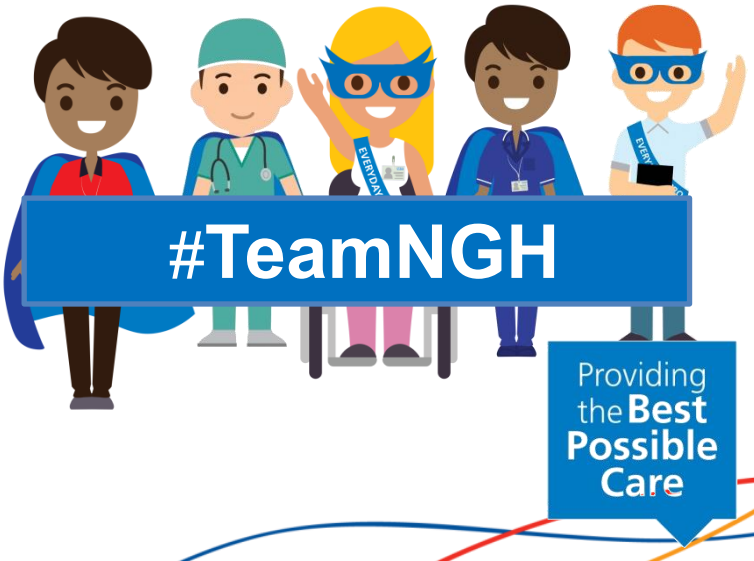
UNIVERSITY OF LEICESTER
Associate Teaching Hospital

NHS
Northampton General Hospital
NHS Trust

ANNUAL REPORT AND ACCOUNTS 2018/19

We put patient safety above all else
We aspire to excellence
We reflect, we learn, we improve
We respect and support each other



CONTENTS

All NHS organisations are required to publish an annual report and financial statements at the end of each financial year. This report provides an overview of the work of Northampton General Hospital NHS Trust between 1 April 2018 and 31 March 2019.

The report is made up of three parts:

SECTION ONE:

PERFORMANCE REPORT

Chairman and Chief Executive's Overview

Welcome to our annual report for 2018/19. Preparing this review provides us with an opportunity to reflect upon our achievements and successes, and also reflect on where we need to do more. As an organisation we know how important it is to celebrate success, particularly in the wider context of the challenges we face. Our annual report provides you with an overview of our performance and an outline of our priorities for the coming years.

As an organisation we have an internal and external perspective when it comes to partnership working. We understand there are internal issues which we can address through our own teams working together, and at the same time we must work collaboratively with others in wider partnerships if we are to be successful.

Our changing care team has supported colleagues in TeamNGH to build on Model Hospital and GIRFT (Getting It Right First Time) opportunities to help deliver efficiency opportunities valued at more than £20.8m since April 2017. We are also working with system partners to look at significant pathway changes that will lead to better patient care at lower cost.

Underpinning our clinical services strategy we have set out to be a hospital that changes the pathways and delivery of care with the overall aim of improving our services from both a clinical outcome and efficiency perspective. Our ambition is for all services to be focused on quality and quality improvement.

Our quality improvement hub has a strong safety focus, with support teams on the ground. We have a well-established range of teaching and development programmes which help educate and energise our staff and equip them with the skills and knowledge they need to both deliver and improve care.

In a year when we celebrated 70 years of the NHS we continued to face increasing pressure and demand for our services, which in turn affected our performance. However, our staff remained focussed on our core value of putting patient safety above all else whilst they responded to the challenges they faced, displaying care and compassion as they strove to deliver the best possible care.

We have struggled to meet the 95% 4hr target in A&E, although throughout the summer of 2018 we were able to improve our performance significantly as the number of attendees decreased and the patients were not as unwell.

The opening of our new 60 bedded assessment unit in October 2018 enabled us to introduce a new medical model, led by our medical director and divisional director for medicine, which saw an increase in the number of consultant physicians at the beginning of the urgent care pathway. This led to a significant reduction in the waiting time to see a medical consultant and this has continued, leading to safer care and rapid diagnosis for our most acutely unwell patients.

We were able to extend our capacity and open a 28-bedded winter ward in December 2018 following a system wide review which showed we needed to increase our bed base significantly in order to reduce occupancy over the winter months. At the same time we realigned our bed base to ensure enable us to better manage admission peaks.

A significant amount of work with our partners and across our wards has taken place since April 2018 to reduce the number of patients who remained in hospital despite being assessed as being medically fit for discharge. By June 2018 the number of had reduced by 40%, which supported flow through our adult bed base during the summer months and improved our elective admission rates.

Despite our operational pressures we were one of the few acute trusts in the East Midlands region to achieve our financial plan in all months during the year as well as our planned deficit. We also delivered our challenging efficiency savings target of £15.9m including £10m of recurrent savings. We believe our approach demonstrates that getting it right first time and providing safe, high quality care is the most efficient way of delivering services.

Throughout the year we were aware that the proposed departure of the United Kingdom from the European Union could cause a number of significant risks to materialise, either at or about the time of departure or in the following days, weeks, months and years.

Our Brexit Planning Group was set up to ensure we acted in accordance with national, regional and local guidance. A trust-wide business continuity plan for a no-deal EU Exit was created which followed through our planning for the events and actions that were within our local control. The document was developed in way that it could be revoked or amended as required, depending on the outcome of negotiations. Processes were put in place to ensure escalation of any issues would be through our existing command and control structure.

Our Chief Operating Officer was identified as the Senior Responsible Officer to oversee the work to ensure continuity of supply of goods and services in the event of a no-deal Brexit. We identified the categories of spend and suppliers which were best engaged at a national level and all other categories and suppliers were reviewed as part of a self-assessment methodology and submitted to the Department of Health and Social Care..

We are following national guidance in preparing for a no-deal exit of the UK from the EU and have arrangements in place to mitigate any risks that may arise from this scenario. The Board is kept informed of any implications of the withdrawal agreement as further information is provided. We are compliant with current guidance; and any risk to our services is being managed so far as is reasonably practicable under the circumstances.

Despite the rising demand and pressure within the hospital and the local health and care system, we have maintained our focus on patient safety, quality and efficiency. Our staff have continued to develop innovate and respond to new ways of working. Our quality improvement team is recognised nationally for their projects. Their portfolio is far-reaching, with all grades of under-graduate doctors in training, doctors in non-training posts, nurses, midwives, clinical and non-clinical staff actively involved in QI projects.

A highlight of our year was being the first hospital in the UK to receive Pathway to Excellence Accreditation® by the American Nurses Credentialing Centre. Hospitals achieving designation are deemed to be among the best places for nurses and

midwives to work, with high job satisfaction and retention. We know research shows that healthy workplaces, where staff work in a positive practice environment, not only improve staff satisfaction and morale, they also improve patient satisfaction and the quality of patient care.

Our Shared Decision Making Councils developed as part of our Pathway to Excellence programme have extended from our wards to other areas and topics, such as Pharmacy and Health and Well-Being. Staff at all levels work together to identify the improvements they want to see happen and are supported to design and deliver their improvement strategy, and share their projects and learning across the organisation.

During the year we were proud to sign up to the Countywide Armed Forces Covenant, pledging our support and commitment to military personnel past and present. We see our job as being the signpost to local services available to all veterans, their families and carers, both staff and patients, should they wish to access them.

We have continued to work closely with the University of Northampton on a number of training and education projects, including an MSc in Quality Improvement and Patient Safety, which is the first of its kind in the UK to be taught within a hospital rather than a university. We have further strengthened our links with the University of Leicester Medical School and are proud to have been given Associate Teaching Hospital status.

Support and recognition for our employees

We are proud to celebrate the achievements of TeamNGH, as well as looking ahead. Our successes have come from the efforts and commitment of our staff, our volunteers, the support of our local community and our partners in the wider health and social care economy.

In July 2018 we launched our Respect and Support campaign to tackle workplace bullying and harassment. Developed with our staff, who took part in focus groups, and taking account of feedback from our staff survey, the respect and support campaign provides staff at all levels with bespoke training to help them respond appropriately to bullying and harassment.

In addition to the training we have introduced a behaviour framework, which includes a self-assessment tool, a telephone hotline, resilience training and round table conversations to help resolve issues of conflict between two people with the aim of achieving resolution informally and maintain positive working relationships.

Our vibrant health and wellbeing programme for staff has grown during the year and more than 30% of staff have taken part in at least one of our health and wellbeing activities which include our in-house slimming group, yoga classes, dance classes, walking and running groups and a choir. There has been a particular focus on mental health throughout the year with workshops on mental health awareness, mindfulness, sleep and stress management workshops and a menopause workshop.

We are also partnered with Public Health and Northamptonshire County Council to establish and deliver key programmes around mental wellbeing alcohol reduction, diet improvement, physical activity and smoking cessation.

Following the success of our Winter Heroes campaign in the winter of 2017/18 we launched our Everyday Hero awards in September 2018 to recognise the effort and commitment of our non-nursing and midwifery members of TeamNGH who have gone above and beyond to improve patient care or support their colleagues. The award gives patients and our staff an opportunity to nominate someone who has really made a difference.

During the year Northamptonshire's first cohort of nursing associates celebrated reaching the end to their two year training at NGH. The thirteen nursing associates are among the first in the country to quality. Their role is to bridge the skills gap between healthcare assistants and registered nurses. They provide more support on wards, help to administer medications and care for patients, having undergone formal training with the University of Northampton and being registered with the Nursing and Midwifery Council.

In December 2018 we were proud to honour our longest-serving members of TeamNGH, when we recognised colleagues who had worked continuously at NGH for more than 25, 30, 35 and 40 years. The 56 individuals had a combined service of 1,725 years at NGH.

Our volunteers

We remain indebted to the commitment shown by our volunteers. A significant change during the year has been the recruitment of young volunteers, who are 16-18 years old. We have been able to offer those young people considering a future career in the NHS an opportunity to gain experience and enhance their university, and future employment, applications. Some of our young volunteers have successfully applied for and secured full time employment within NGH and other local hospitals.

Our volunteer services are well placed to support others in the local community, and continue to work with people with mild learning disabilities, who help co-ordinate our bedside book club and have ensured our gardening team has gone from strength to strength.

More and more of our clinical areas are benefiting from the support our volunteers provide, including help with feeding, dedicated end-of-life companions, dementia buddies and activity assistants for our patients with dementia.

We were delighted to receive support from local business, Mawsley Machinery, who donated a new buggy, designed as a train, to transport children to and from

treatment or surgery. We hope the train will help make the experience of being in hospital less intimidating for our younger patients.

Our buildings and facilities

NGH sits on an old hospital site, parts of which date back to the 18th century. Despite this and the constantly challenged landscape, we have continued to invest in capital spend to maximise patient care and maintain our estate. We also work with the Northamptonshire Health Charity to secure funding for capital schemes for the benefit of our patients.

Our new emergency assessment unit opened in October 2018. The Nye Bevan Building, named by our staff in honour of the architect of the NHS, is a £12 million investment providing 60 beds, a mix of small wards and individual rooms, including dedicated rooms for vulnerable patients who might need end-of-life care or who are suffering from infection.

The new unit has enabled us to introduce a new medical model of care, with greater consultant input and review of patients needing assessment. The principle is to ensure assessment and care plans are completed quickly, avoiding unnecessary hospital admission and helping patients return home as soon as possible.

We also opened a new emergency assessment bay which provides round-the-clock access to specialist emergency care for haematology and oncology patients. The development was made possible with the support our local community and a £350,000 investment by our charity, the Northamptonshire Health Charitable Fund. We are enormously grateful to our charity for funding the project, and to each and every one of our employees, volunteers, patients and families and the local community who helped raise the funds needed for the unit.

During the year we also refurbished Knightley ward and our main theatres to ensure our site is safe, fit-for-purpose and patient-friendly.

Our IT infrastructure

Technology is transforming the delivery of healthcare and we are committed to enabling the benefits of technology to help deliver the best possible care to patients.

Our IT strategy is driven with clinical involvement, not only from our local clinical teams but also in partnership with organisations who help bring innovation to the hospital. Working closely with partners we are working towards providing a unified healthcare environment with patients at the centre of everything we do.

Our strategy is reviewed annually and adjusted to ensure we are keeping up with technological advancements.

Our strategic direction within IT is to work towards providing a digital-first working environment, focussed on securely collecting and sharing quality data, to enable us to be information-led and work with other healthcare providers to provide pathway and patient centric care.

Our priorities have been to:

- Stop the paper and become digital though clinical noting and useful and helpful use of appropriate technology
- Get rid of the paper through scanning and back-office automation/digitisation
- Ensure data is secure, of quality, timely, GDPR compliant and shared appropriately for patient care
- Enable the sharing of information and resources across the local health economy to enable a Northamptonshire care record and mobile working

Three key developments during the year have been:

- The introduction of CaMIS, a new patient administration system after an extensive planning period.
- CareFlow to provide secure, instant messaging to enable our clinical teams to share information and enable real-time discussions and decisions regarding a patient's treatment and care, wherever the individuals are located within the hospital
- Ibox a new electronic whiteboard solution providing real-time information on ward occupancy and activity to help improve patient flow.

Innovation, improvement and awards

Quality improvement is a cornerstone of our services. Throughout the year members of TeamNGH at all levels have continued to embrace opportunities to improve services and our patients' experience.

Our stroke patients receive some of the best care in the UK according to the latest independent study, which credited NGH with achieving the highest possible rating in a national audit of stroke services. This is the eighth time in the past nine audits that our stroke service has achieved this superb score, placing the stroke service at NGH in the top 24% of stroke services in England.

During the summer of 2018 inpatient care for all Northamptonshire stroke patients was centralised at NGH, with increased rehabilitation support at NGH and Isebrook Hospital in Wellingborough. Much of the care is provided by our community stroke team, which has been recognised as being outstanding.

We are extremely proud that the stroke team were able to sustain and improve the ranking of their service as among the best stroke services in the country. We know our patients rely on us to assess them quickly and safely and the centralisation of the service will lead to further development of specialist expertise.

The latest CQC survey of UK maternity services show that maternity care offered by the midwifery team at NGH continues to be highly rated. We value the input of those who took the time to take part in the survey and value their input and feedback. The results reflect the dedication, commitment and effort of our highly skilled maternity teams who work both within NGH and the local community.

Our midwives also provide a dedicated phone service for expectant parents that receives up to 60 calls a day. Our telephone triage service is available, 24 hours a day, seven days a week, for those who are 20 or more weeks' pregnant. Women can call with any problems or worries they have regarding their pregnancy and have told us they find the service reassuring, knowing there is someone they can speak to who is able to offer expert advice.

A number of our nurses have been nominated for and been awarded a Cavell Star Award. The Awards are for nurses, midwives and healthcare assistants who have shown exceptional care for either their colleagues or their patients, and patients' families.

For the third year running we were the most successful NHS organisation at the International Forum on Quality and Safety in Healthcare. We submitted 16 conference posters – the most from any NHS Trust.

Infection prevention and control nurse, Kelly Baptiste, received the Small Steps Award from One Together, for the work she has undertaken to help reduce the incidence of surgical site infections.

Forward look

We continue to work towards our vision of providing the best possible care, underpinned by our core values:

- Patient safety above all else
- Respect and support one another
- Reflect, learn, improve
- Aspire to excellence

However, we operate in an increasingly difficult environment. Demand for our services continues to grow and we must continually strive to improve the quality of the care we provide.

Our NHS partners and partners in health and social care face similar challenges. We are working collaboratively within the Northamptonshire Health and Care Partnership to deliver sustainable high quality and efficient care to our patients. Our aim is to be a strong and effective partner and work collaboratively to develop a unified model of care.

Our work with colleagues at Kettering General Hospital will drive greater efficiencies and improve the use of scarce resources, move bureaucracy and speed-up decision-making to support clinical changes in delivering our vision, and ensure services in both organisations are sustainable in the long term. The aim is to complement and strengthen existing relationships, reduce variation, improve outcomes and efficiency and reduce duplication.

Finally, we would like to offer our sincere thanks on behalf of the trust board to the more than 5,000 members of staff and volunteers who make up what we know as TeamNGH. We are immensely proud to lead an organisation that is so committed to providing the best possible care.

Dr Sonia Swart
Chief Executive Officer

Alan Burns
Chairman

AN INTRODUCTION TO NORTHAMPTON GENERAL HOSPITAL NHS TRUST

About Us

Northampton General Hospital has served the people of Northampton for more than 275 years. We now provide general acute services to our local community of 380,000 people and hyper-acute stroke, vascular and renal services to 692,000 people who live in the wider Northamptonshire area.

As an accredited cancer centre we provide care to a wider population of 880,000 people living in Northamptonshire and parts of Buckinghamshire.

We provide services from our main hospital site located close to Northampton town centre. We also provide a limited range of outpatient services at Danetre Hospital in Daventry. During the year we also provided care for patients awaiting discharge from two wards in the Cliftonville Care Home, while the Angela Grace Care Centre provides more specialist care: both are located adjacent to our main hospital site.

Our Vision, Values and Strategy

Our vision is to provide the best possible care for our patients.

Our aim is to be innovative and provide services in the safest and most clinically-effective way. We aspire to align our efforts around quality improvement. At the same time we know we can't achieve our vision without investing in TeamNGH. Our view is that this investment should incorporate and support the development and nurturing of our workforce so they are able to meet the challenges we face.

Our values underpin all we do and are the behaviours against which we judge ourselves:

- We put patient safety above all else
- We aspire to excellence
- We reflect, we learn, we improve
- We respect & support each other

Our Strategic Aims

Our trust board trust board has agreed our strategic direction in the context of NHS priorities and monitors our performance against those objectives. Our board provides financial stewardship, clinical governance and corporate governance to ensure that we continue to provide high quality care that offers value for money.

To support delivery of these organisational priorities we have developed five strategic aims aligned to our vision and values. They are:

1. **To focus on quality and safety**

   We will avoid harm, reduce mortality, and improve patient outcomes through a focus on quality outcomes, effectiveness and safety

2. **To exceed our patients' expectations**

   We will continuously improve our patient experience and satisfaction by delivering personalised care which is valued by patients

3. **To strengthen our local services**

   Provide a sustainable range of services delivered locally

4. **To enable excellence through our people**

   We will develop, support and value our staff to provide our patients with quality care delivered by a highly trained and motivated workforce**.**

5. **To ensure a sustainable future**

   To provide effective and commercially viable services for our patients, ensuring a sustainable future for NGH

Risks

We continue to operate within a challenging healthcare environment which is seeing persistent growth in demand, particularly for those who aged over 65 years. Delays in sourcing sufficient social care packages for home care and nursing homes impact on the length of stay for our many of our patients, and this, in turn, has a negative impact on our ability to maintain elective activity.

Whilst we have achieved our financial plan in 2018/19, there is more to do in 2019/20 and our ability to recruit and retain a substantive workforce continues to be a strategic risk.

We have increased our focus on the use of GIRFT and Model hospital to support our Divisions in identifying and delivering recurrent cost saving schemes as well as leveraging income generating opportunities. Our patient flow programme, Fixing the Flow, focuses on streamlining patient flow using quality improvement methodology and includes changing the way work is undertaken and the tasks carried out by staff.

Our recruitment priorities focus on nursing and medical staff from a local, national and international perspective. We were able to reduce our nursing vacancy rate from almost 200 in 2016 to 111 in 2019. The number of medical staff in post has increased from 521 in February 2018 to 560 in February 2019 with vacancies reducing from 66 in April 2018 to 22 in March 2019.

We believe there are opportunities to repatriate elective activity from the private sector and if we are successful this will contribute to improving our overall financial position. At the same time we are also actively working to improve both the quality of financial viability of acute services in collaboration with our colleagues at Kettering General Hospital and will be seeking in this process to unblock new economies of scale and remove duplication.

During the year we have continued to focus on:

- transforming the way our staff work and how we deliver key services to respond to changing patient needs, ensuring that we are able to respond to the demands placed on our services and the organisation;
- improvements in collaboration with partner organisations
- maximising efficiency and reducing cost so that we are a high value organisation;
- strengthening the way we work with other organisations and partners, to establish partnerships and strategic alliances where this is mutually beneficial and improves the quality and efficiency of our services for patients;

In February 2019 we were pleased to receive a visit from Matt Hancock, MP, Secretary of State for Health and Social Care, and were delighted to show him round our new assessment unit in the Nye Bevan building.

PERFORMANCE ANALYSIS

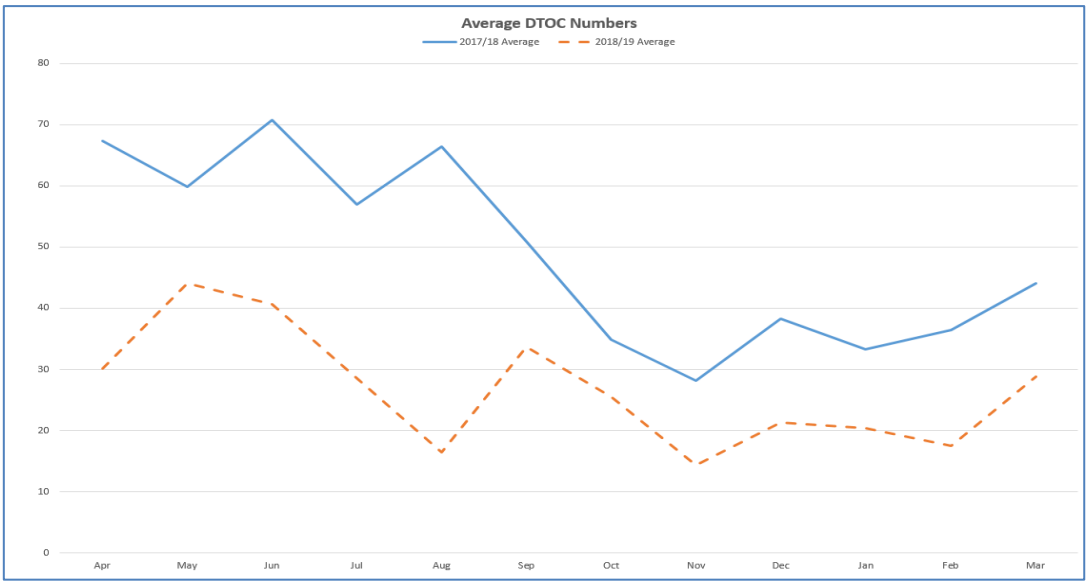
Overview

The past year has seen a continued collaborative approach between service providers across the county to ensure patients are provided with the best possible care in the timeliest manner.

We have seen an overall 4.6% increase in A&E attendances, including type 1 (Emergency Department), type 2 (eye casualty) and type 3 (Springfield house-urgent treatment centre) attendances. The majority of this growth is accounted for by the full-year effect of Springfield House, as the service was first provided in the last four months of 2017/18. A review of the Emergency Department (ED) identifies no growth on attendances but a 4.6% increase in the average conversion rate (patients admitted from ED to a ward) over 2017/18 (22% to 26.4%).

The increase in admissions from ED, compounded with pockets of high acuity patients, has continued to affect patient flow throughout winter, despite a number of initiatives being put in place to improve our position. This has been further compounded by a high number of stranded (patients staying 7 days and over) and the number of super stranded (stays over 21days) patients has remained high.

During the last four months of the year we saw a significant improvement in the number of delayed transfers of care (DToC). Despite this the number of DToC remains higher than 2017/18 and we were unable to meet the 4 hour wait target in our emergency department during the final 7 months of 2018/19.



Increased winter pressures, patient acuity, DToC and exceptionally high bed occupancy levels have also adversely affected our ability to deliver the 18 week referral to treatment (RTT) target, and performance has been below the agreed trajectory since September 2018.

We successfully maintained the 6 week target for diagnostics; more than 99% of patients received their diagnostic test within 6 weeks from the request consistently throughout the year.

There continue to be a number of initiatives both within NGH and at a countywide level to support and improve patient pathways to both improve access and, importantly, enable patients to return home in a safe and timely manner. Safety, quality of care and our patients' experience remain at the forefront of all initiatives.

The fixing the flow programme which commenced at the end of 2017 continues to support and improve patient flow with a focus on:

- SAFER patient flow bundle developed by NHS Improvement, specifically:
  - Clarity of the plan for all of patients and staff
  - Increased % of our patients that are fit to are getting out of bed during the day
  - Focus on the actions for tomorrow's discharges from the afternoon board rounds
  - Organised team, easier to lead, less onerous for medical staff
  - Improved teamwork and morale
- Improved daily information & planning for the site team
- A new IV antibiotic service
- Revised ambulatory pathways
- An advice & guidance line for the GPs to contact consultants directly
- New admission paperwork to stop duplication
- Multi Agency Discharge Events (MADE)
- New models of care for therapy-led unit
- Primary care input into two of the wards
- 'Blended Front Door' with senior specialty consultants supporting ED with senior decision making as assessment
- Spot purchase of care home beds to supports discharge flow out of the hospital
- Daily tracking meetings during the peak of winter with our external colleagues to confirm and challenge every patient's pathway and what blockages if any were present and free them up
- Additional registrars and consultants on duty overnight and at weekends
- Junior doctor allocated to the discharge suite to support the rapid production of TTOs
- Review of the fractured neck of femur pathway

In November 2018 we opened the Nye Bevan building, which hosts our new assessment unit. The unit is a 60 bedded assessment unit on two floors and forms part of the urgent care village alongside A&E, urgent treatment centre and ambulatory care.

Activity

During the year we saw a significant increase in emergency (non-elective) inpatient activity. This created bed pressures and impacted on our ability to deliver elective inpatient care and achieve the 18 week RTT (referral to treatment) target

The growth in A&E attendance largely relates to type 3 activity (minor illness and injuries) which is treated at Springfield House. There was no growth in type 1 activity and type 2, eye casualty, reduced by almost 17% (15,818 vs. 13,174).

Activity Comparison	2015-16	2016-17	2017-18	2018-19	Diff	% Diff
Emergency Inpatients	43,456	47,701	46,061	50,588	4,527	9.8%
Elective Inpatients	5,824	5,634	5,135	5,131	-4	-0.1%
Elective Daycases	39,610	42,393	41,840	42,128	288	0.7%
New outpatient attendances	125,601	133,548	135,239	139,518	4,279	3.2%
Follow-up outpatient attendances	309,974	310,358	314,645	315,666	1,021	0.3%
Total number of outpatient DNA's	34,770	36,708	35,764	43,999	8,235	23.0%
Patients seen in Accident & Emergency (All Types)	114,179	116,183	127,583	133,460	5,877	4.6%
Number of babies born	4,726	4,867	4,760	4,648	-112	-2.4%
Average length of stay (in days)	4.36	4.52	4.88	4.61	-0.27	-5.5%

Elective inpatient activity has shown a steady decrease over the past four years, albeit in 2018/19 the reduction was 0.1% or four patients.

Bed occupancy remained high throughout the year and during the winter months we regularly exceeded 100% bed occupancy, leading to the opening of escalation wards and the cancellation of some non-urgent elective activity. We saw a slight increase in elective day case and outpatient activity as we focused on the provision of activity which did not require a ward bed.

National Performance Standards

We have experienced significant challenges in meeting the national performance standards, especially with the pressure on urgent care in quarters three and four of 2018/19. This also impacted on our elective activity and RTT performance due to the need to cancel inpatient procedures to accommodate the non-elective activity with high levels of DToC. Although DToC reduced towards the end of the year the number was higher than during 2017/18.

Elective activity focused on day case delivery which helped prevent the RTT performance deteriorating.

Despite the pressures on the organisation we were able to maintain the six week performance target for diagnostic tests

Additionally it is worth noting that, due to a change in our Patient Administration System (PAS) there was a change in the profile of RTT and an increase in the number of incomplete pathways both less than and greater than 18 weeks.

To further support delivery of RTT performance we have set up a central pathway management team. The team validates patient pathways and places an increasing importance on the escalation of the patient journey to ensure the provision of timely and safe care.

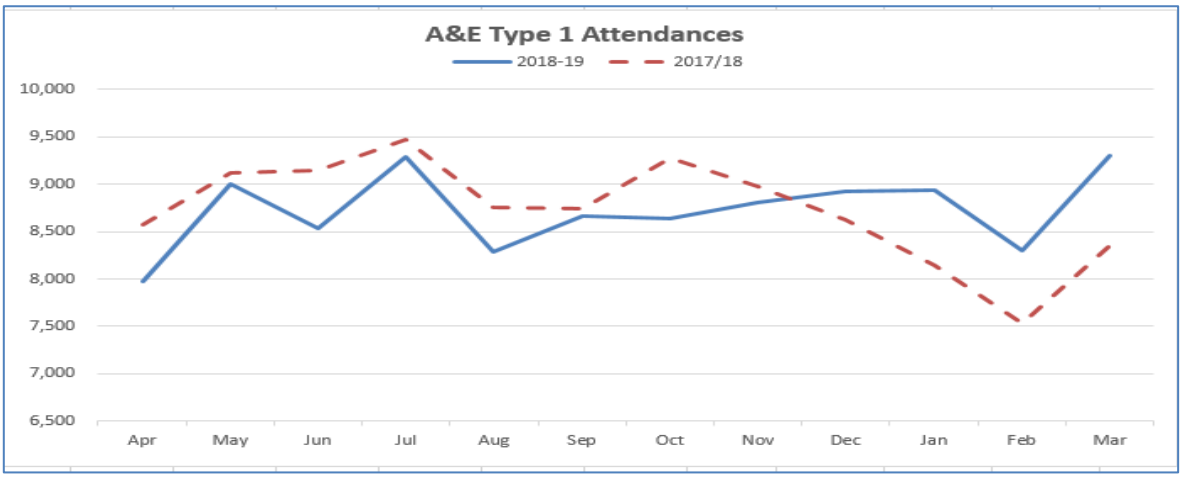
Indicator title	Q1	Q2	Q3	Q4
Cancer waits - 2 weeks wait				
Cancer: Percentage of 2 week GP referral to 1st outpatient appointment	79.4%	72.7%	89.5%	
Cancer: Percentage of 2 week GP referral to 1st outpatient - breast symptoms	58.1%	44.9%	55.5%	
Cancer waits - 31 days				
Cancer: Percentage of patients treated within 31 days - from diagnosis to first definitive treatment	96.2%	95.9%	96.3%	
Cancer: Percentage of patients for second or subsequent treatment treated within 31 days - surgery	86.2%	96.3%	91.3%	
Cancer: Percentage of Patients for second or subsequent treatment treated within 31 days - drug	99.0%	98.5%	100.0%	
Cancer: Percentage of Patients for second or subsequent treatment treated within 31 days - radiotherapy	95.9%	96.9%	95.7%	
Cancer waits - 62 days				
Cancer: Percentage of patients treated within 62 days urgent referral to treatment of all cancers	79.0%	80.1%	80.5%	
Cancer: Percentage of patients treated within 62 days of referral from screening	88.5%	97.9%	88.5%	
RTT				
RTT waiting times – Patients on incomplete pathways with a current wait time < 18 weeks	87.5%	80.5%	81.11%	80.84%
Zero tolerance RTT waits over 52 weeks for incomplete pathways	1	0	0	6
A&E				
A&E: Total time in A&E (month)	90.2%	90.9%	85.38%	79.33%
Trolley Waits in A&E > 12 hours	0	0	0	0

4 hour A&E standard

2018/19 has been another challenging year for our urgent and emergency care pathways, which have seen increased numbers of high acuity patients presenting throughout the year. There has been significant effort on patient flow both before the patient arrives at ED and at the point of discharge. A number of initiatives have been put in place across the county to improve patient flow as part of the system-wide, collaborative approach to the delivery of health and social care.

The number of delayed transfers of care reduced significantly from a high in June 2018 and the opening of the new Nye Bevan assessment unit at the end of November 2018 was expected to lead to improved patient flow and an anticipated improvement in achievement of the A&E 4 hour target. However, the growing demand and the increased acuity of patients attending at A&E coupled with a rise in the number of type 1 A&E attendances led to a deterioration in performance.

A&E	2018/19											
	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19
Total Patients Seen	10,385	11,420	10,843	11,396	10,568	11,011	11,154	11,189	11,272	11,629	10,601	11,992
> 4 hour waits	1,148	1,528	666	874	893	1,213	1,470	1,573	1,873	2,492	2,215	2,360
Actual Performance	88.9%	86.6%	93.9%	92.3%	91.5%	89.0%	86.8%	85.9%	83.4%	78.6%	79.1%	80.3%
Trajectory	88.0%	86.3%	89.0%	89.0%	90.1%	90.3%	90.3%	90.3%	90.3%	90.3%	90.3%	95.0%



Cancer waiting times standard

We were committed to improving our cancer journey throughout the year and addressing the challenges presented. We saw more patients being referred to us on the two week-wait pathway, which led to us achieving the target in October 2018 only. We introduced a new approach to managing performance with clinical accountability across all our Divisions to ensure wider ownership. Progress is regularly reviewed and monitored at our cancer board meetings.

New pathways for patients on the RAPID (prostate pathway), lower GI and lung pathways have undergone an extensive review and changes implemented in line with best practice. County-wide project managers work on the National Optimal Lung Pathway (NOLCP) and Rapid Access Prostate Imaging and Diagnosis pathway (RAPID), as well as a dedicated team delivering the cancer recovery package. Implementation of the FIT programme is also being developed in primary care to support the lower GI pathway.

Additional funding has been secured to enable us to integrate all our systems to the Somerset Cancer Registry, thereby improving data and audit capture and stream-lining the tracking of patients through their pathway. We anticipate this will have significant benefits in as we will be able to enter data onto national cancer registers.

Achieving the national cancer waiting time standards has continued to be a challenge during the year, largely due to capacity and workforce issues. We are aware there is a national shortage of cancer specialists and capacity and improvements will be underpinned and driven forward by substantial funding via the Cancer Alliances.

Throughout the year we have consistently reviewed our strategic goals for cancer and these are overseen by the monthly cancer board and underpinned by all tumour site improvement plans which are regularly discussed at the monthly cancer board.

All teams remain dedicated to improving the patient experience and outcomes for all patients on a suspected cancer pathway

Radiology has shown radical improvements over the course of the year despite the national radiology workforce shortages. All modalities have improved on the time from test to report throughout the year and all are under 10 days. Our ongoing focus is to achieve a target of all diagnostics requested to be reported within 7 days.

Our pathology teams continue to provide an excellent turnaround on specimens from patients on a cancer pathway, although we continue to have some challenge on send-away tests as sometimes turnaround time is slower. However, for the most part the delays are clinically indicated and not due to process.

We sourced additional external capacity to help address the challenges we faced during the year in meeting the two week wait standard. We did not achieve the target, and there is more work to do during 2019/20 to address our challenges and improve the position.

Achieving the 62-day standard proved to be a challenge throughout the year.
A dedicated focus on the target resulted in it being achieved in October 2018. However, we had more success in achieving the 31-day standard and meet this target five times during year.

The number of patients waiting more than 62 days on a cancer pathway been variable this year which in turn has increased the number of 104 day waits. However, a number of delays were due to patient choice, ie when patients chose to delay treatment as they had a planned holiday, or were waiting for tertiary providers for treatment.

The results of the 2017 National Cancer Patient Experience Survey published in 2018 shows a slight drop from 8.8% (national average) to 8.6% in overall care. The Lead Cancer Nurse and Director of Nursing have developed an action plan to address this and ensure we have improvements going forwards, particularly in how we communicate with relatives during a patient's cancer journey.

We continue to work hard to take the cancer agenda forward and are working closely with the Cancer Alliance for the East Midlands and the Northamptonshire Cancer Board to continue to make sustainable changes and improve both our performance and the patient experience. As always, our key challenge is to embed the changes we make to continue to improve so we can provide the best possible care to all of our patients. We continue to work very closely with Nene CCG through our monthly cancer pathway meetings.

SUSTAINABILITY REPORT

Our sustainability initiatives continue to be guided by our Board-approved Sustainability Strategy, our annual plan, external resource efficiency targets and feedback from our staff. The annual plan will be refreshed at the next meeting of the sustainable development committee in April 2019; chaired by the Director of Estates and Facilities, the board lead for sustainability. All sustainability activities are reported informally through a monthly newsletter sent to all departments and a network of champions across the hospital.

Over the last twelve months we have

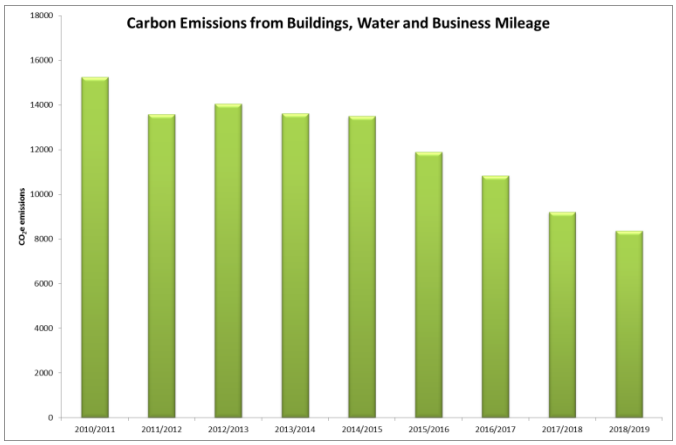
- Reduced carbon emissions from buildings, travel and anaesthetic gases
- Increased recycling
- Maintained Investors in the Environment and Food For Life accreditations.
- Been recognised for its Excellence in Sustainability Reporting by NHSi
- Presented at a local conference to promote local trading and social value

Energy and Carbon Emissions

	2016/2017	2017/2018	2018/2019
Consumption Data			
**Gas kWh	18,937,723	17,723,952	17,912,277
Electricity kWh	15,657,244	15,620,993	16,184,305
*Biomass	2,131,484	3,664,301	4,013,694
*Water m^3	151,982	137,967	155,248
Business Travel miles	894,928	810,214	624,713
Financial Data £			
Gas	1,189,156	1,086,173	1,180,314
Electricity	246,904	289,057	532,839
*Biomass	64,456	102,500	131,399
*Water	297,080	290,414	337,144
Business Mileage	364,465	334,109	307,344
Carbon Credits	171,965	188,038	162,045
Renewable Heat Incentive	(73,343)	(101,523)	(104,618)

*costs and volumes from site meter readings, not supplier

** excludes gas to the CHP



We will achieve the mandated 2020 target of a reduction in carbon emissions from its Scope 1 and 2 emissions. In the last year emissions have reduced by a further 9.2% (848 tonnes of CO_2e) with the decarbonisation of the grid contributing to this reduction. Electricity consumption has increased due to the introduction of the new wards in the Nye Bevan unit and the additional cooling required during the hot summer of 2018. In contrast gas consumption reduced, due to a warmer winter and more efficient running of plant and equipment during the summer months.

In 2018/19 we completed the first phase of the replacement of our calorifiers used to provide heating and hot water to the site. The second phase is planned for 2019/20. This phase was funded through an interest free Salix loan and will reduce carbon emissions by an estimated 200 tonnes a year.

Further installation of LED lights was completed and we successfully bid for NHS funding to replace the lights along the main Hospital Street with LED lighting. A trial of circadian rhythm lighting to aid patient sleep patterns in long stay wards is planned for 2019/20.

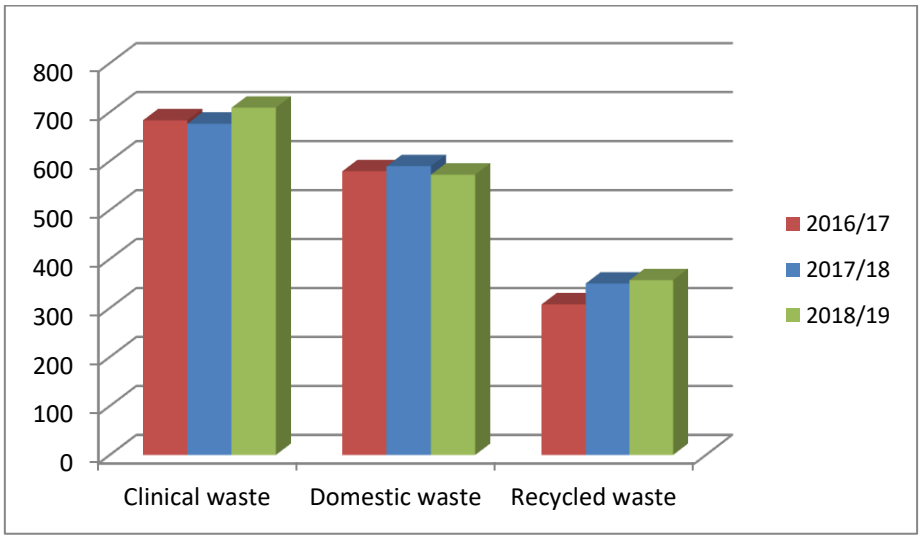
Whilst we are still purchasing some electricity from the Grid, we are ensuring that this amount is generated from renewable sources via the purchase EDF REGO (Renewable Energy Guarantee of Origin) certificates, a further 1168 tonnes.

Water

Water consumption has increased by 12.5% in the last 12 months and costs have also risen by 16%. The reason for this increase in consumption is unknown, which makes additional water metering on the site a priority for the coming year.

Waste

We have increased recycling by 7 tonnes, which means we now recycle 38.3% of non-clinical waste. The figures include site segregated mixed recycling, metal, waste electrical equipment and confidential waste. However, we are not yet meeting the KPI we set ourselves in the sustainability strategy, despite the increased level of recycling from our catering and theatre teams.



In addition, 22 tonnes of food were sent for anaerobic digestion, 45 tonnes of pallets were sold for reuse and 750kg of items were rehomed using the WarpIt recycling platform, saving almost £4,000. Next year we will be collaborating with our local NHS partners to launch a larger reuse project.

Clinical waste output has increased in the last twelve months, reflecting the greater activity within the hospital. Whilst recycling has increased, the weight of domestic waste has reduced. This has allowed the average price per tonne of waste sent for disposal to remain approximately static at £331 per tonne, including all equipment, bin rentals and purchases.

After providing new guidance and training the portering and infection prevention teams have reduced the number of mattresses sent for incineration by over 70 in the first three months of the project. Further reductions are anticipated following the introduction of modular hybrid mattresses so any damage will require the replacement of only a small section of the mattress rather than the entire foam.

Leadership

We maintained our Investors in the Environment Green Level accreditation with a score of 93% following an audit of the site and data in 2018.

Our Adaptation Policy was published in 2018 outlining the steps we will take to adapt to the impact of climate change on services and infrastructure.

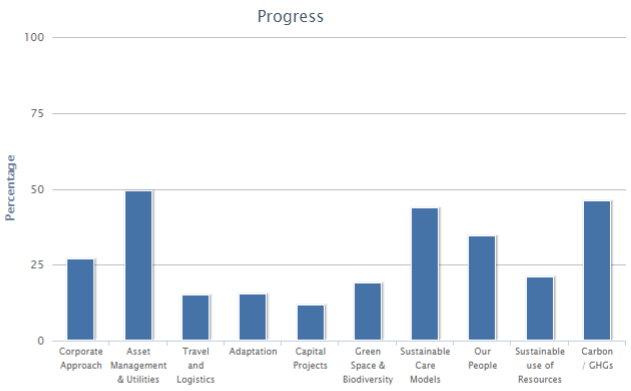
Our first review of the SDAT (Sustainable Development Assessment Tool) was completed and published in 2018. This gave us an overall score of 29%. This compares to an equivalent score of 26% in the previous measurement tool; the Good Corporate Citizenship. We scored well on asset management, sustainable care models and carbon/greenhouse cases (GHGs), but there is more work to do, particularly in the areas of travel and logistics, adaptation and capital projects. The areas for improvement will be used as a basis for our 2019/20 sustainable development action plan.

NORTHAMPTON GENERAL HOSPITAL NHS TRUST

Latest assessment score

29%

Module	Score
Corporate Approach	27.04%
Asset Management & Utilities	49.21%
Travel and Logistics	15.05%
Adaptation	15.38%
Capital Projects	11.67%
Green Space & Biodiversity	19.05%
Sustainable Care Models	43.59%
Our People	34.41%
Sustainable use of Resources	20.83%
Carbon / GHGs	45.95%



SUSTAINABLE DEVELOPMENT GOALS

The SDAT tool shows that we are contributing to the following UN Sustainable Development Goals:

Carbon footprint, procurement and social value

For the past 7 years we have been calculating the greenhouse gas emissions from our anaesthetic gases. In 2018/19 the emissions were calculated at 2571, 16% lower than in the previous year; this is from both anaesthetic and maternity areas.

Other sources of GHG emissions that can be given a calculated value are from the refrigerants used for space and process cooling. These amounted to 453 tonnes, an increase of 32% compared to the previous year.

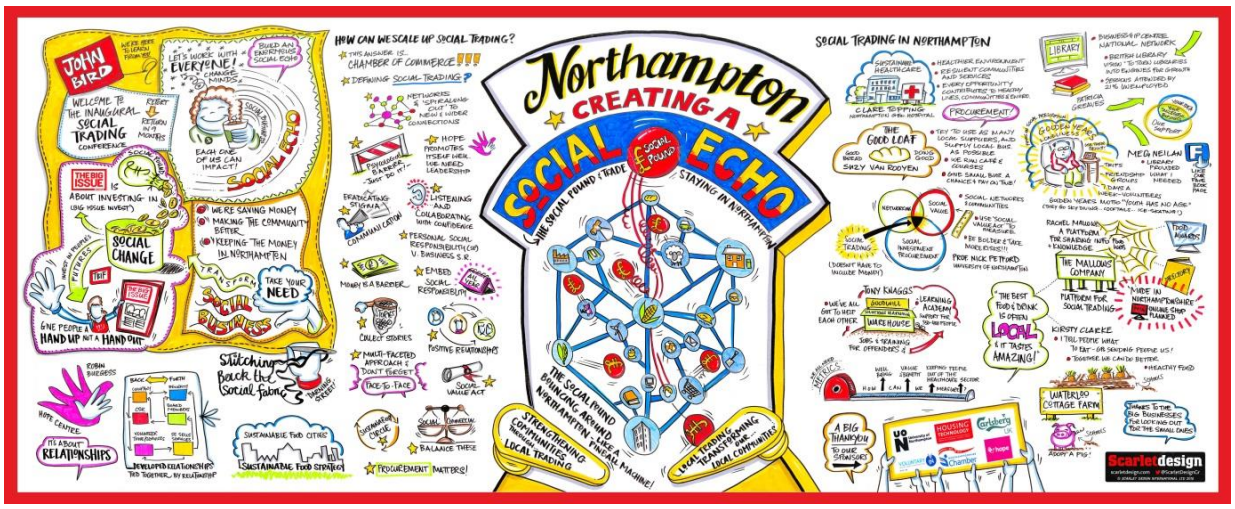
Using the DEFRA Department for Environment, Food and Rural Affairs) procuring for carbon reduction tool, the embedded carbon emissions from the products and services we buy has been calculated at 96113 tonnes. This is an increase of 9.7%. However, this is only an approximate measure and is based on spend.

Wherever possible we promote the use of local suppliers. In 2017/18 7% of our spend was with companies in the NN postcode area whilst 12% of the spend was with companies registered within 25 miles of NGH. In 2018/19 these figures were 9% and 13% respectively).

During the year we were asked to present at a local conference, Creating a Social Echo, organised by the Big Issue about our local procurement and why we believe it is important for sustainable healthcare. We used the opportunity to highlight the work we are doing with The Good Loaf, a local Social Enterprise in Northampton, who supply us with bread rolls, as well as our longer-standing contract with our biomass supplier, Wilby Tree, located 6 miles from the hospital. Our use of The Good Loaf has led to them securing a further contract with Northamptonshire Healthcare NHS Foundation Trust.

As a direct result of this conference we are planning to host a procurement workshop for SMEs in the coming year, and will be working with a local charity for autistic people to improve the recruitment options for some of their service users.

In addition to our quarterly collaborative meeting with the University of Northampton when we review research opportunities that will benefit us, we are exploring further collaborations around logistics, social value and information and communications technology.



Catering

The catering team have been leading efforts to reduce the use of plastic. Metal cutlery has been purchased for wards and catering outlets and wooden cutlery for takeaway food options now replaces the majority of the 1.5 million pieces of plastic cutlery we previously purchased annually. Straws have been removed from retail areas, and plastic cups are being removed from patient areas, being replaced by crockery, thereby reducing environmental impact and enhancing patient experience. Further removal of single use items is being planned, in conjunction with a roll out of recycling on all of the tea trolleys.

Staff Engagement

In conjunction with our current waste management company, we have been running an engagement campaign, Small Action Big Impact (SABI). This project encourages people to make an environmental pledge to change their behaviour and join an online community with its own dedicated website. The first staff engagement event we held was a Plastic Pledge day in October 2018 and the second was an 'Electric Amnesty' day in February 2019, both of which produced remarkable levels of engagement. On the day of the 'Plastic Pledge' the queue of people wanting to pledge and sign to reduce the use of single-use plastics snaked around the central corridor of the hospital. All day, people pledged to make a change, over 400 in total.

The interest in waste reduction and impact of engagement campaigns and social media has resulted in waste reduction and recycling being the subject of a number of projects put forward by individual Shared Decision Making Councils with plastic reduction and removal being the main priority.

Next year we will be surveying our staff to determine their views on our sustainability journey and create a dedicated web space for sustainability projects and information.

Travel

During the year we carried out a travel survey to gauge the current status of staff commute and to gauge the appetite to change to a more sustainable mode of travel and the potential barriers. Approximately 1 in 5 staff completed the survey, and a large number from various professions indicated a desire to help formulate our next travel plan due for completion in 2019.

Of the staff who completed the survey, approximately 77% indicated that they travel to work in a car as a single occupant. This is 10% higher than in previous survey carried out two years ago, but may be a result of fewer paper copies being completed by lower band employees who are likely to live closer to the hospital and, therefore, have a more sustainable commute.

Using the HOTT tool ((Health Outcome of Travel Tool), this has been equated to a total of 3,077 tCO2e for a distance of 12,477,500 miles with an economic cost from pollution of £550,830.

We are working with the University of Northampton and other local partners to improve commuting options across the area and is a member of the local travel plan group. Options such as reduced price bus tickets, car sharing and Park and Ride are under consideration.

The Nye Bevan building, which was completed in 2018, also included an indoor secure cycle shelter for staff and the provision of bike loops for visitors.

As part of the review of models of care, the HOTT tool will be used to review the financial impact on the NHS and local economy of changes brought about by telemedicine and video conferencing facilities.

Dr Sonia Swart
Chief Executive

SECTION TWO

ACCOUNTABILITY REPORT

REPORT OF THE DIRECTOR OF FINANCE

Economic outlook and impact

2018/19 was another year that the NHS was under significant pressure in both operationally and financially. Our response to this was to continue to focus on the provision of high quality clinical care to our patients managed via our clinically led structure.

Despite these pressures we were able to meet the deficit control total for 2018/19 as agreed with our regulators.

The challenge going forward, despite the additional funding given to the NHS for 2019/20, will still be tight for an Acute trust. Although we are well prepared to face what lies ahead, with detailed plans in place that are agreed with our Divisions and regulators, the pressure continues unabated leading to the risk of some non-delivery of performance targets.

We continue to work with our system partners in the development of a sustainable health economy but single year contracts and tariffs are not an aid to working on solutions to the health and care systems sustainability in the long term.

Financial performance

We were set a control total deficit of £27.7m, (£18.5m after receipt of £9.2m Provider Sustainability Funding (PSF)). This compared to a deficit of £23.3m in 2017/18. The actual pre PSF deficit was £27.6m and after receipt of £7.4m (of the £9.2m due to not achieving the A&E targets in Q3 and Q4) PSF and year-end bonus PSF of £5.8m the Trust finished 2018/19 with a deficit of £14.4m.

We met our other financial duties to manage our capital expenditure within our capital resource limit, our borrowing within our external finance limit and to pay our suppliers within 30 days for more than 95% of invoices paid.

Capital Expenditure

We invested £20.3m in 2018/19 improving our estate, medical equipment and IT assets. This included £11.4m in completing the building and opening of our new 60 bedded assessment hub, the Nye Bevan Unit.

Charitable funds

We are supported by the Northamptonshire Health Charitable Funds, which has been legally independent of the Trust since 2016. Its primary purpose is to support our work by providing grant funding, making use of the many generous donations and legacies they receive from the general public and from fund raising activities.

To ensure local governance of funds, our senior nurses and managers are heavily involved as fund advisors, actively recommending the specific projects where funds should be spent.

During the financial year, the charity paid £883k as grants, of specific note:

- The creation of an Emergency Assessment Unit on Talbot Butler ward costing £340k.
- Various medical equipment, including a £14k scanner for the clinical simulation suite and a £14k mini-cooling system for Gosset Ward.
- Staff training and course fees £100k
- Funding of Transition Co-Ordinator for Diabetes £67k
- Funding of Pathway to Excellence – Associate Director of Nursing £73k and Application for Accreditation £40k
- Five treatment chairs in oncology £10k
- Design and printing of support materials for organ donation campaign £10k
- Printing of quarterly issues of Insight Magazine £8k
- Annual funding of holiday caravan for oncology patients and their families £7k

Phil Bradley
Director of Finance

ANNUAL GOVERNANCE STATEMENTS FOR NHS TRUSTS 2018/19

1. Scope of responsibility

As Accountable Officer, I have responsibility for maintaining a sound system of internal control that supports the achievement of the NHS 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 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 Trust Accountable 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 Northampton General Hospital NHS 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 Northampton General Hospital NHS Trust for the year ended 31 March 2019 and up to the date of approval of the annual report and accounts.

3. Capacity to handle risk

Governance arrangements for risk management are as follows:

- Chief Executive: takes Board-level responsibility for governance, including risk management, and has overall responsibility for maintaining an effective risk management system and for meeting all statutory requirements. Executive directors and clinical directors have delegated responsibility for governance and risk management arrangements within their areas of control.
- Board of Directors: The Trust Board and Chief Executive ensure that the risk management arrangements are implemented, monitored and reviewed, and meet all legal and regulatory requirements. The Board receives reports from the Audit Committee, the Finance Committee and the Quality Governance Committee on the Trust's risk control measures.
- Audit Committee: The Audit committee has overall responsibility for independently monitoring, reviewing and reporting to the Trust Board on all aspects of governance, risk management and internal control. It is supported in this role by all Board Committees.
- Finance and Performance Committee: The Finance and Performance committee undertakes on behalf of the Trust Board objective scrutiny of the Trust's financial plans and major investment decisions. Additionally it is responsible for overseeing the delivery of all key performance metrics and is also responsible for the oversight of the Trusts IM&T, Estates and procurement functions.
- Quality Governance Committee: The Quality Governance committee monitors, reviews and reports on the quality and safety of services provided by the Trust.

This includes the review of governance, risk management and internal control systems to ensure the delivery of safe, high quality, patient centred care.

- Workforce Committee: The Workforce Committee monitors, reviews and reports on the organisational development and workforce performance of the Trust. This includes the achievement of associated key performance indicators and advising the Trust Board on key strategic organisational and workforce initiatives.
- Assurance, Compliance and Risk Group (ARC): The ARC Group is chaired by the Director of Corporate Development, Governance and Assurance providing executive oversight of risk management issues. The group is responsible for ensuring the development and implementation of effective systems and processes for risk management at each level of the Trust.
- The Trust has a Governance team with a focus on integrated risk management – the team support the process of identification, assessment, analysis and management of risks and incidents at every level of the organisation and aggregation of results at a corporate level.
- In each of the Trust's Divisions the Divisional Director has lead responsibility for governance and risk issues and is responsible for coordinating risk management processes, including management of the Divisional risk register supported by the Divisional manager. The Divisional management groups have responsibility for monitoring, managing and where necessary escalating risks on their risk registers and significant risks are reviewed at monthly performance review meeting.
- Data Governance Group: The purpose of the group is to set a clear direction of travel in respect of Data & Information Governance and to provide the Trust Board with the assurance that effective governance for data quality & protection is in place.
- The Chief Information Officer is the Trust's Senior Information Risk Owner (SIRO). Working closely with the Medical Director as Caldicott Guardian, the SIRO is responsible for taking ownership of information risk at Board level and advising the Chief Executive accordingly.
- Risk management training is delivered to staff in accordance with the Trust's risk management training needs analysis. This begins at corporate induction which all staff are required to attend.
- There is clear policy and guidance on the type of courses that staff need to attend and the frequency of attendance required. Attendance at mandatory risk management training courses is monitored and fed-back to Divisions and corporate directorates via a central monitoring database which allows corrective action to be taken by management teams as required aimed to improve and sustain attendance rates throughout the year.

4. The risk and control framework

The Trust has adopted an integrated framework for risk management supported by policies and procedures. This provides a comprehensive framework for the management of principal risks and is mapped to the Trust's principal and strategic objectives, and to Care Quality Commission (CQC) outcomes, where applicable. These are in turn mapped to the risk register to assess the potential risks that threaten the achievement of the Trust's objectives, the existing control measures and assurance in place.

There is an established governance framework for risk management which includes high level committees, Trust Board and Quality Governance Committee and their sub committees including the Assurance, Risk and Compliance Group (a sub-group of the Quality Governance Committee) to divisional governance committees and department level risk groups.

The Risk Management Strategy was approved by the Quality Governance Committee on behalf of the Board in February 2019 and will be reviewed annually.

The Trust policy for the Assessment and Management of Risk was ratified in February 2017,due for review February 2020. The policy sets out the approved Trust framework and procedures for risk assessments, risk scoring and management of risks.

The policy provides a clear definition of risk and distinguishes between risks and hazards. Roles and responsibilities are also clearly defined which includes corporate committees and senior staff members; divisional, directorate and departmental responsibilities, and those of individual staff members. Assessment, management, and monitoring of risks within the Datix system are also included.

The policy details the agreed definition of risk appetite, which is consistent with the Risk Management Strategy, however further work is required to raise Board awareness and develop a risk appetite statement for each of the Trusts corporate objectives through Board development sessions and to review the risk appetite statement as part of the business planning process to ensure this is considered at Directorate, Division and Corporate level.

The ARC Group commenced deep dives into the Divisional Risk Registers in year to provide support and guidance with regard to content and identify best practice to improve clarity of the risk register content. Feedback is also provided to the Group from Internal Audit Reviews and standard templates for reports are provided.

The risk management system is continually reviewed to ensure that robust systems are in place at all levels within the Trust. The risk register is an integral part of the system. Amendments to the risk register are generated and actioned at directorate, division and corporate level.

Communication and consultation is undertaken with internal and external stakeholders when appropriate. The Trust has continued to develop communication channels with its partners, and within the Trust. Regular reports are prepared for directorates and divisions, the Quality Governance Committee and the Trust Board on the incidents reported, both clinical and non-clinical.

There is a fully established Internal Audit programme approved by the Audit Committee in the Internal Audit Work Plan. The Audit Committee receives reports which provide assurance of the Trust’s key internal control objectives. The Internal Auditor presents an Annual Audit Opinion to those charged with governance on the overall level of assurance for the system of internal control. Internal Audit recommendations are tracked in a system to record action taken and completed.

The Trust has an established Counter Fraud Service provided by a Local Counter Fraud Specialist (LCFS). In addition to investigation work the LCFS carries out an agreed amount of proactive work. The LCFS regularly attends the Audit Committee meetings and reports back to the Director of Finance and the Audit Committee on any proactive or reactive work undertaken. The LCFS also provides feedback to the Freedom to Speak Up Guardian in regard to any referrals made from that route.

The Trust's External Auditors conduct an Annual review of the Trust's control environment and present an Annual Report to those charged with governance in the form of an Annual Audit letter.

Partners and stakeholders are involved in managing risks which impact on them through their involvement in and contributions to many aspects of the work of the Trust, including for example:

Patients and the public:

- The work of the, the Patient Advice and Liaison Service and specific patient representative groups.
- Patient membership of key Trust committees and groups.
- The work of the local Health and Wellbeing Board.
- Meetings of the Trust Board held in public which include Patient Stories.
- An extensive volunteering programme across hospital departments including volunteers specifically dedicated to supporting the Trust's Friends and Family Test (FFT) agenda, handing out postcards for completion and collating data

Staff:

- Strong focus on encouraging staff to raise concerns with a Freedom to Speak Up Guardian and the Respect and Support campaign led by the Human Resources Division
- Board to Ward and Beat the Bug visits by Executive and non-Executive Directors.
- "Question Time" sessions which allow staff greater access to senior staff to inform and provide discussion forum for topical issues.
- Monthly Core Brief to staff by Executive team.
- Partnership forum with staff-side representation.

Partners:

- Regular performance discussions with commissioners and NHS Improvement.
- Clinical Collaboration work streams between Kettering General Hospital NHS Foundation Trust and Northampton General Hospital NHS Trust.
- Weekly Operations Executive Meeting comprising the Chief Executive Officers of Health and Social Care partners across Northamptonshire.
- Participation in the Sustainability and Transformation Programme for Northamptonshire.
- System Resilience Group, A&E Boards, Sustainability and Transformation Board and county-wide communications group

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

The Trust identified its key workforce objectives by engaging senior leaders from across the organisation; they are part of the Trust's strategic objectives. The Trust also has work plans and initiatives in place to address key areas of development across all workforce areas.

Trust committees including the Trust Board, Changing Care Steering Group, Quality Governance Committee and Workforce Committee receive the key workforce plans and initiatives. They monitor delivery via Key Performance Indicators displayed on an integrated dashboard to ensure effective progress.

The Workforce and Quality Governance Board Committees, regularly receive assurance reports in respect to safer staffing to ensure adherence to the National Quality Board requirements 2016. This assurance includes the provision of monthly safe staffing review and six monthly Safe Staffing Review of Inpatient Staffing Levels. Assurance against the requirements of the NHSI 'Developing Workforce Safeguards' guidance will be reported and monitored through the Workforce Committee and Quality & Governance Committees.

The Trust uses a range of workforce-planning methods:

- Professional judgement method – multi- disciplinary teams (MDTs) of lead clinicians and managers consider workforce requirements. Using their professional judgement, MDT's will review the current performance standards, financial performance, patient feedback and commissioning intentions and consider the benefits/risks of alternative skill–mixes as part of this approach.
- Workload quality method – the Trust uses evidence-based tools to calculate staffing levels based on a variety of inputs, including the Safer Nursing Care tool, Birth Rate plus for maternity services, in addition the Trust uses the Allocate Acuity data, to ensure that the nursing establishment supports the staffing level and skill mix for each ward.
- Triangulation of the above with quality, patient feedback, workforce and workflow metrics.
- Benchmarking internally and externally (where information is available and applicable).

The workforce planning approach detailed above informs the outputs of the annual business planning cycle. Divisions establish their future workforce requirements modelled against planned activity, service developments and financial planning.

Clinical teams have access to key performance data. Data sources for dashboard indicators include: staff HR metrics (e.g. staffing levels, sickness levels and bank staff usage), patient feedback, numbers of complaints, audit outcomes, numbers of incidents reported and CQC self-assessment rating (NB this list is not exhaustive). However; it is acknowledged that further development is required to enable more effective triangulation of information; therefore a Divisional Quality Scorecard is in development.

The Trust's Board and its committees receive triangulated data in a number of key documents including the corporate dashboard, Board Assurance Framework and as part of Patient Safety, Safer Staffing, Workforce and Financial reports. The Trust utilises the information in a number of ways, to:

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

Within the Trust, Cost Improvement Programmes (CIP's), transformational change, new business opportunities and Quality, Innovation, Productivity and Prevention (QIPP) schemes are subject to a Quality Impact Assessment (QIA). The clinically led structure recognises responsibility of Clinical Directors, Clinical Specialists and Divisional Managers in each of the four main divisions in the development of CIPs and associated QIA. The schemes are considered at the Changing Care Steering Group. The QIA must be completed and fully considered by the Medical Director and Director of Nursing prior to approval to proceed. Once QIAs are agreed, a QIA Scorecard is maintained by the PMO which tracks agreed quality metrics and this is monitored monthly by the Trust's Quality Governance Committee.

The Trust acknowledges that there is a need to implement a process for QIA of smaller scale operational changes that result in skill mix/establishment changes but do not require discussion at the Changing Care Steering group. A process is being developed to address this.

An initial assessment of the Trust compliance with the NHSI 'Developing Workforce Safeguards' guidance indicates that there are gaps in assurance processes in terms of meeting the full requirements. This mainly relates to providing assurance to the Board in respect to non-nursing roles. Additional processes for QIA of small scale changes to establishment numbers/skill mix and further development of integrated dashboards that support effective triangulation of data are also required. This is being addressed and will be reported and monitored through the Workforce and Quality Governance Committees to ensure appropriate traction is maintained.

The Trust was rated requires Good by the Care Quality Commission (CQC) in 2017 and remains fully compliant with the registration requirements of the CQC.

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

As an employer with staff entitled to membership of the NHS Pension Scheme, control measures are in place to ensure all employer obligations contained within the

Scheme regulations are complied with. This includes ensuring that deductions from salary, employer's contributions and payments into the Scheme are in accordance with the Scheme rules, and that member Pension Scheme records are accurately updated in accordance with the timescales detailed in the Regulations.

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

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

Risk assessment

The Trust has adopted an approach to risk management with the structures and processes in place to successfully deliver the risk management objectives. Leadership arrangements are defined within the Trust and are supported by job descriptions, objectives and annual appraisals.

Leadership has been further embedded at Divisional and Directorate level, where managers have responsibility for risk identification, assessment and analysis. All staff are required to complete mandatory and role specific update training. All new members of staff are required to attend induction which covers key elements of risk management including Freedom to Speak up.

The Trust policy on the development of policies ensures that all Trust policies must be equality impact assessed before seeking approval.

The Board Assurance Framework (BAF) is based around the Trust's strategic objectives and is mapped to the Care Quality Commission's Fundamental Standards. It identifies the principal risks to the achievement of those objectives, the key controls in place to manage those risks and the sources of assurance about the effectiveness of those controls.

The BAF details any gaps in control and assurance in relation to the risks, including strategic objectives related to service delivery, workforce, finance, service transformation, and infrastructure and information systems, together with actions to address them. The actions include identifying additional resources, putting in place new systems, processes, operating procedures and monitoring arrangements, strengthening project and programme management, and effective working with partners.

The BAF is updated by the Executive Director leads with a full review at the end of each quarter which is then presented to the relevant Board Committee to review their assigned risks and a full Trust Board review quarterly. It is also crossed referenced to risks on the Corporate Risk Register.

The BAF identified areas where the control framework needed improvement and a number of red (extreme) risks as follows:

- Risk of failing to meet local and national quality and performance standards leading to poor experience and financial risk of contract penalties
- Risk of poor standards of care in ward and other areas due to inability to recruit adequate numbers of appropriately qualified nursing staff leading to suboptimal patient care and poor staff experience
- Risk of failures related to failing infrastructure due to aging estate leading to poor patient environment, poor infection control and potential health and safety failures
- Risk of failures in data quality, ICT infrastructure and/or a successful cyber security attack may lead to loss of service with staff being unable to access patient records with a significant impact on patient care and reputational risk to the Trust
- Risk that failure to progress clinical collaboration as an integral part of the Northamptonshire Health and Care Partnership (Northamptonshire's Sustainability and Transformation programme) will not provide the optimal range of core acute services within Northamptonshire leading to a deficit of provision, increased health inequalities and barriers to healthcare access.
- Risk that the Trust fails to have financial control measures in place to deliver its 2018/19 financial plan
- Risk that the Trust fails to deliver the costs savings associated with the Changing Care @NGH programme.

The seven Red (extreme) Risks have been constant in year, with the exception of the last two bullet points with scores reduced in Quarter 4 due to delivery of the financial plan. Each risk and its actions are owned by an Executive Director and they are held to account for progress at the respective Board subcommittee and Board.

The Trust has received a 'Reasonable Assurance' opinion from internal audit on the Board Assurance Framework and Risk Management in April 2019.

The Board completed a self- review of governance arrangements against the NHSI Well-led Framework in February 2019. The output of that review identified where improvements could be made but identified knowledge gaps and learning opportunities for further Board development. Priority areas for action were identified as:

- KLOE 2: Is there a clear vision and a credible strategy to deliver high quality, sustainable care to people, and robust plans to deliver?
- KLOE 6. Is appropriate and accurate information being effectively processed, challenged and acted on?
- KLOE 7. Are the people who use services, the public, staff and external partners engaged and involved to support high quality sustainable services?

The Trust is planning to undertake an external review of the self- assessment to confirm and challenge the evidence and priorities identified.

An Annual Governance Statement is in place and the Trust is compliant with the risk management and assurance framework requirements that support the statement pursuant to the most up to date guidance.

The Board is satisfied that plans in place are sufficient to ensure ongoing compliance with all existing targets as set out in the NHSI single oversight framework; and a commitment to comply with all known targets going forward.
The Board ensures that the trust will at all times operate effectively. This includes maintaining its register of interests, ensuring that there are no material conflicts of interest in the board of directors; and that all board positions are filled, or plans are in place to fill any vacancies.

The Board is satisfied that all executive and non-executive directors have the appropriate qualifications, experience and skills to discharge their functions effectively, including setting strategy, monitoring and managing performance and risks, and ensuring management capacity and capability. The Trust has a number of new Board members both Executive and Non- Executive positions and needs to be cognisant of the need to ensure they gain knowledge of the systems and governance processes in place in the Trust. All Board members complete a “Fit and Proper persons” declaration annually.

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

The Trust has a number of processes in place to ensure that resources are used economically, efficiently and effectively. The Trust has an established process in place for budget setting, monitoring and reporting.

Internal Audit has reviewed the financial systems during the year and based on the work undertaken, have concluded that reasonable assurance can be taken and the system of internal controls is generally adequate and operating effectively but some improvements are required to ensure that risks are managed and process objectives achieved. In addition, Internal Audit also reviewed the Trusts procurement processes and concluded that Substantial assurance can be taken and there is a robust system of internal controls operating effectively to ensure that risks are managed and process objectives achieved.

The Trust started the year with a challenging CIP target of £14.5m and a £4.6m ‘system gap’. The 2018/19 financial plan has been delivered in all months during the year and the Trust has met its pre-PSF control total of £27.7m deficit, and covered off the additional £4.6m ‘system gap’. The Trust received three additional PSF payments relating to 2018/19 in April 2019; £67k for over achieving on the control total, £4.2m general PSF distribution and £1.5m bonus PSF, a total of £5.8m which moved our post-PSF deficit to £14,434k.

The Trust has submitted a draft financial plan for 2019/20 showing a break even position at year end.

In both 2018/19 we have increased our focus on the use of GIRFT and Model Hospital to support the Divisions in identifying and delivering recurrent cost saving schemes as well as leveraging income generating opportunities. This work continues into 2019/20 and beyond.

The Trust is also actively working to improve both the quality and financial viability of acute services in collaboration with Kettering General Hospital NHS Foundation Trust and seek in this process to unlock new economies of scale and remove duplication.

6. Information governance

The Trust completed the Data Security and Protection Toolkit in line with the prescribed timescales achieving 100% with completion of all mandatory assertions.

The Trust has had nine incidents that required reporting to the Information Commissioners Office (ICO). Eight cases have been closed by the ICO with no further action and one remains open.

7. Annual Quality Account

The directors are required under the Health Act 2009 and the National Health Service (Quality Accounts) Regulations 2010 (as amended) to prepare Quality Accounts for each financial year.

The Trust is preparing the Quality Account for 2018/19 and the first draft was presented to the Quality Governance Committee in April. The Quality Account is being prepared in the format required by the Department of Health, building on the experience gained from preparing the accounts in previous years and guidance from the Department of Health including the Quality Accounts Toolkit.

The Quality Account will be submitted for review and comment by local partners/ stakeholders, including:

- NHS Nene and Corby Clinical Commissioning Groups
- Healthwatch Northamptonshire
- Northamptonshire County Council Health Social Care Overview and Scrutiny Committee

It will then be reviewed by the external Auditors (KPMG) to provide an assurance report, during which they will audit two indicators data sets (of four).

Throughout 2018/19 extensive work has been undertaken around data accuracy with a team of external and internal validators engaged to prepare all data for migration into the new Patient Administration System (PAS) in June 2018. Post go-live with the new PAS the same team was again bought in to ensure accuracy in the use of the new system; based on the findings, a suite of validation reports have been set up to alert for poor data entry, including automated email alerts to individuals when incorrect data is input. A quality dashboard Kitemark is currently being developed to provide further assurance to the trust on data accuracy.

A central Pathway Performance Management team is currently being established, which when fully recruited to will enable validation, escalation and spot check audits of elective pathways. Additionally, the trust has now developed an elective patient pathway tool which identifies anomalies in data, alerting for validation as well as alerting for escalation of the patient's journey.

A recent review was undertaken by TIAA (internal audit) around data quality, their overall conclusion was "The Trust is proactively developing and implementing work streams to build a robust data quality governance framework, and this work continues to be in progress" with an overall assurance assessment of "Reasonable Assurance". The introduction of the new PAS impaired RTT reporting for a number of

months but as can be seen by the internal audit report this has now been corrected as reasonable assurance received.'

8. Review of effectiveness

As Accountable Officer, I have responsibility for reviewing the effectiveness of the system of internal control. My review of the effectiveness of the system of internal control is informed by the work of the internal auditors, clinical audit and the executive managers and clinical leads within the NHS trust who have responsibility for the development and maintenance of the internal control framework. I have drawn on the information provided in this annual report and other performance information available to me. My review is also informed by comments made by the external auditors in their management letter and other reports. I have been advised on the implications of the result of my review of the effectiveness of the system of internal control by the board, the audit committee, quality governance committee and a plan to address weaknesses and ensure continuous improvement of the system is in place.

The Trust Board reviews its governance arrangements every year. The latest review was in December 2018 when the Trust Standing Orders were reviewed in the Audit Committee. and a revised declaration of interest policy in March 2019. All relevant Board sub- committees Terms of Reference have been updated.

Board Reporting

The Board meets monthly throughout the year in private and also in public on a bi-monthly basis. A performance report is received each month with performance overviews provided by the director responsible for performance in each area and risks reviewed. The Board receives updates from the chair of each Board sub-committee following individual committee meetings highlighting the key points discussed and any issues which require escalation.

Board effectiveness

The Board has processes in place to review the effectiveness with which it operates annually. Governance arrangements are also subject to review by Internal Audit annually. In the past 12 months Internal Audit reviews include Data Quality Governance- 'Reasonable Assurance', Review of Safety- Emergency Department- 'Reasonable Assurance', BAF and Risk Management (Advisory), and Key Finance Systems- 'Reasonable Assurance'.

The Board has been assured that there are robust mechanisms to ensure that the evidence to support compliance is in place and available and is routinely monitored and reported upon within the Trusts governance and performance framework.

The process that has been applied to maintain the effectiveness of a system of internal control was as follows:

The Trusts Audit Committee approved an Internal Audit programme and received all Internal Audit Reports. The committee has reviewed the establishment and maintenance of an effective system of integrated governance, risk management and internal control across the organisations activities both clinical and non- clinical that supported the achievement of the organisations objectives.

Each Board Committee has reviewed its own effectiveness in year with a number of recommendations made to improve effectiveness. Each Committee has also reviewed its Terms of Reference for Board approval.

The Trusts Clinical Audit and Effectiveness Group meet monthly and oversee the Trust's participation in local and national clinical audit and national confidential enquiries, and reports to the Clinical Quality and Effectiveness Group. Divisions receive a monthly update report from the Clinical Audit & Effectiveness Department as part of the governance structure. This update gives highlights by exception of audit progression, findings and actions. This enables the Divisional and directorate management team oversight and ownership of their element of the Trust audit programme.

The Internal Audit's review of the organisation's overall arrangements for gaining assurance has concluded that:
"Reasonable assurance can be given that there is a generally sound system of internal control, designed to meet the organisation's objectives, and that controls are generally being applied consistently. However, some weakness in the design and/or inconsistent application of controls put the achievement of particular objectives at risk".

The work performed by Internal Audit during 2018/19 has been driven by a robust planning process, which included a focus on particular areas of potential weakness identified by the Trust. Internal Audit reviews have been completed to plan and the recommendations made have been accepted and actioned by the Trust. There are four areas where only "Limited Assurance" has been given – Safeguarding (external Contractors); Sickness Absence- Medical Staffing; GDPR; and Water Management.

Management are fully engaged in making improvements to these areas to address the weaknesses identified and good progress has been made towards implementing the recommendations made in the agreed timescales.
With regard to counter fraud and corruption arrangements during 2018/19, there were ten new referrals and two cases brought forward from the prior year, all of which were investigated.

A number of the referrals were, after initial enquiries not considered suitable for full counter fraud investigation and were therefore referred back to HR or departmental line manager for internal action.

One case was concluded through the criminal justice system and resulted in the former employee being sentenced to a suspended custodial sentence and 200 hrs of Community Service. The remainder of the cases are currently ongoing. The potential financial value of the referrals was not material to the overall finances of the Trust.

The Local Counter Fraud Specialist (LCFS) has supported the Trust to ensure that investigations are carried out promptly and efficiently. In addition, the LCFS has continued to carry out proactive work at the Trust in order to prevent, detect and deter fraud and bribery within the NHS and to also raise awareness of the role of the counter fraud specialist within the Trust and the NHS as a whole. This proactive work has helped to establish an effective anti-fraud culture and zero tolerance approach within the Trust that is fully supported by the Trust Board.

The Trust seeks to learn from incidents to develop good practice. Incidents are discussed at a number of forums, including the Review of Harm Group, Clinical Quality and Effectiveness Group and the Quality Governance Committee.
During the past 12 months, the Trust has recorded 34 serious incidents in 2018/19 which is 41 percent increase from 2017/18. The Trust also reported one Never Event. The largest single trend was around acting on results and recognition of the deteriorating patient. A Deteriorating patient Operational group has been established which has developed and is rolling out a specific Care Plan which supports a number of care bundles in use across the Trust.

Each patient safety incident graded as moderate or serious harm has been investigated, using Root Cause Analysis (RCA) methodology applied to those cases were preventable harm has been identified. Actions are developed and put in place to reduce the likelihood of re-occurrence. Lessons learn are shared at the Trusts monthly 'Dare to Share' Event which is attended by a Multi-disciplinary audience to ensure sharing and discussion of lessons learnt.

The Care Quality Commission (CQC) and NHS Resolution (NHSR) consider trusts who are high reporters of incidents to have a better and a more effective safety culture. In 2018/19, a total of 11,439 patient safety incidents were reported, which shows a three per cent increase on the previous reporting year.
To promote incident reporting, the governance team work closely with the all disciplines of staff to improve incident reporting, identify learning points and provide feedback to staff.

To ensure all patient safety incidents are investigated appropriately and proportionately incidents graded as moderate or above, or other incidents of clinical concern coming to light by complaints, claims or inquests are discussed at the Review of Harm Group (RoHG) This multi-disciplinary group, chaired by the Medical Director, is well versed in providing challenge in a non-threatening environment. The group meets weekly and reports into the Clinical Quality and Effectiveness Group. This is also an opportunity to confirm the Trust has met its obligations of Duty of Candour.

The Trust process of monitoring of action plans arising from Serious and Moderate graded Incidents has been developed to minimise the risk of reoccurrence. This is driven by the directorate governance meetings, and departmental meetings to ensure that lessons learnt are shared across the Trust. This is overseen by RoHG and the Clinical Quality and Effectiveness Group, as well as our Commissioners. The Trusts Governance Compliance team and Clinical Audit and Effectiveness Team are key in support this being kept high on the governance meeting agendas in the clinical areas.

Examples of shared learning from incidents;

- The recent Never Event linking to Surgery in 2018 has highlighted the need for increased use of Interpreting Services for patients whose first language is not English to support the delivery of key clinical information between clinician and patient at all important steps of a patient pathway. This includes written information as well as verbal discussion. Having identified this it has also been noted as a contributory factor in other incidents in the Trust related to both patient safety and

patient experience. Work has been undertaken to increase staff awareness of different methods of obtaining translation and interpreter services independent of the patient.

- Another key piece of learning from incidents investigated this year has been around progressing the implementation of the 'Optimal Lung Cancer Pathway' in NGH. This nationally recognised pathway which has a rapid journey from symptoms to diagnosis with the aim at improving survival by increasing treatment options due to earlier diagnosis.

Conclusion

I am pleased to report that, based on the opinion of Internal Audit; that Northampton General Hospital NHS Trust has a sound system of internal control that supports the achievement of its policies, aims and objectives with no significant internal control issues identified.

Appropriate arrangements are in place for discharge of the Trust's statutory functions. These ensure that any potential issues are highlighted to the Board and that the Trust is legally compliant with its statutory responsibilities.

Signed:

Dr Sonia Swart
Chief Executive **Date: 23 May 2019**

Statement of the Chief Executive's responsibilities as the accountable officer of the trust

The Chief Executive of NHS Improvement, in exercise of powers conferred on the NHS Trust Development Authority, has designated that the Chief Executive should be the Accountable Officer of the trust. The relevant responsibilities of Accountable Officers are set out in the *NHS Trust Accountable Officer Memorandum.* These include ensuring that:

- there are effective management systems in place to safeguard public funds and assets and assist in the implementation of corporate governance;
- value for money is achieved from the resources available to the trust;
- the expenditure and income of the trust has been applied to the purposes intended by Parliament and conform to the authorities which govern them;
- effective and sound financial management systems are in place; and
- annual statutory accounts are prepared in a format directed by the Secretary of State to give a true and fair view of the state of affairs as at the end of the financial year and the income and expenditure, recognised gains and losses and cash flows for the year.

To the best of my knowledge and belief, I have properly discharged the responsibilities set out in my letter of appointment as an Accountable Officer.

Signed:

Dr Sonia Swart
Chief Executive

Date: 23 May 2019

Statement of directors' responsibilities in respect of the accounts

The directors are required under the National Health Service Act 2006 to prepare accounts for each financial year. The Secretary of State, with the approval of HM Treasury, directs that these accounts give a true and fair view of the state of affairs of the trust and of the income and expenditure, recognised gains and losses and cash flows for the year. In preparing those accounts, the directors are required to:

- apply on a consistent basis accounting policies laid down by the Secretary of State with the approval of the Treasury;
- make judgements and estimates which are reasonable and prudent;
- state whether applicable accounting standards have been followed, subject to any material departures disclosed and explained in the accounts.

The directors are responsible for keeping proper accounting records which disclose with reasonable accuracy at any time the financial position of the trust and to enable them to ensure that the accounts comply with requirements outlined in the above mentioned direction of the Secretary of State. They are also responsible for safeguarding the assets of the trust and hence for taking reasonable steps for the prevention and detection of fraud and other irregularities.

The directors confirm to the best of their knowledge and belief they have complied with the above requirements in preparing the accounts.

The directors confirm that the annual report and accounts, taken as a whole, is fair, balanced and understandable and provides the information necessary for patients, regulators and stakeholders to assess the NHS trust's performance, business model and strategy

By order of the Board

23 May 2019

Dr Sonia Swart, Chief Executive

23 May 2019

Phil Bradley, Finance Director

N.B. The auditors will review the Accountability Report for consistency with other information in the financial statements and will provide an opinion on the following disclosures:

- disclosures on Parliamentary accountability
- single total figure of remuneration for each director
- CETV disclosures for each director
- payments to past directors, if relevant
- payments for loss of office, if relevant
- 'fair pay' (pay multiples) disclosures
- exit packages, if relevant and
- analysis of staff numbers and costs

STAFF REPORT

Remuneration

A remuneration and appointments committee meets at least annually and is comprised of non-executive directors. The duties of the remuneration and appointments committee are set out in the terms of reference.

The primary role of the remuneration and appointments committee is to establish a formal process for developing policy on executive remuneration and to oversee the appointment process for executive directors.

The remuneration and appointments committee will determine the remuneration and terms of service for the chief executive and executive directors, acting in accordance with the scheme of delegation and reservation of powers to the Board and approve any non-contractual benefits in relation to the termination of employment for executive directors.

The remuneration and appointments committee will oversee the process for the appointment of new members to the trust board of directors, ensuring that there is a formal, lawful procedure in place.

The committee will also ensure that systems and processes are in place for the development of board members where appropriate.

Pay Multiples

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

The banded remuneration of the highest paid director in the Trust in the financial year 2018/19 was £225-230k (2017/18, £225-230k). This was 9.88 times (2017/8, 10.28 times) the median remuneration of the workforce, which was £23k (2017/18, £22k).

In 2018/19 and 2017/18 no employees received remuneration in excess of the highest-paid director. Remuneration ranged from £2k for part-time staff to £180k for the next highest paid director and £189k for the highest paid agency locum (full year effect) (2017/18 £1k - £178k)

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

The ratio has decreased in 2018/19 by 0.4. Nursing staff represent the largest increase in total average staff numbers. The majority of staff on Agenda for Change terms and conditions received a pay increase as a result of the pay award deal. For staff on the Band 5 lower increments this was 5%. This has contributed to the increase in the overall median remuneration of the workforce.

Salary and pension entitlements of senior managers

Remuneration

Name and Title	2018-19 Salary (bands of £5,000) £000	Expense payments (taxable) to nearest £100* £	Performance Pay and Bonuses (bands of £5,000) £000	Long term Performance Pay and Bonuses (bands of £5,000) £000	All Pension-related Benefits (bands of £2,500) £000	Total - Salary & Benefits (bands of £5,000) £000
Paul Farenden - Chairman (to 18th December 18)	25 - 30	1,300				25 -30
Alan Burns - Chairman (from 20th December 18)	5 - 10					5 - 10
Sonia Swart - Chief Executive Officer	225 - 230				0	225 - 230
Deborah Needham - Chief Operating Officer / Deputy Chief Executive Officer /Acting Chief Exec (from 12 January 19 to 31 March 19)	145 - 150				97.5 - 100	245 - 250
Carl Holland - Acting Chief Operating Officer (from 12 January to 31 March 19)	20- 25				112.5 -115	135 - 140
Lee-Anne Taylor - Acting Chief Operating Officer (from 12 January to 31 March 19)	20 - 25				2. 5 - 5	20 - 25
Matthew Metcalfe - Medical Director	180 - 185				0	180 - 185
Carolyn Fox - Director of Nursing, Midwifery & Patient Services (to 30th September 18)	50 - 55				75 - 77.5	130 - 135
Sheran Oke - Director of Nursing, Midwifery & Patient Services (from 1st October 18)	70 - 75				0	70 - 75
Philip Bradley - Director of Finance from 1st September 18 (Interim Director of Finance to 31st August 18)	135 - 140				105 - 107.5	240 - 245
Stuart Finn - Director of Facilities & Capital Development from 30th October 18 (Interim Director of Facilities & Capital Development to 29th October 18)	100 - 105				15 - 17.5	120 - 125
Janine Brennan - Director of Workforce and Transformation	120 - 125				0	120 - 125
Chris Pallot - Director of Strategy & Partnerships	115 - 120				50 - 52.5	165 - 170
Catherine Thorne - Director of Corporate Development, Governance & Assurance (to 30th September 18)	50 - 55				22.5 - 25	75 - 80
Claire Campbell - Director of Corporate Development, Governance & Assurance (from 22nd October 18)	45 - 50				117.5 - 120	165 - 170
Phil Zeidler - Non-Executive Director (Vice Chairman) (to 30th November 18)	0 - 5					0 - 5
David Noble - Non-Executive Director	5 - 10	1,100				5 - 10
John Archard-Jones - Non-Executive Director	5 - 10					5 - 10
Annette Gill - Non-Executive Director	5 - 10					5 - 10
Jill Houghton - Non-Executive Director (from 1st May18)	5 - 10	1400				5 - 10
David Moore - Non-Executive Director (from 1st August 18)	0 - 5	500				0 - 5
Emma Heap - Associate Non-Executive Director	5 - 10					5 - 10

Name and Title	2017-18 Salary (bands of £5,000) £000	Expense payments (taxable) to nearest £100* £	Performance Pay and Bonuses (bands of £5,000) £000	Long term Performance Pay and Bonuses (bands of £5,000) £000	All Pension-related Benefits (bands of £2,500) £000	Total - Salary & Benefits (bands of £5,000) £000
Paul Farenden - Chairman	25 - 30	1,700				30 - 35
Alan Burns - Chairman (from 20th December 18)						
Sonia Swart - Chief Executive Officer	225 - 230					225 - 230
Deborah Needham - Chief Operating Officer / Deputy Chief Executive Officer	130 - 135				62.5 -65	195 - 200
Carl Holland - Acting Chief Operating Officer (from 12 January to 31 March 19)						
Lee-Anne Taylor - Acting Chief Operating Officer (from 12 January to 31 March 19)						
Matthew Metcalfe - Medical Director (from 2nd October 17)	85 -90				25 - 27.5	115 - 120
Carolyn Fox - Director of Nursing, Midwifery & Patient Services	110 - 115				17.5 - 20	130 - 135
Sheran Oke - Director of Nursing, Midwifery & Patient Services (from 1st October 18)						
Philip Bradley - Interim Director of Finance from (4th December 17)	40 - 45				72.5 - 75	115 - 120
Stuart Finn - Interim Director of Facilities & Capital Development (from 1st September 17)	55 -60				130 - 132.5	185 - 190
Janine Brennan - Director of Workforce and Transformation	120 - 125				20 - 22.5	145 - 150
Chris Pallot - Director of Strategy & Partnerships	105 - 110				77.5 - 80	185 - 190
Catherine Thorne - Director of Corporate Development, Governance & Assurance	100 - 105				22.5 - 25	125 - 130
Claire Campbell - Director of Corporate Development, Governance & Assurance (from 22nd October 18)						
Phil Zeidler - Non-Executive Director (Vice Chairman)	5 - 10	400				5 - 10
David Noble - Non-Executive Director	5 - 10	500				5 - 10
John Archard-Jones - Non-Executive Director	5 - 10					5 - 10
Annette Gill - Non-Executive Director (from 2nd November 17)/Associate Non-Executive Director (to 1st November 17)	5 - 10					5 - 10
Jill Houghton - Non-Executive Director (from 1st May 18)						
David Moore - Non-Executive Director (from 1st August 18)						
Emma Heap - Associate Non-Executive Director (from 25th January 18)	0 - 5					0 - 5

Salary Notes

The 2017-18 salary for the following represents a full year : Paul Farenden, Carolyn Fox, Catherine Thorne & Phil Zeidler
Matthew Metcalfe's 2017-18 salary represents 6 months only
Philip Bradley's 2017-18 salary represents 4 months only
Stuart Finn's 2017-18 salary represents 7 months only
Emma Heap's 2017-18 salary represents 2 months only
Alan Burns, Carl Holland, Lee-Anne Taylor, Sheran Oke, Claire Campbell, Jill Houghton & David Moore were appointed to the Board in 2018-19. There is therefore no salary information for 2017-18

The benefits paid to Non-Executives and Chairman above relate to travel and subsistence between home & office

All pension related benefits represent the annual increase in total pension benefits entitlement. This represents the values payable at the beginning and end of the financial year, adjusted for inflation, irrespective of whether or not the position was held for full or part year and length of NHS service. Where this value is negative a nil balance is shown

* Note: Taxable expenses and benefits in kind are expressed to the nearest £100.

Pension Benefits

Name & Title	Real increase in pension at Pension Age (bands of £2,500)	Real increase in pension lump sum at Pension Age (bands of £2,500)	Total accrued pension at Pension Age at 31 March 2019 (bands of £5,000)	Lump sum at Pension Age related to accrued pension at 31 March 2019 (bands of £5,000)	Cash Equivalent Transfer Value at 31 March 2018	Real increase in Cash Equivalent Transfer Value	Cash Equivalent Transfer Value at 31 March 2019	Employer's contribution to stakeholder pension
	£000	£000	£000	£000	£000	£000	£000	£000
Sonia Swart - Chief Executive Officer	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Deborah Needham - Chief Operating Officer / Deputy Chief Executive Officer /Acting Chief Exec (from 12 January 19 to 31 March 19)	5 - 7.5	7.5 -10	50 - 55	125 - 130	678	163	882	N/A
Carl Holland - Acting Chief Operating Officer (from 12 January to 31 March 19)	0 - 2.5	2.5 - 5	40 - 45	115 - 120	697	38	907	N/A
Lee-Anne Taylor - Acting Chief Operating Officer (from 12 January to 31 March 19)	0 - 2.5	0	0 - 5	0	0	0	3	N/A
Matthew Metcalfe - Medical Director	N/A	N/A	N/A	N/A	482	N/A	N/A	N/A
Carolyn Fox - Director of Nursing, Midwifery & Patient Services (to 30th September 18)	0 - 2.5	0 - 2.5	40 - 45	110 - 115	618	66	775	N/A
Sheran Oke - Director of Nursing, Midwifery & Patient Services (from 1st October 18)	0	0	35 - 40	115 - 120	779	35	882	N/A
Philip Bradley - Director of Finance from 1st September 18 (Interim Director of Finance to 31st August 18)	5 - 7.5	15 - 17.5	55 - 60	170 - 175	1,056	213	1,321	N/A
Stuart Finn - Director of Facilities & Capital Development from 30th October 18 (Interim Director of Facilities & Capital Development to 29th October 18)	0 - 2.5	0	15 - 20	30 - 35	215	34	270	N/A
Janine Brennan - Director of Workforce and Transformation	0 - 2.5	0	50 - 55	150 - 155	1,018	88	1,153	N/A
Chris Pallot - Director of Strategy & Partnerships	2.5 - 5	2.5 - 5	35 - 40	85 - 90	506	102	639	N/A
Catherine Thorne - Director of Corporate Development, Governance & Assurance (to 30th September 18)	0 - 2.5	0	40 - 45	110 - 115	761	46	884	N/A
Claire Campbell - Director of Corporate Development, Governance & Assurance (from 22nd October 18)	0 - 2.5	5 - 7.5	45 - 50	145 - 150	897	90	1,134	N/A

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

Real Increase in CETV - This reflects the increase in CETV effectively funded by the employer. It does not include the increase in accrued pension due to inflation, contributions paid by the employee (including the value of any benefits transferred from another scheme or arrangement) and uses common market valuation factors for the start and end of the period.

The inflation applied to the accrued pension, lump sum (if applicable) and CETV is the percentage (if any) by which the Consumer Prices Index (CPI) for the September before the start of the tax year is

No lump sum is shown for senior managers who only have membership in the 2015 Scheme or 2008 Section (unless they chose to move their 1995 Section benefits to the 2008 Section under the Choice exercise). No CETV is shown for pensioners or senior managers over NPA. Age 60 in the 1995 Section, age 65 in the 2008 Section or SPA or age 65, whichever is the later, in the 2015 scheme. No values are shown for senior managers that have opted out of the NHS Pension scheme.

Off Payroll Engagements 2018/19

Table 1: Off-Payroll Engagements longer than 6 months

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

Narrative	Number
Number of existing engagements as of 31 March 2019	8
Of which, the number that have existed:	
for less than one year at the time of reporting	1
for between 1 and 2 years at the time of reporting	7
for between 2 and 3 years at the time of reporting	0
for between 3 and 4 years at the time of reporting	0
for 4 or more years at the time of reporting	0

Table 2: New Off-Payroll Engagements

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

Narrative	Number
Number of new engagements, or those that reached six months in duration, between 1 April 2018 and 31 March 2019	71
Of which:	
No.assessed as caught by IR35	71
No.assessed as not caught by IR35	0
No.engaged directly (via PSC contracted to department) and are on the departmental payroll	71
No.of engagements reassesed for consistency / assurance purposes during the year	0
No.of engagements that saw a change to IR35 status following the consistency review	0

Table 3: Off-Payroll board membership / senior official engagements

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

Number of off-payroll engagements of board members, and/or senior officers with significant financial responsibility, during the financial year	0
Number of individuals that have been deemed "board members, and/or senior officers with significant financial responsibility" during the financial year. This figure includes both off-payroll and on-payroll engagements	15

Expenditure on consultancy

Details of our expenditure on consultancy can be found at note 6.1 on page 85 in the annual accounts.

Exit Packages

The Trust has no exit packages in 2017/18.

Staff cost and numbers

Staff costs

			2018/19	2017/18
	Permanent	Other	Total	Total
	£000	£000	£000	£000
Salaries and wages	172,641	1,549	**174,190**	164,254
Social security costs	17,548	0	**17,548**	16,692
Apprenticeship levy	851	0	**851**	807
Employer's contributions to NHS pensions	19,238	0	**19,238**	17,970
Pension cost - other	11	0	**11**	5
Other post-employment benefits	0	0	**0**	0
Other employment benefits	0	0	**0**	0
Termination benefits	0	0	**0**	0
Temporary staff	0	12,543	**12,543**	12,196
Total gross staff costs	**210,289**	**14,092**	**224,381**	**211,924**
Recoveries in respect of seconded staff	0	0	**0**	0
Total staff costs	**210,289**	**14,092**	**224,381**	**211,924**
Of which				
Costs capitalised as part of assets	97	0	**97**	454

Average number of employees (WTE basis)

			2018/19	2017/18
	Permanent	Other	Total	Total
	Number	Number	Number	Number
Medical and dental	520	60	**580**	556
Ambulance staff	0	0	**0**	0
Administration and estates	996	77	**1,073**	1,057
Healthcare assistants and other support staff	920	189	**1,109**	1,087
Nursing, midwifery and health visiting staff	1,358	187	**1,545**	1,516
Nursing, midwifery and health visiting learners	0	0	**0**	0
Scientific, therapeutic and technical staff	525	37	**562**	551
Healthcare science staff	149	0	**149**	150
Social care staff	0	0	**0**	0
Other	0	0	**0**	0
Total average numbers	**4,468**	**550**	**5,018**	**4,917**
Of which:				
Number of employees (WTE) engaged on capital projects	0	0	**0**	17

Reporting of compensation schemes - exit packages 2017/18

	Number of compulsory redundancies	Number of other departures agreed	Total number of exit packages
	Number	**Number**	**Number**
Exit package cost band (including any special payment element)			
<£10,000	0	1	**1**
£10,000 - £25,000	0	0	**0**
£25,001 - 50,000	0	0	**0**
£50,001 - £100,000	0	0	**0**
£100,001 - £150,000	0	0	**0**
£150,001 - £200,000	0	0	**0**
>£200,000	0	0	**0**
Total number of exit packages by type	**0**	**1**	**1**
Total cost (£)	£0	£8,000	**£8,000**

Exit packages: other (non-compulsory) departure payments

	2018/19		2017/18	
	Payments agreed		Payments agreed	
	Number	**£000**	**Number**	**£000**
Voluntary redundancies including early retirement contractual costs	0	0	0	0
Mutually agreed resignations (MARS) contractual costs	0	0	0	0
Early retirements in the efficiency of the service contractual costs	0	0	0	0
Contractual payments in lieu of notice	0	0	1	8
Exit payments following Employment Tribunals or court orders	0	0	0	0
Non-contractual payments requiring HMT approval	0	0	0	0
Total	**0**	**0**	**1**	**8**
Of which:				
Non-contractual payments requiring HMT approval made to individuals where the payment value was more than 12 months' of their annual salary	0	0	0	0

Staff numbers

	2018/2019			2017/2018		
Average Staff Numbers	**Total Number**	**Permanently Employed**	**Other**	**Total Number**	**Permanently Employed**	**Other**
Add Prof Scientific and Technical	146	145	1	143	142	1
Additional Clinical Services	920	910	10	876	866	10
Administrative and Clerical	1097	1081	16	1067	1045	22
Allied Health Professionals	253	251	2	247	243	4
Estates and Ancillary	500	498	2	484	482	2
Healthcare Scientists	124	124	0	128	124	4
Medical and Dental	550	259	291	527	232	295
Nursing and Midwifery Registered	1528	1521	7	1525	1510	15
Other	0	0	0	0	0	0
TOTAL	**5118**	**4789**	**329**	**4997**	**4644**	**353**

Staff sickness absence

	2018/19	2017/18
	Number	**Number**
Total days lost	45,251	40,404
Total staff years	4,429	4,316
Average working days lost (per WTE)	10.22	9.36

Staff Sickness Absence % - from April 2018 to March 2019												
	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19
Short Term Sickness	1.89%	1.73%	2.63%	0.25%	2.30%	2.22%	1.98%	1.69%	1.62%	2.07%	2.44%	2.03%
Long Term Sickness	1.92%	2.23%	1.76%	2.80%	2.20%	2.07%	2.01%	2.45%	2.75%	2.89%	2.29%	2.01%
Total Sickness Absence	3.82%	3.96%	4.39%	3.05%	4.49%	4.29%	3.99%	4.14%	4.37%	4.96%	4.74%	4.03%

Early retirements due to ill health

	2018/19	2018/19	2017/18	2017/18
	£000	**Number**	**£000**	**Number**
No of early retirements on the grounds of ill-health		2		1
Value of early retirements on the grounds of ill-health	65		67	

Our Trade Union activity

As part of the Trade Union (Facilities Time Publication Requirements) Regulations 2017, we have collated information regarding the facilities time activities of our recognised Trade Union officials during the relevant period of 1 April 2018 to 31 March 2019. We have undertaken the following calculations and the results are detailed in the tables below:

- Number of employees who were relevant union officials during the relevant period
- Full-time equivalent employee number
- Percentage of time spent on facility time
- Percentage of pay bill spent on facility time
- Paid trade union activities

Relevant Union Officials

Number of Employees Who Were Relevant Union Officials During the Relevant Period	Full-Time Equivalent Employee Number
30	29.51

Percentage of Time Spent on Facility Time

Percentage of Time	Number of Employees
0%	7
1%-50%	23
51%-99%	0
100%	0

Percentage of Pay Bill Spent on Facility Time

Total Cost of Facility Time	£20.002.76
Total Pay Bill	£208,425,036
Percentage of Total Pay Bill Spent on Facility Time	0.01%

Paid Trade Union Activities

Time Spent on Paid Trade Union Activities as a Percentage of Total Paid Facility Time Hours	5.17%

Equality

During 2018/19 we continued to work to and review our progress against our Equality Objectives/4 Year Plan, which is underpinned by our Workforce Equality and Diversity Strategy.

Our equality objectives/four year plan has two main objectives, which are based on the Equality Delivery System (EDS2) outcomes relating to the workforce, with the key actions linked to:

- The Workforce Race Equality Standard (WRES)
- Gender Pay Gap Reporting

- Health and Wellbeing
- Staff Survey Results
- Divisional Equality Objectives
- Leadership and Management Development Programmes.

Our objectives are:

EDS2 Goal	Objective
1. Representative and supported workforce	We will improve our staff satisfaction rates as reported in the annual staff survey. We will make year on year improvements on our staff survey results, aiming to achieve top 20% of acute Trusts for staff engagement. We will improve the experiences and treatment between White staff and BME staff at the Trust by progressing WRES and monitoring outcomes.
2. Inclusive leadership	We will improve our leadership and management capability.

During the coming year we shall be reviewing our Equality and Diversity Strategy and awaiting the national launch of the Equality Delivery System 3, which will shape our future plans and objectives.

The detailed action plan and all our other equality and diversity documents can be accessed via our website: https://www.northamptongeneral.nhs.uk/About/Policies-Reports-and-strategies/Equality-and-diversity-information/Equality-Diversity-Human-Rights.aspx.

2018 NHS Staff Survey Equality and Diversity Key Findings

The demographics of our workforce who responded to the staff survey were broadly similar to our overall workforce with the exception of disabled staff where 19.5% of the respondents were disabled compared to the 3.1% of our workforce.

For the overall 'theme' of Equality, Diversity and Inclusion we scored 8.9 out of 10, which is a deterioration of 0.1 since the 2017 survey. We are below the national average of 9.1.

Underpinning this theme there are 4 questions from the Staff Survey that contribute to the overall 'theme' result:

- **Q** – Does your organisation act fairly with regard to career progression/promotion, regardless of ethnic background, gender, religion, sexual orientation, disability or age?
  - There has been a deterioration of 2.5% since 2017 and we are below the national average by 0.5%. The national average has also deteriorated since the 2017 survey.

- **Q** – In the last 12 months have you personally experienced discrimination at work from patients/service users, their relatives or other members of the public?

- There has been a deterioration of 2.2% since 2017 and we are also below the national average by 2.3%. The national average remains unchanged since the 2017 survey.

- **Q** - In the last 12 months have you personally experienced discrimination at work from managers/team leaders or other colleagues?
  - There has been a deterioration of 0.8% since 2017 and we are also below the national average by 2.5%. The national average has improved since the 2017 survey.

- **Q** – Has you employer made adequate adjustments to enable you to carry out your work?
  - There has been an improvement of 7.5% since 2017 and we are also above the national average by 4.0%. The national average has deteriorated since the 2017 survey.

The survey has highlighted some areas of concern and we will be working with our teams to analyse the results more deeply in order to continue our work in ensuring all our staff are focused on the Trust's values, by displaying positive and inclusive behaviours, high quality care and striving for continuous improvement and meaningful staff engagement to sustainably improve staff satisfaction at work.

Workforce Race Equality Standards

We undertook the data analysis exercise for the National Workforce Race Equality Standard (WRES) in 2018 and compared these results to those of 2017 to establish if there had been improvements or deteriorations in the experiences or the treatment of White staff and BME staff.

We showed improvement in:
- The number of BME staff we employee
- The likelihood of BME staff entering the formal disciplinary process, when compared to White staff.

Deteriorations were seen in:
- The likelihood of BME applicants being shortlisted when compared to White applicants
- The likelihood of BME staff accessing non-mandatory training/Continuous Professional Development when compared to White Staff
- BME staff and White staff experiencing bullying, harassment or abuse from other colleagues in the last 12 months
- BME staff believing career progression/promotion is fair when compared to White staff
- BME staff and White staff experiencing discrimination.

Three areas were unchanged from 2017, namely the number of very senior managers who are BME, the percentage of BME staff experiencing bullying, harassment or abuse from patients, relatives or the public and finally the percentage difference between our Board voting membership and our overall workforce.

We were also able to compare our local analysis with the national NHS position and a number of areas we compared favourably.

We acknowledge there is still work to do to improve the experiences and treatment of our BME workforce and our respect and support campaign, which launched in June 2018, is addressing some of the issues highlighted.

Our WRES report can be accessed via our website.

Gender Pay Gap Reporting 2018

As per the Gender Pay Gap Information Regulations 2017 we compiled and analysed our data and submitted it to the Government as part of the requirements under the Regulations. Although we are not legally required to produce a written report it was agreed this should be done to give context to the data and this was also published on our website.

A small reduction in the gap was seen since 2017, however there is a difference in the average pay of our male and female staff that needs to be addressed, including greater female representation in our senior clinical roles.

Our Gender Pay Gap report can be accessed via our website:

Gender Distribution of Staff

Directors and Non-Executive Directors

Overall Totals

Gender	Count	%
Female	7	46.67
Male	8	53.33
Grand Total	15	100

Senior Managers (Band 8a and above) and Senior Medical Staff

Overall Totals

Gender	Count	%
Female	226	52.31
Male	206	47.69
Grand Total	432	100

Senior Managers (Band 8a and above)

Overall Totals

Gender	Count	%
Female	151	71.90
Male	59	28.10
Grand Total	210	100

Breakdown by Senior Manager Pay Scales

Pay Scale	Count	Female	Male
XN08/XR08	130	100	30
XN09/XR09	40	26	14
XN10/XR10	15	9	6
XN11/XR11	4	4	0
WQ00	21	12	9
Total	210	151	59

Senior Medical Staff (Consultants)

Overall Totals

Gender	Count	%
Female	75	33.78
Male	147	66.22
Grand Total	222	100

Breakdown by Senior Medical Staff (Consultant) Pay Scales

Pay Scale	Count	Female	Male
MC21	1	1	0
WQ00	1	1	0
YC53	2	1	1
YC62	1	1	0
YC72	67	27	40
YC73	12	3	9
YM51	3	2	1
YM52	5	0	5
YM53	11	4	7
YM54	6	1	5
YM55	10	1	9
YM56	5	2	3
YM57	10	3	7
YM58	8	3	5
YM59	1	0	1
YM60	3	1	2
YM61	2	0	2
YM62	1	0	1
YM63	1	1	0
YM69	1	0	1
YM72	69	22	47
YM73	2	1	1
Total	222	75	147

All Employees

Gender	Count	%
Female	3945	78.95
Male	1052	21.05
Grand Total	4997	100

Disability Related Polices

Our key disability related policy is our Employment of Staff with a Disability Policy. This is supported by two other policies, namely the:

- Recruitment, Selection and Retention Policy
- Supporting and Management Workplace Sickness Absence Policy.

The aim of our Employment of People with a Disability Policy is:

- To raise awareness of the employment of people with disabilities throughout the organisation and ensure employees are aware of the Trusts commitment towards disabled people or someone's association with a disabled person
- To ensure recruitment procedures are reviewed and developed to encourage applications and the employment of people with disabilities or someone associated with a disabled person
- To ensure that staff and potential job applicants with a disability, or associated with a disabled person, are treated fairly and receive the same opportunities as other staff to develop within the Trust with appropriate and reasonable support.
- To take all reasonable steps to ensure that the working environment does not prevent disabled people or people associated with a disabled person from taking up positions for which they are suitably qualified.
- To assist staff who become disabled during their employment to adapt to the disability and to continue in post wherever possible, or, if this is not possible, to be redeployed or retrained, where this is practicable.

The policy provides guidance on the recruitment and ongoing employment of people with a disability. The policy focuses in particular on the responsibilities of all staff groups during the recruitment and selection process of an individual who has identified they have a disability or associate with a person who has a disability, in addition to the management of a current employee who develops or has an existing disability.

The Supporting and Management Workplace Sickness Absence Policy provides our managers with clear guidelines when supporting and managing either short term or long term sickness absence and other absences in connection with sickness. It is is designed to ensure a consistent approach and support for employees who due to ill health and/or injury fail to meet reasonable required standards of attendance at work, along with ensuring compliance with the requirements of any relevant employment legislation including the Equality Act 2010 for staff who are absence due to disability related sickness.

The Recruitment, Selection and Retention Policy, together with the associated procedures, provides a framework which promotes a professional approach and the highest possible standards throughout the recruitment and selection process and to ensure a proactive and lawful approach to equality and diversity issues within the process, including the recruitment of disabled people.

We continue to be certified as a Disability Confident Employer (Level 2) and as part of this commitment, we will:

1. Get the right people for our organisation - which includes providing fully inclusive and accessible recruitment processes, offering interviews to disabled people who meet the minimum criteria for the job and making reasonable adjustments as required.
2. Keep and develop our staff - which includes supporting employees to manage their disabilities or health conditions.

We are currently assessing the requirements of Level 3 (Disability Confident Leader) to see what actions we need to take in order to achieve this top level of certification.

In addition NHS England are implementing their National Workforce Disability Standard (WDES) in 2019/2020, which will enable us to compared the experiences and treatment of our disabled staff compared to our non-disabled staff and assess what actions are needed to make improvements.

Dr Sonia Swart, Chief Executive

SECTION THREE:

FINANCIAL STATEMENTS

KPMG

INDEPENDENT AUDITOR'S REPORT TO THE BOARD OF DIRECTORS OF NORTHAMPTON GENERAL HOSPITAL NHS TRUST

REPORT ON THE AUDIT OF THE FINANCIAL STATEMENTS

Opinion

We have audited the financial statements of Northampton General Hospital NHS Trust ("the Trust") for the year ended 31 March 2019 which comprise the Statement of Comprehensive Income, Statement of Financial Position, Statement of Changes in Taxpayers Equity and Statement of Cash Flows, and the related notes, including the accounting policies in note 1.

In our opinion the financial statements:

- give a true and fair view of the state of the Trust's affairs as at 31 March 2019 and of its income and expenditure for the year then ended; and
- have been properly prepared in accordance with the accounting policies directed by the Secretary of State with the consent of the Treasury as being relevant to NHS Trusts in England and included in the Department of Health Group Accounting Manual 2018/19.

Basis for opinion

We conducted our audit in accordance with International Standards on Auditing (UK) ("ISAs (UK)") and applicable law. Our responsibilities are described below. We have fulfilled our ethical responsibilities under, and are independent of the Trust in accordance with, UK ethical requirements including the FRC Ethical Standard. We believe that the audit evidence we have obtained is a sufficient and appropriate basis for our opinion.

Going concern

The Directors have prepared the financial statements on the going concern basis as they have not been informed by the relevant national body of the intention to dissolve the Trust without the transfer of its services to another public sector entity. They have also concluded that there are no material uncertainties that could have cast significant doubt over its ability to continue as a going concern for at least a year from the date of approval of the financial statements ("the going concern period").

We are required to report to you if we have concluded that the use of the going concern basis of accounting is inappropriate or there is an undisclosed material uncertainty that may cast significant doubt over the use of that basis for a period of at least a year from the date of approval of the financial statements. In our evaluation of the Director's conclusions we considered the inherent risks to the Trust's operations, including the impact of the United Kingdom and Northern Ireland exiting the European Union, and analysed how these risks might affect the Trust's financial resources, or ability to continue its operations over the going concern period. We have nothing to report in these respects.

However, as we cannot predict all future events or conditions and as subsequent events may result in outcomes that are inconsistent with judgements that were reasonable at the time they were made, the absence of reference to a material uncertainty in this auditor's report is not a guarantee that the Trust will continue in operation.

Other information in the Annual Report

The Accountable Officer is responsible for the other information presented in the Annual Report together with the financial statements. Our opinion on the financial statements does not cover the other information and, accordingly, we do not express an audit opinion or, except as explicitly stated below, any form of assurance conclusion thereon.

Our responsibility is to read the other information and, in doing so, consider whether, based on our financial statements audit work, the information therein is materially misstated or inconsistent with the financial statements or our audit knowledge. Based solely on that work we have not identified material misstatements in the other information. In our opinion the other

information included in the Annual Report for the financial year is consistent with the financial statements.

Annual Governance Statement

We are required to report to you if the Annual Governance Statement has not been prepared in accordance with the requirements of the Department of Health Group Accounting Manual 2018/19. We have nothing to report in this respect.

Remuneration and Staff Report

In our opinion the parts of the Remuneration and Staff Report subject to audit have been properly prepared in accordance with the Department of Health Group Accounting Manual 2018/19.

Directors' and Accountable Officer's responsibilities

As explained more fully in the statement set out on page 44, the directors are responsible for the preparation of financial statements that give a true and fair view. They are also responsible for: such internal control as they determine is necessary to enable the preparation of financial statements that are free from material misstatement, whether due to fraud or error; assessing the Trust's ability to continue as a going concern, disclosing, as applicable, matters related to going concern; and using the going concern basis of accounting unless they have been informed by the relevant national body of the intention to dissolve the Trust without the transfer of its services to another public sector entity . As explained more fully in the statement of the Chief Executive's responsibilities, as the Accountable Officer of the Trust, on Page 43 the Accountable Officer is responsible for ensuring that annual statutory accounts are prepared in a format directed by the Secretary of State.

Auditor's responsibilities

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

A fuller description of our responsibilities is provided on the FRC's website at www.frc.org.uk/auditorsresponsibilities.

REPORT ON OTHER LEGAL AND REGULATORY MATTERS

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

Under the Code of Audit Practice we are required to report to you if the Trust has not made proper arrangement for securing economy, efficiency and effectiveness in its use of resources.

Qualified conclusion

Subject to the matters outlined in the basis for qualified conclusion paragraph below we are satisfied that in all significant respects Northampton General Hospital NHS Trust put in place proper arrangements for securing economy, efficiency and effectiveness in the use of resources for the year ended 31 March 2019.

Basis for qualified conclusion

In considering the Trust's arrangements for securing sustainable resource deployment, we identified the following matters:

- the Trust has reported a deficit of £14.4 million in 2018/19; and
- the Trust has failed to deliver a number of operational targets for the year. In particular the Trust failed to meet its Accident and Emergency and cancer waiting time targets.

Respective responsibilities in respect of our review of arrangements for securing economy, efficiency and effectiveness in the use of resources

As explained in the statement set out on page 43, the Chief Executive, as the Accountable Officer, is responsible for ensuring that value for money is achieved from the resources available to the Trust. We are required under section 21(3)(c), as amended by schedule 13 paragraph 10(a), of the Local Audit and Accountability Act 2014 to be satisfied that the Trust has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources.

We are not required to consider, nor have we considered, whether all aspects of the Trust's arrangements for securing economy, efficiency and effectiveness in the use of resources are operating effectively.

We have undertaken our review in accordance with the Code of Audit Practice, having regard to the specified criterion issued by the Comptroller and Auditor General (C&AG) in November 2017 as to whether the Trust had proper arrangements to ensure it took properly informed decisions and deployed resources to achieve planned and sustainable outcomes for taxpayers and local people. We planned our work in accordance with the Code of Audit Practice and related guidance. Based on our risk assessment, we undertook such work as we considered necessary.

Statutory reporting matters

We are required by Schedule 2 to the Code of Audit Practice issued by the Comptroller and Auditor General ('the Code of Audit Practice') to report to you if:

- we issue a report in the public interest under section 24 of the Local Audit and Accountability Act 2014; or
- we make a written recommendation to the Trust under section 24 of the Local Audit and Accountability Act 2014.

We have nothing to report in these respects.

We are required to report to you if we refer a matter to the Secretary of State under section 30 of the Local Audit and Accountability Act 2014 because we have reason to believe that the Trust, or an officer of the Trust, is about to make, or has made, a decision which involves or would involve the body incurring unlawful expenditure, or is about to take, or has begun to take a course of action which, if followed to its conclusion, would be unlawful and likely to cause a loss or deficiency.

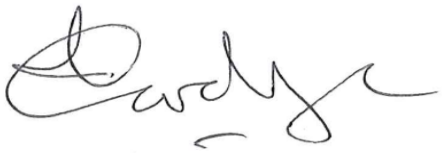
On 16 May 2019 we referred a matter to the Secretary of State under section 30 (1)(b) of the 2014 Act in relation to the breach of the Trust's breakeven duty due to the reported deficit of £14.432 million in 2018/19, and the cumulative deficit of £81.1 million at 31 March 2019.

THE PURPOSE OF OUR AUDIT WORK AND TO WHOM WE OWE OUR RESPONSIBILITIES

This report is made solely to the Board of Directors of Northampton General Hospital NHS Trust, as a body, in accordance with Part 5 of the Local Audit and Accountability Act 2014. Our audit work has been undertaken so that we might state to the Board of the Trust, as a body, those matters we are required to state to them in an auditor's report and for no other purpose. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the Board of the Trust, as a body, for our audit work, for this report or for the opinions we have formed.

CERTIFICATE OF COMPLETION OF THE AUDIT

We certify that we have completed the audit of the accounts of Northampton General Hospital NHS Trust in accordance with the requirements of the Local Audit and Accountability Act 2014 and the Code of Audit Practice.



Andrew Cardoza
for and on behalf of KPMG LLP, Statutory Auditor
Chartered Accountants
One Snowhill
Snowhill Queensway
Birmingham
B4 6GH

29 May 2019

Statement of Comprehensive Income

	Note	2018/19 £000	2017/18 £000
Operating income from patient care activities	3	288,422	276,476
Other operating income	4	38,149	28,284
Operating expenses	7, 9	(338,879)	(329,173)
Operating surplus/(deficit) from continuing operations		**(12,308)**	**(24,413)**
Finance income	12	92	31
Finance expenses	13	(1,815)	(918)
PDC dividends payable		(1,400)	(2,391)
Net finance costs		**(3,123)**	**(3,278)**
Other gains / (losses)	14	14	127
Surplus / (deficit) for the year from continuing operations		**(15,417)**	**(27,564)**
Surplus / (deficit) for the year		**(15,417)**	**(27,564)**
Other comprehensive income			
Will not be reclassified to income and expenditure:			
Impairments	8	(758)	0
Revaluations	18	510	(5,346)
Total comprehensive income / (expense) for the period		**(15,665)**	**(32,910)**
Adjusted financial performance (control total basis):			
Surplus / (deficit) for the period		(15,417)	(27,564)
Remove net impairments not scoring to the Departmental expenditure limit		1,093	4,086
Remove I&E impact of capital grants and donations		(108)	139
Adjusted financial performance surplus / (deficit)		**(14,432)**	**(23,339)**

The increase in impairment of £1,093k relates to a desktop revaluation exercise applied to the Trust's building as at 31 March 2019 and is excluded from retained deficit and statutory breakeven in accordance with the DHSC Group Accounting Manual (GAM), note 16 refers.

Donated asset adjustment of £105k (consisting of £306k donated depreciation less £414k donated additions) is excluded from retained surplus and statutory breakeven duty in accordance with the DHSC Manual for Accounts.

Statement of Financial Position

	Note	31 March 2019 £000	31 March 2018 £000
Non-current assets			
Intangible assets	15	1,993	1,577
Property, plant and equipment	16	159,991	151,867
Receivables	20	183	192
Other assets	21	0	0
Total non-current assets		**162,167**	**153,636**
Current assets			
Inventories	19	5,338	6,272
Receivables	20	23,889	16,479
Other assets	21	0	0
Non-current assets held for sale / assets in disposal groups	21	0	0
Cash and cash equivalents	22	1,553	1,547
Total current assets		**30,780**	**24,298**
Current liabilities			
Trade and other payables	23	(21,868)	(21,475)
Borrowings	25	(42,125)	(20,878)
Other financial liabilities	24	0	0
Provisions	27	(731)	(2,744)
Other liabilities	24	(2,657)	(2,073)
Liabilities in disposal groups	21	0	0
Total current liabilities		**(67,381)**	**(47,170)**
Total assets less current liabilities		**125,566**	**130,764**
Non-current liabilities			
Trade and other payables	23	0	0
Borrowings	25	(64,378)	(53,386)
Other financial liabilities	24	0	0
Provisions	27	(189)	(1,001)
Other liabilities	24	0	0
Total non-current liabilities		**(64,567)**	**(54,387)**
Total assets employed		**60,999**	**76,377**
Financed by			
Public dividend capital		120,538	120,251
Revaluation reserve		31,277	31,782
Income and expenditure reserve		(90,816)	(75,656)
Total taxpayers' equity		**60,999**	**76,377**

The notes on pages 70 to 114 form part of these accounts.

The financial statements on pages 65 to 69 were approved by the Board on 23 May 2019 and signed on its behalf by

Name **Dr Sonia Swart**

Position Chief Executive

Date 23 May 2019

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

	Public dividend capital	Revaluation reserve	Financial assets reserve*	Income and expenditure reserve	Total
	£000	£000	£000	£000	£000
Taxpayers' equity at 1 April 2018 - brought forward	**120,251**	**31,782**	**0**	**(75,656)**	**76,377**
Impact of implementing IFRS 15 on 1 April 2018	0	0	0	0	**0**
Impact of implementing IFRS 9 on 1 April 2018	0	0	0	0	**0**
Surplus/(deficit) for the year	0	0	0	(15,417)	**(15,417)**
Other transfers between reserves	0	(257)	0	257	**0**
Impairments	0	(758)	0	0	**(758)**
Revaluations	0	510	0	0	**510**
Public dividend capital received	287	0	0	0	**287**
Taxpayers' equity at 31 March 2019	**120,538**	**31,277**	**0**	**(90,816)**	**60,999**

* Following the implementation of IFRS 9 from 1 April 2018, the 'Available for sale investment reserve' is now renamed as the 'Financial assets reserve'

Statement of Changes in Equity for the year ended 31 March 2018

	Public dividend capital	Revaluation reserve	Available for sale investment reserve	Income and expenditure reserve	Total
	£000	£000	£000	£000	£000
Taxpayers' equity at 1 April 2017 - brought forward	**119,258**	**37,392**	**0**	**(48,356)**	**108,294**
Prior period adjustment	0	0	0	0	**0**
Taxpayers' equity at 1 April 2017 - restated	**119,258**	**37,392**	**0**	**(48,356)**	**108,294**
Surplus/(deficit) for the year	0	0	0	(27,564)	**(27,564)**
Other transfers between reserves	0	(264)	0	264	**0**
Revaluations	0	(5,346)	0	0	**(5,346)**
Public dividend capital received	993	0	0	0	**993**
Taxpayers' equity at 31 March 2018	**120,251**	**31,782**	**0**	**(75,656)**	**76,377**

Information on reserves

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

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

Financial assets reserve / Available-for-sale investment reserve
This reserve comprises changes in the fair value of financial assets measured at fair value through other comprehensive income. When these instruments are derecognised, cumulative gains or losses previously recognised as other comprehensive income or expenditure are recycled to income or expenditure, unless the assets are equity instruments measured at fair value through other comprehensive income as a result of irrevivable election at recognition.

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

Statement of Cash Flows

	Note	2018/19 £000	2017/18 £000
Cash flows from operating activities			
Operating surplus / (deficit)		(12,308)	(24,413)
Non-cash income and expense:			
Depreciation and amortisation	7.1	10,402	10,056
Net impairments	8	1,093	4,086
Income recognised in respect of capital donations	4	(414)	(181)
(Increase) / decrease in receivables and other assets		(7,904)	7,914
(Increase) / decrease in inventories		934	(502)
Increase / (decrease) in payables and other liabilties		1,820	(907)
Increase / (decrease) in provisions		(2,832)	(2,124)
Other movements in operating cash flows		(88)	(13)
Net cash generated from / (used in) operating activities		**(9,297)**	**(6,084)**
Cash flows from investing activities			
Interest received		92	31
Purchase of intangible assets		(1,175)	(756)
Purchase of property, plant, equipment and investment property		(7,963)	(12,868)
Sales of property, plant, equipment and investment property		14	153
Net cash generated from / (used in) investing activities		**(9,032)**	**(13,440)**
Cash flows from financing activities			
Public dividend capital received		287	993
Movement on loans from the Department of Health and Social Care		20,861	22,325
Movement on other loans		453	(4)
Capital element of finance lease rental payments		(860)	(124)
Interest on loans		(1,152)	(778)
Other interest		(1)	0
Interest paid on finance lease liabilities		(353)	(46)
PDC dividend (paid) / refunded		(900)	(2,916)
Net cash generated from / (used in) financing activities		**18,335**	**19,450**
Increase / (decrease) in cash and cash equivalents		**6**	**(74)**
Cash and cash equivalents at 1 April - brought forward		**1,547**	**1,621**
Prior period adjustments			0
Cash and cash equivalents at 1 April - restated		**1,547**	**1,621**
Cash and cash equivalents at 31 March	22	**1,553**	**1,547**

Notes to the Accounts

Note 1 Accounting policies and other information

Note 1.1 Basis of preparation

The Department of Health and Social Care has directed that the financial statements of the Trust shall meet the accounting requirements of the Department of Health and Social Care Group Accounting Manual (GAM), which shall be agreed with HM Treasury. Consequently, the following financial statements have been prepared in accordance with the GAM 2018/19 issued by the Department of Health and Social Care. The accounting policies contained in the GAM follow International Financial Reporting Standards to the extent that they are meaningful and appropriate to the NHS, as determined by HM Treasury, which is advised by the Financial Reporting Advisory Board. Where the GAM permits a choice of accounting policy, the accounting policy that is judged to be most appropriate to the particular circumstances of the Trust for the purpose of giving a true and fair view has been selected. The particular policies adopted are described below. These have been applied consistently in dealing with items considered material in relation to the accounts.

National consolidations and DHSC ALBs:

These financial statements have been prepared in a form directed by the Secretary of State and in accordance with the Financial Reporting Manual (FReM) 2018-19, issued by HM Treasury, and the Department of Health and Social Care Group Accounting Manual (GAM) 2018-19. The accounting policies contained in the FReM and GAM follow International Financial Reporting Standards (IFRS) as adapted or interpreted for the public sector context. Where the FReM or GAM permits a choice of accounting policy, the accounting policy that is judged to be most appropriate to the particular circumstances of the Trust for the purpose of giving a true and fair view has been selected. The particular policies adopted are described below. These have been applied consistently in dealing with items considered material in relation to the accounts.

Note 1.1.1 Accounting convention

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

Note 1.2 Going concern

These accounts have been prepared on a going concern basis.

Going Concern

International Accounting Standard 1 requires the Board to assess, as part of the accounts preparation process, the Trust's ability to continue as a going concern. In the context of non-trading entities in the public sector the anticipated continuation of the provision of a service in the future is normally sufficient evidence of going concern. The financial statements should be prepared on a going concern basis unless there are plans for, or no realistic alternative other than, the dissolution of the Trust without the transfer of its services to another entity within the public sector.

In preparing the financial statements the Board of Directors has considered the Trust's overall financial position against the requirements of IAS1. The Board has also based its assessment on guidance from NHS Improvement about what is required to undertake a Trust’s Going Concern assessment.

Continuity of service:

The Trust recorded a deficit of £14.4m which was £4.1m better than its planned deficit of £18.5m in 2018-19. This position included incentive PSF of £5.8m as the Trust exceeded its pre-PSF control total of £27.7m. Further, the Trust delivered its challenging CIP target of £14.5m which included £9.9m of recurrent CIPs.

The clinical income assumptions included in the 2019/20 plan are supported by signed contracts with Commissioners. The plan also recognises risks to its delivery such as bed capacity, potential income mitigations from Commissioners, cost pressures within the Northamptonshire STP, in addition to a stretching CIP target.

In spite of the above, as the Trust has not received any notice of discontinuation or notice of transfer of its services to another entity, it intends to prepare its accounts on a going concern basis.

Note 1.3.1 Revenue from contracts with customers

The transition to IFRS 15 has been completed in accordance with paragraph C3 (b) of the Standard, applying the Standard retrospectively recognising the cumulative effects at the date of initial application.

In the adoption of IFRS 15 a number of practical expedients offered in the Standard have been employed. These are as follows;

• As per paragraph 121 of the Standard the Trust will not disclose information regarding performance obligations part of a contract that has an original expected duration of one year or less,

• The Trust is to similarly not disclose information where revenue is recognised in line with the practical expedient offered in paragraph B16 of the Standard where the right to consideration corresponds directly with value of the performance completed to date.

• The FReM has mandated the exercise of the practical expedient offered in C7(a) of the Standard that requires the Trust to reflect the aggregate effect of all contracts modified before the date of initial application.

Where income is derived from contracts with customers, it is accounted for under IFRS 15. The GAM expands the definition of a contract to include legislation and regulations which enables an entity to receive cash or another financial asset that is not classified as a tax by the Office of National Statistics (ONS). As directed by the GAM, the transition to IFRS 15 in 2018/19 has been completed in accordance with paragraph C3 (b) of the Standard: applying the Standard retrospectively but recognising the cumulative effects at the date of initial application (1 April 2018).

Revenue in respect of goods/services provided is recognised when (or as) performance obligations are satisfied by transferring promised goods/services to the customer and is measured at the amount of the transaction price allocated to those performance obligations. At the year end, the Trust accrues income relating to performance obligations satisfied in that year. Where the Trust's entitlement to consideration for those goods or services is unconditional a contract receivable will be recognised. Where entitlement to consideration is conditional on a further factor other than the passage of time, a contract asset will be recognised. Where consideration received or receivable relates to a performance obligation that is to be satisfied in a future period, the income is deferred and recognised as a contract liability. Payment terms are standard reflecting cross government principles.

A full review has been undertaken in conjunction with the Procurement and Contracting leads to understand existing contractual arrangements with non NHS Providers to identify any existing contracts which include performance obligations which relate to the typical timing of payment (ie credit terms) and the effect that these factors have on contract balances. No significant contracts have been identified at this point following review based on the new five stage model outlined in IFRS15:-

• Step 1: Identify the contract(s) with a customer;
• Step 2: Identify the performance obligations in the contract;
• Step 3: Determine the transaction price;
• Step 4: Allocate the transaction price to the performance obligations in the contract;
• Step 5: Recognise revenue when (or as) the entity satisfies a performance obligation

Revenue from NHS contracts

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

Contract / Invoice Challenges

Revenue is recognised to the extent that collection of consideration is probable. Where contract challenges from commissioners are expected to be upheld, the Trust reflects this with an adjustment recognise the relevant portion of income.

Penalties

Where the Trust is aware of a penalty based on contractual performance, the Trust reflects this in an adjustment in recognition of revenue reduction. Revenue is reduced by the value of the penalty.

Readmissions

In 2018/19 the readmission deduction is an agreed block value, reducing the value of the contract with the Lead Commissioner and Specialised Commissioning.

CQUIN
The Trust receives income from commissioners under Commissioning for Quality and Innovation (CQUIN) schemes. The Trust agrees schemes with its commissioners. The CQUIN payments are discrete payments in their own right dependant on meeting specific criteria for each individual scheme. Income is estimated based on forecast performance, and confirmed each quarter.

Revenue from research contracts
Where research contracts fall under IFRS 15, revenue is recognised as and when performance obligations are satisfied. For some contracts, it is assessed that the revenue project constitutes one performance obligation over the course of the multi-year contract. In these cases it is assessed that the Trust's interim performance does not create an asset with alternative use for the Trust, and the Trust has an enforceable right to payment for the performance completed to date. It is therefore considered that the performance obligation is satisfied over time, and the Trust recognises revenue each year over the course of the contract. No contracts have been identified which include any performance obligations for 2018/19.

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

No material contracts have been identified which include performance obligations following review with the Income & Commissioning Team, Contracting Team & Procurement Team.

Note 1.3.2 Revenue grants and other contributions to expenditure
Government grants are grants from government bodies other than income from commissioners or trusts for the provision of services. Where a grant is used to fund revenue expenditure it is taken to the Statement of Comprehensive Income to match that expenditure.

The value of the benefit received when accessing funds from the the Government's apprenticeship service is recognised as income at the point of receipt of the training service. Where these funds are paid directly to an accredited training provider, the corresponding notional expense is also recognised at the point of recognition for the benefit.

Note 1.3.3 Other income
Income from the sale of non-current assets is recognised only when all material conditions of sale have been met, and is measured as the sums due under the sale contract.

Note 1.4 Expenditure on employee benefits

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

Pension costs
NHS Pension Scheme
Past and present employees are covered by the provisions of the NHS Pension Scheme. The scheme is an unfunded, defined benefit scheme that covers NHS employers, general practices and other bodies, allowed under the direction of Secretary of State, in England and Wales. The scheme is not designed in a way that would enable employers to identify their share of the underlying scheme assets and liabilities. Therefore, the scheme is accounted for as though it is a defined contribution scheme.

Employer's 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 operating expenses at the time the trust commits itself to the retirement, regardless of the method of payment.

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

Note 1.6 Property, plant and equipment

Note 1.6.1 Recognition
Property, plant and equipment is capitalised where:

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

Where a large asset, for example a building, includes a number of components with significantly different asset lives, the components are treated as separate assets and depreciated over their individual useful economic lives.

Note 1.6.2 Measurement
Valuation
All property, plant and equipment assets are measured initially at cost, representing the costs directly attributable to acquiring or constructing the asset and bringing it to the location and condition necessary for it to be capable of operating in the manner intended by management.

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

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

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

The Trust undertakes an annual desktop revaluation exercise with a full revaluation exercise undertaken on a five yearly basis, the next full exercise is due to be undertaken in March 2021.

Properties in the course of construction for service or administration purposes are carried at cost, less any impairment loss. Cost includes professional fees and, where capitalised in accordance with IAS 23, borrowings costs. Assets are revalued and depreciation commences when the assets are brought into use.

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

An increase arising on revaluation is taken to the revaluation reserve except when it reverses an impairment for the same asset previously recognised in expenditure, in which case it is credited to expenditure to the extent of the decrease previously charged there. A revaluation decrease that does not result from a loss of economic value or service potential is recognised as an impairment charged to the revaluation reserve to the extent that there is a balance on the reserve for the asset, and thereafter to expenditure. Gains and losses recognised in the revaluation reserve are reported as other comprehensive [income / net expenditure] in the [Statement of Comprehensive Income / Net Expenditure].

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

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

Property, plant and equipment which has been reclassified as 'held for sale' cease to be depreciated upon the reclassification. Assets in the course of construction and residual interests in off-Statement of Financial Position PFI contract assets are not depreciated until the asset is brought into use or reverts to the trust, respectively.

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

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

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

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

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

Note 1.6.3 De-recognition

Assets intended for disposal are reclassified as 'held for sale' once all of the following criteria are met:

• the asset is available for immediate sale in its present condition subject only to terms which are usual and customary for such sales;
• the sale must be highly probable ie:

- management are committed to a plan to sell the asset
- an active programme has begun to find a buyer and complete the sale
- the asset is being actively marketed at a reasonable price
- the sale is expected to be completed within 12 months of the date of classification as 'held for sale' and
- the actions needed to complete the plan indicate it is unlikely that the plan will be abandoned or significant changes made to it.

Following reclassification, the assets are measured at the lower of their existing carrying amount and their 'fair value less costs to sell'. Depreciation ceases to be charged. Assets are de-recognised when all material sale contract conditions have been met.

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

Note 1.6.4
Donated and grant funded assets
Donated and grant funded property, plant and equipment assets are capitalised at their fair value on receipt. The donation/grant is credited to income at the same time, unless the donor has imposed a condition that the future economic benefits embodied in the grant are to be consumed in a manner specified by the donor, in which case, the donation/grant is deferred within liabilities and is carried forward to future financial years to the extent that the condition has not yet been met.

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

Note 1.6.5
Useful lives of property, plant and equipment
Useful lives reflect the total life of an asset and not the remaining life of an asset. The range of useful lives are shown in the table below:

	Min life Years	Max life Years
Buildings, excluding dwellings	6	52
Dwellings	34	34
Plant & machinery	5	15
Transport equipment	7	7
Information technology	1	10
Furniture & fittings	5	5

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

Note 1.7 Intangible assets

Note 1.7.1 Recognition

Intangible assets are non-monetary assets without physical substance which are capable of being sold separately from the rest of the trust's business or which arise from contractual or other legal rights. They are recognised only where it is probable that future economic benefits will flow to, or service potential be provided to, the trust and where the cost of the asset can be measured reliably; and where the cost is at least £5,000.

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

Expenditure on research is not capitalised.

Expenditure on development is capitalised only where all of the following can be demonstrated:
• the project is technically feasible to the point of completion and will result in an intangible asset for sale or use
• the trust intends to complete the asset and sell or use it
• the trust has the ability to sell or use the asset
• how the intangible asset will generate probable future economic or service delivery benefits, eg, the presence of a market for it or its output, or where it is to be used for internal use, the usefulness of the asset;
• adequate financial, technical and other resources are available to the trust to complete the development and sell or use the asset and
• the trust can measure reliably the expenses attributable to the asset during development.

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

Note 1.7.2 Measurement

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

Subsequently intangible assets are measured at current value in existing use. Where no active market exists, intangible assets are valued at the lower of depreciated replacement cost and the value in use where the asset is income generating. Revaluations gains and losses and impairments are treated in the same manner as for property, plant and equipment. An intangible asset which is surplus with no plan to bring it back into use is valued at fair value under IFRS 13, if it does not meet the requirements of IAS 40 of IFRS 5.

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

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

Note 1.7.3 Useful economic life of intangible assets

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

	Min life Years	Max life Years
Information technology	1	5
Software licences	1	5

Note 1.8 Inventories

Drugs and consumables are valued at current replacement costs; this is considered to be a reasonable approximation to fair value due to the high turnover of stocks. Fuel Oil is valued at the lower of cost and net realisable value, recognising that it has limited commercial value.

Note 1.9 Cash and cash equivalents

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

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

Note 1.10 Carbon Reduction Commitment scheme (CRC)

The CRC scheme is a mandatory cap and trade scheme for non-transport CO2 emissions. The trust is registered with the CRC scheme, and is therefore required to surrender to the Government an allowance for every tonne of CO2 it emits during the financial year. A liability and related expense is recognised in respect of this obligation as CO2 emissions are made.

The carrying amount of the liability at the financial year end will therefore reflect the CO2 emissions that have been made during that financial year, less the allowances (if any) surrendered voluntarily during the financial year in respect of that financial year.

The liability will be measured at the amount expected to be incurred in settling the obligation. This will be the cost of the number of allowances required to settle the obligation.

Allowances acquired under the scheme are recognised as intangible assets.

Note 1.11 Financial assets and financial liabilities

Note 1.11.1 Recognition

Financial assets and financial liabilities arise where the Trust is party to the contractual provisions of a financial instrument, and as a result has a legal right to receive or a legal obligation to pay cash or another financial instrument. The GAM expands the definition of a contract to include legislation and regulations which give rise to arrangements that in all other respects would be a financial instrument and do not give rise to transactions classified as a tax by ONS.

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

Note 1.11.2 Classification and measurement

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

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

Financial assets are classified as subsequently measured at amortised cost, fair value through income and expenditure

Financial liabilities classified as subsequently measured at fair value through income and expenditure.

Financial assets and financial liabilities at amortised cost

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

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

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

Impairment of financial assets

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

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

A full review has been undertaken by invoice type which includes general, private patient, overseas visitors, salary overpayments and NHS organisations. This has been analysed by levels of aged debt to determine a level of anticipated loss in relation to these. The overseas visitors assumes an average recovery level based on cash received for invoices raised in 2018/19 circa 27%. A specific loss basis has been included for longstanding debt included in 2017/18 and for specific accounts being undertaken to recover salary overpayments on a case by case basis. This does not include outstanding debt with other NHS organisations.

HM Treasury has ruled that central government bodies may not recognise stage 1 or stage 2 impairments against other government departments, their executive agencies, the Bank of England, Exchequer Funds, and Exchequer Funds' assets where repayment is ensured by primary legislation. The Trust therefore does not recognise loss allowances for stage 1 or stage 2 impairments against these bodies. Additionally, the Department of Health and Social Care provides a guarantee of last resort against the debts of its arm's length bodies and NHS bodies (excluding NHS charities), and the Trust does not recognise loss allowances for stage 1 or stage 2 impairments against these bodies.

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

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

Note 1.11.3 Derecognition

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

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

Note 1.12 Leases

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.

Note 1.12.1 The trust as lessee

Finance leases

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

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

The annual rental charge is split between the repayment of the liability and a finance cost so as to achieve a constant rate of finance over the life of the lease. The annual finance cost is charged to Finance Costs in the Statement of Comprehensive Income. The lease liability, is de-recognised when the liability is discharged, cancelled or expires.

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.

Leases of land and buildings

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

Note 1.12.2 The trust as lessor

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

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

Note 1.13 Provisions
The Trust recognises a provision where it has a present legal or constructive obligation of uncertain timing or amount; for which it is probable that there will be a future outflow of cash or other resources; and a reliable estimate can be made of the amount. The amount recognised in the Statement of Financial Position is the best estimate of the resources required to settle the obligation. Where the effect of the time value of money is significant, the estimated risk-adjusted cash flows are discounted using the discount rates published and mandated by HM Treasury.
Early retirement provisions are discounted using HM Treasury's pension discount rate of positive 0.29% (2017-18: positive 0.10%) in real terms. All general provisions are subject to four separate discount rates according to the expected timing of cashflows from the Statement of Financial Position date:

• A nominal short-term rate of 0.76% (2017-18: negative 2.42% in real terms) for inflation adjusted expected cash flows up to and including 5 years from Statement of Financial Position date.

• A nominal medium-term rate of 1.14% (2017-18: negative 1.85% in real terms) for inflation adjusted expected cash flows over 5 years up to and including 10 years from the Statement of Financial Position date.

• A nominal long-term rate of 1.99% (2017-18: negative 1.56% in real terms) for inflation adjusted expected cash flows over 10 years and up to and including 40 years from the Statement of Financial Position date.

• A nominal very long-term rate of 1.99% (2017-18: negative 1.56% in real terms) for inflation adjusted expected cash flows exceeding 40 years from the Statement of Financial Position date.

All 2018-19 percentages are expressed in nominal terms with 2017-18 being the last financial year that HM Treasury provided real general provision discount rates.

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

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

Note 1.14 Contingencies
Contingent assets (that is, assets arising from past events whose existence will only be confirmed by one or more future events not wholly within the entity's control) are not recognised as assets, but are disclosed in note 28 where an inflow of economic benefits is probable.
Contingent liabilities are not recognised, but are disclosed in note 28, unless the probability of a transfer of economic benefits is remote.

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

Note 1.15 Public dividend capital

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

At any time, the Secretary of State can issue new PDC to, and require repayments of PDC from, the trust. PDC is recorded at the value received.

A charge, reflecting the cost of capital utilised by the trust, is payable as public dividend capital dividend. The charge is calculated at the rate set by HM Treasury (currently 3.5%) on the average relevant net assets of the trust during the financial year. Relevant net assets are calculated as the value of all assets less the value of all liabilities, except for
(i) donated assets (including lottery funded assets),
(ii) average daily cash balances held with the Government Banking Services (GBS) and National Loans Fund (NLF) deposits, excluding cash balances held in GBS accounts that relate to a short-term working capital facility, and
(iii) any PDC dividend balance receivable or payable.

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

Note 1.16 Value added tax

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

Note 1.17 Foreign exchange

The functional and presentational currency of the trust is sterling.

A transaction which is denominated in a foreign currency is translated into the functional currency at the spot exchange rate on the date of the transaction.

Where the trust has assets or liabilities denominated in a foreign currency at the Statement of Financial Position date:

• monetary items are translated at the spot exchange rate on 31 March
• non-monetary assets and liabilities measured at historical cost are translated using the spot exchange rate at the date of the transaction and
• non-monetary assets and liabilities measured at fair value are translated using the spot exchange rate at the date the fair value was determined.

Exchange gains or losses on monetary items (arising on settlement of the transaction or on re-translation at the Statement of Financial Position date) are recognised in income or expense in the period in which they arise.

Exchange gains or losses on non-monetary assets and liabilities are recognised in the same manner as other gains and losses on these items.

Note 1.18 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. However, they are disclosed in a separate note to the accounts in accordance with the requirements of HM Treasury's *FReM*.

Note 1.19 Losses and special payments

Losses and special payments are items that Parliament would not have contemplated when it agreed funds for the health service or passed legislation. By their nature they are items that ideally should not arise. They are therefore subject to special control procedures compared with the generality of payments. They are divided into different categories, which govern the way that individual cases are handled. Losses and special payments are charged to the relevant functional headings in expenditure on an accruals basis, including losses which would have been made good through insurance cover had the trust not been bearing their own risks (with insurance premiums then being included as normal revenue expenditure).

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

Note 1.20 Gifts

Gifts are items that are voluntarily donated, with no preconditions and without the expectation of any return. Gifts include all transactions economically equivalent to free and unremunerated transfers, such as the loan of an asset for its expected useful life, and the sale or lease of assets at below market value.

Note 1.21 Critical judgements in applying accounting policies

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

• Ongoing status as a going concern;
• That no major service discontinuation is anticipated;
• All lease liabilities have been identified through a review of contract documentation.
• Review of Trust revenue contracts in applying with IFRS15 to determine the impact of determing the timing of revenue recognised as required by paragraphs, where not already disclosed within the accounting policy for revenue from contracts with customers.

Note 1.21.1 Sources of estimation uncertainty

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

• Provisions - estimation provided to assess likelihood of possible financial obligations;
• Partially completed spells - estimation required regarding length of stay and case mix;
• Employee Benefits - estimate of levels of employee benefits not fully paid in year;
• Receivables - including injury cost recovery and other accounts receivable - estimation required to assess the level of where it is probable that the debt is irrecoverable in applying IFRS 9

Note 1.22 Early adoption of standards, amendments and interpretations

No new accounting standards or revisions to existing standards have been early adopted in 2018/19.

Note 1.23 Standards, amendments and interpretations in issue but not yet effective or adopted

The DHSC GAM does not require the following IFRS Standards and Interpretations to be applied in 2018-19. These Standards are still subject to HM Treasury FReM adoption, with IFRS 16 being for implementation in 2019-20, and the government implementation date for IFRS 17 still subject to HM Treasury consideration.

● IFRS 16 Leases – Application required for accounting periods beginning on or after 1 January 2019, but not yet adopted by the FReM: early adoption is not therefore permitted.
● IFRS 17 Insurance Contracts – Application required for accounting periods beginning on or after 1 January 2021, but not yet adopted by the FReM: early adoption is not therefore permitted.
● IFRIC 23 Uncertainty over Income Tax Treatments – Application required for accounting periods beginning on or after 1 January 2019.

IFRS 16 Leases

The impact of applying this standard has been considered as follows:-

• IFRS 16 will bring most leases on balance sheet for lessees
• All entities that lease assets for use in their business will see an increase in reported assets and liabilities
• Definition of a lease is a contract or part of a contract that conveys the right to use an asset for a period of time in exchange for consideration
• Most complex area in the NHS is likely to be managed service agreements
• A review of contracts with Procurement, Service and Finance Leads will be undertaken to identify any assets being utilised by the Trust not currently included on the Trust's fixed asset register or identified as an existing operating or finance lease
• We await further guidance to model the financial impact of this standard.

Note 2 Operating Segments

The Trust Board considers all of its operations to be the provision of Healthcare operated as a single segment.

Note 3 Operating income from patient care activities

All income from patient care activities relates to contract income recognised in line with accounting policy 1.3.1

Note 3.1 Income from patient care activities (by nature)	**2018/19**	**2017/18**
	£000	**£000**
Elective income	40,830	39,033
Non elective income	109,412	104,163
First outpatient income	10,189	10,258
Follow up outpatient income	30,634	29,526
A & E income	17,646	15,454
High cost drugs income from commissioners (excluding pass-through costs)	20,967	23,645
Other NHS clinical income	52,705	52,249
All services		
Private patient income	718	845
Agenda for Change pay award central funding	3,692	0
Other clinical income	1,629	1,303
Total income from activities	**288,422**	**276,476**

Note 3.2 Income from patient care activities (by source)

Income from patient care activities received from:	**2018/19**	**2017/18**
	£000	**£000**
NHS England	45,673	50,324
Clinical commissioning groups	235,563	222,649
Department of Health and Social Care	3,692	0
Other NHS providers	962	1,051
NHS other	107	107
Local authorities	0	0
Non-NHS: private patients	718	845
Non-NHS: overseas patients (chargeable to patient)	410	151
Injury cost recovery scheme	1,220	1,152
Non NHS: other	77	197
Total income from activities	**288,422**	**276,476**
Of which:		
Related to continuing operations	288,422	276,476
Related to discontinued operations	0	0

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

	2018/19 £000	2017/18 £000
Income recognised this year	410	151
Cash payments received in-year	122	93
Amounts added to provision for impairment of receivables	223	103
Amounts written off in-year	(9)	49

Note 4 Other operating income

	2018/19 £000	2017/18 £000
Other operating income from contracts with customers:		
Research and development (contract)	211	231
Education and training (excluding notional apprenticeship levy income)	9,959	9,986
Non-patient care services to other bodies	1,570	1,455
Provider sustainability / sustainability and transformation fund income (PSF / STF)	13,206	3,691
Income in respect of employee benefits accounted on a gross basis	3,590	3,423
Other contract income	8,616	8,810
Other non-contract operating income		
Research and development (non-contract)	0	0
Education and training - notional income from apprenticeship fund	66	4
Receipt of capital grants and donations	414	181
Charitable and other contributions to expenditure	470	449
Support from the Department of Health and Social Care for mergers	0	0
Rental revenue from finance leases	0	0
Rental revenue from operating leases	47	54
Amortisation of PFI deferred income / credits	0	0
Other non-contract income	0	0
Total other operating income	**38,149**	**28,284**
Of which:		
Related to continuing operations	38,149	28,284
Related to discontinued operations	0	0

*** Provider sustainability/sustainability and transformation fund income (PSF/STF)**

- core PSF/STF £7,399k (£1,111k)
- incentive PSF (finance) £67k (£0k)
- Incentive PSF (bonus) £1,537k (£0k)
- incentive PSF/STF (general distribution) £4,203k (£2,580k)

Other contract income includes :

Pharmacy Sales £398k (£285k)
Accommodation Charges £532k (£543k)
Clinical Tests £960k (£1,023k)
Car Parking Income £1,398k (£1,259k)
Catering £1,749k (£1,422k)
VAT Audit Claim £0k (£507k)
Sterile Services Sales £456k (£454k)

Note 5.1 Additional information on revenue from contracts with customers recognised in the period

	2018/19 £000
Revenue recognised in the reporting period that was included in within contract liabilities at the previous period end	1,710
Revenue recognised from performance obligations satisfied (or partially satisfied) in previous periods	0

Note 5.2 Transaction price allocated to remaining performance obligations

	31 March 2019 £000
Revenue from existing contracts allocated to remaining performance obligations is expected to be recognised:	
within one year	0
after one year, not later than five years	0
after five years	0
Total revenue allocated to remainig performance obligations	**0**

No contracts have been identified which include performance obligations.

Note 6 Fees and charges

HM Treasury requires disclosure of fees and charges income. The following disclosure is of income from charges to service users where income from that service exceeds £1 million and is presented as the aggregate of such income. The cost associated with the service that generated the income is also disclosed.

	2018/19 £000	2017/18 £000
Income	3,206	2,735
Full cost	(1,652)	(1,405)
Surplus / (deficit)	**1,554**	**1,330**

Note 7.1 Operating expenses

	2018/19	2017/18
	£000	£000
Purchase of healthcare from NHS and DHSC bodies	216	113
Purchase of healthcare from non-NHS and non-DHSC bodies	2,574	3,815
Staff and executive directors costs	224,284	211,470
Remuneration of non-executive directors	77	65
Supplies and services - clinical (excluding drugs costs)	33,240	33,175
Supplies and services - general	3,681	3,659
Drug costs (drugs inventory consumed and purchase of non-inventory drugs)	28,158	29,885
Inventories written down	85	79
Consultancy costs	0	18
Establishment	2,279	1,945
Premises	13,696	13,401
Transport (including patient travel)	521	500
Depreciation on property, plant and equipment	9,682	9,371
Amortisation on intangible assets	720	685
Net impairments	1,093	4,086
Movement in credit loss allowance: contract receivables / contract assets	791	
Movement in credit loss allowance: all other receivables and investments	0	387
Change in provisions discount rate(s)	0	2
Audit fees payable to the external auditor		
audit services- statutory audit	39	39
other auditor remuneration (external auditor only)	10	10
Internal audit costs	158	151
Clinical negligence	11,338	11,198
Legal fees	466	307
Insurance	260	231
Research and development	9	4
Education and training	1,089	716
Rentals under operating leases	1,126	877
Car parking & security	372	343
Hospitality	11	9
Losses, ex gratia & special payments	9	18
Other services, eg external payroll	1,386	1,379
Other	1,509	1,235
Total	**338,879**	**329,173**
Of which:		
Related to continuing operations	338,879	329,173

Other auditors remuneration includes :

- KPMG £39k (£39k)
- Quality Accounts Audit Fee £10k (£10k)

Other expenditure includes :

Translation Services £147k (£118k)

Home Oxygen Service £151k (£130k)

Professional Subscriptions £318k (£319k)

Professional Fees & Services £1,374k (£648k)

N.B. Other costs also includes £4k which was identified as additional proposed costs by KPMG in their 2018/19 audit plan

Note 7.2 Other auditor remuneration

	2018/19 £000	2017/18 £000
Other auditor remuneration paid to the external auditor:		
1. Audit of accounts of any associate of the trust	0	0
2. Audit-related assurance services	10	10
3. Taxation compliance services	0	0
4. All taxation advisory services not falling within item 3 above	0	0
5. Internal audit services	0	0
6. All assurance services not falling within items 1 to 5	0	0
7. Corporate finance transaction services not falling within items 1 to 6 above	0	0
8. Other non-audit services not falling within items 2 to 7 above	0	0
Total	**10**	**10**

Note 7.3 Limitation on auditor's liability

The limitation on auditor's liability for external audit work is £1m (2017/18: £1m).

Note 8 Impairment of assets

	2018/19 £000	2017/18 £000
Net impairments charged to operating surplus / deficit resulting from:		
Loss or damage from normal operations	0	0
Over specification of assets	0	0
Abandonment of assets in course of construction	0	0
Unforeseen obsolescence	0	0
Loss as a result of catastrophe	0	0
Changes in market price	1,093	4,086
Other	0	0
Total net impairments charged to operating surplus / deficit	**1,093**	**4,086**
Impairments charged to the revaluation reserve	758	0
Total net impairments	**1,851**	**4,086**

A desktop revaluation exercise was undertaken as at 31 March 2019.

The impact of the revaluation exercise was a reduction in buildings of £1,851k from £114,679k to £112,828k, there was no impact on the land value.

Note 9 Employee benefits

	2018/19 Total £000	2017/18 Total £000
Salaries and wages	174,190	164,254
Social security costs	17,548	16,692
Apprenticeship levy	851	807
Employer's contributions to NHS pensions	19,238	17,970
Pension cost - other	11	5
Other post employment benefits	0	0
Other employment benefits	0	0
Termination benefits	0	0
Temporary staff (including agency)	12,543	12,196
Total gross staff costs	**224,381**	**211,924**
Recoveries in respect of seconded staff	**0**	0
Total staff costs	**224,381**	**211,924**
Of which		
Costs capitalised as part of assets	97	454

Note 9.1 Retirements due to ill-health

During 2018/19 there were 2 early retirements from the trust agreed on the grounds of ill-health (1 in the year ended 31 March 2018). The estimated additional pension liabilities of these ill-health retirements is £65k (£67k in 2017/18).

The cost of these ill-health retirements will be borne by the NHS Business Services Authority - Pensions Division.

Note 10 Pension costs

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

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

a) Accounting valuation

A valuation of scheme liability is carried out annually by the scheme actuary (currently the Government Actuary's Department) as at the end of the reporting period. This utilises an actuarial assessment for the previous accounting period in conjunction with updated membership and financial data for the current reporting period, and is accepted as providing suitably robust figures for financial reporting purposes. The valuation of the scheme liability as at 31 March 2019, is based on valuation data as 31 March 2018, updated to 31 March 2019 with summary global member and accounting data. In undertaking this actuarial assessment, the methodology prescribed in IAS 19, relevant FReM interpretations, and the discount rate prescribed by HM Treasury have also been used.

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

b) Full actuarial (funding) valuation

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

The latest actuarial valuation undertaken for the NHS Pension Scheme was completed as at 31 March 2016. The results of this valuation set the employer contribution rate payable from April 2019. The Department of Health and Social Care have recently laid Scheme Regulations confirming that the employer contribution rate will increase to 20.6% of pensionable pay from this date.

The 2016 funding valuation was also expected to test the cost of the Scheme relative to the employer cost cap set following the 2012 valuation. Following a judgment from the Court of Appeal in December 2018 Government announced a pause to that part of the valuation process pending conclusion of the continuing legal process.

Note 11 Operating leases

Note 11.1 Northampton General Hospital NHS Trust as a lessor

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

An optician's shop and Boot's chemist operate on the Trust's site under operating leases.

	2018/19 £000	2017/18 £000
Operating lease revenue		
Minimum lease receipts	47	54
Contingent rent	0	0
Other	0	0
Total	**47**	**54**

	31 March 2019 £000	31 March 2018 £000
Future minimum lease receipts due:		
- not later than one year;	47	54
- later than one year and not later than five years;	0	0
- later than five years.	0	0
Total	**47**	**54**

A nursery is situated on the hospital site, the building being originally funded by the childcare provider, with the land being leased at a peppercorn rent. At the end of the lease the building has the potential to transfer to the Trust, this is currently assumed to have a zero fair value.

Note 11.2 Northampton General Hospital NHS Trust as a lessee

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

The Trust has a variety of operating leases, the majority of which when considered on an individual basis are of non material value. These include medical equipment, leased cars, photocopiers, pathology systems and Springfield House.

	2018/19 £000	2017/18 £000
Operating lease expense		
Minimum lease payments	1,126	877
Contingent rents	0	0
Less sublease payments received	0	0
Total	**1,126**	**877**

	31 March 2019 £000	31 March 2018 £000
Future minimum lease payments due:		
- not later than one year;	1,164	760
- later than one year and not later than five years;	3,118	1,774
- later than five years.	4,324	250
Total	**8,606**	**2,784**
Future minimum sublease payments to be received	0	0

Note 12 Finance income

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

	2018/19 £000	2017/18 £000
Interest on bank accounts	92	31
Interest income on finance leases	0	0
Interest on other investments / financial assets	0	0
Other finance income	0	0
Total finance income	**92**	**31**

Note 13.1 Finance expenditure

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

	2018/19 £000	2017/18 £000
Interest expense:		
Loans from the Department of Health and Social Care	1,254	854
Other loans	0	0
Overdrafts	0	0
Finance leases	311	46
Interest on late payment of commercial debt	1	1
Main finance costs on PFI and LIFT schemes obligations	0	0
Contingent finance costs on PFI and LIFT scheme obligations	0	0
Total interest expense	**1,566**	**901**
Unwinding of discount on provisions	7	6
Other finance costs	242	11
Total finance costs	**1,815**	**918**

Note 13.2 The late payment of commercial debts (interest) Act 1998 / Public Contract Regulations 2015

	2018/19 £000	2017/18 £000
Total liability accruing in year under this legislation as a result of late payments	0	0
Amounts included within interest payable arising from claims under this legislation	1	1
Compensation paid to cover debt recovery costs under this legislation	0	0

Note 14 Other gains / (losses)

	2018/19 £000	2017/18 £000
Gains on disposal of assets	14	127
Losses on disposal of assets	0	0
Total gains / (losses) on disposal of assets	**14**	**127**
Gains / (losses) on foreign exchange	0	0
Fair value gains / (losses) on investment properties	0	0
Fair value gains / (losses) on financial assets / investments	0	0
Fair value gains / (losses) on financial liabilities	0	0
Recycling gains / (losses) on disposal of financial assets mandated as fair value through OCI	0	0
Total other gains / (losses)	**14**	**127**

The Gains on disposal of assets includes £3k from the sale of an ultrasound within our Crtical Care department which was disposed of in 2017/18, but the sale transaction was in 2018/19.

Note 15.1 Intangible assets - 2018/19

	Software licences	Internally generated information technology	Intangible assets under construction	Total
	£000	£000	£000	£000
Valuation / gross cost at 1 April 2018 - brought forward	**7,717**	**399**	**0**	**8,116**
Additions	1,105	0	70	**1,175**
Reclassifications	(39)	0	0	**(39)**
Disposals / derecognition	(147)	(54)	0	**(201)**
Valuation / gross cost at 31 March 2019	**8,636**	**345**	**70**	**9,051**
Amortisation at 1 April 2018 - brought forward	**6,140**	**399**	**0**	**6,539**
Provided during the year	720	0	0	**720**
Disposals / derecognition	(147)	(54)	0	**(201)**
Amortisation at 31 March 2019	**6,713**	**345**	**0**	**7,058**
Net book value at 31 March 2019	**1,923**	**0**	**70**	**1,993**
Net book value at 1 April 2018	**1,577**	**0**	**0**	**1,577**

Note 15.2 Intangible assets - 2017/18

	Software licences	Internally generated information technology	Intangible assets under construction	Total
	£000	£000	£000	£000
Valuation / gross cost at 1 April 2017 - as previously stated	**8,704**	**399**	**0**	**9,103**
Prior period adjustments	0	0	0	**0**
Valuation / gross cost at 1 April 2017 - restated	**8,704**	**399**	**0**	**9,103**
Additions	771	0	0	**771**
Reclassifications	287	0	0	**287**
Disposals / derecognition	(2,045)	0	0	**(2,045)**
Valuation / gross cost at 31 March 2018	**7,717**	**399**	**0**	**8,116**
Amortisation at 1 April 2017 - as previously stated	**7,617**	**282**	**0**	**7,899**
Prior period adjustments	0	0	0	**0**
Amortisation at 1 April 2017 - restated	**7,617**	**282**	**0**	**7,899**
Provided during the year	568	117	0	**685**
Disposals / derecognition	(2,045)	0	0	**(2,045)**
Amortisation at 31 March 2018	**6,140**	**399**	**0**	**6,539**
Net book value at 31 March 2018	**1,577**	**0**	**0**	**1,577**
Net book value at 1 April 2017	**1,087**	**117**	**0**	**1,204**

Note 16.1 Property, plant and equipment - 2018/19	Land	Buildings excluding dwellings	Dwellings	Assets under construction	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Valuation/gross cost at 1 April 2018 - brought forward	**9,834**	**115,208**	**516**	**3,556**	**45,314**	**71**	**22,014**	**175**	**196,688**
Transfers by absorption	0	0	0	0	0	0	0	0	**0**
Additions	0	14,913	0	1,562	840	9	1,784	0	**19,108**
Impairments charged to revaluation reserve	0	(1,130)	0	0	0	0	0	0	**(1,130)**
Reversals of impairments credited to revaluation reserve	0	372	0	0	0	0	0	0	**372**
Revaluations - write out of accumulated depreciation	0	(3,524)	(21)	0	1,305	3	0	0	**(2,237)**
Reclassifications	0	527	0	(4,468)	1,135	0	2,845	0	**39**
Transfers to / from assets held for sale	0	0	0	0	0	0	0	0	**0**
Disposals / derecognition	0	0	0	0	(2,281)	0	(4,432)	(18)	**(6,731)**
Valuation/gross cost at 31 March 2019	**9,834**	**126,366**	**495**	**650**	**46,313**	**83**	**22,211**	**157**	**206,109**
Accumulated depreciation at 1 April 2018 - brought forward	**0**	**325**	**0**	**0**	**28,379**	**46**	**15,897**	**174**	**44,821**
Transfers by absorption	0	0	0	0	0	0	0	0	**0**
Provided during the year	0	3,162	21	0	3,642	5	2,851	1	**9,682**
Impairments charged to operating expenses	0	1,543	0	0	0	0	0	0	**1,543**
Reversals of impairments credited to operating expenses	0	(450)	0	0	0	0	0	0	**(450)**
Revaluations - write out of accumulated depreciation	0	(3,524)	(21)	0	796	2	0	0	**(2,747)**
Reclassifications	0	0	0	0	0	0	0	0	**0**
Transfers to / from assets held for sale	0	0	0	0	0	0	0	0	**0**
Disposals / derecognition	0	0	0	0	(2,281)	0	(4,432)	(18)	**(6,731)**
Accumulated depreciation at 31 March 2019	**0**	**1,056**	**0**	**0**	**30,536**	**53**	**14,316**	**157**	**46,118**
Net book value at 31 March 2019	**9,834**	**125,310**	**495**	**650**	**15,777**	**30**	**7,895**	**0**	**159,991**
Net book value at 1 April 2018	**9,834**	**114,883**	**516**	**3,556**	**16,935**	**25**	**6,117**	**1**	**151,867**

Note 16.2 Property, plant and equipment - 2017/18	Land	Buildings excluding dwellings	Dwellings	Assets under construction	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Valuation / gross cost at 1 April 2017 - as previously stated	**13,200**	**121,112**	**576**	**2,726**	**42,628**	**58**	**22,433**	**175**	**202,908**
Prior period adjustments	0	0	0	0	0	0	0	0	**0**
Valuation / gross cost at 1 April 2017 - restated	**13,200**	**121,112**	**576**	**2,726**	**42,628**	**58**	**22,433**	**175**	**202,908**
Transfers by absorption	0	0	0	0	0	0	0	0	**0**
Additions	0	4,559	0	3,948	2,498	18	1,529	0	**12,552**
Impairments	0	(4,086)	0	0	0	0	0	0	**(4,086)**
Reversals of impairments	0	0	0	0	0	0	0	0	**0**
Revaluations	(3,366)	(8,473)	(60)	0	1,439	2	0	0	**(10,458)**
Reclassifications	0	2,096	0	(3,118)	673	0	62	0	**(287)**
Transfers to / from assets held for sale	0	0	0	0	0	0	0	0	**0**
Disposals / derecognition	0	0	0	0	(1,924)	(7)	(2,010)	0	**(3,941)**
Valuation/gross cost at 31 March 2018	**9,834**	**115,208**	**516**	**3,556**	**45,314**	**71**	**22,014**	**175**	**196,688**
Accumulated depreciation at 1 April 2017 - as previously stated	**0**	**3,497**	**39**	**0**	**25,799**	**46**	**14,951**	**171**	**44,503**
Prior period adjustments	0	0	0	0	0	0	0	0	**0**
Accumulated depreciation at 1 April 2017 - restated	**0**	**3,497**	**39**	**0**	**25,799**	**46**	**14,951**	**171**	**44,503**
Transfers by absorption	0	0	0	0	0	0	0	0	**0**
Provided during the year	0	2,739	21	0	3,647	5	2,956	3	**9,371**
Impairments	0	4,307	0	0	0	0	0	0	**4,307**
Reversals of impairments	0	(4,307)	0	0	0	0	0	0	**(4,307)**
Revaluations	0	(5,911)	(60)	0	857	2	0	0	**(5,112)**
Reclassifications	0	0	0	0	0	0	0	0	**0**
Transfers to / from assets held for sale	0	0	0	0	0	0	0	0	**0**
Disposals / derecognition	0	0	0	0	(1,924)	(7)	(2,010)	0	**(3,941)**
Accumulated depreciation at 31 March 2018	**0**	**325**	**0**	**0**	**28,379**	**46**	**15,897**	**174**	**44,821**
Net book value at 31 March 2018	**9,834**	**114,883**	**516**	**3,556**	**16,935**	**25**	**6,117**	**1**	**151,867**
Net book value at 1 April 2017	**13,200**	**117,615**	**537**	**2,726**	**16,829**	**12**	**7,482**	**4**	**158,405**

Note 16.3 Property, plant and equipment financing - 2018/19									
	Land	Buildings excluding dwellings	Dwellings	Assets under construction	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Net book value at 31 March 2019									
Owned - purchased	9,834	106,239	495	650	15,403	30	7,895	0	**140,546**
Finance leased	0	11,804	0	0	0	0	0	0	**11,804**
Owned - donated	0	7,267	0	0	374	0	0	0	**7,641**
NBV total at 31 March 2019	**9,834**	**125,310**	**495**	**650**	**15,777**	**30**	**7,895**	**0**	**159,991**

Note 16.4 Property, plant and equipment financing - 2017/18									
	Land	Buildings excluding dwellings	Dwellings	Assets under construction	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Net book value at 31 March 2018									
Owned - purchased	9,834	106,504	516	3,532	16,482	25	6,113	1	**143,007**
Finance leased	0	1,093	0	0	0	0	0	0	**1,093**
Owned - donated	0	7,286	0	24	453	0	4	0	**7,767**
NBV total at 31 March 2018	**9,834**	**114,883**	**516**	**3,556**	**16,935**	**25**	**6,117**	**1**	**151,867**

Note 17 Donations of property, plant and equipment

The table below details donations of property, plant and equipment received during the year from Northamptonshire Health Charitable Funds

Description	Department	Total £000's
Equipment		
Ophthalmascope	SCBU	7
Venue 50 Scanner	Clinical Simulation Unit	14
Portable Naso-Pharyngo Laryngoscope	Talbot Butler EAB	6
Cystoscope	Urology - 'One Stop'	11
MOTOmed letto2	Critical Care	9
Haag Streit table & Imaging Module	Opthalmology	13
Criticool Mini Cooling system	Gosset Ward	14
Total Equipment Capitalised		**74**
AUC Buildings		
Emergency Assessment Unit	Talbot Butler	340
Total Building Capitalised		**340**
Total Donated Assets		**414**

Note 18 Revaluations of property, plant and equipment

The desktop revaluation exercise was undertaken as at 31 March 2019.

The impact of the revaluation exercise was a reduction in buildings of £1,851k from £114,679k to £112,828k, there was no impact on the land value.

2018/19 Movement on Revaluation Reserve

Asset Category	Historic Cost	Impairment	Indexation	Total
	£000's	£000's	£000's	£000's
Land	0	0	0	**0**
Buildings	0	(758)	0	**(758)**
Equipment	(257)		510	**253**
Total	**(257)**	**(758)**	**510**	**(505)**

The gross carrying amount of fully depreciated assets still in use for plant & equipment is £27,944k (£28,397k) and for intangible assets is £6,174k (£5,922k).

Note 19 Inventories

	31 March 2019	31 March 2018
	£000	£000
Drugs	1,918	1,958
Work In progress	0	0
Consumables	3,401	4,270
Energy	19	44
Other	0	0
Total inventories	**5,338**	**6,272**
of which:		
Held at fair value less costs to sell	0	0

Inventories recognised in expenses for the year were £53,905k (2017/18: £56,048k). Write-down of inventories recognised as expenses for the year were £85k (2017/18: £79k).

Note 20.1 Trade receivables and other receivables

	31 March 2019	31 March 2018
	£000	£000
Current		
Contract receivables*	19,986	0
Contract assets*	0	0
Trade receivables*	0	13,662
Capital receivables	0	3
Accrued income*	0	0
Allowance for impaired contract receivables / assets*	(1,070)	0
Allowance for other impaired receivables	0	(842)
Deposits and advances	0	0
Prepayments (non-PFI)	3,641	2,416
PFI prepayments - capital contributions	0	0
PFI lifecycle prepayments	0	0
Interest receivable	0	0
Finance lease receivables	9	9
PDC dividend receivable	62	562
VAT receivable	1,261	669
Corporation and other taxes receivable	0	0
Other receivables	0	0
Total current trade and other receivables	**23,889**	**16,479**
Non-current		
Contract receivables*	0	0
Contract assets*	0	0
Trade receivables*	0	0
Capital receivables	0	0
Accrued income*	0	0
Allowance for impaired contract receivables / assets*	0	0
Allowance for other impaired receivables	0	0
Deposits and advances	0	0
Prepayments (non-PFI)	0	0
PFI prepayments - capital contributions	0	0
PFI lifecycle prepayments	0	0
Interest receivable	0	0
Finance lease receivables	183	192
VAT receivable	0	0
Corporation and other taxes receivable	0	0
Other receivables	0	0
Total non-current trade and other receivables	**183**	**192**
Of which receivables from NHS and DHSC group bodies:		
Current	14,622	8,489
Non-current	0	0

*Following the application of IFRS 15 from 1 April 2018, the trust's entitlements to consideration for work performed under contracts with customers are shown separately as contract receivables and contract assets. This replaces the previous analysis into trade receivables and accrued income. IFRS 15 is applied without restatement therefore the comparative analysis of receivables has not been restated under IFRS 15.

Note 20.2 Allowances for credit losses - 2018/19

	Contract receivables and contract assets £000	All other receivables £000
Allowances as at 1 Apr 2018 - brought forward		**842**
Impact of implementing IFRS 9 (and IFRS 15) on 1 April 2018	842	(842)
Transfers by absorption	0	0
New allowances arising	1,020	0
Changes in existing allowances	0	0
Reversals of allowances	(229)	0
Utilisation of allowances (write offs)	(563)	0
Changes arising following modification of cotractual cash flows	0	0
Foreign exchange and other changes	0	0
Allowances as at 31 Mar 2019	**1,070**	**0**

Note 20.3 Allowances for credit losses - 2017/18

IFRS 9 and IFRS 15 are adopted without restatement therefore this analysis is prepared in line with the requirements of IFRS 7 prior to IFRS 9 adoption. As a result it differs in format to the current period disclosure.

	All receivables £000
Allowances as at 1 Apr 2017 - as previously stated	**752**
Prior period adjustments	0
Allowances as at 1 Apr 2017 - restated	**752**
Transfers by absorption	0
Increase in provision	567
Amounts utilised	(297)
Unused amounts reversed	(180)
Allowances as at 31 Mar 2018	**842**

Note 21 Non-current assets held for sale and assets in disposal groups

	2018/19 £000	2017/18 £000
NBV of non-current assets for sale and assets in disposal groups at 1 April	**0**	**0**
Prior period adjustment		0
NBV of non-current assets for sale and assets in disposal groups at 1 April - restated	**0**	**0**
Transfers by absorption	0	0
Assets classified as available for sale in the year	0	0
Assets sold in year	0	0
Impairment of assets held for sale	0	0
Reversal of impairment of assets held for sale	0	0
Assets no longer classified as held for sale, for reasons other than sale	0	0
NBV of non-current assets for sale and assets in disposal groups at 31 March	**0**	**0**

Note 22 Cash and cash equivalents movements

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

	2018/19 £000	2017/18 £000
At 1 April	**1,547**	**1,621**
Prior period adjustments	0	0
At 1 April (restated)	**1,547**	**1,621**
At start of period for new FTs	**0**	**0**
Transfers by absorption	0	0
Net change in year	6	(74)
Transfer to FT upon authorisation	0	0
At 31 March	**1,553**	**1,547**
Broken down into:		
Cash at commercial banks and in hand	42	83
Cash with the Government Banking Service	1,511	1,464
Deposits with the National Loan Fund	0	0
Other current investments	0	0
Total cash and cash equivalents as in SoFP	**1,553**	**1,547**
Bank overdrafts (GBS and commercial banks)	0	0
Drawdown in committed facility	0	0
Total cash and cash equivalents as in SoCF	**1,553**	**1,547**

Note 23.1 Trade and other payables

	31 March 2019	31 March 2018
	£000	£000
Current		
Trade payables	4,311	3,355
Capital payables	1,938	2,631
Accruals	6,497	6,995
Receipts in advance (including payments on account)	0	0
Social security costs	4,988	4,513
Accrued interest on loans*	0	150
Other payables	4,134	3,831
Total current trade and other payables	**21,868**	**21,475**
Non-current		
Trade payables	0	0
Capital payables	0	0
Accruals	0	0
Receipts in advance (including payments on account)	0	0
VAT payables	0	0
Other taxes payable	0	0
Other payables	0	0
Total non-current trade and other payables	**0**	**0**
Of which payables from NHS and DHSC group bodies:		
Current	2,380	1,559
Non-current	0	0

*Following adoption of IFRS 9 on 1 April 2018, loans are measured at amortised cost. Any accrued interest is now included in the carrying value of the loan within note . IFRS 9 is applied without restatement therefore comparatives have not been restated.

Note 23.2 Early retirements in NHS payables above

The payables note above includes amounts in relation to early retirements as set out below:

	31 March 2019	31 March 2019	31 March 2018	31 March 2018
	£000	Number	£000	Number
- to buy out the liability for early retirements over 5 years	0		0	
- number of cases involved		0		0

Note 24 Other financial liabilities

	31 March 2019	31 March 2018
	£000	£000
Current		
Derivatives held at fair value through income and expenditure	0	0
Other financial liabilities	0	0
Total	**0**	**0**
Non-current		
Derivatives held at fair value through income and expenditure	0	0
Other financial liabilities	0	0
Total	**0**	**0**

Note 24 Other liabilities

	31 March 2019 £000	31 March 2018 £000
Current		
Deferred income: contract liabilities	2,657	2,073
Total other current liabilities	**2,657**	**2,073**
Non-current		
Total other non-current liabilities	**0**	**0**

Note 25 Borrowings

	31 March 2019 £000	31 March 2018 £000
Current		
Loans from the Department of Health and Social Care	40,917	20,686
Other loans	99	62
Obligations under finance leases	1,109	130
Total current borrowings	**42,125**	**20,878**
Non-current		
Loans from the Department of Health and Social Care	53,177	52,295
Other loans	516	100
Obligations under finance leases	10,685	991
Total non-current borrowings	**64,378**	**53,386**
Total borrowings (current and non-current)	**106,503**	**74,264**

The Trust has taken advantage of participating in the Energy Efficiency Loan Scheme operated by Salix Finance Ltd.

The Trust has agreed fourteen schemes since 2012/13, of which ten have been fully repaid.

Each of these loans are subject to zero interest and are repayable over 4 or 5 years in equal instalments although these have been drawn on completion of each scheme. N.B. The term was extended in 2018 and two loans are repayable over the revised 5 year term

An analysis of the DHSC loans held by the Trust is as follows:-

Loan Type	Note	Agreement Date	Loan Facility Amount	Interes Rate	Repayment Date	Analysis of Loan Balance - 2018/19											
						Capital Loans b/f	Capital Repaid	Interest In Year Accrued	Capital Loans c/f	Revenue Loans b/f	Deficit Funding Drawn	Deficit Funding Repaid	STF/PSF Funding Drawn	STF/PSF Funding Repaid	Interest In Year Accrued	Revenue Balance	Total
			£000's			£000's	£000's	£000's	£000's	£000's	£000's	£000's	£000's	£000's	£000's	£000's	£000's
Capital		Mar-15	7,207	1.60%	Mar-25	5,325	-760	3	**4,567**							**0**	**4,567**
Capital		Mar-16	9,352	1.16%	Feb-26	8,530	-1,075	10	**7,465**							**0**	**7,465**
Revenue	1	Feb-16	18,851	1.50%	Feb-19					18,851					32	**18,883**	**18,883**
Revenue		Feb-17	14,515	1.50%	Jan-20					14,515					43	**14,558**	**14,558**
Revenue		Feb-17	2,995	1.50%	Feb-20					2,995					5	**3,000**	**3,000**
Revenue		Mar-17	2,469	1.50%	Mar-20					2,469					1	**2,470**	**2,470**
Revenue		Apr-17	1,127	1.50%	Apr-20					1,127					8	**1,135**	**1,135**
Revenue		May-17	404	1.50%	May-20					404					2	**406**	**406**
Revenue		Jun-17	1,414	1.50%	Jun-20					1,414					6	**1,420**	**1,420**
Revenue		Jul-17	1,104	1.50%	Jul-20					1,104					3	**1,107**	**1,107**
Revenue		Sep-17	1,516	1.50%	Sep-20					1,516					1	**1,517**	**1,517**
Revenue		Nov-17	1,024	1.50%	Nov-20					1,024					6	**1,030**	**1,030**
Revenue		Dec-17	1,477	1.50%	Dec-20					1,477					6	**1,483**	**1,483**
Revenue		Jan-18	4,697	1.50%	Jan-21					4,697					14	**4,711**	**4,711**
Revenue		Feb-18	3,218	1.50%	Feb-21					3,218					6	**3,224**	**3,224**
Revenue		Mar-18	4,315	1.50%	Mar-21					4,315					2	**4,317**	**4,317**
Revenue		Apr-18	4,439	1.50%	Apr-21						4,439				31	**4,470**	**4,470**
Revenue		May-18	3,143	1.50%	May-21						3,143				17	**3,160**	**3,160**
Revenue		Jun-18	327	1.50%	Jun-21							-1,052	1,379		1	**328**	**328**
Revenue		Jul-18	1,889	1.50%	Jul-21						1,276		613		6	**1,895**	**1,895**
Revenue		Aug-18	845	1.50%	Aug-21						232		613		1	**846**	**846**
Revenue		Sep-18	612	1.50%	Sep-21								612		0	**612**	**612**
Revenue		Oct-18	2,135	1.50%	Oct-21						2,595		919	-1,379	15	**2,150**	**2,150**
Revenue		Nov-18	1,628	1.50%	Nov-21						709		919		9	**1,637**	**1,637**
Revenue		Dec-18	3,377	1.50%	Dec-21						2,458		919		15	**3,392**	**3,392**
Revenue		Jan-19	795	1.50%	Jan-22						1,561		1,072	-1,838	3	**798**	**798**
Revenue		Feb-19	2,698	1.50%	Feb-22						1,626		1,072		5	**2,703**	**2,703**
Revenue		Mar-19	808	1.50%	Mar-22						1,527		751	-1,470	1	**809**	**809**
Total			**98,381**			**13,855**	**-1,835**	**13**	**12,032**	**59,126**	**19,566**	**-1,052**	**8,869**	**-4,687**	**240**	**82,062**	**94,094**
Total - Loan Balance at 31 March 2019						**12,032**				**82,062**							**94,094**

1 - This loan has been extended by DHSC for repayment in February 2020 (additional year extension) following the previous extension to February 2019

Note 25.1 Reconciliation of liabilities arising from financing activities

	Loans from DHSC	Other loans	Finance leases	Total
	£000	£000	£000	£000
Carrying value at 1 April 2018	**72,981**	**162**	**1,121**	**74,264**
Cash movements:				
Financing cash flows - payments and receipts of principal	20,861	453	(860)	**20,454**
Financing cash flows - payments of interest	(1,152)	0	(353)	**(1,505)**
Non-cash movements:				
Impact of implementing IFRS 9 on 1 April 2018	150	0	0	**150**
Additions	0	0	11,424	**11,424**
Application of effective interest rate	1,254	0	354	**1,608**
Other changes	0	0	108	**108**
Carrying value at 31 March 2019	**94,094**	**615**	**11,794**	**106,503**

Note 26 Finance leases

Note 26.1 Northampton General Hospital NHS Trust as a lessor

Future lease receipts due under finance lease agreements where Northampton General Hospital NHS Trust is the lessor:

Northamptonshire Healthcare NHS Foundation Trust occupies Battle House under a Finance Lease arrangement.

	31 March 2019	31 March 2018
	£000	£000
Gross lease receivables	**192**	**201**
of which those receivable:		
- not later than one year;	9	9
- later than one year and not later than five years;	36	36
- later than five years.	147	156
Unearned interest income	0	0
Allowance for uncollectable lease payments	0	0
Net lease receivables	**192**	**201**
of which those receivable:		
- not later than one year;	9	9
- later than one year and not later than five years;	36	36
- later than five years.	147	156
The unguaranteed residual value accruing to the lessor	0	0
Contingent rents recognised as income in the period	0	0

Note 26.2 Northampton General Hospital NHS Trust as a lessee

Obligations under finance leases where Northampton General Hospital NHS Trust is the lessee.

The Trust car park decking and Nye Bevan block were both completed under a Finance Lease arrangement.

	31 March 2019	31 March 2018
	£000	£000
Gross lease liabilities	**11,794**	**1,121**
of which liabilities are due:		
- not later than one year;	1,109	130
- later than one year and not later than five years;	4,919	571
- later than five years.	5,766	420
Finance charges allocated to future periods	0	0
Net lease liabilities	**11,794**	**1,121**
of which payable:		
- not later than one year;	1,109	130
- later than one year and not later than five years;	4,919	571
- later than five years.	5,766	420
Total of future minimum sublease payments to be received at the reporting date	0	0
Contingent rent recognised as an expense in the period	0	0

Note 27.1 Provisions for liabilities and charges analysis

	Pensions: injury benefits*	Other	Total
	£000	£000	£000
At 1 April 2018	**181**	**3,564**	**3,745**
Transfers by absorption	0	0	**0**
Change in the discount rate	0	0	**0**
Arising during the year	0	1,167	**1,167**
Utilised during the year	(14)	(1,022)	**(1,036)**
Reclassified to liabilities held in disposal groups	0	0	**0**
Reversed unused	0	(2,963)	**(2,963)**
Unwinding of discount	7	0	**7**
At 31 March 2019	**174**	**746**	**920**
Expected timing of cash flows:			
- not later than one year;	14	717	**731**
- later than one year and not later than five years;	57	29	**86**
- later than five years.	103	0	**103**
Total	**174**	**746**	**920**

Pension provisions are based on expected lives and current levels of payment. Provisions arising in year relate to injury retirement, outstanding balances on salary sacrifice schemes and legal and associated employment claims.

* In 2018/19 the analysis of provisions has been revised to separately identify provisions for injury benefit liabilities. In previous periods, these provisions were included within other provisions

Note 27.2 Clinical negligence liabilities

At 31 March 2019, £142,009k was included in provisions of NHS Resolution in respect of clinical negligence liabilities of Northampton General Hospital NHS Trust (31 March 2018: £150,933k).

Note 28 Contingent assets and liabilities

	31 March 2019	31 March 2018
	£000	£000
Value of contingent liabilities		
NHS Resolution legal claims	0	0
Employment tribunal and other employee related litigation	0	0
Redundancy	0	0
Other	0	0
Gross value of contingent liabilities	**0**	**0**
Amounts recoverable against liabilities	0	0
Net value of contingent liabilities	**0**	**0**
Net value of contingent assets	**0**	**0**

No contingency liabilities or assets have been identified.

Note 29 Contractual capital commitments

	31 March 2019	31 March 2018
	£000	£000
Property, plant and equipment	310	729
Intangible assets	144	32
Total	**454**	**761**

Note 30 Financial instruments

Note 30.1 Financial risk management

Financial reporting standard IFRS 7 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 NHS Trust has with Clinical Commissioning Groups and the way those Clinical Commissioning Group are financed, the NHS 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 the financial reporting standards mainly apply. The NHS Trust has limited powers to borrow or invest surplus funds and financial assets and liabilities are generated by day-to-day operational activities rather than being held to change the risks facing the NHS Trust in undertaking its activities.

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

The Trust borrows from government for capital expenditure, subject to affordability as confirmed by NHS Improvement. The borrowings are for 1 – 25 years, in line with the life of the associated assets, and interest is charged at the National Loans Fund rate, fixed for the life of the loan. The Trust therefore has low exposure to interest rate fluctuations.

The Trust may also borrow from government for revenue financing subject to approval by NHS Improvement. Interest rates are confirmed by the Department of Health (the lender) at the point borrowing is undertaken.

The Trust therefore has low exposure to interest rate fluctuations.

Credit risk

Because the majority of the Trust 's revenue comes from contracts with other public sector bodies, the Trust has low exposure to credit risk. The maximum exposures as at 31 March 2019 are in receivables from customers, as disclosed in the trade and other receivables note.

Liquidity risk

The Trust 's operating costs are incurred under contracts with primary care, Clinical Commissioning Groups, 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.

Note 30.2 Carrying values of financial assets

IFRS 9 Financial Instruments is applied restrospectively from 1 April 2018 without restatement of comparatives. As such, comparative disclosures have been prepared under IAS 39 and the measurement categories differ to those in the current year analyses.

	Held at amortised cost	Held at fair value through I&E	Held at fair value through OCI	Total book value
Carrying values of financial assets as at 31 March 2019 under IFRS 9	**£000**	**£000**	**£000**	**£000**
Trade and other receivables excluding non financial assets	18,916	0	0	**18,916**
Other investments / financial assets	0	0	0	**0**
Cash and cash equivalents at bank and in hand	1,553	0	0	**1,553**
Total at 31 March 2019	**20,469**	**0**	**0**	**20,469**

	Loans and receivables	Assets at fair value through the I&E	Held to maturity	Available for sale	Total book value
Carrying values of financial assets as at 31 March 2018 under IAS 39	**£000**	**£000**	**£000**	**£000**	**£000**
Trade and other receivables excluding non-financial assets	12,329	0	0	0	**12,329**
Other investments / financial assets	201	0	0	0	**201**
Cash and cash equivalents at bank and in hand	1,547	0	0	0	**1,547**
Total at 31 March 2018	**14,077**	**0**	**0**	**0**	**14,077**

Note 30.3 Carrying value of financial liabilities

IFRS 9 Financial Instruments is applied restrospectively from 1 April 2018 without restatement of comparatives. As such, comparative disclosures have been prepared under IAS 39 and the measurement categories differ to those in the current year analyses.

	Held at amortised cost	Held at fair value through the I&E	Total book value
	£000	**£000**	**£000**
Carrying values of financial liabilities as at 31 March 2019 under IFRS 9			
Loans from the Department of Health and Social Care	94,094	0	**94,094**
Obligations under finance leases	11,794	0	**11,794**
Other borrowings	615	0	**615**
Trade and other payables excluding non financial liabilities	15,371	0	**15,371**
Other financial liabilities	0	0	**0**
Provisions under contract	0	0	**0**
Total at 31 March 2019	**121,874**	**0**	**121,874**

	Other financial liabilities	Held at fair value through the I&E	Total book value
	£000	£000	£000
Carrying values of financial liabilities as at 31 March 2018 under IAS 39			
Loans from the Department of Health and Social Care	72,981	0	**72,981**
Obligations under finance leases	1,121	0	**1,121**
Other borrowings	162	0	**162**
Trade and other payables excluding non financial liabilities	16,962	0	**16,962**
Other financial liabilities	0	0	**0**
Provisions under contract	0	0	**0**
Total at 31 March 2018	**91,226**	**0**	**91,226**

Note 30.4 Fair values of financial assets and liabilities

The Trust holds no financial assets and liabilities on a fair value basis.

Note 30.5 Maturity of financial liabilities

	31 March 2019 £000	31 March 2018 £000
In one year or less	57,496	37,841
In more than one year but not more than two years	23,417	21,996
In more than two years but not more than five years	32,299	26,290
In more than five years	8,662	5,099
Total	**121,874**	**91,226**

Note 31 Losses and special payments

	2018/19		2017/18	
	Total number of cases	Total value of cases	Total number of cases	Total value of cases
	Number	£000	Number	£000
Losses				
Cash losses	1	0	2	5
Bad debts and claims abandoned*	153	(2)	193	51
Total losses	**154**	**(2)**	**195**	**56**
Special payments				
Ex-gratia payments	44	238	47	60
Total special payments	**44**	**238**	**47**	**60**
Total losses and special payments	**198**	**236**	**242**	**116**
Compensation payments received		0		0

*Bad debts and claims abandoned - write on value of cases previously written off exceeds value of cases written off

Note 32.1 Initial application of IFRS 9
IFRS 9 Financial Instruments as interpreted and adapted by the GAM has been applied by the Trust from 1 April 2018. The standard is applied retrospectively with the cumulative effect of initial application recognised as an adjustment to reserves on 1 April 2018.

IFRS 9 replaces IAS 39 and introduces a revised approach to classification and measurement of financial assets and financial liabilities, a new forward-looking 'expected loss' impairment model and a revised approach to hedge accounting.

Under IFRS 9, borrowings from the Department of Health and Social Care, which were previously held at historic cost, are measured on an amortised cost basis. Consequently, on 1 April 2018 borrowings increased by £150k, and trade payables correspondingly reduced.

Reassessment of allowances for credit losses under the expected loss model resulted in a £0k decrease in the carrying value of receivables.

The GAM expands the definition of a contract in the context of financial instruments to include legislation and regulations, except where this gives rise to a tax. Implementation of this adaptation on 1 April 2018 has led to the classifiction of receivables relating to Injury Cost Recovery as a financial asset measured at amortised cost. The carrying value of these receivables at 1 April 2018 was £2,709k.

Overseas visitor income has been recognised at the average recovery rate of 26.89%, previously this was provided on basis of outstanding debt over 90 days. This has resulted in an increase in the provision based on 2018/19 income.

Note 32.2 Initial application of IFRS 15
IFRS 15 Revenue from Contracts with Customers as interpreted and adapted by the GAM has been applied by the Trust from 1 April 2018. The standard is applied retrospectively with the cumulative effect of initial application recognised as an adjustment to the income and expenditure reserve on 1 April 2018.

IFRS 15 introduces a new model for the recognition of revenue from contracts with customers replacing the previous standards IAS 11, IAS 18 and related Interpretations. The core principle of IFRS 15 is that an entity recognises revenue when it satisfies performance obligations through the transfer of promised goods or services to customers at an amount that reflects the consideration to which the entity expects to be entitled to in exchange for those goods or services.

As directed by the GAM, the Trust has applied the practical expedient offered in C7A of the standard removing the need to retrospectively restate any contract modifications that occurred before the date of implementation (1 April 2018).

A full review has been undertaken of the Trust's operating income £288,422k (88%) relates to patient care activities whilst £38,149k relates to other operating income.

The other operating income has been reviewed in detail with Contracting, Procurement and Trust Managers. This review includes the following five steps:-
• identify the contract with the customer
• identify the performance obligations in the contract
• determine the transaction price
• allocate the transaction price to the performance obligations
• recognise revenue when (or as) performance obligation is satisfied

No performance obligations have been identified in Trust's income for 2018/19.

Note 33 Related parties
During the year none of the Department of Health Ministers, Trust board members or members of the key management staff, or parties related to any of them, has undertaken any material transactions with Northampton General Hospital NHS Trust.

The Department of Health is regarded as a related party. During the year Northampton 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. For example :

Revenue Transactions

Health Education England £10.2m (£10.0m)
Nene Clinical Commissioning Group £225.3m (£213.1m)
Corby Clinical Commissioning Group £2.9m (£2.5m)
Milton Keynes Clinical Commissioning Group £2.5m (£2.9m)
East Midlands Specialised Commissioning Hub £39.7m (£41.7m)
Central Midlands Local Office £6.9m (£7.0m)
Northamptonshire Healthcare NHS Foundation Trust £1.5m (£1.4m)
Kettering General Hospital Foundation Trust £2.0m (£1.8m)
University Hospitals of Leicester NHS Trust £0.9m (£0.9m)

Expenditure Transactions

NHS Resolution £11.6m (£11.4m)
Northamptonshire Healthcare NHS Foundation Trust £1.6m (£1.6m)
NHS Blood and Transplant £1.1m (£1.3m)

In addition, the Trust has had a number of material transactions with other government departments and other central and local government bodies. Most of these transactions have been with Northampton Borough Council (Business Rates £1,086k (£1,039k)), Northamptonshire County Council (Pathology Services £149k (£150k)) and HM Revenue & Customs (Employers National Insurance contribution £18.4m (£17.5m)), National Health Service Pension Fund Scheme £19.2m (£17.8m) and NHS Business Services Authority £5.8m (£9.2m))

The Trust has also received revenue and capital payments from Northamptonshire Health Charitable fund.

Grants totalling £447k (£422k), which were received from the Charity, have been treated in the Trust's Accounts as income and have primarily contributed towards staff and patients welfare. The Charity also funded £436k (£208k) of Building Works & Medical Equipment.

The Charity has also purchased Springfield House which is being leased to the Trust, the facility is being utilised to provide a GP streaming service. The annual lease cost is £36k and annual facilities costs is £24k.

The Charitable Fund produces separate Trustees Report and Accounts which are available from the Finance Department of the Trust or on the Charity Commission website www.charity-commision.gov.uk. Should you wish to learn more about the Charitable Fund's activities and current initiatives visit www.nhcfgreenheart.co.uk or contact the Fundraising Team on 01604 626927 or E-mail greenheart@nhcf.co.uk

Note 34 Events after the reporting date
There are no material events after the reporting date of 31 March 2019 which effect the financial position.

Note 35 Better Payment Practice code

	2018/19 Number	2018/19 £000	2017/18 Number	2017/18 £000
Non-NHS Payables				
Total non-NHS trade invoices paid in the year	76,539	113,425	81,245	117,439
Total non-NHS trade invoices paid within target	76,125	112,720	79,785	111,089
Percentage of non-NHS trade invoices paid within target	**99.46%**	**99.38%**	**98.20%**	**94.59%**
NHS Payables				
Total NHS trade invoices paid in the year	1,942	21,374	2,114	20,972
Total NHS trade invoices paid within target	1,939	21,360	2,001	20,469
Percentage of NHS trade invoices paid within target	**99.85%**	**99.93%**	**94.65%**	**97.60%**

The Better Payment Practice code requires the NHS body to aim to pay all valid invoices by the due date or within 30 days of receipt of valid invoice, whichever is later.

Note 36 External financing

The trust is given an external financing limit against which it is permitted to underspend:

	2018/19 £000	2017/18 £000
Cash flow financing	**9,311**	**23,264**
Finance leases taken out in year	**11,424**	**0**
Other capital receipts		**0**
External financing requirement	**20,735**	**23,264**
External financing limit (EFL)	20,737	23,455
Under / (over) spend against EFL	**2**	**191**

Note 37 Capital Resource Limit

	2018/19 £000	2017/18 £000
Gross capital expenditure	20,283	13,323
Less: Disposals	0	0
Less: Donated and granted capital additions	(414)	(181)
Plus: Loss on disposal from capital grants in kind	0	0
Charge against Capital Resource Limit	**19,869**	**13,142**
Capital Resource Limit	19,871	13,340
Under / (over) spend against CRL	**2**	**198**

N.B. In 2017/18 the £198k under-shoot includes £190k which wasn't adjusted by NHSI relating to £158k reduction in depreciation actual EOY position and £32k additional capital loan principal repayments which reduced the cash backed capital resources available to the Trust, therefore under spend against available resources is £8k

Note 38 Breakeven duty financial performance

	2018/19 £000
Adjusted financial performance surplus / (deficit) (control total basis)	(14,432)
Remove impairments scoring to Departmental Expenditure Limit	0
Add back non-cash element of On-SoFP pension scheme charges	0
IFRIC 12 breakeven adjustment	0
Breakeven duty financial performance surplus / (deficit)	**(14,432)**

Note 39 Breakeven duty rolling assessment											
	1997/98 to 2008/09	2009/10	2010/11	2011/12	2012/13	2013/14	2014/15	2015/16	2016/17	2017/18	2018/19
		£000	£000	£000	£000	£000	£000	£000	£000	£000	£000
Breakeven duty in-year financial performance		2,081	1,109	504	399	197	(16,525)	(20,151)	(13,847)	(23,339)	(14,432)
position	2,892	4,973	6,082	6,586	6,985	7,182	(9,343)	(29,494)	(43,341)	(66,680)	(81,112)
Operating income		227,805	236,260	255,481	271,295	276,894	270,358	273,562	298,240	304,760	326,571
Cumulative breakeven position as a percentage of operating income		2.2%	2.6%	2.6%	2.6%	2.6%	(3.5%)	(10.8%)	(14.5%)	(21.9%)	(24.8%)