Dedicated to excellence

NHS
Kettering General Hospital
NHS Foundation Trust

Annual Report and Accounts 2022-23

Kettering General Hospital NHS Foundation Trust

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

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1.1 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 2022/23. 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 welcome from our Chair and statement from our Chief Executive.

1.1.2 Chair's welcome

Welcome to our annual report for 2022-23. It has been a pleasure to be asked to step into the role of Chair of our hospital since the retirement of Alan Burns, our University Hospitals of Northamptonshire Group Chair, in March 2023. I will hold this role until our new Chair, John MacDonald, joins us in July 2023. As a member of the Board I had already witnessed some truly amazing work, putting our patients first to offer the best care possible throughout some of the most challenging times in the NHS's history. Being in the privileged position as Chair, my admiration has only grown for our teams, who show courage, accountability, compassion, integrity and respect throughout their work.

On behalf of our hospitals, and our Group, I would like to thank Alan for the last five years of invaluable support, insight and leadership. He has played an integral role in helping our hospitals, Kettering and Northampton, work together to achieve university hospital status as the University Hospitals of Northamptonshire in July 2021. This was alongside our Group CEO, Simon Weldon, who also stepped down in March after five years with our organisations. Again, we owe a big thanks to Simon for his contribution and dedication – especially around his leadership of our clinical collaboration.

As we enter further into 2023 I look forward to seeing what the teams at our hospital and our Group, alongside our wider healthcare partners, can achieve to offer the best care to our communities across Northamptonshire.

Trevor Shipman
Interim Trust Chair

1.1.3 Chief Executive's Overview

Over the last year the NHS has faced numerous challenges, and we at Kettering General Hospital have been no different, with the impact of the COVID-19- pandemic still being felt across our services, be it through the spreading of the virus itself or the recovery of our services and attempts to reduce those patients waiting for treatment. In addition, we have seen several occurrences of industrial action – starting with our colleagues who are members of the Royal College of Nursing, and more latterly junior doctors. We respect the right of colleagues to take industrial action, and we are grateful to our teams for working together to support each other and continuing to care for our patients in the best way possible during this time. I join with colleagues in hoping for a swift conclusion to these matters.

Our teams have again shown incredible skills, passion and dedication in providing excellent care to our patients. No matter the challenge they are facing, I have witnessed them approach solutions keeping the patients at the heart of their work, with our values of compassion, accountability, respect, integrity and courage proudly on show. I have seen care being offered that goes above and beyond what may be expected. I want to thank them for this. I am incredibly privileged to be your Chief Executive, it is a real honour.

Over the last year, we have found new ways to celebrate and recognise more of our colleagues with the continuation of the Daisy awards and the launch of Rose (Recognising our Staff Excellence) awards across our hospital. Over 60 patients, families and carers have now nominated our nurses and midwives for the internationally recognised Daisy award, which celebrates the exceptional care provided by the recipients. These awards aim to celebrate the excellence in care and the outstanding contribution made by our healthcare support workers, allied health professions, pharmacists, scientists and other non-nursing or medical registrants. I would encourage anyone who has had excellent care to take a look at the nomination pages on our website.

Earlier this year, our hospital implemented shared decision-making (SDM) in response to the requirement for enhanced collaboration and involvement among frontline staff in decision-making. Shared decision making is a fantastic way to engage a team to make improvements in their area of work or beyond. Since we started this journey, our hospital's SDM structure has grown to include eight councils, each with a distinct purpose, and a leadership council that oversees the entire procedure. Councils have been established in the following areas: Internationally Educated Nurses, Skylark Ward, Emergency Department , Centenary Wing, Medical Same Day Emergency Care, Therapies, Fracture Clinic and the Intensive Care Unit.

I have seen some fantastic examples of changes being developed and put into place and I am keen to see even more over the next 12 months; we have set an ambitious target of having at least 10 SDM councils in place by September 2023.

In December, we had an unannounced CQC inspection of our Children and Young People Services. Our service for Children and Young People was subsequently rated inadequate.

I would like to take this opportunity to apologise to any family who has been let down by the care they have received in our children's service. I know I speak on behalf of our teams when I say we are truly sorry. The Board and I are committed to working with and supporting our teams and listening to families to make the changes that are needed. This is a top priority for our hospital over the coming year. Following the inspection, we swiftly put an action plan in place, led by Jayne Skippen, our new Director of Nursing, Midwifery and Allied Health Professionals. I'd like to reassure you that changes have already taken place – in January 2023 we moved our Paediatric Emergency Department so it is better located to serve the needs of our most unwell children and young people, we have recruited more staff and we have put measures in place to ensure we have safe levels of staffing. We have also introduced extra training and audits to check our compliance. There is more to do, and we know these changes will take time to ensure they are embedded but you have my commitment that we will do everything we can to offer the best services to every patient in our care, every time. I want to thank our staff for their dedication to improve the services and our patients and families for their support.

As I mentioned in the introduction, performance across the hospital has continued to be challenged from the impact of the pandemic but our teams have worked together admirably to offer the best service possible to our patients – our Performance Analysis, later in this report, provides details.

We have continued our collaborative working with Northampton General Hospital as part of University Hospitals of Northamptonshire Group, and I look forward to seeing this progressing over the next year. One aspect of collaborative working to highlight is the creation of our Cardiology Centre of Excellence. Our aim is that this integrated service will be known nationally for exemplary outcomes, excellent patient and staff experience, and complexity of caseload. It will provide safe, effective cardiology care for everyone in Northamptonshire across both of our hospital sites regardless of where patients live in our county. The strategy which has recently been approved by both Boards will see the programme of work taking place over a 3-year period. Collaboration between some specialist services across our Group can offer our communities improved and more robust access to care and I am excited to see more clinical services collaborate over the next year.

Our digital transformation programme is a key enabler for successful clinical collaboration. We were very ambitious with our aims for digital transformation over the past year, and although there has been some progress, for example both sites now have scanned medical records, we acknowledge our plans were overly ambitious and we are now looking towards 23/24 to deliver some of our critical projects – such as the first phase of our Northamptonshire Shared Care Record. We recognise having a digital service shared across our two hospitals brings greater flexibility, agility, and support for the clinical collaboration agenda and therefore, our digital team has been undergoing a major restructure to create one Group-wide team. This restructure concludes in 23/24 and I look forward to continuing to work with the Digital Division on some of the key collaboration enablers understanding the sharing of information across KGH and NGH will enable our colleagues to deliver excellent services.

In October, we celebrated Black History Month to recognise the outstanding contributions of people, and especially our team members, from REACH (Race, Ethnicity and Cultural Heritage) backgrounds. The theme for 2022 was ‘Time for change. Time for action’. The REACH network at KGH created a short video explaining why the month is important to them. We also demonstrated several role model stories with colleagues who identify as being from a REACH background. These colleagues were from a variety of areas across the hospital. At the end of October, we held a special social event to celebrate our overseas colleagues and the REACH network. Once again it was a wonderful time to truly celebrate colleagues’ overwhelming energy, dedication, talent, and contribution to our community. I am proud to work alongside you all every month of the year.

Without the contribution of our workforce, we would not be able care for our communities in the way that we do. They are also the ones who understand how a hospital works and are the true experts in their areas of business. In June 2021 we launched our “Let’s Talk ” listening events, which I host along with Directors from the Senior Leadership Team each week. These sessions are attended by our staff to allow them to talk to me and colleagues about the things that really matter to them. The weekly events have continued throughout the year, and I see many examples of colleagues sharing good practice, learning from each other as well as collectively problem solving. Over the next 12 months we will be starting our “be the change” excellence programme, which will further improve our staff engagement, empowerment and inclusion, this is something that the senior leadership team and I are very much looking forward to.

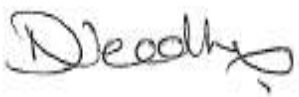
In a very different type of staff event, another highlight of the year was our annual fund-raising panto that was held in October. Written and performed by our troupe of talented colleagues, 2022 marked their 22nd performance. Much anticipated by colleagues, this latest panto was loosely based on The Wizard of Oz with plenty of laughter along the way. As well as being a much-loved staple of the Kettering General Hospital staff calendar, the panto raises funds for the Northamptonshire Health Charity. This most recent production raised £2,000, with this going to support the newly developed Intensive Care Unit garden.

We have also been looking at the future of our NHS workforce. Our People Development Team arranged a comprehensive series of exciting work experience events for young people interested in careers in healthcare. It was lovely to see that space on the four evening sessions booked out quickly with local young

people from Northamptonshire and surrounding counties visiting our hospital to take part. The sessions were focussed on clinical careers, nursing and midwifery, Allied Health Professionals and non-clinical roles within the NHS. Feedback from the young people who attended was overwhelmingly positive, with both young people and their parents telling us how it had been an inspiring and eye-opening series of events. I look forward to seeing some of them join our teams in the future.

Our teams continue to provide care in a number of facilities which are urgent need of improvement to meet modern capacity and demand, and we were very pleased to the Secretary of State's announcement, in May 2023, that the government remains committed to a significant hospital rebuild. Our KGH rebuild is part of phase 4 of the New Hospital Programme, and should be delivered by 2030. Earlier in the year, we received written confirmation from the Department of Health and Social Care and NHS England that we can begin to access £38m of capital from an initial funding allocation of £46m announced in October 2019. This will mean we can start to prepare parts of its site for the major rebuild itself, which, subject to business case approvals and funding, could begin in 2025. The hospital's outline business case for a new Energy Centre was approved and, subject to further approval, we hope to start work in December 2023 and completed it by December 2024. A £4.14m case for electrical infrastructure approved also by the New Hospital Programme Investment Committee with work due to start in 2023 to be completed by the end of the year. These enabling works are vital to a future rebuild. The hospital is currently running its heating and hot water from a 10-year-old temporary boiler plant and steam network system, which has regular maintenance issues. In addition, most of the hospital's high voltage electrical infrastructure is more than 50 years old and its main power supply has reached its maximum capacity. The new Energy Centre will make a significant contribution towards the Trust's ambition to achieve net carbon zero status by 2040.The new facility will deliver 40% of the target reduction in carbon emissions and use less fossil fuel.

I want to finish this introduction by thanking our patients for their support over the last year, our healthcare partners across Northamptonshire, specifically our colleagues at Northampton General Hospital, and our stakeholders including the Northamptonshire Health Charity - with your help we can provide even better services to our communities. And, of course, our wonderful staff and volunteers. The contribution you make is unimaginable and I am truly proud to be your CEO.



Deborah Needham, Chief Executive and Accountable Officer

1.1.4 Purpose and activities of Kettering General Hospital NHS Foundation Trust

Who we are and what we do

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 England through the NHS Provider Licence.

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

Organisational structure: Kettering General Hospital

Anyone who lives in England, works or volunteers 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 Chief Executive (representatives from key partner organisations such as local councils are also 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 360,000 in North Northamptonshire (ONS Mid-Year Population Estimates 2021) as well as many in surrounding areas of West Northamptonshire, south Leicestershire, north Bedfordshire and west Cambridgeshire. Our local population continues to grow and age meaning 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 and Group Clinical ambition, 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 and Wellingborough as well as community facilities in Kettering town. Services are funded primarily through contracts with the Northamptonshire

Integrated Care Board (ICB), NHS England Specialised Commissioners and other ICBs and Public Health bodies.

Developing a shared vision of the future: the University Hospitals of Northamptonshire Group

In 2020, we announced our intention to form a hospital group with Northampton General Hospital NHS Trust (NGH), and appointed a Group Chief Executive of our hospital, and of NGH. Under the Group model, both Trusts work 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. .

In 2021, we adopted (with NGH) a 'Dedicated to Excellence' Strategy, developed following extensive public engagement, which we officially launched with a public and staff stakeholder event, articulating the group's 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.

The Strategy sets out:

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 Group 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.

Our Group Priorities

The Trusts agreed five priority areas of focus and improvement in respect of:

- Patient: excellent patient experience shaped by the patient voice;
- Quality: outstanding quality healthcare, underpinned by continuous, patient-centred improvement and innovation;
- Systems and Partnerships: seamless, timely pathways, working together with our partners;
- Sustainability: a resilient and create University Hospital Group, embracing every opportunity to improve care
- People: an inclusive place to work where people are empowered to make a difference.

Our Clinical Strategy

Our Group Clinical Strategy outlining how the Trusts work together across the Group and local health system to deliver excellent patient care and improve services for its patients.

The strategy sets out how we are building on our existing collaborations to establish clinical centres of excellence in the county, increasing capacity so our patients do not experience cancelled operations and longer waiting times, and becoming a hub for research and innovation. It contains the following core ambitions:

1. Work with our partners to prevent ill-health and reduce hospitalisation, changing the way care is provided along the care pathway
2. Develop centres of excellence in the county, building on our established strengths in each hospital, with cardiology being based in Kettering General Hospital and cancer in Northampton General Hospital, but with consistent access to these services by all patients in the county
3. Protect elective beds to reduce cancelled operations, reduce long waiting times and increase efficiency
4. Build on our University Hospital status, becoming a hub for innovation and research, attracting high calibre talent and growing the number of clinical trials our patients can access.

Many staff in both clinical and non-clinical roles were involved in developing the Group ambition and in the coming weeks and months the Trust is committed to continuing to work together and with patients and stakeholders to develop our strategy further.

During 2022-2023 the Group carried out engagement work to define and set out ambitions for a Cancer Centre of Excellence, and hosted a Cardiology Centre of Excellence Conference to develop our strategy and pathways. Many other clinical services met during the year, to discuss current practice and their future service strategies to collaborate across the Group. In addition, the launch of a surgical robot at NGH in March 2022 has enabled more patients to be treated in Northamptonshire, many of whom previously had to travel to hospitals outside of the county, as well as provide 'mutual aid' to patients waiting for treatment at hospitals in other areas. .

Supporting Strategies

The Trusts have adopted a number of longer-term strategies to enable the right changes to be made to achieve the Group's ambitions. Each of our strategies have begun to deliver exciting improvements for the group, for example:

- *Digital:* MediViewer is live across both KGH and NGH, which allows our clinicians to see records electronically through scanning clinical records
- *People:* Our volunteering teams continue to grow, with an 80% increase in active volunteers in KGH and recent feedback surveys found 100% of patients, staff and visitors found their experience was enhanced by a volunteer and 97% found the volunteer went above and beyond for them.
- *Nursing, Midwifery and Allied Health Professionals (AHP):* The first UHN Allied Health Professionals conference was held in October, highlighting the fantastic work our AHP staff do and promoting the leadership role they play as valued members of the MDT team
- *Academic:* Four clinical academic posts have been recruited to across UHN to grow our research capability and capacity, and we have funded a PhD scholarship to focus on benchmarks in Nursing Excellence.

Dedicated to Excellence: Review of Progress 2022-2023

Here are some examples of achievements against each Group priority: (please see the Performance Analysis below for more detailed analysis of NGH's work over the year)

Patient

- Our Stroke Community Support Team won the UK Stroke Forum's Patient, Carer and Public Involvement Prize for their development of new pathways which truly put patients at the heart of their care.
- Successful Autism listening events were held, hearing our patients experience of pathways and how we can make reasonable adjustments to our care pathways

- The Palliative Care team have opened Swan Rooms to provide a suitable and supportive environment for patients and their families at the end of life.

Quality

- The Patient Safety team's implementation of the deteriorating patient task list in NGH was awarded a high commendation at the HSJ Patient Safety Awards in recognition of the contribution this has made to improving the outcomes of deteriorating patients.
- Our Acute Illness Response team in KGH were also shortlisted for a HSJ Patient Safety Award for their work on Call 4 Concern providing a route for patient families to raise concerns if their loved ones begin deteriorating while in hospital.

Systems and Partnerships

- Through the hard work and dedication of our teams, we have some of the best elective care delivery in region and have provided mutual aid to support neighbouring providers to tackle their long waits.
- We are exceeding the cancer faster diagnosis standard for our patients.
- Our theatre productivity has been increasing with a record month for productivity in both hospitals in November 2022.

The average length of stay of patients aged over 65 years who are fit to be discharged reduced by 7 days compared to 2021/22.

Sustainability

- Both Trusts below the national 5% food waste target;
- Both Trusts have procured a single catering provider to generate financial savings and reduce food waste, which will include the introduction of digital food ordering in the hospitals during 2023/24.
- KGH received business case approval for energy infrastructure schemes that will deliver a reduction in the Trust's carbon emissions of around 58%.

People

- We have revamped our induction process in KGH, with a new induction video containing lots of information before people start, and a 'Welcome breakfast' with stalls from various teams from across the hospital and ensuring that hiring managers come and meet staff members at the start of their first day.
- Our UHN People Pulse survey is now embedded and is run three times a year in line with national guidance. In January 2023 we included bank staff for the first time.

At the Board Meeting in April 2023, a review of the delivery of Group priorities was undertaken as part of our annual Integrated Business Planning cycle:

- Reviewing each Group priority performance measures, projects outlined for delivery, how far our achievements have taken us on our journey to Excellence, the challenges we have faced in delivery and any lessons learned in each area.
- Setting priorities for delivery for the upcoming year.

Full details are available to view in the Board reports at page 129 of the Agenda pack for the April meeting: https://www.kgh.nhs.uk/download.cfm?doc=docm93jijm4n3616.pdf&ver=7223.

Our local health system

The Trusts are key partners in the Northamptonshire Integrated Care Board (ICB), which legally came into being in July 2022 to replace the Northamptonshire Clinical Commissioning Group (CCG) and is the statutory body responsible for local NHS services, functions, performance and budgets. The Trust Chair and Group Chief Executive are Members of the ICB Board. The ICB is responsible for joining up care services to improve patient care in the community within the Integrated Care System (ICS).. In bringing together hospitals and family doctors, physical and mental health, the NHS, local councils and community and voluntary services, the ICB allows for greater input from all those involved in delivering services, resulting in better care wrapped around individuals. The ICB ensures that the best possible care is available to people in our communities. It constantly assesses what needs to change to meet the level and complexity of care in the county. The ICB ensures that integrated care improves population health and reduces inequalities between different groups.

For 2022-23, the Trusts contributed to a single Operating Plan for the Northamptonshire Health and Care Partnership (HCP - the forerunner to the ICB before it formally came into existence), comprising the key elements of activity and performance, workforce, finance and accompanying narrative.

The final submission in July 2022 set out aims for the HCP as a whole to deliver elective performance and 104% of 2019/20 activity levels, achieve a breakeven financial positions and address issues in readiness for winter pressures, particularly to ensure effective ambulance handovers and minimise delayed discharges.

The financial plan was collectively agreed with all parties taking comparable risk whilst retaining positive working relationships to achieve a breakeven position, with the UHN Group committing to improve its financial plan by around £20 million.

Delivery of the plan was dependent upon a number of assumptions:

- a £20m unidentified financial gap (£35m ICS wide) would be closed
- bed capacity could be closed and costs released, saving £5.8m
- that 2% efficiency would be delivered, saving £15.5m
- that impact of COVID-19, unavailability and flow challenges would be minimal, and
- That inflation would be no greater than planned

Risks to the delivery of the plan began to materialise as these assumptions were not met, specifically in respect of above-projected inflation and patient flow challenges caused by sizeable impacts of COVID-19, combined with winter ‘flu. The financial position at 30 September 2022 (Month 6) showed a year-to-date deficit of £28.2 million, which was £12m worse than plan. Following extensive negotiations with NHS England, a revised year-end deficit of £35m was agreed, with the expectation that significant steps would be taken to improve underlying financial performance moving into 2023/24. The KGH element of the overall deficit was a £14.7m variance to plan. NHS England provided significant scrutiny and challenge of performance, and required elective capacity to be maintained in order to minimise the numbers of patients waiting over 52 weeks for treatment.

The Trusts committed to internal work in a number of areas to improve financial controls and performance, included ‘enhanced oversight’ controls on agency and recruitment, ‘stepping down’ additional winter capacity, reviewing increases to workforces since the beginning of the COVID-19 pandemic in 2020 and reorganising urgent care capacity and flows to increase productivity and reduce costs.

Please see the Performance Analysis Section below for detailed Trust performance during the year.

Planning for 2023-2024

ICBs and their partner trusts have a duty to prepare draft and final plans for 2023-24 by 31 March and 30 June 2023 respectively. Planning guidance sets out a number of statutory requirements for the plan to meet the health needs of the local population, deliver a financial plan, implement joint local health and wellbeing

strategies and take steps to address the needs of children and young people and victims of abuse. There are also a range of national NHS objectives around core services, transformation and the delivery of the NHS Long Term Plan, without the prospect of additional resources to deliver these objectives. The Trusts are working closely with ICB partners to agree a sustainable position and ensure that Group priorities are specific, measurable and aligned to the wider needs of the local health economy.

Working together to tackle local health inequalities

Our local population is older than, and growing faster than, the national average so the demand for good quality care and support will increase over the coming years. Some of our local populations have significantly poorer health outcomes and life expectancy than the national average, and many of these people do not get the access to the care they need in a timely way.

Where you are born in Northamptonshire makes a difference to how long you are likely to live. A male in Northamptonshire can expect to live an average of 80 years and a female an average of 83 years. This is in line with the national average; however, males born in the most deprived part of Corby in the north of the county have an average life expectancy of 73 years, compared to males born in the wealthier area of Spratton, who live to an average of 83 years. Similarly, females born in Corby Central live to an average age of 78, while others in Towcester Mill in South Northamptonshire, live to an average age of 87.

Patient referrals resulting in cancer diagnoses are significantly higher in Northamptonshire than the national average (7.8% compared to 7.1% - two-week referral standard), 547 of the 1,385 deaths from cardiovascular diseases amongst those aged under 75 years were considered preventable, had effective public health and primary prevention interventions been delivered. North and West Northamptonshire have significantly higher death rates for respiratory disease in residents age under 75 years compared to the Engand average, 38 per 100,000 in North Northamptonshire compared to 34 per 100,000 for England); 24 of local deaths were considered preventable.

More detailed information on health inequalities in Northamptonshire is available to access online atat icnorthamptonshire.org.uk/health-inequalities

The Group's Clinical Strategy (see above) sets out what we need to do to tackle these challenges, identifying key areas where our population will require care and treatment over the coming years. We are working within the Integrated Care System to transform how services are delivering through collaboratives for:

1. Children and young people
2. Mental health
3. Integrated Care Across Northamptonshire (ICAN, ageing well) and
4. Elective care.

The Trusts have been designated as Lead Providers for the **Elective Care** Collaborative, which aims to transform services so that patients can access the right clinician in the right place, for example in community integrated diagnostic hubs and transformed outpatient services, supported by an ICS-wide patient waiting list to support equitable access.

The **ICAN** initiative has three core aims to:

(1) Ensure we choose well so that no-one is in hospital without a need to be there;
(2) Ensure people can stay well and
(3) Ensure people can live well, staying at home if that is right for them.

The programme has contributed to substantial improvements in open lengths of stay in hospital for patients requiring supported discharge during the year, though admissions of residents aged over 65 increased due to increased 'flu and COVID-19 cases in the community. The number of people who are attending community interventions related to their long-term conditions are at the highest ever levels, with over 140

individuals having attended strength and balance classes by November, over 530 individuals attending memory hubs and nearly 540 individuals having attended community heart disease clinics.

We made significant progress in **community diagnostic** provision during the year, submitting a business case, which was approved by Regional and National panels in February 2023, for national funding of up to £17 million to provide Community Diagnostic Centres in Corby and King's Heath (Northampton)l we have also invested in shorter term capacity to enable CT and MRI facilities at these (existing health centre) locations from April 2023, prior to the new buildings becoming operational – the choice of sites took into account identified local health inequalities; both are highly populated areas with high Indices of Multiple Deprivation compared locally and nationally, and both easily accessible by both public and private transport.

We also developed plans to establish **Cancer and Cardiac Centres of Excellence** for Northamptonshire: see the Group Clinical Strategy Section above for details.

The Trusts' endorsed the Integrated Care Northamptonshire Strategy (icnorthamptonshire.org.uk) (Hyperlink) in February 2023, setting out 10-year plan four our residents to have the best outcomes at every stage of their lives, and how we will work together with a shared responsibility to deliver these outcomes for our communities, which will improve the health of the population so that our services are reserved for the people most in need of them.

1.1.5 History of Kettering General Hospital NHS Foundation Trust

Kettering General Hospital was first opened in 1897 and has grown significantly over the intervening 125 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 since, and submitted a Strategic Outline Case to government for approval for a phased redevelopment scheme in 2021. We submitted an Outline Business Case in summer 2022 which, as at March 2023, remained with the National Programme Team pending clarify on the overall national programme budget. During 2022/23, we received approval to proceed with final designs for an Energy Centre and electrical infrastructure (estimated cost £34 million) and construction of a new high voltage electrical substation (estimated cost £4 million), and are also progressing plans for a new onsite multi-storey car park. We anticipate these key enabling works to be complete by the end of 2024.

The Trust achieved Foundation Trust status in 2008 and is the only acute Foundation Trust in the County. The southern half of the county is served by Northampton General Hospital NHS Acute Trust. Both Trusts are increasingly working collaboratively as part of a Group Model, though each remains a separate legal entity.

In the last decade 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; this remains the Trust's status. Following further inspections, the Trust exited Special Measures in 2019.

1.1.6 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 Board Committees and the Board of Directors on a quarterly basis to ensure that controls and assurances are sufficient and that mitigation plans are being implemented and are taking effect.

During 2022/23, we adopted a Group Board Assurance Framework as part of a wider review to align risk management policy and processes across the Trust and UHN Group – further information is set out in the Annual Governance Statement at Section 3.5 below.

1.1.7 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 18 January 2023.

1.2 Performance Management Framework

The Group Integrated Governance Report is submitted to Board Committees and Boards of Directors at each meeting. The Trust uses Statistical Process Control exception reporting, using longitudinal data and statistical theory to inform judgement and provide greater assurance and trend analysis. During 2022/23, the Trusts progressed to towards an aligned suite of key performance metrics to monitor performance in the context of the University Hospitals of Northamptonshire Group, with consolidated reports to the Board of Directors on a bi-monthly basis.

As part of the alignment of risk management arrangements across the group, links have been strengthened between the Group Board Assurance Framework (BAF) and key linked Corporate Risks within each Trust. This allows for the alignment and escalation of risks from ward through Directorate and Divisional risk registers up to the corporate risk register with the Assurance and Risk and Audit Committees maintaining governance oversight and a reporting line to the Board; over 100 risk registers, identified from ward to board, are in place at KGH.

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

1.3 Trust Performance Analysis

1.3.1 KGH Highlights, 2022/23

April 2022

KGH in world-leading Artificial Intelligence Research

Kettering General Hospital is one of nine NHS endoscopy units taking part in the first UK clinical trial of an innovative artificial intelligence (AI) device which could help better detect bowel cancer. The ground-breaking study – called COLO-DETECT – is being led by leading Gastroenterologists at South Tyneside and Sunderland NHS Foundation Trust.

June 2022

New Macmillan Cancer Support Centre opens

The new Macmillan Cancer Support Centre at Kettering General Hospital has welcomed its first patient. The brand new state-of-the art cancer centre brings together a range of vital cancer information and support services under one roof. It provides cancer information, practical and emotional support as well as advice on welfare benefits, wig-fitting and signposting to other local services.

May 2022

KGH team win award for amazing COVID-19 service using fast-food trailer

An imaginative Kettering General Hospital team that used a fast-food trailer to help provide a drive-through testing service for hundreds of clinically vulnerable patients during the pandemic won a national Cavell Star Award. Kettering General Hospital's Anticoagulation Team set up the INR Drive-Through Service for patients who need regular tests while taking the blood-thinning drug warfarin – used to treat serious heart and pulmonary conditions.

July 2022

KGH gets £1.2 million X-Ray upgrade for better patient care

KGH invested £1.2m in state-of-the-art X-ray technology to improve patient care.

The Trust upgraded two of its seven X-ray rooms – one in main X-ray, and one in A&E – to incorporate two £150,000 (each) state-of-the-art machines which will help patients to be seen more quickly and result in higher quality diagnostic images.

August 2022

KGH gets 22 picnic tables for staff, patients and visitors

The Northamptonshire Health Charity donated 22 picnic tables to the hospital to enable staff to have their breaks outside – as well as benefitting patients and visitors. The– charity, which supports health trusts across the county, donated £10,000 to fund the tables following a funding request from the hospital's Health and Wellbeing Group.

October 2022

Boost for research benefitting patients and staff

The University Hospitals of Northamptonshire NHS Group (Kettering and Northampton hospitals) became a formal partner in the National Institute for Health and Social Care Research (NIHR) Leicester Biomedical Research Centre (BRC). It was announced that the NIHR Leicester Biomedical Research Centre will receive £26m to spend on research over the next five-year funding cycle (2022-2027).

September 2022

KGH midwife receives an award for her outstanding care

Emma Duxon was nominated for a DAISY award by a grateful mum after supporting her through pregnancies which had difficulties associated with them. Emma was recognised for the outstanding, compassionate and sensitive care she provided. The DAISY Awards are an international recognition programme that honours and celebrates the exceptional care that many nurses and midwives provide every day.

November 2022

Work starts on new waiting area

The ground-breaking ceremony took place to launch work on a new £390,000 waiting area and adjoining landscaped garden for breast care patients. The waiting area is being paid for by the Crazy Hats Appeal – a local charity which has raised almost £3.5m for breast care locally (and £1.4m for KGH) since its launch in 2001.

December 2022

Information champions recognised in national awards

Two of our information governance experts were recognised as some of the best in the country in a national awards scheme. Sally Berrill won the Information Sharing Champion of the Year Award in the National Health and Social Care Strategic Information Governance Network Awards. Chris Waller, previous Head of Information Governance at Kettering General Hospital, was also shortlisted for Information Governance Professional of the Year posthumously after he sadly died of cancer in May 2022.

February 2023

Hospital work experience for over 14s

The Hospital announced a comprehensive series of exciting work experience events for young people interested in both clinical and non-clinical careers in healthcare.
Five two-hour events took place in March and April to give teenagers a valuable opportunity to meet members of hospital staff, take part in activities, find out about apprenticeships, and understand what qualifications are needed to get started in healthcare.

January 2023

County hospital patients supporting organ donations

Kettering and Northampton general hospitals released figures to highlight the importance of donation and suggest all adults make their wishes known to their families on their view on donation. Six Northampton General Hospital patients supported 17 organ donations during the calendar year 2022. Three patients supported seven donations at KGH.

March 2023

Making the Patient Voice Heard

A Patient Panel was launched across both Northampton General and Kettering General Hospitals to help ensure the patient and carers voice is heard when we develop and deliver patient care. The patient experience teams at both hospitals developed the idea, which will work to improve services across both hospitals, will be made up of local people who will volunteer their time, experience, and skills, to act as the voice for patients, carers and service users and their needs.

1.3.2 Performance Analysis

Note on the performance charts:

- *The **red lines** denotes the target;*
- *The **lighter and darker dashed lines** denote the upper and lower control limits, calculated from the data, outside which the metric is subject to Special Cause Variation, which suggests significant performance issues requiring urgent attention.*
- *The dots denote the Trust's performance.*

(1) Patient and Quality

Quality Priorities

Progress and actions for the Quality Priorities detailed in the Quality Report continued during 2022-23.

Of the nine priorities, six were achieved:

- Eliminate wrong site surgery;
- Extend/Develop a culture of psychological safety for staff at all levels;
- Embed the Strategy for Excellence in the Care of Patients with a Learning Disability and/or Autism;
- Continue to include patients in planning for the hospital;
- Continue to improve and expand our learning from deaths processes;
- Continue to embed evidence-based care in line with national standards such as National Institute for Clinical Excellence (NICE) Guidance.

Two were almost achieved:

- Progress the implementation of the National Patient Strategy;
- Mental Capacity Assessment (MCA) in relation to Do Not Attempt Cardiopulmonary Resuscitation (DNACPR).

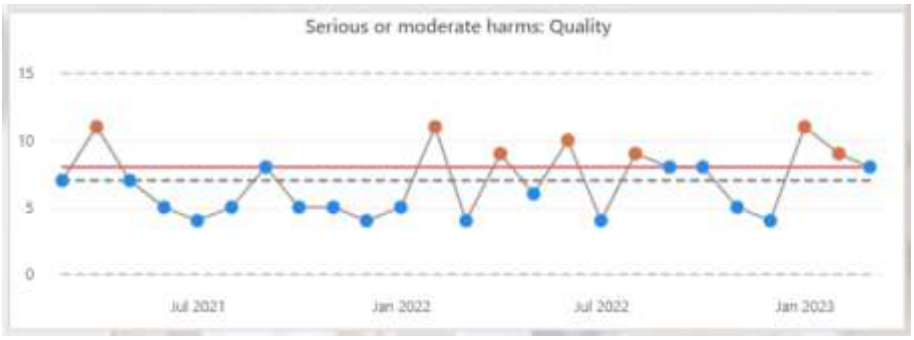
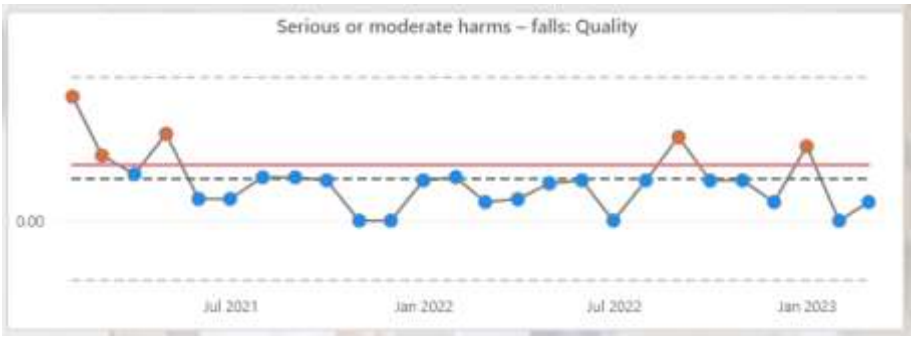
Unfortunately, one was not achieved:

- Improve the way we communicate.

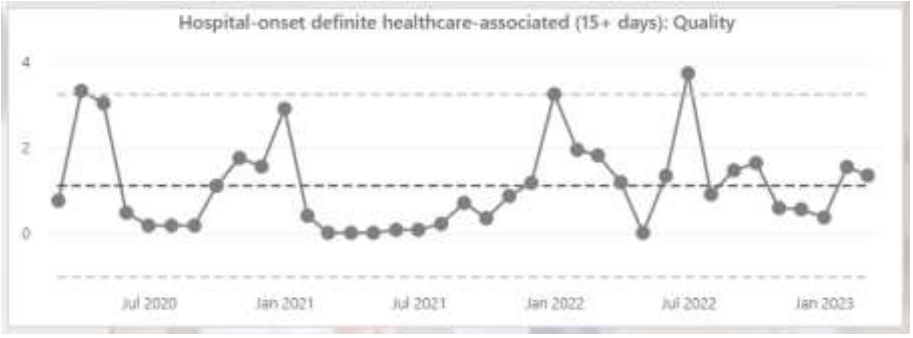
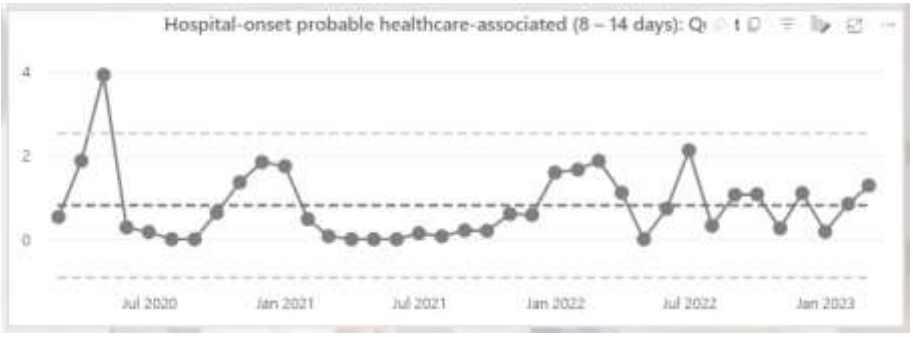
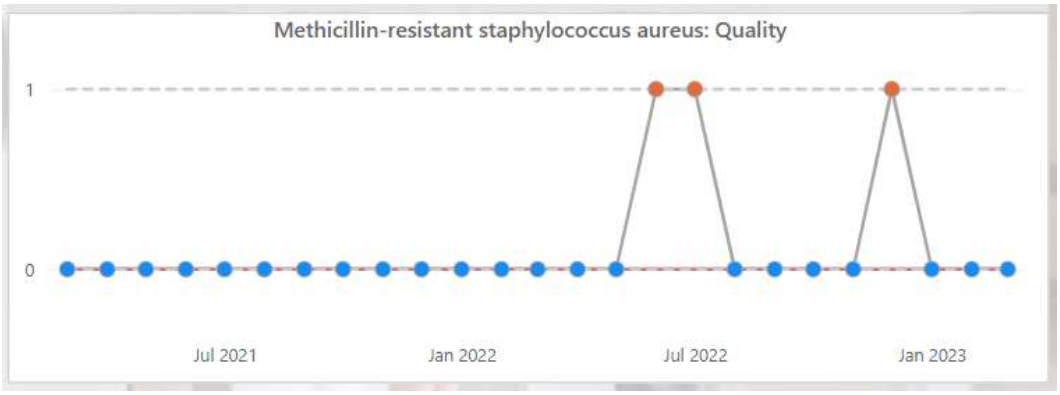
Full details are set out in the Quality Report 2022-2023, which will be made available on our public website following approval of the document in June 2023.

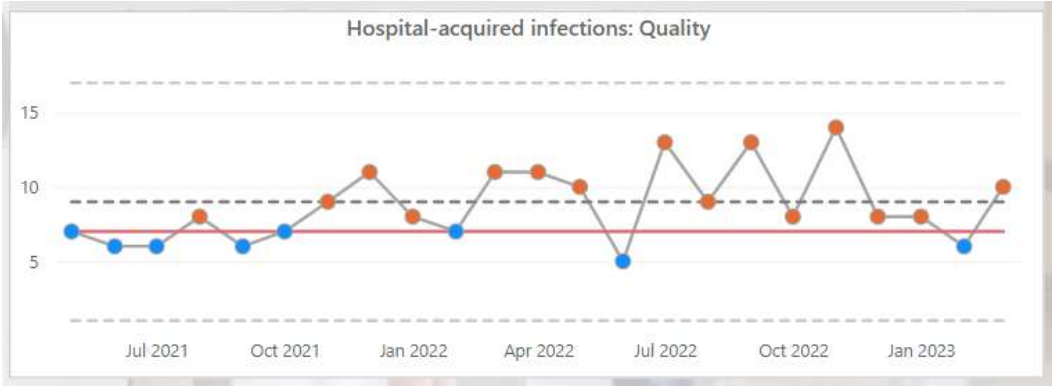
Integrated Governance Report (IGR) Metrics

The Integrated Governance Report is undergoing an evolving process of definitions and group agreement with some alignment, clarification and agreed definition work ongoing. Quality metrics are included in this and whilst they are subject to further refinement, those with a definition and agreed target are listed below.

Quality	**Number of Patients experiencing moderate, severe, catastrophic harm or patient death, as a result of a patient safety incident (vertical Y axis)**  This metric is showing common cause variation[1] with variable assurances. Caution must be applied as harm levels can change pending investigation, up or down, which may take several months. Between March 2022 and March 2023 these harm incidents equate to 3.1% of all incidents with some level of harm and 0.70% of all incidents reported.
Quality	**Patients experiencing falls with moderate harm or above per 1000 bed days (vertical Y axis)**  This metric is showing common cause variation with a low positive trend. During 2021-22, there was a 33% reduction in inpatient falls with moderate harm or above and this has been sustained in 2022-23. The clinical teams should be commended for their hard work to sustain patient experience, outcomes and safety.
Quality	**Patients experiencing pressure tissue damage category 2, 3, 4 or unstageable developed or worsened in hospital per 1000 bed days (vertical Y axis):** Not including moisture associated skin damage or deep tissue injury  This metric is showing common cause variation with a low positive trend. At year end, the number of pressure ulcers has exceeded the ambition to reduce all pressure ulcers by 10% for the last financial year. Category 2 reduced by 43%, Categories 3, 4 and

[1] Variations which are predicable, ongoing and consistent

	unstageable reduced by 33% and all categories combined by 42%. This is a significant reduction, and the clinical teams should be commended for their hard work to improve patient experience, outcomes and safety.
Quality	**Patients experiencing a COVID-19 Hospital probable or definite COVID-19 infection as a percentage of all inpatient COVID-19 positive patients (vertical Y axis),** defined as: HODA – hospital-onset definite healthcare-associated (15+ days) HOPA – hospital-onset probable healthcare-associated (8 – 14 days)   This metric is showing common cause variation. Whilst there is no agreed national, regional, or local tolerance level applied to COVID-19 healthcare associate infections, it is important to recognise the ongoing challenge. It is difficult to establish with certainty whether patients regrettably contracted COVID-19 in hospital. In 2022-23 222 HODA has affected 222 patients and HOPA 161 (383) which equates to 14.3% of all COVID-19 positive in-patients during the year. The rolling percentage since the beginning of the pandemic (March 2020) for the Trust is 14%.
Quality	**Patients experiencing a MRSA Bacteraemia (vertical Y axis)**  This metric is showing low positive variation with variable assurance. Unfortunately, during 2022-23 three patients contracted healthcare-associated MRSA Bacteraemia.

Quality	**Number of attributed Clostridium against CCG ceiling (vertical Y axis)**  This metric is showing common cause variation with low variable assurance. During 2022-23, there were 35 reported C Diff cases, a reduction from 42 in 2021-22 and is below the annual ceiling set by the Clinical Commissioning Group of 41, reduced from 46 in 2021-22. This is a sustained positive reduction, and the clinical teams should be commended for their hard work to improve patient experience, outcomes and safety.
Quality	**Number of Never Events Reported (vertical Y axis)**  A Never Event is the “kind of mistake that should never happen” in the field of medical treatment where guidance or safety recommendations that provide strong systemic protective barriers are available at a national level and have been implemented by healthcare providers. During 2022-23 the Trust has reported zero Never Events achieving the Quality Priority to eliminate wrong site surgery and other Never Events.
Quality	**Hospital Acquired Infections (vertical Y axis):** defined as a Gram-negative E.Coli, Psuedomonas aeruginosa and Klebsiella species) Hospital Onset Hospital Associated (HOHA) or Community Onset Healthcare Associated (COHA) infection  This metric is showing common cause variation with variable assurance. During 2022-23, there were 74 cases of E.Coli, above the ceiling of 55 cases. 11 Pseudomonas

	above the ceiling of 9 and 31 Klebsiella above the ceiling of 26. The Trust is working with the ICB and NHSE England following a recent Infection Prevention and Control visit to make improvements.

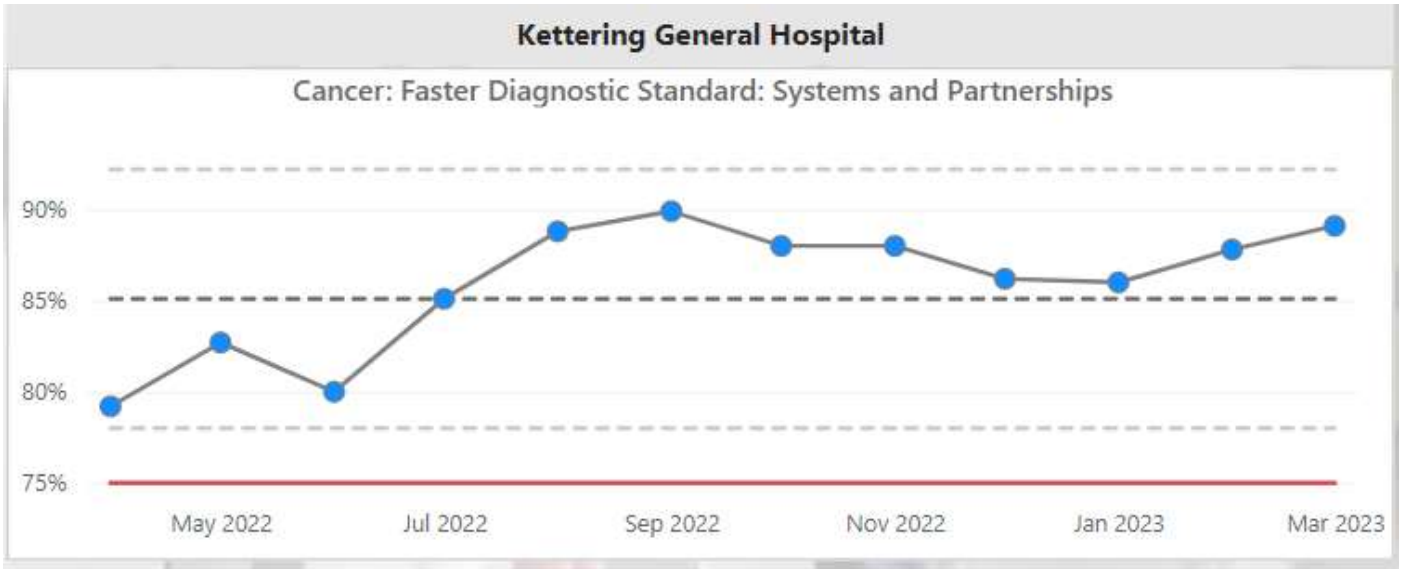
(2) Operations (Group Priorities: Systems and Partnerships/Sustainability)

Cancer

Our aim is to ensure patients are given a diagnosis to confirm or exclude cancer as quickly as possible, to enable their treatment to be commenced. To achieve this, we have set and met the expectation to over-achieve the national aim of 75% of patients referred urgently on a cancer pathway being diagnosed within 28 days of referral. Once diagnosed and treatment is agreed, we aim to initiate that treatment within 31 days, or 62 days from the date of the urgent cancer referral.

Cancer: Faster Diagnosis

The expectation is to ensure 75% of patients have a diagnosis or the all-clear within 28 days of referral. Each of our cancer services have reviewed and developed pathways which has meant we have continually achieved this target and are the top performing hospital across the Midlands region. There is still ongoing work with urology and colorectal, but implementation of the revised 1-stop clinic in the restructured unit, and the implementation of the Faecal Immunochemical Test (FIT) will improve both these sites' performance over the year.



Cancer– 2 week waits referrals

We aim to see patients within two weeks of their urgent cancer referrals. Performance below target since May 2022 was caused by a continued rise in referrals and patients delaying their appointments. Ongoing Industrial Action is continuing to impact on capacity and thus performance in 2023:

31-day Treatments

Once a patient is diagnosed and has agreed their preferred treatment option, we aim to ensure over 96% of patients initiate their treatment with 31 days of that agreement. We have met this target in all but two months. In September due to consultant sickness and the increase in skin referrals over the summer we were unable to achieve this target. Consultant sickness in key services also meant October target was missed.

62-day Referral to First Treatments

Our aim is to ensure 85% of patients who are referred urgently, are diagnosed, and have their treatment initiated within 62 days of the referral. KGH has not consistently achieved this target over the past year. The reasons are multi-factorial, including a significant rise in demand; tertiary centre work and delays for surgery and diagnostics at University Hospitals of Leicester (UHL) and, to a lesser extent, NGH oncology.

From 2023, we utilised new robotic surgical capacity at NGH for prostate surgery, and we aim to expand that to other surgeries during 2023. It should be noted that across the NHS there is significant backlogs in cancer treatments, and our performance across the Midlands is in the top three of hospitals.

Referral to Treatment (RTT)

52 weeks

We have managed to ensure patients have not had significantly extended waits for their treatment, with very few patients wating over a year to initiate their treatment from referral. The Trust is in the top five organisations in the NHS for the lowest number of patients wating over a year.

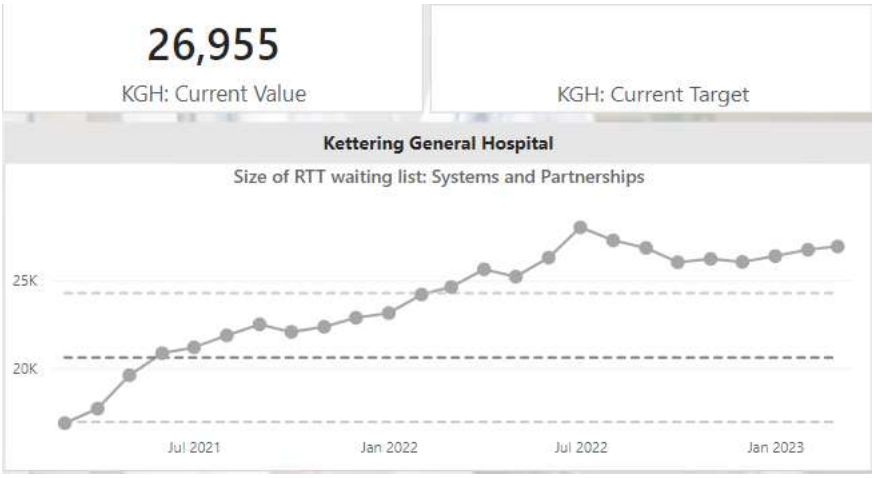
As such we have been asked to support Leicester hospitals as they have patients who have been waiting up to and over 2 years. At the end of March 2023, we had accepted seven transfers who have been waiting over two years. The national picture at 31 March 2023 showed:

	Organisation	52 wk Waiters
Best	Royal Berkshire NHS Foundation Trust	19
12th	Kettering General Hospital NHS Foundation Trust	220
Worst (128th)	Manchester University NHS Foundation Trust	27322
Average		2689

Wait List Size

The overall number of patients who have been referred and are awaiting their initial treatment to start has increased, albeit at a slower rate than experienced in 2021-22, and below level most other hospitals have experienced. Plans to reduce waiting lists include :

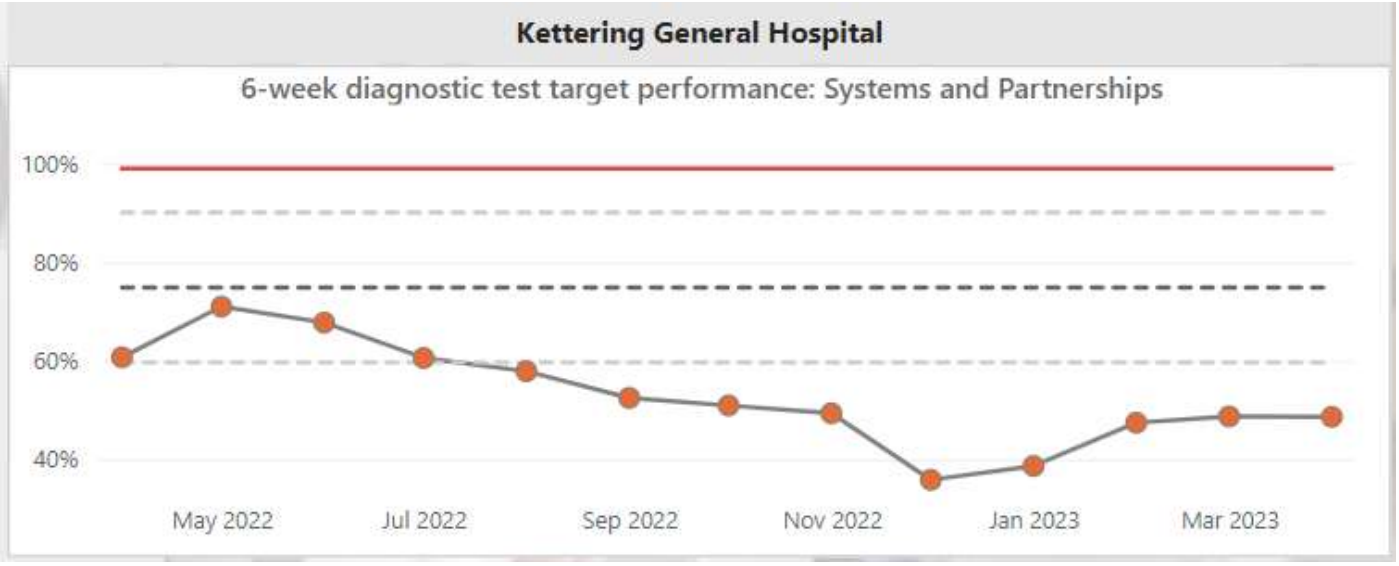
- Increase elective work with improvements in theatre efficiency.
- Outpatient Transformation has plans to support the reduction of follow ups and increase of new appointment capacity.
- Continued validation of patient waiting lists



Diagnostics

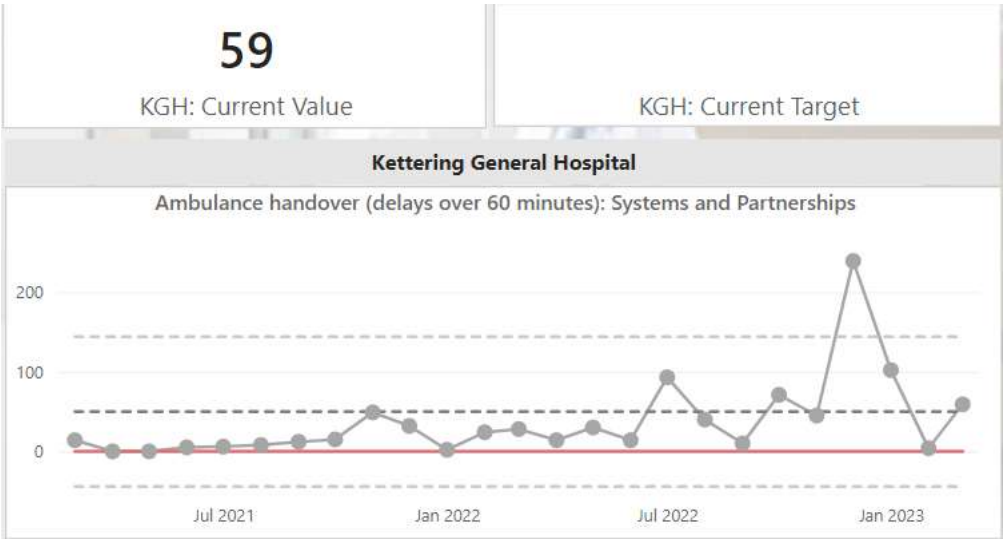
We have seen a significant increase in demand during 22/23, significantly above planned levels and this, combined with our commitment to ensure all urgent (e.g. cancer) requests are prioritised, alongside some capacity constraints with staffing, has led to a continual deterioration of diagnostic performance over the year, in particular with MRI, ultrasound and echo cardiology.

Additional capacity was secured in early 2023 and we have started to see the impact of that in reducing waiting times. This capacity is set to continue and based on expected demand levels we should achieve the national expectation of 85% of patients having their diagnostic test within 6 weeks, during 2023/24.



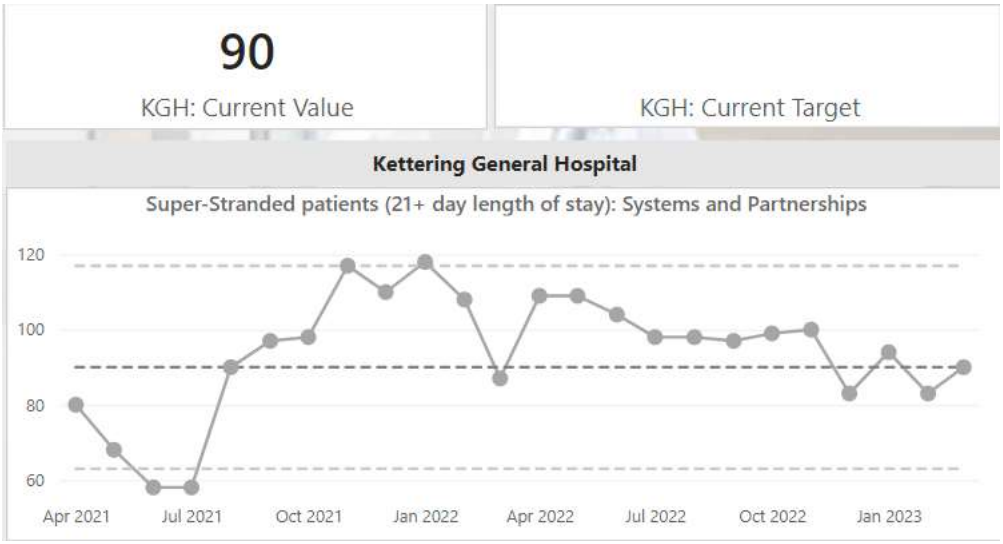
Urgent care

Despite the ongoing pressures, we continue to perform well against the 60-minute ambulance hand over target and have some of the best performance in the country although December 2022 was a particularly challenged month due to demand and increased patient acuity.



The number of ‘super stranded’ patients (patients with a length of stay in hospital greater than 21 days) continues to be a challenge, which at times impacts on flow across the trust and waiting times in the Emergency department. Over the course of the year, we have seen a gradual decline. We ran several Multi agency discharge events (MADE) to support expediting delays, and focussed on internal processes to reduce the time it takes for a patient’s package of care requirements to be identified and agreed.

Safe and timely discharge is a priority for the trust, and we continue to work closely with our ICS partners to ensure that patients are transferred to their chosen destination, as quickly and safely as possible.



Bed Occupancy

Bed utilisation has been continually over 95% and normally about 98% of our adult bed availability. This has meant we flex our capacity, over funded levels, frequently in order to manage demand to maintain flow as best as possible. Ideally bed occupancy, to ensure beds available when needed, and enable patients being placed in the right bed, should be at 85%. NHS England havs set expectations to reach 93% during 2023, which the system plans do not deliver. We are not expecting occupancy to reduce during 2023-24.

(3) Sustainability

3.1 Finance

The Trust ended the financial year, for NHSE performance purposes, with a deficit of -£18.8m (2021-22 - £0.4m deficit).

2022-23 continued to be affected by COVID19, as well as 'flu, with significant ongoing residual impacts on operational flow and continued focus to recover Elective Services up to and above 2019-20 levels of performance. Despite this, the Trust managed to meet the financial performance agreed with the Northamptonshire Integrated Care Board (ICB) and NHS England. The simplified financial regime operated in the NHS during 2021-22 continued in principle into 2022-23 with closer collaborative working relationships with Northamptonshire health and care partners as a system.

The Trust, as part of the wider Northamptonshire ICB, agreed with NHS England a forecast deficit of £19.4m, which was met by year end.

The Trust's financial performance continued to be impacted by the need to support efforts relating to COVID-19 and 'flu, with the additional costs of recovering and improving elective activity performance and providing the necessary capacity over a challenging winter period. This was in addition to the significant inflationary pressures, higher than nationally funded projections. This resulted in continued higher levels of pay and non-pay costs as a result of creating additional capacity, maintaining urgent care flow, wider operational changes required to safely care for our patients, recovering elective care capacity, the continuance of segregation of patients and pathways and enhanced safety protocols.

Whilst there was continued, albeit considerably reduced, funding to support the impact of COVID19 as well as funding to support the recovery of elective activity volumes, there was renewed focus on delivery of transformation and change schemes that would improve use of Trust resources and improve care for its patients. As a result, £5.8m of savings were realised in year. Realising business benefits from Integrated Care System transformation opportunities will be a key priority during 2023-24.

The Trust's capital programme has been significant in 2022-23, with additional capital funding being made available and provided through various national bidding processes during the year. There has been £20.5m capital investment during the year, to maintain the estate, invest in additional medical equipment, the development of the new hospital programme and digital and estate transformation schemes.

3.2 Brief Overview of the KGH Green Plan: development, adoption and implementation

Following the NHS Net Zero report in October 2020[2] the NHS set out a vision to become the world's first net zero carbon health service and respond to the climate change challenge, whilst improving health for the future generations.

The NHS Net Zero Plan sets three key priorities for the National NHS Greener programme, of which all NHS organisations will be required to help support deliver:

1. Meeting the NHS's net zero targets:
   a. An 80% reduction in the emissions we control directly (NHS Carbon Footprint) by 2028-2032, and net zero by 2040
   b. An 80% reduction in our entire emissions profile (NHS Carbon Footprint Plus) by 2036-2039, and net zero by 2045
2. Improving health and patient care and reducing health inequalities
3. Building a more resilient healthcare system that understands and is responding to the direct and indirect threats posed by climate change

Meeting these three outcomes will result in a wide range of ancillary benefits – from improved air quality to reductions in plastic waste, across a broad range of sustainability issues. Importantly, the success of the programme will be measured against the extent to which the three priorities above, are met.

In January 2022, the Board of Directors approved a Green Plan which sets out its vision and priorities for reducing carbon over the next three years.

The Kettering General Hospital Green Plan

A key aim for us is to make the hospital as efficient and environmentally friendly as possible. Our hospital rebuild will be built to the highest possible energy efficiency standards and in the future, we will no longer be relying on fossil fuel.

Staff from across the Trust have produced a hospital Green Plan in accordance with NHSE guidance. The plan highlights some of the actions already underway across the Trust along with those actions planned for the next three years. This first plan is understandably high level and is intended to set an overall direction for next steps whilst also starting to address immediate requirements.

Six monthly reviews of the plan are undertaken to monitor overall progress and incorporate updates from stakeholder groups. Delivery of the plan will be managed via a KGH Sustainability Committee with oversight from the established Group Strategic Development Committee. Key areas of the KGH plan include:

- Building a new energy centre and associated electrical infrastructure based around renewable energies. Plans for a new site wide energy solution are estimated to reduce the Trust's current carbon performance for heating services by 58% - a significant step towards achieving net zero carbon.

- Increasing levels of active travel and public transport. The Trust agreed its Sustainable Travel Plan in May 2021 which identifies ways to make travel to and from the site more sustainable, healthier, and safer. In developing the Travel Plan an analysis of home postcode districts of staff identified

[2] Delivering a 'Net Zero' National health Service, October 2020

that 46% of staff live within a 5km radius of the site and therefore within walking or cycling distance. This also showed clusters of staff living further than 10km from site in neighbouring market towns and Northampton and Leicester – indicating significant potential to reduce reliance upon single occupancy vehicles and develop alternative modes of transport. To encourage uptake of car sharing the trust is widely publicising the car-sharing service Kinto and the associated App, SWAY. There have been regular training sessions and webinars to encourage engagement.

- Using digital technology to transform the services we provide to patients whilst reducing our carbon footprint e.g. Expanding the use of Electronic Patient Records to reduce paper usage and increasing our use of digital correspondence and reduce postage volumes and the future introduction of electronic meal ordering to reduce food waste.

- Reduce the number of staff travelling onto our hospital site by supporting the distributed working of staff and limit car journeys and the amount of physical space and infrastructure required on site. A 'new ways of working' pilot was launched in February 2022 involving 500 members of staff. Early data indicates that on average 30-40% of existing workstations are empty on any typical day, presenting an opportunity for the Trust to utilise this existing space before investing in more workspace and associated infrastructure. This project is continuing with a project to convert a large area of Northfield House into a hot-desking facility.

- Our long-established Pocket Park supports local wildlife and includes a pond, butterfly bushes, native tress and areas set aside for wildflowers and insects.

- KGH has a charging point for its electric vans and has plans for more as part of its rebuild.

We have become commended for our travel plan and been awarded a Modeshift STARS Green Award – thanks to our commitment to promoting alternative modes of transport.

To achieve this national accolade, the hospital has been working with Northamptonshire based Brightwayz, a social enterprise which promotes active travel. Brightwayz have been helping the hospital implement a travel plan to encourage and enable people to, where possible, leave their cars at home and to find alternative and practical ways to get to and from the hospital.

Modeshift STARS (Sustainable Travel Accredited and Recognised) is the UK's leading active travel scheme and recognises schools, businesses and other organisations that have shown excellence in supporting cycling, walking and other forms of sustainable travel.

The development of this Green Plan marks the start of a process to reduce our carbon footprint and achieve net zero carbon. Whilst the plan contains many specific actions, the expectation is that it will develop and evolve over the coming years as our knowledge increases and more staff and partners input into the process.

Carbon Reduction

As a Trust we currently consume approximately 13.6 GW of electricity and 26.2GW of gas per year, this results in a CO_2 emission of approximately 2,635 tonnes for the electrical consumption and 4,718 tonnes for the gas consumption, based on 2022 carbon factors.

For gas and electricity there is a climate change levy (CCL) applied, we pay £0.00775 per kW (£105,614 per year) for electricity and £0.00568per kW (£148,875 per year) for gas.

As the national grid decarbonises the carbon factor for electricity reduces as more power is generated by renewable resources: our current electricity provider produces less than 20 % of electricity from fossil fuels.

The future carbon reduction strategy is now based on more electrically driven air source 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 (BMS) 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

Planned measures:

- 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
- Further enhancements to BMS controls and heating zone controls
- Installation of £500k LED lights (year one of a three year programme)

Food Waste

The trust installed an automatic food waste digester, which takes all our food waste and turns it into Biofuel.

The table shows that in the month of April the food digester reduced greenhouse gases by 3.94 tonnes compared to the equivalent amount of food waste going to landfill, which equates to 14,396 miles in a car or the equivalent to the greenhouse gas created by 495 homes.

(4) People

4.1 Performance Analysis: Workforce Indicators (See also Group People Plan and Staff Survey sections)

Vacancy

We started the year with a vacancy rate of just under 9% and therefore above our target of 7%. Over the last 12 months, an increase in establishment, combined with a difficulty to recruit to 'hot spot' areas has led to a steady increase in our vacancy rate and we ended the year at 11.7%. The areas with the highest vacancy rates by March 2023 were our Estates and Ancillary staff group at 20.7%, these roles typically include our housekeeping, portering and catering teams, and Additional Clinical Services, of which a large proportion is made up of Health Care Support Workers (HCSW) at 15.4%. The recruitment team have been running very successful recruitment days throughout the year, attracting particularly HCSWs; however as indicated below, our focus is also on retention to retain people in these roles, once they have joined us in the Trust, which will contribute toreducing vacancy rates and turnover.

Turnover

Turnover has reduced over the course of the year from 11% in April 2022 and into the Autumn of 2022, to a fairly stable 9% over January, February and March 2023; however, this can mask areas where we experience higher than target levels, such as Estates and Ancillary. Our internal turnover levels for roles that typically sit within this directorate, reflect national trends for hospitality industries which, according to Chartered Institute of Personnel and Development (CIPD) throughout the last two years have experienced highest rates of turnover in catering, hotel and hospitality services as the labour market for these roles becomes much more competitive.

Sickness absence

Sickness absence has gradually decreased over the year which is an improvement. However, some months have shown exceptional levels as we continued to see a resurgence of COVID-19, particularly in July 2022, where the rate rapidly climbed to almost 8% in a matter of days. In April 2022, we entered the year with sickness levels of 6.5% above the 4% Trust target, and remained at those levels until Autumn of 2022. By the end of March 2023, our sickness levels had reduced to 4.8% and alongside a proactive campaign for compassionate rostering – our unavailability levels have also decreased over this period to pre COVID-19 levels.

Appraisal

In April 2022 appraisal completion rates for the Trust were around 80%, below our Trust target of 85%. By March 2023 they improved slightly, but remain below target at 82%. Currently work is underway to review our appraisal systems, with a new system due for launch in Autumn of 2023. This will support compliance and link appraisals into our development offers.

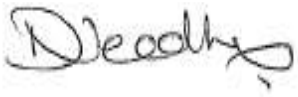
Mandatory training

Mandatory training completion rates have been above 85% target all year, starting in April 2022 at 88.6%, and improving to over 91% by March 2023.

2.1.2 Equality of Service Delivery to Different Groups

KGH has due regard to the aims of the public sector equality duty and makes its public statutory Equality, Diversity and Inclusion (EDI) documentation available on our public website: https://www.kgh.nhs.uk/policies-and-procedures . The 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.

More information about our work, as a Trust and a Group, to identify and tackle local health inequalities, is set out in the Performance Overview Section above.



DEBORAH NEEDHAM
CHIEF EXECUTIVE AND ACCOUNTABLE OFFICER

27 JUNE 2023

2.1.3 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

The Board of Directors

Name	Title	Attendance at Board Meetings (Max 5)
Alan Burns	Chair	5
Simon Weldon	Group Chief Executive Officer (unavailable September 2022 to March 2023 inclusive)	1 / 2
Richard Apps	Director of Integrated Governance	4
Jon Evans	Group Chief Finance Officer	5
Andy Callow	Group Chief Digital Information Officer (to January 2023) / Interim Group Chief Executive (September 2022 to January 2023)	3 / 4
Rabia Imtiaz	Interim Medical Director (to December 2022)	4 / 44
John Jameson	Medical Director (from February 2023)	0 / 0
Deborah Needham	Hospital Chief Executive (Interim Group Chief Executive from January 2023)	5
Fay Gordon	Chief Operating Officer	4
Polly Grimmett	Director of Strategy	5
Fiona Barnes	Interim Director of Nursing & Quality (to January 2023)	4/4
Jayne Skippen	Director of Nursing, Quality and Allied Health Professionals (from January 2023)	1/1
Mark Smith	Group Chief People Officer (to August 2022)	1 / 2
Paula Kirkpatrick	Group Chief People Officer (from September 2022)	3 / 3
Becky Taylor	Group Director of Transformation and Quality Improvement	4
Natalie Armstrong	Non-Executive Director (from January 2023)	1/1
Edmund Burke	Non-Executive Director (to August 2022)	1 / 2
Alice Cooper	Non-Executive Director	5
Liisa Janov	Non-Executive Director (to February 2023)	5
Lise Llewellyn	Non-Executive Director	4
Deborah Manger	Non-Executive Director (from August 2022)	2 / 3
Andrew Moore	Non-Executive Director (from March 2023)	0/0
Trevor Shipman	Non-Executive Director/Vice Trust Chair/Senior Independent Director	3
Damien Venkatasamy	Non-Executive Director	4
Chris Welsh	Non-Executive Director	4

The Board of Directors and Council of Governors

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 meetings open to public observation and, if required, a further limited session in private. During the COVID-19 pandemic, Board meetings took place online with a live web broadcast, returning to face-to-face meetings (which we continued to record and broadcast) from September 2022. 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 (face to face) in each intervening month to provide dedicated time to focus in depth on matters relating to strategy, culture and operations. Since 2021, we have held 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 governance report which includes information on quality, finance, performance and workforce, updated in early 2022 to focus on the Group Priorities of Patient, Quality, Sustainability, Systems and Partnerships 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 adopting (with NGH), a Group Board Assurance framework in July 2022.

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 to Committees and Executive Directors, as set out in Standing Financial Instructions, a Scheme of Delegation and a Schedule of Matters Reserved to the Board. Under Board Standing Orders, there is a general rule that any powers not otherwise dealt with are delegated to the Chief Executive, who may sub-delegate as appropriate. These schemes are reviewed annually. The Board has 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 fora such as Healthwatch are stakeholder members of the Council of Governors and are also encouraged to observe 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, during 2022/23 agreed a shared aim with NGH to work collaboratively to deliver an aligned strategy for patient engagement across both hospitals as part of the

group model. The Trusts launched a Patient Engagement Pool as part of this work, in order to work towards having a diverse range of patient representatives across the county.

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 COVID19 pandemic, meetings were held in private, with the recordings and transcripts of meetings 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. The Lead Governor attends the private section of the Board meeting, disseminating key messages to the Council as required.

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 the Board meeting in April 2023.

Board of Directors Meetings

There were five formal Board meetings held during 2022-23, all of which comprised public and private elements. 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 Trust Chair holds regular meetings with non-executive directors independently of the Executive Directors, and carries out annual performance appraisals, the outcomes of which are reported to the Council of Governors for approval.

During 2022-23, the Trust Chair was also Chair of Northampton General Hospital, having been appointed to this position in December 2018. The Board and Council of Governors were informed of the appointment prior to him taking up the position. The Chair stood down from both roles on 31 March 2023.

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 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 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.

Committees of the Board

In addition to the Nomination and 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,.

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 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.

Group Transformation Committee

The Group Transformation Committee (GTC) oversees the delivery and review of the aims of the Group and steers the delivery of the transformation required to deliver Group Model ambitions as expressed within the Dedicated to Excellence Strategy, aligned to Integrated Care System (ICS) transformation.

Each Trust appoints a Chair to the Committee, one of whom convenes (presides at) monthly meetings, by agreement.

Group Digital Hospital Committee

The 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 resumed monthly meetings from January 2023 and is convened by Non-Executive Director Chairs from each Trust on an alternating basis. The Trust's Performance, Finance and Resources Committee met monthly between April – December 2022 whilst committee in common arrangements were subject to review and development work (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.

Each Trust appoints a Chair to the Committee, one of whom convenes (presides at) monthly meetings, by agreement.

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 the 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 resumed monthly meetings from January 2023. Each Trust appoints a Chair to the Committee, one of whom convenes (presides at) monthly meetings, by agreement. The Trust's Quality and Safety Committee met monthly between April – December 2022 whilst committee in common arrangements were subject to review and development work (see below).

Group 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). During 2022-23, it was chaired by the Trusts' Chair. Initially established as a Trust-only Committee, the Committee was reconstituted as a Group Committee in Common during 2021-2022, to enable it to provide oversight of the NGH site Master Plan.

Group Elective Care (Lead Provider) Collaborative Committee

The Committee was established in May 2022 to oversee the development and implementation of Lead Provider Collaborative arrangements for elective care. The Committee held its first meeting in November 2022 and will meet on a bi-monthly basis from 2023-24. Each Trust appoints a Chair to the Committee, one of whom convenes (presides at) monthly meetings, by agreement.

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

Audit Committee membership 2022-23		
Name	Title	Attendance
Alice Cooper	Non-Executive Director	4/4
Lise Llewellyn	Non-Executive Director	3/4
Trevor Shipman (Chair)	Non-Executive Director	3/4

Significant issues

The Audit Committee met on 26 June 2023 to consider the financial statements for the period 2022-23. 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 £96,000 (including VAT) during 2022-23. This figure is lower than in the audit plan as it includes an over-accrual of £30,000 from 2021-22.

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. There were no non-audit assignments during 2022/23.

Internal Auditors

During the year ended 31 March 2023, 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 met monthly between April – December 2022. The Group Clinical Quality, Safety and Performance Committee met from January 2023 – 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 met monthly between April – December 2022. The Group Finance and Performance Committee met from January 2023 – see above.

Charitable Funds Committee

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 did not meet during 2022-23.

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.

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. The Council of Governors was consulted on the Trust's contributions for the ICS Operational Plans for 2022-23 and 2023-24.

We provide a training and induction programme that runs through the year on all key aspects of NHS business. During 2022-2023, these included consultative briefings and presentations on the Quality Report, digital transformation, hospital redevelopment programme and CQC Inspections of Children's and Young People's Services. We held a comprehensive on-line induction session for new Governors elected in the Autumn 2022 elections, chaired by the Trust Chair and attended by the Interim Group Chief Executive, Lead Governor and Director of Integrated Governance. All governors can attend the Governwell Training courses run by NHS Providers and any other ad-hoc conferences that take place across the UK, whilst several Governors attended the annual NHS Providers Governor Focus conference in July 2022.

We also continued worked with Northamptonshire Healthcare NHS Foundation Trust to deliver joint briefings on the emerging Integrated Care System, in October 2022 and March 2023.

Governors can undertake site visits in the hospital following the protocol provided in the governor handbook, although the frequency of such visits has been impacted by winter pressures and COVID-19 restrictions, Governors have visited the Children's and Young People's and Emergency Departments during the year. Governors receive the majority of Board Committee papers and are invited to observe proceedings, identifying a nominated Governor on each Committee who makes reports to the Council as part of their responsibilities.

The Trust has employed a Governor and Member Engagement Officer to ensure that Governors continue to be engaged in the Trust's activities and enable two-way communication with public and staff membership.

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 non-attendance at meetings, having a conflict of interest or misconduct in carrying out their duties.

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

Council of Governors

At 31 March 2023, the Council of Governors comprised 27 members from three specific groups:

- 15 public governors (plus 3 vacancies)
- 7 staff governors (plus 1 vacancy)
- 5 stakeholder governors (plus 3 vacancies)

Membership of the Council of Governors 1 April 2022 – 31 March 2023

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	3/3
		18 Oct 2016	17 Oct 2019	
		18 Oct 2019	17 Oct 2022	
Mohamed Latif	Kettering	2 Dec 2014	1 Dec 2017	4
		2 Dec 2017	1 Dec 2020	
		2 Dec 2020	1 Dec 2023	
Penny Owens	Kettering	18 Oct 2023	18 Oct 2026	2/2
Anup Pandey	Kettering	1 Dec 2021	1 Dec 2023	4
Eric Jackson	Wellingborough	2 Dec 2020	22 July 2022	0/2
Graham Lawman	Wellingborough	18 Oct 2016	17 Oct 2019	5
		17 Oct 2019	17 Oct 2022	
		17 Oct 2022	17 Oct 2025	1
Annette Bridgeford	Wellingborough	21 Jan 2019	1 Dec 2020	2/3
		2 Dec 2020	31 Oct 2022	
Vinodbhai Patel	Wellingborough	1 Dec 2021	12 Oct 2022	0/3
Amy Wells	Wellingborough	18 Oct 2022	18 Oct 2025	0/2
Simon Baylis	East Northants	1 Dec 2021	1 Dec 2023	5
Satya Biswas	East Northants	2 Dec 2020	1 Dec 2023	3
Mabel Blades	East Northants	2 Dec 2014	1 Dec 2017	5
		2 Dec 2017	1 Dec 2020	
		2 Dec 2020	1 Dec 2023	
Sheila White	East Northants	2 Dec 2020	1 Dec 2023	5
David Harland	Corby	18 Oct 2019	18 Oct 2022	5
		18 Oct 2022	18 Oct 2025	
Jayne Smith	Corby	18 Oct 2022	18 Oct 2025	2/2
Chris York	Corby	18 Oct 2022	18 Oct 2025	0/2
Paul Bremner	Rest of UK	1 Dec 2021	8 June 2022	0/1
Roseann Shanks	Rest of UK	18 Oct 2022	18 Oct 2025	2/2
Rashmi Shah	West Northants	1 Dec 2021	1 Dec 2023	3

STAFF ELECTED GOVERNORS				
Name	Constituency	Elected	End of term	Attended (max 5)
John Bayliss	Staff	18 Oct 2022	31 Mar 2023	2/2
Jayne Chambers	Staff	18 Oct 2019	17 Oct 2022	5
		17 Oct 2022	17 Oct 2025	
Claire Jennings	Staff	1 Dec 2021	30 Nov 2023	1
Vijay Kalathy	Staff	1 Dec 2021	10 Oct 2022	1/2
Claire Knibb	Staff	1 Dec 2021	30 Nov 2023	4
Toral Sengar	Staff	1 Dec 2021	30 Nov 2023	4
Sreejith Nair	Staff	2 Dec 2020	1 Dec 2023	1
Faizal Rayan	Staff	2 Dec 2020	19 Jan 2023	2/4
Charlotte Smith	Staff	1 Dec 2021	30 Nov 2023	5

STAKEHOLDER APPOINTED GOVERNORS				
Name	Organisation		End of appointment	Attended (Max 6)
Jennie Bone	North Northamptonshire Council	1 Dec 2021	5 May 2025	5
Matt Golby	West Northamptonshire Council	1 Dec 2021	31 Mar 2023	2
Sue Watts	Voluntary/ Charitable Sector	March 2015	March 2024	5
Dr Andrew Stephen	Voluntary/ Charitable Sector	April 2016	March 2025	5
Wendy Patel	Healthwatch	December 2017	August 2024	4

*Council of Governors Meetings

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 Trust Chair. 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 Trust Chair and Non-Executive Directors (NEDs); advising on the appointment of NEDs and the Trust Chair; receiving performance/appraisal information relating to the Trust Chair/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 Trust Chair and the Chief People Officer and any other appropriate person.

The Appointments and Remuneration group met seven times during 2022/23 to carry out the appraisals of the Trust Chair and Non-Executive Directors, and recommend the reappointments of Liisa Janov and

Trevor Shipman to additional terms of office as Non-Executive Directors. The Group also oversaw the appointment of Professor Natalie Armstrong as a Non-Executive Director, the nominee of the University of Leicester, and the appointments of Deborah Manger and Andrew Moore 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 Non-Executive Directorss 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 five occasions during 2022/23.

The Council of Governors: Relationship with the Board of Directors

Non-Executive Directors attend Council of Governors meetings to provide feedback from Board Committees. From January 2023, we held a series of engagement sessions between Governors and Non-Executive Board Committee chairs; these events were well-received, and we hope to embed an ongoing rolling schedule from 2023-2024.

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

The Council of Governors 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 Trust Chair 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 newsletters, media releases and any other important information is circulated directly to governors, and we launched a weekly newsletter for Governors in March 2022. 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. During 2021/22, we introduced a development role to aid succession planning.

We also continued to develop relationships with the Council of Governors of the Northamptonshire Healthcare NHS Foundation Trust, which provides mental and community health services in the county. We developed our programme of workshops on the Integrated Care System, holding successful events in October 2022 and March 2023 with an increasing focus on the delivery of improved population health outcomes in local communities, and how Governors can assist in promoting the aims and delivery of ICS strategies.

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. 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.

During 2022-23, Governors were invited to present to the national NHS Providers' conference on their collaboration with Governors from a neighbouring Trust (Northamptonshire NHS Foundation Trust). Working together and supported by our newly appointed Governor and Member Engagement Lead, the presentation and accompanying animation shared their respective experience of navigating the emerging Integrated Care System and what that meant for Governors and members across Northamptonshire. Following that presentation, a number of conference attendees followed up with Governors and have considered adopting a similar approach in their localities.

We also planned for the resumption of Governors' site visits in the hospital during the year, as restrictions were eased following the COVID-19-19 pandemic. Visits to date have included Maternity, Adult General Surgery wards, Pharmacy and the Medical Assessment Unit. In addition, informal visits have also taken place delivered by Staff Governors, which has provided Governors with an 'access all areas' look behind the scenes of the hospital.

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. Additionally, individual Director meetings between interested Governors take place on an ad hoc basis throughout the year, for example, between the Public Governor for Corby and Maternity; and a Public Governor for Kettering (a former ENT Surgeon) and the team responsible for reviewing the Trust's ENT Strategy.

Membership

The Trust has two categories of membership:

- Public members
- Staff Members

All staff, including volunteers, 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 KGH Foundation Trust members are drawn from Kettering, Corby, East Northamptonshire, Wellingborough, East Leicestershire, West Northamptonshire and the Rest of UK. We successfully elected to all but two seats following the 2022 elections

As at 31 March 2023, the Trust had 3,525 public members, with constituencies as described below:

Constituency	Number of Members 31 March 2023
Kettering	1,218
Corby	500
Wellingborough	694
East Northamptonshire	842
West Northamptonshire	139
Rest of UK	132

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. The Council established a Communications and Engagement Sub-Group during the year, which meets monthly to enable two-way communication between the Trust, Governors and the members and communities they serve, and build relationships with the communications and patient experience teams. Additionally, the Sub-Group has received presentations from trust-wide internal and external speakers on a wide range of member topics from alcoholics anonymous to the launch of a new breast service.

A Governor and Member Engagement Officer joined the Trust during the year and is carried out a programme of events for 2022-23: virtual event topics for members included Living with Long COVID-19, Healthy Hips and Breast Cancer. These events have proved highly popular with a broad audience from all corners of Northamptonshire, and often leads to individuals taking up membership of the Trust. The Officer has assisted with the preparation of a membership and engagement strategy to guide this work and lead the work to review the groups Terms of Reference and supporting action plan. During its first year, the group has facilitated a number of initiatives including raising awareness of the Governors' role on hospital radio, published a series of articles in the local newspaper and representation at community events and the Patient Advisory Group for the Integrated Care System. The Group was also consulted on the draft Strategic Communications Framework for the Group.

The launch of a member' monthly e-newsletter has been well-received by members, with members regularly in touch with the Governor and Member Engagement Officer on a range of issues, from car parking concerns to appointment letters. These concerns are followed up on behalf of members and, as such, this named point of contact provides a useful two-way communication loop, making our members feel valued and listened to. A series of Governor profile pieces published in the member newsletter and staff newsletter plus a number of podcasts ensures the role of Governors and ways to contact them are kept visible.

Our Annual Members Meeting was held 'virtually' in November 2022 due to continuing COVID-19 restrictions, and attracted a good public attendance. The 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.

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

Or by emailing Governor and Member Engagement Officer sue.broome@nhs.net

Directors' Biographies

Board of Directors: Non-Executive Directors (at 31 March 2023)

Alan Burns, Trust Chair

Alan has worked in the NHS for 49 years in a variety of senior roles and has also run his own consultancy business supporting leadership and improving performance through coaching. In 2022-23, Alan was also the Trust Chair 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 Trust Chair of the NHS Confederation.

Alan was initially appointed by the Council of Governors in 2017, and reappointed for a second term in 2020. He retired from the role on 31 March 2023, and received a Lifetime Achievement Award at the Staff Excellence Awards held on 16 March 2023. In making this award, the Trusts (Kettering and Northampton) recognised that, through many years of service to the NHS, Alan used his knowledge, expertise, and passion, to advise and influence national policy through deep relationships with local communities and health and social care leaders. Combined with this, Alan brought about local and national change and improvement to a range of health and social care systems by influencing national opinion, policy, and direction.

During 2022-23, Alan chaired the Board of Directors, the Nomination & Remuneration Committee, Group Strategic Development Committee and the Council of Governors.

Trevor Shipman, Vice-Trust Chair, Non- Executive Director and Senior Independent Director

Trevor was appointed in February 2017, and reappointed for a second term in 2020 and third term in 2023. 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 Remuneration and Nomination, Group People and Group Strategic Development Committees. He took up the position of Interim Trust Chair on 1 April 2023.

Professor Natalie Armstrong, Non-Executive Director

Natalie is the University of Leicester nominated Non-Executive Director on the Board. She is currently Deputy Head of the College of Life Sciences at the University, a role she undertakes alongside her own academic work. Natalie's academic background is as a social scientist and her research uses social science theory and methods to support the delivery of high quality, safe healthcare. Her interdisciplinary health services research typically involves mixed-methods collaborations with clinical and non-clinical colleagues across and outside the University.

Natalie was brought up in Northamptonshire, having been born at Kettering General Hospital. The vast majority of her family still lives in the area served by the hospital, and so she is a frequent visitor back to the local area. Natalie is a member of the Nomination and Remuneration and Group Clinical Quality, Safety and Performance Committees and also sits on the partnership steering group between UHN and the university.

Alice Cooper, Non-Executive Director

Alice was appointed in April 2019 and reappointed for a second term, commencing in April 2022. 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. She is a Member of the Remuneration and Nomination, Group Transformation and Audit Committees.

Dr Lise Llewellyn, Non-Executive Director

Lise was appointed in June 2018 and reappointed to serve a second term in June 2021. 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 co-chairs the Elective Care (Lead Provider) Collaborative Committee and is a member of the Nominations and Remuneration Committee, Group Strategic Development Committee, Quality and Safety Committee, Group Clinical Quality, Safety and Performance and Audit Committee. She is also the Trust's Non-Executive Maternity Safety Champion.

Deborah Manger, Non-Executive Director

Deborah Manger joined the Board in August 2022. Deborah has lived and worked in Northamptonshire for over 30 years. Her roles have included Specialist in Special Care Dentistry and Deputy Medical Director in NHFT and more recently Deputy Dental Dean for the Midlands and East of England. In these leadership roles, she has led many quality improvements across healthcare. She has worked across primary and secondary settings in delivering the care, leading theatre teams at KGH and NGH and delivering complex care in Corby and Wellingborough.

She has significant board level experience regionally as a member of the East Midlands Clinical Senate, as chair of regional Managed Clinical Networks and as a Local Dental Network chair. This has enabled her to have direct involvement in the review of complex services, specifically in community care and urgent care, within the region.

Deborah believes that her broad experience of health and social care will enable her to support Kettering General Hospital. She Co-Chairs the Group People Committee, is a member of the Nomination and Remuneration Committee and appointed Trustee on the Northamptonshire Health Care Charitable Fund.

Andrew Moore, Non-Executive Director

Andrew joined the Board in March 2023. Andrew's commercial background is in retail where he held a variety of senior positions including Directorships at Marks & Spencer, Chief Merchandising Officer at Asda-Walmart and Chief Commercial Officer at Wilko. He has also worked in South Africa where he started

his own Retail Consultancy and partnered with Woolworths SA. He retains a close connection with the retail sector through his advisory work with corporate investor institutions.

In 2019 he joined the board of Breast Cancer Now charity as a Trustee where he is now Vice Chair. He is committed to helping the charity navigate the many challenges faced by the Not-For-Profit sector and contributing to its strategic development and operational efficiency; he also chairs the Finance & Investment Committee and sits on the Risk & Governance Committee. Andrew believes his business experience in focusing on quality, value and service can help support the KGH team in the next chapter of the hospital's development.

Andrew will be Co-Chairing and Convening the Group Transformation Committee during 2023-2024, and will be a member of the Nomination and Remuneration Committee and Group Finance and Performance Committee.

Damien Venkatasamy, Non-Executive Director

Damien was appointed in June 2018 and reappointed to serve a second term in June 2021. Damien has over 20 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, co-chairing the Group Finance and Performance Committee with the Northampton General Hospital.

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.

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 (at 31 March 2023)

Simon Weldon, Group Chief Executive (voting)

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,.

Simon left the Trusts' employment on 31 March 2023 to take up a new role with the South East Coast Ambulance Service.

Richard Apps, Interim Group Director of Integrated Governance (non-voting)

Richard joined the Trust in July 2018 and moved into a group role, supporting Northampton General Hospital on an interim basis, in January 2022. 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.

Natasha Chare, Group Chief Digital Information Officer (non-voting)

Natasha took up this role in February 2023 and brings with her a strong track record of leading engaged teams to deliver strategic change for the benefit of patients and staff.

Natasha's focus is to ensure our digital team responds to the needs of our organisation knowing that digital is a key enabler in supporting our colleagues to have the tools and information they need to do their job most effectively. Natasha's emphasis is on digital working with wider teams to bring about digital progress across our hospital including supporting clinicians to have access to full, accurate and timely patient information and giving patients the ability to increasingly be in control of their care.

Natasha's background is in change management and transformation –before joining the digital team in 2020, Natasha was in Kettering's transformation team. Prior to this Natasha was a management consultant working alongside public sector teams to improve operational practices and processes, roles which included that of digital lead. Natasha has also worked in numerous continuous improvement and commercial roles in the logistics sector. More recently, Natasha has received a post graduate diploma in Digital Health Leadership.

Jon Evans, Group Chief Finance Officer (voting)

Jon joined Kettering and Northampton General Hospitals in June 2021 as Group Chief Finance Officer.

Previously, Jon was Director of Finance at Oxford University Hospitals and prior to that worked in various senior finance roles at Imperial College Healthcare and University College hospitals in London, having started his career in the NHS on the national graduate training scheme.

Jon is a qualified chartered management accountant and has an MBA from the Alliance Manchester Business School. He is an active member of the Healthcare Financial Management Association, having been part of various committees and regional branches throughout his career.

Polly Grimmett, Interim Group Director of Strategy (non-voting)

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 has more recently taken on responsibility for strategic estates across the University Hospitals of Northamptonshire Group.

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.

Paula Kirkpatrick, Group Chief People Officer (voting)

Paula joined the Trust in 2019 after a career in HR spanning both public and private sectors, latterly including 15 years in policing where she was half of a job share partnership working in a number of senior roles. Whilst working for Cambridgeshire Constabulary Paula was part of the HR leadership team that developed a collaborated HR service across Bedfordshire, Cambridgeshire and Hertfordshire police forces. Initially joining KGH as Deputy Director HR and OD in September 2019, Paula was appointed as Director HR and OD in June 2020 and Acting Chief People Officer in July 2022.

Paula's areas of interest include health and wellbeing and equality, diversity and inclusion. She believes leadership is about supporting teams and individuals to be the best they can be: by ensuring people are healthy and well in the broadest sense; are able to be themselves in the workplace, bringing all their skills and expertise to their role; and are supported and developed to reach their potential.

On 1st September 2022 Paula was appointed as Group Chief People Officer.

Becky Taylor, Group Director of Transformation and Quality Improvement (non-voting)

Becky joined Kettering and Northampton Hospitals in October 2021, and has responsibility for leading the Transformation and Quality Improvement agenda across University Hospitals of Northamptonshire. This includes being the executive lead for large-scale transformation programmes across KGH and NGH, supporting and enabling a culture of quality improvement, and the monitoring and tracking of programmes and projects.

Becky spent much of her career in management consultancy supporting different acute providers, community providers, local authorities and NHS national bodies to develop strategies and transform services. She is a Health Foundation Q Community Fellow and is passionate about supporting staff to make things work better for both our patients and our staff.

Trust Executive Directors (at 31 March 2023)

Deborah Needham, Hospital Chief Executive (voting)

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 carried out the role of Group Chief Executive between January – March 2023 and was appointed to the role of Chief Executive and Accountable Officer from 1 April – 31 July 2023.

Fay Gordon, Chief Operating Officer (voting)

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.

John Jameson, Medical Director (voting)

John joined KGH in February 2023 having been Deputy Medical Director at the University Hospitals of Leicester NHS Trust since 2015. He was appointed as a colorectal surgeon in 1996 initially at the Glenfield Hospital in Leicester, before moving to the Leicester General Hospital in 2006. He did his surgical training on the Leicester rotation and completed this at St Mark's. He qualified from Emmanuel College Cambridge and Westminster Medical School and has held various educational roles including Critical Care Tutor at the Royal College of Surgeons of England responsible for the continued development and governance of the Care of the Critically Ill Surgical Patient course run throughout the UK and overseas. John is passionate about high quality patient care and empowering our staff to deliver this.

Outside of work he is a keen road cyclist and skier.

Jayne Skippen, Director of Nursing, Quality and Allied Health Professionals (AHPs) (voting)

Jayne is an experienced nurse with over 30 years' experience of working in the NHS, working in both acute and community care. Jayne is also an Emergency Nurse Practitioner, a Queen's Nurse and has an MSc in emergency preparedness.

Jayne completed her training at Sir Gordon Roberts School of Nursing (which later became Nene University) and has worked in a variety of organisations including North Devon Healthcare, Milton Keynes University Trust, Bucks Healthcare and in London. Jayne has held several Director of Nursing and Therapy positions in different organisation and was also Director of the vaccination and immunisation programme across North-West London.

Jayne joined KGH as Director of Nursing, Midwifery and AHPs in January 2023, has strong leadership experience in a variety of settings and has a passion to support staff development and create staff opportunity.

2.1.4 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.

2.1.5 Political donations

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

2.1.6 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 2022-23 is shown below with 2021-22 as a comparator.

	Month 12 2022/23 Number	Month 12 2022/23 £'000	2021/22 Number	2021/22 £'000
Total Non-NHS invoices paid in the year	70,598	137,367	60,335	114,986
Total Non-NHS invoices paid within target	58,363	115,597	54,044	101,333
Percentage of non NHS trade invoices paid within target	**83%**	**84%**	**90%**	**88%**
Total NHS invoices paid in the year	2,857	29,968	2,344	23,886
Total NHS invoices paid within target	2,062	25,487	1,870	22,056
Percentage of NHS trade invoices paid within target	**72%**	**85%**	**80%**	**92%**

The Trust's performance was impacted by the loss of the finance system for six weeks during the year due to a cyber attack on the provider of the finance system. The Trust itself was unaffected by the attack but the system was unavailable as a precautionary measure.

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

Cost allocation and charging

Throughout the year ended 31 March 2023, 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 His Majesty's Treasury.

2.1.7 NHS England's well-led framework

The Trust's overall approach to governance and compliance and reporting against NHS England'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 now published separately to the Annual Report. 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 NHSE 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.

With NGH, the Trust undertook an externally-facilitated self-assessment exercise against the CQC Well-Led domain in early 2023, which included an assessment of trust-level assurance within the context of the Group model. This complemented an independent external review of the Group Model, with a number of common themes/areas for attention emerging from the two pieces to inform next steps during 2023-24, received by the Board of Directors at its April 2023 meeting:

- Communication and Engagement
- Governance, Roles and Accountabilities
- Corporate Strategy and Integration Plans
- Clinical Collaboration
- Culture

Kettering General Hospital endeavours to achieve continual improvement by encouraging patients and relatives to express concerns if they are dissatisfied with the service they have received. This is through our Patient Experience Team, Patient Advice and Liaison Service (PALS), and Complaints Team. We investigate concerns 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. The Trust is struggling to meet targets around the timeliness of complaints responses during the year, however a review of the services was conducted in March 2023 with a change in some of our processes within the team. We have a strategy and trajectory to improve our performance in 2023-24.

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 Integration Care System (ICS), which consists of key health and care providers in the county. The ICS 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 ICS vision for a positive lifetime of health, wellbeing and care in our community.

You can find further information about NHCP at Integrated Care Northamptonshire (icnorthamptonshire.org.uk)

2.1.8 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 2022-23, 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 of the annual accounts for a breakdown on income sources.

DEBORAH NEEDHAM

CHIEF EXECUTIVE AND ACCOUNTABLE OFFICER

27 JUNE 2023

3 Remuneration report

3.1.1 Annual statement on remuneration

Major decisions on Senior Managers' remuneration

The Nomination and Remuneration committee met seven times over the course of the year, making key decisions in respect of the approval of Group and Trust Leadership posts and appointments to these posts, and undertaking its annual review of Executive Director salaries.

Substantial changes made to Senior Managers' remuneration

The Nomination and Remuneration Committee, at its meeting in February 2023, confirmed the advice of the Chief People Officer of NHS England to apply increases of 3% to Very Senior Managers' (VSM) salaries, backdated to 1 April 2022. Decisions in respect of Group leadership posts were made 'in common' with the Remuneration and Appointments Committee of the Northampton General Hospital. In addition, the Committee agreed salaries in respect of key Board positions as vacancies arose during the year (details are available in the Table at Section 3.1.3 below):

- Group Chief People Officer
- Group Chief Digital Information Officer
- Interim Group Chief Executive
- Medical Director
- Director of Nursing, Midwifery and Allied Health Professionals

Statement of the Chair of the Remuneration Committee

The Chair of the Remuneration Committee, has declared that the major items listed above are a true and fair reflection of the matters discussed at the committee during 2022-23.

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 who are members of the Board of Directors only, those on Very Senior Manager (VSM) Terms and Conditions.

With the exception of the Hospital Chief Executive role (details available in the 2021/22 annual report), 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 Chief Executive and approved by the Nomination AND 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, the Chief Executive provides the Committee with a report on each Director, summarising the achievement of specific objectives within the wider frame of the performance for the whole organisation.

The salary component for 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 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.

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 Non-Executive Directors during 2022/23, for alignment and consistency with remuneration rates at Northampton General Hospital:

- Trust Vice-Chair, Audit Committee Chair and Senior Independent Director: £16,500 to £17,000, and
- Non-Executive Directors: £12,500 to £13,000.

There was no change to the Trust Chair's remuneration of £48,000 per annum.

The next review will be undertaken during 2025.

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. A 'staggered' pay award of £1,400 per annum was applied during 2022/23, backdated to 1 April 2022.

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

2022-23	Non Exec Directors	Exec Directors	Governors
Total Number at 31/3/23	9	11	27
Total number receiving expenses	6	6	1
Total expenses paid (£)	1,249	1,973	130

2021-22	Non Exec Directors	Exec Directors	Governors
Total Number	9	13	28
Total number receiving expenses	5	2	1
Total expenses paid (£)	582	298	72

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 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 2022-23, attendances at each are detailed below:

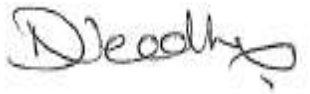
	19/05/22	14/10/22	11/01/23	20/01/23	02/02/23	03/03/23	30/03/23
Alan Burns	Yes	Yes	Yes	Yes	Yes	Yes	No
Natalie Armstrong	-	-	-	No	Yes	Yes Yes	Yes
Edmund Burke	Yes	-	-	-	-	-	-
Alice Cooper	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Liisa Janov	No	Yes	No	No	Yes	-	-
Lise Llewellyn	No	Yes	No	No	Yes	Yes	Yes
Deborah Manger	-	No	No	Yes	No	Yes	Yes
Andrew Moore	-	-	-	-	-	No	Yes
Trevor Shipman	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Damien Venkatasamy	No	Yes	No	Yes	No	Yes	Yes
Chris Welsh	Yes	Yes	Yes	Yes	Yes	Yes	No

SALARY AND PENSION ENTITLEMENTS OF SENIOR MANAGERS (Has been subject to audit – Directors; Financial Year 2022-23)

Name	Title	Start date	End date	Salary (bands of £5,000) £'000	Expense payments (taxable) to nearest £100)	Performance pay and bonuses (bands of £5,000) £'000	All pension-related benefits (bands of £2,500)* £'000	Total Remuneration (bands of £5,000) £'000
Mr S Weldon	Group Chief Executive	**Apr-18**	**Mar-23**	145 – 150	-	-	25 - 27.5	170 – 175
Mr J Evans	Group Chief Finance Officer	**Jun-21**		80 – 85	-	-	30 - 32.5	115 – 120
Ms D Needham	Acting Group Chief Executive (Jan 23 to Mar 23) and Hospital Chief Executive	**Mar-21**		150 – 155	-	-	45 – 47.5	195 - 200
Ms F Gordon	Interim Chief Operating Officer	**Mar-21**		115 – 120	-	-	-	115 – 120
Ms P Kirkpatrick	Group Chief People Officer	**Aug-22**		45 – 50	-	-	17.5 - 20	60 – 65
Ms R Imtiaz	Interim Medical Director	**Jun-21**	**Jan-23**	130 - 135	-	-	52.5 - 55	180 – 185
Mr J Jameson	Medical Director	**Feb-23**		25 - 30	-	-	-	25 - 30
Ms F Barnes	Interim Director of Nursing	**Sep-21**	**Jan-23**	100 – 105	-	-	247.5 - 250	350 – 355
Ms J Skippen	Director of Nursing	**Jan-23**		20 - 25	-	-	52.5 - 55	75 - 80
Mr M Smith	Group Chief People Officer	**Jun-14**	**July-22**	25 - 30	-	-	-	25 - 30
Mr A Callow	Acting Group Chief Executive (Sep 22 to Jan 23) and Group Chief Digital & Information Officer	**Apr-19**	**Jan-23**	60 – 65	-	-	35 – 37.5	95 – 100
Ms N Chare	Group Chief Digital & Information Officer	**Feb-23**		10 - 15	-	-	15 – 17.5	25 – 30
Mr D Howard	Interim Group Chief Digital & Information Officer (Sep 22 to Jan 23)	**Sep-22**	**Jan-23**	20 – 25	-	-	17.5 - 20	35 – 40
Mr R Apps	Group Director of Governance	**Jul-18**		60 – 65	-	-	22.5 - 25	85 – 90
Ms P Grimmett	Director of Strategy	**Dec-19**		120 - 125	-	-	30 - 32.5	150 - 155
Ms R Taylor	Interim Group Director of Transformation & Quality Improvement	**Oct-21**		60 - 65	-	-	12.5 - 15	75 - 80

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.
During the year the Group Chief Executive post, while substantively held by S Weldon was covered by both A Callow (27th September to 13th January) and D Needham (16th January to 31st March). During the period that A Callow was Acting Group Chief Executive officer, D Howard was appointed to cover the Group Chief Digital and Information officer.
The salary for Ms Imtiaz includes £40-£45k in respect of clinical duties.
S Weldon was the Group Chief Executive. His remuneration above reflects the charges made to NGH. His total salary was in the range – £255k- £260k This includes additional contractual payments at the date of his termination from the post on 31st March 2023.
M Smith was the Group Chief People Officer. His remuneration above reflects the charges made to NGH. His total salary was in the range – £55- £60k.
P Kirkpatrick is the Group Chief People Officer. Her remuneration above reflects the charges made to NGH. Her total salary was in the range – £125- £130k.
A Callow was the Group Chief Digital and Information Officer. His remuneration above reflects the charges made to NGH. His total salary for the year was in the range – £120k- £125k.
N Chare is the Group Chief Digital and Information Officer. Her remuneration above reflects the charges made to NGH. Her total salary for the year was in the range – £95- £100k
D Howard was the Interim Group Chief Digital and Information Officer. His remuneration above reflects the charges made from NGH. His total salary for the year was in the range – £110k- £115k
J Evans is the Group Chief Finance Officer. His remuneration above reflects the charges made to NGH. His total salary for the year was in the range – £165k- £170k.
R Apps is the Group Director of Governance. His remuneration above reflects the charges made to NGH. His total salary for the year was in the range – £125k- £130k.
R Taylor is the Group Director of Transformation. Her remuneration above reflects the charges made to NGH. Her total salary for the year was in the range - £120-£125k.
F Barnes and D Howard have been recharged from NGH. D Howard's post reflects a Group position and his salary for the period was £40-45k.



Signed: Ms Deborah Needham – Chief Executive and Accountable Officer Date: 27 June 2023

Chairman and Non- Executive Directors – Financial year 2022-23

Name	Title	Start date	End date	Salary (bands of £5,000) £'000	Expense payments (taxable) (to nearest £100) £	Total Remuneration (bands of £5,000) £'000
Mr A Burns	Chairman	Sep-17	Mar 23	45 -50	600	45 - 50
Mr D Venkatasamy	Non-Executive Director	Jul-18		10 - 15	-	10 - 15
Mr T Shipman	Non-Executive Director	Apr-17		15 - 20	-	15 - 20
Ms A Cooper	Non-Executive Director	Apr-19		10 - 15	200	10 - 15
Dr L Llewellyn	Non-Executive Director	Jun-18		10 - 15	1400	10 - 15
Ms D Manger	Non-Executive Director	Aug-22		5 - 10	-	5 - 10
Ms L Janov	Non-Executive Director	Oct-19	Feb-23	10 - 15	-	10 - 15
Prof C Welsh	Non-Executive Director	Feb-18		10 - 15	900	10 - 15
Prof N Armstrong	Non-Executive Director	Jan-23		0-5	-	0-5
Mr A Moore	Non-Executive Director	Mar-23		0-5	-	0-5
Prof E Burke	Non-Executive Director	Aug-21	Aug-22	5 - 10	-	5 - 10

REMUNERATION REPORT Executive Directors (Voting and Non-Voting) - Financial Year 2021-22

Directors								
Financial Year 2021/22				**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	**Apr-18**		100 - 105	-	-	55 - 57.5	155 - 160
Mr J Evans	Group Chief Finance Officer	**Jun-21**		55 - 60	-	-	55 - 57.5	115 - 120
Ms D Needham	Hospital Chief Executive	**Mar-21**		160 - 165	-	-	155 - 157.5	320 - 325
Ms F Gordon	Interim Chief Operating Officer	**Mar-21**		115 - 120	-	-	167.5 - 170	285 - 290
Mr A Pursooth	Interim Director of Finance	**Aug-20**	**Jun-21**	20 - 25	-	-	35 - 37.5	55 - 60
Prof A Chilton	Medical Director	**Jun-10**	**Jun-21**	40 - 45	-	-	-	40 - 45
Ms R Imtiaz	Interim Medical Director	**Jun-21**		130 - 135	-	-	112.5 - 115	245 - 250
Ms L Hackshall	Director of Nursing	**Oct-14**	**Sep-21**	65 - 70	-	-	-	65 - 70
Ms F Barnes	Interim Director of Nursing	**Sep-21**		65 - 70	-	-	97.5 - 100	165 - 170
Mr M Smith	Group Chief People Officer	**Jun-14**		80 - 85	-	-	-	80 - 85
Mr A Callow	Group Chief Digital & Information Officer	**Apr-19**		70 - 75	-	-	17.5 - 20	85 - 90
Mr R Apps	Director of Governance	**Jul-18**		95 - 100	-	-	20 - 22.5	120 - 125
Ms P Grimmett	Director of Strategy	**Dec-19**		115 - 120	-	-	40 - 42.5	155 - 160
Ms R Taylor	Interim Group Director of Transformation & Quality Improvement	**Oct-21**		30 - 35	-	-	5 - 7.5	35 - 40

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 £20-£25k in respect of clinical duties. The salary for Ms Imtiaz includes £105-110k in respect of clinical duties.
S Weldon is the Group Chief Executive. His remuneration above reflects the charges made to NGH. His total salary was in the range – £210- £215k.
M Smith is the Group Chief People Officer. His remuneration above reflects the charges made to NGH. His total salary was in the range – £165- £170k.

A Callow is the Group Chief Digital and Information Officer. His remuneration above reflects the charges made to NGH. His total salary for the year was in the range – £140- £145k.
J Evans was appointed as Group Chief Finance Officer. His remuneration above reflects the charges made to NGH. His total salary for the year was in the range – £125- £130k.
R Apps was appointed as Group Director of Governance from February 2022. His remuneration above reflects the charges made to NGH. His total salary for the year was in the range – £105- £110k.
R Taylor was appointed as Interim Group Director of Transformation in October 2021. Her remuneration above reflects the charges made to NGH. Her total salary for the year was in the range - £60-£65k.
The remuneration for S Weldon and J Evans includes a reduction under a salary sacrifice scheme. This was not included in the recharge to NGH, but if it had been it would increase the remuneration charge in the table above by £0-£5k
F Barnes has been recharged from NGH.

Trust Chair and Non- Executive Directors – Financial year 2021-22

Name	Title	Start date	End date	Salary (bands of £5,000) £'000	Expense payments (taxable) (to nearest £100) £	Total Remuneration (bands of £5,000) £'000
Mr A Burns	Chairman	Sep 2017		40-45	-	40-45
Mr D Venkatasamy	Non-Executive Director	July 2018		10-15	-	10-15
Mr T Shipman	Non-Executive Director	April 2017		15-20	-	15-20
Ms A Cooper	Non-Executive Director	April 2019		10-15	100	10-15
Dr L Llewellyn	Non-Executive Director	June 2018		10-15	-	10-15
Mrs J Gray	Non-Executive Director	Oct 2014	Mar 2022	10-15	-	10-15
Ms L Janov	Non-Executive Director	Oct 2019		10-15	-	10-15
Prof C Welsh	Non-Executive Director	Feb 2018		10-15	-	10-15
Mr E Burke	Non-Executive Director	Aug 2021		5-10	100	5-10

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 (0.5%), contributions paid by the employee (including the value of any benefits transferred from another pension scheme or arrangement) and uses common market valuation factors for the start and end of the period. Therefore the real increase is not the absolute difference between one year and the next.

Cash equivalent transfer value (CETV) figures are calculated using the guidance on discount rates for calculating unfunded public service contribution rates that was extant on 31 March 2023. HM Treasury published updated guidance on 27 April 2023; this guidance will be used in the calculation of 2023/24 CETV figures.

PENSION BENEFITS (Has been subject to audit)

2022-23 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 2023 (bands of £5000)	Lump sum at pension age related to accrued pension at 31st March 2023 (bands of £5000)	Cash Equivalent Transfer Value (CETV) at 31st March 2023	Cash Equivalent Transfer Value (CETV) at 1st April 2022	Real Increase in Cash Equivalent Transfer Value *	Employer's contribution to stakeholder pension
		£000	£000	£000	£000	£000	£000	£000	£000
Mr S Weldon	Group Chief Executive	0-2.5	-	30-35	60-65	637	577	27	-
Mr J Evans	Group Chief Finance Officer	0-2.5	0-2.5	20-25	30-35	273	238	16	-
Ms D Needham	Trust Chief Executive	2.5-5	-	70-75	145-150	1269	1165	46	-
Ms F Gordon	Interim Chief Operating Officer	-	-	35-40	75-80	712	792	-	-
Ms J Skippen	Director of Nursing	0-2.5	0-2.5	40-45	75-80	694	621	6	-
Ms F Barnes	Interim Director of Nursing	7.5 – 10	22.5 – 25	65 – 70	195 – 200	1,593	1,270	218	-
Mr R Apps	Group Director of Governance	0-2.5	0-2.5	10-15	20-25	216	185	16	-
Ms R Imtiaz	Interim Medical Director	2.5-5	0-2.5	30-35	45-50	595	512	34	-
Mrs P Kirkpatrick	Group Chief People Officer	0-2.5	-	0-5	-	53	34	5	
Mr A Callow	Group Chief Digital & Information Officer	0-2.5	-	5-10	-	123	91	15	-
Ms P Grimmett	Director of Strategy	0-2.5	-	30-35	50-55	489	437	22	-
Ms R Taylor	Interim Group Director of Transformation & Quality Improvement	0-2.5	-	0-5	-	15	5	1	-
Ms N Chare	Group Chief Digital & Information Officer	0-2.5	-	0-5	-	22	14	-	
Mr D Howard	Interim Group Chief Digital & Information Officer	0-2.5	-	0-5	-	19	7	1	-

CPI is 3.1% in 2022/23.There are no additional benefits that become receivable by the individual in the event of their early retirement and no payments have been made to stakeholder pensions by the Trust. For the Group posts S Weldon, J Evans, R Apps, P Kirkpatrick, R Taylor, N Chare and A Callow, the CETV and increases have been apportioned based on the recharge to Northampton General Hospital. F Barnes and D Howard are recharged from NGH and their CETV and increases have been apportioned based on that recharge. M Smith opted out of the pension scheme and J Jameson is not eligible to be added.

2021-22		**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 2022 (bands of £5000)**	**Lump sum at pension age related to accrued pension at 31st March 2022 (bands of £5000)**	**Cash Equivalent Transfer Value (CETV) at 31st March 2022**	**Cash Equivalent Transfer Value (CETV) at 1st April 2021**	**Real Increase in Cash Equivalent Transfer Value ***	**Employer's contributio n to stakeholder pension**
Name	**Title**	**£000**	**£000**	**£000**	**£000**	**£000**	**£000**	**£000**	**£000**
Mr S Weldon	Group Chief Executive	2.5-5	2.5-5	25-30	55-60	577	506	53	-
Mr J Evans	Group Chief Finance Officer	2.5-5	2.5-5	15-20	25-30	238	194	27	-
Ms D Needham	Trust Chief Executive	7.5-10	12.5-15	65-70	145-150	1165	1003	133	-
Ms F Gordon	Interim Chief Operating Officer	7.5-10	17.5-20	40-45	90-95	792	622	153	-
Ms L Hackshall	Director of Nursing	-	37.5-40	45-50	265-270	-	1275	-	-
Ms F Barnes	Interim Director of Nursing	2.5-5	7.5-10	25-30	80-85	635	517	60	-
Mr R Apps	Group Director of Governance	0-2.5	0-2.5	10-15	20-25	185	163	15	-
Ms R Imtiaz	Interim Medical Director	5-7.5	7.5-10	25-30	45-50	512	326	82	-
Mr A Callow	Group Chief Digital & Information Officer	0-2.5	-	5-10	-	91	72	8	-
Ms P Grimmett	Director of Strategy	2.5-5	0-2.5	25-30	45-50	437	391	27	-
Ms R Taylor	Interim Group Director of Transformation & Quality Improvement	0-2.5	-	0-5	-	5	0	-	-
Mr A Pursooth	Interim Director of Finance	0-2.5	-	40-45	85-90	758	715	4	-

CPI is 0.5% in 2021/22.
L Hackshall retired during the year.
There are no additional benefits that become receivable by the individual in the event of their early retirement and no payments have been made to stakeholder pensions by the Trust. 2020/21 figures have been restated to exclude these.
For S Weldon, J Evans, R Apps, R Taylor and A Callow, the CETV and increases have been apportioned based on the recharge to Northampton General Hospital.
F Barnes is recharged from NGH and her CETV and increases have been apportioned based on that recharge. M Smith opted out of the pension scheme.

3.1.4 Fair pay disclosure (Has been subject to audit)

The Trust is required to disclose pay ratio information which discloses the relationship between the remuneration of the highest paid director in the organisation and the lower quartile, median and upper quartile 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" as detailed below:

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

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

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

The annualised highest paid Director was the Medical Director whose banded remuneration included recompense for clinical services. The banded remuneration was £190,000-£195,000 in 2022-23 and £250,000-£255,000 in 2021-22. The difference relates predominantly to clinical related payments.

The percentage change from the previous year, using the mid points of the banding is therefore a reduction of 23%. In 2021-22, the average remuneration for all employees was £36,940, increasing in 2022-23 to £37,265. The change from the prior year is an increase of 1% (this excludes the impact of the Agenda for Change pay award, announced in March 2023 and paid in June 2023). There were no performance pay or bonuses for the highest paid Director or other staff in either 2021-22 or 2022-23.

The table below shows the relationship between the remuneration and salary of the highest paid director against the percentiles shown. For clarity a ratio of 6.68 means that the director earns 6.68 times the relevant salary of employees.

2022/23	25th percentile ratio	Median Pay ratio	75th percentile ratio
Salary component of pay	£21,730	£29,180	£40,588
Total pay and benefits excluding pension benefits	£23,177	£29,180	£41,659
Pay and benefits excluding pension: pay ration for highest paid director	8.41	6.68	4.68
2021/22	25th percentile ratio	Median Pay ratio	75th percentile ratio
Salary component of pay	£19,918	£25,655	£39,027
Total pay and benefits excluding pension benefits	£21,794	£29,084	£40,081
Pay and benefits excluding pension: pay ration for highest paid director	11.59	8.68	6.30

The movement in rations between 2021-22 and 2022-23 is due to a new Medical Director in the year. The salary for this post did not increase, and their remuneration decreased due to clinical pay commitments, whereas other staff received an annual pay award. As the salary and remuneration are annualised, the Medical Director remains the Highest paid director.

In 2022-23 no employees (2021-22 – nil) received remuneration in excess of the highest paid Director.

The range of staff remuneration in 2022-23 was from £9,405 - £199,183 per annum. In 2021-22 this was £8,408 - £252,502.

The Trust confirms that the median pay ratio is consistent with the pay, reward and progression policies for the employees taken as a whole.

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			2022/23	2021/22
	Permanent	Other	Total	Total
	£000	£000	£000	£000
Salaries and wages	182,233	29,153	**211,386**	193,826
Social security costs	21,275	-	**21,275**	18,576
Apprenticeship levy	1,046	-	**1,046**	939
Employer's contributions to NHS pensions	30,355	-	**30,355**	29,246
Pension cost – other	55	-	**55**	44
Termination benefits	-	-	**-**	-
Temporary staff	-	13,091	**13,091**	10,653
Total gross staff costs	**234,964**	**42,244**	**277,208**	**253,284**
Recoveries in respect of seconded staff	(1,527)	**-**	**(1,527)**	(1,001)
Total Staff Costs	**233,437**	**42,244**	**275,681**	**252,283**
Of which				
Costs capitalised as part of assets	1,446	594	**2,040**	1,668

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

Average number of employees (WTE basis)			2022/23	2021/22
	Permanent	Other	Total	Total
	Number	Number	Number	Number
Medical and dental	504	98	**602**	601
Administration and estates	889	65	**954**	925
Healthcare assistants and other support staff	970	188	**1,158**	1,219
Nursing, midwifery and health visiting staff	1,394	166	**1,560**	1,532
Scientific, therapeutic and technical staff	261	25	**286**	284
Healthcare science staff	183	-	**183**	182
Other	133	2	**135**	129
Total average numbers	**4,334**	**544**	**4,878**	**4,872**
Of which involved in capital projects	26	5	31	26

3.2.3 Gender analysis (at 31 March 2023)

Staff Type	Female	Male
Exec Directors	10	5
Senior Manager	29	21
All Other Employees	3766	1085

Senior Managers by Gender:

Band (Agenda for Change)	Female	Male	Grand Total
Band 8 - Range A	9	6	15
Band 8 - Range B	8	3	11
Band 8 - Range C	6	4	10
Band 8 - Range D	6	4	10
Band 9	0	4	4
Grand Total	**29**	**21**	**50**

Gender pay gap reporting

Our Gender pay gap report is available to view at: https://gender-pay-gap.service.gov.uk/

3.2.4 Sickness absence data

Sickness absence data is available on the NHS Digital website using this link: https://digital.nhs.uk/data-and-information/publications/statistical/nhs-sickness-absence-rates The Performance Analysis section at Section 1.3.3 above provides further commentary regarding the Trust's sickness absence levels during 2022-23.

Average FTE for 2022	Adjusted FTE days lost to Cabinet Office Definitions	Average sick days per FTE
4,346	59,904	13.8

3.2.5 Staff policies and actions applied during the financial year

During 2022-23 we continued to work to and review our progress against our Equality, Diversity and Inclusion Strategy 2021-2024. We have met all of our statutory reporting duties and an annual Equality report will be produced and published on our website in line with the Public Sector Equality Duties (PSED).

The key areas of work and actions are linked to and driven by:

- Inclusion Networks
- Workforce Race Equality Standard (WRES)
- Workforce Disability Standard (WDES)
- Gender Pay Gap Reporting
- National Staff Survey results
- Quarterly Pulse Survey results
- Freedom to Speak Up
- Promotion of equality, diversity and inclusion to increase awareness and cultural competence across all staff groups

Our key achievements included:

- Continued support of our staff networks:
- REACH (Race, Equality and Cultural Heritage) Network and DAWN (Disability and Wellbeing),
- Pride (LGBTQ+) Network, and VOICE (Women in Medicine) Network

- Continued roll out of trained 'Inclusive Recruitment Champions' on all interview panels at Band 7 and above
- Celebration event for our REACH and Overseas staff in October 2022, as part of Black History Month
- Review and updating our Equality Impact Assessment processes, to ensure our policies and processes give due regard to people with protected characteristics

NHS Staff Survey Equality and Diversity Key Findings

The demographics of our workforce who responded to the staff survey were broadly similar to 2021-22 with a significantly higher response of staff saying that they had a Long-Term Condition compared to our ESR data.

Kettering General Hospital saw slight improvements in three of the four Workforce Race Equality Standards (WRES) measures; however, discrimination from other staff has continued to increase and has more than doubled since 2019 – up from 12.6 in 2019 to 25.9% this year. This is 8.6% higher than the national average.

Kettering General Hospital saw slight improvements in seven of the nine Workforce Disability Equality Standards (WDES), including a positive 7.3% decrease in bullying, harassment and abuse from managers, and a 7% decrease in bullying, harassment and abuse from staff.

The Trust produces an annual Health and Safety Report, which showed an improved reduction in the number of reported staff accidents from 195 in 2021-22 to 168 in 2022-23. This 13.9 % decrease has been achieved by various methods: continued discussions around accident trends at the monthly Health & Safety committee meetings, sharing lessons learnt from accident investigations, Health and safety Carnival conducted last year in October, plus various Health and safety communications sent out in staff weekly e-bulletins. A drive on recruiting Health and safety champions across the Trust for each ward is ongoing to improve knowledge and engagement staff with regards to their responsibilities around Health and Safety will also contribute to this further.

The Trust experienced a serious incident in February 2022, resulting in injury to a colleague and subsequent internal and Health and Safety Executive investigations. The initial focus of the Trust's response was a 15-point plan to manage and deliver the findings of the detailed review of compliance and health and safety management in Estates and Facilities, following which the Trust commissioned an external audit of management systems. The department recruited a Dedicated Health and Safety Manager, who commenced in March 2023, with the remit to review all procedures, risk assessments and custom and practice, to introduce best practice and to embed a Health and Safety culture into the department. Cultural change was identified as key to sustaining and embedding improved practice, and meant all colleagues taking responsibility for their own safety, and being prepared to challenge concerns around potentially unsafe practice.

3.2.6 Staff survey results

Staff engagement is well recognised as being vital to delivering high quality, compassionate care. In addition to the National Staff Survey, Kettering General Hospital runs the 'National Quarterly Pulse Survey' to track the nine staff engagement questions. These are reported through the Group People Committee and shared with Divisional leadership and HR colleagues to better understand the feedback from staff. The Trust seeks feedback from staff through a variety of mechanisms, including a weekly 'Let's Talk' forum with Senior Leaders and several Staff Inclusion networks to listen and lead actions based on staff feedback. The Trust is in the process of introducing 'Shared Decision Making Councils' as part of the 'Pathway to Excellence' accreditation.

The NHS National staff survey is a key piece of intelligence which ran at Kettering General Hospital NHS Foundation Trust from 20 September to 25 November 2022 with 2,073 colleagues taking part representing 43.3% of our workforce. This compares with the national median average of 44.5% and marks a slight decrease from 2021.

2022-23 and 2021-22

Scores for each indicator together with that of the survey benchmarking group (Acute/Acute and Community Trusts) are presented below.

Indicators (People Promise elements and themes)	2022-23		2021-22	
People promise element	Trust score	Benchmark group	Trust score	Benchmark group
We are compassionate and inclusive	6.8	7.2	6.9	7.2
We are rewarded and recognised	5.3	5.7	5.5	5.8
We each have a voice that counts	6.3	6.6	6.4	6.7
We are safe and healthy	5.7	5.9	5.7	5.9
We are always learning	5.1	5.4	5.1	5.2
We work flexibly	5.7	6.0	5.7	5.9
We are a team	6.3	6.6	6.3	6.6
Staff engagement	6.4	6.8	6.5	6.8
Morale	5.4	5.7	5.5	5.7

2020-21

Scores for each indicator together with that of the survey benchmarking group are below:

	2020/21	
	Trust score	Benchmark group
Equality, Diversity and Inclusion	9.0	9.1
Health and Wellbeing	6.1	6.1
Immediate Managers	6.7	6.8
Morale	6.2	6.2
Quality of Care	7.5	7.5
Safe environment – bullying and harassment	7.9	8.1
Safe environment – violence	9.5	9.5
Safety culture	6.8	6.8
Staff engagement	7.0	7.0
Team working	6.5	6.5

The Trust performance was below the national average in all People Promise elements and themes, with no change in four areas, slight decreases of between -0.1 and -0.2 in the remaining five elements.

The results for the survey have been analysed and shared across the organisation with visual results at Trust and Divisional level being made available to staff. Full survey results are available here: https://www.nhsstaffsurveys.com/results/local-results/Continuing from 2021, the main four themes continued to be:

- Team working
- Respect
- Leadership and management, and
- Reward and recognition

The results under the elements of 'We are Compassionate and Inclusive' and 'We are a Team' are particularly disappointing and concerning. The Trust has committed to following NHS England's 'Culture and Leadership Programme' across the Group to improving the experience of our staff, with the 'Scoping phase' being concluded and planning to begin the 'Discovery phase' in Q1 2023-24. This will include an explicit focus on co-producing an anti-racism policy and approach to improve the experience of our REACH staff. More information on NHS England's Culture and Leadership Programme can be found here: https://www.england.nhs.uk/culture/culture-leadership-programme/**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.

3.2.7 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 2022/23, total expenditure on consultancy was £180k, compared to £1,029k in 2021/22.

3.2.8 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 3 on page 86 of the Group Accounting Manual 2022/23.

The Trust did not have any off payroll engagements during 2022-23.

The Board of Directors 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.

3.2.9 Exit packages (Has been subject to audit)

There was one exit package agreed during 2022-23 with a total value of £28k.

Exit packages (non-compulsory) departure payments

	2022/23 (2021/22)	
	Payments agreed	**Total value £000**
Contractual costs of mutually-agreed resignations	**0 (0)**	**0(0)**
Contractual payments in lieu of notice	**1 (5)**	**28 (5)**
TOTAL	**1 (5)**	**28 (5)**
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 2022-23 disclosures are set out in the Annual Governance Statement (see below). A new Code of Governance for NHS Provider Trusts came into effect from 1 April 2023; disclosures in future annual reports will be based on the new code; disclosures below relate to the 2014 Code, which was applicable to 31 March 2023.

3.3.1 NHS Oversight Framework

NHS England's NHS Oversight Framework provides the framework for overseeing systems including providers and identifying potential support needs. NHS organisations are allocated to one of four 'segments'. A segmentation decision indicates the scale and general nature of support needs, from no specific support needs (segment 1) to a requirement for mandated intensive support (segment 4).

A segment does not determine specific support requirements. By default, all NHS organisations are allocated to segment 2 unless the criteria for moving into another segment are met. These criteria have two components:

a) objective and measurable eligibility criteria based on performance against the six oversight themes using the relevant oversight metrics (the themes are: quality of care, access and outcomes; people; preventing ill-health and reducing inequalities; leadership and capability; finance and use of resources; local strategic priorities)

b) additional considerations focused on the assessment of system leadership and behaviours, and improvement capability and capacity. An NHS foundation trust will be in segment 3 or 4 only where it has been found to be in breach or suspected breach of its licence conditions.

Segmentation

The trust's position at 31 March 2023 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/publication/nhs-system-oversight-framework-segmentation/.

The Trust is currently in receipt of draft Enforcement Undertakings from NHS England in relation to its financial position; these are expected to be agreed during 202324.

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 England.

NHS England, in exercise of its powers conferred 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:

Deborah Needham

Chief Executive and Accountable Officer Date: 27 June 2023

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 2023 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 England, 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 6 April 2023 (see page 413): https://www.kgh.nhs.uk/download.cfm?doc=docm93jijm4n3246.pdf&ver=6460. 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 Assurance and Risk 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;
- Horizon scanning by services and the Head of Risk Management to identify potential emerging issues and risks.

Through these processes, the Board of Directors is able to receive and be provided with assurance that the trust has a clear line of sight of all risks across the organisation.

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.

Public stakeholders’ involvement in managing risks is specified within detailed risk controls and actions within the Board Assurance Framework, which is submitted to public Board of Directors on a quarterly basis 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 Our People

In 2021, both Trusts (Kettering and Northampton) adopted a Group People Plan to deliver the Group's 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.

The Boards received a report in November 2022 setting out progress against the pledges within the plan in the context of ongoing and unrelenting pressures caused by COVID-19 and demand on emergency services. Highlights included:

- Significant support offered to colleagues in response to the cost-of-living crisis, including the introduction of Wagestream, Financial wellbeing days and the hardship payment paid to lower paid employees this month.
- Development of the UHN Health Care Support Worker (HCSW) recruitment event enabling HCSW to be recruited at scale
- Management training programme pilot to support new and emerging managers and a forerunner to our new UHN Management and Leadership programme
- Reduction in the numbers of formal employee relations cases and significant improvement in WRES 3 score at both Trusts
- Significant work undertaken in the scoping phase of the UHN Culture and Leadership programme
- Significant improvements in the diversity of our volunteers and an increase in the number of volunteers at KGH which had significantly less volunteers than NGH prior to initiating Group leadership of the volunteer function.

The Board's identified key deliverables for the next 12-18 months, prioritising:

- Culture and leadership – progressing through the scoping and starting the discovery phase of this significant programme of work (Appendix 2).
- Management and leadership development – delivering learning and education to our leaders to improve the quality of management and leadership skills across our organisations
- Workforce grip and control – ensuring appropriate grip and oversight of agency spend and providing assurance on our controls on temporary staffing spend
- Workforce plans - ensuring our Integrated Business Plan incorporates a credible and sustainable workforce plan supported by attraction, resourcing and retention strategies that will ensure workforce supply
- Developing an anti-racism strategy to strengthen inclusion within our organisations and to directly address bullying and harassment

- Supporting clinical collaboration – ensuring we optimise every opportunity to improve the experience for those leading within collaborated services to make leading and managing their people as simple and as effective as it can be given the limitations of legislative and regulatory requirements
- Continuing to support the health and wellbeing of our staff with a focus on financial wellbeing and equity of access to services across the Group
- Delivery of a new common appraisal process across the Group.

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 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 Group Clinical Quality, Safety and Performance 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 Group 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 July 2022, the Trusts (Kettering and Northampton) adopted a shared Group Board Assurance Framework (BAF) to overcome duplication and confusion from similar risks describing the same issues across the Group and provide clearer alignment with Group objectives and delivery strategies. Each Trust retains a Corporate Risk Register which will inform the Group BAF and provide oversight of key cross-cutting risks at an organisational level. The risks identified consolidated and replaced existing Trust BAF risks.

At 31 March 2023, there were eight risks tracked through the Group BAF.

- Failure to deliver the Group People Plan may result in reduced staff engagement, empowerment and lack of inclusion which would impact negatively on staff satisfaction, recruitment and retention..
- Failure to deliver the group Clinical Strategy may result in fragmented and inefficient service delivery, fragile service provision, and sub-optimal outcomes of care alongside negatively impacting staff retention, recruitment and morale.
- Failure to deliver the group Nursing, Midwifery and Allied Health Processionals Strategy may result in inequity of clinical voice, failure to become a truly clinically-led organisation and centre of excellence for patient care
- Failure to deliver the NHCP Integrated Care System Partnership may result in an impact on the quality of service provided across the group.

- Failure to deliver the group Strategic Estates programme may result in care delivery from poor clinical environments, cost inefficiencies, patient safety incidents and statutory non-compliance attributable to some degree to substandard existing estate, and lost opportunities for integrated care delivery at place, resulting in serious incidents, possible prosecution and associated reputational damage
- Failure to deliver the Group Academic Strategy may result in non-delivery of University Hospital status, reducing the ability to attract high calibre staff and research ambitions.
- Failure to deliver the group Digital Strategy may result in poor performance of systems resulting in a lack of consistency and expected levels of quality of patient and staff experience of digital services across the group
- Failure to deliver a Group Medium Term Financial Plan results in an inability to deliver Trust, Group and system objectives.

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

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

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)

The prompt and effective management of serious incidents is paramount to ensure the services provided by KGH are safe and high quality. On some occasions, these types of incidents have serious consequences for those patients, service users and staff affected. Robust management of these incidents provides KGH with very valuable learning opportunities which trigger improvements in the services we provide. These patient safety improvements strive to preventing the occurrence of serious incidents and the potential effects these may have.

Clear functions and responsibilities, resources, policies and procedures are in place to undertake, monitor and continually improve the recognition of serious incidents and the processes for reporting, investigating and learning from these events. These processes enable a very successful collaboration with agencies external to KGH (Commissioners, regulators, etc.) and ensure effective engagement with all those involved or affected by serious incidents (patients, service users, families, carers, members of staff, etc.).

During the period 2022/2023, 0.6% of all patient incidents were serious incidents. This adds up to 73 serious incidents, which constitutes a reduction of almost 10% in respect to the previous year. The most common category of SI reported was 'Clinical Care & Treatment (Policy & Procedure)'. The main type of incident within that category was 'Delay In Treatment / Diagnosis'. Other incident categories of interest were HCA/Infection Control (mostly COVID-19 related) and Patient Falls. Improvement plans, both

associated to each individual case and in some cases Trust wide also, are implemented and closely monitored to ensure improvements are implemented to prevent the recurrence of these incidents.

KGH has strong governance arrangements in place to ensure the effective operation of all processes described above. Each individual incident causing moderate harm and above is analysed in detail by the Patient Safety Team and discussed at the Serious Incident Review Group (SIRG) to determine the most appropriate level of investigation required to identify the potential learning from each incident.

Thorough analysis of the profile of KGH from a patient safety perspective is completed on a continued basis. This analysis, reflected in quarterly and annual reports, is considered at relevant stages within the organisation's Governance processes, committees and groups ` . The different Governance organisations and processes confirm Trust wide learning and have oversight of its effective application as part of the continuous improvement activity in KGH.

National audits

The Trust outsources elements of its transactional financial services to two third party suppliers including the NHS Electronic Staff Record (ESR) Programme. Assurance on the effective operation of the control environments with this supplier is gained through various measures, including independent auditors' reports. The national independent audit on the NHS Electronic Staff Record Programme for the period 1 April 2022 to 31 March 2023 has received a qualified opinion arising from issues relating to security configurations. The Trust is satisfied that there are compensating controls at the Trust that are sufficient to mitigate the control deficiencies with the third party and is furthermore assured by the additional procedures performed and conclusion reached by external audit.

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. This Code will be replaced by an updated Code of Governance for NHS Provider Trusts from 1 April 2023, which will apply to the 2023-24 and subsequent annual reports.

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.
- Group 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 Committee of the Board has the relevant strategic risks on the Group 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.

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.

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 and maintaining an absolute standard of honesty and integrity in dealing with our assets. We are committed to the elimination of fraud and illegal acts within the Trust. The Trust has a counter fraud and bribery policy and response plan and contracts a Local Counter Fraud Specialist to promote the service and investigate any allegations of fraud corruption or bribery. All investigations are conducted to a criminal prosecution standards and the maximum sanction is sought for each case including disciplinary, civil or criminal sanctions. The Trusts will seek to recover any money lost due to fraud.

The Trust complies with the 12 NHS Counter Fraud Authority (CFA) Requirements which sets the standards for countering fraud in the NHS and adheres to the Government Functional Standards 013. 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 2022 to 31 March 2023 inclusive, with outcomes received by the Audit Committee. The 12 NHS Requirements ensure that the profile of the counter fraud service is raised within the Trust and that momentum of awareness is maintained. The LCFS attends all Audit Committees to update on the progress of counter fraud activity.

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 at a national level. Any investigations will be handled in accordance with NHS Counter Fraud Authority guidance and investigated to a criminal prosecution standard.

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.

Net Zero Carbon

Section 3.2 of the Performance Analysis above sets out the Trust’s plans to deliver a net zero health service as part of the Greener NHS programme.

3.5.7 Care Quality Commission

Kettering General Hospital NHS Foundation Trust is required to register with the Care Quality Commission and its current registration status is unconditional. Kettering General Hospital NHS Foundation Trust has no conditions on registration. The Care Quality Commission has taken enforcement action against Kettering General Hospital NHS Foundation Trust during 2022-23. The Trust is fully compliant with the registration requirements of the Care Quality Commission.

The Trust was inspected by the Care Quality Commission on 6, 7 and 19December 2022. The unannounced inspection was focussed on the Children and Young Peoples core service and the Paediatric

Emergency Department within the Urgent and Emergency Care core service. Subsequent to the inspection, the Trust was issued with a Section 29A Warning Notice under the Health and Social Care Act 2008. The warning notice serves to notify the Trust that the Care Quality Commission had formed the opinion that the quality of healthcare required significant improvement. The Board of Directors formally received the final report from these inspections at its meeting on 8 June 2023: Agenda and Papers (link).

The Trust continues with its governance processes and quality improvement programmes across all services to ensure that previous improvement actions are addressed. Progress and any identified risks continue to be reported to the Board and its nominated committees to ensure the actions are delivered. Section 2.1.5 of the report above provides an assessment of the Trust's performance against NHS England and Improvement's Well-Led framework, including the outcomes of the last review undertaken in 2020.

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

The Trust's 2019 CQC inspection included a Use of Resources assessment, the aim of which was to understand how effectively providers are using their resources to provide high quality, efficient and sustainable care for patients.

The Trust underwent its assessment in 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.

NHS England paused its Use of Resources assessments in response to the COVID-19 pandemic. The assessments remain paused and are subject to re-evaluation and fresh to ensure they are fit for purpose. Inspections do not currently include a Use of Resources assessment.

3.5.9 Information governance

The Trust assesses its management of Data Security and Protection via the NHS National Standards tool - The Data Security and Protection Toolkit (DSPT). This is an annual assessment for health and care organisations which sets out the 10 National Data Guardian's (NDG) data security standards. The Trust successfully completed the DSPT in 2021/22 with 'Standards Met' and the submission was independently audited and provided significant assurance with high confidence. The deadline for completion for 22/23 is 30 June 2023; the Trust has currently met 60 of the 113 mandatory evidence items required. It is expected that the Trust will be able to complete all assertions for the 2023 submission.

In 2022-23, the Trust reported four Information Governance incidents to the Information Commissioners Office (ICO) that met the NHSD reporting criteria, with 12 incidents reported in the previous year. All cases have been closed by the ICO with no further action. No action has been taken by the ICO against the Trust regarding incidents reported to date. The incidents reported all relate to a breach of confidentiality either through system issues, staff inappropriate use /access and an incident relating to human error. All incidents have been appropriately investigated with actions and learning identified.

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 2022 to 31 March 2023 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 included 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 Group Clinical Quality, Safety and Performance Committee on 23 June 2023; 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/Group Finance and Performance Committees and a plan to address weaknesses and ensure continuous improvement of the system is in place.

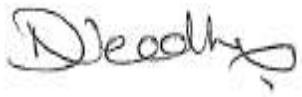
The Head of Internal Audit provides me with an opinion on the overall arrangements for gaining assurance on the controls reviewed as part of the internal audit work. The regular performance reports provide me with evidence that the effectiveness of the controls in place to manage the risks to the organisation 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 Assurance and Risk 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 2022-23



Signed:

Deborah Needham

Chief Executive and Accountable Officer Date: 23 June 2023

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 2023, which comprise the Statement of Comprehensive Income, the Statement of Financial Position, the Statement of Changes in 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 2022-23.

In our opinion, the financial statements:

- give a true and fair view of the financial position of the Trust as at 31 March 2023 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 2022-23; 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 2022-23 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 2022) 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.

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.

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.

Our responsibilities and the responsibilities of the Accounting Officer with respect to going concern are described in the relevant sections of this report.

Other information

The other information comprises the information included in the annual report, other than the financial statements and our auditor's report thereon. The Accounting Officer is responsible for the other information contained within the annual report. 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.

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 themselves. If, based on the work we have performed, we conclude that there is a material misstatement of this other information, we are required to report that fact.

We have nothing to report in this regard.

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 2022/23 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:

- the parts of the Remuneration Report and the Staff Report to be audited have been properly prepared in accordance with the requirements of the NHS foundation trust annual reporting manual 2022/23; and
- based on the work undertaken in the course of the audit of the financial statements 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

As explained more fully in the Statement of the Chief Executive's responsibilities as the accounting officer set out on pages 80 to 81, 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 2022/23, 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.

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. Irregularities, including fraud, are instances of non-compliance with laws and regulations. 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 2022-23).
- We enquired of management and the Adit 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, evaluating management's incentives and opportunities for manipulation of the financial statements. This included the evaluation of the risk of management override of controls, the presumed risk of fraud in revenue and the risk of fraud or error in the completeness of expenditure and accruals. 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, especially in relation to:
    - The calculation of the valuation of the Trust's land and buildings;
    - Accruals of variable income and expenditure at the end of the financial year; and
    - Estimation of the annual leave accrual.
- 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 focus on journal entries posted by senior members of the finance team and significant journal entries 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 buildings valuations and accruals of variable income and expenditure at the end of the financial year;
- 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. The risk of not detecting a material misstatement due to fraud is higher than the risk of not detecting one resulting from error and detecting irregularities that result from fraud is inherently more difficult than detecting those that result from error, as 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 valuation of the Trust's land and buildings and accruals of variable income and expenditure at the end of the financial year.
- Our 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 England'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.

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

Report on other legal and regulatory requirements – 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 2023.

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 significant weaknesses in these arrangements, they will be reported by exception in a further auditor's report. 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 2023.

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 undertake our review in accordance with the Code of Audit Practice, having regard to the guidance issued by the Comptroller and Auditor General in January 2023. 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 consider 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 2023 in accordance with the requirements of Schedule 10 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
27 June 2023

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

In our auditor's report issued on 27 June 2023, we explained that we could not formally conclude the audit and issue an audit certificate for the Trust for the year ended 31 March 2023, 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 2023 issued on 27 June 2023 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 2023 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 2022-23; and
- have been prepared in accordance with the requirements of the National Health Service Act 2006.

No matters have come to our attention since 27 June 2023 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 2023.

We have nothing to report in respect of the above matter except on 15 September 2023 we identified two significant weaknesses. These were in relation to:

- How the Trust plans and manages its resources to ensure it can continue to deliver its services. During 2022/23 the Trust amended its forecast for the year from a £5.1m deficit to a £19.8m deficit – which was achieved. This represents a significant movement from the plan submitted at the start of the year. The financial plan the Trust agreed to was unrealistic, but we note that the Trust followed the national planning guidelines issued by NHSE.
- The Trust's arrangements for the effective delivery of its Children and Young People Services. Following an inspection, the CQC took enforcement action against the Trust and in December 2022 issued a Section 29A Warning Notice under the Health and Social Care Act. The Trust were required to make significant improvements regarding the quality of healthcare by 5 January 2023. The Trust have progressed the significant issues identified.

We recommended that:

- The Trust needs to ensure it agrees credible annual budgets which are based on realistic assumptions and which allows them to avoid having to change forecast during the year. In order to support the annual budget setting process, the Trust needs to develop a Medium-Term Financial Plan (MTFP) in agreement with other system partners. The Trust needs to ensure that savings schemes and efficiencies that are included in the budget, are fully worked up and realistic.
- The Trust should work with the CQC to improve the Children and Young Peoples Services to ensure that the remaining issues are addressed. The Trust should ensure that any learning resulting from this inspection is embedded across the Trust and with Northampton General Hospital.

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 January 2023. 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 Hospital NHS Foundation Trust for the year ended 31 March 2023 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

15 September 2023

Kettering General Hospital NHS Foundation Trust

Annual accounts for the year ended 31 March 2023

Foreword to the accounts

Kettering General Hospital NHS Foundation Trust

These accounts, for the year ended 31 March 2023, 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 **Deborah Needham**
Job title **Chief Executive Officer**
Date **26 June 2023**

Statement of Comprehensive Income

	Note	2022/23 £000	2021/22 £000
Operating income from patient care activities	3	363,852	350,668
Other operating income	4	23,645	23,773
Operating expenses	7, 9	(402,282)	(368,724)
Operating (deficit) / surplus from continuing operations		**(14,785)**	**5,717**
Finance income	11	470	29
Finance expenses	12	(215)	(162)
PDC dividends payable		(4,809)	(4,604)
Net finance costs		**(4,554)**	**(4,737)**
Other gains / (losses)		4	(19)
(Deficit) / surplus for the year from continuing operations		**(19,335)**	**961**
(Deficit) / surplus for the year		**(19,335)**	**961**
Other comprehensive income			
Will not be reclassified to income and expenditure:			
Impairments	8	(315)	(872)
Revaluations	15	6,648	7,635
Total comprehensive (expense) / income for the year		**(13,002)**	**7,724**

NHS England Control Total

Adjusted financial performance (control total basis):		
(Deficit) / surplus for the year	(19,335)	961
Remove net impairments not scoring to the Departmental expenditure limit	142	(1,745)
Remove I&E impact of capital grants and donations	257	172
Remove net impact of inventories received from DHSC group bodies for COVID response	138	250
Adjusted financial performance deficit	**(18,798)**	**(362)**

Statement of Financial Position

	Note	31 March 2023 £000	31 March 2022 £000
Non-current assets			
Intangible assets	13	7,760	8,559
Property, plant and equipment	14	180,582	164,482
Right of use assets	16	7,533	-
Receivables	18	1,133	1,005
Total non-current assets		**197,008**	**174,046**
Current assets			
Inventories	17	5,309	5,108
Receivables	18	16,422	6,985
Cash and cash equivalents	19	4,401	19,879
Total current assets		**26,132**	**31,972**
Current liabilities			
Trade and other payables	20	(41,386)	(29,830)
Borrowings	22	(3,290)	(1,751)
Provisions	23	(815)	(616)
Other liabilities	21	(900)	(714)
Total current liabilities		**(46,391)**	**(32,911)**
Total assets less current liabilities		**176,749**	**173,107**
Non-current liabilities			
Borrowings	22	(7,988)	(3,720)
Provisions	23	(634)	(751)
Total non-current liabilities		**(8,622)**	**(4,471)**
Total assets employed		**168,127**	**168,636**
Financed by			
Public dividend capital		262,952	250,459
Revaluation reserve		48,387	43,255
Income and expenditure reserve		(143,212)	(125,078)
Total taxpayers' equity		**168,127**	**168,636**

The notes on pages 5 to 41 form part of these accounts.

Name Deborah Needham
Position Chief Executive Officer
Date 26 June 2023

Statement of Changes in Taxpayers' Equity for the year ended 31 March 2023

	Public dividend capital	Revaluation reserve	Income and expenditure reserve	Total
	£000	£000	£000	£000
Taxpayers' and others' equity at 1 April 2022 - brought forward	**250,459**	**43,255**	**(125,078)**	**168,636**
Deficit for the year	-	-	(19,335)	**(19,335)**
Other transfers between reserves	-	(1,201)	1,201	**-**
Impairments	-	(315)	-	**(315)**
Revaluations	-	6,648	-	**6,648**
Public dividend capital received	12,493	-	-	**12,493**
Taxpayers' and others' equity at 31 March 2023	**262,952**	**48,387**	**(143,212)**	**168,127**

Statement of Changes in Taxpayers' Equity for the year ended 31 March 2022

	Public dividend capital	Revaluation reserve	Income and expenditure reserve	Total
	£000	£000	£000	£000
Taxpayers' and others' equity at 1 April 2021 - brought forward	**243,209**	**37,486**	**(127,033)**	**153,662**
Surplus for the year	-	-	961	**961**
Other transfers between reserves	-	(994)	994	**-**
Impairments	-	(872)	-	**(872)**
Revaluations	-	7,635	-	**7,635**
Public dividend capital received	7,250	-	-	**7,250**
Taxpayers' and others' equity at 31 March 2022	**250,459**	**43,255**	**(125,078)**	**168,636**

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	2022/23 £000	2021/22 £000
Cash flows from operating activities			
Operating (deficit) / surplus		(14,785)	5,717
Non-cash income and expense:			
Depreciation and amortisation	7	13,810	9,425
Net impairments	8	142	(1,745)
Income recognised in respect of capital donations	4	(127)	(203)
(Increase) / decrease in receivables and other assets		(9,609)	4,816
(Increase) / decrease in inventories		(201)	65
Increase in payables and other liabilities		12,311	474
Increase in provisions		24	165
Net cash flows from operating activities		**1,565**	**18,714**
Cash flows from investing activities			
Interest received		412	14
Purchase of intangible assets		(3,784)	(955)
Purchase of PPE and investment property		(17,047)	(13,020)
Net cash used in investing activities		**(20,419)**	**(13,961)**
Cash flows from financing activities			
Public dividend capital received		12,493	7,250
Movement on loans from DHSC		(1,480)	(1,480)
Capital element of lease liability repayments		(2,564)	(275)
Interest on loans		(133)	(172)
Interest element of lease liability repayments		(108)	(13)
PDC dividend paid		(4,832)	(4,160)
Net cash flows from financing activities		**3,376**	**1,150**
(Decrease) / increase in cash and cash equivalents		**(15,478)**	**5,903**
Cash and cash equivalents at 1 April - brought forward		**19,879**	**13,976**
Cash and cash equivalents at 31 March	19.1	**4,401**	**19,879**

Notes to the Accounts

Note 1 Accounting policies and other information

Note 1.1 Basis of preparation

NHS England 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 2022/23 issued by the Department of Health and Social Care. The accounting policies contained in the GAM follow International Financial Reporting Standards to the extent that they are meaningful and appropriate to the NHS, as determined by HM Treasury, which is advised by the Financial Reporting Advisory Board. Where the GAM permits a choice of accounting policy, the accounting policy that is judged to be most appropriate to the particular circumstances of the Trust for the purpose of giving a true and fair view has been selected. The particular policies adopted are described below. These have been applied consistently in dealing with items considered material in relation to the accounts

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

Note 1.2 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. The Directors have a reasonable expectation that this will continue to be the case.

Note 1.3 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.
The Trust receives set monthly payments with variations received on a regular basis.

Revenue from NHS contracts

The main source of income for the Trust is contracts with commissioners for health care services. Funding envelopes are set at an Integrated Care System (ICS) level. The majority of the Trust's income is earned from NHS Commissioners in the form of fixed payments to fund an agreed level of activity.

In 2022/23 fixed payments are set at a level assuming the achievement of elective activity targets. These are termed 'aligned payment and incentive' contracts. These payments are accompanied by a variable-element to adjust income for actual activity delivered on elective services and advice and guidance services. Where actual elective activity delivered differs from the agreed level set in the fixed payments, the variable element either increases or reduces the income earned by the Trust at a rate of 75% of the tariff price. However these variable elements were not transacted in year.
Elective recovery funding provides additional funding for the delivery of elective services. In 2022/23 elective recovery funding was included within the aligned payment and incentive contracts. In 2021/22 income earned by the system based on achievement of elective recovery targets was distributed between individual entities by local agreement and income earned from the fund was accounted for as variable consideration.

The Trust also receives income from commissioners under Commissioning for Quality Innovation (CQUIN) and Best Practice Tariff (BPT) schemes. Delivery under these schemes is part of how care is provided to patients. As such CQUIN and BPT payments are not considered distinct performance obligations in their own right; instead they form part of the transaction price for performance obligations under the overall contract with the commissioner. In 2022/23 payment under these schemes is included in fixed payments from commissioners based on assumed achievement of criteria.

Note 1.4 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 1.5 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 the 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 1.6 Expenditure on other goods and services

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

Note 1.7 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.

This includes assets donated to the Trust by the Department of Health and Social Care or NHS England 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	5	51
Plant & machinery	5	15
Information technology	8	8
Furniture & fittings	5	10

Note 1.8 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	2	8

Note 1.9 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.

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 1.10 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 1.11 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 leasing arrangements 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 1.12 Leases

A lease is a contract or part of a contract that conveys the right to use an asset for a period of time in exchange for consideration. An adaptation of the relevant accounting standard by HM Treasury for the public sector means that for NHS bodies, this includes lease-like arrangements with other public sector entities that do not take the legal form of a contract. It also includes peppercorn leases where consideration paid is nil or nominal (significantly below market value) but in all other respects meet the definition of a lease. The Trust does not apply lease accounting to new contracts for the use of intangible assets.

The Trust determines the term of the lease term with reference to the non-cancellable period and any options to extend or terminate the lease which the Trust is reasonably certain to exercise.

The Trust as a lessee

Recognition and initial measurement

At the commencement date of the lease, being when the asset is made available for use, the Trust recognises a right of use asset and a lease liability.

The right of use asset is recognised at cost comprising the lease liability, any lease payments made before or at commencement, any direct costs incurred by the lessee, less any cash lease incentives received. It also includes any estimate of costs to be incurred restoring the site or underlying asset on completion of the lease term.

The lease liability is initially measured at the present value of future lease payments discounted at the interest rate implicit in the lease. Lease payments includes fixed lease payments, variable lease payments dependent on an index or rate and amounts payable under residual value guarantees. It also includes amounts payable for purchase options and termination penalties where these options are reasonably certain to be exercised.

Where an implicit rate cannot be readily determined, the Trust's incremental borrowing rate is applied. This rate is determined by HM Treasury annually for each calendar year. A nominal rate of 0.95% applied to new leases commencing in 2022 and 3.51% to new leases commencing in 2023.

The Trust does not apply the above recognition requirements to leases with a term of 12 months or less or to leases where the value of the underlying asset is below £5,000, excluding any irrecoverable VAT. Lease payments associated with these leases are expensed on a straight-line basis over the lease term. Irrecoverable VAT on lease payments is expensed as it falls due.

Subsequent measurement

As required by a HM Treasury interpretation of the accounting standard for the public sector, the Trust employs a revaluation model for subsequent measurement of right of use assets, unless the cost model is considered to be an appropriate proxy for current value in existing use or fair value, in line with the accounting policy for owned assets. Where consideration exchanged is identified as significantly below market value, the cost model is not considered to be an appropriate proxy for the value of the right of use asset.

The Trust subsequently measures the lease liability by increasing the carrying amount for interest arising which is also charged to expenditure as a finance cost and reducing the carrying amount for lease payments made. The liability is also remeasured for changes in assessments impacting the lease term, lease modifications or to reflect actual changes in lease payments. Such remeasurements are also reflected in the cost of the right of use asset. Where there is a change in the lease term or option to purchase the underlying asset, an updated discount rate is applied to the remaining lease payments.

The Trust as a lessor

The Trust assesses each of its leases and classifies them as either a finance lease or an operating lease. 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.

Where the Trust is an intermediate lessor, classification of the sublease is determined with reference to the right of use asset arising from the headlease.

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

Income from operating leases is recognised on a straight-line basis or another systematic 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.

Initial application of IFRS 16

IFRS 16 Leases as adapted and interpreted for the public sector by HM Treasury has been applied to these financial statements with an initial application date of 1 April 2022. IFRS 16 replaces *IAS 17 Leases, IFRIC 4 Determining whether an arrangement contains a lease* and other interpretations.

The standard has been applied using a modified retrospective approach with the cumulative impact recognised in the income and expenditure reserve on 1 April 2022. Upon initial application, the provisions of IFRS 16 have only been applied to existing contracts where they were previously deemed to be a lease or contain a lease under IAS 17 and IFRIC 4. Where existing contracts were previously assessed not to be or contain a lease, these assessments have not been revisited.

The Trust as lessee

For continuing leases previously classified as operating leases, a lease liability was established on 1 April 2022 equal to the present value of future lease payments discounted at the Trust's incremental borrowing rate of 0.95%. A right of use asset was created equal to the lease liability and adjusted for prepaid and accrued lease payments and deferred lease incentives recognised in the statement of financial position immediately prior to initial application. Hindsight has been used in determining the lease term where lease arrangements contain options for extension or earlier termination.

No adjustments have been made on initial application in respect of leases with a remaining term of 12 months or less from 1 April 2022 or for leases where the underlying assets has a value below £5,000. No adjustments have been made in respect of leases previously classified as finance leases.

The Trust as lessor

Leases of owned assets where the Trust is lessor were unaffected by initial application of IFRS 16.

2021/22 comparatives

Comparatives for leasing transactions in these accounts have not been restated on an IFRS 16 basis. Under IAS 17 the classification of leases as operating or finance leases still applicable to lessors under IFRS 16 also applied to lessees. In 2021/22 lease payments made by the Trust in respect of leases previously classified as operating leases were charged to expenditure on a straight line basis.

Note 1.13 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 from 31 March 2023:

		Nominal rate	Prior year rate
Short-term	Up to 5 years	3.27%	0.47%
Medium-term	After 5 years up to 10 years	3.20%	0.70%
Long-term	After 10 years up to 40 years	3.51%	0.95%
Very long-term	Exceeding 40 years	3.00%	0.66%

HM Treasury provides discount rates for general provisions on a nominal rate basis. Expected future cash flows are therefore adjusted for the impact of inflation before discounting using nominal rates. The following inflation rates are set by HM Treasury, effective from 31 March 2023:

	Inflation rate	Prior year rate
Year 1	7.40%	4.00%
Year 2	0.60%	2.60%
Into perpetuity	2.00%	2.00%

Early retirement provisions and injury benefit provisions both use the HM Treasury's pension discount rate of 1.70% in real terms (prior year: minus 1.30%).

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 1.14 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 1.15 Public dividend capital

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

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

A charge, reflecting the cost of capital utilised by the Trust, is payable as public dividend capital dividend. The charge is calculated at the rate set by HM Treasury (currently 3.5%) on the average relevant net assets of the trust during the financial year. Relevant net assets are calculated as the value of all assets less the value of all liabilities, with certain additions and deductions as defined by the Department of Health and Social Care.

This policy is available at https://www.gov.uk/government/publications/guidance-on-financing-available-to-nhs-trusts-and-foundation-trusts.

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 1.16 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 1.17 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 1.18 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 1.19 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 1.20 Early adoption of standards, amendments and interpretations

No new accounting standards or revisions to existing standards have been early adopted in 2022/23.

Note 1.21 Standards, amendments and interpretations in issue but not yet effective or adopted

No new accounting standards or revisions to existing standards have been early adopted 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 1.22 Critical judgements in applying accounting policies

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

a) the Trust has included an annual leave accrual of £4.1m (2021/22-£3.6m) to reflect a conservative management assessment of the outstanding leave at year end.

b) determining the appropriate asset lives for the Trust's buildings following a professional review undertaken by professionally qualified chartered surveyors

c) determining the appropriate method of valuation of the Trust's property assets and in particular when and how to apply the Modern Equivalent Asset method of valuation. The key assumptions applied in using this approach are set out in note 1.7.

Note 1.23 Sources of estimation uncertainty

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

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. An interim valuation, building on this was provided with a valuation date of 31 March 2021 and a desktop exercise undertaken for the valuation provided at 31 March 2023.

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. The BCIS index of 1.08% has been used for the valuation of the £139,401k of buildings. In order for a material misstatement of the accounts to occur (£7m), a BCIS cost indices or location factor movement of 5% would be required for Northamptonshire.

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 operational 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 1.3

Note 3.1 Income from patient care activities (by nature)	2022/23	2021/22
	£000	£000
Acute services		
Income from commissioners under API contracts*	312,359	305,593
High cost drugs income from commissioners (excluding pass-through costs)	23,308	20,644
Other NHS clinical income	119	101
All services		
Private patient income	20	16
Elective recovery fund	7,763	4,318
Agenda for change pay award central funding***	8,224	-
Additional pension contribution central funding**	9,267	8,919
Other clinical income	2,792	11,077
Total income from activities	**363,852**	**350,668**

*Aligned payment and incentive contracts are the main form of contracting between NHS providers and their commissioners. More information can be found in the 2022/23 National Tariff payments system documents.

https://www.england.nhs.uk/publication/past-national-tariffs-documents-and-policies/

**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.

*** In March 2023, the Government accounced an additional pay offer for 2022/23, in addition to the pay award earlier in the year. Additional funding was made available by NHS England for implementing this pay offer for 2022/23 and the income and expenditure have been included in these accounts as guided by the Department of Health and Social Care and NHS England. In May 2023, the Government confirmed this offer will be implemented as a further pay award in respect of 2022/23 based on indiviudals in employment at 31 March 2023.

Note 3.2 Income from patient care activities (by source)

	2022/23	2021/22
Income from patient care activities received from:	**£000**	**£000**
NHS England	57,852	46,654
Clinical commissioning groups	73,607	302,996
Integrated care boards	231,141	
Other NHS providers	275	254
NHS other	29	-
Non-NHS: private patients	20	16
Non-NHS: overseas patients (chargeable to patient)	152	175
Injury cost recovery scheme	657	462
Non NHS: other	119	111
Total income from activities	**363,852**	**350,668**
Of which:		
Related to continuing operations	363,852	350,668
Related to discontinued operations	-	-

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

	2022/23	2021/22
	£000	£000
Income recognised this year	152	175
Cash payments received in-year	51	79
Amounts added to provision for impairment of receivables	67	136
Amounts written off in-year	32	89

Note 4 Other operating income

	2022/23		
	Contract income	Non-contract income	Total
	£000	£000	£000
Research and development	689	-	**689**
Education and training	11,591	742	**12,333**
Non-patient care services to other bodies	3,103		**3,103**
Reimbursement and top up funding	-		**-**
Receipt of capital grants and donations and peppercorn leases		127	**127**
Charitable and other contributions to expenditure		871	**871**
Revenue from operating leases		278	**278**
Other income	6,193	51	**6,244**
Total other operating income	**21,576**	**2,069**	**23,645**
Of which:			
Related to continuing operations			23,645
Related to discontinued operations			-

	2021/22		
	Contract income	Non-contract income	Total
	£000	£000	£000
Research and development	623	-	**623**
Education and training	10,180	872	**11,052**
Non-patient care services to other bodies	2,571	-	**2,571**
Reimbursement and top up funding	424	-	**424**
Receipt of capital grants and donations and peppercorn leases	-	203	**203**
Charitable and other contributions to expenditure	-	1,166	**1,166**
Revenue from operating leases	-	196	**196**
Other income	7,362	176	**7,538**
Total other operating income	**21,160**	**2,613**	**23,773**
Of which:			
Related to continuing operations			23,773
Related to discontinued operations			-

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

	2022/23	2021/22
	£000	£000
Revenue recognised in the reporting period that was included in within contract liabilities at the previous period end	714	2,329
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:

	2022/23	2021/22
	£000	£000
Income from services designated as commissioner requested services	253,028	252,778
Income from services not designated as commissioner requested services	110,824	97,890
Total	**363,852**	**350,668**

Note 6 Operating leases - Kettering General Hospital NHS Foundation Trust as lessor

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

The Trust has applied IFRS 16 to account for lease arrangements from 1 April 2022 without restatement of comparatives. Comparative disclosures in this note are presented on an IAS 17 basis. This includes a different maturity analysis of future minimum lease receipts under IAS 17 compared to IFRS 16.

The Trust had six lease arrangements during the year, one relating to a telecommunications mast, one for accommodation provided to Internal Audit and 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. Two of the leases (internal audit and one of the franchise operations) have terminated during the year.

Note 6.1 Operating lease income

	2022/23	2021/22
	£000	£000
Lease receipts recognised as income in year:		
Minimum lease receipts	187	196
Variable lease receipts / contingent rents	91	-
Total in-year operating lease income	**278**	**196**

Note 6.2 Future lease receipts

	31 March 2023
	£000
Future minimum lease receipts due at 31 March 2023:	
- not later than one year	223
- later than one year and not later than two years	223
- later than two years and not later than three years	46
- later than three years and not later than four years	11
- later than four years and not later than five years	11
- later than five years	50
Total	**564**

	31 March 2022
	£000
Future minimum lease receipts due at 31 March 2022:	
- not later than one year;	190
- later than one year and not later than five years;	592
- later than five years.	33
Total	**815**

Note 7.1 Operating expenses

	2022/23	2021/22
	£000	£000
Purchase of healthcare from NHS and DHSC bodies	5,307	3,361
Purchase of healthcare from non-NHS and non-DHSC bodies	5,357	6,569
Staff and executive directors costs	271,865	248,953
Remuneration of non-executive directors	155	158
Supplies and services - clinical (excluding drugs costs)	29,007	26,906
Supplies and services - general	3,832	3,431
Drug costs (drugs inventory consumed and purchase of non-inventory drugs)	30,403	27,782
Inventories written down	164	150
Consultancy costs	180	1,029
Establishment	4,285	4,409
Premises	18,436	14,881
Transport (including patient travel)	594	649
Depreciation on property, plant and equipment and right of use assets	11,431	8,000
Amortisation on intangible assets	2,379	1,425
Net impairments	142	(1,745)
Movement in credit loss allowance: contract receivables / contract assets	136	180
Increase/(decrease) in other provisions	35	(16)
Change in provisions discount rate(s)	(150)	24
Fees payable to the external auditor		
audit services- statutory audit	96	185
Internal audit costs	93	104
Clinical negligence	12,353	11,369
Legal fees	111	172
Insurance	126	191
Research and development	827	677
Education and training	2,643	2,865
Expenditure on short term leases (current year only)	213	-
Expenditure on low value leases (current year only)	36	-
Operating lease expenditure (comparative only)	-	3,166
Car parking & security	538	1,074
Hospitality	4	17
Losses, ex gratia & special payments	39	73
Other services, eg external payroll	314	291
Other	1,331	2,394
Total	**402,282**	**368,724**
Of which:		
Related to continuing operations	402,282	368,724
Related to discontinued operations	-	-

Staff and executive directors costs includes the following:

a) an employers pension increase of £9.3m (2021/22 - £8.9m), relating to an increase of 6.3% in this contribution from 1 April 2019. An equal amount is included in clinical income.

b) a payaward estimate relating to 22/23 of £8.6m (2021/22 - nil). Included in clinical income is £8.2m of funding to support this payment.

In 2021/22, other expenditure includes £982k of Elective Care Board funding transferred to other NHS bodies.

Note 7.2 Limitation on auditor's liability

The limitation on auditor's liability for external audit work is £1 million (2021/22: £1 million).

Note 8 Impairment of assets

	2022/23	2021/22
	£000	£000
Net impairments charged to operating deficit / surplus resulting from:		
Changes in market price	142	(2,130)
Other	-	385
Total net impairments charged to operating deficit / surplus	**142**	**(1,745)**
Impairments charged to the revaluation reserve	315	872
Total net impairments	**457**	**(873)**

The change in market price impairment relates to the impact of the valuation of the Trust estate. The other impairment in 2021/22 related to some medical equipment which was not fit for purpose.

Note 9 Employee benefits

	2022/23	2021/22
	Total	Total
	£000	£000
Salaries and wages	211,386	193,826
Social security costs	21,275	18,576
Apprenticeship levy	1,046	939
Employer's contributions to NHS pensions	30,355	29,246
Pension cost - other	55	44
Temporary staff (including agency)	13,091	10,653
Total gross staff costs	**277,208**	**253,284**
Recoveries in respect of seconded staff	(1,527)	(1,001)
Total staff costs	**275,681**	**252,283**
Of which		
Costs capitalised as part of assets	2,040	1,688

Note 9.1 Retirements due to ill-health

During 2022/23 there were 4 early retirements from the Trust agreed on the grounds of ill-health (4 in the year ended 31 March 2022). The estimated additional pension liabilities of these ill-health retirements is £168k (£295k in 2021/22).

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

Note 10 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 2023, is based on valuation data as at 31 March 2022, updated to 31 March 2023 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 actuarial valuation as at 31 March 2020 is currently underway and will set the new employer contribution rate due to be implemented from April 2024.

Note 11 Finance income

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

	2022/23	2021/22
	£000	£000
Interest on bank accounts	469	29
Other finance income	1	-
Total finance income	**470**	**29**

Note 12.1 Finance expenditure

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

	2022/23	2021/22
	£000	£000
Interest expense:		
Interest on loans from the Department of Health and Social Care	114	154
Interest on lease obligations	108	13
Total interest expense	**222**	**167**
Unwinding of discount on provisions	(7)	(5)
Total finance costs	**215**	**162**

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 13.1 Intangible assets - 2022/23

	Software licences	Total
	£000	£000
Valuation / gross cost at 1 April 2022 - brought forward	**13,825**	**13,825**
Transfers by absorption	-	-
Additions	1,580	**1,580**
Valuation / gross cost at 31 March 2023	**15,405**	**15,405**
Amortisation at 1 April 2022 - brought forward	**5,266**	**5,266**
Provided during the year	2,379	**2,379**
Amortisation at 31 March 2023	**7,645**	**7,645**
Net book value at 31 March 2023	**7,760**	**7,760**
Net book value at 1 April 2022	**8,559**	**8,559**

Note 13.2 Intangible assets - 2021/22

	Software licences	Total
	£000	£000
Valuation / gross cost at 1 April 2021 brought forward	**10,666**	**10,666**
Additions	3,159	**3,159**
Valuation / gross cost at 31 March 2022	**13,825**	**13,825**
Amortisation at 1 April 2021 brought forward	**3,841**	**3,841**
Provided during the year	1,425	**1,425**
Amortisation at 31 March 2022	**5,266**	**5,266**
Net book value at 31 March 2022	**8,559**	**8,559**
Net book value at 1 April 2021	**6,825**	**6,825**

In January 2023, the Audit Committee reviewed, and did not amend, the policy for valuing intangible assets.

Note 14.1 Property, plant and equipment - 2022/23

	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 2022 - brought forward	**6,688**	**127,590**	**6,974**	**42,367**	**12,276**	**15**	**195,910**
IFRS 16 implementation - reclassification of existing finance leased assets to right of use assets	-	(1,519)	-	-	-	-	**(1,519)**
Additions	-	7,676	3,129	5,363	2,750	16	**18,934**
Impairments	(190)	(1,686)	-	-	-	-	**(1,876)**
Reversals of impairments	-	1,419	-	-	-	-	**1,419**
Revaluations	-	2,630	-	-	-	-	**2,630**
Reclassifications	-	3,291	(1,804)	-	-	-	**1,487**
Disposals / derecognition	-	-	-	(1,780)	(1,387)	(7)	**(3,174)**
Valuation/gross cost at 31 March 2023	**6,498**	**139,401**	**8,299**	**45,950**	**13,639**	**24**	**213,811**
Accumulated depreciation at 1 April 2022 - brought forward	**-**	**-**	**-**	**26,964**	**4,450**	**14**	**31,428**
Provided during the year	-	4,018	-	3,472	1,495	1	**8,986**
Revaluations	-	(4,018)	-	-	-	-	**(4,018)**
Disposals / derecognition	-	-	-	(1,774)	(1,386)	(7)	**(3,167)**
Accumulated depreciation at 31 March 2023	**-**	**-**	**-**	**28,662**	**4,559**	**8**	**33,229**
Net book value at 31 March 2023	**6,498**	**139,401**	**8,299**	**17,288**	**9,080**	**16**	**180,582**
Net book value at 1 April 2022	**6,688**	**127,590**	**6,974**	**15,403**	**7,826**	**1**	**164,482**

Note 14.2 Property, plant and equipment - 2021/22

	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 2021 brought forward	**6,266**	**118,117**	**2,735**	**41,740**	**9,650**	**59**	**178,567**
Transfers by absorption	-	-	-	-	-	-	**-**
Additions	-	4,492	4,239	2,654	3,827	-	**15,212**
Impairments	-	(1,568)	-	-	-	-	**(1,568)**
Reversals of impairments	-	2,826	-	-	-	-	**2,826**
Revaluations	422	3,723	-	-	-	-	**4,145**
Disposals / derecognition	-	-	-	(2,027)	(1,201)	(44)	**(3,272)**
Valuation/gross cost at 31 March 2022	**6,688**	**127,590**	**6,974**	**42,367**	**12,276**	**15**	**195,910**
Accumulated depreciation at 1 April 2021 brought forward	**-**	**-**	**-**	**25,152**	**4,601**	**33**	**29,786**
Provided during the year	-	3,490	-	3,454	1,050	6	**8,000**
Impairments	-	-	-	385	-	-	**385**
Revaluations	-	(3,490)	-	-	-	-	**(3,490)**
Disposals / derecognition	-	-	-	(2,027)	(1,201)	(25)	**(3,253)**
Accumulated depreciation at 31 March 2022	**-**	**-**	**-**	**26,964**	**4,450**	**14**	**31,428**
Net book value at 31 March 2022	**6,688**	**127,590**	**6,974**	**15,403**	**7,826**	**1**	**164,482**
Net book value at 1 April 2021	**6,266**	**118,117**	**2,735**	**16,588**	**5,049**	**26**	**148,781**

Note 14.3 Property, plant and equipment financing - 31 March 2023

	Land	Buildings excluding dwellings	Assets under construction	Plant & machinery	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000
Owned - purchased	6,498	136,619	8,178	15,482	9,017	16	**175,810**
Owned - donated/granted	-	2,782	121	1,806	63	-	**4,772**
Total net book value at 31 March 2023	**6,498**	**139,401**	**8,299**	**17,288**	**9,080**	**16**	**180,582**

Note 14.4 Property, plant and equipment financing - 31 March 2022

	Land	Buildings excluding dwellings	Assets under construction	Plant & machinery	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000
Owned - purchased	6,688	123,198	6,974	13,368	7,826	1	**158,055**
Finance leased	-	1,519	-	-	-	-	**1,519**
Owned - donated/granted	-	2,873	-	2,035	-	-	**4,908**
Total net book value at 31 March 2022	**6,688**	**127,590**	**6,974**	**15,403**	**7,826**	**1**	**164,482**

14.3 (was 15.3) donated assets missed for buildings

Note 14.5 Property plant and equipment assets subject to an operating lease (Trust as a lessor) - 31 March 2023

	Land	Buildings excluding dwellings	Assets under construction	Plant & machinery	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000
Subject to an operating lease	-	-	-	-	-	-	**-**
Not subject to an operating lease	6,498	139,401	8,299	17,288	9,080	16	**180,582**
Total net book value at 31 March 2023	**6,498**	**139,401**	**8,299**	**17,288**	**9,080**	**16**	**180,582**

Note 15 Revaluations of property, plant and equipment

The Trust's land and buildings are valued on the basis explained in Note 1 to the accounts. Gerald Eve LLP provided an independent valuation of land and building assets (estimated fair value and remaining useful life) as at 31 March 2023.

Note 16 Leases - Kettering General Hospital NHS Foundation Trust as a lessee

The Trust leases land and buildings for the provision of clinical and administrative services as well as car parking. This includes the lease of a temporary ward for clinical services.

The Trust also leases the Trusts boilers, some equipment and vehicles. The largest lease for equipment relates to the Photocopiers and printers in use across the Trust.

At 31st March the Trust purchased 4 buildings which had been leased throughout the year.

The Trust has applied IFRS 16 to account for lease arrangements from 1 April 2022 without restatement of comparatives. Comparative disclosures in this note are presented on an IAS 17 basis.

Note 16.1 Right of use assets - 2022/23

	Property (land and buildings) £000	Plant & machinery £000	Transport equipment £000	Total £000	Of which: leased from DHSC group bodies £000
IFRS 16 implementation - reclassification of existing finance leased assets from PPE	1,519	-	-	**1,519**	-
IFRS 16 implementation - adjustments for existing operating leases	11,121	116	78	**11,315**	874
Additions	133	694	-	**827**	-
Remeasurements of the lease liability	45	-	-	**45**	-
Movements in provisions for restoration costs	65	-	-	**65**	-
Reclassifications	(1,519)	-	-	**(1,519)**	-
Disposals / derecognition	(2,778)	-	-	**(2,778)**	-
Valuation/gross cost at 31 March 2023	**8,586**	**810**	**78**	**9,474**	**874**
Provided during the year	2,227	178	40	**2,445**	87
Reclassifications	(32)	-	-	**(32)**	-
Disposals / derecognition	(472)	-	-	**(472)**	-
Accumulated depreciation at 31 March 2023	**1,723**	**178**	**40**	**1,941**	**87**
Net book value at 31 March 2023	**6,863**	**632**	**38**	**7,533**	**787**
Net book value of right of use assets leased from other NHS providers					-
Net book value of right of use assets leased from other DHSC group bodies					787

Note 16.2 Reconciliation of the carrying value of lease liabilities

Lease liabilities are included within borrowings in the statement of financial position. A breakdown of borrowings is disclosed in note 22.1.

	2022/23
	£000
Carrying value at 31 March 2022	206
IFRS 16 implementation - adjustments for existing operating leases	11,315
Lease additions	827
Lease liability remeasurements	45
Interest charge arising in year	108
Early terminations	(2,317)
Lease payments (cash outflows)	(2,672)
Carrying value at 31 March 2023	**7,512**

Lease payments for short term leases, leases of low value underlying assets and variable lease payments not dependent on an index or rate are recognised in operating expenditure.

These payments are disclosed in Note 7.1. Cash outflows in respect of leases recognised on-SoFP are disclosed in the reconciliation above.

Note 16.3 Maturity analysis of future lease payments at 31 March 2023

	Total	Of which leased from DHSC group bodies:
	31 March 2023	31 March 2023
	£000	£000
Undiscounted future lease payments payable in:		
- not later than one year;	1,764	92
- later than one year and not later than five years;	3,376	367
- later than five years.	2,647	366
Total gross future lease payments	**7,787**	**825**
Finance charges allocated to future periods	(275)	(35)
Net lease liabilities at 31 March 2023	**7,512**	**790**
Of which:		
Leased from other DHSC group bodies		790

Note 16.4 Maturity analysis of finance lease liabilities at 31 March 2022 (IAS 17 basis)

The following table details the maturity of obligations under leases the Trust previously determined to be finance leases under IAS 17 at 31 March 2022.

	31 March 2022 £000
Undiscounted future lease payments payable in:	
- not later than one year;	216
Total gross future lease payments	**216**
Finance charges allocated to future periods	(10)
Net finance lease liabilities at 31 March 2022	**206**
of which payable:	
- not later than one year;	206

Note 16.5 Commitments in respect of operating leases at 31 March 2022 (IAS 17 basis)

This note discloses costs incurred in 2021/22 and commitments as at 31 March 2022 for leases the Trust previously determined to be operating leases under IAS 17.

	2021/22 £000
Operating lease expense	
Minimum lease payments	3,166
Total	**3,166**

	31 March 2022 £000
Future minimum lease payments due:	
- not later than one year;	2,361
- later than one year and not later than five years;	4,184
- later than five years.	2,755
Total	**9,300**
Future minimum sublease payments to be received	-

Note 16.6 Initial application of IFRS 16 on 1 April 2022

IFRS 16 as adapted and interpreted for the public sector by HM Treasury has been applied to leases in these financial statements with an initial application date of 1 April 2022.

The standard has been applied using a modified retrospective approach without the restatement of comparatives. Practical expedients applied by the Trust on initial application are detailed in the leases accounting policy in note 1.12.

Lease liabilities created for existing operating leases on 1 April 2022 were discounted using the weighted average incremental borrowing rate determined by HM Treasury as 0.95%.

Reconciliation of operating lease commitments as at 31 March 2022 to lease liabilities under IFRS 16 as at 1 April 2022

	1 April 2022
	£000
Operating lease commitments under IAS 17 at 31 March 2022	**9,300**
Impact of discounting at the incremental borrowing rate	**(401)**
IAS 17 operating lease commitment discounted at incremental borrowing rate	**8,899**
Less:	
Commitments for short term leases	(248)
Commitments for leases of low value assets	(77)
Irrecoverable VAT previously included in IAS 17 commitment	(1,056)
Other adjustments:	
Differences in the assessment of the lease term	3,878
Rent increases/(decreases) reflected in the lease liability, not previously reflected in the IAS 17 commitment	(81)
Finance lease liabilities under IAS 17 as at 31 March 2022	206
Total lease liabilities under IFRS 16 as at 1 April 2022	**11,521**

Note 17 Inventories

	31 March 2023	31 March 2022
	£000	£000
Drugs	1,823	1,736
Consumables	3,414	3,346
Energy	72	26
Total inventories	**5,309**	**5,108**
of which:		
Held at fair value less costs to sell	-	-

Inventories recognised in expenses for the year were £41,747k (2021/22: £36,352k). Write-down of inventories recognised as expenses for the year were £164k (2021/22: £150k).

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 2022/23 the Trust received £753k of items purchased by DHSC (2021/22: £1,109k).

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.

The deemed cost of these inventories was charged directly to expenditure on receipt with the corresponding benefit recognised in income.

Note 18.1 Receivables

	31 March 2023 £000	31 March 2022 £000
Current		
Contract receivables	11,988	2,967
Allowance for impaired contract receivables / assets	(753)	(657)
Prepayments	3,196	2,875
Interest receivable	73	15
Operating lease receivables	66	-
VAT receivable	624	1,022
Other receivables	1,228	763
Total current receivables	**16,422**	**6,985**
Non-current		
Contract receivables	800	628
Prepayments	114	142
Other receivables	219	235
Total non-current receivables	**1,133**	**1,005**
Of which receivable from NHS and DHSC group bodies:		
Current	10,006	1,139
Non-current	219	235

Contract receivables includes £8.2m relating to the 2022/23 payaward funding.

Note 18.2 Allowances for credit losses

	2022/23		2021/22	
	Contract receivables and contract assets £000	All other receivables £000	Contract receivables and contract assets £000	All other receivables £000
Allowances as at 1 April - brought forward	**657**	**-**	**514**	**-**
New allowances arising	208	-	208	-
Reversals of allowances	(72)	-	(28)	-
Utilisation of allowances (write offs)	(40)	-	(37)	-
Allowances as at 31 Mar 2023	**753**	**-**	**657**	**-**

Note 19 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.

	2022/23	2021/22
	£000	£000
At 1 April	**19,879**	**13,976**
Net change in year	(15,478)	5,903
At 31 March	**4,401**	**19,879**
Broken down into:		
Cash at commercial banks and in hand	21	79
Cash with the Government Banking Service	4,380	19,800
Total cash and cash equivalents as in SoFP and SoCF	**4,401**	**19,879**

Note 20.1 Trade and other payables

	31 March 2023	31 March 2022
	£000	£000
Current		
Trade payables	6,987	5,784
Capital payables	5,569	6,115
Accruals	9,135	7,742
Social security costs	6,262	4,994
PDC dividend payable	201	224
Pension contributions payable	2,889	2,792
Other payables	10,343	2,179
Total current trade and other payables	**41,386**	**29,830**
Of which payables from NHS and DHSC group bodies:		
Current	3,763	2,716

Other payables includes £8.6m due to Agenda for Change staff as an assessment of the National pay award.

Note 21 Other liabilities

	31 March 2023	31 March 2022
	£000	£000
Current		
Deferred income: contract liabilities	897	711
Other deferred income	3	3
Total other current liabilities	**900**	**714**

Note 22.1 Borrowings

	31 March 2023	31 March 2022
	£000	£000
Current		
Loans from DHSC	1,526	1,545
Lease liabilities*	1,764	206
Total current borrowings	**3,290**	**1,751**
Non-current		
Loans from DHSC	2,240	3,720
Lease liabilities*	5,748	-
Total non-current borrowings	**7,988**	**3,720**

* The Trust has applied IFRS 16 to lease arrangements within these accounts from 1 April 2022 without restatement of comparatives. More information about leases and the impact of this change in accounting policy can be found in note 18.

Note 22.2 Reconciliation of liabilities arising from financing activities - 2022/23

	Loans from DHSC	Lease Liability	Total
	£000	£000	£000
Carrying value at 1 April 2022	**5,265**	**206**	**5,471**
Cash movements:			
Financing cash flows - payments and receipts of principal	(1,480)	(2,564)	**(4,044)**
Financing cash flows - payments of interest	(133)	(108)	**(241)**
Non-cash movements:			
Impact of implementing IFRS 16 on 1 April 2022	-	11,315	**11,315**
Additions	-	827	**827**
Lease liability remeasurements	-	45	**45**
Application of effective interest rate	114	108	**222**
Early terminations	-	(2,317)	**(2,317)**
Carrying value at 31 March 2023	**3,766**	**7,512**	**11,278**

Note 22.3 Reconciliation of liabilities arising from financing activities - 2021/22

	Loans from DHSC	Lease Liability	Total
	£000	£000	£000
Carrying value at 1 April 2021	**6,763**	**482**	**7,245**
Cash movements:			
Financing cash flows - payments and receipts of principal	(1,480)	(275)	**(1,755)**
Financing cash flows - payments of interest	(172)	(13)	**(185)**
Non-cash movements:			
Application of effective interest rate	154	13	**167**
Other changes	-	(1)	**(1)**
Carrying value at 31 March 2022	**5,265**	**206**	**5,471**

Note 23.1 Provisions for liabilities and charges analysis

	Pensions: injury benefits	Legal claims	Other	Total
	£000	£000	£000	£000
At 1 April 2022	**539**	**582**	**246**	**1,367**
Change in the discount rate	(150)	-	(197)	**(347)**
Arising during the year	16	84	605	**705**
Utilised during the year	(24)	(145)	(9)	**(178)**
Reversed unused	-	(95)	-	**(95)**
Unwinding of discount	(7)	-	4	**(3)**
At 31 March 2023	**374**	**426**	**649**	**1,449**
Expected timing of cash flows:				
- not later than one year;	24	426	365	**815**
- later than one year and not later than five years;	92	-	219	**311**
- later than five years.	258	-	65	**323**
Total	**374**	**426**	**649**	**1,449**

Other provisions relates to the clinicians pension provision, staffing costs relating to pay in lieu of accrued annual leave and dilapidation provisions relating to Right of Use Assets under IFRS16.

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.

Note 23.2 Clinical negligence liabilities

At 31 March 2023, £207,492k was included in provisions of NHS Resolution in respect of clinical negligence liabilities of Kettering General Hospital NHS Foundation Trust (31 March 2022: £333,097k).

Note 24 Contractual capital commitments

	2023	2022
	£000	£000
Property, plant and equipment	1,982	4,620
Intangible assets	1,786	1,860
Total	**3,768**	**6,480**

Note 25 Financial instruments

Note 25.1 Financial risk management

Credit risk
Due to the continuing service provider relationship that the Trust has with local Integrated care Boards (ICB) and the way those ICBs are financed, the Trust is not exposed to the same degree of credit risk faced by some entities. Those items in dispute or under query have been assessed and a provision for impairment made, if deemed appropriate. Totals are included in the trade and other receivables in note 20.1.

Liquidity risk
The Trust's net operating costs are incurred mainly in respect of delivering on legally-binding long term contracts with ICBs. ICBs themselves are financed by resources voted annually by Parliament. As noted above, this means that the Trust is not exposed to the same level of risk as some other business entities.

Market risk
The Trust has historically 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 2023. This adjustment was due to the Covid Pandemic's impact on the fluctuating costs of these items during the year.

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 25.2 Carrying values of financial assets

Carrying values of financial assets as at 31 March 2023	Held at amortised cost	Total book value
	£000	£000
Trade and other receivables excluding non financial assets	13,621	**13,621**
Cash and cash equivalents	4,401	**4,401**
Total at 31 March 2023	**18,022**	**18,022**

Carrying values of financial assets as at 31 March 2022	Held at amortised cost	Total book value
	£000	£000
Trade and other receivables excluding non financial assets	3,941	**3,941**
Cash and cash equivalents	19,879	**19,879**
Total at 31 March 2022	**23,820**	**23,820**

Note 25.3 Carrying values of financial liabilities

Carrying values of financial liabilities as at 31 March 2023	Held at amortised cost	Total book value
	£000	£000
Loans from the Department of Health and Social Care	3,766	**3,766**
Obligations under leases	7,512	**7,512**
Trade and other payables excluding non financial liabilities	31,833	**31,833**
Provisions under contract	108	**108**
Total at 31 March 2023	**43,219**	**43,219**

Carrying values of financial liabilities as at 31 March 2022	Held at amortised cost	Total book value
	£000	£000
Loans from the Department of Health and Social Care	5,265	**5,265**
Obligations under leases	206	**206**
Trade and other payables excluding non financial liabilities	22,054	**22,054**
Provisions under contract	308	**308**
Total at 31 March 2022	**27,833**	**27,833**

Note 25.4 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.

	2023	2022
	£000	£000
In one year or less	35,484	24,190
In more than one year but not more than five years	5,677	3,873
In more than five years	2,647	-
Total	**43,808**	**28,063**

Note 25.5 Fair values of financial assets and liabilities

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

Note 26 Losses and special payments

	2022/23		2021/22	
	Total number of cases	Total value of cases	Total number of cases	Total value of cases
	Number	£000	Number	£000
Losses				
Cash losses	47	32	24	5
Bad debts and claims abandoned	22	33	15	94
Stores losses and damage to property	3	156	3	148
Total losses	**72**	**221**	**42**	**247**
Special payments				
Compensation under court order or legally binding arbitration award	1	49	-	-
Ex-gratia payments	36	374	42	457
Total special payments	**37**	**423**	**42**	**457**
Total losses and special payments	**109**	**644**	**84**	**704**
Compensation payments received				

The Trust had one case in 2022/23 in excess of £300k. This related to a hardship payment made to all Agenda for change staff on Bands 1 - 3. HMT appproval is being sought nationally by NHS England.

The Trust had one case in 2021/22 in excess of £300k. This was the special payment relating to overtime corrective payments following the judgement in a legal case. HMT approval was sought nationally by NHS England on behalf of the Trust. The nationally funded element of the claim was £310k.

Note 27 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 ICB**
NHS England
Northampton General Hospital NHS Trust*
Northamptonshire Healthcare NHS Foundation Trust
University Hospitals of Leicester NHS Trust
Cambridgeshire and Peterborough ICB**
Leicester, Leicestershire and Rutland ICB**
NHS Resolution
NHS Blood & Transplant
Health Education England
NHS Property Services

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.

** ICB's were formed during the year with transactions in the first quarter being undertaken with their predecessor organisations - Clinical Commissioning Groups (CCG). It is assumed for related parties that the ICB's includes reference to the predecessor CCG's

The Trust receives benefits from the Northamptonshire Health Charitable Fund which merged with the Kettering General Hospital NHSFT Charitable Fund on 1st April 2021.

Note 28 Prior period adjustments

The Trust had no prior period adjustments.

Note 29 Events after the reporting date

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