UNIVERSITY OF LEICESTER
Affiliated Teaching Hospital

NHS
Kettering General Hospital
NHS Foundation Trust

Annual Report and Accounts 2020/21

Kettering General Hospital NHS Foundation Trust

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

Contents

1 Performance Report

1.1 Overview

1.1.1 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 2020/21. 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 joint statement from our Chair and Group Chief Executive.

1.1.2 Trust Chair and Chief Executive's Overview

This year has been a year like no other we have experienced in the history of the NHS. The COVID pandemic has placed significant challenges both on our services and upon our people; and we have all to some degree experienced the tragic loss and suffering of people we care for, or care about.

We would therefore like to begin this year's annual report with a heartfelt thank you. Thank you to our dedicated colleagues across the Trust for everything you have done under the most difficult of circumstances to ensure our patients continue to experience high quality, compassionate care. Thank you to our much-valued volunteers for helping us to keep services going and for supporting our colleagues, our patients and our carers in every way you possibly can. Thank you to patients and carers for your patience, understanding and support throughout. Thank you to our local communities for the strength of solidarity you have shown towards our NHS colleagues and for your kind donations which have helped to boost morale when we needed it the most. Thank you to our health and care partners for your ongoing assistance and collaboration which have enabled us all to make an important contribution to health and wellbeing across Northamptonshire; and thank you to our Governors for your ongoing commitment to the Trust on behalf of local people, and in ensuring that our services continue to improve.

Our focus in 2020/21 has understandably been on responding to the pandemic, and we are proud of our efforts in doing so. Not only have we needed to adapt and flex our services more so than ever before, but we have introduced many health and wellbeing initiatives to support our colleagues, some of which you can read about in this report.

If it is at all possible to find a silver lining, the pandemic has undeniably driven significant innovation and positive change, not least the accelerated implementation of many aspects of our digital strategy. Virtual outpatient consultations and community monitoring are now a reality, and we have implemented new technology in weeks instead of months – or even years. We can look forward to enjoying more of the same, which means a sustainable difference to how we provide care and how people access our services.

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 2020, we welcomed Satya Biswas, Eric Jackson and Sheila White as public governors (Sheila was already a Stakeholder Governor, representing Healthwatch) and Sreejith Nair and Faizal Rayan to represent our staff. Congratulations also to Peter Woolliscroft and Mabel Blades who, having been re-elected to the Council, were appointed to the positions of Lead and Deputy Lead Governor respectively.

The Trust leadership team has remained stable during the past year with two Non-Executive Directors, Janet Gray and Chris Welsh, reappointed to lead our quality and safety and people committee work programmes respectively. Alan Burns was also reappointed to serve a second term as Trust Chair during

the year. We have further developed our Group Leadership Team, appointing Mark Smith as Chief People Officer in August and Andy Callow as Group Chief Digital Information Officer in December 2020. During the year we have also appointed Jon Evans to the position of Group Chief Finance Officer: Jon starts in June 2021. We also welcomed Deborah Needham as our Hospital Chief Executive in March.

Despite the pressures the pandemic has imposed upon us we have made major progress developing our group model with Northampton General Hospital NHS Trust. Following extensive engagement with clinical leaders, staff, governors, patient and carer representatives, partners, and others we approved the 'Dedicated to Excellence' Group strategy in January 2021. We will launch the group strategy this coming Summer (see Section 1.1.3 below for further information).

Since last year we have progressed proposals for major investment in our hospital building programme. We now have a granular, ambitious programme for which we have the funding needed to start with phase one. This will see the building of a new urgent care hub beginning in 2023-2024.

Finally, we would like to thank our staff once again for their dedication and commitment during an unprecedented year for healthcare workers. This year's staff survey results showed our best ever engagement score with 58% of staff taking the opportunity to let us know their experience of working at the Trust. We will continue to look after staff as we embark upon elective recovery in the year to come, whilst increasing efficiency, reducing costs and turning the aspirations of the Group Strategy into demonstrable benefits for our patients, staff and the population of Northamptonshire – look out for the official launch in July 2021 for more information.

We hope you enjoy reading this report, which truly demonstrates the adage 'triumph over adversity'. As always, we welcome your comments and feedback and look forward to hearing from you.

Best Wishes

Alan Burns, Chair

Simon Weldon, Chief Executive Officer

1.1.3 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), known as the Northamptonshire Health and Care Partnership (NHCP), with Northampton General Hospital NHS Trust, Northamptonshire Healthcare NHS Foundation Trust, Northamptonshire County Council (from 1 April 2021, split into two organisations, covering the north and west of the county), Northamptonshire Clinical Commissioning Group (CCG), General Practice federations and alliances, and Voluntary Impact Northamptonshire.

We are working closely with system partners to develop an Integrated Care System (ICS) which, following the publication of the Government White Paper, 'Integration and Innovation: working together to improve health and social care for all' in February 2021, will create new statutory body, replacing the CCG, to deliver a shared vision for integrated and digitally enabled care to meet whole-population needs. We will continue to engage fully with system partners to take forward conversations around integrated care prior to the new structures formally coming into being in April 2022. Integrated work is underway in a number of areas, with the work of the Integrated Care Across Northamptonshire (iCAN) programme in the process of procuring a delivery partner to ensure people can live well, stay well, and only be admitted to hospital when they absolutely need to.

Organisational structure

Anyone who lives in England or works for our Foundation Trust can become a Member. Members elect our Council of Governors, who appoint the Chair and Non-Executive Directors as well as approve the appointment of our Group Chief Executive (representatives from key partner organisations such as local councils are appointed as Governors). 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 (three clinical, one 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 the Northamptonshire CCG, NHS England Specialised Commissioners and other CCGs and Public Health bodies.

Developing a shared vision of the future

In January 2020, we announced our intention to form a hospital group with Northampton General Hospital NHS Trust, and in July 2020 appointed Simon Weldon as Group Chief Executive of our hospital, and of Northampton General Hospital NHS Trust. This is not an organisational merger but sees both Trusts working collaboratively to improve the quality of the care we provide, enable more equitable access to services across the county, and make better use of our valuable resources.

Over the past year we have been developing plans and arrangements with a view to launching the new Group in Summer 2021. One of the first steps was to develop a common vision and mission, supported by shared priorities and values. From the outset we were committed to involving staff, governors and volunteers, patient representatives, healthcare partners and other stakeholders in this activity.

Over the course of four months, many facilitated discussions were held within open forums, regular meetings and committees, and with targeted groups using on-line engagement tools. The COVID pandemic provided a challenging backdrop for the engagement programme, and most activities were undertaken virtually owing to the travel restrictions and social distancing measures in place.

More than 1,000 people were directly involved in discussions, with staff across both organisations also receiving regular updates about the emerging vision, mission and values. Staff and members of the public were invited to attend open events and share information via the #LetsTalkNow email, and activities were also publicised within the local media.

We engaged:

- Staff across both organisations
- KGH Governors
- Staffside
- Staff forums representing Black, Asian and Minority Ethnic (BAME), disabilities, equalities and COVID shielding groups, as well as the newly formed Joint Staff Reference Group
- Patient groups, including representatives from Healthwatch/Young Healthwatch, Carers Northamptonshire, Kettering Mind and Northamptonshire Association for the Blind - such as the Patient Experience & Involvement Steering Group, the Patient & Carer Experience & Engagement Group, the Patient and Family Partners Group and the Prostate Cancer Support Group
- Volunteers
- Discussion session with Northants Healthwatch/Young Healthwatch
- Engagement with health and care partners, including representatives from mental health, primary and community care, commissioners, local authorities and the Local Medical Committee

‘Dedicated to Excellence’ Group Strategy – agreed January 2021

Our Group vision:

Dedicated to outstanding patient care and staff experience by becoming a university hospital group and a leader in clinical excellence, inclusivity and collaborative healthcare.

Our Group mission:

Provide safe, compassionate and clinically excellent patient care by being an outstanding employer for our people, creating opportunity and supporting innovation, and working in partnership to improve local health and care services.

Our new values:

The Group's core values directly reflect the most common themes shared by staff, patient representatives and other stakeholders during the engagement programme. The top aspirational values we need to nurture have been woven into the vision and mission statements and will form an important part of our Group organisational development plans.


NHS
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STAFF AND PUBLIC EVENTS
NOVEMBER 2020
A CHANCE FOR US TO SHARE OUR VISION (THE FUTURE)
"DEDICATED TO EXCELLENCE"
THIS IS ALWAYS DEVELOPING BASED ON YOUR FEEDBACK
AND OUR MISSION
AND OUR PRIORITIES
TO PROVIDE A BETTER PATIENT EXPERIENCE
AND CREATING SOMETHING NEW
BUILDING ON OUR SEPARATE HISTORIES
TOGETHER WE CAN DO GREAT THINGS
THE DOOR IS OPEN FOR COLLABORATION
BY BEING A LEADER IN:
CLINICAL EXCELLENCE
INCLUSIVITY
COLLABORATIVE HEALTHCARE
OUR VISION IS FOR OUTSTANDING PATIENT CARE AND STAFF EXPERIENCE
****!!
CAR PARKS!!
THE RIGHT CARE AT THE RIGHT PLACE IN THE RIGHT TIME
TO ATTRACT TALENT
HEY!
TO PROVIDE CHOICE
IT'S NOT ABOUT SAVING MONEY...
...IT'S ABOUT ENSURING HIGH QUALITY, CONSISTENT SERVICES FOR EVERYONE IN NORTHANTS
WE HAVE LISTENED TO DIVERSE GROUPS
ACCOUNTABILITY
KINDNESS, COMPASSION AND CARING
SUPPORTIVE, PATIENT
RESPECT
OUR EMERGING CORE VALUES
YOU ARE HELPING US DEVELOP OUR VALUES
THEY REFLECT WHO WE ARE
HEALTH WATCH, HEALTH AND CARE PARTNERS AND ACROSS THE ORGANISATION AT ALL LEVELS
ALL CONTRIBUTING TO HOW THE FUTURE IS SHAPED
TO PROVIDE EVERYONE WITH A VOICE
INTEGRITY HONESTY TRUST
OUR EMERGING ASPIRANT VALUES
INNOVATIVE
INCLUSIVITY
EXCELLENCE
COLLABORATION
SUPPORT
AND OUR CONVERSATIONS WITH YOU...
... HAVE GIVEN US KEY AREAS OF FOCUS
ALL OF WHICH...
COLLABORATION
BECOMING A UNIVERSITY HOSPITAL GROUP
HELPING ATTRACT TOP TALENT
INCLUSIVITY
DIGITAL INNOVATION
INCLUDING UNIVERSAL ACCESS TO NOTES
COMMUNICATION AND INFORMATION SHARING
ACROSS ALL STAKEHOLDER GROUPS HERE AND BEYOND
... WILL HELP US SUCCEED IN OUR MISSION
SAFE
COMPASSIONATE
CLINICALLY EXCELLENT
PATIENT CARE
BY BEING AN OUTSTANDING EMPLOYER
#1
CREATING OPPORTUNITY AND SUPPORTING INNOVATION
WORKING IN PARTNERSHIP TO IMPROVE LOCAL HEALTH AND CARE SERVICES
INCLUDING SOCIAL

1.1.4 History of Kettering General Hospital NHS Foundation Trust

Kettering General Hospital was first opened in 1897 and has grown significantly over the intervening 124 years, 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. We have progressed these schemes at pace during the year, and submitted a Strategic Outline Case to government for approval for a phased redevelopment scheme in March 2021. Subject to approval, we will proceed with the preparation of Outline and Full Business Cases in accordance with HM Treasury approved processes over the next 12 months.

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 have committed to working collaboratively as part of a Group Model, though each remains 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. Following further inspections, the Trust exited Special Measures in 2019.

1.1.5 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 Board Committees on a monthly basis to ensure that controls and assurances are sufficient and that mitigation plans are being implemented and are taking effect.

1.1.6 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 Audit Committee agreed the Trust's Going Concern Assessment at its meeting on 26 April 2021.

1.1.7 Equality of Service Delivery to Different Groups

KGH has due regard to the aims of the public sector equality duty and makes public statutory Equality, Diversity and Inclusion (EDI) documentation on our public website here. Our strategy team works with Northamptonshire public health to understand the local population and their healthcare needs as part of the Joint Strategic Needs Assessment. Patient experience scores are collected and reported by equality status these are reported through patient experience team. Performance KPIs against equality of service is defined and delivered locally by services as part of their Quality/Equality Impact Assessments.

Since December 2020 we have been working with the wider National and Northamptonshire healthcare system to actively redress the racial imbalance of Covid vaccination update given the disproportionate

outcomes of Covid on those patients. Actively promoting via social media the benefits of Covid vaccinations to people from Black, Asian and Ethnic communities.

1.1.8 Kettering Improvement, Innovation, Transformation and Clinical Effectiveness (KIITE)

In April 2020 the Trust introduced a new function to bring together Improvement, Innovation Transformation and clinical Effectiveness (KIITE). The key role of this team is to support and facilitate Continuous Quality Improvement (CQI) through the delivery of CQI strategy. The approach taken is based on the "Inch-wide Mile Deep" principle the Trust agreed to support the delivery of CQI priorities for 2020/21:

- To build a CQI Infrastructure including QI capacity & capability
- Improve Organisational culture
- Strengthen Clinical Effectiveness
- To improve Frailty and Safe & Timely discharge

The Trust has made good progress against each of these priorities during the year, for example:

- Launching a regular programme of YOKOTEN (a Japanese term to denote the horizontal deployment of learning) Sessions to embed quality improvement through best practice sharing;
- Recognising best practice quality improvement projects and Clinical Audits at the inaugural CQI Awards held in November 2020 with Board Members and key partners within the local health system in attendance;
- Full implementation of new software to capture CQI improvements and provide assurance;
    - Demonstrable examples of the use of quality improvement tools to deploy change at pace e.g. the move of paediatric patients to provide additional access to oxygen services needed to support adults requiring that level of support with Covid.
    - Participation in the 'Integrated Care Across Northamptonshire' (ICAN) Programme to develop a series of pillars, supported by the KIITE Team, to improve patient flow and work collaboratively within the local health system to enable earlier discharge to the community.

The Team will be working to consolidate and develop CQI during 2021/22, focussing on alignment with transformation made possible by the Group Model with Northampton.

1.2 Performance Summary

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 (BAF) 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; over 100 risk registers, identified from ward to board, are in place. BAF reviews are overseen by the Audit Committee.

In addition to the BAF, an overarching COVID-19 pandemic risk register has been developed, aligning risks to quality and safety, business operations and infrastructure. This register is submitted to the Board and Committees alongside the BAF.

Assurance and escalation of the Trust's performance on quality, risk, operational performance and finance is achieved through management action and accountabilities through the Hospital Management Team.

Links to the Integrated Governance Reports, considered by the Board of Directors during the year, are available on our public website: https://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: https://www.kgh.nhs.uk/about-us-kgh-together-magazine.

SUMMARY PERFORMANCE DASHBOARD – 2020/21

To provide high quality care to individuals, communities and the population we serve – Quality

- Progress and actions for the **Quality Priorities** continued during 2020/21. Of the nine priorities, five were achieved: Nutrition and Hydration; Smoking in pregnancy; patient engagement and the full implementation of electronic prescribing and utilisation of the Perfect Ward App. Three were partially achieved: pain assessment in the emergency department; patient experience steering groups and improving documentation around Mental Capacity decisions. One was not achieved, relating to complaints (see below). Full details are set out in the Quality Report 2020-2021.
- Responding to **patient complaints** failed to achieve the target. In March 2020, the Trust suspended the complaints process in line with national guidance to ensure that frontline staff were able to provide urgent care and support during the COVID-19 pandemic. Responses to questions and concerns both formal and local resolution continued supported by the complaints team and some staff who were shielding. The annual compliance with responding to complaints within timeframe was 47%.
- **Falls** – 2020 saw an increase in patient falls resulting in harm leading to poorer outcomes and experience for our patients. Actions have been implemented and along with the activities emerging from our two Falls Summits have we aim to reduce falls with harm by 33%. This has been selected as a Quality Priority for 2021/22
- **Mental Capacity assessment** documentation has also been included as a Quality Priority for 2021/22 in relation to the robust completion of Do Not Attempt Cardiopulmonary Resuscitation decisions and association with Mental Capacity assessment.
- The Quality metrics reported in the Quality Assurance Dashboard and Integrated Governance Report are currently being revised. The new metrics will be focused on outcome measures rather than processes. Previous process measures will be reported through the regular reporting from the Perfect Ward system

To be a strong and effective partner in the wider health and social care community – Operations

- The Trust has consistently achieved the 2-week referral and 31 day **cancer treatment standards**, despite the pressure caused by the Covid-19 pandemic. Performance against the 62-day target was below standard in each month during 2020/2021 as a direct impact of Covid-19 on diagnostic and treatment capacity. This led to an increase in the number of patients waiting over 62 days. The prioritisation of patients on the cancer pathway for treatment in Q4 has caused the backlog of patients to be significantly decreased by the end of the year.
- Performance against the incomplete **Referral to Treatment (RTT)** target was below standard in each month during 2020/2021 as a direct impact of Covid-19 on diagnostic, outpatient and treatment capacity. **KGH was the only NHS acute Trust to report zero 52-week breaches during the calendar year 2020.** The 3rd wave of Covid-19 at the end of December had a significant adverse impact on operating capacity, causing patients to wait more than 52 weeks from referral to treatment. During March 2021, the Trust identified a number of patients that were inappropriately discharged when their new outpatient appointment was cancelled. The referrals were reopened and the patients contacted. Those that needed to be seen were booked to be seen by mid-April 2021. The number of patients waiting more than 52 weeks from referral to treatment was 16 in January 2021, 60 in February 2021 and 89 in March 2021.
- Performance against the **diagnostic standard** has consistently improved throughout the year, though the target was not met due to significantly affected capacity caused by the Covid-19 pandemic. Improvement is expected to continue into 2021/22.

To maintain a fulfilling and developmental working environment for our staff – Workforce

- **Turnover** remained consistently better than target in 2020/21, typical of the wider labour market where Covid 19 has reduced desire/opportunity to change employers. At the end of the year turnover was 8.8% compared to a target of 11%. The Staff Survey in 2020 showed a significant improvement in the number of staff who would recommend KGH as a place to work (67.1%).
- Service improvements have resulted in an increased establishment with which recruitment did not keep pace and hence **vacancy rates** remained above target. Covid interrupted International recruitment, but since travel restrictions were lifted the vacancy rate has begun to improve.
- **Statutory and mandatory training** has remained consistently above target all year. From March - September 2020 the expiry dates of all mandatory training were extended due to covid keeping completion rates high. Since September original expiry dates have remained in place and efforts have been made to encourage staff to complete training. A risk assessment has been conducted to ensure all critical skills on a department by department basis are prioritized.
- **Appraisal completion** rates have been under target during 2020/21 as managers and staff have struggled with operational priorities. An Appraisal Light process has been introduced to give an alternative methodology with a focus on wellbeing, short term priorities and support.
- **Sickness** peaked in April 2020 due to the effects of Covid and again in January 2021, although this second peak was smaller due to enhanced testing and social distancing protocols. Significant provision has been made to support good psychological health for staff in response to the pandemic.

To be a clinical and financially sustainable organisation – Finance

- The Trust ended the financial year with a surplus of £4.1m (2019/20 £12.3m deficit).
- 2020/21 was a year in which the Trust, and the wider NHS, faced unparalleled challenges due to the COVID-19 pandemic. Despite this, the Trust managed to meet its major financial objectives. A simplified financial regime operated in the NHS in 2020/21, with block contract payments for NHS activity and the suspension of the usual Payment by Results national tariff reimbursement.
- All costs were reimbursed in the first half of the financial year and a fixed funding envelope allocated at a system level in the second half, with the expectation that financial performance would reach breakeven at worst. Financial performance was managed at a system level, that being the Northamptonshire Health and Care Partnership (NHCP).
- The Trust financial performance was impacted heavily by the need to support efforts relating to the COVID-19. This resulted in increased pay and non-pay costs in the first half of the year as a result of additional capacity, PPE and wider operational changes required to safely care for our patients, and higher pay costs in the second half of the year as part of the reset plan, to recover elective care capacity, whilst managing the ongoing operational disruption, be it segregation of patients and pathways or lost productivity of hospital capacity due to enhanced safety protocols.
- With the easing of the pandemic, the second half of the year was focused on plans to reset activity for elective and outpatient services and a separate financial plan for September to March was agreed (as part of a system plan) to recognise this. This too was set to deliver a breakeven position.
- The challenge of ensuring safe staffing levels in clinical areas has remained, resulting in higher costs in clinical areas. The continued national shortage of trained staff and higher than usual sickness and absence, due to a second wave of COVID-19, led to an increase in agency costs during the last six months of the year. The Trust has continued to invest in international nurse recruitment and trainee nurse development programmes to reduce nursing vacancy levels and this programme will continue to do so.
- As directed nationally, the focus for 2020/21 has been on ensuring all reasonable resources have been made available to clinical teams to manage the impact of COVID-19 and elective recovery. In 2021/22 the Trust will renew its focus on the delivery of transformation and change schemes that will make improved use of its resources and improve care for its patients.
- There has been £15m of capital investment during the year, to maintain the estate, invest in additional medical equipment, the development of the HIP2 programme and to support the management of COVID-19 through estate reconfiguration and additional medical equipment.

KGH Highlights, 2020/21

April 2020

Respiratory Service Award

The Respiratory Service won the Royal College of Physicians (RCP) Innovation Award for their ambulatory management of spontaneous pneumothorax work – a service which helps to reduce the need for patients with lung conditions to spend time in hospital.

May 2020

Food4Heroes meals for staff

A Food4Heroes scheme to support Kettering General Hospital during the coronavirus emergency delivered its 10,000th meal to staff in less than a month.

Staff from the Old White Hart in Lyddington – who have cooked the meals – have celebrated producing their 10,000th meal – supported by many other local companies.

National award for COVID response

June 2020

The Ophthalmology team at Kettering General Hospital won a national award for its flexibility and unstinting dedication to patients during the Covid-19 pandemic.

The team has won a Cavell Star Award for the way in which they readily agreed to be redeployed to front line services like intensive care, infection control and other wards to support the hospital's response against coronavirus.

Life-saving organ donation

July 2020

NHS Blood and Transplant marked publication of its national annual Transplant Activity report by drawing attention to fifteen people who received life-saving organ transplants thanks to Kettering General Hospital patients who agreed to organ donation.

August 2020

Upgraded Cardiac Catheter Lab procedures rooms completed

The Hospital completed a £2.3m upgrade of two of its Cardiac Catheter Laboratory procedures rooms for heart patients, giving consultant cardiologists and their teams access to the latest in cardiac intervention, x-ray and ultrasound equipment when carrying out potentially life-saving heart procedures.

October 2020

£300k expansion to same-day emergency care service completed

Work was completed on a £300,000 expansion to a major 'second front door' emergency care service for patients.

The Same Day Emergency Care (SDEC) service - based next to the main A&E entrance – is for patients who – with specialist input - can be reviewed, treated and discharged on the same day rather than be admitted to a hospital bed.

September 2020

KGH Team wins prestigious HSJ Award

Kettering General Hospital won a prestigious national HSJ (Health Service Journal) Award for the way it collects and records data about patients to support clinical care. KGH entered its Clinical Coding Transformation Programme in the Operations and Performance category of the awards under the title - Getting it right for our patients, staff and the Trust.

November 2020

KGH achieves nationally-recognised quality standard for collecting information about joint replacement surgery

KGH was awarded the National Joint Registry (NJR) Quality Data Provider certificate for the scrupulous way in which it gathers and submits information to support a national safety system for joint replacements.

December 2020

Intensive Care Matron receives MBE

Matron for Critical Care Services, Joanna Snow, received the award for her services to the NHS and patients, particularly during the Covid-19 pandemic.

January 2021

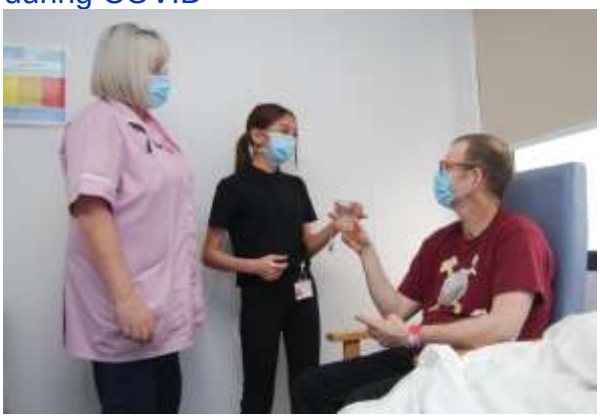
KGH completes contribution to national ongoing research

Kettering General Hospital completed its contribution to a major ongoing national research trial to see if Bio-Detection dogs can sniff out coronavirus in humans.

A total of 200 KGH staff took part in the work to determine whether dogs can be used as a rapid, non-invasive way of detecting the virus.

February 2021

Tresham College students help KGH during COVID



A Ward Host scheme enabled 67 students from Tresham College to support busy Kettering General Hospital staff during the COCID pandemic.

March 2021

Gender Equality Network Launches

KGH launched its first Gender Equality Network to ensure the hospital meets all gender needs.

SIMON WELDON
CHIEF EXECUTIVE

28 JUNE 2021

2 Accountability report

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

2.1 Directors' report

2.1.1 The Board of Directors

Name	Title	Attendance at Board Meetings (Max 10)
Alan Burns	Chairman	9
Simon Weldon	Chief Executive Officer (Group Chief Executive Officer from July 2020)	10
Richard Apps	Director of Integrated Governance	10
Nicci Briggs	Director of Finance (April to August 2020)	4
Anil Pursooth	Interim Director of Finance (From August 2020)	6
Andy Callow	Chief Digital and Information Officer (CDIO) (Group CDIO from January 2021)	9
Andrew Chilton	Medical Director	9
Eileen Doyle (September 2020 to January 2021)	Interim Hospital Chief Executive	5
Deborah Needham (From March 2021)	Hospital Chief Executive	1
Jo Fawcus	Chief Operating Officer (April 2020 to February 2021)	9
Fay Gordon	Interim Chief Operating Officer (from March 2021)	1
Polly Grimmett	Director of Strategy	10
Leanne Hackshall	Director of Nursing & Quality	8
Mark Smith	Chief People Officer	9
Alice Cooper	Non-Executive Director	10
Janet Gray	Non-Executive Director	10
Liisa Janov	Non-Executive Director	10
Lise Llewellyn	Non-Executive Director	9
Trevor Shipman	Non-Executive Director/Vice Chairman/Senior Independent Director	10
Damien Venkatasamy	Non-Executive Director	9
Chris Welsh	Non-Executive Director	10

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 it 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. During the COVID pandemic, we were able to move seamlessly to 'virtual' meetings with a live web broadcast, and will seek the retain the benefits of a hybrid model of in-person and virtual meetings following the pandemic. 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. In early 2021, we introduced a programme on joint development sessions with Northampton General Hospital in order to embed and advance the group model of working.

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.

The Board also receives a patient or staff story focus at every meeting.

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 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. During 2020-2021, the Board formally established Group Committees in Common with Northampton; legally, these are committees of both Boards, undertaking functions under delegated powers from each.

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, with prominent examples during the year including the Travel Plan for the hospital redevelopment and patient experience group informing the development of clinical collaborations with Northampton in the Head and Neck specialty.

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. As a consequence of the COVID-19 pandemic, meetings were held in private, with the transcript of the meeting being made available on the

Trust's website. 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. The Trust Chair confirmed that all Board Members continued to meet Fit and proper requirements, at its meeting in January 2021. An independent review, conducted as part of an assessment of the Trust's preparedness against the CQC's 'Well-Led' domain, confirmed the Trust's arrangements as robust.

Board of Directors Meetings

There were ten formal Board meetings held during 2020/21, six public and four private. Directors' attendance at Board meetings is included in the table at Section 2.1.1 above.

Independent Non-Executive Directors

The independence of the Non-Executive Directors is reviewed annually; having regard to the criteria in the Code of Governance, to identify any factors that might indicate that a Non-Executive Director was no longer independent. Having considered those matters, the Board considers that all of the Non-Executive Directors are independent of the management of the Trust. No matters have been identified that might indicate that a Non-Executive Director was not 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 33 below.

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 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.

As part of the development of the Group Model, of working, the Boards of Kettering and Northampton will be undertaking joint team development work to review and improve cohesion and maturity, as part of the 2021/22 work plan.

Committees of the Board

In addition to the Nominations & Remuneration Committee there are 10 Board Committees. Each of the Committees has delegated authority provided with sufficient resources to enable it to undertake its duties:

(1) Group Committees in Common with Northampton General Hospital NHS Foundation Trust (Committees of both Boards)

Kettering General Hospital (KGH) Foundation Trust and Northampton General Hospital (NGH) are working together under a Group Management Model to strengthen acute care service provision across Northamptonshire, under the leadership of a jointly appointed Chair and CEO for both Trust Boards.

A common approach of working across both organisations and emphasis on acute pathway transformation and quality improvement is recognised as a priority. The approach of working as a Group Model across both organisations maintains the statutory duties and responsibilities of two separate Trust Boards.

As part of the collaboration planning work, and to facilitate the seamless implementation of Group Priorities following approval by Boards in January 2021, both Trusts have agreed to establish Committees in Common.

Committee in Common meetings are a recognised governance approach that enables collaboration between organisations to take decisions together on projects that cross boundaries without compromising the integrity of their own statutory requirements.

Collaboration Programme Committee

The Collaboration Programme Committee (CPC) develops and delivers the aims of the Group and steers the delivery of the Group Model ambitions. It advises the Boards of Kettering General Hospital NHS Foundation Trust and Northampton General Hospital NHS Trust on all matters relevant to identifying and sharing best practice at pace.

The CPC identifies opportunities to improve outcomes for patients through innovative practice and partnerships, and agrees and confirms areas of common interest and priorities for joint work, within strategic objectives agreed by the Boards.

It meets monthly and is chaired by Non-Executive Director representatives from each Trust on an alternating basis.

Group Digital Hospital Committee

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

- Steering the creation of the Group Digital Strategy to align with the Group's overall strategy, and driving the overall digital ambition for the Group., with particular regard to:
    - Creating a seamless experience for patients across both trusts; and
    - Providing clinicians with the right digital tools to work safely and efficiently.
- Overseeing Trust specific roadmap development and delivery in line with developing a group Digital Strategy, and delivering the digital component of Group priorities.
- Driving the NGH and KGH roadmaps and ensuring any workstreams are clinically-led and delivered successfully.
- Overseeing the Group's digital risk exposure and cyber security capabilities and seeking assurance that appropriate risk management processes are in place.
- Assuring the delivery of major Group digital transformation programmes, monitoring progress and supporting the alignment and assignment of relevant IT, project management and transformation teams across both Trusts, and
- Promoting the application of the culture, processes, business models and technologies of the internet era to respond to people's raised expectations.

The Committee meets on a bi-monthly basis and is chaired by a Kettering Non-Executive Director.

Group Finance and Performance Committee

The Committee:

- Oversees an aligned and integrated approach across the group, so as to ensure consistency in operational and financial management, including the efficient use of resources through optimal allocation of capital and resources.
- Improves operational and financial outcomes by identifying and understanding unwarranted variances as a driver for transformational change, thus enabling better patient care, experience and outcome.
- Works with the Local Health System to ensure financial sustainability of the group through collaborative working.

The Committee holds quarterly meetings and is chaired by Non-Executive Directors from each Trust on an alternating basis. The Trust's Performance, Finance and Resources Committee continues to meet twice per quarter to receive assurance on KGH-specific issues (see below).

Group People Committee

The committee oversees an aligned and integrated approach to ensure 10,000 colleagues across NGH and KGH are engaged and supported through the successful delivery of the Group People Plan.

It meets bi-monthly and is chaired by Non-Executive Directors from each Trust on an alternating basis.

Group Clinical Quality, Safety and Performance Committee

The Committee supports both organisations' collaborative objectives for delivering the best possible outcomes of care for patients where it has been agreed to provide these services as a countywide initiative. The Committee provides Trust Boards with strategic oversight and assurance for activities relating to acute clinical service models that cross organisational and geographical boundaries for both Trusts, as well as quality performance across both Trusts.

The Committee holds bi-monthly meetings and is chaired by Non-Executive Directors from each Trust on an alternating basis. The Quality and Safety Committee continues to meet in the alternating months from the Committee in Common to receive Trust-level assurance (see below).

(2) Committees of the Board of Directors

Audit Committee

The Audit Committee, comprised of three 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 2020/21		
Name	Title	Attendance
Alice Cooper	Non-Executive Director	4/5
Lise Llewellyn	Non-Executive Director	5/5
Trevor Shipman (Chairman)	Non-Executive Director	5/5

Significant issues

The Audit Committee met on 26 April 2021 to consider the financial statements for the period 2020/21. 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. The Trust incurred external audit costs of £78,100 (ex-VAT) during 2020/21.

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 2021, 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 ensures there is an effective system of integrated governance, risk management, and internal control across the clinical activities of the organisation that support the organisation's objectives of delivering the best possible outcomes of care to patients.

The Committee receives instructions from the Board of Directors on areas where additional assurance is required and formally reports to the Board. The Committee meets six times per year, in alternate months to the Group Clinical Quality, Safety and Performance Committee (see above).

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. The Committee meets eight times per year, in months when the Group Finance and Performance Committee does not meet (see above).

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.

Following the approval by the Board of Directors of the transfer of the Charity's assets to the Northamptonshire Health Care Charity on 31 March 2021, the Committee is not anticipated to meet during 2021/22 and is likely to be disbanded.

Strategic Development Committee

This Committee oversees 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.

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. 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 closer 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 2021-22.

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 2020-2021, we ran a regular series of on-line consultation briefings for Governors on key initiatives such as the infrastructure development programme, group strategy and people plan, and worked with NHS Providers to put in place a more robust new Governor induction programme following Governors election in Autumn 2020. We will continue to respond to the needs and requirements of our governors on an ongoing basis.

The role and responsibilities of the Council of Governors is set out in the Council of Governors Code of Conduct, which 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, although visiting restrictions and national lockdowns made this particularly challenging during 2020/21. Following the approval of a funding bid for additional capacity to support Governor and Member engagement, and the hoped-for easing of pandemic restrictions, it is expected that activity will increase during 2021/22.

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

Council of Governors

At 31 March 2021, the Council of Governors comprised 17 members from three specific groups:

- 10 public governors
- 3 staff governors
- 4 stakeholder governors

Membership of the Council of Governors 1 April 2020 – 31 March 2021

PUBLIC ELECTED GOVERNORS				
Name	Constituency	Elected	End of Term	Attended (Max 5)
Peter Woolliscroft	Kettering	2 Dec 2017	1 Dec 2020	5
		2 Dec 2020	1 Dec 2023	
Gail Chapman	Kettering	18 Oct 2013	17 Oct 2016	4
		18 Oct 2016	17 Oct 2019	
		18 Oct 2019	17 Oct 2022	
Mohamed Latif	Kettering	2 Dec 2017	1 Dec 2020	3
		2 Dec 2020	1 Dec 2023	
Eric Jackson	Wellingborough	2 Dec 2020	1 Dec 2023	3
Pat Jackson	Wellingborough	2 Dec 2017	28 Jul 2020	1
Graham Lawman	Wellingborough	18 Oct 2016	17 Oct 2019	5
		17 Oct 2019	17 Oct 2022	
Annette Bridgeford	Wellingborough	21 Jan 2019	1 Dec 2020	5
		2 Dec 2020	1 Dec 2023	
Satya Biswas	East Northants	2 Dec 2020	1 Dec 2023	3
Mabel Blades	East Northants	2 Dec 2014	1 Dec 2017	4
		2 Dec 2017	1 Dec 2020	
		2 Dec 2020	1 Dec 2023	
Reg Talbot	East Northants	2 Dec 2017	1 Dec 2020	2
Sheila White	East Northants	2 Dec 2020	1 Dec 2023	5
David Harland	Corby	18 Oct 2019	18 Oct 2022	5
Pam Marray	Corby	18 Oct 2019	15 Dec 2020	3
Angela Mason	East Northants	18 Oct 2019	12 Aug 2020	0
STAFF ELECTED GOVERNORS				
Name	Constituency	Elected	End of term	Attended (max 5)
Jayne Chambers	Staff	18 Oct 2019	17 Oct 2022	4
Bev Bone	Staff	18 Oct 2019	4 Nov 2020	0
Jennifer McCaffery	Staff	26 April 2018	2 December 2020	2
Sreejith Nair	Staff	2 Dec 2020	1 Dec 2023	2
Faizal Rayan	Staff	2 Dec 2020	1 Dec 2023	2
STAKEHOLDER APPOINTED GOVERNORS				
Name	Organisation		End of appointment	Attended (Max 5)

Wendy Brackenbury	Local Authority	March 2014	March 2023	2
Sue Watts	Voluntary/ Charitable Sector	March 2015	March 2024	3
Dr Andrew Stephen	Voluntary/ Charitable Sector	April 2016	March 2025	5
Wendy Patel	Healthwatch	December 2017	August 2024	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 reappointed to the position in December 2020 to serve a three-year term, coinciding with his Term of Office as a Governor.

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 four times during 2020/21 to carry out the appraisals of the Chairman and Non-Executive Directors, and recommend the reappointments of Alan Burns as Trust Chair, and Janet Gray and Chris Welsh to additional terms of office as Non-Executive Directors.

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 four occasions during 2020/21.

The Council of Governors: Relationship with the Board of Directors

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

In addition, bi-annual joint meetings of the Board and Council took place in May and November 2020 to consider matters of common interest on key issues such as the Trust's COVID response, Group Model Collaboration proposals with Northampton General Hospital, integrated care proposals for the county and the quality improvement programme.

The Group and Hospital Chief Executives 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 takes 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 are invited to raise comments, concerns or queries from the Council in advance, and have the opportunity to meet with Chairs to discuss these matters to gain assurances on behalf of the Council.

Should a dispute arise between the Council and the Board of Directors then the disputes resolution procedure set out in the Trust's 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. During 2021/22, we are planning for the resumption of Governors' site visits in the hospital, as restrictions are eased following the COVID-19 pandemic.

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. In February 2021, the Trust agreed changes to its Constitution to create a new public constituency for West Northamptonshire, aligned to the boundaries of the new Council, and extended its 'Rest of UK' constituency to the whole of England to maximise the pool from which new members and governors can be drawn.

As at 31 March 2021 the Trust had 3,680 public members, with constituencies as described below:

Constituency	Number of Members 31 March 2021
Kettering	1,249
Corby	547
Wellingborough	742
East Northamptonshire	876
Rest of UK	266

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. Whilst the COVID-19 pandemic restricted much activity, Governors have continued to seek new ways of communicating with their localities including, in 2020-2021, the launch of a series of Governor-led articles on the *Northants Evening Telegraph* website explaining the role and work of the Council, and disseminating key messages about the hospital; informal feedback and web views suggests these articles have been popular.

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.

Our Annual Members Meeting was held 'virtually' on 30 September 2020 due to continuing COVID-19 restrictions, and attracted a good public attendance. 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 undertook a data cleansing exercise to its membership database during 2020, as a result of which total membership reduced by around 25%. We have obtained additional resources to recruit a Governor and Membership Engagement Officer during 2021, who will lead a membership recruitment campaign and reintroduce key engagement activities which were paused as a result of the pandemic.

Contacting Governors

Members can contact Governors via:

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

Email: kgh-tr.Corporate@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 was reappointed to a second term as Trust Chair by the Council of Governors in July 2020. In confirming this reappointment, the Council acknowledged Alan's strong leadership of key ongoing work programmes, particularly the NGH collaboration and hospital redevelopment, and key contributions in bringing stability and improvement since his first appointment.

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, Group People 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 Group Digital Hospital Committee and Co-Chairs the Collaboration Programme Committee with Northampton General Hospital. She 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, having served two full terms, was re-appointed for a further year in October 2020. 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 had 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 Co-chairs the Group People Committee with Northampton General Hospital and chaired the Charitable Funds Committee during 2020-2021. Upon the transfer of the assets of the KGH Charity to the Northamptonshire Health Care Charity on 1 April 2021, Janet was appointed as one of the Trust's Trustees to this charity. Janet is also 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 18 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's experience of improving profitability through transformation will help her support KGH on its journey to outstanding.

Liisa is a member of the Remuneration and Nomination, Group People and Performance, Finance and Resources Committees. She also represents the Trust on the Finance Committee for the local health system.

Professor Chris Welsh, Non-Executive Director

Chris was appointed to a second term in March 2021. 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. He also co-chairs the Group Clinical Quality, Safety and Performance Committee with Northampton General Hospital.

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, Strategic Development Committee, Quality and Safety Committee, Group Clinical Quality, Safety and Performance 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 a member of the Nominations and Remuneration Committee and Group Digital Hospital Committee and chairs the Performance Finance & Resources Committee.

Terms of Office

All Non-Executive Directors are appointed initially for 3-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. 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 the Trust's Constitution, which can be viewed on the Trust's public website.

Group Executive Directors

Simon Weldon, Group Chief Executive

Simon Weldon was appointed as KGH Chief Executive 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, and formally took up this role on 1 July 2020.

Andy Callow, Group Chief Digital Information Officer

Andy became Digital Chief Information Officer with the Trust in April 2019 and was appointed to the Group Position in December 2020, bringing 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.

Mark Smith, Chief People Officer

Mark joined the Trust in June 2014 and has 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.

Trust Executive Directors

Deborah Needham, Hospital Chief Executive

Deborah has 30 years' experience of working in the NHS, in Manchester, London and, for the last 16 years, in Northamptonshire.

Deborah started her career in Greater Manchester where she trained and qualified as a Registered General Nurse, having experience in respiratory and acute assessment ward nursing, practice development & clinical site management. Deborah moved into General Management in 1999 and has been a Board Director since April 2014 taking the roles of Chief Operating Officer/Deputy CEO. Deborah took up the role of Hospital CEO in March 2021.

Working as part of the group and KGH, she cares passionately about the NHS and firmly believes in creating an environment where staff are included, happy and can excel and in turn patients are very well cared for, feel safe and have an excellent experience.

Deborah lives in Northamptonshire, she is a volunteer for the German Shepherd Rescue UK and she loves spending time with her own dog when not at work. Deborah is also the chair of NHS Providers national Chief Operating Officers forum.

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 (QA), authoring the national QA colonoscopy guidelines for bowel cancer screening, and works at a regional and national level in this area.

Anil Pursooth, Interim Director of Finance

Anil joined the Trust as Deputy Director of Finance in February 2020 and took up the position of Interim Director of Finance in August 2020.

Anil has a background in financial management and joined the NHS in 1993. Starting out in the mental health sector, he swiftly moved into working within Acute Trusts in Leicestershire. Prior to this post, Anil worked as Deputy Director of Finance at George Eliot in Nuneaton and has worked at various Trusts throughout the UK.

Anil is passionate about improving financial awareness within the NHS and is looking forward to improving patient care by managing the best use of resources.

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.

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.

Fay Gordon, Interim Chief Operating Officer

Fay initially started her career in the NHS as a Registered General Nurse at KGH, before moving to the University Hospitals of Leicester (UHL) where she undertook many nursing roles in acute and Elective surgery. Later, Fay moved into General Management at UHL, where she managed large complex services across the Trust, gaining significant operational and strategic experience, before moving to NGH as the Divisional Manager for Medicine and Urgent care. In April 2020 Fay joined KGH as Deputy Chief Operating Officer and became acting Chief Operating Officer in March 2021.

Fay is passionate about developing high performing teams in order to ensure the delivery of quality services for our patients and carers.

2.1.2 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 Trust's public website.

2.1.3 Political donations

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

2.1.4 Better payment practice

The Trust applies standard payment policy terms of 30 days to suppliers of the Trust.

Detail of the Trust's performance in 2020/21 is shown below with 2019/20 as a comparator.

	Month 1-12 2020/21 Number	Month 1-12 2020/21 £'000	2019/20 Number	2019/20 £'000
Total Non-NHS invoices paid in the year	63,325	107,385	74,140	105,935
Total Non-NHS invoices paid within target	55,138	88,449	53,502	70,661
Percentage of non NHS trade invoices paid within target	**87%**	**82%**	**72%**	**67%**
Total NHS invoices paid in the year	2,241	9,926	2,475	10,103
Total NHS invoices paid within target	1,715	8,441	1,634	6,895
Percentage of NHS trade invoices paid within target	**77%**	**85%**	**66%**	**68%**

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

Cost allocation and charging

Throughout the year ended 31st March 2021, 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.

2.1.5 NHS Improvement's well-led framework

The Trust's overall approach to governance and compliance and reporting against NHS Improvement's 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.

During 2020, the Trust's CQC advisors undertook a review of the Trust's Well-led performance against the eight Key Lines of Enquiry (KLOEs) that inform the CQC and NHSI Well-led frameworks. Specifically, the review undertook a 'focused' compliance assessment of the Trust's leadership and governance arrangements against CQC Well-led KLOEs. The assessment found that seven of the eight Key Lines of Enquiry (KLOEs) were rated as 'Good – Rated Green'; and that only KLOE 6 (which relates to the accuracy of information received and leadership response) fell below this level achieving a status of 'Requires Improvement – Rated Amber'. The findings of the review were reported in full to the Audit Committee in April 2021, which indicated its assurance in respect of the Trust's preparedness in the CQC Well-Led Domain.

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 Sustainability and Transformation Partnership, 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

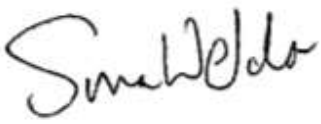
The Trust also actively engages with the Northamptonshire Health & Well-being Board.

2.1.5.1 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 2020/21, 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 17 of the annual accounts for a breakdown on income sources.



SIMON WELDON

CHIEF EXECUTIVE

28 JUNE 2021

3 Remuneration report

3.1.1 Annual statement on remuneration

Major decisions on Senior Managers' remuneration

The Remuneration committee met seven times over the course of the year, and also approved senior appointments by electronic resolution.

During the year, the Committee has made a number of key decisions in respect of the approval of Group Leadership posts and appointments to these posts, and undertaken its annual review of Executive Director salaries.

Substantial changes made to Senior Managers' remuneration

The Nomination and Remuneration Committee, at its meeting in February 2021, approved annual pay increases for very senior managers, as recommended by NHS Improvement.

The Committee agreed salaries for the Group Leadership positions of Chief Executive, Chief People Officer, Director of Finance and Chief Digital Information Officer, as well as for the Hospital Chief Executive responsible for the day to day running of the Trust. The Committee also agreed salaries for the Interim Director of Finance, and also a one-off payment to the Director of Nursing and Quality in recognition of 'acting up' arrangements prior to the Interim Hospital Chief Executive taking up her post.

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.

Group Chief Executive Salary

In November 2019, the KGH Nomination and Remuneration Committee and NGH Remuneration and Appointments Committee met to discuss options for implementing the group model and specifically agreed to appoint a group CEO by February 2020. A salary of £220,000 per annum for the role was also agreed, subject to an application being submitted to NHSE/I for ministerial approval and comment.

On 30 June 2020 the Remuneration Committees agreed the Terms and Conditions for the group CEO. At this stage the salary application of £220,000 had not been agreed by NHS England and Improvement. The committee noted this outcome and supported a revised business case to be submitted so the advertised salary of £220,000 pa could be paid.

On this basis, a revised case was submitted and the Group CEO was placed on a salary of £220,000 pending this approval, as the group CEO took up his position on 1st July 2020.

Following a series of follow ups, on the 2nd October 2020 confirmation was received from NHSE/I that a salary of £219,500 pa was agreed by the Minster of State for Care, Helen Whately, as this was the median salary given the size of the group. Following the application of the annual uplift of 1.03% for Very Senior Managers, as directed by NHSE/I, a salary of £221,761 was agreed.

The Group Chief Executive was seconded to the role of Operational Senior Responsible Officer for the Independent Sector Covid sub-cell (NHS England and Improvement) between 19 October 2020 – 23 April 2021 inclusive.

Hospital Chief Executive

The Committee, along with its NGH counterpart, agreed to create a Hospital Chief Executive post in June 2020. This post is responsible for the day to day running of the hospital. Reporting to the Group CEO, the Hospital Chief Executive provides strategic and operational leadership to the trust and ensures that safety, high quality care and high quality service are embedded as the key drivers. Their role is to integrate the strategic and operational planning and delivery of all services within the Trust and to support the development of a group/organisational culture that supports clinical leadership and engagement in decision making and demonstrates a commitment to continuous quality improvement. Eileen Doyle fulfilled the role on an interim basis, with Deborah Needham appointed to the post on a substantive basis with effect from 1 March 2021.

The Hospital Chief Executive's salary is within the range £155,000 - £165,000 per year. This was based upon the NHS Providers 2019/20 Executive Director remuneration survey outcomes, which suggested an average of £161,627 pa total remuneration for a post of this type, as a Deputy CEO and combined role post within a peer Acute Trust; the Trust sought and received NHS England and Improvement approval for this salary. Contractual provision has been made for an earn back clause to the value of 10% of the Hospital Chief Executive's salary, on terms agreed with the Group Chief Executive. The Nomination and Remuneration Committee would be consulted before any earn back provision was applied.

Statement of the Chair of the Remuneration Committee

The Chair of the Remuneration Committee, Alan Burns, has declared that the major items listed above are a true and fair reflection of the matters discussed at the committee during 2020/21.

3.1.2 Senior managers' remuneration policy

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

With the exception of the Hospital Chief Executive role described above, 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. 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 Group 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 Group Chief Executive and Hospital Chief Executive, the Hospital 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 Executive Directors 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 Group Chief Executive and all Executive Directors are in accordance with the NHS Pension Scheme.

Full details of remuneration are provided in the Annual Remuneration Report, below. Salary uplifts of 1.03% were applied to Executive Directors on VSM Terms and Conditions during the year, in line with direction given by NHS England and Improvement in a letter of December 2020.

No directors received performance-related payments during the year.

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.

Details of Non-Executive Directors' remuneration are provided in the annual remuneration report, below.

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.

The next review will be undertaken during 2022.

Service contract obligations

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

Policy of payment on loss of office

The Trust's approach to setting the notice period for Directors is, unless specific circumstances indicate otherwise, a period of 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.

3.1.3 Annual report on remuneration

Service Contract Obligations

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

2020/21

	Non Exec Directors	Exec Directors	Governors
Total Number at 31/3/21	8	13	17
Total number receiving expenses	3	7	2
Total expenses paid (£)	647	1,067	504

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 Chair. The Committee reviews the structure, size and composition of the board and makes 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 seven occasions during 2020/21, attendances at each are detailed below:

	30/06/20	28/08/20	30/09/20	30/10/20	30/11/20	26/02/21	31/03/21
Alan Burns	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Alice Cooper	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Janet Gray	Yes	Yes	Yes	Yes	Yes	No	Yes
Liisa Janov	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Lise Llewellyn	Yes	Yes	No	No	Yes	Yes	Yes
Trevor Shipman	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Damien Venkatasamy	Yes	Yes	Yes	No	Yes	No	No
Chris Welsh	Yes	Yes	Yes	No	Yes	Yes	Yes

SALARY AND PENSION ENTITLEMENTS OF SENIOR MANAGERS (Has been subject to Audit)

REMUNERATION REPORT

Executive Directors (Voting and Non-Voting)								
Financial Year 2020/21				**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***	Group Chief Executive	2 Apr 2018		140-145	-	-	-	140-145
Mrs E Doyle	Interim Hospital Chief Executive	15 Sep 2020	14 Mar 2021	100-105	-	-	22.5-25	125-130
Ms D Needham	Hospital Chief Executive	15 Mar 2021		10-15	-	-	50-52.5	60-65
Ms J Fawcus	Chief Operating Officer	15 Oct 2018	28 Feb 2021	115-120	100	-	30-32.5	145-150
Ms F Gordon	Interim Chief Operating Officer	1 Mar 2021		5-10	-	-	72.5-75	80-85
Miss N Briggs	Director of Finance	1 Dec 2016	31 July 2020	45-50	-	-	35-37.5	80-85
Mr A Pursooth	Interim Director of Finance	1 Aug 2020		85-90	-	-	147.5-150	235-240
Prof A Chilton**	Medical Director	2 Jun 2010		255-260	100	-	-	255-260
Ms L Hackshall	Director of Nursing	1 Oct 2014		130-135	-	-	30-32.5	160-165

Mr M Smith****	Chief people Officer	2 Jun 2014		70-75	-	-	2.5-5	75-80
Mr R Apps	Director of Governance	18 Jul 2018		105-110	-	-	22.5-25	130-135
Mr A Callow*****	Chief Digital & Information Officer	8 April 2019		95-100	100	-	30-32.5	130-135
Ms Polly Grimmett	Director of Strategy	20 Dec 2019		110-115	-	-	62.5-65	175-180

* 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 £125-£130k in respect of clinical duties.
*** S Weldon was appointed as Group Chief Executive from 1st July 2020. His remuneration above reflects the charges made to NGH. His total salary was in the range – £225- £230k. The Group Chief Executive was seconded to the role of Operational Senior Responsible Officer for the Independent Sector Covid sub-cell (NHS England and Improvement) between 19 October 2020 – 23 April 2021 inclusive.
**** M Smith was appointed as Group Chief People Officer on 1st September 2019. His remuneration above reflects the charges made to NGH. His total salary was in the range – £145-£150k.
***** A Callow was appointed as Group Chief Digital and Information Officer from 9th November 2020. His remuneration above reflects the charges made to NGH. His total salary for the year was in the range – £125- £130k.
Expense payments are taxable reimbursements relating to travel claims.

Signed: Mr Simon Weldon – Chief Executive Date: 28 June 2021

Chairman and Non-Executive Directors						
Financial Year 2020/21				**Salary (bands of £5000)**	**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	-	**15-20**
Ms A Cooper	Non-Executive Director	5 April 2019		10-15	-	**10-15**
Dr L Llewellyn	Non-Executive Director	1 Jul 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		10-15	-	**10-15**
Mr C Welsh	Non-Executive Director	1 Feb 2018		10-15	-	**10-15**

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 Integrated 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 1st 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.

CHAIRMAN AND NON-EXECUTIVE DIRECTORS						
Financial Year 2019/20				**Salary (bands of £5000)**	**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**

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 (1.7%), 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 is not the absolute difference between one year and the next.

PENSION BENEFITS (Has been subject to audit)

2020/21 Name	Title	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 31ST March 2021 (bands of £5000)	Lump sum at pension age related to accrued pension at 31st March 2021 (bands of £5000)	Cash Equivalent Transfer Value (CETV) at 31st March 2020	Cash Equivalent Transfer Value (CETV) at 1st April 2021	Real Increase in Cash Equivalent Transfer Value *	Employer's contribut-ion to stakeholder pension
		£000	£000	£000	£000	£000	£000	£000	£000
Ms E Doyle	Interim Hospital Chief Executive	0-2.5	-	15-20	20-25	214	248	1	15
Ms D Needham	Hospital Chief Executive	0-2.5	-	55-60	130-135	938	1,003	2	2
Ms J Fawcus	Chief Operating Officer	0-2.5	0-2.5	35-40	70-75	551	603	22	16
Ms F Gordon	Interim Chief Operating Officer	0-2.5	0-2.5	30-35	75-80	540	622	-	14
Miss N Briggs	Director of Finance	0-2.5	-	20-25	-	197	225	2	9
Mr A Pursooth	Interim Director of Finance	2.5-5	12.5-15	35-40	85-90	557	715	88	17
Mr M Smith	Chief People Officer	0-2.5	-	10-15	-	109	122	-	7
Ms L Hackshall	Director of Nursing	0-2.5	5-7.5	55-60	170-175	1,181	1,275	55	19
Mr R Apps	Director of Governance	0-2.5	-	20-25	35-40	293	326	13	16
Mr A Callow	Chief Digital Officer	0-2.5	-	10-15	-	110	144	14	14
Ms P Grimmett	Director of Strategy	2.5-5	2.5-5	25-30	45-50	327	391	43	16
CPI is 1.7% in 2020/21. N Briggs, M Smith and E Doyle all re-joined the NHS pension scheme during the year. There are no additional benefits that become receivable by the individual in the event of their early retirement.									

2019/20 Name	Title	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 31ST March 2020 (bands of £5000)	Lump sum at pension age related to accrued pension at 31st March 2020 (bands of £5000)	Cash Equivalent Transfer Value (CETV) at 31st March 2020	Cash Equivalent Transfer Value (CETV) at 31st March 2019	Real Increase in Cash Equivalent Transfer Value *	Employer's contribution to stakeholder pension
		£000	£000	£000	£000	£000	£000	£000	£000
Mr S Weldon	Chief Executive	0-2.5	-	50-55	105-110	964	891	31	20
Miss N Briggs	Director of Finance	2.5-5	-	20-25	-	197	166	19	8
Ms J Fawcus	Chief Operating Officer	5-7.5	10-12.5	30-35	70-75	551	434	89	17
Mr M Smith	Chief People Officer	0-2.5	-	10-15	-	109	88	12	7
Ms L Hackshall	Director of Nursing and Quality	5-7.5	20-22.5	55-60	165-170	1181	986	153	18
Mr R Apps	Director of Integrated Governance	2.5-5	5-7.5	15-20	35-40	293	220	53	15
Mrs E Doyle	Deputy Chief Executive	0-2.5	-	10-15	20-25	214	184	3	8
Mr A Callow	Chief Digital and Information Officer	7.5-10	-	5-10	-	110	-	92	16
Ms P Grimmett	Director of Strategy	0-2.5	0-2.5	20-25	40-45	327	265	12	15

CPI was 2.4% in 2019/20.
Simon Weldon, Nicola Briggs, Mark Smith and Eileen Doyle all left the NHS pension scheme during the year. Mark 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

3.1.4 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 that 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 2020/21 was £255,000-£260,000 (This is the annualised full time equivalent of the payments made in 2020/21). This was 9.9 times the median remuneration of the workforce which was £25,503. 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 was 8.48 times the median remuneration of the workforce which was £26,966. The change between the two years is driven partly by a move from agency to bank staff. Staff remuneration was in the range £8,115 to £221,761.

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

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

3.1.6 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			2020/21	2019/20
	Permanent	Other	Total	Total
	£000	£000	£000	£000
Salaries and wages	150,279	27,289	**177,568**	153,581
Social security costs	16,591	-	**16,591**	14,410
Apprenticeship levy	840	-	**840**	747
Employer's contributions to NHS pensions	26,604	-	**26,604**	24,09
Pension cost – other	-	35	**35**	22
Termination benefits	23	-	**23**	697
Temporary staff	-	12,623	**12,623**	16,110
Total gross staff costs	**194,337**	**39,947**	**234,284**	**209,665**
Recoveries in respect of seconded staff	(153)	-	**(153)**	(151)
Total Staff Costs	**194,184**	**39,947**	**234,131**	**209,514**
Of which				
Costs capitalised as part of assets	1,660	253	**1,913**	1,503

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

Average number of employees (WTE basis)			2020/21	2019/20
	Permanent	Other	Total	Total
	Number	Number	Number	Number
Medical and dental	474	119	**593**	522
Administration and estates	822	50	**872**	834
Healthcare assistants and other support staff	1,012	182	**1,194**	1,078
Nursing, midwifery and health visiting staff	1,163	250	**1,413**	1,281
Scientific, therapeutic and technical staff	259	26	**285**	277
Healthcare science staff	182	-	**182**	182
Other	118	3	**121**	108
Total average numbers	**4,030**	**630**	**4,660**	**4,280**
Of which involved in capital projects	31	3	34	23

3.2.3 Gender analysis

Staff Type	Female	Male
Exec Directors	5	6
Senior Manager	23	22
All Other Employees	3753	999

Senior Managers by Gender:

Band (Agenda for Change)	Female	Male	Grand Total
Band 8 - Range A	9	9	18
Band 8 - Range B	10	5	15
Band 8 - Range C	1	5	6
Band 8 - Range D	3	1	4
Band 9		2	2
Grand Total	**23**	**22**	**45**

The Trust's Gender Pay Gap report for 2019/20 is available on its website here: https://www.kgh.nhs.uk/download.cfm?ver=5371. The deadline for reporting the 2021 Gender Pay Gap has been extended due to the impact of the COVID-19 pandemic: the report will be submitted to the Group People Committee in July 2021.

3.2.4 Sickness absence data

Sickness absence data will be available on the NHS Digital website using this link: https://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 continues to purposefully value the diversity in its staff, patients and visitors. This drives the Trust to continue treating its diversity and inclusion with great importance, working to ensure they provide fair and equitable treatment. This is being driven ensuring that all actions and working practices comply with both the determination and intention of the Human Rights Act (1998) and the Equality Act (2010).

The Trust has ensured all those with protected characteristics (age, disability, gender reassignment, marriage & civil partnerships, pregnancy & maternity, race, religion or belief, sex and sexual orientation) have safe spaces in which they are able to influence the changes within the organisation.

The organisation has gone from having just three Equality, Diversity and Inclusion (EDI) Networks *(LGBTQ+ EDI Network; BAME EDI Network; DisAbility EDI Network)* to ensuring they supported the launch of three new Networks *(Gender Equality EDI Network; Young Peer Support EDI Network; Overseas Nurses EDI Network)*. This was to ensure a safe platform was available to encourage staff to have a voice and speak up about work-life experiences, wellbeing and any other issues of concern as well as have influence in the changes to be implemented within the organisation.

EDI

The increase in membership for all the EDI Networks will have a positive impact in enhancing a culture of inclusivity and ensuring staff feel able to bring their whole selves to work and give them a sense of belonging. This is a platform the organisation is also utilising to build trust with those who are dis-engaged and will have a huge impact on inclusivity within KGH.

The KGH EDI Strategy Plan is a key driver which is enabling the organisation to keep monitoring itself on changes being implemented within the Trust, relating to agreed changes that will positively impact those from different protected groups.

The barriers that the organisation identified which would impact the diversity and inclusivity of its workforce which are being addressed are:

- Training **Inclusive Recruitment Champions** who will be part of the recruitment process and part of interview panels. They will ensure the process is fair and this will enable the appointment of the best candidate for the position and increase the number of successful candidates with a protected characteristic.
- **Reverse Mentoring** which is empowering colleagues to have open discussions about their experiences of EDI within the Trust with Senior Management and Board Members.
- **Board Member Sponsors** championing the EDI Network they are advocating for within the Trust during their Board Sessions and supporting the Co-Chairs in the work they are doing, which is in the KGH EDI Strategy Plan, results in positive feedback from members of staff across the Trust which then has a positive impact in the Staff Survey etc. This also has a positive impact on inclusivity within the organisation as decision makers are involved in understanding EDI matters.
- **Protected Time for Co-Chairs** will ensure those members in the different EDI Networks will have more support. The Co-Chairs will be more driven by the inclusivity agenda as the organisation clearly shows how engaged it is when it comes to EDI. This will encourage the EDI Networks to continue growing with supported and empowered Co-Chairs.
- Support given to those from protected groups in becoming trained **Freedom to Speak Up Champions** and supporting the organisation in creating more safe spaces for colleagues within the Trust. The organisation has gone from having zero EDI Network Co-chairs and members as FTSU Champions to having over 13 trained champions.
- **Empowering those in protected groups** in becoming influential Staff Governors. The organisation has seen in 2020/21 two BAME members become staff governors and having a positive voice in encouraging others to be courageous in putting themselves forward so they can also support the organisation.
- The organisation to introduce and encourage the use of the **Health Passport** within the Trust (NHS Employers - https://www.nhsemployers.org/-/media/Employers/Publications/AFA/Health-passport-Final-online.pdf. This will continuously improve the working, environment and wellbeing of staff members who need Reasonable Adjustments to enable them to carry out their roles.
- The organisation is having **EDI Presentation for Overseas Nurses** during their Induction to raise awareness on the importance of having a **Positive voice** and **understanding what EDI means to them** within the Trust.
- The Trust is implementing the **Building Cultural Bridges** Facilitation for all Teams within the organisation. This is will support the organisation on its inclusive journey in supporting all staff in understanding race and culture in the workplace. These facilitations will restore work relationships that are broken in teams, and support individuals in being aware of how to **reduce their unconscious bias** by utilising **their own compassionism towards each other** and being more inclusive in their teams. This will foster a diverse and inclusive culture within the organisation.
- **Rainbow Badge training** to continue within the organisation ensuring all staff have greater understanding and are able to support their colleagues, patients and families , who identify as LGBTQ+.

The work the organisation is implementing to mitigate any diversity and inclusion barriers shows how committed the Trust is. This has also been shown by the organisation continuing to retain its Disability Confident Employer with Committed status.

The Trust's Recruitment and Selection Policy and Procedure requires recruiting managers to shortlist applications where candidates meet all the essential criteria and have indicated they qualify under the disability confident scheme. Appropriate support is given to employees with disabilities through referrals to Access to Work for assessment, training and reasonable adjustments. The Trust's DisAbility network works to promote disability equality across the organisation, as part of which it ensures training and mentoring schemes are developed to improve the promotion and development of disabled staff.

The Trust has proudly retained having the Mindful Employer Status. The mental health awareness and great support the organisation has given to all staff and patients during the Covid-19 pandemic has been a real example of a Mindful Employer.

The work the organisation has been doing relating to EDI has not gone unnoticed, as the Trust in January 2021 was nominated for a WorldSkills UK Diversity and Inclusion Heroes Awards. The Diversity and Inclusion Heroes Awards was honouring, celebrating, and shining a light on organisations that are going above and beyond, championing diversity and inclusion within their organisations.

The Trust also continues to ensure inequalities are being reduced in all policies, initiatives, services etc. within the organisation by requesting Equality Impact Assessments (EIA) from those implementing any change. The process has ensured the organisation works closely with all EDI Networks and our Patients to better understand the impact of changes to them and is supported in driving the best responses to mitigate or reduce the risks identified in the EIA.

The Trust continues to maintain excellent relationships with different key stakeholders (Staff side representatives, FTSU Guardian, Employment Relations, Recruitment, Learning & Development etc.) in driving and ensuring the EDI agenda is successful within the organisation.

Staff health and wellbeing is the highest priority for the Trust, whose Occupational Health service supports colleagues to manage the effects of work on health and work on health, specifically sickness absence, immunisations and vaccinations (including playing a key role in the COVID-19 vaccination programme for staff between December 2020 – March 2021) and health surveillance.

The Trust produces an annual Health and Safety Report, which showed a decrease in the number of reported employee accidents from 237 in 2019/20 to 200 in 2020/21, equating to a 15.6% decrease. Some of this decrease could be attributed to increased staff awareness of their responsibilities with regards to Health & Safety towards themselves and others. This was achieved by sharing of learning post-accident investigations and by learning bulletins included in the weekly A-Z communication to all staff.

3.2.6 Staff survey results

The NHS National staff survey is a key piece of intelligence which ran at Kettering General Hospital NHS Foundation Trust from the 30 September to 27 November 2020 with 2,574 colleagues taking part representing 58% of KGH workforce. This compares with the national median average of 45% and marks a continued year on year improvement in our response in the last 5 years.

The results are then reviewed against 10 themes looking at how we compare with the national averages as follows:

Kettering General NHS Foundation Trust considers that this data is as described given we have been

- dealing with the impact of a healthcare pandemic
- adopting a command and control approach with bronze/silver and gold meetings
- improving our wellbeing offer to support staff given the increasing pressures on capacity and demands of the service

Kettering General NHS Foundation Trust intends to take the following actions to improve by:

- reviewing the national NHS People Plan and localising it to the newly formed Northampton and Kettering Hospital Group
- reviewing division and department specific feedback and implement local action plans to celebrate success and address areas of concern
- delivering programmes to support early and open development conversations through facilitated round table conversations, promoting early intervention, and training line managers in coaching techniques
- Update and Implement our Equality, Diversity and Inclusion strategy and actions to support improvements in experience and provide greater awareness within the Trust

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 2020/21 total expenditure on consultancy was £1,955k, compared to £806k in 2019/20.

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 78 of the NHS Foundation Trust annual reporting manual 2020/21.

The Trust did not have any off payroll engagements during 2020/21

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)

2020/21	No. of compulsory redundancies	No. of other departures agreed number	Cost of other departures agreed £
Band (including any special payment element)			
£25,001-£50,000	-	1	28,000
Total	0	1	28,000

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

Exit packages (non-compulsory) departure payments

	2020/21 (2019/20)	
	Payments agreed	**Total value £000**
Costs	**1 (6)**	**23 (647)**
Contractual payments in lieu of notice	**1 (5)**	**5 (79)**
TOTAL	**2 (11)**	**28 (726)**
Of which Non-contractual payments requiring HMT approval made to individuals where the payment value was more than 12 months' of their annual salary	**-**	**-**

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 2020/21 disclosures are set out in the Annual Governance Statement (see page 61 below)

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

The trust's position at 31 March 2021 was in segment 3: 'Mandated support needs identified in Quality of care. Targeted support needs identified in Finance & use of resources and Operational performance.' Current segmentation information for NHS trusts and foundation trusts is published on the NHS Improvement website: https://www.england.nhs.uk/financial-accounting-and-reporting/single-oversight-framework-segmentation/.

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.

Signed: 

Chief Executive Date: 28 June 2021

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 2021 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.

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.

Effectiveness of the Trust's principles, systems and standards of corporate governance

The Board of Directors self-certified that the Trust continued to meet the obligations set out in its NHS Provider licence in respect of the effectiveness of the Trust's principles, systems and standards of corporate governance – details are available in the report submitted to the meeting on 28 May 2021 (see page 154): Board of Directors, 28 May 2021. The assessment confirmed that specific monthly reports provided timely and accurate data on quality of care, using a variety of sources, which enabled the Board to take an accurate, timely and accurate account of quality of care, and other reports throughout the year, which provide more comprehensive oversight of quality.

3.5.3 Capacity to handle risk

Leadership

The Trust Board of Directors, with the support of its 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 Committees 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), including oversight of reviews of Board Assurance Framework risks by Board Committees.

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 2020/21 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: https://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 supports 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 Trusts monitor key performance indicators for people issues such as turnover, vacancy numbers on a monthly basis and this is reported to Board through the People Committee and Quality and Safety Committee (QSC). People Committee 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.

In March 2021, the Trust (along with Northampton General Hospital), adopted a Group People Plan to deliver the Group priority vision for people in the development of ***"An inclusive place to work where people are empowered to be the difference"***. This will be monitored against national staff survey results, with our ambition being to reach the top 20% nationally.

In light of the development of our Group model, as well as the challenges of the ongoing Covid-19 pandemic, the context for our People is, and will continue to be, complex and challenging in many ways.

There are areas of strength in our organisations that we will recognise and build on as we move forwards and tackle these challenges particularly demonstrated during this past year. This provides a platform for us to build upon, whilst pointing to the need to continue to improve to bring ourselves in line with high performing acute Trusts and achieve our goal of being in the top 20% nationally for staff engagement.

Through the 2020 annual staff survey results, engagement with HR teams and senior leaders within the Trusts including People Committee, Board colleagues and governors in KGH, we have recognised some areas of success across our organisations:

- Our focus on wellbeing, and the enhancements to this during Covid-19
- New ways of working were implemented effectively during Covid-19, with opportunities to now maintain and build on these
- There are strong volunteering schemes in place in both Trusts that have to be built upon, particularly given the circumstances likely to be in place as we move out of the acute phase of the pandemic and our corporate social responsibility within our county
- The quality of care colleagues feel they are delivering at both hospitals

- If a relative of friend needed treatment, colleagues would be happy with the standards of care at NGH and KGH.
- A growing number of colleagues would recommend our hospitals as places to work
- There are significant numbers of staff progressing from HCA to qualified nursing roles through our development programmes
- Successful apprenticeship schemes are in place for nursing staff, with opportunities to expand this to other staff groups
- Our international nursing programmes have seen phenomenal results

These successes along with other provide opportunities to develop further, whilst also recognising other areas that we must work to improve. Data from the NHS Staff Survey, responded to by more than half of our staff and internal engagement, shows the most difference from the best Acute trusts nationally in responses related to:

- Feeling empowered and able to make improvements
- Support from managers
- The use of technology
- Health and wellbeing
- Diversity and Inclusion

These areas therefore form key focuses for improvement throughout our People Plan, alongside other core priorities such as building in proactive and positive processes to drive inclusive behaviour and thinking.

Some of the work within the plan was already underway: full plan approval has enabled greater focus and resourcing in some areas such as Organisational Development. Following approval, a process of aligning both current HR and OD teams is being established, including changing the title of the services to the People Directorate. The implementation of the plan will be overseen by the Group People Committee.

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 who chair Board Committees.

Risk appetite refers to the amount of risk that the Board is prepared to accept, tolerate, or be exposed to in pursuit of its strategic objectives. The higher the appetite, the greater the autonomy that is granted to the risk owner before the threshold is crossed for escalating issues to the Board; the lower the appetite, the greater the control that the Board will wish to exercise over its management. The Board determines risk appetite for its strategic risks on an annual basis against the following definitions:

Assessment	Description of potential effect
Zero Risk Appetite	The Trust Board aspires to avoid risks under any circumstances that may result in reputation damage, financial loss or exposure, major breakdown in services, information with no or negligible potential risk to staff /patients.
Low Risk Appetite	The Trust Board aspires to avoid (except in very exceptional circumstances) risks that may result in reputation damage, financial loss or exposure, major breakdown in services, information systems or integrity, significant incidents of regulatory and / or legislative compliance, potential risk of injury to staff / patients.
Moderate Risk Appetite	The Trust Board is willing to accept some risks in certain circumstances that may result in reputation damage, financial loss or exposure, major breakdown in services, information systems or integrity, significant incidents of regulatory and / or legislative compliance, potential risk of injury to staff / patients.
High Risk Appetite	The Trust Board is willing to accept risks that may result in reputation damage, financial loss or exposure, major breakdown in services, information systems or integrity, significant incidents of regulatory and / or legislative compliance, potential risk of injury to staff / patients.
Very High Risk Appetite	The Trust Board accepts risks that are likely to result in reputation damage, financial loss or exposure, major breakdown in services, information systems or integrity, significant incidents of regulatory and / or legislative compliance, potential serious risk of injury to staff / patients.

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 Board Assurance Framework (BAF) risk is held on a rotational basis at Board committee meetings and is a standing agenda item.

The Trust Board of Directors, with the support of its committees has a key role in ensuring a robust risk management system is effectively maintained and to develop a culture whereby risk management is “business as usual” at all levels across the organisation.

Escalation of risk issues takes place through the Divisional Governance structure that allows two-way communication from the Board and its Committees. Trust wide committees and 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 bi-monthly Risk Management Steering Group for consideration and potential inclusion in the Corporate Risk Register.

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

The 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, assessment and prioritisation of risks throughout the organisation via structured risk assessments recorded on Datix (the Trust’s integrated risk management system). 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 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.

In May 2020, Quality and Safety Committee received and endorsed the recommendation that the existing overarching corporate risk on the management of Covid-19 should be escalated from the Corporate Risk Register to the Board Assurance Framework, under the Quality and Safety Committee / Quality objective.

At 31 March 2021, there were 11 risks tracked through the BAF.

- Failure to deliver patient focused care may lead to poor patient experience and reputational risk.
- Non-delivery of the quality strategy may impact on staff experience, patient experience and quality of care.
- Failure to have correct skill mix and competency may have adverse effect in wards and clinical areas on quality of care and safety of patients and staff.
- Failure to plan sufficiently for and respond to an outbreak of Coronavirus (COVID-19), then it may cause negative impacts to the health and safety of patients, staff and visitors as well as causing widespread service disruption.
- During periods of high bed occupancy or high levels of activity in ED there is a potential that safe patient care may be impacted on.
- If sufficient commissioned Out of Hospital capacity is not maintained then there is the potential to impact on adult patient care, experience, and length of stay.
- Without a suitable hospital estate and provision of hard and soft facilities management services the Trust will be unable to support delivery of the long-term clinical strategy
- Inefficient, fragile or loss-making services may impact on the delivery of long-term quality and sustainability of the organisation.
- Failure to deliver the digital strategy would impact the quality and effectiveness of clinical care and financial sustainability.
- Failure to deliver our control total and meet the trajectory to live within our financial means, means we cannot meet our financial duties nor secure sufficient funding for infrastructure and equipment improvements.
- Failure to improve staff morale has consequential impacts on staff retention, impacting on patient experience and care.

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 Trust's 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 Trust's 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 takes place 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 (https://www.kgh.nhs.uk/board-of-directors-and-board-meetings), 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. A serious incident report is submitted to every meeting of the Quality and Safety Committee.

63 Serious Incidents were reported in 2020/2021. The most common categories of SI's reported were slips/trips/falls and maternity/obstetric incidents – baby only. 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 to seek assurance that learning from previous incidents has been embedded into practise. This thematic review will also be triangulated with data from the Claims team in order to review whether claims of negligence or poor care have previously been correctly identified as a patient safety incident, and appropriately reported and reviewed through the patient safety processes in place at the Trust.

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: https://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	No external evaluation undertaken
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 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 and champions in divisions and departments in place for staff to raise concerns, which is promoted within the Trust.

COVID-19

The Trust 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 identified risks to the delivery of their services as a result of COVID-19. Over 100 risks were identified, which were be robustly monitored within the Trust's control framework during 2020/21: in addition to the BAF, an overarching COVID-19 pandemic risk register has been developed, aligning risks to quality and safety, business operations and infrastructure. This register is submitted to the Board and Committees alongside the BAF.

The Trust implemented a Gold, Silver and Bronze command structure to manage operations in response to the pandemic, with key exceptions reported regularly to the Board of Directors and Quality and Safety Committee. A number of additional support measures have been introduced to maintain and enhance staff wellbeing including the 'We care' café, evening meals service, free car parking and extension of access of psychological support. The Trust put in place a reset plan to ensure elective and non-elective activity levels were maintained during the winter COVID peak, with monthly monitoring reports submitted to the Hospital Management Team and Board Committees to provide assurance in respect of delivery, and actions to address exceptions. The Trust's response has enabled it to innovate in a number of areas including virtual meetings, outpatient appointments and patient visits, whilst a new staffing trigger tools has been recognised as an example of good practice to be shared with other trusts.

As part of the agreed workplan for 2020/21, Internal Audit undertook a review of the Trust's governance arrangements in relation to the initial, and subsequent, responses to the pandemic. The review examined the incident response approach, capacity planning and demand management, the implementation of central guidance, compliance with risk management arrangements in relation to the pandemic and the reporting lines through to the Trust Board. The review concluded an overall opinion of Substantial Assurance, reflecting the positive actions that the Trust had undertaken.

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 response, 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 Performance and Staffing Reports sets out more information in Sections 1.1.7 and 3.2.5 above.

Carbon Reduction

As a Trust we consume approximately 13 GW of electricity and 27GW of gas per year, this results in a CO2 emission of approximately 3000 tonnes for the electrical consumption and 4950 tonnes for the gas consumption based on current carbon factors.

For gas and electricity there is a climate change levy (CCL) applied, we pay £0.00811 per kW (£105,403 per year) for electricity and £0.00406per kW (£109,620 per year).

As the national grid decarbonises, the carbon factor for electricity reduces as more power is generated by renewable resources. Our current electricity provider (EDF) produces over 85 % of electricity with zero carbon emissions. It is currently possible to procure carbon neutral electricity with a zero CCL charge and this will become standard in the future.

The future carbon reduction strategy is now based on more electrically driven heating, hot water and ventilation systems rather than gas and other carbon-based fuels. Efficient use of electricity is also a key factor.

Measures already taken:

- Optimising building management system Building Energy Management System (BEMS) controls to turn off plant when not required.
- Replacing fleet vehicles with hybrid and pure electric
- Investigating the possibility of introducing low temperature flow hot water to reduce losses

Responding to a "Net Zero" National Health Service, the Trust will be adopt measures to reduce its carbon footprint by introducing a range of initiatives to include: -

- Replacing aging steam heat distribution system with a system incorporating air source and water source heat pumps
- Insulation to building fabric to prevent heat loss in winter and heat gain in summer
- Solar photovoltaic panels on available roof space
- Installation of LED lighting on refurbishment projects
- Further enhancements to Building Energy Management System (BEMS) controls.

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.

Countering fraud and bribery in the NHS

This Trust is committed to providing a zero tolerance culture to fraud, bribery and corruption whilst maintaining an absolute standard of honesty and integrity in dealing with our assets. The Trust has a counter fraud and bribery policy and response plan. We are committed to the elimination of fraud and illegal acts within the Trust. We ensure the rigorous investigation of reported matters of fraud, bribery or corruption and the pursuance of redress for financial losses stemming from such acts, and the application of disciplinary sanctions or other actions as appropriate. We adopt best practice procedures to tackle fraud, bribery and corruption, as recommended by the NHS Counter Fraud Authority (NHS CFA).

The Trust complies with the NHS CFA Requirements which sets the standards for countering fraud in adherence with the Government Functional Standards 0:13. An annual assessment against the standards is undertaken by the Counter Fraud Service on behalf of the Trust for the work conducted during the period 1 April 2020 to 31 March 2021 inclusive.

This confirms the Trust's assessment that it met the required standard set by the NHS CFA, with some areas where it could improve the liaison with the NHS CFA. The Counter Fraud Team is accountable to the Director of Finance and the Audit Committee. All allegations relating to fraud are investigated by our Counter Fraud Team.

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-Executives, 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 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 was published in March 2020. The Trust also received the Routine Provider Information Request (RPIR) on the 11th February 2020, this information request precedes an inspection, usually within the next three months; however, due to COVID-19, this is likely to be delayed until August 2021.

The CQC is moving away from using comprehensive, on-site inspection as the main way of updating ratings. Instead, the CQC want to use wider sources of evidence, tools, and techniques to assess quality. This includes the gathering of appropriate evidence following focused or targeted inspections and continuous assessments without a site visits. However, inspection will remain an important part of how the CQC assess quality – they will still carry out on-site inspections where they have received information about significant risks to patient safety and to ensure the rights of vulnerable people are protected.

These process changes mean that the CQC will make more use of information that it holds on organisations when updating ratings, such that site visits may not always be necessary.

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 29th 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) 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. The Trust submitted its assessment for 19/20 on 29th September 2020 following the nationally extended deadline in recognition of reallocation of resources required for the coronavirus pandemic. The Trust achieved all 116 mandatories with 30 additional non-mandatories met. The submission was independently audited and provided significant assurance.

Work is now ongoing on the extended 20/21 submission with a baseline having been submitted in February 2021 ahead of a full deadline of 30th June 2021.

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 a continued focus on IG breaches throughout the Trust, seven incidents were discovered that were externally reportable to the Information Commissioners Office (ICO) in the past year. Three of these were confidentiality breaches and two of these were availability breaches. In all concluded investigations, 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 to prepare Quality Accounts for each financial year.

The Quality Report presents a balanced picture of Kettering General Hospital Foundation Trust's performance over the period covered from 1 April 2020 to 31 March 2021 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 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
- 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 was approved by the Quality and Safety Committee on 18 June 2021; it describes 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.

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 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 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 2020/21.

Signed: 

Chief Executive Date: 28 June 2021

4 External Audit Opinion and Annual accounts

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 on financial statements

We have audited the financial statements of Kettering General Hospital NHS Foundation Trust (the 'Trust') for the year ended 31 March 2021, 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 accounting standards in conformity with the requirements of the Accounts Directions issued under Schedule 7 of the National Health Service Act 2006, as interpreted and adapted by the Department of Health and Social Care Group Accounting Manual 2020 to 2021.

In our opinion, the financial statements:

- give a true and fair view of the financial position of the Trust as at 31 March 2021 and of its expenditure and income for the year then ended; and
- have been properly prepared in accordance with international accounting standards as interpreted and adapted by the Department of Health and Social Care Group Accounting Manual 2020 to 2021; 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, as required by the Code of Audit Practice (2020) ("the Code of Audit Practice") approved by the Comptroller and Auditor General. 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.

Conclusions relating to going concern

We are responsible for concluding on the appropriateness of the Accounting Officer's use of the going concern basis of accounting and, based on the audit evidence obtained, whether a material uncertainty exists related to events or conditions that may cast significant doubt on the Trust's ability to continue as a going concern. If we conclude that a material uncertainty exists, we are required to draw attention in our report to the related disclosures in the financial statements or, if such disclosures are inadequate, to modify the auditor's opinion. Our conclusions are based on the audit evidence obtained up to the date of our report. However, future events or conditions may cause the Trust to cease to continue as a going concern.

In our evaluation of the Accounting Officer's' conclusions, and in accordance with the expectation set out within the Department of Health and Social Care Group Accounting Manual 2020 to 2021 that the Trust's financial statements shall be prepared on a going concern basis, we considered the inherent risks associated with the continuation of services provided by the Trust. In doing so we had regard to the guidance provided in Practice Note 10 Audit of financial statements and regularity of public sector bodies in the United Kingdom (Revised 2020) on the application of ISA (UK) 570 Going Concern to public sector entities. We assessed the reasonableness of the basis of preparation used by the Trust and the Trust's disclosures over the going concern period.

Based on the work we have performed, we have not identified any material uncertainties relating to events or conditions that, individually or collectively, may cast significant doubt on the Trust's ability to continue as a going concern for a period of at least twelve months from when the financial statements are authorised for issue.

In auditing the financial statements, we have concluded that the Accounting Officer's use of the going concern basis of accounting in the preparation of the financial statements is appropriate.

The responsibilities of the Accounting Officer with respect to going concern are described in the 'Responsibilities of the Accounting Officer and Those Charged with Governance for the financial statements' section of this report.

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.

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 in April 2020 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 comply with the disclosure requirements set out in the NHS foundation trust annual reporting manual 2020/21 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.

Opinion on other matters required by the Code of Audit Practice

In our opinion, based on the work undertaken in the course of the audit:

- the parts of the Remuneration Report and the Staff Report to be audited have been properly prepared in accordance with international accounting standards in conformity with the requirements of the Accounts Directions issued under Schedule 7 of the National Health Service Act 2006[1]; and
- based on the work undertaken in the course of the audit of the financial statements and our knowledge of the Trust, 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 an officer of the Trust, is about to make, or has made, a decision which involves or would involve the incurring of unlawful expenditure, or is about to take, or has begun to take a course of action which, if followed to its conclusion, would be unlawful and likely to cause a loss or deficiency.

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

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

As explained more fully in the Statement of the Chief Executive's responsibilities as the accounting officer [set out on pages 62 and 63], 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 2020/21, 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 its 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.

Explanation as to what extent the audit was considered capable of detecting irregularities, including fraud

Irregularities, including fraud, are instances of non-compliance with laws and regulations. We design procedures in line with our responsibilities, outlined above, to detect material misstatements in respect of irregularities, including fraud. Owing to the inherent limitations of an audit, there is an unavoidable risk that material misstatements in the financial statements may not be detected, even though the audit is properly planned and performed in accordance with the ISAs (UK).

The extent to which our procedures are capable of detecting irregularities, including fraud is detailed below:

- We obtained an understanding of the legal and regulatory frameworks that are applicable to the Trust and determined that the most significant which are directly relevant to specific assertions in the financial statements are those related to the reporting frameworks (international accounting standards and the National Health Service Act 2006, as interpreted and adapted by the Department of Health and Social Care Group Accounting Manual 2020 to 2021).
- We enquired of management and the Audit Committee, concerning the Trust's policies and procedures relating to:
  - the identification, evaluation and compliance with laws and regulations;
  - the detection and response to the risks of fraud; and
  - the establishment of internal controls to mitigate risks related to fraud or non-compliance with laws and regulations.
- We enquired of management, internal audit and the Audit Committee, whether they were aware of any instances of non-compliance with laws and regulations or whether they had any knowledge of actual, suspected or alleged fraud.

- We assessed the susceptibility of the Trust's financial statements to material misstatement, including how fraud might occur, by evaluating management's incentives and opportunities for manipulation of the financial statements. This included the evaluation of the risk of management override of controls. We determined that the principal risks were in relation to:
  - journal entries that altered the Trust's financial performance for the year;
  - potential management bias in determining accounting estimates and judgements, especially in relation to:
    - the valuation of the Trust's land and buildings; and
    - accruals of income and expenditure at the end of the financial year.
- Our audit procedures involved:
  - evaluation of the design effectiveness of controls that management has in place to prevent and detect fraud;
  - journal entry testing, with a particular focus on significant journals at the end of the financial year which impacted on the Trust's financial performance;
  - challenging assumptions and judgements made by management in its significant accounting estimates in respect of land and building valuations, and in the estimation of income and expenditure accruals**;**
  - assessing the extent of compliance with the relevant laws and regulations as part of our procedures on the related financial statement item.
- These audit procedures were designed to provide reasonable assurance that the financial statements were free from fraud or error. However, detecting irregularities that result from fraud is inherently more difficult than detecting those that result from error, as those irregularities that result from fraud may involve collusion, deliberate concealment, forgery or intentional misrepresentations. Also, the further removed non-compliance with laws and regulations is from events and transactions reflected in the financial statements, the less likely we would become aware of it.
- The team communications in respect of potential non-compliance with relevant laws and regulations, including the potential for fraud in revenue and expenditure recognition, and the significant accounting estimates related to related to the valuations of the Trust's land and buildings.
- Assessment of the appropriateness of the collective competence and capabilities of the engagement team included consideration of the engagement team's.
  - understanding of, and practical experience with audit engagements of a similar nature and complexity through appropriate training and participation
  - knowledge of the health sector and economy in which the Trust operates
  - understanding of the legal and regulatory requirements specific to the Trust including:
    - the provisions of the applicable legislation
    - NHS Improvement's rules and related guidance
    - the applicable statutory provisions.
- In assessing the potential risks of material misstatement, we obtained an understanding of:
  - the Trust's operations, including the nature of its income and expenditure and its services and of its objectives and strategies to understand the classes of transactions, account balances, expected financial statement disclosures and business risks that may result in risks of material misstatement.
  - the Trust's control environment, including the policies and procedures implemented by the Trust to ensure compliance with the requirements of the financial reporting framework.

Report on other legal and regulatory requirements –the Trust's arrangements for securing economy, efficiency and effectiveness in its use of resources

Matter on which we are required to report by exception – the Trust's arrangements for securing economy, efficiency and effectiveness in its use of resources

Under the Code of Audit Practice, we are required to report to you if, in our opinion, we have not been able to satisfy ourselves that the Trust has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources for the year ended 31 March 2021.

We have nothing to report in respect of the above matter except on 28 June 2021 we identified a significant weakness in how the Trust plans and manages its resources to ensure it can continue to deliver its services. This was in relation to the Trust's failure during 2020/21 to:

- develop plans to address its underlying deficit and to deliver required efficiency savings
- establish a dedicated programme management office to plan, deliver, monitor and report on efficiency schemes.

We recommended that the Trust prepare a medium term financial plan which addresses its underlying deficit, develops comprehensive and achievable plans for delivering efficiency savings, and establishes a programme management office to deliver efficiency schemes.

Our work on the Trust's arrangements for securing economy, efficiency and effectiveness in its use of resources is not yet complete. The outcome of our work will be reported in our commentary on the Trust's arrangements in our Auditor's Annual Report. If we identify any further significant weaknesses in these arrangements, these will be reported by exception in our Audit Completion Certificate. We are satisfied that this work does not have a material effect on our opinion on the financial statements for the year ended 31 March 2021.

Responsibilities of the Accounting Officer

The Chief Executive, as 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. 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 issued by the Comptroller and Auditor General in April 2021. This guidance sets out the arrangements that fall within the scope of 'proper arrangements'. When reporting on these arrangements, the Code of Audit Practice requires auditors to structure their commentary on arrangements under three specified reporting criteria:

- Financial sustainability: how the Trust plans and manages its resources to ensure it can continue to deliver its services;
- Governance: how the Trust ensures that it makes informed decisions and properly manages its risks; and
- Improving economy, efficiency and effectiveness: how the Trust uses information about its costs and performance to improve the way it manages and delivers its services.

We document our understanding of the arrangements the Trust has in place for each of these three specified reporting criteria, gathering sufficient evidence to support our risk assessment and commentary in our Auditor's Annual Report. In undertaking our work, we have considered whether there is evidence to suggest that there are significant weaknesses in arrangements.

Report on other legal and regulatory requirements – Delay in certification of completion of the audit

We cannot formally conclude the audit and issue an audit certificate for Kettering General Hospital NHS Foundation Trust for the year ended 31 March 2021 in accordance with the requirements of Chapter 5 of Part 2 of the National Health Service Act 2006 and the Code of Audit Practice until we have completed our work on the Trust's arrangements for securing economy, efficiency and effectiveness in its use of resources.

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

28 June 2021

Independent auditor's report to the Council of Governors of Kettering General Hospital NHS Foundation Trust

In our auditor's report issued on 28 June 2021, we explained that we could not formally conclude the audit and issue an audit certificate for the Trust for the year ended 31 March 2021, in accordance with the requirements of Chapter 5 of Part 2 of the National Health Service Act 2006 and the Code of Audit Practice, until we had completed our work on the Trust's arrangements for securing economy, efficiency and effectiveness in its use of resources. We have now completed this work, and the results of our work are set out below.

Opinion on the financial statements

In our auditor's report for the year ended 31 March 2021 issued on 28 June 2021 we reported that, in our opinion the financial statements:

- give a true and fair view of the financial position of the Trust as at 31 March 2021 and of its expenditure and income for the year then ended;
- have been properly prepared in accordance with international accounting standards as interpreted and adapted by the Department of Health and Social Care Group Accounting Manual 2020 to 2021; and
- have been prepared in accordance with the requirements of the National Health Service Act 2006.

No matters have come to our attention since that date that would have a material impact on the financial statements on which we gave this opinion.

Report on other legal and regulatory requirements - the Trust's arrangements for securing economy, efficiency and effectiveness in its use of resources

Matter on which we are required to report by exception – the Trust's arrangements for securing economy, efficiency and effectiveness in its use of resources

Under the Code of Audit Practice, we are required to report to you if, in our opinion, we have not been able to satisfy ourselves that the Trust has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources for the year ended 31 March 2021.

We have nothing to report in respect of the above matter except on 28 June 2021 we identified a significant weakness in how the Trust plans and manages its resources to ensure it can continue to deliver its services. This was in relation to the Trust's failure during 2020/21 to:

- develop plans to address its underlying deficit and to deliver required efficiency savings
- establish a dedicated programme management office to plan, deliver, monitor and report on efficiency schemes.

We recommended that the Trust prepare a medium term financial plan which addresses its underlying deficit, develops comprehensive and achievable plans for delivering efficiency savings, and establishes a programme management office to deliver efficiency schemes. Responsibilities of the Accounting Officer

Responsibilities of the Accounting Officer

The Chief Executive, as 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. 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 issued by the Comptroller and Auditor General in April 2021. This guidance sets out the arrangements that fall within the scope of 'proper arrangements'. When reporting on these arrangements, the Code of Audit Practice requires auditors to structure their commentary on arrangements under three specified reporting criteria:

- Financial sustainability: how the Trust plans and manages its resources to ensure it can continue to deliver its services;
- Governance: how the Trust ensures that it makes informed decisions and properly manages its risks; and
- Improving economy, efficiency and effectiveness: how the Trust uses information about its costs and performance to improve the way it manages and delivers its services.

We have documented our understanding of the arrangements the Trust has in place for each of these three specified reporting criteria, gathering sufficient evidence to support our risk assessment and commentary in our Auditor's Annual Report. In undertaking our work, we have considered whether there is evidence to suggest that there are significant weaknesses in arrangements.

Report on other legal and regulatory requirements – Audit certificate

We certify that we have completed the audit of Kettering General Hospital NHS Foundation Trust for the year ended 31 March 2021 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

14 September 2021

Kettering General Hospital NHS Foundation Trust

Annual accounts for the year ended 31 March 2021

Foreword to the accounts

Kettering General Hospital NHS Foundation Trust

These accounts, for the year ended 31 March 2021, have been prepared by Kettering General Hospital NHS Foundation Trust in accordance with paragraphs 24 & 25 of Schedule 7 within the National Health Service Act 2006.

Signed ……

Name **Simon Weldon**
Job title **Group Chief Executive**
Date **28 June 2021**

Statement of Comprehensive Income

	Note	2020/21 £000	2019/20 £000
Operating income from patient care activities	3	296,563	257,390
Other operating income	4	51,264	34,060
Operating expenses	6, 8	(338,292)	(300,162)
Operating surplus/(deficit) from continuing operations		**9,535**	**(8,712)**
Finance income	11	-	91
Finance expenses	12	(242)	(3,798)
PDC dividends payable		(3,629)	-
Net finance costs		**(3,871)**	**(3,707)**
Other gains / (losses)	13	(151)	87
Surplus / (deficit) for the year from continuing operations		**5,513**	**(12,332)**
Surplus / (deficit) for the year		**5,513**	**(12,332)**
Other comprehensive income			
Will not be reclassified to income and expenditure:			
Impairments	7	(1,075)	(395)
Revaluations	17	2,668	3,406
Total comprehensive income / (expense) for the period		**7,106**	**(9,321)**

NHS Improvement Control Total

Adjusted financial performance (control total basis):		
Surplus / (deficit) for the period	5,513	(12,332)
Remove net impairments not scoring to the Departmental expenditure limit	825	(930)
Remove I&E impact of capital grants and donations	(1,697)	56
Remove 2018/19 post audit PSF reallocation (2019/20 only)	-	(212)
Remove net impact of inventories received from DHSC group bodies for COVID response	(543)	-
Adjusted financial performance surplus / (deficit)	**4,098**	**(13,418)**

During 2020/21, the Trust moved into a position of positive net assets and therefore a PDC dividend became payable in the year (see Note 1.17).

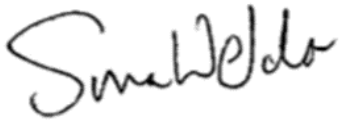
Statement of Financial Position

	Note	31 March 2021 £000	31 March 2020 £000
Non-current assets			
Intangible assets	14	6,825	5,917
Property, plant and equipment	15	148,781	142,734
Receivables	19	991	867
Other assets	20	-	-
Total non-current assets		**156,597**	**149,518**
Current assets			
Inventories	18	5,173	3,466
Receivables	19	11,919	12,193
Cash and cash equivalents	22	13,976	2,819
Total current assets		**31,068**	**18,478**
Current liabilities			
Trade and other payables	23	(23,222)	(19,800)
Borrowings	25	(1,838)	(170,463)
Provisions	27	(690)	(585)
Other liabilities	24	(2,329)	(1,528)
Total current liabilities		**(28,079)**	**(192,376)**
Total assets less current liabilities		**159,586**	**(24,380)**
Non-current liabilities			
Trade and other payables	23	-	-
Borrowings	25	(5,407)	(7,161)
Provisions	27	(517)	(473)
Total non-current liabilities		**(5,924)**	**(7,634)**
Total assets employed		**153,662**	**(32,014)**
Financed by			
Public dividend capital		243,209	64,639
Revaluation reserve		37,486	36,850
Income and expenditure reserve		(127,033)	(133,503)
Total taxpayers' equity		**153,662**	**(32,014)**

During 2020/21 all revenue loans and interim capital loans (£168m) were converted to Public Dividend Capital. These were shown as Current liabilities in 2019/20.

The notes on pages 5 to 37 form part of these accounts.

Name Simon Weldon
Position Group Chief Executive
Date 28 June 2021



Statement of Changes in Taxpayers' Equity for the year ended 31 March 2021

	Public dividend capital	Revaluation reserve	Income and expenditure reserve	Total
	£000	£000	£000	£000
Taxpayers' and others' equity at 1 April 2020 - brought forward	**64,639**	**36,850**	**(133,503)**	**(32,014)**
Surplus for the year	-	-	5,513	**5,513**
Other transfers between reserves	-	(957)	957	**-**
Impairments	-	(1,075)	-	**(1,075)**
Revaluations	-	2,668	-	**2,668**
Public dividend capital received	178,570	-	-	**178,570**
Taxpayers' and others' equity at 31 March 2021	**243,209**	**37,486**	**(127,033)**	**153,662**

During 2020/21 all revenue loans and interim capital loans (£168m) were converted to Public Dividend Capital.

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

	Public dividend capital	Revaluation reserve	Income and expenditure reserve	Total
	£000	£000	£000	£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)**

Information on reserves

Public dividend capital
Public dividend capital (PDC) is a type of public sector equity finance based on the excess of assets over liabilities at the time of establishment of the predecessor NHS organisation. Additional PDC may also be issued to Trusts by the Department of Health and Social Care. A charge, reflecting the cost of capital utilised by the Trust, is payable to the Department of Health as the public dividend capital dividend.

Revaluation reserve
Increases in asset values arising from revaluations are recognised in the revaluation reserve, except where, and to the extent that, they reverse impairments previously recognised in operating expenses, in which case they are recognised in operating income. Subsequent downward movements in asset valuations are charged to the revaluation reserve to the extent that a previous gain was recognised unless the downward movement represents a clear consumption of economic benefit or a reduction in service potential.

Income and expenditure reserve
The balance of this reserve is the accumulated surpluses and deficits of the Trust.

Statement of Cash Flows

	Note	2020/21 £000	2019/20 £000
Cash flows from operating activities			
Operating surplus / (deficit)		9,535	(8,712)
Non-cash income and expense:			
Depreciation and amortisation	6.1	8,689	7,457
Net impairments	7	825	(930)
Income recognised in respect of capital donations	4	(1,974)	(147)
(Increase) / decrease in receivables and other assets		(87)	(3,764)
(Increase) / decrease in inventories		(1,707)	132
Increase / (decrease) in payables and other liabilities		5,852	(4,712)
Increase in provisions		151	167
Net cash flows from / (used in) operating activities		**21,284**	**(10,509)**
Cash flows from investing activities			
Interest received		4	88
Purchase of intangible assets		(3,047)	(3,102)
Purchase of PPE and investment property		(11,290)	(9,490)
Sales of PPE and investment property		-	87
Receipt of cash donations to purchase assets		108	-
Net cash flows used in investing activities		**(14,225)**	**(12,417)**
Cash flows from financing activities			
Public dividend capital received		178,570	152
Movement on loans from DHSC		(169,403)	28,247
Capital element of finance lease rental payments		(275)	(299)
Interest on loans		(885)	(3,680)
Other interest		(47)	-
Interest paid on finance lease liabilities		(13)	(17)
PDC dividend paid		(3,849)	-
Net cash flows from financing activities		**4,098**	**24,403**
Increase in cash and cash equivalents		**11,157**	**1,477**
Cash and cash equivalents at 1 April - brought forward		**2,819**	**1,342**
Cash and cash equivalents at 31 March	22.1	**13,976**	**2,819**

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 2020/21 issued by the Department of Health and Social Care (DHSC). 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 Going concern

These accounts have been prepared on a going concern basis. The financial reporting framework applicable to NHS bodies, derived from the HM Treasury Financial Reporting Manual, defines that the anticipated continued provision of the entity's services in the public sector is normally sufficient evidence of going concern. After making enquiries, the Directors have a reasonable expectation that the services provided by the Trust will continue to be provided for the forseeable future. For this reason, the Directors have adopted the going concern basis in preparing the accounts, following the definition of going concern in the public sector adopted by HM Treasury's Financial Reporting Manual..

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's clinical income and employee benefits expenditure have been notionally increased by £8.0m (2019/20 - £7.3m) to reflect the increase in Employers Pension contributions from 1st April 2019. (see note 3.1)

Note 1.4 Sources of estimation uncertainty

The following is the major source of estimation uncertainty that has a significant risk of resulting in a material adjustment to the carrying amounts of assets and liabilities within the next financial year:

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 as provided with a valuation date of 31 March 2021.

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. A 1.09% movement in the BCIS cost indices or location factor for Northamptonshire would have an impact of increasing or reducing the valuation of the Trust's estate by £1.288m (£1.356m overall valuation less £0.68m for land).

Note 1.5 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 accounting policies for revenue recognition and the application of IFRS 15 are consistently applied. The contracting arrangements in the NHS changed between 2019/20 and 2020/21 affecting the application of the accounting policy under IFRS 15. This difference in application is explained below:

2020/21
The main source of income for the Trust is contracts with Commissioners for health care services. In 2020/21 the majority of the Trust's income from NHS Commissioners was in the form of block contract arrangements. During the first half of the year the Trust received block funding from its Commissioners. For the second half of the year, block contract arrangements were agreed at a Sustainability and Transformation Partnership level, The related entitlement to consideration not varying based on the levels of activity performed.

The Trust has received additional income outside of the block and system envelopes to reimburse specific costs incurred and other income top-ups to support the delivery of services. Reimbursement and top-up income is accounted for as variable consideration.

Comparative period (2019/20)
In the comparative period (2019/20), the Trust's contracts with NHS Commissioners included those where the Trust's entitlement to income varied according to services delivered. A performance obligation relating to delivery of a spell of health care was generally satisfied over time as healthcare was received and consumed simultaneously by the customer as the Trust performed it. The customer in such a contract was the commissioner, but the customer benefited as services were provided to their patient. Even where a contract could be broken down into separate performance obligations, healthcare generally aligned with paragraph 22(b) of the Standard entailing a delivery of a series of goods or services that were substantially the same and had a similar pattern of transfer. At the year end, the Trust accrued income relating to activity delivered in that year, where a patient care spell was incomplete. This accrual was disclosed as a contract receivable as entitlement to payment for work completed was usually only dependent on the passage of time.

In 2019/20, the Provider Sustainability Fund and Financial Recovery Fund enabled providers to earn income linked to the achievement of financial controls and performance targets. Income earned from the funds is accounted for as variable consideration.

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 perfomance 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. Some research income alternatively falls within the provisions of IAS 20 for government grants.

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 Works and Pension's Compensation Recovery Unit, has completed the NHS2 form and confirmed there are no discrepancies with the treatment. 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.

Note 1.6 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 1.7 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 1.8 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 and intangible assets.

Note 1.9 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.

Property, plant and equipment which has been reclassified as ‘held for sale’ cease to be depreciated upon the reclassification. Assets in the course of construction 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’ once the criteria in IFRS 5 are met. The sale must be highly probable and the asset available for immediate sale in its present condition.

Following reclassification, the assets are measured at the lower of their existing carrying amount and their ‘fair value less costs to sell’. Depreciation ceases to be charged and the assets are not revalued, except where the 'fair value less costs to sell' falls below the carrying amount. Assets are de-recognised when all material sale contract conditions have been met.

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

Donated and grant funded assets

Donated and grant funded property, plant and equipment assets are capitalised at their fair value on receipt. The donation/grant is credited to income at the same time, unless the donor has imposed a condition that the future economic benefits embodied in the grant are to be consumed in a manner specified by the donor, in which case, the donation/grant is deferred within liabilities and is carried forward to future financial years to the extent that the condition has not yet been met.

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

In 2020/21 this includes assets donated to the Trust by the Department of Health and Social Care as part of the response to the coronavirus pandemic. As defined in the GAM, the Trust applies the principle of donated asset accounting to assets that the Trust controls and is obtaining economic benefits from at the year end.

Useful lives of property, plant and equipment

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

	Min life Years	Max life Years
Buildings, excluding dwellings	10	51
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 1.10 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 1.11 Inventories

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

In 2020/21, the Trust received inventories including personal protective equipment from the Department of Health and Social Care at nil cost. In line with the GAM and applying the principles of the IFRS Conceptual Framework, the Trust has accounted for the receipt of these inventories at a deemed cost, reflecting the best available approximation of an imputed market value for the transaction based on the cost of acquisition by the Department.

Note 1.12 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 1.13 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 1.14 Leases

Leases are classified as finance leases when substantially all the risks and rewards of ownership are transferred to the lessee. All other leases are classified as operating leases.

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 1.15 Provisions

The Trust recognises a provision where it has a present legal or constructive obligation of uncertain timing or amount; for which it is probable that there will be a future outflow of cash or other resources; and a reliable estimate can be made of the amount. The amount recognised in the Statement of Financial Position is the best estimate of the resources required to settle the obligation. Where the effect of the time value of money is significant, the estimated risk-adjusted cash flows are discounted using HM Treasury's discount rates effective for 31 March 2021:

Injury benefit provisions both use the HM Treasury's pension dicount rate of minus 0.95% in real terms (19/20 - minus 0.5%).

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 1.16 Contingencies

Contingent assets (that is, assets arising from past events whose existence will only be confirmed by one or more future events not wholly within the entity's control) are not recognised as assets, but are disclosed in note 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 1.17 Public dividend capital

Public dividend capital (PDC) is a type of public sector equity finance, which represents the DHSC's investment in the Trust. HM Treasury has determined that, being issued under statutory authority rather than under contract, PDC is not a financial instrument within the meaning of IAS 32.

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

An annual charge, reflecting the cost of capital utilised by the Trust, is payable to the DHSC as a PDC dividend. The charge is calculated at the real rate set by HM Treasury (currently 3.5%) on the average relevant net assets of the Trust. Relevant net assets are calculated as the value of all assets less all liabilities, except for: donated and grant funded assets, average daily balances held with the Government Banking Service (GBS), approved expenditure on Covid 19 capital assets, assets under constrution for nationally directed schemes and any PDC divident balance receivable or payable.

The average relevant net assets are calculated as a simple average of opening and closing relevant net assets.

In accordance with the requirements laid down by the Department of Health and Social Care (as the issuer of PDC), the dividend for the year is calculated on the actual average relevant net assets as set out in the "pre-audit" version of the annual accounts. The dividend calculated is not revised should any adjustment to net assets occur as a result the audit of the annual accounts.

Note 1.18 Value added tax

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

Note 1.19 Climate change levy

Expenditure on the climate change levy is recognised in the Statement of Comprehensive Income as incurred, based on the prevailing chargeable rates for energy consumption.

Note 1.20 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 1.21 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 1.22 Early adoption of standards, amendments and interpretations

No new accounting standards or revisions to existing standards have been early adopted in 2020/21.

Note 1.23 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 2022. 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 2022, 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 defined by HM Treasury. Currently this rate is 0.91% but this may change between now and 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. For existing peppercorn leases not classified as finance leases, a right of use asset will be measured at current value in existing use or fair value. The difference between the asset value and the calculated lease liability will be recognised in the income and expenditure reserve on transition. No adjustments will be made on 1 April 2022 for existing finance leases.

For leases commencing in 2022/23, 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 2022/23 on the opening statement of financial position and the in-year impact on the statement of comprehensive income and capital additions as follows:

	£000
Estimated impact on 1 April 2022 statement of financial position	
Additional right of use assets recognised for existing operating leases	6,832
Additional lease obligations recognised for existing operating leases	(7,510)
Net impact on net assets on 1 April 2022	**(678)**
Estimated in-year impact in 2022/23	
Additional depreciation on right of use assets	(1,273)
Additional finance costs on lease liabilities	(83)
Lease rentals no longer charged to operating expenditure	1,590
Estimated impact on surplus / deficit in 2022/23	**234**
Estimated increase in capital additions for new leases commencing in 2022/23	**-**

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 therefore not permitted.

Note 2 Operating Segments

The Trust operates as a single operating segment. The Board of Directors, led by the Group 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 opertional performance of the Trust is assessed.

Note 3 Operating income from patient care activities

All income from patient care activities relates to contract income recognised in line with accounting policy 1.5

Note 3.1 Income from patient care activities (by nature)	2020/21	2019/20
	£000	£000
Acute services		restated*
Block contract / system envelope income*	265,603	230,808
High cost drugs income from commissioners (excluding pass-through costs)	17,453	15,352
Other NHS clinical income	-	-
All services		
Private patient income	27	96
Additional pension contribution central funding**	8,073	7,329
Other clinical income	5,407	3,805
Total income from activities	**296,563**	**257,390**

*As part of the coronavirus pandemic response, transaction flows were simplified in the NHS and providers and their commissioners moved onto block contract payments at the start of 2020/21. In the second half of the year, a revised financial framework built on these arrangements but with a greater focus on system partnership and providers derived most of their income from these system envelopes. Comparatives in this note are presented to be comparable with the current year activity. This does not reflect the contracting and payment mechanisms in place during the prior year.

**The employer contribution rate for NHS pensions increased from 14.3% to 20.6% (excluding administration charge) from 1 April 2019. Since 2019/20, NHS providers have 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.

Note 3.2 Income from patient care activities (by source)

	2020/21	2019/20
Income from patient care activities received from:	**£000**	**£000**
NHS England	46,617	43,881
Clinical commissioning groups	248,953	212,318
Department of Health and Social Care	7	-
Other NHS providers	178	215
NHS other	94	94
Non-NHS: private patients	27	96
Non-NHS: overseas patients (chargeable to patient)	228	145
Injury cost recovery scheme	420	566
Non NHS: other	39	75
Total income from activities	**296,563**	**257,390**
Of which:		
Related to continuing operations	296,563	257,390
Related to discontinued operations	-	-

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

	2020/21	2019/20
	£000	£000
Income recognised this year	228	145
Cash payments received in-year	25	51
Amounts added to provision for impairment of receivables	62	166
Amounts written off in-year	186	24

Note 4 Other operating income

	2020/21		
	Contract income	Non-contract income	Total
	£000	£000	£000
Research and development	564	-	**564**
Education and training	8,640	568	**9,208**
Non-patient care services to other bodies	2,273		**2,273**
Reimbursement and top up funding	26,788		**26,788**
Receipt of capital grants and donations		1,974	**1,974**
Charitable and other contributions to expenditure		5,409	**5,409**
Rental revenue from operating leases		169	**169**
Other income	4,697	182	**4,879**
Total other operating income	**42,962**	**8,302**	**51,264**
Of which:			
Related to continuing operations			51,264
Related to discontinued operations			-

Reimbursement and Top up funding relates to the funding of Non clinical income for the Trust during the Covid pandemic .It specifically includes funding to replace the Marginal rate Emergency tariff.

Other income includes £1.8m of local Sustainability and Transformation Partnership funding to support the Trust during the pandemic.

Charitable and other contributions to expenditure includes £5.19m of donated consumales and minor medical equipment from DHSC as part of the Covid response.

Reciept of capital grants and donations includes £1.83m of donated medical equipment from DHSC as part of the Covid response.

	2019/20		
	Contract income	Non-contract income	Total
	£000	£000	£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 (2019/20 only)	4,045		**4,045**
Financial recovery fund (2019/20 only)	9,608		**9,608**
Marginal rate emergency tariff funding (2019/20 only)	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			-

Note 5.1 Additional information on contract revenue (IFRS 15) recognised in the period

	2020/21	2019/20
	£000	£000
Revenue recognised in the reporting period that was included in within contract liabilities at the previous period end	1,528	1,348
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 (i) contracts with an expected duration of one year or less and (ii) 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:

	2020/21	2019/20
	£000	£000
Income from services designated as commissioner requested services	252,969	211,816
Income from services not designated as commissioner requested services	43,594	45,574
Total	**296,563**	**257,390**

Note 6.1 Operating expenses

	2020/21	2019/20
	£000	£000
Purchase of healthcare from NHS and DHSC bodies	2,945	3,944
Purchase of healthcare from non-NHS and non-DHSC bodies	7,798	4,954
Staff and executive directors costs	229,427	205,995
Remuneration of non-executive directors	149	141
Supplies and services - clinical (excluding drugs costs)	24,815	22,473
Supplies and services - general	3,135	2,749
Drug costs (drugs inventory consumed and purchase of non-inventory drugs)	23,381	22,561
Inventories written down	504	220
Consultancy costs	1,955	806
Establishment	2,521	2,343
Premises	13,182	11,234
Transport (including patient travel)	391	712
Depreciation on property, plant and equipment	7,516	6,823
Amortisation on intangible assets	1,173	634
Net impairments	825	(930)
Movement in credit loss allowance: contract receivables / contract assets	22	133
Increase/(decrease) in other provisions	356	115
Change in provisions discount rate(s)	30	45
Audit fees payable to the external auditor		
audit services- statutory audit	94	76
other auditor remuneration (external auditor only)	-	3
Internal audit costs	99	105
Clinical negligence	9,648	8,366
Legal fees	102	110
Insurance	205	172
Research and development	536	536
Education and training	2,132	1,844
Rentals under operating leases	2,863	1,382
Redundancy	23	697
Car parking & security	1,055	801
Hospitality	8	29
Losses, ex gratia & special payments	89	50
Other services, eg external payroll	243	326
Other	1,070	713
Total	**338,292**	**300,162**
Of which:		
Related to continuing operations	338,292	300,162
Related to discontinued operations	-	-

Staff and executive directors costs includes an employers pension increase of £8.1m (19/20 - £7.3m), relating to an increase of 6.3% in this contribution from 1 April 2019. An equal amount is included in clinical income.

Note 6.2 Other auditor remuneration

	2020/21	2019/20
	£000	£000
Other auditor remuneration paid to the external auditor:		
Audit-related assurance services	-	3
Total	**-**	**3**

Note 6.3 Limitation on auditor's liability

The limitation on auditor's liability for external audit work is £1 million (2019/20: £1 million).

Note 7 Impairment of assets

	2020/21	2019/20
	£000	£000
Net impairments charged to operating surplus / deficit resulting from:		
Changes in market price	825	(1,043)
Other	-	113
Total net impairments charged to operating surplus / deficit	**825**	**(930)**
Impairments charged to the revaluation reserve	1,075	395
Total net impairments	**1,900**	**(535)**

The change in marktet price impairment relates to the impact of the valuation of the Trust estate.

Note 8 Employee benefits

	2020/21	2019/20
	Total	Total
	£000	£000
Salaries and wages	177,310	153,581
Social security costs	16,591	14,410
Apprenticeship levy	840	747
Employer's contributions to NHS pensions	26,604	24,098
Pension cost - other	35	22
Termination benefits	23	697
Temporary staff (including agency)	11,516	16,110
Total gross staff costs	**232,919**	**209,665**
Recoveries in respect of seconded staff	(153)	(151)
Total staff costs	**232,766**	**209,514**
Of which		
Costs capitalised as part of assets	1,913	1,503

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 £8.1m (19/20 - £7.3m) reflecting the increase in employer pension contributions from 1 April 2019. This represented an increase from 14.38% to 20.68%.

Note 8.1 Retirements due to ill-health

During 2020/21 there were 4 early retirements from the Trust agreed on the grounds of ill-health (1 in the year ended 31 March 2020). The estimated additional pension liabilities of these ill-health retirements is £48k (£50k in 2019/20).

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 2021, is based on valuation data as at 31 March 2020, updated to 31 March 2021 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 at 20.6% of pensionable pay. The 2016 funding valuation was also expected to test the cost of the Scheme relative to the employer cost cap that was set following the 2012 valuation. In January 2019, the Government announced a pause to the cost control element of the 2016 valuations, due to the uncertainty around member benefits caused by the discrimination ruling relating to the McCloud case.

The Government subsequently announced in July 2020 that the pause had been lifted, and so the cost control element of the 2016 valuations could be completed. The Government has set out that the costs of remedy of the discrimination will be included in this process. HMT valuation directions will set out the technical detail of how the costs of remedy will be included in the valuation process. The Government has also confirmed that the Government Actuary is reviewing the cost control mechanism (as was originally announced in 2018). The review will assess whether the cost control mechanism is working in line with original government objectives and reported to Government in April 2021. The findings of this review will not impact the 2016 valuations, with the aim for any changes to the cost cap mechanism to be made in time for the completion of the 2020 actuarial valuations.

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 five lease arrangements, one relating to a telecommunications mast, the other four relating to franchise operations providing amenities for patients, staff and visitors. Three of these leases contain a profit share element included in contingent rent.

	2020/21	2019/20
	£000	£000
Operating lease revenue		
Minimum lease receipts	183	177
Contingent rent	(14)	97
Total	**169**	**274**

	31 March 2021	31 March 2020
	£000	£000
Future minimum lease receipts due:		
- not later than one year;	200	177
- later than one year and not later than five years;	605	681
- later than five years.	44	28
Total	**849**	**886**

Note 10.2 Kettering General Hospital NHS Foundation Trust as a lessee

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

The Trust has seventeen land and building lease arrangements relating to clinical service provision on the main Trust and 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.

	2020/21	2019/20
	£000	£000
Operating lease expense		
Minimum lease payments	2,863	1,382
Total	**2,863**	**1,382**

	31 March 2021	31 March 2020
	£000	£000
Future minimum lease payments due:		
- not later than one year;	1,609	1,132
- later than one year and not later than five years;	3,361	2,822
- later than five years.	2,418	2,819
Total	**7,388**	**6,773**
Future minimum sublease payments to be received	-	-

Note 11 Finance income

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

	2020/21	2019/20
	£000	£000
Interest on bank accounts	-	90
Other finance income	-	1
Total finance income	**-**	**91**

Note 12.1 Finance expenditure

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

	2020/21	2019/20
	£000	£000
Interest expense:		
Loans from the Department of Health and Social Care	184	3,779
Finance leases	13	17
Total interest expense	**197**	**3,796**
Unwinding of discount on provisions	(2)	1
Other finance costs	47	1
Total finance costs	**242**	**3,798**

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)

	2020/21	2019/20
	£000	£000
Gains on disposal of assets	-	87
Losses on disposal of assets	(151)	-
Total gains / (losses) on disposal of assets	**(151)**	**87**
Total other gains / (losses)	**(151)**	**87**

Note 14 Intangible assets - 2020/21

	Software licences	Total
	£000	£000
Valuation / gross cost at 1 April 2020 - brought forward	**8,585**	**8,585**
Additions	2,081	**2,081**
Valuation / gross cost at 31 March 2021	**10,666**	**10,666**
Amortisation at 1 April 2020 - brought forward	**2,668**	**2,668**
Provided during the year	1,173	**1,173**
Amortisation at 31 March 2021	**3,841**	**3,841**
Net book value at 31 March 2021	**6,825**	**6,825**
Net book value at 1 April 2020	**5,917**	**5,917**

Note 14.1 Intangible assets - 2019/20

	Software licences	Total
	£000	£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**

In January 2021, the Audit Committee reviewed, and did not amend, the policy for valuing Intangible assets for 2020/21.

Note 15.1 Property, plant and equipment - 2020/21

	Land	Buildings excluding dwellings	Assets under construction	Plant & machinery	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000
Valuation/gross cost at 1 April 2020 - brought forward	**6,261**	**117,080**	**623**	**39,151**	**8,539**	**59**	**171,713**
Additions	-	3,697	2,112	5,627	1,510	-	**12,946**
Impairments	-	(2,223)	-	-	-	-	**(2,223)**
Reversals of impairments	-	323	-	-	-	-	**323**
Revaluations	5	(760)	-	-	-	-	**(755)**
Disposals / derecognition	-	-	-	(3,038)	(399)	-	**(3,437)**
Valuation/gross cost at 31 March 2021	**6,266**	**118,117**	**2,735**	**41,740**	**9,650**	**59**	**178,567**
Accumulated depreciation at 1 April 2020 - brought forward	**-**	**-**	**-**	**25,016**	**3,936**	**27**	**28,979**
Provided during the year	-	3,423	-	3,154	933	6	**7,516**
Revaluations	-	(3,423)	-	-	-	-	**(3,423)**
Disposals / derecognition	-	-	-	(3,018)	(268)	-	**(3,286)**
Accumulated depreciation at 31 March 2021	**-**	**-**	**-**	**25,152**	**4,601**	**33**	**29,786**
Net book value at 31 March 2021	**6,266**	**118,117**	**2,735**	**16,588**	**5,049**	**26**	**148,781**
Net book value at 1 April 2020	**6,261**	**117,080**	**623**	**14,135**	**4,603**	**32**	**142,734**

Note 15.2 Property, plant and equipment - 2019/20

	Land	Buildings excluding dwellings	Assets under construction	Plant & machinery	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000
Valuation / gross cost at 1 April 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 15.3 Property, plant and equipment financing - 2020/21

	Land	Buildings excluding dwellings	Assets under construction	Plant & machinery	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000
Net book value at 31 March 2021							
Owned - purchased	6,266	113,908	2,614	14,453	5,039	26	**142,306**
Finance leased	-	1,398	-	-	-	-	**1,398**
Owned - donated/granted	-	2,811	121	2,135	10	-	**5,077**
NBV total at 31 March 2021	**6,266**	**118,117**	**2,735**	**16,588**	**5,049**	**26**	**148,781**

Donated Plant and machinery includes £1.8m of assets donated to the Trust by DHSC as part of the Covid response.

Note 15.4 Property, plant and equipment financing - 2019/20

	Land	Buildings excluding dwellings	Assets under construction	Plant & machinery	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000
Net book value at 31 March 2020							
Owned - purchased	6,261	112,795	610	13,682	4,575	32	**137,955**
Finance leased	-	1,488	-	-	-	-	**1,488**
Owned - donated/granted	-	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 16 Donations of property, plant and equipment

The Trust received £1.8m of plant and equipment from DHSC as part of the Covid response. In addition the Trust received a Low carbon Fund grant of £108k, the expenditure for which is included in Assets Under Construction and £40k of equipment from the Kettering General Hospital NHSFT Charitable Fund (2019/20 £147k)

Note 17 Revaluations of property, plant and equipment

The Trust's land and buildings are valued on the basis explained in Note1 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 2021.

Note 18 Inventories

	2021	2020
	£000	£000
Drugs	1,404	1,261
Consumables	3,744	2,186
Energy	25	19
Total inventories	**5,173**	**3,466**
of which:		
Held at fair value less costs to sell	-	-

Inventories recognised in expenses for the year were £32,317k (2019/20: £33,526k). Write-down of inventories recognised as expenses for the year were £504k (2019/20: £220k).This write down includes £118k of consumable stock donated by DHSC as part of the Covid response and subsequently revalued to market value.

Consumables includes £543k of Stocks donated by DHSC as part of the Covid response. The Trust has opened new clinical areas in response to the pandemic and is also holding additional drug and consumable stocks while the pandemic continues.

In response to the COVID 19 pandemic, the Department of Health and Social Care centrally procured personal protective equipment and passed these to NHS providers free of charge. During 2020/21 the Trust received £5.2m of items purchased by DHSC.

These inventories were recognised as additions to inventory at deemed cost with the corresponding benefit recognised in income. The utilisation of these items is included in the expenses disclosed above.

Note 19.1 Receivables

	31 March 2021	31 March 2020
	£000	£000
Current		
Contract receivables	7,333	9,051
Allowance for impaired contract receivables / assets	(514)	(622)
Prepayments	3,530	2,824
Interest receivable	-	10
PDC dividend receivable	220	-
VAT receivable	723	481
Other receivables	627	449
Total current receivables	**11,919**	**12,193**
Non-current		
Contract receivables	732	701
Prepayments (non-PFI)	259	166
Total non-current receivables	**991**	**867**
Of which receivable from NHS and DHSC group bodies:		
Current	5,858	7,007
Non-current	-	-

The contract receivables figure for 2019/20 includes £2.8m of income to support additional Covid 19 expenditure incurred. This has been funded in year during 2020/21.

Note 19.2 Allowances for credit losses

	2020/21		2019/20	
	Contract receivables and contract assets	All other receivables	Contract receivables and contract assets	All other receivables
	£000	£000	£000	£000
Allowances as at 1 April - brought forward	**622**	**-**	**535**	**-**
New allowances arising	36	-	148	-
Reversals of allowances	(14)	-	(15)	-
Utilisation of allowances (write offs)	(130)	-	(46)	-
Allowances as at 31 Mar 2021	**514**	**-**	**622**	**-**

Note 20 Other assets

The Trust holds no Other Assets (2019/20 - nil)

Note 21.1 Non-current assets held for sale

The Trust holds no Non -current assets held for sale (2019/20 - nil)

Note 22.1 Cash and cash equivalents movements

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

	2020/21	2019/20
	£000	£000
At 1 April	**2,819**	**1,342**
Net change in year	11,157	1,477
At 31 March	**13,976**	**2,819**
Broken down into:		
Cash at commercial banks and in hand	67	55
Cash with the Government Banking Service	13,909	2,764
Deposits with the National Loan Fund		
Other current investments		
Total cash and cash equivalents as in SoCF	**13,976**	**2,819**

The improvement in the Trust's cash position is due to the surplus position of £3.4m, an underspend against the capital programme of £4.5m and movements in working capital balances.

Note 22.2 Third party assets held by the Trust

The Trust held no cash and cash equivalents which relate to monies held by the Trust on behalf of patients or other parties (2019/20-nil),

Note 23.1 Trade and other payables

	31 March 2021 £000	31 March 2020 £000
Current		
Trade payables	5,053	4,364
Capital payables	1,820	3,449
Accruals	6,197	4,786
Social security costs	4,743	4,015
Other payables	5,409	3,186
Total current trade and other payables	**23,222**	**19,800**
Of which payables from NHS and DHSC group bodies:		
Current	1,070	1,843
Non-current	-	-

Other payables includes £2.6m due to the NHS Pensions Agency (2019/20 - £2.3m)and £314k of overtime claims following a court ruling during 2020/21. These claims were included as a contingent liability in the 2019/20 accounts The remainder of the increase relates mostly to additional staffing creditors.

Accruals includes £2.3m of annual leave accruals (2019/20 - nil) This accrual acknowledges the annual leave staff have been unable to take due to the Covid pandemic and is funded by NHS England. The Trust has received £1.6m in cash terms in the year and has a debtor of £0.7m.

Note 23.2 Early retirements in NHS payables above

There were no early retirement costs included in NHS payables (2019/20 - nil)

Note 24 Other Liabilities

	31 March 2021 £000	31 March 2020 £000
Current		
Deferred income: contract liabilities	2,329	1,528
Total other current liabilities	**2,329**	**1,528**

Note 25.1 Borrowings

	31 March 2021 £000	31 March 2020 £000
Current		
Loans from DHSC	1,563	170,187
Obligations under finance leases	275	276
Total current borrowings	**1,838**	**170,463**
Non-current		
Loans from DHSC	5,200	6,680
Obligations under finance leases	207	481
Total non-current borrowings	**5,407**	**7,161**

Under the NHS capital and cash regime reforms for 2020/21, all revenue loans and interim capital loans (£168m) were converted to Public Dividend Capital.

Note 25.2 Reconciliation of liabilities arising from financing activities - 2020/21

	Loans from DHSC	Finance leases	Total
	£000	£000	£000
Carrying value at 1 April 2020	**176,867**	**757**	**177,624**
At start of period for new FTs	**-**	**-**	**-**
Cash movements:			
Financing cash flows - payments and receipts of principal	(169,403)	(275)	**(169,678)**
Financing cash flows - payments of interest	(885)	(13)	**(898)**
Non-cash movements:			
Application of effective interest rate	184	13	**197**
Carrying value at 31 March 2021	**6,763**	**482**	**7,245**

Note 25.3 Reconciliation of liabilities arising from financing activities - 2019/20

	DHSC	leases	Total
	£000	£000	£000
Carrying value at 1 April 2019	**148,521**	**1,056**	**149,577**
At start of period for new FTs	-	-	**-**
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 26 Finance leases

Note 26.1 Kettering General Hospital NHS Foundation Trust as a lessor

The Trust held no finance leases as a lessor (2019/20 - 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 2021	31 March 2020
	£000	£000
Gross lease liabilities	**505**	**793**
of which liabilities are due:		
- not later than one year;	288	288
- later than one year and not later than five years;	217	505
Finance charges allocated to future periods	(23)	(36)
Net lease liabilities	**482**	**757**
of which payable:		
- not later than one year;	275	276
- later than one year and not later than five years;	207	481

Note 27.1 Provisions for liabilities and charges analysis

	Pensions: injury benefits	Legal claims	Re-structuring	Other	Total
	£000	£000	£000	£000	£000
At 1 April 2020	**496**	**512**	**50**	**-**	**1,058**
At start of period for new FTs	-	-	-	-	**-**
Transfers by absorption	-	-	-	-	**-**
Change in the discount rate	30	-	-	-	**30**
Arising during the year	39	219	-	419	**677**
Utilised during the year	(23)	(165)	-	-	**(188)**
Reversed unused	-	(318)	(50)	-	**(368)**
Unwinding of discount	(2)	-	-	-	**(2)**
At 31 March 2021	**540**	**248**	**-**	**419**	**1,207**
Expected timing of cash flows:					
- not later than one year;	23	248	-	**419**	**690**
- later than one year and not later than five years;	95	-	-	**-**	**95**
- later than five years.	422	-	-	**-**	**422**
Total	**540**	**248**	**-**	**419**	**1,207**

Other provisions relates to a potential loss on disposal of some ventilators bought at the start of the Pandemic which are being assessed as to their clinical appropriateness for the Trust. The provision is based on the Net Book Value at 31st March 2021.

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.

Note 27.2 Clinical negligence liabilities

At 31 March 2021, £207m was included in provisions of NHS Resolution in respect of the clinical negligence liabilities of the Trust (31 March 2020: £175.5m).

Note 28 Contingent assets and liabilities

	31 March 2021	31 March 2020
	£000	£000
Value of contingent liabilities		
NHS Resolution legal claims	(24)	(53)
Gross value of contingent liabilities	**(24)**	**(53)**
Amounts recoverable against liabilities	-	-
Net value of contingent liabilities	**(24)**	**(53)**
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.

Note 29 Contractual capital commitments

	31 March 2021 £000	31 March 2020 £000
Property, plant and equipment	3,859	3,900
Intangible assets	2,964	3,289
Total	**6,823**	**7,189**

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.

Market risk

The Trust has borrowed from the government for normal capital expenditure. The only borrowing has the last repayment in April 2025, in line with the 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. The Trust has also revalued its Personal Protective Equipment stock to Market Value at 31st March 2021. This adjustment was due to the Covid Pandemic's impact on the fluctuating costs of these items during the year and is expected to only be relevant for the 2020/21 accounts.

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

Carrying values of financial assets as at 31 March 2021	Held at amortised cost	Total book value
	£000	£000
Trade and other receivables excluding non financial assets	8,178	**8,178**
Cash and cash equivalents	13,976	**13,976**
Total at 31 March 2021	**22,154**	**22,154**

Carrying values of financial assets as at 31 March 2020	Held at amortised cost	Total book value
	£000	£000
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**

Note 30.3 Carrying values of financial liabilities

Carrying values of financial liabilities as at 31 March 2021	Held at amortised cost	Total book value
	£000	£000
Loans from the Department of Health and Social Care	6,763	**6,763**
Obligations under finance leases	482	**482**
Trade and other payables excluding non financial liabilities	16,227	**16,227**
Provisions under contract	1,207	**1,207**
Total at 31 March 2021	**24,679**	**24,679**

Carrying values of financial liabilities as at 31 March 2020	Held at amortised cost	Total book value
	£000	£000
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**

Under the NHS capital and cash regime reforms for 2020/21, all revenue loans and interim capital loans (£168m) were converted to Public Dividend Capital.

Note 30.4 Maturity of financial liabilities

The following maturity profile of financial liabilities is based on the contractual undiscounted cash flows. This differs to the amounts recognised in the statement of financial position which are discounted to present value.

	31 March 2021	31 March 2020 restated*
	£000	£000
In one year or less	18,859	184,578
In more than one year but not more than five years	5,797	6,964
In more than five years	422	1,151
Total	**25,078**	**192,693**

* This disclosure has previously been prepared using discounted cash flows. The comparatives have therefore been restated on an undiscounted basis.

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

	2020/21		2019/20	
	Total number of cases	Total value of cases	Total number of cases	Total value of cases
	Number	£000	Number	£000
Losses				
Cash losses	25	11	31	15
Fruitless payments and constructive losses	1	-	-	-
Bad debts and claims abandoned	24	188	19	32
Stores losses and damage to property	3	120	3	220
Total losses	**53**	**319**	**53**	**267**
Special payments				
Ex-gratia payments	42	66	69	68
Total special payments	**42**	**66**	**69**	**68**
Total losses and special payments	**95**	**385**	**122**	**335**
Compensation payments received		-		-

The fruitless payment, made by the Trust during the year, was below £150 and therefore does not record as a value in the table above.

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:

Northamptonshire 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 is in a Group management arrangement with Northampton General Hospital NHS Trust. Transactions relating to this Group arrangement are transacted on an arms length basis, with all relevant costs, including Directors pay, being recharged between the two organisations.

The Trust has also received revenue payments and capital donations from Kettering General Hospital NHSFT Charitable Funds whose Corporate Trustee is the Trust Board. An administration charge of £22k (2019/20: £25k) was made by the Trust to the charity.

Note 33 Charitable Funds Consolidation

Up to 31st March 2021, the Trust is the Corporate Trustee to Kettering General Hospital NHSFT General charitable Funds. The Trust has assessed its relationship to the charitable fund and determined it to be a subsidiary because the 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.

From 1st April 2021 the charitable funds merged with Northamptonshire Health Charity and the Trust will no longer have the power to govern the financial and operating policies of the charitable fund.

Note 34 Prior period adjustments

The Trust had no prior period adjustments.

Note 35 Events after the reporting date

There have been no events after the reporting date that would impact on the financial statements.