn on the performance information available to me. My review is also informed by comments made by the external auditors in their management letter and other reports. I have been advised on the implications of the result of my review of the effectiveness of the system of internal control by the board, the audit committee and the Performance, Finance & Resources Committee and a plan to address weaknesses and ensure continuous improvement of the system is in place.

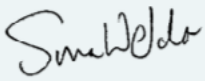
The Head of Internal Audit provides me with an opinion on the overall arrangements for gaining assurance on the controls reviewed as part of the internal audit work. The monthly performance reports provide me with evidence that the effectiveness of the controls in place to manage the risks to the organisation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

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

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

3.5.13 Conclusion

There were no significant internal control issues identified during 2019/20.



Mr Simon Weldon
Chief Executive
17 June 2020

Independent auditor's report

to the Council of Governors of Kettering General Hospital NHS Foundation Trust

REPORT ON THE AUDIT OF THE FINANCIAL STATEMENTS

Opinion

Our opinion on the financial statements is unmodified

We have audited the financial statements of Kettering General Hospital NHS Foundation Trust (the 'Trust') for the year ended 31 March 2020 which comprise the Statement of Comprehensive Income, the Statement of Financial Position, the Statement of Changes in Taxpayers' Equity, the Statement of Cash Flows and notes to the financial statements, including a summary of significant accounting policies. The financial reporting framework that has been applied in their preparation is applicable law and International Financial Reporting Standards (IFRSs) as adopted by the European Union, and as interpreted and adapted by the Accounts Directions issued under the National Health Service Act 2006, the NHS foundation trust annual reporting manual 2019/20 and the Department of Health and Social Care Group Accounting Manual 2019 to 2020.

In our opinion the financial statements:

- give a true and fair view of the financial position of the Trust as at 31 March 2020 and of its expenditure and income for the year then ended;
- have been properly prepared in accordance with International Financial Reporting Standards (IFRSs) as adopted by the European Union, as interpreted and adapted by the Department of Health and Social Care Group Accounting Manual 2019 to 2020; and
- have been prepared in accordance with the requirements of the National Health Service Act 2006.

Basis for opinion

We conducted our audit in accordance with International Standards on Auditing (UK) (ISAs (UK)) and applicable law. Our responsibilities under those standards are further described in the Auditor's responsibilities for the audit of the financial statements section of our report. We are independent of the Trust in accordance with the ethical requirements that are relevant to our audit of the financial statements in the UK, including the FRC's Ethical Standard, and we have fulfilled our other ethical responsibilities in accordance with these requirements. We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our opinion.

The impact of macro-economic uncertainties on our audit

Our audit of the financial statements requires us to obtain an understanding of all relevant uncertainties, including those arising as a consequence of the effects of macro-economic uncertainties such as Covid-19 and Brexit. All audits assess and challenge the reasonableness of estimates made by the Accounting Officer and the related disclosures and the appropriateness of the going concern basis of preparation of the financial statements. All of these depend on assessments of the future economic environment and the Trust's future operational arrangements.

Covid-19 and Brexit are amongst the most significant economic events currently faced by the UK, and at the date of this report their effects are subject to unprecedented levels of uncertainty, with the full range of possible outcomes and their impacts unknown. We applied a standardised firm-wide approach in response to these uncertainties when assessing the Trust's future operational arrangements. However, no audit should be expected to predict the unknowable factors or all possible future implications for an entity associated with these particular events.

Material uncertainty related to going concern

We draw attention to note 1.2 in the financial statements which indicates that the Trust reported an operating deficit in 2019/20 of £12.3 million.

As disclosed in note 1.2, the Trust expects to have agreed contracts with its local commissioners for 2020/21, however at the date of the accounts, and for the first 4 months of the year, the Trust's activity is being commissioned through financial arrangements

put in place by the NHS to ensure focus is on dealing with the Covid-19 pandemic. Nationally devised contracts are in place for the period to 31 July 2020 and the Directors have an expectation that any shortfall in earned income over expenditure for the remainder of the year will be met in the form of revenue support from the Department of Health and Social Care. The Trust expects to receive additional Public Dividend Capital (PDC) in 2020/21 to meet any deficit, but this additional PDC has not been confirmed.

These events and conditions, along with the other matters disclosed in note 1.2 indicate that a material uncertainty exists that may cast significant doubt about the Trust's ability to continue as a going concern. Our opinion is not modified in respect of this matter.

In concluding that there is a material uncertainty, our audit work included but was not restricted to:

- Reviewing the draft operational plan for 2020/21 submitted prior to the changes applying following the Covid-19 outbreak;
- Reviewing the cashflow forecast for the year following the date of the opinion;
- Agreeing certain disclosures to underlying records;
- Ensuring the assessment concurred with our knowledge of the Trust;
- Discussing the financial standing of the Trust with Officers; and
- Reviewing the disclosures made by Management in relation to the material uncertainty around going concern as detailed within the Trust's accounting policies.

Overview of our audit approach

Financial statements audit

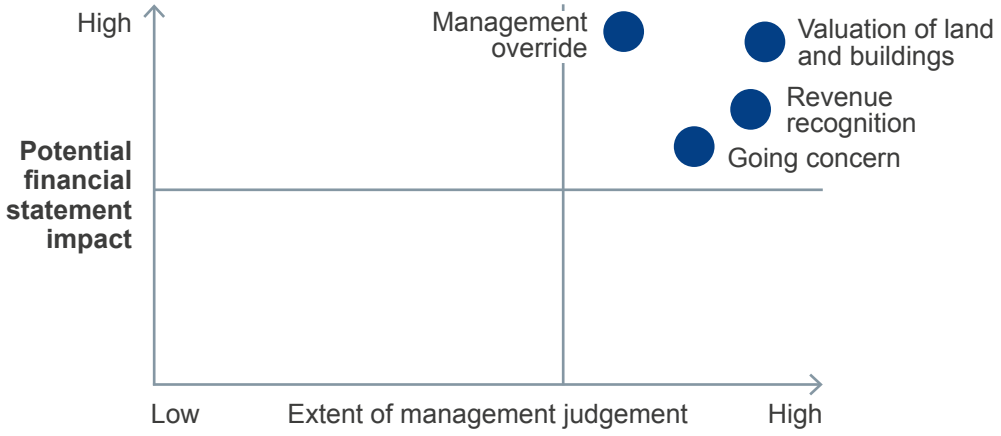
- Overall materiality: £5,000,000, which represents 1.65% of the Trust's gross operating costs (consisting of operating expenses and finance expenses);
- Key audit matters were identified as:
  - Revenue recognition, and
  - Valuation of land and buildings.
- We have tested the Trust's material income and expenditure streams and assets and liabilities covering 97.8% of the Trust's income, 99.9% of the Trust's expenditure, 97% of the Trust's assets and 98.7% of the Trust's liabilities.

Conclusion on the Trust's arrangements for securing economy, efficiency and effectiveness in its use of resources

- We identified one significant risk in respect of the Trust's arrangements for securing economy, efficiency and effectiveness in its use of resources with regards to financial outturn and sustainability (see Report on other legal and regulatory requirements section).

Key audit matters

The graph below depicts the audit risks identified and their relative significance based on the extent of the financial statement impact and the extent of management judgement.



Key audit matters are those matters that, in our professional judgment, were of most significance in our audit of the financial statements of the current year and include the most significant assessed risks of material misstatement (whether or not due to fraud) that we identified. These matters included those that had the greatest effect on: the overall audit strategy; the allocation of resources in the audit; and directing the efforts of the engagement team. These matters were addressed in the context of our audit of the financial statements as a whole, and in forming our opinion thereon, and we do not provide a separate opinion on these matters. In addition to the matter described in the Material Uncertainty Related to Going Concern section, we have determined the matters described below to be the key audit matters to be communicated in our report.

Key Audit Matter	How the matter was addressed in the audit
Risk 1 Valuation of land and buildings The Trust revalues its land and buildings on a five-yearly basis to ensure the carrying value in the financial statements is not materially different from current value in use at the year-end date. In the intervening years, such as in 2019/20, the Trust requests a desktop valuation from its valuation expert. The valuation represents a significant accounting estimate by management in the financial statements, which is sensitive to changes in assumptions and market conditions. Management engage the services of a qualified valuer, who is a Regulated Member of the Royal Institute of Chartered Surveyors (RICS), to estimate the current value of its land and buildings as at 31 March 2020. The valuation of land and buildings is a key accounting estimate which is sensitive to changes in assumptions and market conditions. The effects of the COVID-19 virus will affect the work carried out by the Trust's valuer in a variety of ways. Inspecting properties could prove difficult and access to evidential data, such as values of comparable assets may be less freely available. RICS Regulated Members have therefore been considering whether a material uncertainty declaration is now appropriate in their reports. Its purpose is to ensure that any client relying upon the valuation report understands that it has been prepared under extraordinary circumstances. In their 2019/20 valuation report the Trust's valuer Gerald Eve included a material uncertainty and this was disclosed in note 15 to the financial statements. We identified valuation of land and buildings, particularly revaluations and impairments, as a significant risk, which was one of the most significant assessed risks of material misstatement.	*Our audit work included, but was not restricted to:* • evaluating management's processes and assumptions for the calculation of the estimate, and the appropriateness of the instructions issued to valuation experts, the basis of valuations and the scope of their work; • assessing the competence, capabilities and objectivity of any management experts used by the Trust; • discussions with the valuer about the basis on which the valuation was carried out and challenge of the key assumptions; • challenging the information used by the valuer to ensure it is complete and consistent with our understanding; • assessing the overall reasonableness of the valuation movement including how the impact of market volatility had been considered, and how management had satisfied themselves that the existing valuations were not materially different to current value at 31 March 2020; • testing, on a sample basis, of revaluations made during the year to ensure they were input correctly into the Trust's asset register; and • evaluating the assumptions made by management for those assets not revalued during the year and how management has satisfied themselves that these are not materially different to current value. The Trust's accounting policy on valuation of property, including land and buildings, is shown in note 1.10 to the financial statements and related disclosures are included in note 15. As disclosed in note 1.4 to the financial statements, which discloses estimation uncertainties, the outbreak of Covid-19 has caused uncertainties in markets. As a result, the Trust's valuer has declared a 'material valuation uncertainty' in their valuation report of land and buildings which had a valuation date of 31 March 2020. The values in the valuation report have been used to inform the measurement of property assets at valuation in the financial statements. Management has assessed the impact of Covid-19 on the valuation of their land and buildings and considers that as the valuation has taken the latest information on Covid-19 as at the date of the valuation, that any further movement would not be material to the accounts. The Trust's valuer prepared their valuations in accordance with the RICS Valuation – Global Standards using the information that was available to them at the valuation date in deriving their estimates.

Key Audit Matter	How the matter was addressed in the audit
	Key observations *We obtained sufficient audit assurance to conclude that:* • the basis of the valuation of land and buildings was appropriate, and • the assumptions and processes used by management in determining the estimate of valuation of property were reasonable; and • the valuation of land and buildings disclosed in the financial statements is reasonable.
Risk 2 Revenue recognition Trusts are facing significant external pressure to restrain budget overspends and meet externally set financial targets, coupled with increasing patient demand and cost pressures. All the Trust's income from activities is derived from contracts with NHS commissioners. These contracts include the rates for, and level of, patient care activity to be undertaken by the Trust. The Trust recognises income from activities during the year based on the completion of these activities. This includes the block contract, which is agreed in advance at a fixed price, and patient care income from contract variations. Any patient care activities that are additional to those incorporated in these block contracts with commissioners (contract variations) are subject to verification and agreement by commissioners. As such, there is the risk that income is recognised in the accounts for these additional services that is not subsequently agreed to by the commissioners. Due to the nature of block contracts we have not identified a significant risk of material misstatement in relation to block contracts. 8.9% of the group's income is recorded as other operating revenues (excluding Education & Training income). The risk around other operating revenues is related to the improper recognition of revenues. Education & Training income is principally derived from contracts that are agreed in advance at a fixed price. We have not identified a significant risk of material misstatement in relation to Education & Training income. We therefore identified the occurrence and accuracy of patient care income from contract variations and other operating revenues, and the existence of associated receivable balances as a significant risk, which was one of the most significant assessed risks of material misstatement.	*Our audit work included, but was not restricted to:* • evaluating the Trust's accounting policy for recognition of income from patient care activities and other operating revenue for appropriateness and compliance with the DHSC Group Accounting Manual 2019/20; • gaining an understanding of the Trust's system for accounting for income from patient care and other operating revenue, and evaluated the design of the associated controls; *In respect of patient care income:* • obtaining an exception report from the Department of Health and Social Care DoHSC) that details differences in reported income and expenditure between NHS bodies; agreeing the figures in the exception report to the Trust's financial records; and for differences calculated by the DoHSC as being in excess of £250,000, obtaining corroborating evidence to support the amount recorded in the financial statements by the Trust; • agreeing, on a sample basis, income from contract variations and year end receivables to signed contract variations, invoices or other supporting evidence such as correspondence from the Trust's commissioners; • evaluating the Trust's estimates and the judgments made by management on patient care income with regard to corroborating evidence in order to arrive at the total income from contract variations recorded in the financial statements; *In respect of other operating income:* • agreeing, on a sample basis, income and year end receivables from other operating revenue to invoices and cash payment or other supporting evidence; • agreeing in totality, the Provider Sustainability Fund (PSF), Financial Recovery Funds (FRF) and Marginal Rate Emergency Tariff Funding (MRET) income received from NHS Improvement, back to supporting documentation.

Key Audit Matter	How the matter was addressed in the audit
	The Trust's accounting policy on income recognition, including contract income, is shown in note 1.6 to the financial statements and related disclosures are included in note 3. **Key observations** *We obtained sufficient audit evidence to conclude that:* • the Trust's accounting policy for income from patient activities and other operating income is in accordance with the Department of Health and Social Care Group Accounting Manual 2019/20 and has been properly applied; and • income from patient activities and other operating income is not materially misstated.

Our application of materiality

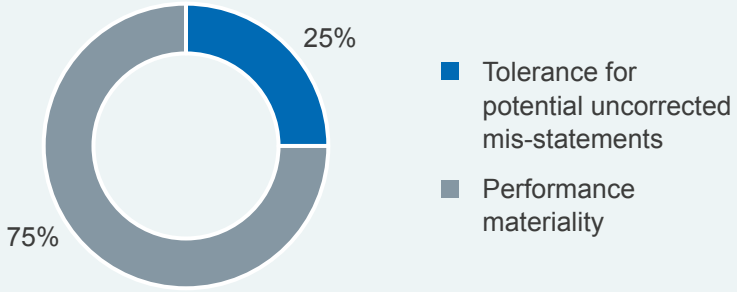
We define materiality as the magnitude of misstatement in the financial statements that makes it probable that the economic decisions of a reasonably knowledgeable person would be changed or influenced. We use materiality in determining the nature, timing and extent of our audit work and in evaluating the results of that work.

Materiality was determined as follows:

Materiality Measure	Trust
Financial statements as a whole	£5,000,000 which is 1.65% of the Trust's gross operating costs. This benchmark is considered the most appropriate because we consider users of the financial statements to be most interested in how the Trust has expended its revenue and other funding. Materiality for the current year is lower than the level we determined for the year ended 31 March 2019 due to the Trust's gross operating costs increasing. We had set materiality initially at the same percentage as 2018/19 based upon budgeted gross operating costs. The Trust's gross operating costs exceeded their budget but we considered that the additional risk of Covid-19 was such that we kept the same materiality value at £5,000,000, which provided a lower materiality percentage overall.
Performance materiality used to drive the extent of our testing	75% of financial statement materiality
Specific materiality	We applied a specific level of materiality of £100,000 to the senior manager remuneration disclosures and £250,000 to the cash equivalent transfer value disclosures of pension entitlement (both included in the Remuneration Report) due to the public interest in these disclosures and the statutory requirement for these to be made.
Communication of misstatements to the Audit Committee	£250,000 and misstatements below that threshold that, in our view, warrant reporting on qualitative grounds.

The graph below illustrates how performance materiality interacts with our overall materiality and the tolerance for potential uncorrected misstatements.

Overall materiality – Trust



An overview of the scope of our audit

Our audit approach was a risk-based approach founded on a thorough understanding of the Trust's business, its environment and risk profile and in particular included:

- Gaining an understanding of and evaluating the Trust's internal control environment including its IT systems and controls over key financial systems;
- Assessing whether the accounting policies are appropriate to the Trust's circumstances and have been consistently applied and adequately disclosed;
- Assessing the reasonableness of significant accounting estimates made by the Chief Executive as Accounting Officer;
- Testing, on a sample basis, all of the Trust's material income streams covering 97.8% of the Trust's income;
- Testing, on a sample basis, for 99.9% of the Trust's expenditure;
- Testing, on a sample basis, property plant and equipment and 97.9% of the Trusts other assets and liabilities.

Other information

The Accounting Officer is responsible for the other information. The other information comprises the information included in the Annual Report, other than the financial statements and our auditor's report thereon. Our opinion on the financial statements does not cover the other information and, except to the extent otherwise explicitly stated in our report, we do not express any form of assurance conclusion thereon.

In connection with our audit of the financial statements, our responsibility is to read the other information and, in doing so, consider whether the other information is materially inconsistent with the financial statements or our knowledge obtained in the audit or otherwise appears to be materially misstated. If we identify such material inconsistencies or apparent material misstatements, we are required to determine whether there is a material misstatement in the financial statements or a material misstatement of the other information. If, based on the work we have performed, we conclude that there is a material misstatement of the other information, we are required to report that fact.

We have nothing to report in this regard.

In this context, we also have nothing to report in regard to our responsibility to specifically address the following items in the other information and to report as uncorrected material misstatements of the other information where we conclude that those items meet the following conditions:

- Fair, balanced and understandable set out on page 55 in accordance with provision C.1.1 of the NHS Foundation Trust Code of Governance – the statement given by the directors that they consider the Annual Report and financial statements taken as a whole is fair, balanced and understandable and provides the information necessary for patients, regulators and other stakeholders to assess the Trust's performance, business model and strategy, is materially inconsistent with our knowledge of the Trust obtained in the audit; or
- Audit Committee reporting set out on page 24 in accordance with provision C.3.9 of the NHS Foundation Trust Code of Governance – the section describing the work of the Audit Committee does not appropriately address matters communicated by us to the Audit Committee.

Other information we are required to report on by exception under the Code of Audit Practice

Under the Code of Audit Practice published by the National Audit Office on behalf of the Comptroller and Auditor General (the Code of Audit Practice) we are required to consider whether the Annual Governance Statement does not meet the disclosure requirements set out in the NHS foundation trust annual reporting manual 2019/20 or is misleading or inconsistent with the information of which we are aware from our audit. We are not required to consider whether the Annual Governance Statement addresses all risks and controls or that risks are satisfactorily addressed by internal controls.

We have nothing to report in this regard.

Our opinion on other matters required by the Code of Audit Practice is unmodified

In our opinion:

- the parts of the Remuneration Report and the Staff Report to be audited have been properly prepared in accordance with IFRSs as adopted by the European Union, as interpreted and adapted by the NHS foundation trust annual reporting manual 2019/20 and the requirements of the National Health Service Act 2006; and
- based on the work undertaken in the course of the audit of the financial statements and our knowledge of the Trust gained through our work in relation to the Trust's arrangements for securing economy, efficiency and effectiveness in its use of resources, the other information published together with the financial statements in the Annual Report for the financial year for which the financial statements are prepared is consistent with the financial statements.

Matters on which we are required to report by exception

Under the Code of Audit Practice, we are required to report to you if:

- we issue a report in the public interest under Schedule 10 (3) of the National Health Service Act 2006 in the course of, or at the conclusion of the audit; or
- we refer a matter to the regulator under Schedule 10 (6) of the National Health Service Act 2006 because we have reason to believe that the Trust, or a director or officer of the Trust, is about to make, or has made, a decision which involves or would involve the incurring of expenditure that was unlawful, or is about to take, or has begun to take a course of action which, if followed to its conclusion, would be unlawful and likely to cause a loss or deficiency.

We have nothing to report in respect of the above matters.

Responsibilities of the Accounting Officer and Those Charged with Governance for the financial statements

As explained more fully in the Statement of the chief executive's responsibilities as the accounting officer of Kettering General Hospital NHS Foundation Trust set out on pages 54 to 55, the Chief Executive, as Accounting Officer, is responsible for the preparation of the financial statements in the form and on the basis set out in the Accounts Directions included in the NHS foundation trust annual reporting manual 2019/20, for being satisfied that they give a true and fair view, and for such internal control as the Accounting Officer determines is necessary to enable the preparation of financial statements that are free from material misstatement, whether due to fraud or error.

In preparing the financial statements, the Accounting Officer is responsible for assessing the Trust's ability to continue as a going concern, disclosing, as applicable, matters related to going concern and using the going concern basis of accounting unless the Accounting Officer has been informed by the relevant national body of the intention to dissolve the Trust without the transfer of the Trust's services to another public sector entity.

The Audit Committee is Those Charged with Governance. Those charged with governance are responsible for overseeing the Trust's financial reporting process.

Auditor's responsibilities for the audit of the financial statements

Our objectives are to obtain reasonable assurance about whether the financial statements as a whole are free from material misstatement, whether due to fraud or error, and to issue an auditor's report that includes our opinion. Reasonable assurance is a high level of assurance, but is not a guarantee that an audit conducted in accordance with ISAs (UK) will always detect a material misstatement when it exists. Misstatements can arise from fraud or error and are considered material if, individually or in the aggregate, they could reasonably be expected to influence the economic decisions of users taken on the basis of these financial statements.

A further description of our responsibilities for the audit of the financial statements is located on the Financial Reporting Council's website at: *www.frc.org.uk/auditorsresponsibilities*. This description forms part of our auditor's report.

REPORT ON OTHER LEGAL AND REGULATORY REQUIREMENTS – CONCLUSION ON THE TRUST'S ARRANGEMENTS FOR SECURING ECONOMY, EFFICIENCY AND EFFECTIVENESS IN ITS USE OF RESOURCES

Adverse conclusion

On the basis of our work, having regard to the guidance on the specified criterion issued by the Comptroller and Auditor General in April 2020, because of the significance of the matters described in the basis for adverse conclusion section of our report, we are not satisfied that, in all significant respects, Kettering General Hospital NHS Foundation Trust put in place proper arrangements for securing economy, efficiency and effectiveness in its use of resources for the year ended 31 March 2020.

Basis for adverse conclusion

Our review of the Trust's arrangements for securing economy, efficiency and effectiveness in its use of resources identified the following matters:

- During the course of 2019/20 the Trust incurred a deficit of £12.3 million which meant that they did not deliver the planned break-even position. This deficit is made up of £5.1 million overspend against plan and £7.2 million of funding not received as a result of missing the control total in Quarter 4.
- The Trust received loans during 2019/20 through an 'uncommitted interim revenue support facility' from (NHS Improvement) totaling £31.4 million; £10.7 million of capital loans and £20.7 million of revenue loans. This is an indication of the Trust's underlying deficit position.
- The Trust's 2020/21 draft financial plan, pre Covid-19, indicated an underlying deficit position of around £30 million. Although alternative financial measures have been put in place by NHS Improvement for the first few months of the year, the underlying key dynamics to achieve financial sustainability remain. The Trust's growth rate in non-elective activity needs to reduce in favour of increased elective and specialised services activity. Managing non-elective activity growth is a health system issue and a key challenge for the Trust to work on with its commissioners as part of the Northamptonshire STP's key priorities.

These matters identify weaknesses in the Trust's arrangements for setting and delivering a sustainable budget with sufficient capacity to absorb emerging cost pressures.

They are evidence of weaknesses in proper arrangements for sustainable resource deployment in planning finances effectively to support the sustainable delivery of strategic priorities and maintain statutory functions.

Significant risks

Under the Code of Audit Practice, we are required to report on how our work addressed the significant risks we identified in forming our conclusion on the adequacy of the Trust's arrangements for securing economy, efficiency and effectiveness in its use of resources. Significant risks are those risks that in our view had the potential to cause us to reach an inappropriate conclusion on the audited body's arrangements. The table below sets out the significant risks we have identified. These significant risks were addressed in the context of our conclusion on the Trust's arrangements as a whole, and in forming our conclusion thereon, and we do not provide a separate opinion on these risks.

Significant risks forming part of our qualified conclusion	How the matter was addressed in the audit
Risk 1 Financial Sustainability The Trust received a control total offer of nil (i.e. breakeven) after the receipt of Provider Sustainability Funds, Financial Recovery Funds, Marginal Rate Emergency Tariff Funding of £25.2 million. As at December 2019 the Trust forecast a risk to its financial position in the region of £8 million. This provides a risk that the Trust will not be able to deliver financial balance due to inefficiencies within the Trust's delivery and the pace of change being driven by the Sustainability and Transformation Plan not providing health economy solutions fast enough.	*Our audit work included, but was not restricted to:* • assessing how the Trust has responded to its financial challenges in 2019/20 both in terms of the 2019/20 outturn performance and its plans for future years. *In arriving at our conclusion, our main considerations were:* • the financial performance of the Trust in 2019/20 including its loans and borrowing and delivery against the cost improvement programme; • the Trust's 2020/21 financial plans including contracting arrangements, capital expenditure and the wider Hospital Improvement Programme (HIP2); and • the collaborative working with Northampton General Hospital NHS Trust and the impact this is projected to have on the Trust's longer-term financial position. **Key findings** We have qualified our conclusion in respect of this risk, as set out in the basis for adverse conclusion section of the report.

Responsibilities of the Accounting Officer

The Accounting Officer is responsible for putting in place proper arrangements for securing economy, efficiency and effectiveness in the use of the Trust's resources.

Auditor's responsibilities for the review of the Trust's arrangements for securing economy, efficiency and effectiveness in its use of resources

We are required under paragraph 1 of Schedule 10 of the National Health Service Act 2006 to be satisfied that the Trust has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources and to report where we have not been able to satisfy ourselves that it has done so. We are not required to consider, nor have we considered, whether all aspects of the Trust's arrangements for securing economy, efficiency and effectiveness in its use of resources are operating effectively.

We have undertaken our review in accordance with the Code of Audit Practice, having regard to the guidance on the specified criterion issued by the Comptroller and Auditor General in April 2020, as to whether in all significant respects, the Trust had proper arrangements to ensure it took properly informed decisions and deployed resources to achieve planned and sustainable outcomes for taxpayers and local people. The Comptroller and Auditor General determined this criterion as that necessary for us to consider under the Code of Audit Practice in satisfying ourselves whether the Trust put in place proper arrangements for securing economy, efficiency and effectiveness in its use of resources for the year ended 31 March 2020, and to report by exception where we are not satisfied.

We planned our work in accordance with the Code of Audit Practice. Based on our risk assessment, we undertook such work as we considered necessary to be satisfied that the Trust has put in place proper arrangements for securing economy, efficiency and effectiveness in its use of resources.

REPORT ON OTHER LEGAL AND REGULATORY REQUIREMENTS - CERTIFICATE

We certify that we have completed the audit of the financial statements of Kettering General Hospital NHS Foundation Trust in accordance with the requirements of Chapter 5 of Part 2 of the National Health Service Act 2006 and the Code of Audit Practice.

Use of our report

This report is made solely to the Council of Governors of the Trust, as a body, in accordance with Schedule 10 of the National Health Service Act 2006. Our audit work has been undertaken so that we might state to the Trust's Council of Governors those matters we are required to state to them in an auditor's report and for no other purpose. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the Trust and the Trust's Council of Governors, as a body, for our audit work, for this report, or for the opinions we have formed.

M C Stocks

Mark Stocks, Key Audit Partner
for and on behalf of Grant Thornton UK LLP, Local Auditor

Birmingham, 25 June 2020

Annual Accounts

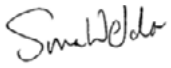
for the year ended 31 March 2020

4

Foreword to the accounts

These accounts, for the year ended 31 March 2020, have been prepared by Kettering General Hospital NHS Foundation Trust in accordance with paragraphs 24 & 25 of Schedule 7 within the National Health Service Act 2006.

Mr Simon Weldon
Chief Executive
17 June 2020



Statement of Comprehensive Income

	Note	2019/20 £000	2018/19 £000
Operating income from patient care activities	3	257,390	230,433
Other operating income	4	34,060	21,737
Operating expenses	6	(300,162)	(280,533)
Operating deficit from continuing operations		**(8,712)**	**(28,363)**
Finance income	11	91	82
Finance expenses	12	(3,798)	(3,357)
Net finance costs		**(3,707)**	**(3,275)**
Other gains / (losses)	13	87	(28)
Deficit for the year from continuing operations		**(12,332)**	**(31,666)**
Deficit for the year		**(12,332)**	**(31,666)**

Other comprehensive income

Will not be reclassified to income and expenditure:

Impairments	7	(395)	(3,894)
Revaluations	17	3,406	4,288
Total comprehensive expense for the period		**(9,321)**	**(31,272)**

NHS Improvement Control Total

Adjusted financial performance (control total basis):

Deficit for the period	(12,332)	(31,666)
Remove net impairments not scoring to the Departmental expenditure limit	(930)	4,711
Remove I&E impact of capital grants and donations	56	76
Remove 2018/19 post audit PSF reallocation (2019/20 only)	(212)	
Adjusted financial performance deficit	**(13,418)**	**(26,879)**

Operating income and Operating expenses include £7.3m of pension costs funded by NHS England for the increased pension liability to the Trust from 1 April 2019.

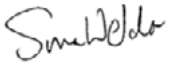
Statement of Financial Position

	Note	31 March 2020 £000	31 March 2019 £000
Non-current assets			
Intangible assets	14	5,917	2,759
Property, plant and equipment	15	142,734	136,644
Receivables	19	867	1,069
Total non-current assets		**149,518**	**140,472**
Current assets			
Inventories	18	3,466	3,598
Receivables	19	12,193	7,772
Cash and cash equivalents	22	2,819	1,342
Total current assets		**18,478**	**12,712**
Current liabilities			
Trade and other payables	23	(19,800)	(24,214)
Borrowings	25	(170,463)	(60,180)
Provisions	27	(585)	(451)
Other liabilities	24	(1,528)	(1,348)
Total current liabilities		**(192,376)**	**(86,193)**
Total assets less current liabilities		**(24,380)**	**66,991**
Non-current liabilities			
Borrowings	25	(7,161)	(89,397)
Provisions	27	(473)	(439)
Total non-current liabilities		**(7,634)**	**(89,836)**
Total assets employed		**(32,014)**	**(22,845)**
Financed by			
Public dividend capital		64,639	64,487
Revaluation reserve		36,850	34,763
Income and expenditure reserve		(133,503)	(122,095)
Total taxpayers' equity		**(32,014)**	**(22,845)**

The Trust has been advised that during 2020/21 all revenue loans and any interim capital loans will be converted to Public dividend capital. Therefore at the balance sheet date, these loans have been treated as current liabilities.

The notes on pages 66 to 97 form part of these accounts.

Simon Weldon
Chief Executive
17 June 2020



Statement of Changes in Taxpayers' Equity for the year ended 31 March 2020

	Public dividend capital £000	Revaluation reserve £000	Income and expenditure reserve £000	Total £000
Taxpayers' and others' equity at 1 April 2019 - brought forward	**64,487**	**34,763**	**(122,095)**	**(22,845)**
Deficit for the year	-	-	(12,332)	**(12,332)**
Other transfers between reserves	-	(924)	924	**-**
Impairments	-	(395)	-	**(395)**
Revaluations	-	3,406	-	**3,406**
Public dividend capital received	152	-	-	**152**
Taxpayers' and others' equity at 31 March 2020	**64,639**	**36,850**	**(133,503)**	**(32,014)**

Statement of Changes in Taxpayers' Equity for the year ended 31 March 2019

	Public dividend capital £000	Revaluation reserve £000	Income and expenditure reserve £000	Total £000
Taxpayers' and others' equity at 1 April 2018 - brought forward	**61,129**	**34,885**	**(90,945)**	**5,069**
Deficit for the year	-	-	(31,666)	**(31,666)**
Other transfers between reserves	-	(516)	516	-
Impairments	-	(3,894)	-	**(3,894)**
Revaluations	-	4,288	-	**4,288**
Public dividend capital received	3,358	-	-	**3,358**
Taxpayers' and others' equity at 31 March 2019	**64,487**	**34,763**	**(122,095)**	**(22,845)**

Statement of Cash Flows

	Note	2019/20 £000	2018/19 £000
Cash flows from operating activities			
Operating deficit		(8,712)	(28,363)
Non-cash income and expense:			
Depreciation and amortisation	6.1	7,457	4,699
Net impairments	7	(930)	4,711
Income recognised in respect of capital donations	4	(147)	(98)
Increase in receivables and other assets		(3,764)	(2,309)
(Increase) / decrease in inventories		132	(222)
Increase / (decrease) in payables and other liabilities		(4,712)	5,132
Increase / (decrease) in provisions		167	(158)
Net cash flows used in operating activities		**(10,509)**	**(16,608)**
Cash flows from investing activities			
Interest received		88	77
Purchase of intangible assets		(3,102)	(1,047)
Purchase of Property, Plant & Equipment		(9,490)	(12,216)
Sales of Property, Plant & Equipment		87	85
Receipt of cash donations to purchase assets		-	98
Net cash flows used in investing activities		**(12,417)**	**(13,003)**
Cash flows from financing activities			
Public dividend capital received		152	3,358
Movement on loans from DHSC	25.2	28,247	28,407
Capital element of finance lease rental payments	25.2	(299)	(303)
Interest on loans	25.2	(3,680)	(3,170)
Interest paid on finance lease liabilities	25.2	(17)	(18)
PDC dividend refunded		-	9
Net cash flows from / financing activities		**24,403**	**28,283**
Increase / (decrease) in cash and cash equivalents		**1,477**	**(1,328)**
Cash and cash equivalents at 1 April - brought forward		**1,342**	**2,670**
Cash and cash equivalents at 31 March	22	**2,819**	**1,342**

Notes to the Accounts

NOTE 1 ACCOUNTING POLICIES AND OTHER INFORMATION

Note 1.1 Basis of preparation

NHS Improvement, in exercising the statutory functions conferred on Monitor, has directed that the financial statements of the Trust shall meet the accounting requirements of the Department of Health and Social Care Group Accounting Manual (GAM), which shall be agreed with HM Treasury. Consequently, the following financial statements have been prepared in accordance with the GAM 2019/20 issued by the Department of Health and Social Care. The accounting policies contained in the GAM follow International Financial Reporting Standards to the extent that they are meaningful and appropriate to the NHS, as determined by HM Treasury, which is advised by the Financial Reporting Advisory Board. Where the GAM permits a choice of accounting policy, the accounting policy that is judged to be most appropriate to the particular circumstances of the Trust for the purpose of giving a true and fair view has been selected. The particular policies adopted are described below. These have been applied consistently in dealing with items considered material in relation to the accounts

Accounting convention

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

Note 1.2

These accounts have been prepared on a going concern basis as assessed by the Board. Non-trading entities in the public sector are assumed to be going concerns where there is a continued provision of a service in the future. A statement from NHS England and NHS Improvement issued on 27th May 2020 confirms that the financial statements are prepared on a going concern basis unless there are plans for, or no realistic alternative other than the dissolution of the Trust without the transfer of its services to another entity within the public sector. There are no plans to dissolve the Trust. In addition the Government has issued a mandate to NHS England for the continued provision of services in England in 2020/21.

The Board of Directors considered the Trust's going concern position at its meeting of 29 May 2020 and the key areas considered were:

1. The Trust's deficit position of £12.3m in 2019/20 compared to the previous years' deficit of £31.6m. The planning for 2020/21 has been delayed due to the Covid19 pandemic and the measures being put in place for the first few months of the year. However the Trust does have an underlying deficit position which presents a material uncertainty relating to the financial stability of the Trust. Taking all matters into consideration, the Directors consider that the services currently provided by the Trust will continue to be provided in the foreseeable future.
2. The Trust expects to have agreed contracts with its local commissioners for 2020/21, however at the date of the accounts, and for the first 4 months of the year, the Trust's activity is being commissioned through financial arrangements put in place by the NHS to ensure focus is on dealing with the Covid19 pandemic. The original intention was to have joint discussions with commissioners regarding contract plans for 2020/21 and this was expected to consider block arrangements as a primary approach to financial planning. Going forward, the national approach on post Covid contract and financial arrangements is still under consideration, but assurance is provided that funding will continue to flow at similar levels to those previously provided.
3. The Trust has been advised that all interim revenue and capital loans will be converted to Public Dividend Capital (PDC see note 1.20), during 2020/21 which will remove £168.7m of the Trusts £176.8m loan liability. For 2019/20, £56m of these loans had their terms extended as the Trust was unable to repay them on the settlement date. During 2019/20 the Trust received financial support through £20.7m of revenue loans, £7.2m relating to the 18/19 deficit and £13.5m relating to the 19/20 deficit. The conversion to PDC will mean the Trust no longer makes interest payments but will instead be paying a dividend on its net assets to the Department of Health.
4. In January 2020, the Trust announced a joint management arrangement with Northampton General Hospital NHS Trust to support and lead strengthened collaboration between the two hospitals for the benefit of the communities we serve. The formation of the group is not a merger and both Trusts will continue to provide core services such as A&E and maternity services but will collaborate more closely on other clinical and support services with the aim of providing the best care possible for patients.

The Board of Directors concluded that there is sufficient evidence that the Trust will continue as a going concern for the foreseeable future and that it was appropriate to prepare the Annual Report and Accounts on a going concern basis.

Note 1.3 Critical judgements in applying accounting policies

The following are the judgements, apart from those involving estimations (see below) that management has made in the process of applying the Trust's accounting policies and that have the most significant effect on the amounts recognised in the financial statements:

a) Going Concern status - as described in 1.2, the Trust has prepared the accounts on a going concern basis.

b) The Trust has assumed that all interim capital and revenue loans will be converted to PDC during 2020/21 and has therefore treated these as current liabilities.

c) The Trust has received income relating to the Covid19 pandemic. This includes £2.8m of revenue income to offset additional expenditure and £0.3m of funding for capital expenditure.

d) The Trusts clinical income and employee benefits expenditure have been notionally increased by £7.3m to reflect the increase in Employers Pension contributions from 1st April 2019.

Note 1.4 Sources of estimation uncertainty

The following are assumptions about the future and other major sources of estimation uncertainty that have a significant risk of resulting in a material adjustment to the carrying amounts of assets and liabilities within the next financial year:

a) **Valuation of Property** - The quinquennial valuation of the estate was undertaken as at 31 March 2019 by Gerald Eve LLP to provide the value of land and property together with asset lives. A desktop valuation, building on this was provided with a valuation date of 31 March 2020. In applying he Royal Institute of Chartered Surveyors (RICS) Valuation Global Standards 2020 ('Red Book'), the valuer has declared a 'material valuation uncertainty' in the valuation report. This is on the basis of uncertainties in markets caused by COVID-19. The values in the report have been used to inform the measurement of property assets at valuation in these financial statements. With the valuer having declared this material valuation uncertainty, the valuer has continued to exercise professional judgement in providing the valuation and this remains the best information available to the Trust this year, with a valuation date of 31 March 2020.

The impact of Covid has been assessed and reported in the accounts as a reduction in land value of 11% (£684k) and a reduction in buildings value of 2.3% (£2,725k). The Trust has a materiality level of £5m and the value of land and buildings would need to reduce by a further 4%to have a material impact on the Trusts accounts.

The net book value of the land and buildings of the trust are all specialised assets valued on a depreciated replacement cost basis. Here the valuer bases their assessment on the cost to the Trust of replacing the service potential of the assets. The uncertainty explained above relates to the estimated cost of replacing the service potential, rather than the extent of the service potential to be replaced. It is possible that the COVID-19 pandemic will affect the Trust's future assessment of what would be required in a modern equivalent asset, but as yet there is insufficient evidence to affect the assumptions used in the valuation.

b) **Inventories** - Due to the Covid19 pandemic, the Trust did not undertake the usual stocktakes at year end. *The Inventory figure in the accounts are based on the following:-*

- Computerised stock systems - for pharmacy and the main inventory areas of Theatres and Cardiology, computerised stock systems continued to be maintained under normal procedures.
- manual stock takes were undertaken in some areas including pathology and oil stock.
- prior year inventories figures, including some adjustments for increased expenditure in March in areas such as A&E and ITU where increased inventory levels were expected.

The unverified inventory values accounts for 32% of the reported inventory value.

Note 1.5 Interests in other entities

The Trust has no interest in other entities (2018/19 - nil)

Note 1.6 Revenue from contracts with customers

Where income is derived from contracts with customers, it is accounted for under IFRS 15. The GAM expands the definition of a contract to include legislation and regulations which enables an entity to receive cash or another financial asset that is not classified as a tax by the Office of National Statistics (ONS).

Revenue in respect of goods/services provided is recognised when (or as) performance obligations are satisfied by transferring promised goods/services to the customer and is measured at the amount of the transaction price allocated to those performance obligations. At the year end, the Trust accrues income

relating to performance obligations satisfied in that year. Where the Trust's entitlement to consideration for those goods or services is unconditional a contract receivable will be recognised. Where entitlement to consideration is conditional on a further factor other than the passage of time, a contract asset will be recognised. Where consideration received or receivable relates to a performance obligation that is to be satisfied in a future period, the income is deferred and recognised as a contract liability.

Revenue from NHS contracts

The main source of income for the Trust is contracts with commissioners for health care services. A performance obligation relating to delivery of a spell of health care is generally satisfied over time as healthcare is received and consumed simultaneously by the customer as the Trust performs it. The customer in such a contract is the commissioner, but the customer benefits as services are provided to their patient. Even where a contract could be broken down into separate performance obligations, healthcare generally aligns with paragraph 22(b) of the Standard entailing a delivery of a series of goods or services that are substantially the same and have a similar pattern of transfer. At the year end, the Trust accrues income relating to activity delivered in that year, where a patient care spell is incomplete. This accrual is disclosed as a contract receivable as entitlement to payment for work completed is usually only dependent on the passage of time.

The Trust has agreed its 2019/20 income position with its two lead Commissioners, taking into account partially completed spells and maternity pathway income. Any future invoice challenges or penalties arising from other Commissioners relating to 2019/20 would not be material to the income reported in these accounts.

Revenue from research contracts

Where research contracts fall under IFRS 15, revenue is recognised as and when performance obligations are satisfied. For some contracts, it is assessed that the revenue project constitutes one performance obligation over the course of the multi-year contract. In these cases it is assessed that the Trust's interim performance does not create an asset with alternative use for the Trust, and the Trust has an enforceable right to payment for the performance completed to date. It is therefore considered that the performance obligation is satisfied over time, and the Trust recognises revenue each year over the course of the contract.

NHS injury cost recovery scheme

The Trust receives income under the NHS injury cost recovery scheme, designed to reclaim the cost of treating injured individuals to whom personal injury compensation has subsequently been paid, for instance by an insurer. The Trust recognises the income when performance obligations are satisfied. In practical terms this means that treatment has been given, it receives notification from the Department of Work and Pension's Compensation Recovery Unit, has completed the NHS2 form and confirmed there are no discrepancies with the treatment. The income is measured at the agreed tariff for the treatments provided to the injured individual, less an allowance for unsuccessful compensation claims and doubtful debts in line with IFRS 9 requirements of measuring expected credit losses over the lifetime of the asset.

Provider sustainability fund (PSF) and Financial recovery fund (FRF)

The PSF and FRF enable the Trust to earn income linked to the achievement of financial controls and performance targets. Income earned from the funds is accounted for as variable consideration.

Note 1.7 Other forms of income

Grants and donations

Government grants are grants from government bodies other than income from commissioners or Trusts for the provision of services. Where a grant is used to fund revenue expenditure it is taken to the Statement of Comprehensive Income to match that expenditure. Where the grants is used to fund capital expenditure, it is credited to the consolidated statement of comprehensive income once conditions attached to the grant have been met. Donations are treated in the same way as government grants.

Apprenticeship service income

The value of the benefit received when accessing funds from the Government's apprenticeship service is recognised as income at the point of receipt of the training service. Where these funds are paid directly to an accredited training provider from the Trust's Digital Apprenticeship Service (DAS) account held by the Department for Education, the corresponding notional expense is also recognised at the point of recognition for the benefit.

Note 1.8 Expenditure on employee benefits

Short-term employee benefits

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

Pension costs

NHS Pension Scheme

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

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

Note 1.9 Expenditure on other goods and services

Expenditure on goods and services is recognised when, and to the extent that they have been received, and is measured at the fair value of those goods and services. Expenditure is recognised in operating expenses except where it results in the creation of a non-current asset such as property, plant and equipment.

Note 1.10 Property, plant and equipment

Recognition

Property, plant and equipment is capitalised where:

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

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

Subsequent expenditure

Subsequent expenditure relating to an item of property, plant and equipment is recognised as an increase in the carrying amount of the asset when it is probable that additional future economic benefits or service potential deriving from the cost incurred to replace a component of such item will flow to the enterprise and the cost of the item can be determined reliably. Where a component of an asset is replaced, the cost of the replacement is capitalised if it meets the criteria for recognition above. The carrying amount of the part replaced is de-recognised. Other expenditure that does not generate additional future economic benefits or service potential, such as repairs and maintenance, is charged to the Statement of Comprehensive Income in the period in which it is incurred.

Measurement

Valuation

All property, plant and equipment assets are measured initially at cost, representing the costs directly attributable to acquiring or constructing the asset and bringing it to the location and condition necessary for it to be capable of operating in the manner intended by management.

Assets are measured subsequently at valuation. Assets which are held for their service potential and are in use (ie operational assets used to deliver either front line services or back office functions) are measured at their current value in existing use. Assets that were most recently held for their service potential but are surplus with no plan to bring them back into use are measured at fair value where there are no restrictions on sale at the reporting date and where they do not meet the definitions of investment properties or assets held for sale.

Revaluations of property, plant and equipment are performed with sufficient regularity to ensure that carrying values are not materially different from those that would be determined at the end of the reporting period. Current values in existing use are determined as follows:

- Land and non-specialised buildings – market value for existing use
- Specialised buildings – depreciated replacement cost on a modern equivalent asset basis.

For specialised assets, current value in existing use is interpreted as the present value of the asset's remaining service potential, which is assumed to be

at least equal to the cost of replacing that service potential. Specialised assets are therefore valued at their depreciated replacement cost (DRC) on a modern equivalent asset (MEA) basis. An MEA basis assumes that the asset will be replaced with a modern asset of equivalent capacity and meeting the location requirements of the services being provided. Assets held at depreciated replacement cost have been valued on an alternative site basis where this would meet the location requirements.

Properties in the course of construction for service or administration purposes are carried at cost, less any impairment loss. Cost includes professional fees. Assets are revalued and depreciation commences when the assets are brought into use.

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

Depreciation

Items of property, plant and equipment are depreciated over their remaining useful lives in a manner consistent with the consumption of economic or service delivery benefits. Freehold land is considered to have an infinite life and is not depreciated.

Assets in the course of construction and residual interests in off-Statement of Financial Position PFI contract assets are not depreciated until the asset is brought into use or reverts to the Trust, respectively.

Revaluation gains and losses

Revaluation gains are recognised in the revaluation reserve, except where, and to the extent that, they reverse a revaluation decrease that has previously been recognised in operating expenses, in which case they are recognised in operating expenditure.

Revaluation losses are charged to the revaluation reserve to the extent that there is an available balance for the asset concerned, and thereafter are charged to operating expenses.

Gains and losses recognised in the revaluation reserve are reported in the Statement of Comprehensive Income as an item of 'other comprehensive income'.

Impairments

In accordance with the GAM, impairments that arise from a clear consumption of economic benefits or of service potential in the asset are charged to operating expenses. A compensating transfer is made from the revaluation reserve to the income and expenditure reserve of an amount equal to the lower of (i) the impairment charged to operating expenses; and (ii) the balance in the revaluation reserve attributable to that asset before the impairment.

An impairment that arises from a clear consumption of economic benefit or of service potential is reversed when, and to the extent that, the circumstances that gave rise to the loss is reversed. Reversals are recognised in operating expenditure to the extent that the asset is restored to the carrying amount it would have had if the impairment had never been recognised. Any remaining reversal is recognised in the revaluation reserve. Where, at the time of the original impairment, a transfer was made from the revaluation reserve to the income and expenditure reserve, an amount is transferred back to the revaluation reserve when the impairment reversal is recognised.

Other impairments are treated as revaluation losses. Reversals of 'other impairments' are treated as revaluation gains.

De-recognition

Assets intended for disposal are reclassified as 'held for sale'. The Trust holds no such assets (2018/19 - nil).

Property, plant and equipment which is to be scrapped or demolished does not qualify for recognition as 'held for sale' and instead is retained as an operational asset and the asset's useful life is adjusted. The asset is de-recognised when scrapping or demolition occurs.

Donated assets

Donated property, plant and equipment assets are capitalised at their fair value on receipt. The donation is credited to income at the same time.

The donated assets are subsequently accounted for in the same manner as other items of property, plant and equipment.

Useful lives of property, plant and equipment

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

	Min life Years	Max life Years
Land	-	-
Buildings, excluding dwellings	10	99
Plant & machinery	5	15
Information technology	8	8
Furniture & fittings	5	10

Finance-leased assets (including land) are depreciated over the shorter of the useful life or the lease term, unless the Trust expects to acquire the asset at the end of the lease term in which case the assets are depreciated in the same manner as owned assets above.

Note 1.11 Intangible assets

Recognition

Intangible assets are non-monetary assets without physical substance which are capable of being sold separately from the rest of the Trust's business or which arise from contractual or other legal rights. They are recognised only where it is probable that future economic benefits will flow to, or service potential be provided to, the Trust and where the cost of the asset can be measured reliably.

Internally generated intangible assets

Internally generated goodwill, brands, mastheads, publishing titles, customer lists and similar items are not capitalised as intangible assets.

Expenditure on research is not capitalised. Expenditure on development is capitalised where it meets the requirements set out in IAS 38.

Software

Software which is integral to the operation of hardware, eg an operating system, is capitalised as part of the relevant item of property, plant and equipment. Software which is not integral to the operation of hardware, eg application software, is capitalised as an intangible asset.

Measurement

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

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

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

Amortisation

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

Useful lives of intangible assets

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

	Min life Years	Max life Years
Software licences	8	8

Note 1.12 Inventories

Inventories are valued at the lower of cost and net realisable value. The cost of inventories is measured using the current or weighted average cost method.

Note 1.13 Cash and cash equivalents

Cash is cash in hand and deposits with any financial institution repayable without penalty on notice of not more than 24 hours. Cash equivalents are investments that mature in 3 months or less from the date of acquisition and that are readily convertible to known amounts of cash with insignificant risk of change in value.

In the Statement of Cash Flows, cash and cash equivalents are shown net of bank overdrafts that are repayable on demand and that form an integral part of the Trust's cash management. Cash, bank and overdraft balances are recorded at current values.

Note 1.14 Carbon Reduction Commitment scheme (CRC)

The CRC scheme was a mandatory cap and trade scheme for non-transport CO2 emissions. The scheme was closed as of 31 March 2019. The Trust was registered with the CRC scheme, and was therefore required to surrender to the Government an allowance for every tonne of CO2 it emits during the financial year.

Note 1.15 Climate Change Levy

Expenditure is recognised in line with the levy charged, based on chargeable rates for energy consumption as detailed in the Climate Change Levy documentation.

Note 1.16 Financial assets and financial liabilities

Recognition

Financial assets and financial liabilities arise where the Trust is party to the contractual provisions of a financial instrument, and as a result has a legal right to receive or a legal obligation to pay cash or another financial instrument. The GAM expands the definition of a contract to include legislation and regulations which

give rise to arrangements that in all other respects would be a financial instrument and do not give rise to transactions classified as a tax by ONS.

This includes the purchase or sale of non-financial items (such as goods or services), which are entered into in accordance with the Trust's normal purchase, sale or usage requirements and are recognised when, and to the extent which, performance occurs, ie, when receipt or delivery of the goods or services is made.

Classification and measurement

Financial assets and financial liabilities are initially measured at fair value plus or minus directly attributable transaction costs except where the asset or liability is not measured at fair value through income and expenditure. Fair value is taken as the transaction price, or otherwise determined by reference to quoted market prices or valuation techniques.

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

Financial assets are classified as subsequently measured at amortised cost.

Financial liabilities classified as subsequently measured at amortised cost.

Financial assets and financial liabilities at amortised cost

Financial assets and financial liabilities at amortised cost are those held with the objective of collecting contractual cash flows and where cash flows are solely payments of principal and interest. This includes cash equivalents, contract and other receivables, trade and other payables, rights and obligations under lease arrangements and loans receivable and payable.

After initial recognition, these financial assets and financial liabilities are measured at amortised cost using the effective interest method less any impairment (for financial assets). The effective interest rate is the rate that exactly discounts estimated future cash payments or receipts through the expected life of the financial asset or financial liability to the gross carrying amount of a financial asset or to the amortised cost of a financial liability.

Interest revenue or expense is calculated by applying the effective interest rate to the gross carrying amount of a financial asset or amortised cost of a financial liability and recognised in the Statement of Comprehensive Income and a financing income or expense. In the case of loans held from the Department of Health and Social Care, the effective interest rate is the nominal rate of interest charged on the loan.

Impairment of financial assets

For all financial assets measured at amortised cost including lease receivables, contract receivables and contract assets, the Trust recognises an allowance for expected credit losses.

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

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

Expected losses are charged to operating expenditure within the Statement of Comprehensive Income and reduce the net carrying value of the financial asset in the Statement of Financial Position.

Derecognition

Financial assets are de-recognised when the contractual rights to receive cash flows from the assets have expired or the Trust has transferred substantially all the risks and rewards of ownership.

Financial liabilities are de-recognised when the obligation is discharged, cancelled or expires.

Note 1.17 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.

The Trust as a lessee

Finance leases

Where substantially all risks and rewards of ownership of a leased asset are borne by the Trust, the asset is recorded as property, plant and equipment and a corresponding liability is recorded. The value at which both are recognised is the lower of the fair value of the asset or the present value of the minimum lease payments, discounted using the interest rate implicit in the lease. The implicit interest rate is that which produces a constant periodic rate of interest on the outstanding liability.

The asset and liability are recognised at the commencement of the lease. Thereafter the asset is accounted for an item of property plant and equipment.

The annual rental charge is split between the repayment of the liability and a finance cost so as to achieve a constant rate of finance over the life of the lease. The annual finance cost is charged to finance costs in the Statement of Comprehensive Income.

Operating leases

Operating lease payments are recognised as an expense on a straight-line basis over the lease term. Lease incentives are recognised initially in other liabilities on the statement of financial position and subsequently as a reduction of rentals on a straight-line basis over the lease term. Contingent rentals are recognised as an expense in the period in which they are incurred.

Leases of land and buildings

Where a lease is for land and buildings, the land component is separated from the building component and the classification for each is assessed separately.

The Trust as a lessor

Finance leases

Amounts due from lessees under finance leases are recorded as receivables at the amount of the Trust's net investment in the leases. Finance lease income is allocated to accounting periods to reflect a constant periodic rate of return on the Trust's net investment outstanding in respect of the leases.

Operating leases

Rental income from operating leases is recognised on a straight-line basis over the term of the lease. Initial direct costs incurred in negotiating and arranging an operating lease are added to the carrying amount of the leased asset and recognised as an expense on a straight-line basis over the lease term.

Note 1.18 Provisions

The Trust recognises a provision where it has a present legal or constructive obligation of uncertain timing or amount; for which it is probable that there will be a future outflow of cash or other resources; and a reliable estimate can be made of the amount. The amount recognised in the Statement of Financial Position is the best estimate of the resources required to settle the obligation. Where the effect of the time value of money is significant, the estimated risk-adjusted cash flows are discounted using the discount rates published and mandated by HM Treasury and effective for 31 March 2020.

Early retirement provisions and injury benefit provisions both use the HM Treasury's pension discount rate of minus 0.5% in real terms.

Clinical negligence costs

NHS Resolution operates a risk pooling scheme under which the Trust pays an annual contribution to NHS Resolution, which, in return, settles all clinical negligence claims. Although NHS Resolution is administratively responsible for all clinical negligence cases, the legal liability remains with the Trust. The total value of clinical negligence provisions carried by NHS Resolution on behalf of the Trust is disclosed at note 27.2 but is not recognised in the Trust's accounts.

Non-clinical risk pooling

The Trust participates in the Property Expenses Scheme and the Liabilities to Third Parties Scheme. Both are risk pooling schemes under which the Trust pays an annual contribution to NHS Resolution and in return receives assistance with the costs of claims arising. The annual membership contributions, and any excesses payable in respect of particular claims are charged to operating expenses when the liability arises.

Note 1.19 Contingencies

Contingent assets (that is, assets arising from past events whose existence will only be confirmed by one or more future events not wholly within the entity's control) are not recognised as assets, but are disclosed in note 28 where an inflow of economic benefits is probable.

Contingent liabilities are not recognised, but are disclosed in note 28, unless the probability of a transfer of economic benefits is remote.

Contingent liabilities are defined as:

- possible obligations arising from past events whose existence will be confirmed only by the occurrence of one or more uncertain future events not wholly within the entity's control; or
- present obligations arising from past events but for which it is not probable that a transfer of economic benefits will arise or for which the amount of the obligation cannot be measured with sufficient reliability.

Note 1.20 Public dividend capital

Public dividend capital (PDC) is a type of public sector equity finance based on the excess of assets over liabilities at the time of establishment of the predecessor NHS organisation. HM Treasury has determined that PDC is not a financial instrument within the meaning of IAS 32.

The Secretary of State can issue new PDC to, and require repayments of PDC from, the Trust. PDC is recorded at the value received.

A charge, reflecting the cost of capital utilised by the Trust, is payable as public dividend capital dividend. As the Trust has negative net assets, no charge is payable in 2019/20.

During 2020/21, the revised NHS capital and cash regime will mean that the Trust will be issued PDC in order to repay ts interim loan liabilities. The Trust will rreceived £168m of PDC which will move the Trust into posititve net assets and therefore a dividend will be payable in 2020/21.

Note 1.21 Value added tax

Most of the activities of the Trust are outside the scope of VAT and, in general, output tax does not apply and input tax on purchases is not recoverable. Irrecoverable VAT is charged to the relevant expenditure category or included in the capitalised purchase cost of fixed assets. Where output tax is charged or input VAT is recoverable, the amounts are stated net of VAT.

Note 1.22 Third party assets

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

Note 1.23 Losses and special payments

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

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

Note 1.24 Early adoption of standards, amendments and interpretations

No new accounting standards or revisions to existing standards have been early adopted in 2019/20.

Note 1.25 Standards, amendments and interpretations in issue but not yet effective or adopted

IFRS 16 Leases

IFRS 16 Leases will replace IAS 17 Leases, IFRIC 4 Determining whether an arrangement contains a lease and other interpretations and is applicable in the public sector for periods beginning 1 April 2021. The standard provides a single accounting model for lessees, recognising a right of use asset and obligation in the statement of financial position for most leases: some leases are exempt through application of practical expedients explained below. For those recognised in the statement of financial position the standard also requires the remeasurement of lease liabilities in specific circumstances after the commencement of the lease term. For lessors, the distinction between operating and finance leases will remain and the accounting will be largely unchanged.

IFRS 16 changes the definition of a lease compared to IAS 17 and IFRIC 4. The Trust will apply this definition to new leases only and will grandfather its assessments made under the old standards of whether existing contracts contain a lease.

On transition to IFRS 16 on 1 April 2021, the Trust will apply the standard retrospectively with the cumulative effect of initially applying the standard recognised in the income and expenditure reserve at that date. For existing operating leases with a remaining lease term of more than 12 months and an underlying asset value of at least £5,000, a lease liability will be recognised equal to the value of remaining lease payments discounted on transition at the Trust's incremental borrowing rate. The Trust's incremental borrowing rate will be at a rate defined by HM Treasury. Currently this rate is 1.27% but this may change between now and the adoption of the standard. The related right of use asset will be measured equal to the lease liability adjusted for any prepaid or accrued lease payments. No adjustments will be made on 1 April 2021 for existing finance leases.

For leases commencing in 2021/22, the Trust will not recognise a right of use asset or lease liability for short term leases (less than or equal to 12 months) or for leases of low value assets (less than £5,000). Right of use assets will be subsequently measured on a basis consistent with owned assets and depreciated over the length of the lease term.

The Trust has estimated the impact of applying IFRS 16 in 2021/22 on the opening statement of financial position and the in-year impact on the statement of comprehensive income and capital additions as follows:

Estimated impact on 1 April 2021 statement of financial position	**£000**
Additional right of use assets recognised for existing operating leases	7,180
Additional lease obligations recognised for existing operating leases	(8,186)
Changes to other statement of financial position line items	-
Net impact on net assets on 1 April 2021	**(1,006)**
Estimated in-year impact in 2021/22	
Additional depreciation on right of use assets	(1,218)
Additional finance costs on lease liabilities	(91)
Lease rentals no longer charged to operating expenditure	1,315
Other impact on income / expenditure	-
Estimated impact on surplus / deficit in 2021/22	**6**

The estimates above are based on current operaqting leases and available information. The majority of these leases have been extended beyond their current lease terms to reflect the likely operational requirements of the Trust. This has been completed based on current lease liabilities and does not reflect any increased charges when leases are re-negotiated. Therefore the Trust is unable to estimate any capital additions relating to IFRS16 for 2021/22.

Other standards, amendments and interpretations

IFRS17 Insurance Contracts - Application required for accounting periods beginning on or after 1 January 2023, but not yet adopted by the FReM, early adoption is not therefore permitted.

NOTE 2 OPERATING SEGMENTS

The Trust operates as a single operating segment. The Board of Directors, led by the Chief Executive, is the chief operating decision maker within the Trust. It is only at this level that revenues are fully reported and the overall financial and operational performance of the Trust is assessed. In addition, full service line reporting by the Divisions is not currently provided on a regular basis to the Board of Directors.

NOTE 3 OPERATING INCOME FROM PATIENT CARE ACTIVITIES

All income from patient care activities relates to contract income recognised in line with accounting policy 1.6.

Note 3.1 Income from patient care activities (by nature)

	2019/20 £000	2018/19 £000
Acute services		
Elective income	38,978	36,896
Non elective income	76,331	77,174
First outpatient income	14,120	13,288
Follow up outpatient income	20,094	19,308
A & E income	16,458	12,854
High cost drugs income from commissioners (excluding pass-through costs)	15,352	14,496
Other NHS clinical income	64,827	52,168
All services		
Private patient income	96	128
Agenda for Change pay award central funding*	-	2,806
Additional pension contribution central funding**	7,329	-
Other clinical income***	3,805	1,315
Total income from activities	**257,390**	**230,433**

*Additional costs of the Agenda for Change pay reform in 2018/19 received central funding. From 2019/20 this funding is incorporated into tariff for individual services.

**The employer contribution rate for NHS pensions increased from 14.3% to 20.6% (excluding administration charge) from 1 April 2019. For 2019/20, NHS providers continued to pay over contributions at the former rate with the additional amount being paid over by NHS England on providers' behalf. The full cost and related funding have been recognised in these accounts.

*** The increase in other clinical income includes £2.8m income relating to additional Covid19 pandemic expenditure.

Note 3.2 Income from patient care activities (by source)

	2019/20 £000	2018/19 £000
Income from patient care activities received from:		
NHS England	43,881	32,147
Clinical commissioning groups	212,318	193,807
Department of Health and Social Care	-	2,806
Other NHS providers	215	211
NHS other	94	94
Non-NHS: private patients	96	128
Non-NHS: overseas patients (chargeable to patient)	145	196
Injury cost recovery scheme	566	906
Non NHS: other	75	138
Total income from activities	**257,390**	**230,433**
Of which:		
Related to continuing operations	257,390	230,433
Related to discontinued operations	-	-

Note 3.3 Overseas visitors (relating to patients charged directly by the provider)

	2019/20 £000	2018/19 £000
Income recognised this year	145	196
Cash payments received in-year	51	49
Amounts added to provision for impairment of receivables	166	5
Amounts written off in-year	24	56

NOTE 4 OTHER OPERATING INCOME

2019/20

	Contract income £000	Non-contract income £000	Total £000
Research and development	541	-	541
Education and training	7,910	283	8,193
Non-patient care services to other bodies	2,326	-	2,326
Provider sustainability fund (PSF)	4,045	-	4,045
Financial recovery fund (FRF)	9,608	-	9,608
Marginal rate emergency tariff funding (MRET)	4,560	-	4,560
Receipt of capital grants and donations	-	147	147
Charitable and other contributions to expenditure	-	103	103
Rental revenue from operating leases	-	274	274
Other income	4,076	187	4,263
Total other operating income	**33,066**	**994**	**34,060**

Of which:

Related to continuing operations	**34,060**
Related to discontinued operations	**-**

Other income includes income from car parking of £1.79m (2018/19 - £1.87m). The Trust incurs expenditure against this income shown both in operating expenses and finance leases.

Also included in other income, from CCG's and NHS England is cancer alliance and transformation income of £271k, medical staff payaward funding of £204k. Funding of collaboration work from Nene CCG and Northampton General Hospital NHST totalled £265k.

2018/19

	Contract income £000	Non-contract income £000	Total £000
Research and development	496	-	496
Education and training	8,057	-	8,057
Non-patient care services to other bodies	2,126	-	2,126
Provider sustainability fund (PSF)	6,972	-	6,972
Receipt of capital grants and donations	-	98	98
Charitable and other contributions to expenditure	-	85	85
Rental revenue from operating leases	-	252	252
Other income	3,181	470	3,651
Total other operating income	**20,832**	**905**	**21,737**
Of which:			
Related to continuing operations			**21,737**
Related to discontinued operations			**-**

NOTE 5.1 ADDITIONAL INFORMATION ON CONTRACT REVENUE (IFRS 15) RECOGNISED IN THE PERIOD

	2019/20 £000	2018/19 £000
Revenue recognised in the reporting period that was included in within contract liabilities at the previous period end	1,348	1,317
Revenue recognised from performance obligations satisfied (or partially satisfied) in previous periods	-	-

Note 5.2 Transaction price allocated to remaining performance obligations

The Trust has exercised the practical expedients permitted by IFRS 15 paragraph 121 in preparing this disclosure. Revenue from contracts with an expected duration of one year or less and contracts where the Trust recognises revenue directly corresponding to work done to date is not disclosed.

Note 5.3 Income from activities arising from commissioner requested services

Under the terms of its provider licence, the Trust is required to analyse the level of income from activities that has arisen from commissioner requested and non-commissioner requested services. Commissioner requested services are defined in the provider licence and are services that commissioners believe would need to be protected in the event of provider failure. *This information is provided in the table below:*

	2019/20 £000	2018/19 £000
Income from services designated as commissioner requested services	211,816	188,067
Income from services not designated as commissioner requested services	45,574	42,366
Total	**257,390**	**230,433**

NOTE 6.1 OPERATING EXPENSES

	2019/20 £000	2018/19 £000
Purchase of healthcare from NHS and DHSC bodies	3,944	3,765
Purchase of healthcare from non-NHS and non-DHSC bodies	4,954	6,040
Staff and executive directors costs	205,995	183,960
Remuneration of non-executive directors	141	128
Supplies and services - clinical (excluding drugs costs)	22,473	21,785
Supplies and services - general	2,749	2,888
Drug costs (drugs inventory consumed and purchase of non-inventory drugs)	22,561	22,200
Inventories written down	220	129
Consultancy costs	806	1,670
Establishment	2,343	1,902
Premises	11,234	11,262
Transport (including patient travel)	712	589
Depreciation on property, plant and equipment	6,823	4,569
Amortisation on intangible assets	634	130
Net impairments	(930)	4,711
Movement in credit loss allowance: contract receivables / contract assets	133	118
Increase/(decrease) in other provisions	115	42
Change in provisions discount rate(s)	45	(11)
Audit fees payable to the external auditor		
audit services- statutory audit	76	70
other auditor remuneration (external auditor only)	3	8
Internal audit costs	105	142
Clinical negligence	8,366	8,690
Legal fees	110	108
Insurance	172	331
Research and development	536	549
Education and training	1,844	1,181
Rentals under operating leases	1,382	1,016
Redundancy	697	127
Car parking & security	801	1,106
Hospitality	29	17
Losses, ex gratia & special payments	50	21
Other services, eg external payroll	326	359
Other	713	931
Total	**300,162**	**280,533**
Of which:		
Related to continuing operations	300,162	280,533
Related to discontinued operations		-

Staff and Executive directors costs includes an employers pension increase of £7.3m, relating to in increase of 6.3% in this contribution from 1 April 2019. An equal amount is included in clinical income.

Depreciation has increased as a result of revised RCIS guidance issued in November 2019 relating to asset lives.

Note 6.2 Other auditor remuneration

	2019/20 £000	2018/19 £000
Other auditor remuneration paid to the external auditor:		
Audit-related assurance services	3	8
Total	3	8

Note 6.3 Limitation on auditor's liability

The limitation on auditor's liability for external audit work is £1m (2018/19: £1m).

NOTE 7 IMPAIRMENT OF ASSETS

	2019/20 £000	2018/19 £000
Net impairments charged to operating surplus / deficit resulting from:		
Changes in market price	(1,043)	4,711
Other	113	-
Total net impairments charged to operating surplus / deficit	**(930)**	**4,711**
Impairments charged to the revaluation reserve	395	3,894
Total net impairments	**(535)**	**8,605**

The change in market price impairment relates to the impact of the valuationof the Trust estate, taking into consideration the impact of the Covid19 pandemic. The 2018/19 figure reflects the impact of the quinquennial valuation of the estate undertaken as at 31 March 2019.

NOTE 8 EMPLOYEE BENEFITS

	2019/20 Total £000	2018/19 (Restated) Total £000
Salaries and wages	153,581	141,780
Social security costs	14,410	13,226
Apprenticeship levy	747	683
Employer's contributions to NHS pensions	24,098	15,430
Pension cost - other	22	13
Termination benefits	697	127
Temporary staff (including agency)	16,110	14,759
Total gross staff costs	**209,665**	**186,018**
Recoveries in respect of seconded staff	(151)	(33)
Total staff costs	**209,514**	**185,985**
Of which:		
Costs capitalised as part of assets	1,503	681

Employee benefits are included in operating expenses within Research and development, education and training and Staff and Executive Directors costs

The employers contribution to NHS pension schemes includes £7,329k reflecting the increase in employer pension conributions from 1 April 2019. This represented an increase from 14.38% to 20.68%.

Recoveries in respect of seconded staff have been restated for 2018/19 in order to analyse this from salaries and wages.

Note 8.1 Retirements due to ill-health

During 2019/20 there was 1 early retirement from the Trust agreed on the grounds of ill-health (4 in the year ended 31 March 2019). The estimated additional pension liabilities of these ill-health retirements is £50k (£180k in 2018/19).

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

NOTE 9 PENSION COSTS

Past and present employees are covered by the provisions of the two NHS Pension Schemes. Details of the benefits payable and rules of the Schemes can be found on the NHS Pensions website at www.nhsbsa.nhs.uk/pensions. Both are unfunded defined benefit schemes that cover NHS employers, GP practices and other bodies, allowed under the direction of the Secretary of State in England and Wales. They are not designed to be run in a way that would enable NHS bodies to identify their share of the underlying scheme assets and liabilities. Therefore, each scheme is accounted for as if it were a defined contribution scheme: the cost to the NHS body of participating in each scheme is taken as equal to the contributions payable to that scheme for the accounting period.

In order that the defined benefit obligations recognised in the financial statements do not differ materially from those that would be determined at the reporting date by a formal actuarial valuation, the FReM requires that "the period between formal valuations shall be four years, with approximate assessments in intervening years".

An outline of these follows:

a) Accounting valuation

A valuation of scheme liability is carried out annually by the scheme actuary (currently the Government Actuary's Department) as at the end of the reporting period. This utilises an actuarial assessment for the previous accounting period in conjunction with updated membership and financial data for the current reporting period, and is accepted as providing suitably robust figures for financial reporting purposes. The valuation of the scheme liability as at 31 March 2020, is based on valuation data as 31 March 2019, updated to 31 March 2020 with summary global member and accounting data. In undertaking this actuarial assessment, the methodology prescribed in IAS 19, relevant FReM interpretations, and the discount rate prescribed by HM Treasury have also been used.

The latest assessment of the liabilities of the scheme is contained in the report of the scheme actuary, which forms part of the annual NHS Pension Scheme Accounts. These accounts can be viewed on the NHS Pensions website and are published annually. Copies can also be obtained from The Stationery Office.

b) Full actuarial (funding) valuation

The purpose of this valuation is to assess the level of liability in respect of the benefits due under the schemes (taking into account recent demographic experience), and to recommend contribution rates payable by employees and employers.

The 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 to 20.6% and the Scheme regulations were amended accordingly.

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.

NOTE 10 OPERATING LEASES

Note 10.1 Kettering General Hospital NHS Foundation Trust as a lessor

This note discloses income generated in operating lease agreements where Kettering General Hospital NHS Foundation Trust is the lessor.

The Trust has four lease arrangements, one relating to a telecommunications mast, the other three relating to franchise operations providing amenities for patients, staff and visitors. These three leases contain a profit share element included in contingent rent.

	2019/20 £000	2018/19 £000
Operating lease revenue		
Minimum lease receipts	177	172
Contingent rent	97	80
Total	**274**	**252**

	31 March 2020 £000	31 March 2019 £000
Future minimum lease receipts due:		
- not later than one year;	177	172
- later than one year and not later than five years;	681	674
- later than five years.	28	186
Total	**886**	**1,032**

Note 10.2 Kettering General Hospital NHS Foundation Trust as a lessee

This note discloses costs and commitments incurred in operating lease arrangements where Kettering General HospitalNHS Foundation Trust is the lessee.

The Trust has thirteen land and building lease arrangements relating to services provided from other sites, car parking and office arrangements. In addition, the Trust leases equipment, including all of the printers for the Trust, and several vehicles for departments who work across sites.

	2019/20 £000	2018/19 £000
Operating lease expense		
Minimum lease receipts	1,382	1,016
Total	**1,382**	**1,016**

	31 March 2020 £000	31 March 2019 £000
Future minimum lease receipts due:		
- not later than one year;	1,132	1,043
- later than one year and not later than five years;	2,822	2,661
- later than five years.	2,819	2,637
Total	**6,773**	**6,341**
Future minimum sublease payments to be received	-	-

In 2019/20, 6 property arrangements with NHS Property Services Ltd and part of the Trusts Boiler hire arrangements were reclassified as leases (£285k of minimum lease payment). In 2018/19 these were included in property expenses.

NOTE 11 FINANCE INCOME

Finance income represents interest received on assets and investments in the period.

	2019/20 £000	2018/19 £000
Interest on bank accounts	90	81
Other finance income	1	1
Total finance income	**91**	**82**

NOTE 12.1 FINANCE EXPENDITURE

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

	2019/20 £000	2018/19 £000
Interest expense:		
Loans from the Department of Health and Social Care	3,779	3,339
Finance leases	17	18
Total interest expense	**3,796**	**3,357**
Unwinding of discount on provisions	1	-
Other finance costs	1	-
Total finance costs	**3,798**	**3,357**

Note 12.2 The late payment of commercial debts (interest) Act 1998 / Public Contract Regulations 2015

The Trust made no payments of interest under the late payment of commercial debts (interest) Act.

NOTE 13 OTHER GAINS / (LOSSES)

	2019/20 £000	2018/19 £000
Gains on disposal of assets	87	18
Losses on disposal of assets	-	(46)
Total gains / (losses) on disposal of assets	**87**	**(28)**
Total other gains / (losses)	**87**	**(28)**

NOTE 14 INTANGIBLE ASSETS - 2019/20

	Software licences £000	Total £000
Valuation / gross cost at 1 April 2019 - brought forward	**4,793**	**4,793**
Additions	3,905	**3,905**
Impairments	(113)	**(113)**
Valuation / gross cost at 31 March 2020	**8,585**	**8,585**
Amortisation at 1 April 2019 - brought forward	**2,034**	**2,034**
Provided during the year	634	**634**
Amortisation at 31 March 2020	**2,668**	**2,668**
Net book value at 31 March 2020	**5,917**	**5,917**
Net book value at 1 April 2019	**2,759**	**2,759**

Note 14.1 Intangible assets - 2018/19

	Software licences £000	Total £000
Valuation / gross cost at 1 April 2018 - brought forward	**3,583**	**3,583**
Additions	1,210	**1,210**
Valuation / gross cost at 31 March 2019	**4,793**	**4,793**
Amortisation at 1 April 2018 - brought forward	**1,904**	**1,904**
Provided during the year	130	**130**
Amortisation at 31 March 2019	**2,034**	**2,034**
Net book value at 31 March 2019	**2,759**	**2,759**
Net book value at 1 April 2018	**1,679**	**1,679**

In January 2020, the Audit Committee reviewed, and did not amend, the policy for valuing Intangible assets for 2019/20.

NOTE 15.1 PROPERTY, PLANT AND EQUIPMENT - 2019/20

	Land £000	Buildings excluding dwellings £000	Assets under construction £000	Plant & machinery £000	Information technology £000	Furniture & fittings £000	Total £000
Valuation/gross cost at 1 April 2019 - brought forward	**4,633**	**116,239**	**361**	**36,435**	**6,708**	**59**	**164,435**
Additions	-	1,712	262	5,023	1,862	-	**8,859**
Impairments	-	(471)	-	-	-	-	**(471)**
Reversals of impairments	-	1,119	-	-	-	-	**1,119**
Revaluations	1,628	(1,519)	-	-	-	-	**109**
Disposals / derecognition	-	-	-	(2,307)	(31)	-	**(2,338)**
Valuation/gross cost at 31 March 2020	**6,261**	**117,080**	**623**	**39,151**	**8,539**	**59**	**171,713**
Accumulated depreciation at 1 April 2019 - brought forward	**-**	**-**	**-**	**24,468**	**3,300**	**23**	**27,791**
Provided during the year	-	3,297	-	2,855	667	4	**6,823**
Revaluations	-	(3,297)	-	-	-	-	**(3,297)**
Disposals / derecognition	-	-	-	(2,307)	(31)	-	**(2,338)**
Accumulated depreciation at 31 March 2020	**-**	**-**	**-**	**25,016**	**3,936**	**27**	**28,979**
Net book value at 31 March 2020	**6,261**	**117,080**	**623**	**14,135**	**4,603**	**32**	**142,734**
Net book value at 1 April 2019	**4,633**	**116,239**	**361**	**11,967**	**3,408**	**36**	**136,644**

Note 15.2 Property, plant and equipment - 2018/19

	Land £000	Buildings excluding dwellings £000	Assets under construction £000	Plant & machinery £000	Information technology £000	Furniture & fittings £000	Total £000
Valuation / gross cost at 1 April 2018 - brought forward	**4,950**	**113,111**	**2,036**	**34,165**	**6,606**	**59**	**160,927**
Additions	-	6,954	52	3,286	821	-	**11,113**
Impairments	(317)	(9,225)	-	-	-	-	**(9,542)**
Reversals of impairments	-	937	-	-	-	-	**937**
Revaluations	-	2,358	-	-	(282)	-	**2,076**
Reclassifications	-	2,104	(1,727)	-	(377)	-	**-**
Disposals / derecognition	-	-	-	(1,016)	(60)	-	**(1,076)**
Valuation/gross cost at 31 March 2019	**4,633**	**116,239**	**361**	**36,435**	**6,708**	**59**	**164,435**
Accumulated depreciation at 1 April 2018 - brought forward	**-**	**-**	**-**	**22,786**	**3,593**	**18**	**26,397**
Provided during the year	-	1,930	-	2,585	49	5	**4,569**
Revaluations	-	(1,930)	-	-	(282)	-	**(2,212)**
Disposals / derecognition	-	-	-	(903)	(60)	-	**(963)**
Accumulated depreciation at 31 March 2019	**-**	**-**	**-**	**24,468**	**3,300**	**23**	**27,791**
Net book value at 31 March 2019	**4,633**	**116,239**	**361**	**11,967**	**3,408**	**36**	**136,644**
Net book value at 1 April 2018	**4,950**	**113,111**	**2,036**	**11,379**	**3,013**	**41**	**134,530**

Note 15.3 Property, plant and equipment financing - 2019/20

	Land £000	Buildings excluding dwellings £000	Assets under construction £000	Plant & machinery £000	Information technology £000	Furniture & fittings £000	Total £000
Net book value at 31 March 2020							
Owned - purchased	6,261	112,795	610	13,682	4,575	32	**137,955**
Finance leased	-	1,488	-	-	-	-	**1,488**
Owned - donated	-	2,797	13	453	28	-	**3,291**
NBV total at 31 March 2020	**6,261**	**117,080**	**623**	**14,135**	**4,603**	**32**	**142,734**

Note 15.4 Property, plant and equipment financing - 2018/19

	Land £000	Buildings excluding dwellings £000	Assets under construction £000	Plant & machinery £000	Information technology £000	Furniture & fittings £000	Total £000
Net book value at 31 March 2019							
Owned - purchased	4,633	111,957	348	11,493	3,368	36	**131,835**
Finance leased	-	1,495	-	28	-	-	**1,523**
Owned - donated	-	2,787	13	446	40	-	**3,286**
NBV total at 31 March 2019	**4,633**	**116,239**	**361**	**11,967**	**3,408**	**36**	**136,644**

NOTE 16 DONATIONS OF PROPERTY, PLANT AND EQUIPMENT

The Trust received donations of equipment and towrds some minor building works from the Kettering General Hospital NHSFT General Charitable Fund of £147k (2018/19 - £98k)

NOTE 17 REVALUATIONS OF PROPERTY, PLANT AND EQUIPMENT

The Trust's land and and building assets are valued on the basis explained in Note 1 to the accounts. Gerald Eve LLP provided an independent valuation of land and building assets (estimated fair value and remaining useful life) as at 31 March 2020. This valuation took into accounts, the latest information on the impact of the Covid 19 pandemic, though this not deemed material to the accounts.

NOTE 18 INVENTORIES

	31 March 2020 £000	31 March 2019 £000
Drugs	1,261	1,306
Consumables	2,186	2,270
Energy	19	22
Total inventories	**3,466**	**3,598**
Of which:		
Held at fair value less costs to sell	-	-

Inventories recognised in expenses for the year were £33,526k (2018/19: £32,769k). Write-down of inventories recognised as expenses for the year were £220k (2018/19: £129k).

Due to the Coronavirus Pandemic, and the impact on clinical staff and the Procurement team, the decision was made to not undertake stocktakes where these were not operationally required. The majority of the Trusts stock figures are held within Stores systems and these were unaffected by this. See note 1.4.

NOTE 19.1 RECEIVABLES

	31 March 2020 £000	31 March 2019 £000
Current		
Contract receivables	9,051	4,352
Contract assets	-	2,123
Allowance for impaired contract receivables / assets	(622)	(535)
Prepayments	2,824	1,155
Interest receivable	10	7
VAT receivable	481	208
Other receivables	449	462
Total current receivables	**12,193**	**7,772**
Non-current		
Contract assets	701	1,016
Prepayments	166	53
Total non-current receivables	**867**	**1,069**
Of which receivable from NHS and DHSC group bodies:		
Current	7,007	4,907
Non-current	-	-

The contract receivables figure for 2019/20 includes £2.8m of income to support additional Covid 19 expenditure incurred.

The current prepayments figure includes £662k of prepayments made for Covid 19 related items that were not delivered until after 31 March 2020.

Note 19.2 Allowances for credit losses

	2019/20		2018/19	
	Contract receivables & contract assets £000	All other receivables £000	Contract receivables & contract assets £000	All other receivables £000
Allowances as at 1 April - brought forward	**535**	**-**	**-**	**504**
Impact of implementing IFRS 9 (and IFRS 15) on 1 April 2018			504	(504)
New allowances arising	148	-	123	-
Reversals of allowances	(15)	-	(5)	-
Utilisation of allowances (write offs)	(46)	-	(87)	-
Allowances as at 31 Mar 2020	**622**	**-**	**535**	**-**

NOTE 20 OTHER ASSETS

The Trust hold no Other Assets (2018/19 - nil)

NOTE 21 NON-CURRENT ASSETS HELD FOR SALE

The Trust holds no Non-current assets held for sale (2018/19 - nil)

NOTE 22 CASH AND CASH EQUIVALENTS MOVEMENTS

Cash and cash equivalents comprise cash at bank, in hand and cash equivalents. Cash equivalents are readily convertible investments of known value which are subject to an insignificant risk of change in value.

	2019/20 £000	2018/19 £000
At 1 April	**1,342**	**2,670**
Net change in year	1,477	(1,328)
At 31 March	**2,819**	**1,342**
Broken down into:		
Cash at commercial banks and in hand	55	35
Cash with the Government Banking Service	2,764	1,307
SoCF	**2,819**	**1,342**

Note 22.1 Third party assets held by the Trust

The Trust held no cash and cash equivalents which relate to monies held by The Trust on behalf of patients or other parties. (2018/19 - nil).

NOTE 23.1 TRADE AND OTHER PAYABLES

	31 March 2020 £000	31 March 2019 £000
Current		
Trade payables	4,364	7,910
Capital payables	3,449	2,971
Accruals	4,786	5,634
Social security costs	4,015	3,870
Other payables	3,186	3,829
Total current trade and other payables	**19,800**	**24,214**
Of which payables from NHS and DHSC group bodies:		
Current	1,843	1,930

During March, the Trust settled all approved supplier invoices regardless of age, resulting in a reduction to trade payables.

Note 23.2 Early retirements in NHS payables above

There were no early retirement costs included in NHS paybles (2018/19 - nil).

NOTE 24 OTHER LIABILITIES

	31 March 2020 £000	31 March 2019 £000
Current		
Deferred income: contract liabilities	1,528	1,348
Total other current liabilities	**1,528**	**1,348**

NOTE 25.1 BORROWINGS

	31 March 2020 £000	31 March 2019 £000
Current		
Loans from DHSC	170,187	59,881
Obligations under finance leases	276	299
Total current borrowings	**170,463**	**60,180**
Non-current		
Loans from DHSC	6,680	88,640
Obligations under finance leases	481	757
Total non-current borrowings	**7,161**	**89,397**

The Trust funds its cash deficit position through borrowinfgs from the DHSC. This has led to an increase in revenue borrowings in the year of £20,700k.

Following reforms to the NHS capital and cash regimes for 2020/21, the Trust will, during 2020/21, be issued PDC to enable it to repay all existing DHSC interim loans. This is an adjusting event after the reporting period but required all interim loans to be presented as current borrowings. The Trust has one DHSC capital loan that will not be repaid under these arrangements and that is reflected in current loans from DHSC at £1,480k and in non current loans from DHSC. The interest payable as at 31 March 2020 and included in borrowings above will be paid by the Trust during 2020/21.

Note 25.2 Reconciliation of liabilities arising from financing activities - 2019/20

	DHSC £000	Leases £000	Total £000
Carrying value at 1 April 2019	**148,521**	**1,056**	**149,577**
Cash movements:			
Financing cash flows - payments and receipts of principal	28,247	(299)	**27,948**
Financing cash flows - payments of interest	(3,680)	(17)	**(3,697)**
Non-cash movements:			
Application of effective interest rate	3,779	17	**3,796**
Carrying value at 31 March 2020	**176,867**	**757**	**177,624**

Note 25.3 Reconciliation of liabilities arising from financing activities - 2018/19

	DHSC £000	Leases £000	Total £000
Carrying value at 1 April 2018	**119,428**	**1,359**	**120,787**
Cash movements:			
Financing cash flows - payments and receipts of principal	28,407	(303)	**28,104**
Financing cash flows - payments of interest	(3,170)	(18)	**(3,188)**
Non-cash movements:			
Impact of implementing IFRS 9 on 1 April 2018	517	-	**517**
Application of effective interest rate	3,339	18	**3,357**
Carrying value at 31 March 2019	**148,521**	**1,056**	**149,577**

NOTE 26 FINANCE LEASES

Note 26.1 Kettering General Hospital NHS Foundation Trust as a lessor

The Trust held no finance leases as a lessor (2018/19 - nil).

Note 26.2 Kettering General Hospital NHS Foundation Trust as a lessee

Obligations under finance leases where the trust is the lessee. The Trust holds one finance lease, for a car park deck.

	31 March 2020 £000	31 March 2019 £000
Gross lease liabilities	**793**	**1,110**
of which liabilities are due:		
- not later than one year;	288	299
- later than one year and not later than five years;	505	811
Finance charges allocated to future periods	(36)	(54)
Net lease liabilities	**757**	**1,056**
of which payable:		
- not later than one year;	276	299
- later than one year and not later than five years;	481	757

NOTE 27.1 PROVISIONS FOR LIABILITIES AND CHARGES ANALYSIS

	Pensions: injury benefits £000	Legal claims £000	Restructuring £000	Total £000
At 1 April 2019	**461**	**429**	**-**	**890**
Change in the discount rate	**45**	**-**	**-**	**45**
Arising during the year	**12**	**550**	**50**	**612**
Utilised during the year	(23)	(431)	-	**(454)**
Reversed unused	**-**	**(36)**	**-**	**(36)**
Unwinding of discount	**1**	**-**	**-**	**1**
At 31 March 2020	**496**	**512**	**50**	**1,058**
Expected timing of cash flows:				
- not later than one year;	23	512	50	**585**
- later than one year and not later than five years;	92	-	-	**92**
- later than five years.	381	-	-	**381**
Total	**496**	**512**	**50**	**1,058**

The provision for legal claims includes non-clinical claims made against the Trust. The amounts shown for these provisions are based on advice provided by NHS Resolution and the Trusts solicitors. In addition to the provision, contingent liabilities for non clinical negligence claims are given in note 28.

The provision for restructuring relates to the Collaboration arrangements with Northampton General Hospital NHS Trust, which will be formalised in 2020/21.

Note 27.2 Clinical negligence liabilities

At 31 March 2020, £175,488k was included in provisions of NHS Resolution in respect of clinical negligence liabilities of Kettering General Hospital NHS Foundation Trust (31 March 2019: £181,094k).

NOTE 28 CONTINGENT ASSETS AND LIABILITIES

	31 March 2020 £000	31 March 2019 £000
Value of contingent liabilities		
NHS Resolution legal claims	(53)	(46)
Gross value of contingent liabilities	**(53)**	**(46)**
Amounts recoverable against liabilities	-	-
Net value of contingent liabilities	**(53)**	**(46)**
Net value of contingent assets	**-**	**-**

The Trust's contingent liabilities relate to NHS Resolution non-clinical claims which have also been provided for in provisions, note 27.1.

The Trust is aware of a Court of Appeal case relating to Employee benefits which could impact on the Trust. As at 31/03/2020, the Trust cannot quantify this contingent liability.

NOTE 29 CONTRACTUAL CAPITAL COMMITMENTS

	31 March 2020 £000	31 March 2019 £000
Property, plant and equipment	3,900	4,271
Intangible assets	3,289	1,418
Total	**7,189**	**5,689**

The increase in capital commitments relates to the on going roll out of Electronic Patient records and capital orders relating to the Covid19 pandemic.

NOTE 30 FINANCIAL INSTRUMENTS

International Financial Reporting Standard (IFRS) 7 requires disclosure of the role that financial instruments have had during the period in creating or changing the risks an entity faces in undertaking its activities. Financial Instruments play a much more limited role in creating or changing risk within the NHS than would be typical of commercial business entities. The Trust has limited powers to borrow or invest surplus funds. Financial assets and liabilities are generated by day-to-day operational activities rather than being held to change the risks facing the Trust in undertaking its activities.

Note 30.1 Financial risk management

Credit risk

Due to the continuing service provider relationship that the Trust has with local Clinical Commissioning Groups (CCGs) and the way those CCGs are financed, the Trust is not exposed to the same degree of credit risk faced by some entities. Those items in dispute or under query have been assessed and a provision for impairment made, if deemed appropriate. Totals are included in the trade and other receivables in note 19.1.

Liquidity risk

The Trust's net operating costs are incurred mainly in respect of delivering on legally-binding long term contracts with CCGs. CCGs themselves are financed by resources voted annually by Parliament. As noted above, this means that the Trust is not exposed to quite the same level of risk as some other business entities, but as has been evidenced during the year, if the Trust experiences liquidity issues, provided certain criteria can be evidenced, Department of Health and Social Care funding (not categorised as a Financial Instrument) may become eligible for drawdown to ensure the Trust can continue to meet its liabilities as they fall due. As noted in the 'Going Concern' disclosure in note 1, the Board has reasonable expectation that the Trust will have access to adequate resources in the next 12 months.

Market risk

The Trust has borrowed from the government for capital expenditure and revenue support, subject to affordability as confirmed by NHS Improvement. The borrowings are for 1 – 25 years, in line with the life of the associated assets or agreed repayment terms, and interest is charged at a rate fixed for the life of the loan. The Trust therefore has low exposure to interest rate fluctuations.

Foreign currency risk

The Trust is principally a domestic organisation with the great majority of transactions, assets and liabilities being in the UK and sterling based. The Trust has no overseas operations and therefore has low exposure to currency rate fluctuations.

Note 30.2 Carrying values of financial assets

	Held at amortised cost £000	Total book value £000
Carrying values of financial assets as at 31 March 2020		
Trade and other receivables excluding non financial assets	9,401	**9,401**
Cash and cash equivalents	2,819	**2,819**
Total at 31 March 2020	**12,220**	**12,220**
Carrying values of financial assets as at 31 March 2019		
Trade and other receivables excluding non financial assets	7,425	**7,425**
Cash and cash equivalents	1,342	**1,342**
Total at 31 March 2019	**8,767**	**8,767**

Note 30.3 Carrying values of financial liabilities

	Held at amortised cost £000	Total book value £000
Carrying values of financial liabilities as at 31 March 2020		
Loans from the Department of Health and Social Care	176,867	**176,867**
Obligations under finance leases	757	**757**
Trade and other payables excluding non financial liabilities	13,388	**13,388**
Provisions under contract	1,058	**1,058**
Total at 31 March 2020	**192,070**	**192,070**
Carrying values of financial liabilities as at 31 March 2019		
Loans from the Department of Health and Social Care	148,521	**148,521**
Obligations under finance leases	1,056	**1,056**
Trade and other payables excluding non financial liabilities	18,197	**18,197**
Provisions under contract	890	**890**
Total at 31 March 2019	**168,664**	**168,664**

Note 30.4 Maturity of financial liabilities

	31 March 2020 £000	31 March 2019 £000
In one year or less	184,448	78,829
In more than one year but not more than two years	1,802	32,315
In more than two years but not more than five years	4,679	41,028
In more than five years	1,141	16,492
Total	**192,070**	**168,664**

Note 30.5 Fair values of financial assets and liabilities

The carrying value of financial assets and liabilities is a reasonable approximation of fair value.

NOTE 31 LOSSES AND SPECIAL PAYMENTS

	2019/20		2018/19	
	Total number of cases Number	Total value of cases £000	Total number of cases Number	Total value of cases £000
Losses				
Cash losses	31	15	15	8
Bad debts and claims abandoned	19	32	21	64
Stores losses	3	220	3	130
Total losses	**53**	**267**	**39**	**202**
Special payments				
Ex-gratia payments	69	68	84	85
Total special payments	**69**	**68**	**84**	**85**
Total losses and special payments	**122**	**335**	**123**	**287**
Compensation payments received		-		-

NOTE 32 RELATED PARTIES

During the year none of the Trust Board members, members of the key management staff, or parties related to any of them, have undertaken any material transactions with Kettering General Hospital NHS Foundation Trust.

The Department of Health and Social Care is regarded as a related party. During the year the Trust has had a significant number of material transactions with the Department, and with other entities for which the Department is regarded as the parent. *These include:*

Nene CCG
Corby CCG
NHS England
Northampton General Hospital NHS Trust
Northamptonshire Healthcare NHS Foundation Trust
University Hospitals of Leicester NHS Trust
Cambridgeshire and Peterborough CCG
East Leicester & Rutland CCG
NHS Resolution
NHS Blood & Transplant
Health Education England
NHS Improvement

In addition, the Trust has had a number of material transactions with other government departments and other central and local government bodies. Most of these transactions have been with the NHS Business Services Authority in respect of pension contributions, HMRC in respect of taxation and local councils in relation to business rates.

The Trust has also received revenue payments and capital donations from Kettering General Hospital NHSFT General Charitable Funds whose Corporate Trustee is the Trust Board. An administration charge of £25k (2018/19: £22k) was made by the Trust to the charity.

NOTE 33 CHARITABLE FUNDS CONSOLIDATION

The Foundation Trust is the Corporate Trustee to Kettering General Hospital NHSFT General Charitable Funds. The Foundation Trust has assessed its relationship to the charitable fund and determined it to be a subsidiary because the Foundation Trust has the power to govern the financial and operating policies of the charitable fund so as to obtain benefits from its activities.

The Trust Board believe that the transactions involving the charitable fund are not material to the Foundation Trust accounts and have chosen not to consolidate the accounts on this basis.

NOTE 34 PRIOR PERIOD ADJUSTMENTS

The Trust had no prior period adjustments.

NOTE 35 EVENTS AFTER THE REPORTING DATE

Reforms to the NHS cash and capital regime for 20/21 explain that issues of PDC to the Trust during 2020/21 will enable the Trust to repay DHSC interim loans existing at 31st March 2020. All relevant loans have been reclassified as current borrowings see note 25.1.

On 1st April 2020, Nene and Corby CCG merged to form Northamptonshire CCG. This CCG will be the Trust's main commissioner for 2020/21.

In April 2020, the Trust announced that the Chief Executive Officer (CEO) has been appointed as the joint CEO for the group management arrangement with Northampton General Hospital. Other posts, including Chief People Officer and Director of Finance will be appointed to during 2020/21.

NOTES

NOTES

NHS
Kettering General Hospital
NHS Foundation Trust