

# Annual Report and Accounts 2008-2009

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

Kettering General Hospital NHS Foundation Trust

**Annual Report and Accounts 2008-2009** 

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# Directors' Report

# Chairman and Chief Executive's Management Commentary

2008-2009 has been a major year of achievement for Kettering General Hospital culminating in our successful bid to become a Foundation Trust on November 1, 2008.

This report sets out how the Trust has developed during 2008-2009 and includes information about our financial and service performance, what we have done to improve care for patients and details of our plans for the future.

Some of the Trust's achievements during 2008-2009 have been to:

- Improve our overall performance and achieve an "excellent" rating for quality in the national Annual Health Check ratings produced by the Healthcare Commission (see page 11)
- Develop plans to improve the quality of the patient experience at Kettering General Hospital (see pages 18-19, 25 and 58-71)
- Continue to reduce the key healthcare associated infections C difficile and MRSA (see page 13-14)
- Push ahead with plans to improve our wards and departments to a high quality standard (see pages 15-17)
- Achieve Foundation Trust status, develop a good level of local Membership, hold elections for our first representative Council of Members (see page 10 and 44-48) and work closely with the Council to develop a firm platform for future engagement with the Trust's Board of Directors

We are delighted to be able to report good progress in all of these areas – more details of which follow later in this report.

During 2008-2009 the Trust has also continued to build on our strong overall performance which culminated in an excellent rating for quality in the Annual Health Check. At March 31, 2009, the Trust has met key waiting time targets in A&E, for routine treatments (18-week patient journey), and in a variety of other detailed measures of our performance (see page 12).

The Trust's financial performance remains strong and in October 2008 we received a score of Good for use of resources in the 2008 Annual Health Check. We also received an overall score of 3 out of a maximum of 4 for our use of resources in the Audit Commission's third annual Auditors' Local Evaluation Report (ALE). The ALE report showed that we are in the top 25% best performing Trusts in England for how well we manage our finances. In the same review we also scored 4:4 for our financial standing which means that the Trust has delivered all of our financial targets for the last three years.

Overall the Trust achieved a surplus of £3.5m on March 31, 2009 (see pages 53-55). Under Foundation Trust rules the Trust is able to retain this surplus and reinvest it in patient services in areas determined by the Board of Directors in consultation with the Trust's Council of Members.

# Directors' Report

The Trust has made a series of significant service developments during the reporting year which are highlighted in this report.

#### They include:

- Opening a £1.5m new short-stay medical ward (Clifford Ward) as part of the first phase of the Trust's ward refurbishment programme. Preparations are underway to carry out the next phase – refurbishment of some of the hospital's main medical wards – during 2009 (see page 16)
- Launching a new breast reconstruction service which has benefited patients by enabling them to have reconstructive surgery in Kettering rather than having to travel to such specialist centres at Leicester Royal Infirmary following treatment to remove cancer (see page 15)
- Establishing a coronary angioplasty service in the hospital's Cardiac Centre to perform this life changing procedure (see page 17) locally, again reducing the need for patients to travel to specialist regional cardiac centres
- Completing the first phase a of £3.4m refurbishment of the Trust's pathology department and launching the £1.2m revamp of the hospital's sterile services department (see pages 16 and 17)

Looking ahead the Trust has launched a five-year development programme called Improving Healthcare Together which aims to address issues about the care we provide which we have identified through local market research (see page 18-19).

The aim is to improve the quality of personal care we provide to patients by ensuring that we pay attention to details like being friendly and helpful throughout a person's time in hospital and beyond – including giving advice to people once they have left us about their recovery.

And finally the Trust recognises that all of its achievements stem from its excellent staff. So one of our aims in 2009-2010 is to be recognised an excellent employer. We have already made significant progress in this area and were identified by the Nursing Times/Health Service Journal as one of the UK's top 100 best health employers (see page 26).

Achieving Foundation Trust status means that Kettering General Hospital has become one of the top performing hospitals of its kind in England. We want to work together with our Foundation Trust Members, staff, patients, and the local community, to build on this substantial achievement in 2009-2010 and beyond.

**Dr Mark Newbold** – Chief Executive

m/Comes.

Steve Hone - Chairman

# Brief history of the Trust

- Kettering General Hospital opened as a publicly funded cottage hospital in 1897 on its present 33-acre site
- It became a standard NHS Trust on April 1, 1994
- It became an NHS Foundation Trust on November 1, 2008
- It is now run by a Board of Directors and a Council of Members. The Board of Directors meets monthly and the Council of Members five times a year
- The Board of Directors is made up of five Non-Executive Directors (members of the public), five Executive Directors (hospital managers) and a Chairman (who is a member of the public)
- The Council of Members is made up of 40 representatives of the local community these are divided into 13 appointed members (eg representatives of local organisations such as district councils, 21 elected members of the public representing local areas (eg Kettering, Wellingborough, Corby etc) and 6 staff members (see pages 44-48)
- Foundation Trusts are responsible to local people via their Council of Members and are also regulated by the independent body Monitor <a href="https://www.monitor-nhsft.gov.uk">www.monitor-nhsft.gov.uk</a>

# Part of our local community

- Kettering General Hospital NHS Foundation Trust plays an important role in its local community and is one of the largest employers in Northamptonshire
- It provides acute hospital services to North Northamptonshire and South Leicestershire covering the council districts and boroughs of Kettering, Corby, Wellingborough, East Northamptonshire and Market Harborough (and their surrounding small towns and villages)
- Overall the population in the area served by Kettering General Hospital (North Northamptonshire) is expected to grow by 50 per cent from circa 300,000 to 450,000 by 2031
- All health Trusts in Northamptonshire will be working together to meet this challenge alongside their local authority and other public partners
- The county has a body called the Northamptonshire Partnership made up of the major health bodies county, district and borough councils and other relevant public and voluntary bodies - which aims to make the best use of money to deliver the best overall services for local people
- The Partnership aims to make Northamptonshire one of the top five counties in England by 2030 and the leading economy in the East Midlands by 2020
- The Trust is also part of the Northamptonshire NHS Partnership Board established in 2007 to encourage and develop co-operation between all four NHS health Trusts in Northamptonshire. This body has become the local vehicle for co-ordination between all local public health and social care bodies and, amongst other things, has helped deliver the NHS Next Stage Review. The Partnership Board aims to develop a shared vision for healthcare in Northamptonshire over the next 25 years
- The Trust also interacts with the local community in many other ways (see pages 21-24) from liaising with local interest groups to encouraging the public to support its facilities via fundraising.

#### **CONTACT US**

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# Principal activities of Kettering General Hospital NHS Foundation Trust

Kettering General Hospital NHS Foundation Trust is a medium-sized district general hospital which provides a wide range of services to about 310,000 people in North Northamptonshire and South Leicestershire.

The Trust aims to provide the highest standards of care for all of its patients and to fully support its carers and visitors. It has developed many state-of-the-art facilities run by highly qualified staff including:

- An £18m short-stay surgery centre The Treatment Centre which enables the majority of operations to be done with stays of less than 48 hours
- A £4.7m Cardiac Centre providing heart-related treatments closer to people's homes

The Trust also has 600 inpatient and day case beds, a modern A&E department, 17 operating theatres, an intensive care unit, skin care centre (the Jubilee Wing) and cancer care wing (the Centenary Wing).

In its maternity unit, Rockingham Wing, the Trust provides a wide range of midwifery services including a labour ward, neonatal intensive care unit, fetal health unit, and post and antenatal wards. It also runs services in the local community such as clinics in GP surgeries, home visits by its community midwifery team and consultant led clinics.

The Trust has excellent diagnostic facilities, for example CT and MRI scanners, and carries out some 8 million tests in its pathology laboratories each year. In 2007/8 the Trust became the NHS bowel screening centre for Leicestershire, Northamptonshire and Rutland and extended its breast screening programme to women aged up to 70.

The Trust also runs a wide range of outpatient clinics in Corby, Wellingborough and Rushden and plans to expand its outpatient facilities in 2009-2010 to bring more clinics closer to people's homes and away from the main Kettering site, which is somewhat congested.

At March 31, 2009, the Trust employed 3,340 staff which it considers its greatest asset. Of those:

- 324 are doctors
- 1,044 Qualified Nurses/Midwives
- 337 Health Care Assistants (Nursing)
- 238 Scientific, technical and professional
- 1,397 other staff including maintenance, clerical staff, finance, IT and human resources staff

#### In 2008-2009 the Trust:

- Treated 76,123 patients in Accident and Emergency (includes Corby Minor Injuries Unit) - an average of 209 per day
- Admitted 35,523 patients to hospital beds as emergencies
- Served 211,779 outpatients
- Performed 7,101 inpatient and 24,803 day case operations / procedures.

# Strategic objectives 2009-2010

The Trust set high-level strategic objectives for 2009/10 at its March meeting of the Board of Directors. Each objective has a corresponding enabling programme.

The strategic objectives are:

- Develop services to meet local need
- Provide a clean and modern environment
- Establish excellence in service quality
- Build confidence amongst stakeholders and local people
- Maximise efficiency to ensure best value from our investments and resources
- Become a model employer

# Principal risks, uncertainties and future trends

The principal risks to Kettering General Hospital Foundation Trust are as follows:

- That, in an era of greater competition and consumer choice, the Trust does not remain as hospital of first choice in North Northamptonshire affecting the Trust's elective workload and income. This risk is offset by the Trust's comprehensive programme of patient centred, and driven, improvements which aim to increase the quality of our patients' experience. The Trust is also developing good relationships with key stakeholders such as Northamptonshire Primary Care Trust and Nene Commissioning (see page 23) to ensure that its facilities provide the most effective and appropriate care for local people
- The Trust must also plan for the impact of the global economic recession on its business over the next two years. The recession is likely to impact on the Trust's finances through reduced central funding.

#### Making sure we are prepared for an emergency

During 2008-2009 the Trust progressed work to ensure that it has plans in place to deal with any major incident and its aftermath. The Trust has an Emergency Planning department and an Emergency Planning Group to take the emergency planning agenda forward. It is working towards full compliance within the core standard C024, Civil Contingencies Act 2004, BS25999 and NHS Emergency Planning Guidance 2005 and supporting guidance.

# **Working to reduce our Carbon Footprint**

The Trust has continued to work to reduce the impact its business has on the environment in line with national initiatives on sustainability. As part of its sustainable development strategy the Government encourages both companies, and public bodies, to disclose their sustainability and environmental performance through their Annual Reports.

During 2008-2009 the Trust has:

- Successfully applied for £250,000 from the Department of Health Carbon Fund for energy efficiency measures including replacing inefficient heating and hot water generators. The Trust is on target to achieve a reduction of 290 tonnes of carbon dioxide per year and has submitted business cases to achieve further reductions
- A whole site waste management service is at the tender analysis stage. It is believed that this will present increased re-cycling opportunities, thus reducing landfill demand
- The NEAT assessment tool (NHS Environmental Assessment Tool) used to assess a Trust's energy and operational efficiency has been replaced with the more prescriptive BREEAM programme (Building Research Establishment Environmental Assessment Method). A site wide reassessment is being undertaken.

# Key achievements and developments during the reporting year

# Achieving Foundation Trust status

On Saturday, November 1 2009, Kettering General Hospital became England's 109<sup>th</sup> Foundation Trust after undergoing an intensive assessment by the independent regulator Monitor.

To achieve Foundation Trust status the Trust had to prove that it had excellent financial controls, good systems in place to provide patients with safe care and a good grasp of what it plans to do in the future and how it will involve local people.

Achieving Foundation Trust status means that the hospital remains part of the NHS but is able to act more independently, have more control of its finances and be more accountable to local people through an elected Council of Members (see pages 44-52).

Foundation Trusts are public benefit corporations which means that - while retaining core NHS values such as providing free care based on need (not ability to pay) - they have greater freedom to focus resources on providing services tailored exactly to local needs in consultation with local people and partner organisations.

While Foundation Trusts are less directly accountable to the Department of Health than other NHS Trusts they are still subject to strict financial and governance controls by Monitor www.monitor-nhsft.gov.uk

The Trust began its Foundation Trust journey in 2006 and carried out a public consultation in November of that year which involved approaching more than 12,000 individuals and organisations. The consultation showed that 91% of local people were in favour of the move.

The Trust then produced a comprehensive five-year Integrated Business Plan outlining how it proposed to develop its services, improve care for patients and face the future challenges of things like population growth.

On July 24, 2008, Health Secretary Alan Johnson gave the Trust's application the green light to move on to the final stage of Foundation Trust assessment and on October 30 Monitor approved the Trust's application.

In the build up to its successful application Kettering General Hospital had to actively recruit local people, and its own staff, to become Members of the Trust.

Membership is open to all local people and it enables people to become more involved in the work of the hospital and receive more information about it.

So far about 7,000 people have become Members of Kettering General Hospital and the Trust is actively encouraging more people to join. It aims to have 8,500 members by the end of the calendar year.

People who would like to become a Member of Kettering General Hospital Foundation Trust and get involved in events and developments can contact the hospital's Membership Manager Christine Harrison on 01536-492169 or email <a href="mailto:Christine.Harrison@kgh.nhs.uk">Christine.Harrison@kgh.nhs.uk</a>

# Excellent rating in the Healthcare Commission's Annual Health Check

Kettering General Hospital improved its Annual Health Check ratings for the third year running achieving an Excellent rating for quality of services and a Good rating for use of resources.

The Excellent rating puts the Trust into the top 30% of Trusts in England for quality of services and is a significant improvement on its rating of Fair in 2006/7 and 2005/6.

It is the first time the Trust has achieved such a high score in the very detailed assessment the Healthcare Commission carries out, for all NHS Trusts, to enable local people to see just how well their local hospital is doing across a broad range of performance indicators.

The Annual Health Check results were published in October 2008 and can be accessed at <a href="https://www.healthcarecommision.org.uk">www.healthcarecommision.org.uk</a>

The scores reflect considerable work the Trust has done across many of its areas of its business to improve patient care. It also reflects the extra resources the Trust put as an organisation into improving its facilities, successfully tackling infection and hitting all of its national targets. (see pages 12-17)

The score of Good for use of resources also illustrates how well the Trust has generally managed its finances. It has achieved breakeven, or made a surplus, for the last three years and achieved a surplus of £3.5m by the end of March 2009. (see pages 53-54)

The Trust's quality of service rating was based on how well it met:

- The Standards for Better Health core standards the Trust fully met the 24 standards which cover a wide range of activities including infection control, complaints handling, medicines management and wide variety of other service areas
- **Existing national standards** the Trust fully met its ten key national targets including areas such as not making people wait more than four hours to be seen in A&E or more than two weeks before being seen by a consultant for suspected cancer
- New national targets The Trust received a rating of excellent for its work towards new national targets such as encouraging breast feeding during pregnancy and achieving Government referral to treatment time waiting time targets

This year's Annual Health Check also assessed the Trust in six key areas.

- Safety and cleanliness (scored 13 out of a possible 13)
- Standard of care (scored 9 out of a possible 9)
- Waiting to be seen (scored 12 out of a possible 12)
- Dignity and respect (scored 10 out of a possible 10)
- Keeping the public healthy (scored 4 out of a possible 4)
- Good management (scored 17 out of a possible 17)

The Trust is planning considerable work to improve patient experience of its services – see pages 18-19.

# How the Trust scores against its key performance indicators

The Trust is regularly measured against key performance indicators in various aspects of the care it provides. Performance is monitored continually and reported to monthly meetings of the Board of Directors.

Certain key performance indicators also shape the Trust's overall score in the Annual Health Check (see page 11) which enables local people to judge how well the Trust is doing overall against its many targets and standards.

Here are some of the Trust's key targets and how it performed against them.

- Overall wait to treat 90% of admitted patients within 18 weeks (from GP referral to treatment) – achieved 2008-2009. Admitted means admitted to hospital for elective not emergency treatment
- Overall wait to treat 95% of non-admitted patients within 18 weeks (from GP referral to treatment) achieved 2008-2009. Non-admitted means where patients have their treatment in areas such as outpatients
- A&E wait patient to spend no more than 4 hours in A&E from arrival to admission, transfer or discharge target 98% achieved in 2008-2009 quarter one and two, underachieved in quarter three and four but overall average for the year was 98.1% which achieved the target for 2008-2009.

Cancer Waiting Time targets – April to December 2008 (new targets post December 2008 not available at the time of going to press) the Trust achieved:

- Cancer wait 98% of patients to be seen within two weeks by a specialist following urgent referral by a GP achieved 99.9%
- Cancer wait diagnosis to first treatment with 31 days target 98% achieved 99.1%
- Cancer wait from GP urgent referral to treatment within 62 days target 95% achieved 96.6%
- Thrombolysis To ensure that at least 68% of patients have to wait no more than 60 minutes from first call to emergency services to injection of clot busting drugs (where this is the preferred local treatment for heart attack) Trust achieved 77%
- MRSA bacteraemia Maintaining the annual number of MRSA bloodstream at no more than 11 cases per year. The Trust had 12 cases in 2008-2009
- Clostridium difficile To reduce the level of Clostridium difficile infection by 10%.
   This relates to no more than 191 cases in the year Trust had 95 cases and achieved the 2008-2009 target
- To achieve all 24 of the Standards for Better Health core standards Trust will declare full compliance on 23 standards and insufficient assurance on one standard clean and well designed environment.

As a Foundation Trust the hospital has to maintain its performance against these standard NHS targets. It will also work to develop and agree new performance targets in terms of developing its quality of care – see pages 25 and 58-71.

#### Introduction

During 2008-2009 the Trust carried out a wide variety of initiatives and service improvements designed to improve the overall patient and visitor experience at Kettering General Hospital. It is also working through plans to further improve the quality of patient care in 2009-2010 (see pages 25 and 58-71).

#### Infection control and environmental cleanliness

Research commissioned by East Midlands Strategic Health Authority (February 2009) has shown that when rating a healthcare facility the three most important things to Northamptonshire residents were: Cleanliness (30%) Staff who are caring for the patient (23%) Excellent Clinical Treatment (19%) - cleanliness being closely associated with infection control in the public mind.

The Trust started its ongoing infection control campaign from a strong position in 2008. At March 31, 2008, the Trust had managed to cut its 2007-2008 C difficile and MRSA case totals in half following an intensive campaign to reduce infections. This meant it achieved two important 50% reduction targets set by the Department of Health and Northamptonshire PCT. This achievement was the culmination of an 18 month infection control campaign which reduced C diff cases from 641 in 2006 to down to 306 in 2007-8. The MRSA 50% target was to have no more than 12 cases in 2007-2008 (set against the 2004-5 total of 23 cases). The Trust had 11 cases.

The Trust has maintained its focus on infection control during 2008-2009 and has achieved a 2011 target of reducing Trust attributed C difficile by 30% two years early. This equated to having no more than 129 cases by 2011. The Trust had 95 cases in 2008-2009.

The Trust also aimed to maintain its level of MRSA cases at no more than 11 for the year 2008-2009. At March 31, 2009 the Trust had 12 cases – which still meant that it was one of the top performing Trusts in England for MRSA. It should be noted that 8 of the 12 cases were acquired in the community and present at the time of admission to KGH. The Trust is working closely with the PCT to establish a target for 2009/10 that is split with community services to encourage whole health economy co-operation in the management of MRSA.

# Work done during 2008-2009 included:

- Maintaining the Trust's focus on a wide range of routine infection control measures and procedures including emphasis on basic hand washing and prescription of antibiotics
- Completing an additional deep cleaning and minor repairs programme in July 2008 on top of basic deep clean requirements achieved at March 31, 2008. The Trust 'gold standard' deep clean received many positive comments from its Patient and Public Council and Patient and Public Involvement Forum (now Northamptonshire LINK)
- Taking part in a region wide infection control campaign called "Hand in Hand" developed by the SHA during the month of November 2008. At a local level this involved promoting improved public understanding of infection control issues through media events surrounding cleaning, hand hygiene and MRSA screening. At the same time staff were also encouraged to be more 'infection aware' through a series of internal initiatives including quizzes and competitions
- Rolling out the use of the Trust's pioneering Kettering Infection Predictor assessment tool which is used by staff to assess patients on admission, and during their stay, for their potential risk of developing an infection such as MRSA or C diff. Staff are then prompted to ensure that infection control precautions are implemented for patients who, because of things like their age and personal medical history, have a greater potential risk of infection.

## **Hygiene Code visit 2009**

As part of its programme to visit every Trust in England during 2009-2010 the Healthcare Commission visited the Trust on January 27-28, 2009, to assess its compliance with the Code of Practice for the Prevention and Control of Healthcare Associated Infections – commonly known as the Hygiene Code.

The visit showed that the Trust complied with three of the four duties tested and its pioneering KIP tool (see page 13) was highlighted as an example of best practice for the NHS. Its successful record on reducing infections, both in the short and long term, was also noted. The Trust was asked to carry out further work to establish full compliance with duty 4 – providing and maintaining a clean and appropriate environment. This will involve ensuring it has better cleaning schedules for non-patient areas (notably cleaning store cupboards) and developing better documented liaison between infection control and cleaning teams.

## Inpatient survey

95% of patients at Kettering General Hospital rated the overall care they received highly in a national Healthcare Commission Inpatient Survey released on May 14, 2008.

The survey found that 50% of patients rated overall care at Kettering General Hospital as excellent, 33% as very good, and 12% as good. Only 3% rated the overall care they received as fair and only 1% as poor. The 95% rating puts Kettering General Hospital into the top 20% best performing Trusts in England on that survey question.

Overall the Trust was in the top 20% of Trusts in 20 areas of care; In the middle 60% of Trusts in 35 areas of care and in the lower 20% of Trusts in 7 areas of care. The survey highlighted issues around patient information, noise at night, staffing levels and communication with patients after having had an operation. The Trust had increased its staff levels since the time of survey and is planning improvements to patient information, both before, during and after receiving care in hospital, as part of its Improving Healthcare Together programme (see page 18-19)

#### **High Dependency Unit opened**

- The Trust opened a specialist High Dependency Unit on its Labour ward on June 2, 2008, for women with problems such as high blood pressure and haemorrhage
- The unit is aimed at helping the 5% of women who can experience complications during pregnancy
- It consists of a two-bedded bay equipped with its own nurse station and specialist monitoring equipment.

# Official opening of the Treatment Centre and NHS 60<sup>th</sup> birthday celebrations

- The Trust officially opened its £18m Treatment Centre to deliver day case and short stay surgery - during the 60<sup>th</sup> anniversary of the NHS celebrations
- The Centre was opened on July 10 by KGH housekeeper Marie Joy who has the same birthday as the NHS, July 5, 1948
- In its first year of operation (April 2, 2007 April 2, 2008) the Treatment Centre saw a total of 22,448 patients; carried out 6,648 surgical procedures or treatments and saw some 15,800 women for screening or treatment in its breast unit
- This increased to seeing 24,943 patients in 2008-2009, carrying out 7,462 surgical procedures or treatments and screening or treating 17,481 women in its breast unit.

#### **Breast reconstruction service**

- In January 2008 the Trust launched a six month surgical breast reconstruction pilot service patients being treated for breast cancer
- The new service reduces the need for women to travel to specialist centres such as Leicester Royal Infirmary or Nottingham City Hospital to have reconstructive surgery following treatment to remove cancer
- It was so successful the pilot was extended to 12 months during which time 12 women received reconstruction and many more benefited from advice and care which otherwise they would have had to travel to Leicester to receive
- 2009 will be the service's first full year and it is estimated that some 240 patients will be seen regarding breast problems of whom 30% may undergo breast reconstruction surgery at Kettering
- The service has had excellent feedback from patients who have benefited from it
- During the calendar year 2008 the Trust's breast service diagnosed 255 new cancers

# £25,000 Elective Admissions Lounge

- In August 2008 the Trust has developed a new way to ensure that people who are being admitted to hospital for routine operations go through a smooth, well organised and comfortable admission process while being allocated a bed
- Previously a common source of patient concern had been that, at busy times, they
  needed to phone up repeatedly to check they had a bed allocated to them ready for
  their routine operation. This led to feelings of uncertainty and waits, sometimes of
  several hours, for confirmation to travel in to hospital
- The Trust's new Admissions Lounge, located next to Deene A, enables people to arrive at hospital at a fixed time, receive any pre-operative checks immediately and then be allocated a bed prior to their surgery with much less difficulty

# £30,000 new Paediatric Assessment Unit opened

- On September 15, 2008, a specialist unit was opened to improve and speed up the way in which about 60 children a week are admitted to hospital
- Families had been concerned that sometimes they were having to wait for a long period to be assessed by a paediatric doctor following a GP referral to hospital
- The new unit ensures children are assessed, treated and sent home, or admitted to hospital care, quickly and efficiently, in a child friendly environment, with good access to specialist doctors and nurses

## £1.2m cellular pathology department opened

- In October 2008 the Trust completed the first phase of a £3.4m revamp of its pathology service by opening a newly built £1.2m cellular pathology department
- The redevelopment helped to improve and extend the hospital's diagnostic and testing services which perform more than 1.2 million requests - which equate to about 8 million blood, urine and other diagnostic tests for GPs and hospital staff each year. The second phase of the refurbishment should be complete by September 2009
- The development will help the laboratories to maintain their speeding reporting of patient test results to hospital staff and GPs at a time of population growth

# Trust opens £1.5m Clifford ward as part of its five year ward refurbishment programme

- In January 2008 the Trust launched a five year multi-million pound ward refurbishment programme
- The aim is to progressively upgrade the hospital's wards many of which are more than 30 years old to high modern standards
- On October 24 the Trust opened its first revamped ward a £1.5m new short-stay medical ward for people with acute illnesses
- The ward is called Clifford Ward in memory of Dr Guy Clifford a physician who worked at the Trust for six years but sadly died in May 2008
- The ward is specifically aimed at improving the care of patients with medical problems which can often be brought quickly under control following assessment and treatment by specialist staff enabling an early discharge home
- It is designed to reduce waiting times, prevent unnecessary stays in hospital and ensure that patients are seen promptly by relevant specialist clinicians.

# Next stage of the ward refurbishment programme

- In November 2008 the Trust began enabling works to facilitate redevelopment of its main medical wards (Harrowden A, B, and C) by March 2010
- The plans include elimination of traditional six bed bays to be replaced by threebedded bays with ensuite toilets and showers. In addition the Trust plans to double the number of single rooms available to patients in this area.

# **Healthcare Commission Accident and Emergency Review**

- The Trust scored in the top 20% of Trusts nationally in 11 out of 40 areas of care measured and in the middle 60% of Trusts in the remaining areas in a Healthcare Commission Review of Accident and Emergency Service published on December 16, 2008.
- The review demonstrated that patients were very pleased with how quickly they were seen by doctors and nurses, how their treatments were explained to them and that they felt they were treated with dignity and respect.
- The report follows a series of improvements in the Trust's A&E and emergency facilities in recent years including developing a fast-track "greet and treat" assessment system; a five-bed short stay observation ward; minor injuries unit in Corby to prevent the need to travel to the main hospital site and short-stay medical ward (Clifford Ward described earlier).

# £1.2m upgrade of the hospital's instrument decontamination unit (sterile services department)

- To meet new European and national standards for surgical instrument decontamination the Trust is investing £1.2m in refurbishing its existing sterile services department from January 2009
- The project will involve a major building refurbishment and alterations to include improved instrument reception and processing areas, new ventilation systems and new decontamination equipment
- On completion of the project the Trust's sterile services department will be fully compliant with all current standards

# Official opening of Cardiac Centre and development of the angioplasty service

- The Department of Health's National Director for Heart Disease, Professor Roger Boyle, officially opened the Trust's £4.7m Cardiac Centre on January 16, 2009
- Prof Boyle who is implementing national plans to improve heart care congratulated the Trust on its work improving care for people in North Northamptonshire
- The Cardiac Centre opened in July 2007 and helped some 1,787 local people with heart problems in its first year by providing care previously only available from regional cardiac centre's outside of the local area such as cardiac catheterisation and angioplasty
- The Centre enables the majority of heart attack patients to receive their specialist treatment within 48 hours of admission. This allows for the best outcomes and is in keeping with best practice as defined by European and American cardiac guidelines.
- Since May 2008 the Centre has also begun to perform coronary angioplasty a special procedure for clearing blocked arteries in the heart which involves expanding the artery using a balloon and then inserting a small metal sleeve called a stent to keep it open
- The Trust carried out more than 200 angioplasty treatments in its first seven months.
   The treatments can significantly improve the quality of life for people who have suffered severe chest pain or had a heart attack.
- The operations are very successful and there is a 90-95% chance that the patient will have no further problem with the artery that has been treated.

# Listening to patients and responding to their needs

The Trust is committed to responding well to the needs of its local community and will be actively seeking local people's views on how best to do this in the year ahead.

One key way will be harnessing the power of its 7,000 Foundation Trust members. Already the Trust has been communicating with its members by newsletter, telephone, email, via its website <a href="https://www.kgh.nhs.uk">www.kgh.nhs.uk</a> and by organising events for Members.

Events held for members in 2008-2009 included a Healthy Hearts seminar in April 2008, an Adult Allergy seminar in July, the Trust's Annual General Meeting in October and a Cardiac and Respiratory Diseases seminar in March 2009. The Trust has also held focus groups on particular subjects including dignity and care, nutrition, falls and facilities for women and children.

In 2010-2011 the Trust is planning to engage with its Membership in various other areas of care including occupational and physiotherapy, wound healing and the prevention of infection, alcohol awareness, bowel screening, stroke awareness and haematology.

The Trust aims to increase its Membership to 8,500 by the end of the year.

For more details on how to become a Member and how the Trust's Council of Members works see pages 10 and 44-52.

# Patient surveys and research – Improving Healthcare Together

During 2007-2008 the Trust began to carry out extensive market research into what its patients and key stakeholders most wanted from the hospital.

The result of this work was a new programme called "Improving Healthcare Together" which was co-created with patients, staff, GPs, and a cross section of the general public.

The Trust plans to develop an ambitious and all encompassing programme of work to improve patients, staff and GPs' experience of Kettering General Hospital.

Working groups have been developed to examine the key issues raised by the research and find ways to address them.

The research showed that some of the most important things to patients were:

- Tell me what is going to happen to me before I arrive in hospital, give me good directions, remind me to come for my appointment, help me to know more about my treatment
- Greet me positively when I arrive, help me get where I need to go, be happy and cheerful, don't make me wait unnecessarily
- Keep me informed, listen to me, look me in the eye, give me privacy, make sure I understand
- Admit me quickly, I want everything to be clean, pay attention to my needs, treat my family well and keep them informed, don't rush me
- Value my views on my experience, help me manage my condition after I leave hospital, make sure I know what happens next, help me to understand the signs if things are going wrong again, tell my GP what has happened to me.

# Improving Healthcare Together

As a result the Trust is developing programmes of work that will:

- Give patients a more personal service, listen to and respond to their needs and the needs of their families and friends
- Give people more control of their care and more information before, during and after their stay with us
- Work to make our services more convenient for them to fit in with their busy lives
- Find ways of improving our relations with GPs

# **Practical improvements the Trust is planning include:**

- Improving our help desk areas
- Improving our call centre
- Giving wards the power to develop their own individuality and focus on patient experience in their areas
- Improving the information we give to patients before, during and after their arrival to hospital
- A strong commitment to seeking feedback from patients and relatives and acting on their comments.

The Trust has condensed some of the work down to a simple patient promise which is:

"We will always treat you as a person, always working together, always there for you, always caring for you and always improving"

The Trust has then further defined what this means in practice for staff in all of its components and will be working to develop a corporate consciousness, at every level, so that patients experience this promise in a real way.

Examples of work which is under way include:

**Ward pilots** – In December 2008 and January 2009 the Trust launched two IHT ward pilot projects. These are being run by front-line staff and involve regularly monitoring the experience of their patients and looking for ways to improve it.

**Patient Information** – The Trust is developing new generic information leaflets to help people with accessing outpatient and inpatient appointments and is looking at ways to establish reliable and cost effective ways of addressing patient information needs.

In addition the Trust has a full time Patient Information Co-ordinator who works with staff to ensure that patient information meets Government and NHSLA requirements. The Trust has a Patient Information Committee, and has patient representation on it, which meets monthly to review, edit and approve all leaflets produced within the Trust.

**GPs** - The Trust has worked with some GPs, and Nene Commissioning (see page 23) to address their priorities. We have recruited a GP relationship manager to work closely with them in the future

**Staff training** – The Trust has contacted its local further education establishment – Tresham Institute – to look at developing a training package for staff to develop IHT focussed skills

# Patient and Public Council

The Trust also has a voluntary Patient and Public Council which is made up of patients and carers and since 2000 has been working alongside hospital managers to improve patients' experience of care.

The Council makes many improvement suggestions which are taken forward by managers – they also perform valuable audit work gathering information about things like compliance with hand washing and the supply of patient information.

Improvements during 2008-2009 which Patient and Public Council members have been involved in have included:

- Improved lighting near outpatients to make the use of a wheelchair ramp safer at night
- Introducing disposable tickets instead of waiting number cards in pathology to improve cleanliness/infection control in the waiting area
- Highlighting areas where cleanliness is an issue on wards
- Monitoring the use of gel dispensers around the Trust to ensure they are in areas where they will be noticed and used by patients

# Compliments and complaints

The Trust also learns from its patients and carers by listening to both their compliments and complaints about its services. The Trust receives many compliments via thank you letters to its wards, departments, to the Chief Executive and to its website <a href="https://www.kgh.nhs.uk">www.kgh.nhs.uk</a>. The Trust also pays a lot of attention to observations, issues and complaints raised via its Patient Advice and Liaison Service (PALS), which has an office at main reception, or via formal complaints made to the Trust's Quality Governance Department by phone, email or letter.

# Patient Advice and Liaison Service (PALS)

The PALS service is on hand during normal office hours to help patients or carers who are seeking information or have a concern they need resolving. The service speaks with about 800 people per year about a wide range of issues including things like individual patient care, hospital appointments, cancellations, discharge, waiting times, parking and staff behaviour. The PALS service can be contacted on 01536-493305.

# Complaints

The Trust's Quality Governance Department provides a free and accessible complaints procedure that is compliant with up-to-date guidance from the Department of Health. The Trust's complaints procedure guides staff and complainants on the process to be followed in resolving a complaint. It provides a process to enable a timely, fair, open, thorough and confidential resolution of concerns. It also enables the Trust to improve the quality and safety of its care through lessons learned. The total number of complaints received during 2007-2008 was 355 – some 77 less than in 2006-2007. The number for 2008-2009 was 343. Complaints are dealt with flexibly to meet the needs of the complainant wherever possible. This may involve face-to-face meetings at the hospital, telephone contact, letter or e-mail. Staff at all levels of the organisation are encouraged to deal with complaints on the spot if possible or escalate to an appropriate manager so that prompt action to be taken.

# Complaints performance

The performance on response times for 2007-2008 was 67.3% of responses completed within the 25 working day guideline. The Trust improved this for the period 2008-2009 to 100%. This considerable improvement was largely due to the decentralisation of complaints management to the Clinical Management Teams.

The Trust deals with complainants in as equitable and balanced a manner as possible taking account of the Principles of Remedy outlined by the Parliamentary and Health Service Ombudsman. Where there is loss, injustice or hardship incurred by a complainant the Trust assesses the individual case and seeks to give suitable and proportionate remedy including an apology, explanation, remedial action or compensation as appropriate.

The Trust regularly makes improvements resulting from complaints and these have included improving ward round communications in the medical assessment unit, training Harrowden B staff in the care of Parkinson's disease patients and developing nurse led clinics to improve waiting times for colposcopy.

# Spiritual and emotional support

Coming into hospital, even for a short planned visit, can be a demanding and worrying time for patients, their family and friends. The Trust helps to support people emotionally and spiritually during these difficult times through its well-established multi-faith chaplaincy service. The chaplaincy department actively involves members of the Hindu, Muslim, Jewish, Bahai and Humanist communities. The department's work ranges from direct patient support through to staff training and the development of policies relating to spiritual care. Some 30 Chaplaincy Volunteers, specifically trained to work in the hospital, also assist in the department's work. The department can be contacted on 01536-492609.

# Working with disability and sensory impairment

Ensuring the needs of people with a disability or sensory impairment are met is important to Kettering General Hospital and for many years the Trust has had an active Disability and Sensory Impairment Working Group (DSIWG) which oversees practical measures to achieve this goal.

The group is made up of representatives from local community organisations, disability and sensory awareness associations, and health professionals and managers.

In 2007-2008 the Trust introduced a 'Disability Equality Scheme' (DES) and the DSIWG has helped to oversee an action plan to further improve services. Work done in 2008-2009 has included fitting extra hearing loops, providing additional staff training on dementia care and learning disability, purchasing extra wheelchairs and ensuring appropriate modification work is carried out in places like ward bathrooms.

Other improvement have included a ramp and disabled parking in four Trust car parks and significant input into the Trust's ward improvement programme. The Trust's Disability and Sensory Impairment Facilitator, Joanne Taylor, can be contacted on 01536 493340 or by email on Joanne.taylor@kgh.nhs.uk

# Consultation, engagement and partnership work

The Trust is committed to developing meaningful engagement with its stakeholders. Work done during the reporting year has included:

- Working with its Foundation Trust Membership to establish its first Council of Members - including expanding local Membership to 7,000 (page 10 and 50-52)
- Developing the Trust's Improving Healthcare Together programme (pages 18-19)
- Responding to improvements suggested by our Patient and Public Council (page 20)
- Engaging with the local disabled community via the Trust's Disability and Sensory Impairment Working Group (page 21)
- Engaging with local faith communities via the Trust's Chaplaincy department (page 21)
- Responding to patients and visitors via the PALS and complaints service (page 20-21)
- Responding to survey work with local patients carried out by bodies such as the Healthcare Commission (for example the inpatient survey see page 14)
- Working with local voluntary, charity and support groups. The Trust is actively supported by the local WRVS which provide cafés and other catering facilities on site. It also works closely with groups such as the county's Voluntary Car Schemes, Age Concern and support groups such as Alzheimer's Society (Kettering Corby District Branch) and Parkinson's Association (Northamptonshire Younger Parkinson's Support Group) and its own patient-led cardiac and cancer groups.

The Trust is developing a Patient and Public Involvement Strategy in addition to a new Communication Strategy developed during 2008-2009.

Other key partners the Trust regularly engages with include:

- Northamptonshire Local Involvement Network (LINk) On March 31, 2008 the county's system of Patient and Public Involvement Forums were transformed into a new organisation designed to have a wider remit called Northamptonshire LINk. The organisation is in its formative year and represents the views of local people who use health and social care services. It is composed of volunteers whose administration and support services are based at Northampton Volunteering Centre (01604-637619). Previously the hospital had its own Patient and Public Involvement Forum whose members attended Trust Board meetings. Members of Kettering General Hospital's Patient and Public Involvement Forum have now crossed over to LINk and are continuing to work with the hospital on health matters. One key area of business during 2008-2009 has been providing the patient commentary for the Trust's Standards for Better Health submission. LINk is able to refer matters of interest to the Northamptonshire Overview and Scrutiny Committee (adult social care and health)
- Northamptonshire Overview and Scrutiny Committee (adult social care and health) The Trust's chairman and chair of the Council of Members Mr Steve Hone attends the Overview and Scrutiny Committee (adult social care and health) of Northamptonshire County Council to engage with the committee on health policies and service developments. The County Council has four Overview and Scrutiny Committees and their purpose is to scrutinise policies and decisions made on how to spend public money and ensure they are fair, practical and in the public's best interest. Overview and Scrutiny Committees can put also forward their own ideas/recommendations for improvements, and influence decisions being made.

- NHS Northamptonshire (Northamptonshire Teaching Primary Care Trust The Trust's senior management are actively involved in the Northamptonshire NHS Partnership Board established in 2007 to encourage and develop co-operation between all four NHS health Trusts in Northamptonshire. It has since become the local vehicle for co-ordination between all local public health and social care bodies and, amongst other things, has helped deliver the NHS Next Stage Review. The Partnership Board aims to develop a shared vision for healthcare in Northamptonshire over the next 25 years. It provides a single mechanism for the whole health community to determine the changes necessary across primary and secondary care to achieve sustainable, safe and high quality services. Its aim is to not only sustain, but wherever possible to improve, the quality of services provided to the patients and public serve.
- Nene Commissioning -Nene Commissioning is a practice based commissioning (PBC) organisation that acts on behalf of 61 participating GP practices from within Northamptonshire. The organisation is structured around three locality areas: Wellingborough Ketterina and Corby, and East Northants. Northampton. Kettering General Hospital's senior management work with Nene Commissioning at both a strategic level and by agreeing initiatives at a practical level which benefit the people of Northamptonshire. Examples during the reporting year have included GPs working alongside hospital clinicians in A&E and working with particular hospital clinicians to reduce the number of emergency admissions in outpatients. Nene Commissioning GPs cover 75.6% of the registered population of Northamptonshire.

# Consultation Exercises

During 2008-2009 the Trust began to utilise the public membership it has established as part of the Foundation Trust process to widen its approach to consultation and engagement.

In August, after notifying the Overview and Scrutiny Committee of its plans to provide a wider range of outpatient clinics in East Northamptonshire, the Trust undertook a public engagement exercise which entailed the Trust writing to the following groups of people and inviting them to complete a short questionnaire to assist us in developing our plans.

- 500 users of outpatients services attending at Rushden Memorial Clinic
- 500 users of outpatients (with a Rushden area postcode) currently attending at the main Kettering General Hospital outpatients department
- 473 public members of the Trust with postcodes local to Rushden Memorial Clinic
- GP Practices
- Northamptonshire County Councillors with Rushden/Irthlingborough/Finedon postcodes (5 in total)
- East Northants Councillors

This exercise was later supplemented by a series of public display events at 6 venues across East Northamptonshire in January.

Other consultation work has included consultation with 16 - 19 year olds, drawn from Foundation Trust Members and local schools, to seek views and preferences to assist the Trust in the design development of a facilities for young people within a planned new Children's Unit.

# Kettering General Hospital Charity Fund – a new look

- The KGH Charity Fund developed a brand new look in 2008-2009 with new objectives to help improve the lives of patients, their families, visitors and staff
- Bids were requested from departments and wards throughout the Trust and then a Wish List was put together based on the successful bids.
- The entire Wish List, worth over £90,000, was fully funded via donations, fundraising activities and legacies left to purchase equipment.
- Some of the Wishes that were granted and made possible from KGH Charity Fund donations were; special parents beds on the children's wards, state of the art equipment for new born babies to detect any defects or conditions, an additional bladder scanner for the Stroke Unit and many more additions to benefit everyone who accesses or works at the Trust.
- One particular area of the Wish List was the Air Filtered rooms for immunosuppressed patients on Lilford Ward. Matthew White, one of the charity's key supporters helped the Trust to raise over £21,000 to fund these vital rooms in memory of his loving wife, Kara. These additional benefits can sometimes be life saving as well as creating a comforting environment for patients with serious illnesses.
- The Trust plans to continue to develop new Wish Lists and rotate the areas that benefit. The list has been welcomed by many staff as a new opportunity to gain additional funds for their own wards or departments

# KGH Charity Fund – Cardiac Care Appeal

- In late November 2008 the Trust launched a Cardiac Care Appeal in partnership with its local newspaper, the Northamptonshire Evening Telegraph.
- The aim of the Trust's first appeal in many years was to raise additional funds for its cardiac care services in anticipation of future improvements planned to these facilities
- A fundraising target of £100,000 has been set which will help to pay for a Rehabilitation Room, a Relatives Quiet Room, Information Support Portals and State of the Art Monitoring Stations.
- All funds raised will help the Trust to create a healing and caring environment where people receive the best possible care in the most appropriate surroundings
- By March 2009 an impressive £35,000 had been raised by the local community, including Evening Telegraph readers, past and present patients and their families, and grants were donated by the local group – Kettering & District Charitable Medical Trust.
- The fundraising will continue towards the end of 2009 when refurbishment planning will begin
- Many important local partners have supported the Trust's charitable efforts. Kettering Borough Council is making the annual town Fun Run an event that will support the Appeal.
- Staff at KGH are also actively supporting the Appeal a notable effort is staff who
  have signed up to take part in the Three Peaks Challenge
- It is hoped that this appeal will be the first of many and that Fundraising will continue to play a key part in the development and modernisation of the Trust.

# Working to improve the quality of our care

#### Introduction

In July 2007 the Prime Minister asked Lord Darzi to develop a review to set the national direction for the NHS for the next ten years. The NHS Next Stage Review was carried out across the country with a wide-ranging consultation focussing on the views of NHS staff and the communities they serve.

Ten strategic visions were developed by the ten Strategic Health Authorities across England and all of these fed into the national review.

In June 2008 the review resulted in a final report called "High quality care for all – the NHS Next Stage Review." This sets out a new agenda for the NHS and – as the title suggests – the theme is to develop high quality care at every NHS facility in England.

# Quality at Kettering General Hospital

Kettering General Hospital had already carried out its own research (see page 18-19) into what local people and staff thought were the most important aspects of care for them.

The findings of "High quality care for all" and the Trust's own local research findings are very similar. Both emphasise the need to improve the patient's overall experience of care, for it to be personalised, safe, convenient and developed in partnership with local people. Both aim to make quality "the beating heart" of the Kettering General Hospital experience.

The Trust plans to take quality issues forward by developing a Patient Experience Strategy with its Foundation Trust Council of Members. This will ensure that the Trust is developing its care in areas which local people feel are important to them.

The Trust is focussing on the three elements of quality outlined in "High quality care for all" namely:

- Safety
- Patient Outcomes
- Patient Experience.

The Trust has developed these into a **Quality Report** which it will report on throughout the year and monitor through its Health of the Trust Report (HOTT) which is discussed at monthly Board of Directors meetings and Council of Members meetings. This is the first year that such a report has been produced and this is attached to this Annual Report as an accompanying document.

At the end of the year the Trust will publish a Quality Account that will show how it has improved quality of care. (see also Appendix 1 pages 58-71 for more information in the Trust's Quality Report)

# Working to become a top employer

# Healthcare Top 100 - Nursing Times and Health Service Journal

On March 2, 2009, the Trust was named as one of the UK's top 100 healthcare employers in a rating produced by the Nursing Times and Health Service Journal. The Trust made the grade because staff rated the Trust highly in the areas of work life balance, relationships at work, engagement, having a healthy workplace and promoting diversity.

The Nursing Times/HSJ, backed by NHS Employers, gave every NHS trust and healthcare organisation in England, Scotland, Wales and Northern Ireland an opportunity to survey their entire workforce and find out how nurses and other staff felt about working for them. NHS hospitals, Primary Care Trusts, the private sector, nursing and residential homes, hospices, charitable organisations and the armed forces were all invited to enter the event.

The results, produced in collaboration with the Nursing Time's sister title HSJ and independent pollsters Ipsos MORI, highlighted organisations which go the extra mile in looking after their staff and ensuring they maximise their individual potential.

The Trust achieved a creditable 88<sup>th</sup> position in the top 100 and hopes to improve on this significantly in next year's event. Taking part in the evaluation meant the hospital had to answer questions about what it did as an organisation for its staff and its staff were independently sent questionnaires on their experience. Some staff were independently telephoned by Ipsos Mori. The hospital will receive a certificate and a logo which it can use to highlight its achievement.

## **National Staff Survey 2008**

The Trust performed well in a national NHS Staff Survey released on April 8, 2008. The Trust achieved high levels of performance (in the top 20% of Trusts in England) in 6 key areas (out of 26) and was close to this high level in a further two areas. It was in the middle 60% of Trusts in 16 areas and in the lowest 20% of Trusts in two areas.

The NHS Staff Survey is a national survey carried out each year by the Healthcare Commission and is designed to help Trusts to improve the working lives of their staff by identifying areas in need of further development.

( www.healthcarecommission.org.uk/staffsurveys )

The survey was carried out at Kettering General Hospital in October 2007 and surveys were sent to a random selection of 839 of the hospital's 3,180 staff. The results are based on 441 completed surveys. The results form part of the Trust's Annual Health Check rating (see page 11).

#### Staff development

The Trust is one of the largest employers in Northamptonshire and is constantly looking for new ways to develop the skills, and improve the working lives, of its workforce. The Trust has 3,340 staff employed across a very wide range of departments including doctors, nurses, midwives, healthcare assistants, healthcare scientists, chefs, housekeepers, porters, computer experts, finance, administration workers, and switchboard, diagnostic testing and human resources staff. In 2007-2008 the Trust carried out an audit to monitor how many of its staff have had an appraisal and a national Knowledge and Skills Framework outline developed around their role. Actions are now in place to ensure that staff undertake an annual appraisal. A number of groups have now been established to take forward these plans and staff from across the Trust will be encouraged to participate and contribute their ideas.

# Working to become a top employer

## **Talent Management**

The Trust has in place a Talent Management Development programme to support the development of senior managers, aspiring leaders and employees with outstanding potential. The Trust also supports the Leadership Development programme being developed by the Strategic Health Authority. This systematic approach to talent and leadership planning is in line with the Department of Health's ambition to develop first class leaders across the NHS.

# Signing the Skills Pledge - January 2009

On January 28, 2009 the Trust's Chief Executive, Dr Mark Newbold, signed a "Skills Pledge" to support all of the Trust's employees who want to develop basic skills. The Skills Pledge is a Government initiative designed to ensure that anyone who wants to improve their literacy, numeracy, and general education up to GCCE level has the opportunity to do so in line with the needs of the organisation they work for. Employers like Kettering General Hospital make the pledge to encourage and support their employees in gaining relevant skills and qualifications up to level 2 – the equivalent of 5 good GCSEs. The Skills Pledge is part of a Government initiative to improve the skills of the workforce across Britain to improve productivity and meet the needs of the competitive international market place.

#### Existing staff communication and consultation channels

The Trust has developed a comprehensive workforce strategy as part of its work to become a Foundation Trust. This strategy is closely linked to the Trust's plan to deliver high quality healthcare for its local population. Work programmes have included staff involvement and communication; recruitment and retention; new ways of working; developing a healthy workplace and actions related to the staff survey.

The new workforce strategy work is in addition to the existing channels of communication the Trust's management has with its staff which include arrangements such as a joint staff and management committee (Joint Staff Consultative and Negotiating Committee) and an annual staff opinion survey.

Close working arrangements have been developed with the staff side (unions). The Trust has robust routine corporate communication arrangements in place including a staff newsletter (Acute News) an e-newsletter, (Newsflash), a report of the Board of Director's meeting (Foundation Trust Board Brief) a staff intranet and regular face-to-face Meet the Chief Executive sessions. These devices also enable Trust employees to stay up to date with the Trust's corporate progress. Regular articles and updates are given on the Trust's Integrated Business Plan, financial performance and general progress through these initiatives and comments and feedback on the Trust's process are encouraged. There are plans to further develop these areas during 2009-2010.

A monthly human resources report is also taken to the Trust's Board of Directors and any issues of concern are considered by appropriate directors for immediate action.

# Equality and diversity

The Trust takes its obligations under Equality Legislation very seriously and its Equality and Diversity Agenda is led by a Non-Executive Director.

The Trust aims to provide fair and equitable treatment to, and value diversity in, its staff, patients and visitors. In doing so it aims to ensure that its actions and working practices comply with both the spirit and intention of the Human Rights Act (1998) and the current Equality Act which aims to consolidate all legislation relating to the six strands of diversity i.e. race, gender, disability, religion/faith, sexual orientation and age.

The Trust has continued with its programme of ensuring all staff are trained in recognising and responding positively to equality and diversity issues through its "Appreciating Difference" and "Managing Diversity" programme, the former being standard at staff induction. Equality monitoring is routinely carried out to ensure fair and effective employment practices, including recruitment and selection.

In March 2007 the Trust formed a Community Diversity Group which now comprises of representatives from the local Scottish, Muslim, Polish and Hindu community. The group consults with the Trust on policies, health care needs, and patient services. The Trust also has a long established (1997) Disability & Sensory impairment group which works jointly with local representatives of this community to improve facilities and access to services for the public and members of staff. (see also page 21)

The Trust has trained 252 staff in equality impact assessments to ascertain that there is no adverse impact within its policies. More than 760 documents had been assessed at March 31, 2009.

This work, which relates to the Race Equality Scheme, was followed in 2007 by attention to the Disability Equality Scheme and, in March 2008, to the Gender Equality Scheme. The three schemes are now being drawn together into a single Equality Scheme.

In December 2008 the Trust initiated staff training in all six strands of diversity, as well as human rights, to ensure that it takes account of these factors in everything that it does. Where appropriate equality impact assessments will include public consultation to ensure that the Trust invests its resources in line with the spirit and intention of Government policy on patient centred quality care.

The Trust is committed to reviewing its workforce practices, policies and procedures on an ongoing basis to ensure that they take our equality and diversity commitments into account. It works in partnership with the Employment and Disability Service and participates in national Equality and Diversity projects such as the Department of Health's Proof of Concept initiative. The Trust also encourages its staff to participate in national Equality and Diversity developmental programmes.

The Human Resources department works closely with Occupational Health in ensuring that redeployment options are sought for employees who become disabled and the Trust's Attendance and Redeployment Policy outlines its obligations to make reasonable adjustments for disabled individuals. All recruiting managers are required to attend the recruitment and selection training programme to enhance their understanding of equality legislation. The Trust is an accredited user of the national 'two ticks' disability symbol and has in place a guaranteed interview scheme for all disabled applicants who meet the essential requirements for the role. The new Equality Act will inform the Trust's further progress in this area.

#### Sickness Absence

The Trust monitors its sickness absence rates and they are reported to its Board of Directors' meeting on a monthly basis. The rate at March 31, 2008, was 4.34% as a rolling average for the year. In the in month rate itself was 4.00%. The rolling average at March 31, 2009 was 4.46% against the Trust's own target of 4.5%.

# Risk and health and safety

The Trust's Risk Management Strategy was reviewed during 2008–2009 and a number of policies furthering the delivery of staff, patient and visitor safety were also developed or reviewed. The identification of risk, at a local level as well as at a strategic level, has become more comprehensive as a result of the wider use of Local Risk Registers. The wider use of the Operational Risk Register is anticipated to further improve proactive risk management while improvements in incident reporting, analysis and lessons learned processes will improve reactive risk management.

An encouraging indicator of an improving work environment is the reduction in the number of incidents reported to the Health and Safety Executive under the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations (RIDDOR) down to 23 in 2008-2009 from 35 in 2007-2008. Specifically in relation to patients' safety incidents reported to the National Patient Safety Agency, the Trust had less patient accidents than the national average with 23% of all its incidents against 34% nationally. A further good indicator is the fact that of all patient incidents reported, 90% were classed as 'No Harm' against a national average of 70% and, in addition, in all the other classes of harm, the Trust reported less numbers than the national average.

# **Occupational Health**

The Trust provides a comprehensive Occupational Health Service promoting and maintaining the physical and mental well being of staff. It strives to enable employees to achieve their full potential and thus maximise contributions to the objectives of the Trust and improve patient care. This year the team has been joined by a new part time consultant and plans for next year include further development of the counselling services and a fast track physiotherapy service for staff.

# **Counterfraud and Corruption**

The Trust has well established policies and procedures in respect of countering fraud and corruption. The Trust has an accredited Counterfraud Specialist appointed as required by the Secretary of State's directions. The Counterfraud Specialist is accountable to the Finance Director and reports regularly to the Audit Committee. The Trust regularly publicises the work of its Counterfraud Specialist to its staff.

# Research and development

In 2008-2009 Kettering General Hospital researchers recruited to 54 studies. (65% are part of the National Institute of Health Research UK Clinical Research Network portfolio). Patients have been able to participate in 21 (multi-centre) cancer clinical trials or genetic studies. The Trust has developed its portfolio in multi-centre Stroke trials in collaboration with the Trent Stroke Research Network. The Trust is also involved in local studies which aim to improve local practice, and support the professional development of internal and external researchers, through their Masters level research.

#### Information risks and data losses 2008-2009

There was one serious untoward incident involving data loss or breach of confidentiality in 2008/09. The incident, assessed at category 2, involved part of a patient's notes being dropped in the hospital grounds. The notes involved were recovered and Trust procedure and staff awareness reviewed. An audit of the transportation of patient records was already underway at the time of the incident and recommendations of this audit are being implemented. The Senior Information Risk Owner at Board level (as described in the information governance toolkit) is the Director of Strategy & Partnerships, Mike Smeeton, the Caldicott Guardian is Dr Brendan O'Malley, Medical Director. All staff sign up to the Staff Code of Confidentiality and receive mandatory training.

#### Freedom of Information

The Freedom of Information Act 2000 (which came into force on January 1, 2005) requires public authorities to respond to written requests for information within 20 working days. The Trust keeps hard copy and electronic copies of all requests and replies and seeks to respond to them all within the time limit. Requests for information have increased year-on-year from 2005 (25); 2006 (59) 2007 (66) and 2008 (200).

# **Board of Directors**

#### **November 2008 - March 2009**

An effective Board of Directors should lead every NHS Foundation Trust since the Board is collectively responsible for the exercise of the powers and performance of the NHS Foundation Trust.

The Board of Directors has a business focus - developing, monitoring and delivering plans. The Board members have collective responsibility for all aspects of the performance of the Trust including financial performance, clinical and service quality, management and governance.

The Board consists of a Chairman, Senior Independent Director, Chief Executive, Non-Executive Directors and Executive Directors. Its role includes:

- Setting targets, monitoring performance and ensuring the resources are used in the most appropriate way
- Providing active leadership of the NHS Foundation Trust within a framework of prudent and effective controls, which enables risk to be assessed and managed
- Making sure the NHS Foundation Trust performs in the best interests of the public, within legal and statutory requirements
- Responsibility for ensuring the quality and safety of healthcare services, education, training and research delivered by the NHS Foundation Trust and applying the principles and standards of clinical governance set out by the Department of Health, the Healthcare Commission and other relevant NHS bodies
- Being accountable for the services provided and how public funds are used, and exercising those functions effectively, efficiently and economically
- Making sure the NHS Foundation Trust complies with its 'terms of authorisation' set by Monitor
- Having specific duties relating to audit, remuneration, clinical governance, charitable funds and risk assurance
- Deciding the Trust's strategic direction in consultation with the Council of Members
- Setting the Trust's values and standards of conduct and ensure that its obligations to its members, patients and other stakeholders are understood and met.
- Working in partnership with the Council of Members

All members of the Board of Directors have joint responsibility for every decision of the Board of Directors regardless of their individual skills or status. The Trust's Directors are appointed on permanent tenure.

# **Director Biographies**

Under section 17 and 19 of schedule 7 of the National Health Service Act 2006, the Chairman, Chief Executive, Executive and Non-Executive Directors have been appointed to the Trust's Board of Directors. The removal of the Chairman or another Non-Executive Director shall require the approval of three-quarters of the Members of the Council of Members and shall follow the process as described within the constitution.

# Chairman

Steve Hone - Appointed in December 2006

Experience: Managing Director – Steve Hone Consulting Ltd

Managing Director – Spicers Ltd, Cambridge Regional Director/ Acting General Manager – RS

Components Ltd, Corby

Qualification: BSc (Hons) Electrical/Electronic Engineering – Leeds

University

Member Institute of Engineering & Technology

Member Institute of Directors

Advanced Management Studies, Insead, France

# Non-Executive Directors:

Abhai Rajguru - Appointed November 2005

Experience: Managing Partner – Advana Capital LLP (Hedge Fund & Private Equity Fund

Manager)

Non-Executive Director & Audit Committee Chair Simplyhealth Group (Health Insurance Company)

Non-Executive Director, Bluecrest Capital Management (Venture Capital

Firm)

Governor, Northampton College

Formerly Director, Ernst & Young Financial Services Practice

Qualifications: BSc (Hons) Computer Science

MSc Financial Management Systems

**ACMA** 

lan Russell - Appointed November 2005

Experience: Director of Finance, Waltham Forest Health Authority

Chief Social Services Officer, Calderdale Borough Council

Member and Chair of the Audit Committee, Northamptonshire Probation

Board

Mental Health Act Hospital Manager, Northamptonshire Healthcare NHS

Trust

Qualifications: Associate Member Chartered Institute of Public Finance & Accountancy

# Chris Saunby - Appointed November 2005

Experience: RAF Officer (Pilot)

Senior Partner, Tollers Solicitors Part-time Employment Tribunals Judge

Governor Northampton College

Qualifications: Solicitor

Fellow of Chartered Institute of Arbitrators

John Tate - Appointed November 2004

Experience: Board Member

Northampton Probation Board Member

**Probation Service National Negotiating Committee** 

Former Board Member, Peterborough Environment City Trust

Former Managing Director, Viscount Travel

Former Managing Director, United Counties Omnibus Company

Former Executive Director, London Crusader Extensive experience with Industrial Society

Qualifications: M.A (Oxford) in Politics, Philosophy and Economics

Frank Walsh – Appointed August 2007

Experience: Head of Logistics at the Foreign and Commonwealth Office

Operations Director on the Board of Baxter Healthcare U.K. National Distribution Manager for Baxter Healthcare U.K.

Merchant Navy

Experience of Accredited Quality Systems Experience of NHS inventory controls

Qualifications: MBA 2002

Management Diploma 2000 Certificate in Management 1998

# **Executive Directors**

Chief Executive: Dr Mark Newbold, MD FRCpath DipBA - Appointed September

2007

Experience: Managing Director of Rugby St Cross Hospital

**Executive Director UHCW NHS Trust** 

Project Director for Coventry and Warwickshire Acute Services Review

Head of Division and Associate Medical Director, Clinical Services, UHCW

**NHS Trust** 

Clinical Director of Pathology, UHCW NHS Trust Clinician (Consultant Histopathologist) for 16 years

Qualifications: MBChB 1983 University of Birmingham

MRCPath 1989 Royal College of Pathologists

MD 1991 University of Birmingham

Dip BA 1998 University of Warwick Business School

FRCPath 1999 Royal College of Pathologists

#### Chief Operating Officer: Jayne Tunstall — Appointed November 2007

Experience: Director of Operations, Rugby St Cross Hospital and University Hospitals

Coventry and Warwickshire

Turnaround Director, Trauma and Orthopaedics Deputy Director of Operations, Clinical Support

General Manager, Endoscopy, Haematology, Health Records, Outpatients

and Clinical Governance

Senior Manager Local Taxation, Leicester City Council Court Officer, Debt Recovery, Coventry City Council

Qualifications: Diploma, Managing Health and Social Care, De Montfort University

HND in Business Studies, Lanchester Polytechnic, Coventry

NHC in Business Studies

# Medical Director: Brendan O'Malley- Appointed October 2004

Experience: Clinical – General Medicine, Diabetes and Endocrinology from House

Officer to Senior Registrar 1972 – 1989

Appointed as Consultant Physician, Kettering General Hospital in 1990 Managerial – Clinical Director in Medicine October 1996 to October 1997 and

October 2002 to March 2003. Honorary Senior Lecturer

Qualifications: BA Hons (Cantab) 1969

MB BCh (Cantab) 1972

MA

MRCP (UK) 1976 MD (Leicester) 1987

**FRCP** 

Medical Leadership Programme CD5 April 2002

# **Director of Finance: Marcus Thorman** – Appointed December 2008

Experience: Deputy Director of Finance – Kettering General Hospital

Associate Director of Finance – Northamptonshire Healthcare Trust (NHT)

Head of Financial Planning – NHT Development Accountant – NHT

NHS Financial Management Trainee – NHS Graduate Scheme with

Northamptonshire Health Authority, NHT and Northampton General Hospital

Qualifications: CiPFA 1999

BSc Mathematics with Management 1994

#### Director of Nursing & Quality: Liz Libiszewski – Appointed September 2008

Experience: Deputy Chief Nurse working on Workforce Development and Education at

United Lincoln Hospital Trust (ULHT)

Hospital Director of Nursing at Grantham Hospital

Variety of General Management roles United Lincoln Hospital Trust Divisional Nurse Manager for Surgery United Lincoln Hospital Trust

Senior Nurse for Critical Care United Lincoln Hospital Trust

Nursing positions, started training in Nottingham and worked a number of

critical care jobs in nursing

Qualifications: Registered General Nurse

**BSc Hons** 

Post Grad Diploma – HR Leadership 2009

# Non-Voting Directors

# Director of Human Resources & Organisational Development: Geoffrey Etule – Appointed November 2008

Experience: Deputy Director of HR – Hull & East Yorkshire Hospital

HR Manager - University Hospitals Coventry & Warwickshire

HR Officer – City Hospital Birmingham

Personnel Officer - Bradgate Bakery Leicester

Qualification: MSc HR Leadership - 2009

MA Personnel & Development 1999

BA HRM - 1998

Chartered Member of Chartered Institute of Personnel & Development

(CIPD)

# Director of Strategy and Partnerships: Mike Smeeton — Appointed January 2001

Experience: Head of IM&T, Leicester General Hospital

Deputy Director of IM&T, Leicester General Hospital Asst. Director of Contracts, Leicester General Hospital Acute Unit Information Officer, Chase Farm Hospital Information Officer, Basildon & Thurrock Health Authority

Qualifications: BA Hons Combined Studies (Leicester)

James Hayward - Director of Estates - Appointed December 1989

Experience: Hospital Engineer, Royal Hampshire County Hospital, Winchester

Medical Physics Engineer, St. Mary's Hospital, Portsmouth

Former Member of OFWAT Eastern Customer Services Committee

Former Governor Tresham Institute

Qualifications: MA in Health Facility Planning

B Eng (Hons) Environmental Engineering

HNC Mechanical Engineering Certificate in Industrial Management

Chartered Engineer – Registered with the Engineering Council Member, Chartered Institute of Building Services Engineers

Membership of Board/Committees	Board of Directors	Audit Committee	Governance Committee	Nomination & Remuneration Committee	Charitable Funds Committee	PFR Committee
Steve Hone				$\sqrt{}$	$\sqrt{}$	
Mark Newbold						
Marcus Thorman	$\sqrt{}$					
Jayne Tunstall			V			
Brendan O'Malley						
Liz Libiszewski						
Mike Smeeton						
Geoffrey Etule						$\sqrt{}$
James Hayward						
John Tate			V	$\sqrt{}$		
Ian Russell			V	$\sqrt{}$		
Abhai Rajguru	$\sqrt{}$	V		V	V	V
Chris Saunby	$\sqrt{}$			V	V	
Frank Walsh	V	_	V	√ -	V	

# Board of Directors attendance at meetings

(November 2008 – March 2009)

Name	Board							
	7 <sup>th</sup> Nov	12 <sup>th</sup> Dec	23 <sup>rd</sup> Jan	27 <sup>th</sup> Feb	27 <sup>th</sup> Mar			
Steve Hone	√	V	√	√	V			
John Tate	V	<b>√</b>	V	√	V			
lan Russell	<b>√</b>	<b>√</b>	<b>√</b>	<b>√</b>	V			
Abhai Rajguru	V	V	V	<b>√</b>	V			
Chris Saunby	<b>√</b>	V	<b>√</b>	<b>√</b>	V			
Frank Walsh	А	<b>√</b>	<b>√</b>	<b>√</b>	V			
Mark Newbold	V	V	<b>√</b>	<b>√</b>	V			
Jayne Tunstall	<b>√</b>	V	<b>√</b>	<b>√</b>	V			
Marcus Thorman	<b>√</b>	V	<b>√</b>	√	V			
Brendan O'Malley	<b>√</b>	А	<b>√</b>	V	А			
Liz Libiszewski	А	V	V	V	V			

Name	Audit Committee		Charitable Funds Committee		Governance Committee		PFR Committee		Nomination & Remuneration
	19 <sup>th</sup> Dec	25 <sup>th</sup> Feb	23 <sup>rd</sup> Jan	27 <sup>th</sup> Mar	5 <sup>th</sup> Dec	5 <sup>th</sup> Feb	5 <sup>th</sup> Dec	5 <sup>th</sup> Feb	23 <sup>rd</sup> Jan
Steve Hone			√	√					<b>√</b>
John Tate	√	<b>√</b>			√	<b>√</b>			√
Ian Russell	<b>√</b>	<b>√</b>			V	V			А
Abhai Rajguru	√	<b>√</b>	√	√			<b>√</b>	√	<b>√</b>
Chris Saunby			√	√			<b>√</b>	√	√
Frank Walsh					√	<b>√</b>			√
Mark Newbold			<b>√</b>	<b>√</b>					
Jayne Tunstall					Α	А	А		
Marcus Thorman			<b>√</b>	√			<b>V</b>	Α	
Brendan O'Malley			<b>√</b>	√	Α	А	Α		
Liz Libiszewski					√	√			

## Register of Director's interests

The Trust holds a register listing any interests declared by members of the Board of Directors. They must disclose details of company directorships or other positions held, particularly if they involve companies or organisations likely to do business, or possibly seeking to do business with the Trust. The public can access the register at: <a href="https://www.kgh.nhs.uk">www.kgh.nhs.uk</a> or by making a request in writing to:

The Trust Board Secretary
Kettering General Hospital NHS Foundation Trust
Rothwell Road
Kettering
NN16 8UZ

or by emailing: communications@kgh.nhs.uk

## Resolutions of disputes between the Board of Directors and the Council Members

The Board of Directors is working to promote effective communications between Council Members and the Board of Directors. The Chairman of the Trust also acts as Chairman the Council of Members. The Chairman's position is unique and allows him to have an understanding of a particular issue expressed by the Council of Members. Where a dispute between the Council of Members and the Board of Directors occurs, in the first instance the Chairman of the Trust would endeavour to resolve the dispute.

Should the Chairman not be able to resolve the dispute the senior independent director and the vice-chairman of the Council of Members would jointly attempt to resolve the dispute.

Should the senior independent director and the vice chairman of the Council of Members not be able to resolve the dispute, the Board of Directors, pursuant to section 15(2) of Schedule 7 of the 2006 Act, will decide the disputed matter.

# The operation of the Board of Directors and Council of Members including high level statement of decisions taken by each.

The Board of Directors and Council of Members recognise the importance of the operational relationship of both forums. The opinion of the Council of Members will be sought by the Board of Directors on all strategic issues considered by the Trust. The Council Members are invited to discuss issues in detail at the Council of Members meetings and advise the Chairman of their views. The Chairman ensures their views are considered at the Board of Directors meeting as part of the decision making process.

#### **Board Sub-Committees**

The Board of Directors has delegated decision-making authority to the Governance Committee, the Performance Finance & Resources Committee, the Nomination & Remuneration Committee, the Audit Committee and the Charitable Funds Committee. These committees are required to provide the Board with written minutes of their proceedings.

## **Audit Committee**

The membership of the Committee during 2008 - 09 consisted of:

Mr Ian Russell – Non-Executive Director Mr John Tate – Non-Executive Director Mr Abhai Rajguru – Non-Executive Director

The committee receives reports from internal and external auditors and undertakes detailed examination of financial and value for money reports received by the Board of Directors.

The committee's terms of reference are as follows:

- Monitor the integrity of the financial statement of the Trust and any formal announcements relating to the Trust's financial performance;
- Monitor governance, risk management and internal control;
- Monitor the effectiveness of internal audit function;
- Review and monitor external audit's independence and objectivity and the
  effectiveness of the audit process. Develop and implement policy on the employment
  of the external auditors to supply non-audit services;
- Review of standing orders, financial instructions and scheme of delegation. Review of schedule of losses and compensation;
- Review of the annual counterfraud report
- Provide assurance to the Board of Directors on a regular basis;
- Report annually to the Council of Members, identifying any matters in respect of which it considers that action or improvement is needed

The committee meets at least five times a year. Each meeting considers the business that will enable the committee to provide assurance to the Board of Directors that systems and processes in operation within the Trust are functioning effectively.

The Audit Committee reviews the arrangements by which staff of the Kettering General Hospital NHS Foundation Trust raise issues of concern in confidence about possible improprieties in matters of financial reporting and control, clinical quality, patient safety or other matters. The review includes consideration of the proportionate and independent investigation of such matters and appropriate follow up action.

The Council of Members undertook the appointment of the external auditors during 2008. The Audit Commission were awarded the contract, which came into effect from November 2008. The appointment was for two years and five months.

#### **Audit Committee Activities**

The list of activities below shows some of the work the committee has undertaken during the year, it has:

- Considered 29 internal audit reports and reviewed the recommendations associated with the reports;
- Reviewed the progress against the work programme for internal and external audit and the counter fraud service
- Considered the annual accounts and associated documents and provided assurance to the Board of Directors:
- Considered and approved various ad hoc reports about the governance of the Trust;
- Promoted the counter fraud service:
- Received the quarterly reports from Monitor;
- Provided continuing monitoring of the financial status of the Trust;

#### **Audit Confirmation**

The Trust's Directors can confirm, both individually and as a group, that there is no relevant audit information of which the auditors of this report are unaware. Directors have taken all reasonable steps to make themselves aware of any relevant audit information and to establish that the auditors are aware of that information.

The appointment of the Trust's external auditor was approved by the Council of Members in line with the NHS Act 2006.

## **Governance Committee**

This committee was established to support the Board of Directors in discharging their responsibilities by providing objective assurance that processes are in place across the Trust to ensure high quality clinical services are provided. Its main duties are defined in its terms of reference and include:

- 1. To provide leadership and be accountable for all matters relating to governance including the preparation of an Annual Quality Governance Report.
- 2. To oversee the relevant activities of the subgroups i.e. Quality Governance Board, including responding to any significant issues highlighted through the subgroups.
- 3. To monitor the response to significant and extreme clinical risks and quality issues and advise the board on any actions that may be required to safeguard standards of care and improve quality of service.
- 4. To require assurance that the programmes of work in place for corporate governance:
  - a) meet the national regulatory compliance framework
  - b) are of a sufficiently high standard to ensure delivery of the Trust's strategic objectives
  - reflect best practice, national policy and guidance and
  - d) provide evidence that lessons for clinical practice are systematically learnt and implemented.
- 5. To oversee the Trusts progress in the preparation and participation in external reviews including Healthcare Commission activities, Standards for Better Health declaration and National Health Service Litigation Authority assessments. Provide assurance that processes are in place to make progress and take action in order to meet requirements in line with these.
- 6. To monitor through regular reporting the adequacy of systems for corporate research and information governance and to encourage continuous improvement in these areas.
- 7. To monitor and review the Committees work programme in line with the priorities within the Trust's Assurance Framework.
- 8. To take due account of the views of the Trusts membership, as expressed through the Council of members, on matters relevant to the work of the Committee.

In addition, the committee received the following reports:

- Quarterly clinical standards and governance report
- Research strategy 2007 and research annual report
- Medicines management annual report
- Library services annual report
- Maternity risk management strategy

## Performance, Finance & Resources Committee

The overall duty of the Committee is to provide assurance to the Board that the Trust is fulfilling its statutory duties and business objectives in respect of financial management and service delivery. It will review business plans before submission to the Board, assess and manage the risks of non-delivery, monitor performance against the plans and decide upon corrective measures as appropriate.

#### **PERFORMANCE**

- To advise and be accountable to the Trust Board for all performance management within the Trust.
- To review and amend where appropriate the content of the Health of the Trust Report.
- To ensure that performance management principles and processes are embedded throughout the Trust in order to drive improvement in service delivery.
- Monitor strategic priorities, including review of Assurance Framework, as appropriate to the work of the Committee.
- To annually review the Trust Performance Management Strategy
- To ensure that the Trust Board is fully briefed on emerging performance management requirements, taking into account local and national policy initiatives.

#### **FINANCE**

- Financial Planning
- Financial Management
- Financial Reporting

### **BUSINESS**

- Review existing services to assess value for money and contribution to the Trust
- Consider proposals for new business developments consistent with the vision and objectives of the Trust.
- Commission market analysis and testing of new business development proposals
- Review the findings of activity and financial modelling and due diligence testing of new business proposals
- Make recommendations to the Board on new business opportunities

## **RESOURCES**

- To approve the annual capital plan for onward submission to the Trust Board
- To receive reporting on scheme progress against timescales
- Approve capital business cases for schemes below £350,000 in accordance with the Scheme of Delegation.
- Consider any reports into scheme variations/cost over-runs in excess of 5% or £20,000 whichever is the higher amount.
- Consider capital scheme benefits realisation reports for schemes above £1million in value.
- To monitor the implementation of the Workforce Strategy.
- Review workforce plans before submission to the Board.
- Monitor workforce performance against the plan, identifying the impacts on financial and operational performance
- To monitor the implementation of the IM&T Strategy
- Review project plans and monitor implementation of major ICT Projects
- Monitor the delivery of benefits from ICT implementation

## Nomination & Remuneration Committee

A Nomination & Remuneration Committee determines the appointment and remuneration of the Chief Executive and Executive Directors.

The membership of the committee during 2008/09 was as follows:

Mr Steve Hone Mr Frank Walsh Mr Chris Saunby Mr John Tate Mr Abhai Rajguru Mr Ian Russell

The committee met in January 2009 to consider the remuneration of the Chief Executive and Executive Directors. Further details of the working of the remuneration committee are within the remuneration report on page 56-57 of the annual report.

A process for the appointment of the Chairman and Non-Executive Directors is the responsibility of the Appointments and Remuneration Committee of the Council of Members. An external consultant will be engaged to assist the committee in the process.

## Charitable Funds Committee

The committee is responsible for making sure money donated to the hospital is spent wisely. The committee's terms of reference identify the following duties:

- Administration of all existing charitable funds
- To identify any new charity that may be created (of which the Trust is Trustee) and to deal with any legal steps that may be required to formalise the Trusts of any such charity
- Provide guidelines in respect of donations, legacies and bequests, fundraising and trading income
- Responsibility for the management of investment of funds held on Trust
- Ensure appropriate banking services are available to the Trust
- Prepare reports to the Trust Board including the Annual Accounts

The accounting records and the day-to-day administration of the funds are dealt with by the finance department located at Kettering General Hospital NHS Foundation Trust, Rothwell Road, Kettering, Northants, NN16 8UZ.

The membership of the committee during 2008/09 was as follows:

Mr Steve Hone Mr Chris Saunby Mr Abhai Rajguru Mr Frank Walsh

## Code of Governance

Monitor published the code of governance at the end of October 2006. The code was released on a 'comply or explain' basis. The Trust reviewed its governance arrangements in light of the code.

The Board of Directors will seek to apply the main and supporting principles of the NHS Foundation Trust Code of Governance. The Trust will regularly review its governance arrangements against those laid down within the Code of Governance.

## Information, Development and Evaluation

The information received by the Board of Directors and Council of Members is timely, appropriate and in a form that is suitable for members of the Board and Council to discharge their duty.

The Trust runs an induction programme for Council of Members and Non-Executive Directors. All Council of Members and Non-Executive Directors are given the opportunity to attend a number of training sessions during the year.

The Council of Members has to agree the process for the evaluation of the Chairman and Non-Executive Directors and has agreed the process for appointment or re-appointment of the Non-Executive Directors.

The Chief Executive evaluates the performance of the Executive Directors on an annual basis and the outcome is reported to the Nomination & Remuneration Committee.

#### Insurance Cover

The Trust has insurance arrangements through the NHS Litigation Authority (NHSLA) to cover the risk of legal action against its Directors and officers.

### **Code of Conduct**

The Board of Directors operates a code of conduct that builds on the values of the Trust and reflects the high standards of respect, fairness, dignity and individual need. The Board of Directors follows the policy of openness, integrity and transparency in its proceedings and decision-making wherever possible and has clear guidance when a potential conflict of interest occurs and how that should be dealt with.

## Related Party Transaction

Under Financial Reporting 8 'Related Party Transactions', the Trust is required to disclose, in the annual accounts, any material transactions between the NHS foundation Trust and members of the Board, members of the key management staff or parties related to them.

Any such disclosures can be found in the annual accounts for the period November 2008 – March 2009.

## Council of Members

Every NHS Foundation Trust is required to have either a Board or Council of Members; Kettering General Hospital NHS Foundation Trust has a Council of Members which is responsible for representing the interests of NHS Foundation Trust members, and partner organisations in the local health economy.

As a public benefit corporation the Trust is accountable to the local people and staff who have registered for membership and to those elected to seats on the Council.

The Council's roles and responsibilities are outlined in law and detailed in the Trust's constitution.

During the financial year ending 31 March 2009 the Council met twice to discuss and comment on a number of aspects of the functioning of the Trust.

The Council's prime role is to represent the local community and other stakeholders in the stewardship of the Trust. It has a right to be consulted on the Trust's strategies and plans and any matter of significance affecting the Trust or the services it provides.

The Council is specifically responsible for the:

- Appointment and removal of the chairman and other Non-Executive Directors
- Approval of the appointment of the chief executive
- Appointment and removal of the external auditors.

The Council will consider and receive:

- The annual accounts, auditors' report and annual report
- Views from staff and community members on matters of significance affecting the Trust or the services it provides

The Council of Members elected and appointed to the Council act in the best interest of the NHS Foundation Trust and adhere to the values and code of conduct of the Trust.

The Council holds the Board of Directors to account for the performance of the Trust.

The Council of Members has regularly received details of significant projects and strategies, which the Council discusses before the Board of Directors (BoD). In this way comments from the Council are taken into account by the BoD in discussions and decision-making.

## **Elections**

The 'returning officer' role is undertaken by the Association of Election Administrators who act as returning officer - to ensure they are independent and impartial.

In 2008, the Association of Election Administrators oversaw the Trust's elections in all six of our public constituencies.

Partner organisations appointed their representatives on the Council.

## **Election Turnout**

The turnout rates for the initial elections were as follows:

## Public Member elections October 2008

Constituency	Number of seats	Number of candidates	% Turnout at Poll	
Kettering	6	15	21.3%	
Corby	4	2	Uncontested	
Wellingborough	4	1	Uncontested	
East Northants	5	6	19.3%	
Harborough	1	1	Uncontested	
Daventry & Northampton	1	0		

The new Council Members took up their seats on the Council on the 1<sup>st</sup> November 2008.

Appointments were made on a two year and three year term for continuity purposes.

## Public By-Election December 2008

Constituency	Number of Seats	Number of Candidates	% Turnout at Poll
Corby	2	6	16%
Wellingborough	3	4	17.5%
Daventry & Northampton	1	1	Uncontested

## Staff elections October 2008

Constituency	Number of seats	Number of candidates	% Turnout at Poll	
Medical & Dental	1	2	34.1%	
Nursing & Midwifery	2	3	27.6%	
All Other Clinical	1	0		
Non Clinical	1	1	Uncontested	

The Trust did not receive any nominations from staff for 'Other Clinical'. To be legally constituted, the Trust had to have at least 1 member of staff in each class by the 1<sup>st</sup> November 2008. The Board decided to merge the classes – Nursing & Midwifery and Other Clinical, giving that class 3 seats by the time of the by-election.

## Staff By-elections October 2008

Constituency	Number of seats	Number of candidates	% Turnout at Poll
Nursing & Midwifery Other Clinical	1	3	25.5%
Non Clinical	1	2	27.8%

These appointments were made on a three and two year terms.

#### **Board assurance**

The Board of Directors confirms that elections were held in accordance with the rules stated within the Trust's constitution. This is verified in the election report of October 2008 and December 2008, as follows:

"... This concludes my report of the voting in the above election. The election was conducted in accordance with the rules and constitutional arrangements as set out previously by the Trust, and Association of Election Administration (AEA) is satisfied that these were in accordance with accepted good electoral practice. I further confirm that all candidates were eligible for the constituency in which they stood...'

Gina Armstrong Returning Officer On behalf of Kettering General Hospital NHS Foundation Trust

## **Promoting Elections**

The Trust will continue to work to promote its elections and to encourage greater interest and turnout. It will:

- Work with AEA (Trust's independent scrutineers) to adopt fair electoral procedures that encourage participation of all active members
- Maintain guidelines for running elections, including policies on canvassing, election expenses and election material
- Work with local media and other organisations (such as local Councils) to feature elections and the public Council role in newspaper, magazine and radio media
- Organise election briefing opportunities for members who are potential governor candidates
- Ensure <u>all</u> members are fully informed about elections and the opportunity to become a Council Member

## Our Council Members - Public Council Members

MEMBER	BODY/CONSTITUENCY
	Chris Pallot
APPOINTED	Northamptonshire Primary Care Trust
MEMBERS	Cllr Rosemary Bromwich
	Northamptonshire County Council
	Cllr Mark Pengelly
	Corby Borough Council
	Cllr Andy Mercer
	East Northants Council
	Cllr Maurice Bayes
	Kettering Borough Council
	Cllr Alistair Swatridge
	Harborough District Council
	Cllr Barbara Ainge Wellingborough Borough Council
	Sue Allen
	The University of Northampton
	To be confirmed
	The University of Leicester
	Sir Patrick Walker
	North Northants Development Company
	Pat Jackson
	Northamptonshire Local Involvement Network
	Rosemary Hadaway
	Nene Valley Community Action (Voluntary Sector)
	Mags Maquire
	Corby VCS Ltd
	Andrew Steel
ELECTED	Medical Practitioners & Dental Practitioners
STAFF	Margaret Paragreen, Jonathan West, Carolyn Ginns
MEMBERS	Nursing, Midwifery & Other Clinical
	Paul Fantini. Geoffrey Sergison.
	Non Clinical Staff Frank Adams, Elizabeth Cairney, Priscilla Davies, Alexander Gordon, David Moody,
PUBLIC	Glenda Weston
ELECTED	Kettering
MEMBERS	Gordon Reynolds, Kenneth Elms, David Bradford, James McKechnie.
MEMBERO	Corby
	Marian Holloman, Eunice Jones, Jim Morrison, Sheila White, Emma Wilson.
	East Northamptonshire & Bedford
	Paul Bell, Martin Adams, Jennifer Dixon, Katherine Forsdyke
	Wellingborough
	Peter Radcliffe
	Harborough District
	Ian Pridding
	Daventry & Northampton

# Attendance at the Council of Members meeting during the year November 2008 – March 2009

A record is kept of the attendance of Council Member meetings. Below is a table showing, which Members have attended during the year.

Council Members	27 <sup>th</sup> Nov	19 <sup>th</sup> Feb	Total
Chris Pallot	V	Α	1
Rosemary Bromwich	V	√	2
Mark Pengelly	Α	Α	0
Andy Mercer		Α	0
Maurice Bayes	V	1	2
Alistair Swatridge		1	1
Barbara Ainge	V	1	2
Sue Allen	V	1	2
To be confirmed			
Patrick Walker	Α	<b>√</b>	1
Pat Jackson	V	<b>√</b>	2
Rosemary Hadaway	V	<b>√</b>	2
Mags Maquire	Α	Α	0
Andrew Steel	V	√	2
Margaret Paragreen	Α	Α	0
Jonathan West	V	√	2
Carolyn Ginns		Α	0
Paul Fantini	V	√	2
Geoffrey Sergison		√	1
Frank Adams,	V	<b>√</b>	2
Elizabeth Cairney	V	<b>√</b>	2
Priscilla Davies	V	√	2
Alexander Gordon	V	<b>√</b>	2
David Moody	V	√	2
Glenda Weston	V	√	2
Gordon Reynolds	V	√	2
Kenneth Elms	V	√	2
David Bradford		√	1
James McKechnie.		√	1
Marian Holloman	V	√	2
Eunice Jones	V	Α	1
Jim Morrison	Α	√	1
Sheila White	V	√	2
Emma Wilson	V	√	2
Paul Bell	Α	A	0
Martin Adams		<b>√</b>	1
Jennifer Dixon		<b>√</b>	1
Katherine Forsdyke			0
Peter Radcliffe	V	√	2
Ian Pridding		<b>√</b>	1

 $<sup>\</sup>sqrt{\,$  - Attended

A - Apologies

## Register of Council Interests

The Trust holds a register listing any interests declared by members of the Council of Members. Members must disclose details of company directorships or other positions held, particularly if they involve companies or organisations likely to do business, or possibly seeking to do business with the Foundation Trust. The public can access the register at: <a href="https://www.kgh.nhs.uk">www.kgh.nhs.uk</a> or by making a request in writing to:

The Trust Secretary
Kettering General Hospital NHS Foundation Trust
Rothwell Road
Kettering
Northants
NN16 8UZ

or by e-mailing: sharan.madeley@kgh.nhs.uk

## **Council Expenses**

Council Members are not remunerated, but are entitled to claim expenses for costs incurred while undertaking duties for the Trust as a Council Member, (ie. travel expenses to attend the Council meeting).

## Related party transactions

Under Financial Reporting 8 "Related Party Transactions", the Trust is required to disclose, in the annual accounts, any material transactions between the NHS Foundation Trust and Members of the Council or parties related to them.

There were no such transactions for the period April 1 2007 to March 31 2008.

## Other Key Committees

The committees listed below also play a key role in the running of the Council of Members:

- Appointments & Remuneration Sub Committee
- Membership Sub Committee
- Audit & Finance Sub Committee
- Patient Experience Topic Group
- Training & Development Topic Group
- Strategy & Marketing Topic Group

## Membership

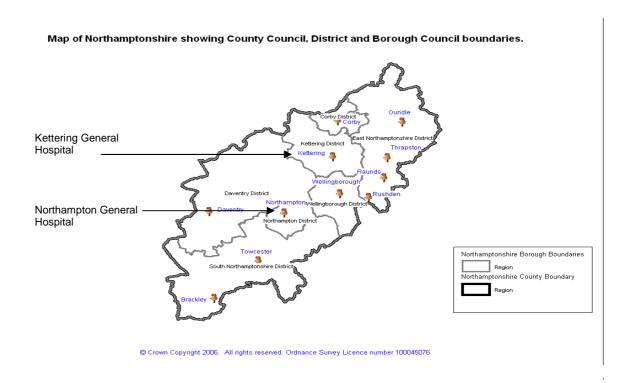
## Foundation Trust Membership

The Trust has two constituencies – staff and community. It does not host a patient constituency.

## Community Membership Eligibility

The Trust's available public constituency is defined as 'those people aged 16 and over living in specific wards of local authorities within the area'. It represents a catchment population of over 400,000 - with more than 350,000 people eligible for Foundation Trust membership:

During 2007/08, residents of the Kettering, Corby, Market Harborough, Wellingborough, East Northants and Daventry & Northampton were eligible for membership of the NHS Foundation Trust (see map below):



Eligible population information and community membership breakdown at 31<sup>st</sup> March 2009:

Constituency	Total Numbers of Members	Total Population of Constituency	Number Eligible for Membership (aged 16 years & over)	Number of Members as a % of Eligible Population
Kettering	1113	81,844	65,033	1.7
Corby	554	53,174	41,151	1.3
Wellingborough	759	72,519	57,087	1.3
East Northants	878	76,550	60,344	1.5
Harborough	111	81,300	65,100	0.2
Daventry	76	71,838	56,419	0.1
Northampton	87	194,458	163,865	0.1
<b>Total Members</b>	3578	631,683	508,999	6.2

## Our community membership by age at 4<sup>th</sup> March 2009:

Age	Kettering	Corby	Wellingborough	East	Harborough	Daventry	Northampton
				Northants			
16 – 21	46	21	27	14	39	37	10
22 – 44	397	204	299	324	39	31	48
45 – 64	368	186	233	282	36	21	24
65+	274	132	185	238	31	17	10
Unknown	27	11	15	20	5	1	5
Total	1113	554	759	878	111	76	87

## Age representation at 31st March 2009:

Age	Number of Members	Representing % of current membership
16 – 44	1456	40.8
45 – 64	1150	32.1
65+	887	24.8
Unknown	84	2.4
Total	3578	100.0

## Our membership by ethnicity at 31st March 2009:

Ethnicity	Kettering	Corby	Wellingborough	East	Harborough	Daventry	Northampton
				Northants			
White	1017	533	656	855	98	51	39
Mixed	9	4	8	2	2	6	5
Asian	36	1	58	9	3	13	23
Black	14	9	25	2	1	1	11
Chinese	5	0	6	0	3	3	3
Unknown	32	7	6	10	4	2	6
Total	1113	554	759	878	111	76	87

## Our membership by gender at 31st March 2009:

Gender	Kettering	Corby	Wellingborough	East Northants	Harborough	Daventry	Northampton
Male	418	218	311	351	50	36	36
Female	694	336	448	527	61	39	51
Not	1	0	0	0	0	1	0
Stated							
Total	1113	554	759	887	111	76	87

All our population figures are based on figures from the Census 2001.

## Socio-economic report of our membership at 31<sup>st</sup> March 2009:

	Wellingbo	rough	Corby Ketter		Kettering		East Northants	
	% Eligible	Recruited	% Eligible	Recruited	% Eligible	Recruited	% Eligible	Recruited
Rank of IMD (where 1 is most deprived)								
0 - 6496	12.23	105	25.3	125	7.91	63		0
6497 – 12992	25.2	180	38.82	205	18.25	185	9.55	69
12993 – 19488	11.9	81	18.14	112	19.16	230	21.63	186
19489 – 25984	27.49	183	11.98	33	23.31	193	26.55	213
25985 - 32482	23.18	174	5.76	32	31.37	378	42.27	371
Others	0	36	0	47	0	64	0	39

## Membership Strategy

The Trust continues to believe that membership should be 'voluntary' – to show definite willing and interested participation. The Council of Members, through the Membership Sub-Group, has the responsibility of monitoring the implementation of action plans to ensure the Trust continually engages with, and increases, its membership and that membership is representative. Members wishing to communicate with the Council of Members/Board of Directors will be able to do so by contacting the Trust Board Secretary on 01536-491362.

## Financial Review

## **Summary Financial Performance**

The Trust has had another strong year financially ending the period with a surplus of £3.5million, £0.1million for the five months as a Foundation Trust. This reported position includes an impairment of £1.4million, which is a non-cash, non-operational charge relating to the downward valuation of the Trust's building assets. If this item was excluded then the reported financial position of the Trust would be an annual surplus of £4.9million. This is the fourth year in succession that the Trust has reported a surplus, which is a significant achievement in a health economy with historic deficits.

The Trust has continued to deliver the financial savings programme with a target of £4.5million in 2008/09 achieved through good financial management and an increase in clinical activity.

The Trust's cash balance as at 31 March 2009 was £9.2million the majority of which is already committed by the Trust to fund the future capital investment programme.

The Trust was given a financial risk rating of 4 at its inception as a Foundation Trust and this will be the outturn position for the financial year 2008/09.

	2007/08 £m	Period to 31/10/08 £m	Period to 31/03/09 £m	Annual Equivalent £m	2008/09 plan £m
Total Income	146.0	95.2	67.2	162.4	153.0
Operating Expenses	(140.8)	(90.2)	(65.8)	(156.0)	(148.2)
Retained Surplus	2.7	3.4	0.1	3.5	2.0
Cash Balance	5.2	6.3	9.2	9.2	5.0

## **Trust Income**

The majority of the income for the period as a Foundation Trust (£59.2million or 88% of total income) was earned by providing clinical services to NHS patients, under Service Level Agreements (SLA) with Commissioners, principally Primary Care Trusts (PCTs).

The Trust has seen growth against the plan for the period against all points of delivery. The elective growth is due to the continued investment in the Cardiac Centre, whereas the non elective and A&E growth is due to the population increases within the Kettering General catchment area. However, owing to the inclement weather, particularly during February where the region registered the worst snowfall for 18 years, the Trust cancelled 2 days worth of elective and outpatient activity. This equated to £0.3million in reduced income for the Trust, some of which was recovered in March.

The Trust also earned a total of £3.1million from the Strategic Health Authority for providing teaching for undergraduate medical students and to provide further training for post-graduate doctors as well as training for other clinical staff.

## **Trust Expenditure**

The Trust incurs costs that are predominantly associated with the provision of clinical activity. The largest category of expenditure is pay which accounts for 70% of the total. Pay expenditure exceeded the plan for the period due to additional activity, investment in services and the increased use of agency staff due to shortages in key posts, particularly medical staff where there is a national shortage. Drug expenditure is the main non pay item and the Trust had an increase in these costs against the plan too.

The drug cost increase is due to activity changes both volume and case-mix, but is also linked to the increase use of NICE drugs the majority of which are funded through the SLA with the PCT.

## **Delivering Value for Money**

The national tariff had an implied efficiency of 3% and other contracts utilised this amount too. Therefore the Trust had a savings target of £4.5million to achieve in order to deliver the planned surplus for the year, £1.9million of which related to the period as a Foundation Trust. Performance to deliver savings is closely monitored by the Trust and the key themes for this period were:

- Savings from efficiency and productivity reviews
- More effective procurement
- Increasing Trust income

## **Cash Flow and Capital**

The Trust ended the year with a cash balance of £9.2million compared to a plan of £5.0million. The primary reasons for this change are linked to the increased surplus against the plan and an under spend against capital expenditure mainly due as a result of phasing changes to key capital projects.

The Trust invested £6.2million in the capital programme during the year against a plan of £9.7million. This included the first stage of refurbishment of the pathology department (£1.3m), refurbishment of Clifford Ward (£1.2m), the start of the next stage of ward refurbishment with the Harrowden floor (£0.6m), backlog maintenance schemes (£1.6m), start of refurbishment of sterile services (£0.3m), equipment (£0.4m), IT (£0.4m) and other schemes (£0.3m). The capital programme was funded through internally generated resources apart from a successful bid from the national carbon fund of £0.3million and donated assets of £0.2million.

## **The Prudential Borrowing Limit**

As an NHS foundation trust, greater freedoms have been earned to borrow money to finance capital investment. The limits on the amount the Trust can borrow and the conditions that it must meet to demonstrate that the levels of borrowing are affordable are set out in the Trust's Prudential Borrowing Limit (PBL), issued by Monitor, the Independent Regulator of Foundation Trusts.

The PBL sets out five minimum financial ratios that the Trust must meet. The Trust has a PBL of £34.4million, during the reported period, the Trust did not have any borrowing and, as a result, does not have any actual data to report against four of the five PBL ratios, in line with the plan.

**Prudential Borrowing Code Ratio Performance** 

Frudential Borrowing Code Natio Ferrormance						
Debt Cover Ratios	Actual Nov 2008 – Mar 2009	Approved Full Year 2008/09				
Maximum Debt/ Assets Ratio	0	0				
Minimum Dividend Cover	3.1	3.6				
Minimum Interest Cover	0	0				
Minimum Debt Service Cover	0	0				
Maximum Debt Service to Revenue	0	0				

## **Performance Against Monitor's Compliance Framework**

As a Foundation Trust, the Trust is required to demonstrate that it is operating within Monitor's Compliance Framework. The Framework sets out Monitor's approach to regulating Foundation Trusts using a risk based methodology.

A key element of the Framework sets out the approach by which the level of financial risk facing the Trust is assessed and the likelihood that the Terms of Authorisation will be breached.

A Foundation Trust that has a high risk of breaching the financial element of their Terms of Authorisation would achieve a financial risk rating of 1. A low risk would achieve a financial risk rating of 5.

Based on its financial performance for 2008/09, the Trust achieved a risk rating of 4. The table below shows the Trust's performance against the Compliance Framework metrics.

## **Compliance Framework Metric Ratios**

Compilation Francework Metric Ratios					
	2008/09 Annual	2008/09			
	Performance	Plan			
EBITDA Margin	8.7%		7.6%		
EBITDA % Achieved	122.3%		100.0%		
ROA %	8.8%		5.2%		
I&E Surplus Margin	3.1%		1.3%		
Liquidity days	34.6 days		25.0 days		

## **Management Costs**

	FOR THE PERIOD
	<b>NOV 2008 TO MAR 2009</b>
	£000
Management costs (Excluding CEAC staff)	2,578
Income (Excluding CEAC income)	65,977
Management costs as a % of income	3.91%

## **Accounting Policies**

The accounts have been prepared in accordance with guidance issued by Monitor, and in line with UK GAAP (Generally Accepted Accounting Principles). So far as the directors are aware, there is no relevant information of which the auditors are unaware.

In addition, the Foundation Trust has complied with the cost allocation and charging requirements set out in HM Treasury and Office of Public Sector Information guidance

## **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, they continue to adopt the going concern basis in preparing the accounts.

#### **External Auditors**

The Council of Members has approved the continued appointment of the Audit Commission as the Trust's external auditors until 31 March 2011. The Audit Commission were paid £40,134 (Exc. VAT) in respect of statutory audit fees for the period as a Foundation Trust.

## SALARY AND PENSION ENTITLEMENTS OF SENIOR MANAGERS

## REMUNERATION REPORT

November 2008 to N	March 2009				
			Salary (bands of £5000)	Other Remunerati on (Bands of £5,000)	Benefits in kind (travel /lease benefit) (Rounded to the nearest £100)
Name	Title	Start date	£000	£000	£00
Mr S Hone	Chairman	1 <sup>st</sup> Dec 2006	15-20		3
Dr M Newbold	Chief Executive	3 <sup>rd</sup> Sep 2007	65-70		2
Mrs J Tunstall	Chief Operating Officer	12 <sup>th</sup> Nov 2007	45-50		13
Mr M Thorman	Finance Director	7 <sup>th</sup> April 2008	45-50		2
Dr B O'Malley	Medical Director	1 <sup>st</sup> Oct 2004	30-35	35-40	4
Mrs L Libiszewski	Director of Nursing & Quality	1 <sup>st</sup> Sep 2008	30-35		
Mr G Etule	Director of HR & Org Dev	3 <sup>rd</sup> Nov 2008	30-35		
Mr M Smeeton	Director of Strategy & Partnerships	1 <sup>st</sup> Feb 2001	40-45		
Mr A Rajguru	Non-Executive Director	1 <sup>st</sup> Nov 2005	5-10		2
Mr F Walsh	Non-Executive Director	1 <sup>st</sup> Aug 2007	5-10		
Mr I Russell	Non-Executive Director	1 <sup>st</sup> Nov 2005	5-10		
Mr C Saunby	Non-Executive Director	1 <sup>st</sup> Nov 2005	5-10		
Mr J Tate	Non-Executive Director	1 <sup>st</sup> Nov 2004	5-10		2
Senior managers employment	s who have left the Trusts'	Leaving date			
Mr J Hayward	Director of Estates	31 <sup>st</sup> Mar 2009	30-35		1

The Nomination & Remuneration Committee is a sub-committee of the Board which oversees the process for identification and nomination of senior posts including the Chief Executive. Non-Executive Directors, including the Chairperson, are appointed by the Council of Members and can be appointed for a minimum of 3 and a maximum of 7 years. The Appointments & Remuneration Committee of the Council has been appointed to agree a transparent process for the appointment of Non Executive Directors.

The Trust does not have performance-related salaries and the terms and conditions of contracts for its senior managers are subject to the normal terms and conditions of other NHS staff.

The Trust's pension policies are detailed in paragraph 1.15 on page ten of the Trust's published annual financial statements (accounts).

## **PENSION BENEFITS**

Name	Title	Real increase in pension at age 60 (bands of £2500)	Real increase in lump sum at age 60 (bands of £2500	Total accrued pension at age 60 at 31 <sup>ST</sup> March 2009 (bands of £5000)	Lump sum at age 60 related to accrued pension at 31 <sup>st</sup> March 2009 (bands of £5000)	Cash Equivalent Transfer Value at 31 <sup>st</sup> March 2009	Cash Equivalent Transfer Value at 31 October 2008	Real Increase in Cash Equivalent Transfer Value
		£000	£000	£000	£000	£000	£000	£000
Dr M Newbold	Chief Executive	0-2.5	2.5-5	40-45	130-135	832	790	42
Mr J Hayward	Director of Estates	0-2.5	2.5-5	30-35	100-105	727	684	43
Dr B O'Malley	Medical Director	0-2.5	5-7.5	65-70	200-205	n/a	n/a	n/a
Mr M Smeeton	Director of Strategy & Partnerships	0-2.5	0-2.5	15-20	55-60	248	239	9
Mrs J Tunstall	Chief Operating Officer	0-2.5	2.5-5	25-30	75-80	398	382	16
Mr M Thorman	Finance Director	2.5-5	12.5-15	15-20	45-50	203	146	57
Mr G Etule	Director of HR & Organisational Dev	N/A	N/A	5-10	15-20	60	N/A	60
Mrs L Libiszewski	Director of Nursing & Quality	0-2.5	5-7.5	25-30	75-80	449	411	38

As Non-Executive members do not receive pensionable remuneration, there will be no entries in respect of pensions for Non-Executive members.

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, 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.

Signed: Dr Mark Newbold - Chief Executive

Date: June 3, 2009

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# **Kettering General Hospital NHS Foundation Trust**

# Quality Report 2008-09



## **CHIEF EXECUTIVE'S STATEMENT**

I would like to congratulate the staff of KGH on an excellent performance over the past year. Whilst maintaining a sound financial position, and meeting our contractual obligations, we have delivered a high quality service to our patients. We have developed an exciting and innovative quality strategy, starting in the last year and building as we move through the coming months and year. We have identified priorities that are our own, that are important to the community we serve. The coming year will be an exciting one as we start to embed our quality programmes and initiatives and, truly, put quality first.

Dr Mark Newbold, May 2009

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**Chief Executive Kettering General Hospital NHS Foundation Trust** 

## **Quality Narrative**

## Current view of trust's position and status for quality

- During 2008-2009 the Trust carried out a wide variety of initiatives and service improvements designed to improve the overall patient and visitor experience at Kettering General Hospital.
- We achieved an "Excellent" for Quality of Care and "Good" for Use of Resources in the annual health check.
- The Trust achieved NHSLA Level 2 which is an indicator of safe working practices.
- We have greatly exceeded the target reduction in C difficile infection. This is very
  pleasing but we must continue all efforts to further reduce the rate of this infection in
  our hospital.
- Our hospital standardised mortality rate, a previous challenge for us, has continued
  to decline through the year, to a point at which we now have an average rate of 102.
  The Improving Outcomes Group will continue to monitor this, analysing all alerts and
  unexpected deaths, to ensure we thoroughly understand the data and are able to act
  on any concerns raised.
- We continue to perform well in the national patient and staff surveys, and have action plans to improve on the areas of weaker performance over the coming year.
   We also entered for the HSJ / NT 100 Best Employer survey last year, achieving a creditable 88<sup>th</sup> position. This is our baseline from which we aim to improve over the coming year recognising the critical role that good staff management and cultural development will play in delivering an improving quality of service.
- Whilst we continue to receive plaudits from patients for the greatly improved
  cleanliness of our clinical areas, the Hygiene Act visit by the Healthcare Commission
  did find that the cleanliness of some non-patient facing areas could be improved. We
  have therefore made cleaning a major priority for the Board for the coming year,
  aiming to have an exemplar system in place by the year end.

## Overview of organisational effectiveness initiatives

The Trust has three ongoing programmes in place to deliver improved quality:

- Improving Healthcare Together: During the past year a large consumer research programme was carried out to allow us to fully understand the views of our public, and the priorities they would set for us as we work to continuously improve our care standards. Following on from that we have developed a training programme for our staff to help them better understand the needs and wishes of our patients, particularly in the area of delivering an improved patient experience. The first wards are now trained and starting to evaluate the experience of their patients, and this training and evaluation will be rolled out across our hospital over the coming year. Associated with this work is a 'brand' for our hospital which states our values and defines our patient promise of "we will always treat you as a person, always working together, always there for you, always caring for you and always improving"
- Patient Safety Campaign: The Trust signed up to this campaign last year and will implement it fully over the coming year, to include 'safety ward rounds' by directors and senior staff. In addition the Trust has maintained its focus on infection control during 2008-2009, achieving the 2011 target of reducing Trust attributed C difficile by 30% two years early. This equated to having no more than 129 cases by 2011. The Trust had 95 cases in 2008-2009. The Trust aimed to maintain its level of MRSA cases at no more than 11 for the year 2008-2009. At March 31, 2009 the Trust had 12 cases which still meant that it was one of the top performing Trusts in England for MRSA at this time.
- Improving Outcomes Group: This group of clinicians has scrutinised all the data emanating from the Hospital Standardised Mortality Ratio analysis, following up all alerts with a full review of the patient notes. To date, no excess mortality has been identified and, with improved coding, we have seen the ratio fall to 100 during the past year. This group will continue with this work, and widen its remit to include working with the new clinical effectiveness measures we have implemented in our 09/10 Quality Accounts.

## How we have prioritised our quality improvement initiatives

The Trust Board has further developed our Trust objectives for 2009/10. Each objective is underpinned by enabling programmes which will support the deliver of each objective. These build on the work of 2008/09 issues identified through our work with users, staff and our membership.

Key performance indicators have also been developed, to provide self-determined standards the Trust aims to achieve this year against our six strategic objectives. These will be monitored at the monthly Trust Board meetings.

Strategic Objectives	Develop services to meet local need	Provide a clean & modern environment	Establish excellence in service quality	Build confidence amongst stakeholders and local people	Maximise efficiency to ensure best value from our resources	Become a model employer
Enabling programmes	Locality OPD     Darzi –response to NHS East Midlands tendering on:-      PPCI Stroke Major Trauma	Ward Refurbishment Programme Paediatrics Midwifery Led Unit ITU CCU Back log maintenance	<ul> <li>Improving         Healthcare         Together</li> <li>Patient Safety         Campaign</li> <li>Improving         Outcomes         Programme</li> </ul>	Improving     Healthcare     Together	SLM implementation     Service productivity & efficiency programme     Service review (eg. FTN Ophthalmology)     Productive ward     Lorenzo     ERostering	<ul> <li>Improving         Healthcare         Together</li> </ul>
KPIs	Increased market share Increased offsite OP provision, EN (facility 2010) & MH (%inc)  Increased offsite OP provision, EN (facility 2010) & MH (%inc)	Exemplar cleaning service, with award	Nursing award HSMR <100 >5% reduction in cardiac arrests Pt Exp training complete, >10% better satisfaction rates Exemplar complaints service Reduction in medical outliers/ward moves Improved venous thromboembolis m AHC 'excellent'	80% positive column inches	Efficiency measures     Aspires to level 4 finance     Clinical productivity measure – 3 specialties     10% more work in Treatment Centre     E procurement – theatre pilot     SLR all areas     PP unit in TC	■ Top 100 employers – 30% up on 08/09 ■ Sickness absence <4.5% Q3,4

## Our selected priorities and proposed initiatives

In this report, we have highlighted 6 key priorities for the coming year 09/10, and these are detailed on the following pages:

## **Priority 1:**

## To reduce our hospital standardised mortality rates

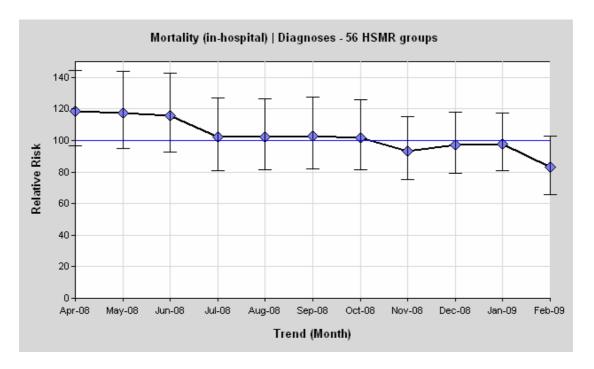
## Description of issue and rationale for prioritising

Our current HSMR is 102.2% with a national average of 100%. This is a significant improvement year on year and the Trust is committed to review and improvement in this area.

#### Aim/Goal

To maintain our HSMR at less than 100 throughout 2009/10

#### **Current Status**



## **Identified Areas for Improvement**

Led by the Trust Medical Director the Improving Outcomes Group will continue to conduct case review wherever an outlier flag is raised by Dr Foster. The group will also focus on particular care areas for review, such as myocardial infarction.

The group will review and adopt tools as part of the Patient Safety Campaign

## **Board Sponsor**

Dr Brendan O'Malley Medical Director

## **Priority 2:**

## Acutely ill patients

## Description of issue and rationale for prioritising

The national Patient Safety Campaign and NICE Clinical Guideline 50 identified recognition and response to acute illness in adults in hospital as a key priority for acute trusts. KGH recognises that whilst some pockets of good practice exist, for example Critical Care Outreach, and use of the Kettering Early Warning System, more needs to be achieved.

#### Aim/Goal

Reduce the number of in-hospital cardiac arrests by 5% by improving our identification of acutely ill patients.

#### **Current Status**

Outreach Team play an active role in supporting clinical staff to identify and treat acutely ill patients.

Kettering Early Warning System (KEWS) is in place.

## **Identified Areas for Improvement**

#### **Identify Deterioration**

- Develop and implement a Trust standard for patient observations
- Develop and implement a competency package for recording/understanding physiological observations
- Further develop the KEWS tool to ensure it is supported by a trigger system

## Respond to Deterioration

- Develop a graded response strategy
- Put in place an escalation protocol
- Implement a communication tool

## **Board Sponsor**

Liz Libiszewski Director of Nursing & Quality

## Implementation Lead

Dr Watt Consultant Anaesthetist Andy Chatwin Critical Care Outreach Lead Nurse

## **Priority 3:**

## Complaints handling

## Description of issue and rationale for prioritising

New instructions issued by the Dept of Health NHS England Complaints Regulation 2009 require the NHS to provide a more responsive complaints service where the needs of the complainant are met.

#### Aim/Goal

To provide an exemplar complaint service

## **Current Status**

The Trust currently complies with the old guidance and has put temporary arrangements in place to ensure a timely and responsive service.

## **Identified Areas for Improvement**

To engage with the Council of Members to define and describe an exemplar complaints service.

To invite a peer review once the process is implemented

To ensure that the new system complies with the new legislation on complaints handling.

To ensure that the proportion of complaints that are resolved at the first attempt increases.

To ensure that the new system does not reduce the speed of response.

## **Board Sponsor**

Liz Libiszewski Director of Nursing & Quality

## **Implementation Lead**

Emma Payne Patient Experience Manager

## **Priority 4:**

## Reduce the rate of venous thrombo-embolism

## Description of issue and rationale for prioritising

Venous thrombo-embolism is thought to be responsible for around 40,000 deaths per year across the UK, as well as causing longer hospital stays and greater treatment costs. The evidence shows that risk assessing patients on admission to hospital can be used to reduce the occurrence of this condition.

## Aim/Goal

To ensure that patients have a risk assessment completed in accordance with the DH guidance, and that where required the appropriate action is taken.

#### **Current Status**

Some patients have their risk assessed but this is not consistently applied across the Trust. Some patients receive mechanical or pharmacological intervention.

## **Identified Areas for Improvement**

Apply risk assessment across the trust and audit compliance with policy. Audit adherence to treatment modalities as described in policy

## **Board Sponsor**

Brendan O'Malley Medical Director

## **Implementation Lead**

Matthew Lyttelton Consultant Haematologist

## **Priority 5:**

## To become a better employer

## Description of issue and rationale for prioritising

Delivering a quality service is dependent upon a well trained and motivated workforce, who operates within a culture in which the behaviours that promote safe, effective, and personal care delivery are both valued and facilitated. To develop this culture requires high standards of leadership and management and the promotion of a consistent set of values and principles.

In 08/09 we were 88<sup>th</sup> in the HSJ / NT Healthcare 100 top employers survey, a good baseline from which to build during the coming year.

### Aim / Goal

To improve our performance in the HSJ / NT Healthcare 100 Top Places to Work survey by at least 30%

## **Identified areas of improvement**

- 1. Leadership on the 'shop floor'
- 2. Opportunities for staff to use their initiative to improve care
- 3. Communications within the organisation
- 4. Promoting a healthy workplace
- 5. Achieving a satisfactory work life balance

## New initiatives to be implemented in 2009-10

- 1. Middle management development through Talent Management programme
- 2. Improved internal communications arrangements
- 3. Establishing a common set of values for all staff through the Improving Healthcare Together programme
- 4. Improved staff recognition and reward schemes
- 5. Opportunities for front line staff to develop their ideas and careers

## **Board Sponsor and Implementation Lead**

Mr Geoffrey Etule, Director of HR and Organisational Development

## **Priority 6:**

## To develop an exemplar cleaning service

## Description of issue and rationale for prioritising

A critical part of our strategy to reduce healthcare-associated infection is to maintain high standards of cleanliness throughout the hospital. This year we are aiming to build on previous improvements to create a hospital that is as clean as it possibly can be. This will impact on both safety and patient experience aspects of quality.

#### Aim / Goal

To create an exemplar cleaning service, as defined by:

- Greater than 95% compliance with performance standards
- Achievement of an award for cleanliness
- Confirmatory report from LINKs inspection
- Confirmatory report from external peer review

## Identified areas of improvement

- 1. Rapid response service to provide greater coverage
- 2. Strengthening of the management team
- 3. Audit process needs to be more comprehensive
- 4. Further improvement of standards in non-patient areas

## New initiatives to be implemented in 2009-10

- 1. Specific patient feedback on ward cleanliness
- 2. Introduction of new individual training manuals
- 3. More comprehensive monitoring system to be introduced
- 4. Wider role for Housekeeping Managers
- 5. Public and external peer inspection to be introduced

## **Board Sponsor and Implementation Lead**

Mrs Jayne Tunstall, Chief Operating Officer

## Response to regulators

The Kettering General Hospital NHS Foundation Trust declaration to the Healthcare Commission indicated our compliance with all of the Standards for Better Health, with the exception of C21. This relates to our Hygiene Act inspection in January 09. A comprehensive action plan is in place and we expect to be fully compliant by the end of May 09.

The Trust is currently on an Amber Governance Rating from Monitor.

We have taken action to respond to regulator reports and examples include:

## 1. Infection Control – MRSA Bacteraemia

In Quarter 3 seven bacteraemias were detected in patients, more than the quarter trajectory of three. This contributed to a Monitor risk rating of 1.5. The Trust had 12 cases for the full year against a full year trajectory of 11; eight of these were acquired before being admitted to hospital. Kettering General Hospital has been working with the Primary Care Trust to ensure that a full investigation is conducted into each case, and that learning from all parts of the patient journey is put into place.

## 2. <u>Infection Control</u>

Following the Hygiene Code inspection, the Healthcare Commission identified as an area of good practice the risk assessment tool developed to identify patients coming into hospital who may be at a higher risk of developing a healthcare associated infection. However, the Healthcare Commission also identified that the Trust was not fully meeting some areas within the duties. The Trust has addressed these issues by greatly strengthening the cleaning schedules and monitoring arrangements for all areas within the Trust.

#### Response to LINks and to feedback from members and council members

As a new Foundation Trust our Council of Members are currently identifying sub committees and areas of interest. Council Members are already participating in our Dignity in Care Steering Group and will become more actively involved as their role develops.

Our patients when surveyed told us that we were above average for the cleanliness of our wards and bathrooms, and that our food was good. However, we need to do more work on our staff not talking in front of the patient as though they weren't there, and improving our information to patients, particularly before an operation and about their medicines.

## **Quality overview**

## Performance of the Trust against selected metrics

We have chosen to measure our performance against the following metrics.

Safety measures reported

		2008/09	2007/08	National Average
1	Clostridium difficile infection rate per 1,000 bed days	0.58	1.13	0.91
2	MRSA rate per 10,000 bed days	0.69	0.63	1.19
3	Elective Screening for MRSA	100%	NA	NA

## **Clinical outcome measures**

		2008/09	2007/08	National Average
5	HSMR	102	111.6	100
6	To reduce the level of emergency readmission to hospital (within 28 days)	12.3%	12.3%	11.7%
7	Thrombolysis – 60 minute call to needle time	78.4%	88.9%	Not known
8	Fractured Neck of Femur patients operated on within 48 hours of admission	78%	78%	Not known
9	Reduction in the level of Caesarean Sections without complications to national average levels	23%	22%	20%

Patient experience measures reported

		2008/09	2007/08	National Average
10	Complaints – maintenance of core standards target	Achieved Complaints reduced by 4.2%	Achieved	
11	% who spend less than 4 hours waiting in A&E	98.2%	98.1%	Not Known
12	A&E survey	Overall improvement in scores		

## NHS Foundation Trusts Clinical Quality and Service Performance

		2008/09	2007/08	09/10Target
1	Compliance with HCC Core Standards and national targets as declared to the CQC	23/24	24/24	24
2	Clostridium difficile year on year reduction	95	185	148
3	MRSA – Maintaining the annual number of MRSA bloodstream infections at less than half the 2003/04 baseline	12	11	10
4	Maximum waiting time of 31 days from decision to treat to start of treatment extended to cover all cancer treatments	99.1%	98.8%	98%
5	Maximum waiting time of 62 days from all referrals to treatment for all cancers (Extended Target)	96.6%	96.4%	95%
6	18 week maximum wait by Dec 08 referral to treatment (admitted pathway)	99.3%	N/A	90%
7	18 week maximum wait by Dec 08 referral to treatment (non admitted pathway)	96.7%	N/A	95%
8	Maximum waiting time of 4 hours in A&E from arrival to admission, transfer or discharge	98.2%	98.1%	98%
9	Maximum waiting time of 31 days from diagnosis to treatment of all cancers	99.1%	98.8%	98%
10	Maximum waiting time of 62 days from urgent referral to treatment for all cancers	96.6%	96.4%	95%
11	People suffering heart attack to receive thrombolysis within 60 minutes of call (where this is the preferred local treatment for a heart attack)	78.4%	88.9%	68%
12	Maximum waiting time of 2 weeks from urgent GP referral to first outpatient appointment for all urgent suspect cancer referrals	99.9%	100%	98%

# Kettering General Hospital MHS

**NHS Foundation Trust** 

ANNUAL ACCOUNTS
2008/2009 (for the period 1<sup>st</sup>
November 2008 to 31<sup>st</sup> March 2009)

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

The National Health Service Act 2006 states that the chief executive is the accounting officer of the NHS Foundation Trust. The relevant responsibilities of 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 accounting officers' Memorandum issued by the Independent Regulator of NHS Foundation Trusts ("Monitor").

Under the National Health Service Act 2006, Monitor has directed the Kettering General Hospital NHS Foundation Trust to prepare for each financial year a statement of accounts in the form and on the basis set out in the Accounts Direction. The accounts are prepared on an accruals basis and must give a true and fair view of the state of affairs of Kettering General Hospital NHS Foundation Trust and of its income and expenditure, total recognised gains and losses and cash flows for the financial year.

In preparing the accounts, the Accounting Officer is required to comply with the requirements of the NHS Foundation Trust Financial Reporting Manual and in particular to:

- observe the Accounts Direction issued by Monitor, 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 Financial Reporting Manual have been followed, and disclose and explain any material departures in the financial statements;

and

prepare the financial statements on a going concern basis.

The accounting officer is responsible for keeping proper accounting records which disclose with reasonable accuracy at any time the financial position of the NHS foundation trust and to enable him to ensure that the accounts comply with requirements outlined in the above mentioned Act. The accounting officer is also responsible for safeguarding the assets of the NHS foundation trust and hence for taking reasonable steps for the prevention and detection of fraud and other irregularities.

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

Date: 3<sup>rd</sup> June 2009

Dr M Newbold, Chief Executive

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#### STATEMENT ON INTERNAL CONTROL

#### 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.

#### 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 2009 and up to the date of approval of the annual report and accounts.

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.

#### 3. Capacity to handle risk

The Trust has continued to progress the findings of the 'Quality Governance Action Plan' building upon the work that commenced in 2007.

The Quality Governance Board underpins the management of risk throughout the organisation and membership consists of the majority of the executive team and senior management drawn from the Clinical Management Teams (CMTs), namely the Heads of Nursing and Associate Medical Directors (AMDs). The Director of Nursing and Quality chairs the Quality Governance Board (QGB). Significant progress has been made to implement the actions around the three core areas within the plan:

### Development of the clinical management teams

- Leadership development for senior managerial and clinical staff has been completed
- The trust-wide appraisal process has been strengthened
- Decentralisation of the complaints process is well under way and examples of learning from complaints are being demonstrated

#### Development of the role and function of the clinical governance team:

- A new structure (Quality Governance Department) has been implemented which focuses on three streams of
  work; learning and improvement, quality and safety and patient experience. This work now seeks to further
  embed governance functions within the CMT's by allocating facilitators to those teams
- The addition of Information Officers also strengthens the provision of meaningful information and trends around clinical governance issues to the CMTs with the focus on actions taken as a result

#### Reporting to the Trust Board

- A complete review of the reporting structures to the board to provide further improvements in assurance and performance management in relation to quality, safety and patient experience
- Improvements in the systems to manage and respond to external reviews
- Strengthening of the risk register process to ensure that the operational and corporate risk registers are subject to regular review through the existing performance and assurance processes

Any issues of major concern are brought to the attention of the Associate Director of Quality Governance and subsequently the QGB.

All managers and staff have a duty to recognise, act on and report risks of all kinds and act upon these within their own skills and competencies in the management of risk

The Clinical Risk Lead provides risk management training for staff as follows:

- Corporate induction programmes
- Medical staff induction programmes
- Trust Board programmes, when appropriate
- · Consent to treatment
- Incident reporting and providing feedback

Risk assessment and health and safety training is provided by the Health and Safety Lead, the Patient Relations Manager provides training on the complaints process.

#### 4. The risk and control framework

Key elements of the Trust's Risk Management Strategy (2008/09) includes an explanation of the Trust's philosophy towards risk management and explanation of the risk management systems in place, together with clear definition of individuals' role and responsibilities. The Strategy outlines the Trust's approach including the following:

- The responsibility of every member of staff to recognise, respond to, report, record and reduce risks whilst they are undertaking work for the Trust
- Risk assessment
- The commitment to continuously improve the delivery and safety of services
- The commitment to identify, manage and minimise events and activities that could result in unnecessary risk to patients
- The environment of honesty and openness, where mistakes and adverse events are identified quickly and dealt with in a positive, responsive and non-adversarial manner
- The requirement for staff to report all accidents and incidents in accordance with the 'Policy and Procedure for the Reporting of Accidents and Incidents'
- · Risk management principles and processes
- Accountability arrangements for risk management
- Governance arrangements

In support of the Strategy, the Trust has a range of key policies that provide clear guidance for staff on how to deal with concerns, complaints, claims, accidents and incidents, on behalf of patients, visitors or themselves.

The Trust has an assurance framework that identifies strategic and operational objectives, risks, key controls in place to manage these, and identifies gaps in control with an action plan to address these. The risks are prioritised and assessed using the Trust's risk grading matrix. Risk assessment processes are undertaken at both the corporate and local level and integrated into the Trust's assurance framework following a structured process to allow for consistency.

Risk management is embedded within the activity of the organisation as follows:

- Effective utilisation and performance management of the Assurance Framework;
- Compliance with external assessments including the Healthcare Commission in relation to the Standards for Better Health and NHSLA;
- · Mechanisms for the reporting of all accidents and incidents;
- Information from clinical and non clinical risk data is integrated into new service developments;
- All serious untoward incidents (SUI) are actively managed and monitored to ensure compliance with action plans;
- Training and educational programmes for all staff including induction programmes;
- Compliance with external assessment processes (NHSLA level 2 for acute services and level 2 for maternity services, RPST level 1); Achieved NHSLA Level 2 for Acute in 2008. Currently CNST Level 2 for Maternity but due to be assessed against the new NHSLA Maternity standards in 2009.
- Use of the risk-grading matrix within the service delivery development planning cycle.

The Trust's Board Assurance Framework fulfils the functions as described in 'Guidance on Completing the Statement on Internal Control 2004/2005':

- Covers all the organisations main activities;
- Identifies the Trust's strategic and corporate objectives;
- Identifies the risks to achievement of those objectives;
- Identifies and examines the system of internal control in place to manage the risks;
- Identifies the review and assurance mechanisms which relate to the effectiveness of the system of internal control:
- Records the actions taken by the Hospital Management Board (HMB) to address control and assurance gaps

Patients and visitors are encouraged to report any risk issues, concerns or complaints they may have or suggest areas for improvement by means of leaflets positioned in public areas. The Patient Advice and Liaison Service (PALS) is well established and provides central reporting of concerns and issues raised by patients and the public. Internal and external stakeholders are identified within the Risk Management Strategy.

Information Governance Assurance Programme

As part of its Governance programme the Trust has ensured that the relevant roles are identified in the Trust management structure and that appropriate reporting lines of communication are in place.

The Trust has an Information Governance Group with terms of reference which ensure that all aspects of information governance within the Trust are managed giving due cognisance to current legislation and to directives emanating from the Department of Health and HM Government. The Group meets monthly and reports to the Trust Board through the Healthcare Governance structure.

The Trust also ensures compliance through audits, third party probity and assessments and through the use of the DoH Information Governance toolkit providing the requisite assessments and returns.

The Trust liaises with local partners and with the Strategic Health Authority by participating in monthly SHA Information Governance Groups.

Control measures are in place to ensure that all the organisation's obligations under equality, diversity and human rights legislation are complied with.

#### 5. Review of economy, efficiency and effectiveness of the use of resources

The Trust has robust performance management processes in place that review the economy, efficiency and effectiveness of the use of resources. As well as the monthly reporting of finance and performance at a range of operational meetings, the executive team reviews the operational performance of the Trust through regular performance management meetings. The Performance, Finance and Resources Committee regularly reviews the overall progress against the financial plan and reports through to the Board of Directors. The reports include details on progress against the financial plan, ensuring delivery of service productivity and cost improvements.

The Trust has a policy framework in place to guide staff on the appropriate use of resources through its Standing Orders, Standing Financial Instructions and Human Resource policies.

Independent assurance is provided through the Trust's internal audit programme and the local counter fraud specialist, reports of which are reviewed at the Audit Committee. In addition, other external agencies such as Monitor, External Audit and the Healthcare Commission provide further assurance on the use of resources.

#### 6. 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 and the executive managers within the NHS foundation trust who have responsibility for the development and maintenance of the internal control framework, and comments made by the external auditors in their reports. I have been advised on the implications of the result of my review of the effectiveness of the system of internal

control by the board, the audit committee and a plan to address weaknesses and ensure continuous improvement of the system is in place. My review is also informed by:

- The Board Assurance Framework for 2008/09
- Monitor's Foundation Trust Process awarded Foundation Trust status 1 November 2008
- NHSLA assessment for acute services in September 2008 (achieved level 2)
- Auditors Local Evaluation 2007/08.
- External review of the mortuary service October 2007 (action plan monitored for implementation)
- Trust clinical performance indicator reports
- Trust wide incident trend analysis reports
- National NHS patient survey reports
- Staff Survey
- PALS reports
- Complaints and claims reports
- Standards for Better Health assessment process and Declaration April 2008
- Health Protection Agency Review
- Clinical pathology accreditation
- Patient environment action team (PEAT) scores
- Foundation Trust application SHA gateway process
- Completion of Audit Committee work plan
- Governance Committee
- Internal and external audit reports
- Patient & Public Council Report
- Hygiene Code Inspection 2008. Action plan implemented
- The Trust participated in the review of all health and social care serious case reviews as required by the Lord Laming Inquiry. A review by the commissioning PCT of the Children's Safeguarding Markers of Good Practice identified no areas of weakness.
- The management of infection control is consistent with the "hygiene code" within the Health Act 2006. The Healthcare Commission who visited the Trust on 27<sup>th</sup> and 28<sup>th</sup> January 2009 assessed the compliance. An improvement notice was not served but the Trust was found to have breached duty 4 subduties a,c,d and e. An action plan has been developed and is being implemented. The Trust has fully met the target of 50% improvement on Clostridium Difficile rates with 95 cases against a trajectory of 191. The trajectory for MRSA bacteraemia was 11 with 12 reported cases 8 cases were pre 48 hours. An action plan has been developed with the PCT to ensure health community solutions are put in place.
- The Care Quality Commission granted the Trust application for registration subject to a condition. The condition applied stated that: the registered service provider must, by 30<sup>th</sup> April 2009, review it arrangements for monitoring and assuring the Board that it is maintaining appropriate standards of cleanliness throughout its premises and ensure that such arrangements are implemented. The Trust has implemented a plan to ensure not only standards of cleanliness but also a rigorous audit and reporting mechanism are in place to ensure that the board is assured and the condition is met.
- The Trust is intending to declare that it has not met standard C21 Clean, well designed environments: element 2 (Care is provided in clean environments) within the Standards for Better Health for 2008/09

The Audit and the Governance Committees and the Hospital Management Board have advised me on the implications of the result of my review of the effectiveness of the system of internal control. A plan to address weaknesses and ensure continuous improvement of the system is in place.

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

- Annual review of the Risk Management Strategy by the Trust Board;
- The Audit Committee reviews governance and assurance arrangements. The Committee also receives and ensures external assurance reports are appropriately acted upon;
- The Governance Committee is responsible for the scrutiny of clinical governance matters including providing input to the strategic direction and reporting of the Trust's approach to patient safety and quality to ensure a safe environment in which to deliver the best care to patients;
- All managers have the responsibility for developing and implementing the Risk Management Strategy within the line management of individual directorates;

 The Central England Audit and Consultancy (CEAC) verify that a suitable and effective system of risk management internal controls is in place. This includes independent review of the Board Assurance Framework.

The Trust has identified a control issue in respect of cleaning and has put in place a comprehensive action plan to address the cleaning, audit and assurance processes.

The Trust has declared that it will not have met standard C21 but will declare fully met for the remaining 23 core standards within Standards for Better Health for 2008/09. However, the Trust is committed to the continuous improvement of processes of internal control and assurance and, as such may introduce additional controls within the forthcoming financial year (2009/2010), as the Trust Board deems necessary.

Dr Mark Newbold Chief Executive

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Kettering General Hospital NHS Foundation Trust

15<sup>th</sup> April 2009

# INDEPENDENT AUDITOR'S REPORT TO THE BOARD OF GOVERNORS OF KETTERING GENERAL HOSPITAL NHS FOUNDATION TRUST

I have audited the financial statements of Kettering General Hospital NHS Foundation Trust for the period ended 31 March 2009 under the National Health Service Act 2006. The financial statements comprise the Income and Expenditure Account, the Balance Sheet, the Cash Flow Statement, the Statement of Total Recognised Gains and Losses and the related notes. These financial statements have been prepared under the accounting policies set out within them. I have also audited the information in the Remuneration Report that is described as having been audited.

This report is made solely to the Board of Governors of Kettering General Hospital NHS Foundation Trust as a body in accordance with paragraph 24(5) of Schedule 7 of the National Health Service Act 2006. My work was undertaken so that I might state to the Board of Governors those matters I am required to state to it in an auditor's report and for no other purpose. In those circumstances, to the fullest extent permitted by law, I do not accept or assume responsibility to anyone other than the Foundation Trust as a body, for my audit work, for the audit report or for the opinions I form.

## Respective responsibilities of the Accounting Officer and auditor

The Accounting Officer's responsibilities for preparing the financial statements in accordance with directions made by the Independent Regulator of NHS Foundation Trusts (Monitor) are set out in the Statement of Accounting Officer's Responsibilities.

My responsibility is to audit the financial statements in accordance with statute, the Audit Code for NHS Foundation Trusts and International Standards on Auditing (UK and Ireland).

I report to you my opinion as to whether the financial statements give a true and fair view in accordance with the accounting policies directed by Monitor as being relevant to NHS Foundation Trusts. I report whether the financial statements and the part of the Remuneration Report to be audited have been properly prepared in accordance with the accounting policies directed by Monitor as being relevant to NHS Foundation Trusts. I also report to you whether, in my opinion, the information which comprises the Directors' Report included in the Annual Report, is consistent with the financial statements.

I review whether the Accounting Officer's statement on internal control reflects compliance with the requirements of Monitor contained in the NHS Foundation Trust Financial Reporting Manual 2008/09. I report if it does not meet the requirements specified by Monitor or if the statement is misleading or inconsistent with other information I are aware of from my audit of the financial statements. I am not required to consider, nor have I considered, whether the Accounting Officer's statement on internal control covers all risks and controls. Neither am I required to form an opinion on the effectiveness of the Trust's corporate governance procedures or its risk and control procedures.

I read the other information contained in the Annual Report and consider whether it is consistent with the audited financial statements. This other information comprises Chairman and Chief Executive's Management Commentary, Background Information, Financial Review, the sections on the Board of Governors, the Board of Directors, membership and public interest disclosures and the un-audited part of the Remuneration Report. I consider the implications for my report if I become aware of any apparent misstatements or material inconsistencies with the financial statements. My responsibilities do not extend to any other information.

### Basis of audit opinion

I conducted my audit in accordance with the National Health Service Act 2006 and the Audit Code for NHS Foundation Trusts issued by Monitor, which requires compliance with International Standards on Auditing (United Kingdom and Ireland) issued by the Auditing Practices Board. An audit includes examination, on a test basis, of evidence relevant to the amounts and disclosures in the financial statements and the part of the Remuneration Report to be audited. It also includes an assessment of the significant estimates and judgments made by the

directors in the preparation of the financial statements, and of whether the accounting policies are appropriate to the Trust's circumstances, consistently applied and adequately disclosed.

I planned and performed my audit so as to obtain all the information and explanations which I considered necessary in order to provide me with sufficient evidence to give reasonable assurance that:

- the financial statements are free from material misstatement, whether caused by fraud or other irregularity or error; and
- the financial statements and the part of the Remuneration Report to be audited have been properly prepared.

In forming my opinion I also evaluated the overall adequacy of the presentation of information in the financial statements and the part of the Remuneration Report to be audited.

### **Opinion**

In my opinion:

- the financial statements give a true and fair view of the state of affairs of Kettering General Hospital Foundation Trust as at 31 March 2009 and of its income and expenditure for the year/period then ended in accordance with the accounting policies adopted by the Trust;
- the part of the Remuneration Report to be audited has been properly prepared in accordance with the accounting policies directed by Monitor as being relevant to NHS Foundation Trusts; and
- information which comprises the Directors' Report included in the annual report, is consistent with the financial statements.

#### Certificate

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I certify that I have completed the audit of the accounts in accordance with the requirements of the National Health Service Act 2006 and the Audit Code for NHS Foundation Trusts issued by Monitor.

Mr John Cornett, Officer of the Audit Commission

Date: 3<sup>rd</sup> June 2009

Rivermead House, 7 Lewis Court, Grove Park, Enderby, Leicestershire, LE19 1SU

#### FOREWORD TO THE ACCOUNTS

#### KETTERING GENERAL HOSPITAL NHS FOUNDATION TRUST

Kettering General Hospital NHS Foundation Trust is required to "keep accounts in such form as Monitor (The Independent Regulator for NHS Foundation Trusts) may with the approval of Treasury direct" (paragraph 25(1), Schedule 7 to the National Health Service Act 2006 ('the 2006 Act'). The Trust is required to "prepare in respect of each financial year annual accounts in such form as Monitor may with the approval of the Treasury direct" (paragraphs 24 and 25, Schedule 7 to the 2006 Act). In preparing their annual accounts, the Trust must comply with any directions given by Monitor, with the approval of the Treasury, as to the methods and principles according to which the accounts are to be prepared and the information to be given in the accounts.

The Trust attained Foundation status on the 1<sup>st</sup> November 2008, therefore these accounts are for the 5 month period ending 31 March 2009. In accordance with the Foundation Trust Financial Reporting Manual, no prior year figures have been shown in the accounts.

All opening balance sheet amounts reflect those contained in the audited accounts of Kettering General Hospital NHS Trust, the predecessor body of the Foundation Trust

Date: 3<sup>rd</sup> June 2009

Chief Executive:

Knylemes

Dr M Newbold

# INCOME AND EXPENDITURE ACCOUNT For the Period 1<sup>st</sup> November 2008 to 31<sup>st</sup> March 2009

	Note	2008/09 £000
Income from activities	3	60,279
Other operating income	4	6,909
Operating expenses	5-7	(65,840)
OPERATING SURPLUS/(DEFICIT)		1,348
Profit/(loss) on disposal of fixed assets	8	(19)
SURPLUS/(DEFICIT) BEFORE INTEREST		1,329
Finance income	9.1	60
SURPLUS/(DEFICIT) BEFORE TAXATION		1,389
Taxation		0
SURPLUS/(DEFICIT) AFTER TAXATION AND MINORITY INTEREST		1,389
PDC dividends payable		(1,284)
RETAINED SURPLUS/(DEFICIT) FOR THE YEAR		105

The notes on pages 6 to 32 form part of these accounts. All income and expenditure is derived from continuing operations.

# **BALANCE SHEET**

	Note	31 March 2009 £000	1 November 2008 £000
FIXED ASSETS:			
Intangible assets	10	1,437	1,461
Tangible assets	11	83,500	84,065
Investments	12	0	0
TOTAL FIXED ASSETS		84,937	85,526
CURRENT ASSETS:			
Stocks and work in progress	13	2,430	2,448
Debtors	14	4,242	7,676
Investments	15	0	0
Cash at bank and in hand	19.3	9,149	6,294
TOTAL CURRENT ASSETS		15,821	16,418
CREDITORS:			
Creditors falling due within one year	16.1	(9,855)	(10,933)
NET CURRENT ASSETS/(LIABILITIES)		5,966	5,485
TOTAL ASSETS LESS CURRENT LIABILITIES		90,903	91,011
CREDITORS:	_		
Creditors falling due after more than one year	16	(10)	(12)
PROVISIONS FOR LIABILITIES AND CHARGES	17	(921)	(1,048)
TOTAL ASSETS EMPLOYED		89,972	89,951
FINANCED BY TAXPAYER'S EQUITY			
Public dividend capital	18.2	62,125	62,125
Revaluation reserve	18.3	24,608	25,043
Donated asset reserve	18.3	3,981	4,065
Available for sale investments reserve		0	0
Other reserves		0	0
Income and expenditure reserve	18.3	(742)	(1,282)
TOTAL TAXPAYERS' EQUITY	_	89,972	89,951

The financial statements on pages 1 to 32 were approved by the Board on the 3<sup>rd</sup> June 2009 and signed on its behalf by:

Chief Executive:

Dr M Newbold, Date: 3<sup>rd</sup> June 2009

# STATEMENT OF TOTAL RECOGNISED GAINS AND LOSSES FOR THE PERIOD 1 NOV 2008 TO 31 MARCH 2009

	Note	£000
Surplus/(deficit) for the financial year before dividend payments		1,389
Fixed asset impairment losses		0
Unrealised surplus/(deficit) on fixed asset revaluations		0
Net gains / losses on available for sale investments		0
Increase in the donated asset reserve due to receipt of donated assets	18.3	84
Reduction in the donated asset reserve due to depreciation, impairment, and/or disposal of donated assets	18.3	(168)
Additions/(reduction) in "Other reserves"		0
TOTAL RECOGNISED GAINS AND LOSSES FOR THE FINANCIAL YEAR		1,305
Prior period adjustments		
TOTAL RECOGNISED GAINS AND LOSSES IN THE FINANCIAL YEAR		1,305

# **CASH FLOW STATEMENT**

	Note	0003	31 March 2009 £000
OPERATING ACTIVITIES	Note	2000	2000
NET CASH INFLOW/(OUTFLOW) FROM OPERATING ACTIVITIES RETURNS ON INVESTMENTS AND SERVICING OF FINANCE:	19.1		6,073
Interest received		87	
NET CASH INFLOW/(OUTFLOW) FROM RETURNS ON INVESTMENTS AND SERVICING OF FINANCE			87
TAXATION PAID / RECEIVED			0
CAPITAL EXPENDITURE:			
(Payments) to acquire tangible fixed assets		(1,733)	
(Payments) to acquire intangible fixed assets		(115)	
NET CASH INFLOW/(OUTFLOW) FROM CAPITAL EXPENDITURE			(1,848)
DIVIDENDS PAID			(1,541)
NET CASH INFLOW/(OUTFLOW) BEFORE MANAGEMENT OF LIQUID RESOURCES AND FINANCING			2,771
MANAGEMENT OF LIQUID RESOURCES:			
(Purchase) of current asset investments		0	
Sale of current asset investments		0	
NET CASH INFLOW/(OUTFLOW) FROM MANAGEMENT OF LIQUID RESOURCES			0
NET CASH INFLOW/(OUTFLOW) BEFORE FINANCING		_	2,771
FINANCING:			
Other capital receipts		84	
NET CASH INFLOW/(OUTFLOW) FROM FINANCING			84
INCREASE/(DECREASE) IN CASH		- -	2,855

## NOTES TO THE ACCOUNTS

## 1. Accounting policies

Monitor has directed that the financial statements of NHS foundation trusts shall meet the accounting requirements of the NHS Foundation Trust Financial Reporting Manual which shall be agreed with HM Treasury. Consequently, the following financial statements have been prepared in accordance with the 2008/09 NHS Foundation Trust Financial Reporting Manual issued by Monitor. The accounting policies contained in that manual follow UK generally accepted accounting practice for companies (UK GAAP) and HM Treasury's Financial Reporting Manual to the extent that they are meaningful and appropriate to NHS foundation trusts. The accounting policies have been applied consistently in dealing with items considered material in relation to the accounts.

#### 1.1 Accounting convention

These accounts have been prepared under the historical cost convention modified to account for the revaluation of tangible fixed assets at their value to the business by reference to their current costs. NHS foundation trusts, in compliance with HM Treasury's *Financial Reporting Manual*, are not required to comply with the FRS 3 requirements to report "earnings per share" or historical profits and losses.

#### 1.2 Acquisitions and discontinued operations

Activities are considered to be 'discontinued' where they meet all of the following conditions:

- a. the sale (this may be at nil consideration for activities transferred to another public sector body) or termination is completed either in the period or before the earlier of three months after the commencement of the subsequent period and the date on which the financial statements are approved;
- b. if a termination, the former activities have ceased permanently;
- c. the sale or termination has a material effect on the nature and focus of the reporting NHS foundation trust's operations and represents a material reduction in its operating facilities resulting either from its withdrawal from a particular activity or from a material reduction in income in the NHS foundation trust's continuing operations; and
- d. the assets, liabilities, results of operations and activities are clearly distinguishable, physically, operationally and for financial reporting purposes.

Operations not satisfying all these conditions are classified as continuing.

#### 1.3 Income Recognition

Income is accounted for applying the accruals convention. The main source of income for the Trust is under contracts from commissioners in respect of healthcare services. Income is recognised in the period in which services are provided. Where income is received for a specific activity which is to be delivered in the following financial year, that income is deferred.

Revenue relating to patient care spells that are part-completed at the year end are apportioned across the financial years on the basis of length of stay at the balance sheet date, expected total length of stay/costs incurred to date and compared to total expected costs.

Interest revenue is accrued on a time basis, by reference to the principal outstanding and interest rate applicable.

#### 1.4 Expenditure

Expenditure is accounted for applying the accruals convention.

# 1.5 Intangible fixed assets

Intangible assets are capitalised when they are capable of being used in a Trust's activities for more than one year; they can be valued; and they have a cost of at least £5,000.

Intangible fixed assets held for operational use are valued at historical cost and are depreciated over the estimated life of the asset on a straight line basis, except capitalised Research and Development which is

carried at historic cost as a proxy for current cost. The carrying value of intangible assets is reviewed for impairment at the end of the first full year following acquisition and in other periods if events or changes in circumstances indicate the carrying value may not be recoverable.

Purchased computer software licences are capitalised as intangible fixed assets where expenditure of at least £5,000 is incurred. They are amortised over the shorter of the term of the licence and their useful economic lives.

## 1.6 Tangible fixed assets

#### Capitalisation

Tangible assets are capitalised if they are capable of being used for a period which exceeds one year and they:

- individually have a cost of at least £5,000; or
- collectively have a cost of at least £5,000 and individually have a cost of more than £250, where the assets
  are functionally interdependent, they had broadly simultaneous purchase dates, are anticipated to have
  simultaneous disposal dates and are under single managerial control; or
- form part of the initial equipping and setting-up cost of a new building, ward or unit irrespective of their individual or collective cost.

#### Valuation

Tangible fixed assets are stated at the lower of replacement cost and recoverable amount. On initial recognition they are measured at cost (for leased assets, fair value) including any costs such as installation directly attributable to bringing them into working condition. The carrying values of tangible fixed assets are reviewed for impairment in periods if events or changes in circumstances indicate the carrying value may not be recoverable.

All land and buildings are restated to current value using professional valuations in accordance with FRS 15 every five years and an interim valuation in the intervening years. Professional valuations are carried out by the District Valuers of the Revenue and Customs Government Department. The valuations are carried out in accordance with the Royal Institute of Chartered Surveyors (RICS) Appraisal and Valuation Manual insofar as these terms are consistent with the agreed requirements of the Department of Health and HM Treasury. In accordance with the requirements of the Department of Health, the last asset valuations were undertaken in 2004 as at the prospective valuation date of 1 April 2005 and were applied on the 31 March 2005. The predecessor Trust undertook a valuation of all Trust Land and Buildings at a valuation date of the 31 st October 2008. The valuations are carried out primarily on the basis of Depreciated Replacement Cost for specialised operational property and Existing Use Value for non-specialised operational property. The value of land for existing use purposes is assessed at Existing Use Value. For non-operational properties including surplus land, the valuations are carried out at Open Market Value.

Additional alternative Open Market Value figures have only been supplied for operational assets scheduled for imminent closure and subsequent disposal. In line with Treasury guidance, the revaluation effective from the 31 October 2008 was based on "modern equivalent assets" rather than the "like for like" replacement basis used in previous valuations.

Gains arising from revaluations are taken to the Revaluation Reserve. Losses arising from revaluation are recognised as impairments and are charged to the revaluation reserve to the extent that a balance exists in relation to the revalued asset. Losses in excess of that amount are charged to the current year's Income & Expenditure account, unless it can be demonstrated that the recoverable amount is greater than the revalued amount in which case the impairment is taken to the revaluation reserve. Diminutions in value when newly constructed assets are brought into use are charged in full to the Income & Expenditure account. These falls in value result from the adoption of ideal conditions as the basis for depreciated replacement cost valuations. Assets in the course of construction are valued at actual cost until complete, at which point a valuation is performed by the District Valuer, as above. These assets include any existing land or buildings under the control of a contractor.

Residual interests in off-balance sheet Private Finance Initiative properties are included in tangible fixed assets as 'assets under construction and payments on account' where the PFI contract specifies the amount, or a nil value, at which the assets will be transferred to the Trust at the end of the contract. The residual interest is built up, on an actuarial basis, during the life of the contract by capitalising part of the unitary charge so that at the end of the contract the balance sheet value of the residual value plus the specified amount equal the expected fair value of the residual asset at the end of the contract. The estimated fair value of the asset on reversion is determined by the District Valuer based on Department of Health guidance. The District Valuer should provide

an estimate of the anticipated fair value of the assets on the same basis as the District Valuer values the NHS Trust's estate.

Operational equipment is carried at current value. Where assets are of low value, and/or have short useful economic lives, these are carried at depreciated historic cost as a proxy for current value. Equipment is depreciated on current value evenly over the estimated life. The useful economic lives including the range within which useful economic lives fall for the main classes of asset is detailed below.

	Min life	Max life
Asset category	(years)	(years)
Software Licences	5	5
Development Expenditure	5	5
Buildings exc dwellings	15	90
Plant & Machinery	5	15
Information Technology	5	5
Furniture and Fittings	10	10

At each balance sheet date, the Trust checks whether there is any indication that any of its tangible or intangible non-current assets have suffered an impairment loss. (The value of high value/long life fixtures and equipment are re-valued by a suitably qualified valuer on an annual basis). If there is indication of an impairment loss, the recoverable amount of the asset is estimated to determine whether there has been a loss and, if so, its amount. Intangible assets not yet available for use are tested for impairment annually.

Equipment surplus to requirements is valued at net recoverable amount.

#### Depreciation, amortisation and impairments

Tangible fixed assets are depreciated at rates calculated to write them down to estimated residual value on a straight-line basis over their estimated useful lives. No depreciation is provided on freehold land, and assets surplus to requirements.

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

Buildings, installations and fittings are depreciated on their current value over the estimated remaining life of the asset as advised by the District Valuer. Leaseholds are depreciated over the primary lease term. Equipment is depreciated on current cost evenly over the estimated life of the asset.

Fixed asset impairments resulting from losses of economic benefits are charged to the income and expenditure account. All other impairments are taken to the revaluation reserve and reported in the statement of total recognised gains and losses to the extent that there is a balance on the revaluation reserve in respect of the particular asset.

### **Donated fixed assets**

Donated fixed assets are capitalised at their current value on receipt and this value is credited to the Donated Asset Reserve. Donated fixed assets are valued and depreciated as described above for purchased assets. Gains and losses on revaluations are also taken to the Donated Asset Reserve and, each year, an amount equal to the depreciation charge on the asset is released from the Donated Asset Reserve to the Income and Expenditure account. Similarly, any impairment on donated assets charged to the Income and Expenditure Account is matched by a transfer from the Donated Asset Reserve. On sale of donated assets, the value of the sale proceeds is transferred from the Donated Asset Reserve to the Income and Expenditure Reserve.

## 1.7 Liquid Resources

Deposits and other investments that are readily convertible into known amounts of cash at or close to their carrying amounts are treated as liquid resources in the cash flow statement.

#### 1.8 Government grants

Government grants are grants from Government bodies other than income from primary care trusts or NHS trusts for the provision of services. Grants from the Department of Health, are accounted for as Government grants as are grants from the Big Lottery Fund. Where the Government grant is used to fund revenue expenditure it is taken to the Income and Expenditure account to match that expenditure. Where the grant is used to fund capital expenditure the grant is held as deferred income and released to the income and expenditure account over the life of the asset on a basis consistent with the depreciation charge for that asset.

#### 1.9 Private Finance Initiative (PFI) transactions

The NHS follows HM Treasury's Technical Note 1 (Revised) "How to Account for PFI transactions" which provides practical guidance for the application of the FRS 5 amendment and the guidance 'Land and Buildings in PFI schemes Version 2'.

Where the balance of the risks and rewards of ownership of the PFI property are borne by the PFI operator, the PFI obligations are recorded as an operating expense. Where the Trust has contributed land and buildings, a prepayment for their fair value is recognised and amortised over the life of the PFI contract by charge to the income and expenditure account. Where, at the end of the PFI contract, a property reverts to the Trust, the difference between the expected fair value of the residual on reversion and any agreed payment on reversion is built up over the life of the contract by capitalising part of the unitary charge each year, as a tangible fixed asset.

Where the balance of risks and rewards of ownership of the PFI property are borne by the Trust, it is recognised as a fixed asset along with the liability to pay for it which is accounted for as a finance lease. Contract payments are apportioned between an imputed finance lease charge and a service charge.

#### 1.10 Stocks and work-in-progress

Stocks and works in progress are valued at current or weighted average cost. This is considered to be a reasonable approximation to the lower of cost or net realisable value due to the high turnover of stocks. Workin-progress comprises goods in intermediate stages of production. Partially completed contracts for patient services are not accounted for as work-in-progress.

#### 1.11 Cash, bank and overdrafts

Cash, bank and overdraft balances are recorded at the current values of these balances in the NHS Foundation Trust's cash book. These balances exclude monies held in the NHS Foundation Trust's bank account belonging to patients (see "third party assets" below). Account balances are only set off where a formal agreement has been made with the bank to do so. In all other cases overdrafts are disclosed within creditors. Interest earned on bank accounts and interest charged on overdrafts is recorded as, respectively, "interest receivable" and "interest payable" in the periods to which they relate. Bank charges are recorded as operating expenditure in the periods to which they relate.

#### 1.12 Research and development

Expenditure on research is not capitalised. Expenditure on development is capitalised if it meets the following criteria:

- there is a clearly defined project;
- the related expenditure is separately identifiable;
- the outcome of the project has been assessed with reasonable certainty as to its technical feasibility and its resulting in a product or services that will eventually be brought into use; and
- adequate resources exist, or are reasonably expected to be available, to enable the project to be completed and to provide any consequential increases in working capital.

Expenditure so deferred is limited to the value of future benefits expected and is amortised through the income and expenditure account on a systematic basis over the period expected to benefit from the project. It is revalued on the basis of current cost. Expenditure which does not meet the criteria for capitalisation is treated as an operating cost in the year in which it is incurred. Where possible, NHS foundation trusts disclose the total amount of research and development expenditure charged in the Income and Expenditure account separately. However, where research and development activity cannot be separated from patient care activity it cannot be identified and is therefore not separately disclosed.

Fixed assets acquired for use in research and development are amortised over the life of the associated project.

### 1.13 Provisions

The NHS Foundation Trust provides for legal or constructive obligations that are of uncertain timing or amount at the balance sheet date on the basis of the best estimate of the expenditure required to settle the obligation. Where the effect of the time value of money is material, the estimated risk-adjusted cash flows are discounted using HM Treasury's discount rate of 2.2% in real terms.

# Clinical negligence costs

The NHS Litigation Authority (NHSLA) operates a risk pooling scheme under which the NHS Foundation Trust pays an annual contribution to the NHSLA, which, in return, settles all clinical negligence claims. Although the NHSLA is administratively responsible for all clinical negligence cases, the legal liability remains with the NHS Foundation Trust. The total value of clinical negligence provisions carried by the NHSLA on behalf of the NHS Foundation Trust is disclosed at note 16.

#### Non-clinical risk pooling

The NHS Foundation 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 the NHS Litigation Authority 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.

#### Commercial insurance cover

The NHS Foundation Trust has additional insurance commercial cover for property cover in excess of that provided by the NHS Litigation authority. In addition the Foundation Trust has insurance cover for loss of income and increased cost of working in case of an insurable event.

#### 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 22 where an inflow of economic benefits is probable.

Contingent liabilities are provided for where a transfer of economic benefits is probable. Otherwise, they are not recognised, but are disclosed in note 22 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.

#### 1.15 Pension costs

Past and present employees are covered by the provisions of the NHS Pensions Scheme. Details of the benefits payable under these provisions can be found on the NHS Pensions website at www.pensions.nhsbsa.nhs.uk. The Scheme is an unfunded, defined benefit scheme that covers NHS employers, General Practices and other bodies, allowed under the direction of the Secretary of State, in England and Wales. The scheme is not designed to be run in a way that would enable the Foundation Trust to identify their share of the underlying Scheme assets and liabilities. Therefore, the Scheme is accounted for as if it were a defined contribution scheme: the cost to the NHS Body of participating in the Scheme is taken as equal to the contributions payable to the Scheme for the accounting period. Employers pension cost contributions are charged to operating expenses as and when they become due.

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

The Scheme is subject to a full actuarial valuation every four years, and a FRS17 accounting valuation every year. An outline of these follows:

#### a) Full actuarial (funding) valuation

The purpose of this valuation is to assess the level of liability in respect of the benefits due under the scheme (taking into account its recent demographic experience), and to recommend the contribution rates to be paid by

employers and scheme members. The last such valuation, which determined current contribution rates was undertaken as at 31 March 2004 and covered the period from 1 April 1999 to that date.

The conclusion from the 2004 valuation was that the Scheme had accumulated a notional deficit of £3.3 billion against the notional assets as at 31 March 2004. However, after taking into account the changes in the benefit and contribution structure effective from 1 April 2008, the Scheme actuary reported that employer contributions could continue at the existing rate of 14% of pensionable pay. On advice from the Scheme actuary, scheme contributions may be varied from time to time to reflect changes in the scheme's liabilities. Up to 31 March 2008, the vast majority of employees paid contributions at the rate of 6% of pensionable pay. From 1 April 2008, employees contributions are on a tiered scale from 5% up to 8.5% of their pensionable pay depending on total earnings.

#### b) FRS17 Accounting valuation

In accordance with FRS17, a valuation of the Scheme liability is carried out annually by the Scheme Actuary as at the balance sheet date by updating the results of the full actuarial valuation. Between the full actuarial valuations at a two-year midpoint, a full and detailed member data-set is provided to the Scheme Actuary. At this point the assumptions regarding the composition of the Scheme membership are updated to allow the Scheme liability to be valued.

The valuation of the Scheme liability as at 31 March 2008, is based on detailed membership data as at 31 March 2006 (the latest midpoint) updated to 31 March 2008 with summary global member and accounting data. The latest assessment of the liabilities of the Scheme is contained in the Scheme Actuary report, which forms part of the annual NHS Pension Scheme (England and Wales) Resource Account, published annually. These accounts can be viewed on the NHS Pensions website. Copies can also be obtained from The Stationery Office.

### Scheme provisions as at 31 March 2008

The Scheme is a "final salary" scheme. Annual pensions are normally based on 1/80th of the best of the last 3 years pensionable pay for each year of service. A lump sum normally equivalent to 3 years pension is payable on retirement. Annual increases are applied to pension payments at rates defined by the Pensions (Increase) Act 1971, and are based on changes in retail prices in the twelve months ending 30 September in the previous calendar year. On death, a pension of 50% of the member's pension is normally payable to the surviving spouse.

Early payment of a pension, with enhancement, is available to members of the Scheme who are permanently incapable of fulfilling their duties effectively through illness or infirmity. A death gratuity of twice final year's pensionable pay for death in service, and five times their annual pension for death after retirement, less pension already paid, subject to a maximum amount equal to twice the member's final year's pensionable pay less their retirement lump sum for those who die after retirement, is payable.

For early retirements other than those due to ill health the additional pension liabilities are not funded by the scheme. The full amount of the liability for the additional costs is charged to the income and expenditure account at the time the Trust commits itself to the retirement, regardless of the method of payment.

The Scheme provides the opportunity to members to increase their benefits through money purchase Additional Voluntary Contributions (AVCs) provided by an approved panel of life companies. Under the arrangement the employee/member can make contributions to enhance an employee's pension benefits. The benefits payable relate directly to the value of the investments made.

#### Scheme provisions from 1 April 2008

From 1 April 2008 changes have been made to the NHS Pension Scheme contribution rates and benefits. Further details of these changes can be found on the NHS Pensions website www.pensions.nhsbsa.nhs.uk.

#### 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.

#### 1.17 Corporation tax

The Foundation Trust does not have a corporation tax liability and this is in accordance with current tax legislation as it relates to NHS foundation trusts.

#### 1.18 Foreign Exchange

Transactions that are denominated in a foreign currency are translated into sterling at the exchange rate ruling on the dates of the transactions. Resulting exchange gains and losses are taken to the Income and Expenditure Account.

#### 1.19 Third Party Assets

Assets belonging to third parties (such as money held on behalf of Patients) are not recognised in the accounts since the Trust has no beneficial interest in them. Details of third party assets are given in Note 28 to the accounts.

#### 1.20 Leases

#### 1.20.1 Finance leases

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

#### The Trust as lessee

Amounts held under finance leases are initially recognised, at the inception of the lease, at fair value or, if lower, at the present value of the minimum lease payments, with a matching liability for the lease obligation to the lessor. Lease payments are apportioned between finance charges and reduction of the lease obligation so as to achieve a constant rate on interest on the remaining balance of the liability. Finance charges are charged directly to the Finance Charges in the Statement of Comprehensive Income.

#### The Trust as lessor

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 so as to reflect a constant periodic rate of return on the Trust's net investment outstanding in respect of the leases.

#### 1.20.2 Operating leases

Operating lease payments are recognised as an expense on a straight-line basis over the lease term. Lease incentives are recognised initially as a liability and subsequently as a reduction of rentals on a straight-line basis over the lease term.

Contingent rentals are recognised as an expense in the period in which they are incurred.

#### 1.21 Public Dividend Capital (PDC) and PDC Dividend

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 Trust. HM Treasury has determined that PDC is not a financial instrument within the meaning of IAS 32.

A charge, reflecting the forecast cost of capital utilised by the Foundation Trust, is paid over as public dividend capital dividend. The charge is calculated at the real rate set by HM Treasury (currently 3.5%) on the forecast average carrying amount of all assets less liabilities, except for donated assets and cash with the Office of the Paymaster General. The average carrying amount of assets is calculated as a simple average of opening and closing relevant net assets.

#### 1.22 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 each individual case is handled.

Losses and special payments are charged to the relevant functional headings, including losses which would have been made good through insurance cover had NHS Trusts not been bearing their own risks (with insurance premiums then being included as normal revenue expenditure). However, note 27 is compiled directly from the losses and compensations register which is prepared on a cash basis.

#### 1.23 EU Emissions Trading Scheme

EU Emission Trading Scheme (allowances are accounted for as Government Granted current asset investments, valued at open market value). As the emissions for this hospital are less than the minimum emission level (20 megawatts per site), this Trust is not required to join the scheme. The Head of Estates undertakes an annual review of the hospital emissions.

#### 1.24 Annual leave

The Trust allows employees to carry forward up to 5 days leave at the end of each financial year (excluding medical staff employees who have a different leave year dependant upon their employment start date). The value of any untaken leave is accrued as an expense at the balance sheet date.

#### 1.25 Financial Instruments

#### **Financial assets**

Financial assets are recognised on the balance sheet when the Trust becomes party to the financial instrument contract or, in the case of trade receivables, when the goods or services have been delivered. Financial assets are derecognised when the contractual rights have expired or the asset has been transferred.

#### Financial assets are initially recognised at fair value.

Financial assets are classified into the following categories: financial assets 'at fair value through profit and loss'; 'held to maturity investments'; 'available for sale' financial assets, and 'loans and receivables'. The classification depends on the nature and purpose of the financial assets and is determined at the time of initial recognition.

## Financial assets at fair value through profit and loss

Embedded derivatives that have different risks and characteristics to their host contracts, and contracts with embedded derivatives whose separate value cannot be ascertained, are treated as financial assets at fair value through profit and loss. They are held at fair value, with any resultant gain or loss recognised in the income statement. The net gain or loss incorporates any interest earned on the financial asset.

#### Held to maturity investments

Held to maturity investments are non-derivative financial assets with fixed or determinable payments and fixed maturity, and there is a positive intention and ability to hold to maturity. After initial recognition, they are held at amortised cost using the effective interest method, less any impairment. Interest is recognised using the effective interest method.

#### Available for sale financial assets

Available for sale financial assets are non-derivative financial assets that are designated as available for sale or that do not fall within any of the other three financial asset classifications. They are measured at fair value with changes in value taken to the revaluation reserve, with the exception of impairment losses. Accumulated gains or losses are recycled to the income statement on de-recognition.

#### Loans and receivables

Loans and receivables are non-derivative financial assets with fixed or determinable payments which are not quoted in an active market. After initial recognition, they are measured at amortised cost using the effective interest method, less any impairment. Interest is recognised using the effective interest method.

Fair value is determined by reference to quoted market prices where possible, otherwise by valuation techniques in accordance with IAS 39 AG 74 and following paragraphs.

The effective interest rate is the rate that exactly discounts estimated future cash receipts through the expected life of the financial asset, to the net carrying amount of the financial asset.

At the balance sheet date, the Trust assesses whether any financial assets, other than those held at 'fair value through profit and loss' are impaired. Financial assets are impaired and impairment losses recognised if there

is objective evidence of impairment as a result of one or more events which occurred after the initial recognition of the asset and which has an impact on the estimated future cash flows of the asset.

For financial assets carried at amortised cost, the amount of the impairment loss is measured as the difference between the asset's carrying amount and the present value of the revised future cash flows discounted at the asset's original effective interest rate. The loss is recognised in the income statement and the carrying amount of the asset is reduced directly, or through a provision for impairment of receivables.

If, in a subsequent period, the amount of the impairment loss decreases and the decrease can be related objectively to an event occurring after the impairment was recognised, the previously recognised impairment loss is reversed through the income statement to the extent that the carrying amount of the receivable at the date of the impairment is reversed does not exceed what the amortised cost would have been had the impairment not been recognised.

#### **Financial liabilities**

Financial liabilities are recognised on the balance sheet when the Trust becomes party to the contractual provisions of the financial instrument or, in the case of trade payables, when the goods or services have been received. Financial liabilities are de-recognised when the liability has been discharged, that is, the liability has been paid or has expired.

#### Financial liabilities are initially recognised at fair value.

Financial liabilities are classified as either financial liabilities 'at fair value through profit and loss' or other financial liabilities.

#### Financial liabilities at fair value through profit and loss

Embedded derivatives that have different risks and characteristics to their host contracts, and contracts with embedded derivatives whose separate value cannot be ascertained, are treated as financial liabilities at fair value through profit and loss. They are held at fair value, with any resultant gain or loss recognised in the income statement. The net gain or loss incorporates any interest earned on the financial asset.

#### Other financial liabilities

After initial recognition, all other financial liabilities are measured at amortised cost using the effective interest method. The effective interest rate is the rate that exactly discounts estimated future cash payments through the life of the asset, to the net carrying amount of the financial liability. Interest is recognised using the effective interest method.

#### **NOTE 2. SEGMENTAL ANALYSIS**

From 1/4/2001 Kettering General Hospital NHS Trust has been the lead body responsible for the Central England Audit Consultancy (CEAC). CEAC provide internal audit and PFI audit services to NHS organisations and some non-NHS organisations. The responsibility for CEAC transferred to the Foundation Trust at its inception date.

The following information segments the results of the Trust by:

- Healthcare activities, being all the other activities of the Trust and
- Central England Audit & Consultancy

Segmental reporting	Healthcare	CEAC	TOTAL
	5 months ending 31 March 2009 £000	5 months ending 31 March 2009 £000	5 months ending 31 March 2009 £000
Income by segment			
Income from activities	60,279	0	60,279
Other operating income	5,698	1,211	6,909
TOTAL INCOME	65,977	1,211	67,188
Surplus/(deficit) by segment			
Surplus/(deficit) before interest and common costs	1,329	0	1,329
Common costs	0	0	0
SURPLUS/(DEFICIT) BEFORE INTEREST	1,329	0	1,329
TOTAL ASSETS EMPLOYED	89,972	0	89,972

# Note 3.1 Income from activities

Income by activity	5 months ending 31 March 2009 £000
Elective income	13,981
Non elective income	23,972
Outpatient income	9,534
A & E income	2,632
Other NHS clinical income	9,745
Private patient income	90
Other non-protected clinical income	325
TOTAL	60,279

## Note 3.2 Private patient income

, , , , , , , , , , , , , , , , , , ,	5 months ending 31 March 2009 £000	Base year 2003 £000
Private patient income	90	665
Total patient related income	60,279	78,946
Proportion (as percentage)	0.1%	0.8%

Section 44 of the 2006 Act requires that the proportion of private patient income to the total patient related income of NHS foundation trusts should not exceed its proportion whilst the body was an NHS Trust in 2002/03 (The private patient income cap contained within the Trust Terms of Authorisation). This cap was not exceeded in 2008/09.

# Note 3.3 Income from activities

	5 months
	ending
	31 March 2009 £000
Strategic Health Authorities	647
Primary Care Trusts	54,760
Department of Health - other	4,455
NHS Other	2
Non NHS: Private patients	90
Non-NHS: Overseas patients (non-reciprocal)	2
NHS injury scheme (was RTA)*	276
Non NHS: Other	47
TOTAL	60,279

 $<sup>^{\</sup>star}$  Injury Cost Recovery income are subject to a provision for doubtful debts of 36% to reflect expected rates of collection

# Note 4 Other operating income

	5 months ending
	31 March 2009 £000
Research and development	51
Education and training	3,131
Charitable and other contributions to expenditure	41
Transfers from the donated asset reserve in respect of depreciation, impairment and disposal of donated assets	168
Non-patient care services to other bodies	2,927
Other *	591
TOTAL	6,909
TOTAL INCOME	67,188

# \* Breakdown of Other Operating Income:

·	5 months ending 31 March 2009	
	£000£	
Car Parking	245	
Catering	152	
Property rentals	15	
Pharmacy sales	10	
Other	169	
Total	591	

# Note 5.1 Operating expenses :

	5 months ending
	31 March 2009 £000
Services from NHS Foundation Trusts	115
Services from NHS Trusts	480
Services from other NHS Bodies	1,207
Purchase of healthcare from non NHS bodies	11
Executive directors costs	287
Non-executive directors costs	52
Staff costs	45,946
Drug costs	3,585
Supplies and services - clinical (excluding drug costs)	5,266
Supplies and services - general	856
Establishment	728
Research and development	0
Transport	48
Premises	2,618
Increase / (decrease) in bad debt provision	(12)
Other impairment of financial assets	0
Depreciation and amortisation	2,584
Fixed asset impairments	0
Fixed asset reversal of impairments	0
Audit fees –statutory audit	47
Other auditors remuneration	0
Clinical negligence	775
Exceptional items	0
Other **	1,247
TOTAL	65,840

# \*\* Breakdown of Operating Expenditure: Other

	5 months ending 31 March 2009
	£000
Legal fees	115
Consultancy costs	70
Training, courses and conferences	166
Patient travel	24
Hospitality	50
Insurance	123
Other services, eg external payroll	255
Losses, ex gratia & special payments	134
Other	310
Total	1,247

# **Note 5 Operating Leases**

# Note 5.2 Operating lease rentals

	5 Months ending 31 March 2009 £000
Hire of plant and machinery	134
Other operating lease rentals	54
TOTAL	188

## Note 5.2 Operating lease commitments

Note 5.2 Operating lease communicates	5 months ending 31 March 2009 Land and Buildings £000	5 months ending 31 March 2009 Other £000
Annual commitments on leases expiring:		
- within one year	0	83
- between one and five years	45	199
- after five years	86	0
TOTAL	131	282

### **Note 6 Staff Costs and Numbers**

#### Note 6.1 Staff costs

	5 Months ending 31 March 2009
	£000
Salaries and wages	37,728
Social security costs	2,770
Employers contributions to NHS Pensions Agency	4,189
Other pension costs	0
Agency/contract staff	1,546
TOTAL	46,233

# Note 6.2 Average number of persons employed (WTE basis)

	Total
	5 Months ending
	31 March 2009
	Number
Medical and dental	320
Administration and estates	597
Healthcare assistants and other support staff	757
Nursing, midwifery and health visiting staff	890
Scientific, therapeutic and technical staff	213
Bank and agency staff	78
Other	76
TOTAL	2931

# Note 6.3 Employee benefits

There were no staff benefits in the period

# Note 6.4 Early retirements due to ill health

From the 1<sup>st</sup> November 2008 there were no early retirements from the Trust agreed on the grounds of ill-health.

## Note 7. 1 The late payment of commercial debts (interest) Act 1998

5 Months ending 31 March 2009 £000

0

Amounts included within other interest payable arising from claims made under this legislation

Compensation paid to cover debt recovery costs under this legislation

7.2 . Better Payments Practice Code	5 months ending 31 March 2009		
	Number	£000	
Total Non-NHS trade invoices paid in the year	16,548	15,164	
Total Non-NHS trade invoices paid within target	15,911	14,504	
Percentage of Non-NHS trade invoices paid within target	96.2%	95.6%	
Total NHS trade invoices paid in the year	859	17,269	
Total NHS trade invoices paid within target	838	17,030	
Percentage of NHS trade invoices paid within target	97.6%	98.6%	

The Better Payment Practice Code requires the Trust to aim to pay all undisputed invoices by the due date or within 30 days of receipt of goods or a valid invoice, whichever is later. During the year, as a result of the Prime Minister's announcement, the Trust pays suppliers in Northamptonshire immediately provided an authenticated invoice has been received.

Note 8 Disposal of fixed assets	5 Months ending 31 March 2009
	£000
Loss on disposal of intangible fixed assets	(1)
Loss on disposal of other tangible fixed assets	(18)
TOTAL	(19)
Note 9.1 Finance income	5 Months ending 31 March 2009
	£000
Bank and Paymaster Officer account interest	60
TOTAL	60

Note 10.1 Intangible fixed assets	Total	Software licences
	£000	£000
Gross cost at 1 Nov 2008	2,217	2,217
Additions - purchased	115	115
Disposals	(1)	(1)
Gross cost at 31 March 2009	2,331	2,331
Amortisation at 1 Nov 2008	756	756
Provided during the year	138	138
Amortisation at 31 March 2009	894	894
Net book value		
NBV - Purchased at 31 March 2009	1437	1437
NBV - Donated at 31 March 2009	0	0
NBV total at 31 March 2009	1,437	1,437

Note 11.1 Tangible fixed assets

	Total	Land	Buildings excluding dwellings	Assets under Construction & POA	Plant & Machinery	Information Technology	Furniture & Fittings
	£000	£000	£000	£000	£000	£000	£000
Cost or valuation 1 November 2008	100,132	9,000	65,819	52	23,700	1,299	262
Additions - purchased	1,816		1,619	121	42	34	
Additions - donated	83		28		55		
Impairments	0						
Reclassifications	0		36	(36)			
Other revaluations	0						
Disposals	(1,013)				(971)	(19)	(23)
Cost or valuation at 31 March 2009 Depreciation at 1	101,018	9,000	67,502	137	22,826	1,314	239
November 2008	16,067	0	0		15,092	755	220
Provided during the year	2,446		1,291		1,096	53	6
Impairments	0						
Disposals	(995)				(964)	(8)	(23)
Depreciation at 31 March 2009	17,518	0	1,291		15,224	800	203
Net book value							
NBV - Purchased at 31 March 2009	79,519	9,000	63,087	137	6,749	514	32
NBV - Donated at 31 March 2009	3,981	0	3,124	0	853	0	4
NBV total at 31 March 2009	83,500	9,000	66,211	137	7,602	514	36
Note 11.2 Analysis of tangible fixed assets							
	Total	Land	Buildings excluding dwellings	Assets under Construction & POA	Plant & Machinery	Information Technology	Furniture & Fittings
	£000	£000	£000	£000	£000	£000	£000
Net book value							
NBV - Protected assets at 31 March 2009 NBV - Unprotected assets	75,211	9,000	66,211				
at 31 March 2009	8,289			137	7,602	514	36
Total at 31 March 2009	83,500	9,000	66,211	137	7,602	514	36

## 11.3 Assets held at open market value

	Total Land exclu		Buildings excluding dwellings	Dwellings
	£000	£000	£000	£000
Open market value at 31 March 2009	0	0	0	0

# 11.4a Net book value of assets held under finance leases and hire purchase contracts at the balance sheet date

	Total	Plant & Machinery
	£000	£000
Cost or valuation at 31 March 2009	14	14

# 11.4b The total amount of depreciation charged to the income and expenditure account in respect of assets held under finance leases and hire purchase contracts

	Total	Plant & Machinery
	£000	£000
Depreciation 2009	3	3

# 11.5 The net book value of land, buildings and dwellings at 31 March 2009 comprises

	Total £000	Protected £000	Unprotected £000
Freehold	75,211	75,211	0
Long leasehold	0	0	0
Short leasehold	0	0	0
TOTAL	75,211	75,211	0

## 11.6 Impairment of assets

The Trust has not impaired any assets during the reporting period.

#### 12. Fixed asset investments

The Trust held no fixed asset investments at the balance sheet date

## 13. Stocks and work in progress

	31 Mar 2009
	£000
Raw materials and consumables	2,430
Work in progress	
Finished goods	
TOTAL STOCKS AND WORK IN PROGRESS	2,430

# **Note 14.1 Debtors**

	Total 2008/09 £000	Financial assets 2008/09 £000	Non-financial assets 2008/09 £000
Amounts falling due within one			
year:			
NHS Debtors	2,141	2,141	
Provision for impaired debtors	(447)	(447)	
Prepayments	552	0	552
Other debtors	1,374	745	629
Debtors falling due within one year	3,620	2,439	1,181
Amounts due after more than			
one year:			
Prepayments	42	0	42
Other debtors	580	0	580
Debtors falling due after more than one year	622	0	622
TOTAL DEBTORS	4,242	2,439	1,803

# Note 14.2 Provision for impairment of debtors

	2008/09
	£000
At 1 November 2008	459
Increase in provision	34
Amounts utilised	(4)
Unused amounts reversed	(42)
At 31 March 2009	447

# Note 14.3 Analysis of impaired debtors

	2008/09
	£000
Ageing of impaired debtors	
Up to three months	1
In three to six months	3
Over six months	443
Total	447
Ageing of non-impaired debtors past their due date	
Up to three months	190
In three to six months	133
Over six months	82
Total	405

# **Note 15 Current asset investments**

The Trust does not hold current asset investments at the balance sheet date.

# **Note 16 Creditors**

# **Note 16.1 Creditors**

	Total 31 Mar 2009 £000	Financial liabilities 31 Mar 2009 £000	Non-financial liabilities 31 Mar 2009 £000
Amounts falling due within one year:			
NHS creditors (from FTC20)	659	659	
Corporation tax payable	0		0
Other tax and social security costs	2,211		2,211
Obligations under finance leases and HP contracts	6	6	
Capital Creditors	502	502	
Other Creditors	5,407	4,170	1,237*
Accruals	748	748	
Deferred income	322		322
Creditors falling due within one year	9,855	6,085	3,770
Amounts falling due after more than one year:			
Obligations under finance leases and HP contracts	10	10	
Creditors falling due after more than one year	10	10	0
TOTAL CREDITORS	9,865	6,095	3,770

# Note 16.1 Creditors - early retirements detail

Included in NHS creditors at 31 March 2009 above :	£000	Number
- to buy out the liability for early retirements over 5 years	0	
- number of cases involved		0
- outstanding pension contributions at 31 March 2009 (*)	1,237	

# 16.2 Loans

The Trust had no loans at the Balance sheet date.

# Note 16.3 Prudential borrowing limit

	2009
	£000
Total long term borrowing limit set by Monitor	34,400
Working capital facility agreed by Monitor	11,000
TOTAL PRUDENTIAL BORROWING LIMIT	45,400

The Trust has not taken out long term borrowing in the accounting period and has not accessed the working capital facility.

The key ratios of which the trust reports to Monitor are:

Financial Ratios	Actual Nov 2008 – Mar 2009	Approved Full Year 2008/09
Maximum Debt/ Capital Ratio	0	0
Minimum Dividend Cover	3.1	3.6
Minimum Interest Cover	0	0
Minimum Debt Service Cover	0	0
Maximum Debt Service to Revenue	0	0

The NHS foundation trust is required to comply and remain within a prudential borrowing limit. This is made up of two elements:

- the maximum cumulative amount of long-term borrowing. This is set by reference to the five ratio tests set out in Monitor's *Prudential Borrowing Code*. The financial risk rating set under Monitor's *Compliance Framework* determines one of the ratios and therefore can impact on the long term borrowing limit.
- the amount of any working capital facility approved by Monitor.

Apart from the minimum dividend cover ratio, all other ratios are nil because the Trust did not plan to take on any interest bearing debt in 2008/09, and no long term debt was taken on.

# Note 16.4 Finance lease obligations

and the second of the second o	2009 £000
- within one year	7
- between one and five years	11
- after five years	0
Subtotal	18
Finance charges allocated to future periods	(2)
NET OBLIGATIONS	16

#### Note 16.5 Future finance lease obligations

	2009	2009
	£000	Number
Minimum payments	20	
Number of years of commitment		4

# Note 17. Provisions for liabilities and charges

	Total £000	Injury allowances and other claims £000	Other legal claims £000
At 1 November 2008	1,048	593	455
Change in the discount rate	0		
Arising during the year	154	3	151
Utilised during the year	(174)	(156)	(18)
Reversed unused	(107)	(75)	(32)
Unwinding of discount	0		
At 31 March 2009	921	365	556
Expected timing of cashflows:			
- within one year	592	36	556
- between one and five years	78	78	
- after five years	251	251	
TOTAL	921	365	556

Amount included in provisions of the NHSLA at 31/03/2009 in respect of Clinical Negligence liabilities of the Trust is £ 25.129m

#### Legal claims

The amount shown against legal claims include non-clinical claims made against the Trust. The amounts shown for these provisions are based on advice provided by the NHS Litigation Authority and Trust solicitors. The Trust has also provided for costs associated with the termination of a contract in respect of our clinical information system. The amounts and timing of estimated settlement will necessarily alter as the case progresses.

#### Other provisions

The amount shown against other provisions include permanent injury allowances payable to former employees of the Trust. With affect from 1/4/2002, trusts are required to account for the full cost of the injury allowance payable to the individual based on their life expectancy. Tables produced by the Governments Actuaries Department provide the estimates of life expectancy.

In addition to the provision, contingent liabilities for non-clinical negligence claims are given in note 22.

#### Note 18.1 Movement in taxpayers' equity

	2008/09
	£000
Taxpayers' equity at 1 November 2008	89,951
Surplus/(deficit) for the financial year	1,389
Public dividend capital dividends	(1,284)
Additions/(reductions) in donated asset reserve	(84)
Taxpayers' equity at 31 March	89,972

#### Note 18.2 Movements in public dividend capital

	2008/09 £000
Public dividend capital at 1 November 2008	62,125
New public dividend capital received	0
Public dividend capital repaid in year	0
Public dividend capital at 31 March	62,125

# Note 18.3 Movements on reserves

Total £000 27,826	Revaluation Reserve £000 25,043	asset reserve £000	expenditure reserve £000 (1,282)
105			105
84		84	
(168)		(168)	
0	(435)		435
27,847	24,608	3,981	(742)
	£000 27,826 105 84 (168)	Total Reserve £000 27,826 25,043  105 84  (168)  0 (435)	Revaluation asset reserve £000 £000 £000 £000 £000 £000 £000 £0

Donatod

Income and

from operating activities	2008/09 £000
Total operating surplus/(deficit)	1,348
Depreciation and amortisation	2,584
Transfer from the donated asset reserve	(168)
Other movements	5
(Increase)/decrease in stocks	18
(Increase)/decrease in debtors	3,408
Increase/(decrease) in creditors	(995)
Increase/(decrease) in provisions	(127)
Net cash inflow/(outflow) from operating activities before restructuring costs	6,073
Payments in respect of fundamental reorganisation/restructuring	0
Net cash inflow/(outflow) from operating activities	6,073

Note 19.2 Reconciliation of net cash flow to movement in net	
funds / (debt)	2008/09
	£000
Increase/(decrease) in cash in the year	2,855
Cash (inflow) from new debt	0
Cash outflow from debt repaid and finance lease capital payments	2
Cash (inflow)/outflow from (decrease)/increase in liquid resources	0
Change in net funds / (debt) resulting from cash flows	2,857
Non-cash changes in debt	0
Change in net funds / (debt)	2,857
Net funds / (debt) at 1 April 2008	0
Net funds / (debt) at 1 November 2008	6,276
Net funds / (debt) at 31 March 2009	9,133

# Note 19.3 Analysis of changes in net funds / (debt)

	At 1 November 2008	Cash changes in year	Non-cash changes in year	At 31 March 2009
	£000	£000	£000	£000
Cash at commercial banks and in hand	65	(13)		52
Cash at OPG (Office of Paymaster General)	6,229	2,868		9,097
Bank overdrafts				0
Debt due within one year				0
Debt due after one year				0
Finance leases	(18)	2		(16)
Current asset investments				0
TOTAL	6,276	2,857	0	9,133

**Note 20. Contractual Capital Commitments** 

Scheme Description	Description of scheme	Completion Date	Commitment £000
•	A major refurbishment of Harrowden		
Harrowden Ward Refurbishment	Floor in the Main Hospital Block	Mar 2010	3,183
	A refurbishment of the Sterile Services		,
Sterile Services Department	Block	Nov 2009	408
Replacement of Existing Chimney &	Take down and replace the Trust's main		
Flues	chimney on the Boiler house	May 2009	70
	Alterations to internal room layout for		
	Anti-Coagulation and Chronic Pain	Jun 2009	
Alterations to Warren Hill House	Clinic		150
	Replace/Upgrade Fire Doors around the		
Fire Door Maintenance	Trust to comply with current regulations	Jul 2009	86
New Wash Hand Basins - Eye Clinic	Replacement of wash hand basins to		
& MAU	comply with current regulations	Jun 2009	10
	Essential repairs to lift in		
Lamport & Twywell Lift Repairs	Lamport/Twywell block	Apr 2009	6
	Total as at 31 March 2009		3,913

#### 21. Post Balance Sheet Events

The Trust will be applying the International Financial Reporting Standards (IFRS) from the 1<sup>st</sup> April 2009. The application of these new standards will not have a material impact upon the Trusts' financial performance or balance sheet.

#### 22. Contingencies

The Trust has contingent liabilities detailed below. The Trusts' financial liability, if any, cannot be determined until the related claims are resolved. An estimate of the amount involved, inclusive of legal costs, is:

24 Mar 2000

	31 War 2009
	£000
Gross value of contingent liabilities	(102)
Amounts recoverable against liabilities	0
Net value of contingent liabilities	(102)
Net value of contingent assets	30

The contingent liability relates to legal claims made against the Trust. In addition to the above contingent liabilities, provisions are given in Note 17.

The contingent asset relates to a claim the Trust has made against 2 suppliers for the cost of capital remedial works

## 23 Related Party Transactions

## 23.1 Related Party Transactions

	£000	£000
Value of transactions with board members in 2008/09	0	1
Value of transactions with key staff members in 2008/09	0	0
Value of transactions with other related parties in 2008/09	65,974	12,394

#### **Note 23.2 Related Party Balances**

	Debtor £000	Creditor £000
Value of balances (other than salary) with board members at 31 Mar 2009	0	0
Value of balances (other than salary) with key staff members at 31 Mar 2009	0	0
Value of balances with other related parties at 31 March 2009	2,469	4,112

Kettering General Hospital NHS Foundation Trust is a body corporate established by order of the Secretary of State for Health.

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

The Department of Health is regarded as a related party. During the year Kettering General Hospital NHS 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 Department. These entities with material transactions (income or expenditure over £40k) are listed below:

	Income	Expenditure
Organisation	£000	£000
NHS bodies		
Bedfordshire PCT	64	
Buckinghamshire PCT	122	
Department of Health	4,481	1
East Midlands Ambulance Service NHS Trust	0	177
East Midlands Strategic Health Authority	3,553	0
Ipswich Hospital NHS Trust	67	
Leicester City PCT	58	
Leicestershire County And Rutland PCT	4,628	
Lincolnshire PCT	48	
Milton Keynes PCT	119	
NHS Blood And Transplant Agency		513
NHS Litigation Authority		805
NHS Pension Scheme (Employers)		4,189
NHS Shared Business Services		1,554
Northampton General Hospital NHS Trust	65	52
Northamptonshire Healthcare NHS Trust	309	13
Northamptonshire PCT	50,233	1,220
Oxford And Buckinghamshire Mental Health NHS Foundation Trust	72	165
Oxford Radcliffe Hospitals NHS Trust	81	
Oxfordshire Learning Disability NHS Trust	25	51
Oxfordshire PCT	179	
Royal Berkshire NHS Foundation Trust	69	1
Suffolk Mental Health Partnership NHS Trust	67	
Suffolk PCT	59	
University Hospital Birmingham NHS Foundation Trust	0	74
University Hospitals Of Leicester NHS Trust	257	285
Warwickshire PCT	69	
West Suffolk Hospitals NHS Trust	69	
Yorkshire And The Humber Strategic Health Authority	647	
Other Government bodies		
Audit Commission		47
HM Revenue & Customs – Employers costs		2,766

The Trust has also received revenue and capital payments from a number of charitable funds, the corporate trustee for which is Kettering General Hospital NHS Foundation Trust. The audited accounts of the Funds Held on Trust can be obtained from the Finance Director.

#### Note 24.1 For PFI schemes deemed to be off-balance sheet

	1 Nov 2008
	to 31
	Mar 2009
O	£000
Gross charge to operating expenses in respect of off balance sheet PFI transaction(s)	134
Amortisation of PFI deferred asset(s)	0
Net charge to operating expenses in respect of off-balance sheet PFI transaction(s)	134
Note 24.2 The Trust is committed to make the following payments for off-balance sheet PFIs during the next year in which the commitment	2009
expires:	Total
	£000
Within one year	0
2nd to 5th years (inclusive) *	422
Estimated capital value of project	2,437
N 4 040 F BEL I I I I I I I I I I I I I I I I I I I	,
Note 24.3 For PFI schemes deemed to be off-balance sheet	
	2009
	years
Total length of project (years)	11

#### **Description of Scheme**

Number of years to the end of the project

This was an investment in an Integrated Clinical Information System which enabled the Trust to incrementally, over several years, implement an information system which directly supports the integrated care of patients and achieve the longer-term goal of a level 3 to 5 electronic patient record.

2

\*This is based on the current 2008/09 contract payments. The IM&T programme has been reviewed in light of the Connecting for Health Programme. This will involve migration to another suite of software products. This is expected to bring forward the contract end date within the next financial year.

## 24.4 'Service' element of PFI schemes deemed to be onbalance sheet

The Trust has no PFI schemes deemed to be on-balance sheet.

#### 25. Financial Instruments.

#### Financial risk management

Financial reporting standard 29 requires disclosure of the role that financial instruments have had during the period in creating or changing the risks a body faces in undertaking its activities. Because of the continuing service provider relationship that the Trust has with Primary Care Trusts and the way those Primary Care Trusts are financed, the Trust is not exposed to the degree of financial risk faced by business entities. Also financial instruments play a much more limited role in creating or changing risk than would be typical of listed companies, to which these standards mainly apply.

The Trust's treasury management operations are carried out by the finance department, within parameters defined formally within the Trust's Standing Financial Instructions and policies agreed by the Board of Directors. Trust treasury activity is subject to review by the Trust's internal auditors.

#### **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. The Trust therefore has low exposure to currency rate fluctuations.

#### Interest rate risk

100% of the NHS Foundation Trust's financial assets and 100% of its financial liabilities carry nil or fixed rates of interest and therefore it has low exposure to interest rate fluctuations

#### Credit risk

Because the majority of the Trust's income comes from contracts with other public sector bodies, the Trust has low exposure to credit risk. The maximum exposures as at 31 Mar 2009 are in receivables from customers, as disclosed in the Trade and Other Receivables note. The majority of the Trust's cash balances are held with HM Paymaster General at the Bank of England, thereby not subject to any credit risk.

#### Liquidity risk

The Trust's new operating costs are incurred under contracts with Primary Care Trusts, which are financed from resources voted annually by Parliament. The Trust funds its capital expenditure from funds obtained within its Prudential Borrowing Limit. The Trust is not, therefore, exposed to significant liquidity risks. The Trust had in place a guaranteed working capital facility of £11m with its commercial bankers.

The following are not financial instruments because they arise under legislation rather than under contract:

- a. Public Dividend Capital
- b. Early retirement liabilities (with the NHS Business Services Authority)
- c. Injury benefit liabilities ( "" )

Payments due under the injury cost recovery scheme are not financial instruments as they are not under contract with the Trust.

## Note 25.1 Financial assets by category

	Total	Loans and receivables
	£000	£000
Assets as per balance sheet		
NHS Debtors (at 31 Mar 2009)	2,141	2,141
Provision for irrecoverable debts (at 31 Mar 2009)	(447)	(447)
Other debtors (at 31 Mar 2009)	745	745
Cash (at bank and in hand (at 31 Mar 2009)	9,149	9,149
Total at 31 March 2009	11,588	11,588

# Note 25.2 Financial liabilities by category

	Total £000	Other financial liabilities £000
Liabilities as per balance sheet		
NHS creditors (at 31 Mar 2009)	659	659
Other creditors (at 31 Mar 2009)	4,170	4,170
Accruals (at 31 Mar 2009)	748	748
Capital creditors (at 31 Mar 2009)	502	502
Finance lease obligations (at 31 Mar 2009)	16	16
Provisions under contract (at 31 Mar 2009)	921	921
Total at 31 March 2009	7,016	7,016

# Note 25.3 Fair values of financial assets at 31 March 2009

	Book Value £000	Fair Value £000
Debtors over 1 year	0	0
Fixed asset investments	0	0
Other	0	0
Total *	0	0

# Note 25.4 Fair values of financial liabilities at 31 March 2009

	<b>Book Value</b>	Fair Value
	£000	£000
Creditors over 1 year - Finance lease obligations (already discounted)	10	0
Provisions under contract (due within 1 year)	921	0
Total *	931	0

# 26. Third party assets

The Trust held £1,260 cash at bank and in hand at 31/03/2009 that relates to monies held by the Foundation Trust on behalf of patients. This has been excluded from cash at bank and in hand figure reported in the accounts.

# 27. Losses and special payments

There were 42 cases of losses and special payments totalling £134,353 approved from November to March 2009. The total costs included in this note are on a cash basis