Northampton General Hospital NHS
NHS Trust

Annual Report and Accounts 2014/15

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Northampton General Hospital NHS
NHS Trust

Section 1

Annual Review

Chairman and Chief Executive's Introduction

The time period covered by this annual report was dominated by the most sustained period of urgent care we have ever experienced. Factors contributing to this include increased numbers of people attending our A&E department coupled with the highest levels of admission of high-acuity patients that we have ever had. There have also been delays in discharging our patients who no longer need acute medical care but require support in place before they can safely leave hospital.

Such an unprecedented level of high demand increases the risks to patient safety and places unsustainable levels of pressure on our workforce. The problem is complex – as will be any solution. That's why we have been working increasingly closely with our partners in the health and social care economy throughout the year to highlight the risks and how we can best work together for the benefit of our patients.

Looking to our own responsibilities, we implemented a year-long expansion project for the emergency department with the aim of increasing capacity in key areas, alleviating pressure on bed space and improving our patients' experience. This has included a £1million investment in a new resuscitation area, doubling our capacity to care for our most critically-ill patients. We created dedicated A&E facilities for children and a new discharge suite where patients can wait comfortably for their discharge paperwork, prescriptions or transport. Running alongside those capital programmes, we increased our support for the emergency department with the creation of a new team of Advanced Associate Practitioners (AAPs) and improved pharmacy support to the department at weekends.

This year has seen the introduction of significant structural and process changes: we laid the foundations for a clinically managed and led structure so that decision-making is as near the frontline as possible; we realigned our committees with more focus on quality and workforce; we strengthened the alignment between various programmes of work; and we introduced a command-and-control process for complex discharges.

Underpinning all of these changes is our aim of providing the best possible care and, to further bolster those changes, we began a large-scale recruitment programme. Key appointments were made to the executive team during the year as Dr Mike Cusack was appointed as Medical Director, Catherine Thorne as Director of Corporate Development Governance and Assurance and more recently Carolyn Fox as Director of Nursing, Midwifery and Patient Experience. We're grateful to all those employees who worked in interim posts to ensure we continued to provide the best possible care during this period of transition. Particular thanks go to Jane Bradley and Rachael Corser for their contributions to the post of interim director of nursing and to Dr Mike Wilkinson as interim medical director.

This year also marked a number of milestones which gave us the opportunity to pause and reflect on some of our achievements. We celebrated 50 years of wonderful Gosset care for premature babies and the 25th anniversary of our tireless Friends of NGH. We launched our first Strictly NGH dance competition which raised over £10k towards the cost of refurbishing our chemotherapy suite. The new Willow garden provides a welcome breath of fresh air for our patients and we're now officially an eco-friendly hospital, having achieved national Green Level accreditation.

Operationally, we have benefited enormously from the introduction of VitalPac for nurses and we're committed to rolling out that technology further. Our patients in the south of the county can once again access cardiac rehabilitation services at Danetre Hospital. We had the opportunity to put our extensive training into practice when a patient was admitted with a suspected case of Ebola: although we had assessed the patient as being at very low risk of carrying the virus – and this was confirmed by test results - we nevertheless made headlines at home and abroad so great is public concern about the disease.

Turning to finances, despite our best efforts we ended the financial year in deficit. Caring for higher numbers of patients with increasingly complex medical and nursing needs presents enormous challenges for a hospital in one of the UK's biggest growth areas and one of our key priorities is to work with partners locally and the wider NHS economy to look for realistic and sustainable solutions.

Finally, it would not be possible to present our year in retrospect without paying tribute to our staff and volunteers whose passion and commitment to the hospital, the NHS and our patients is beyond compare. Everyone who works at Northampton General Hospital has two jobs: to deliver excellent care and to improve care. We believe that, whatever their role, everyone at NGH can make a difference.

Paul Farenden
Chairman

Dr Sonia Swart
Chief Executive

An introduction to Northampton General Hospital

Who are we

Northampton General Hospital is an acute NHS hospital trust that offers a full range of hospital services from the main hospital site close to the centre of Northampton. Our staff also provide day case and outpatient services at Danetre hospital in Daventry.

We have formally pledged our commitment to continuous improvements in the quality of care we provide and patient safety by strengthening our focus on corporate accountability for clinical performance. We are committed to providing the best possible care for all our patients and this is central to our strategy for the future.

What We Do

We provide general acute services for a population of 380,000 and hyper-acute stroke, vascular and renal services to 692,000 people living throughout the whole of Northamptonshire. The trust is also an accredited cancer centre, providing services to a wider population of 880,000 who live in Northamptonshire and parts of Buckinghamshire. For one highly specialist urological treatment we serve an even wider catchment.

Our principal activity is the provision of free healthcare to eligible patients. We provide a full range of outpatients, diagnostics, inpatient and day case elective and emergency care and also a growing range of specialist treatments that distinguishes our services from many district general hospitals. We also provide a very small amount of healthcare to private patients.

Quality has always been a driving force of our work at NGH. We believe that the application of high quality standards to the work of everyone at NGH will result in the best outcomes for patients and higher levels of satisfaction for our workforce who help deliver those outcomes.

We are committed to training, teaching and development and provide training for a wide range of clinical staff including doctors, nurses, therapists, scientists and other professionals. Our training and development department offers a wide range of clinical and non-clinical training courses, accessed in a variety of ways through a range of media including e-learning. We have excellent training facilities, which includes a simulation suite.

Our Vision and Values

Our vision is to provide the best possible care for all of our patients. This means we deliver safe, clinically effective acute services focused entirely on the needs of the patient, their relatives and carers. These services may be delivered from our hospital sites or by our staff in the community.

Our values underpin all we do and were developed following discussion and consultation with our staff. They are:

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

For patients this means they can expect to

- Receive the right treatment at the right time and in the right place in line with national guidelines
- Be kept safe from avoidable harm
- Be treated as individuals and have their individual needs addressed
- Be treated with compassion, respect and dignity
- Be kept fully informed and share in decision making about their care
- Have any concerns addressed as early as possible
- Be cared for in a clean and safe environment

We define quality as embracing three key components:

- Patient safety – there will be no avoidable harm to patients from the healthcare they receive, this means ensuring that the environment is clean and safe at all times and that harmful events never happen
- Effectiveness of care – the most appropriate treatments, interventions, support and services will be provided at the right time and in the right place to those patients who will benefit. Our patients will have healthcare outcomes which achieve those described in the NHS Outcomes Framework and NICE Quality standards
- Patient experience – patients will experience compassionate, caring and communicative staff who work in partnership with patients, relatives and their carers to achieve the best possible health outcomes

Our Strategic Aims

We have five strategic aims that are aligned to our vision and values and are the foundation of our corporate objectives. They are:

1. **To focus on quality and safety**
   To be an organisation focussed on quality outcomes, effectiveness and safety
2. **To exceed our patients' expectations**
   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**
   Develop, support and value our staff
5. **To ensure a sustainable future**
   To provide effective and commercially viable services for our patients, ensuring a sustainable future for NGH

Strategic Priorities

We have developed eight strategic priories to steer the delivery of our vision and strategic aims. These are:

- Provide resilient core hospital services
- Continue to improve urgent care services
- Collaborate and integrate with other providers to provide care closer to home
- Develop partnerships with Kettering General Hospital in response to the Challenged Health Economy work-stream
- Strengthen our hyper-acute services through working with our tertiary providers

- To become the hospital provider of choice for local GPs and patients
- To deliver excellence in the care of elective patients
- Develop our hospital as a health and wellbeing campus

Operating and Financial Performance Review

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 1st April 2014 and 31st March 2015.

The report is made up of four parts:

The first covers our **operational performance** during the year and includes details of our performance, commentary on wider events that have shaped our business and priorities and information about some of the projects we have invested in over the year.

The second is our **quality report** which describes the trust's performance against key quality indicators during 2013-14 and our plans for improvements against indicators for 2014-15.

The third section covers our **statutory obligations**, a summary of financial statements for the year 2013-14 and the **remuneration** report.

The final section covers our annual accounts, including our annual governance statement

PART ONE: Operational Performance

Performance against our strategic objectives

In 2014/15 we re-designed our structure in line with external recommendations to become a clinically-led organisation. Our new structure will help us to deliver the following objectives, which will support our delivery Five Year Forward View (October 2014) as well as improving our resilience:

- To re-shape care delivery through developing effective technological innovations
- To embed prevention strategies to reduce health inequalities
- To develop and expand partnerships with other providers around the patient and service user's needs to strengthen specialist hospital services
- To exploit collaborative working opportunities with neighbouring organisations with the patient's experience in mind
- To continue to play a key role in the Healthier Northamptonshire programme
- To review and implement new and sustainable models of care through internal clinical sustainability reviews
- To ensure that we attract more referrals and becomes a provider of choice for local GPs
- To develop our hospital site to increase its physical capacity

Achievement against key standards

This was a challenging year for us, particularly in respect of our performance against cancer and urgent care.

Urgent care

Over the past year we saw an increase of 1.4 per cent in patients attending our accident and emergency department and an increase of 8.3 per cent in patients requiring emergency admission.

Although there has been a slight improvement on 2013/14, this year we did not achieve the government-set target of 95 per cent of patients seen, treated, admitted or discharged within four hours. The four-hour target was met for 90.97 per cent of patients.

The main area which continues to be our biggest and most concerning challenge is the number of patients we have who are medically fit to be discharged but are delayed from leaving the hospital for a variety of reasons which are not directly within our control. These reasons include waiting for ongoing care at home or within a nursing/residential home, waiting for ongoing rehabilitation in a community hospital and housing issues. The number of such cases expressed as a percentage of our total bed stock ranged from 10 per cent to 17 per cent during the year.

We achieved the target that no patient should wait more than 12 hours from decision to admit in A&E to arrival at a ward.

What are we doing to improve performance in urgent care

Through our Changing Care at NGH programme, we plan:

- To increase our workforce within A&E to incorporate primary care specialists who will be able to advise patients on the best place for their treatment if A&E is not required.
- To increase our workforce at weekends to ensure our patients receive the same level of input seven days a week
- To work with our partners in health and social care to discharge differently with the aim of discharging patients as soon they are medically fit. This will mean discharging some patients and undertaking assessment for ongoing needs in an environment outside the hospital.

Cancer waiting times

Throughout the year, the performance against the cancer standards has been variable and due to vacancies and recruitment challenges, we have been unable to meet the 31 and 62 day targets consistently. The increase in referrals requiring diagnostic tests and the urgent care pressures have also adversely impacted on performance in this area.

Indicator (Target)	Q1	Q2	Q3	Q4
2 week wait (93%)	94.0%	89.6%	95.4%	92.6%
31 days (96%)	95.5%	96.6%	97.1%	96.8%
62 days (90%)	76.4%	81.8%	78.8%	76.4%

What are we doing to improve performance in cancer wait times

Through our cancer steering board, we plan:

- To continue to work closely with University Hospitals Leicester (UHL) in joint recruiting to some consultant vacancies
- To increase our capacity in endoscopy and radiology to ensure timely diagnostics
- To work with partners to agree a breach-sharing protocol for late referrals
- To develop and build on our joint work with UHL for oncology services

18 weeks referral to treatment (RTT)

During the year we continued to achieve the 18 week journey time, despite continued overall increases in the number of people requiring our services.

Until quarter 4, we delivered all 18 week referral-to-treatment indicators. However, for the admitted pathway we developed an increasing number of patients waiting over 18 weeks:

therefore we took the decision to validate our waiting list, treat those patients who had been waiting the longest and discharge others as necessary if other treatment had been commenced or a different decision made. This meant that for January and February we did not achieve the RTT target. This decision was taken to ensure all our patients received their treatment in the quickest time possible.

Diagnostics

With the exception of January 2015, we achieved the standard of no patients waiting more than six weeks for a diagnostic test. The decrease in performance was due to an administration error which was immediately rectified.

Mixed sex accommodation

During the year, we had no patients placed in mixed sex bays with the exception of when this was required for an urgent clinical reason.

Patient Activity

Activity Comparison	2013-14	2014-15	Diff	% Diff
Non-Elective Inpatients	35,907	40,349	4,442	12%
Elective Inpatients	7,329	6,208	-1,121	-15%
Elective Daycases	38,052	38,346	294	1%
New outpatient attendances - Consultant led	77,973	80,037	2,064	3%
Follow-up outpatient attendances - Consultant led	152,425	149,977	-2,448	-2%
New outpatient attendances - Nurse led	39,775	38,571	-1,204	-3%
Follow-up outpatient attendances - Nurse led	81,535	114,953	33,418	41%
Total number of outpatient DNA's	26,513	29,913	3,400	13%
Patients seen in Accident & Emergency	107,786	109,305	1,519	1%
Number of babies born	4,573	4,685	112	2%
Average length of stay (in days)	4.60	3.92	-1	-15%

Service developments

During the year we continued to see a steep increase in non-elective admissions. This led to the procurement of a primary care streaming service whereby a significant proportion of patients presenting at A&E benefit from appropriate signposting in line with their care needs and receiving prompt treatment where required.

Investments have been made to support the clinical infrastructure of the organisation through procuring a third CT scanner, a second breast ultrasound unit and creating greater radiographer provision. Such developments shall help to lay the foundation for seven-day working in the near future.

We invested in more nursing staff to increase our workforce. The growing needs of our

expanding population led to the adoption of an international recruitment strategy to secure the staff required to ensure quality services.

Further consultant appointments will be in place across ophthalmology, breast surgery and cardiology in line with the growing needs of the population as well as developing collaborative support networks with KGH.

We will offer patients an enhanced countywide corneal service and countywide vascular service comprising exercise therapy and one-stop clinics. Service development will also include growing our paediatric diabetes nursing team to support the prevalence of diabetes in the local paediatric community.

Risks and uncertainties

We understand that clear strategic plans are required to make sure that future financial sustainability does not compromise patient care. We have aligned with national and local health economy plans to ensure we can deliver sustainable and high quality services going forward.

During the year we were heavily involved with the Healthier Northamptonshire programme and Challenged Health Economy work-streams to ensure ongoing resilience of acute and specialist services. Collaborative working with local providers, such as Kettering General Hospital NHS Foundation Trust and University Hospitals of Leicester NHS Trust, will continue to be developed to enhance our range and delivery of hospital-based and specialist services respectively. Discussions continue with primary care to develop Primary and Acute Care Systems (PACs) to help realise local clinical optimisation and achieve financial efficiencies.

We intend to take every opportunity to be at the forefront of the development of new care models and will engage with primary and secondary care organisations to optimise service delivery.

Looking forward

- We are committed to providing the following in 2015/16:
- A discharge-to-assess process to reduce the numbers of delayed transfers of care
- Integrated reablement and admission avoidance pathways e.g. heart failure, cardiac, pulmonary vascular rehabilitation
- Integrated services for out-of-hospital care
- Integrated pathways for frail and elderly patients through new and innovative approaches
- Multi-disciplinary community clinics to include dermatology, cardiology, and musculoskeletal services
- Standardised pathways for all services

The Trust’s Estate

The 2014/15 estates capital plan continued to focus on reducing the impact of the growing backlog maintenance - a consequence of the high age profile of the estate - ensuring our statutory obligations were met, minimising our carbon footprint and continually improving the patient environment.

As in previous years, there has been continued investment to make sure we remain compliant with statutory obligations. In particular we extended the fire misting system, upgraded fire dampers across the hospital, replaced emergency lighting, upgraded nurse call systems and

installed a catalytic chlorine dioxide dosing system to help combat the risk of legionella.

To improve our site resilience we carried out the final phase of our back-up generator replacement programme by replacing a further two, forty-year-old electricity generators.

Improvement works to the environment and access for staff, patients and visitors with a disability were also completed. These included new disabled toilets and compliant reception desks.

Following our successful £2.7 million bid in 2013/14 to the Department of Health Energy Efficiency Fund, we installed a new biomass boiler, a waste heat boiler and a combined heat and power unit as part of our Green Energy Scheme. This scheme will deliver savings in excess of £500k per annum, reduce CO^2 emissions by 3,000 tonnes and reduce the growing impact of backlog maintenance.

We continued to take advantage of the Carbon Trust's Salix fund for improving energy efficiency in public sector buildings and installed more energy efficient lighting and refrigerated controls.

A number of refurbishment schemes were completed during the year including the development of a state-of-the-art extended resuscitation unit within A&E, a new fracture clinic, a new discharge suite, a paediatric assessment unit and a new blood taking unit.

All these projects will not only improve considerably the experience of patients but have also improved the working environment for our staff.

Working with our local community

During 2014/15, we sought to improve and refine the ways in which we talk with, respond to, and work with our stakeholders.

We carried out a number of consultations during the year to ensure that our members, staff, governors and the public had opportunities to influence the decisions we took about our direction and our priorities. We consulted on our strategic priorities as well as our priorities for improvements to the quality of our services. We also supported consultations undertaken by Healthier Northamptonshire and HealthWatch Northamptonshire on end of life care.

A number of developments took place during the year to strengthen our patient engagement and to ensure that we used the knowledge and insight of those who use our services to understand and learn from their experience and help us identify areas in need of improvement:

- We bolstered the membership of our patient & carer experience and engagement group (PCEEG) to include HealthWatch Northamptonshire and carers' representatives. We also ensured that, at every meeting, the group received updates from our end of life focus group; dementia action group; black and ethnic minority forum; dignity forum; and the disability partnership forum.
- We established a patient & public engagement network (PPEN), made up of members of the public, patients and carers. The network has driven a number of projects including the Patient Experience Questionnaire and Sleep Well Campaign audits. Members of the network contributed to the production of new patient information materials and supported the Friends & Family Test through the collection process and gaining feedback from patients.
- We introduced a new element to our Trust Board meetings so that each meeting now starts with a patient's story
- Patient representatives took on key roles within project groups including the development of our Flagship Ward project and supporting the quarterly Quality Effectiveness Safety

(QuEST) audits to review patient care in addition to forming their own self-led working groups, including the Hotel Services Focus Group.

- We carried out, with the help of 100 volunteers and our shadow governors, a hospital-wide patient experience questionnaire to capture patient's views on mealtimes, noise at night and information provision. In order to learn, reflect and improve we used the information we collected to help us identify themes and trends.
- As a direct result of what we learned, we introduced our Sleep Well campaign targeted at helping patients to rest and sleep while in hospital; we introduced new menus for patient meals and continue to carry out monthly food tasting audits and visit the wards to assess the overall experience for patients during mealtimes; and we updated the patients' section of our website to reflect the feedback we had received.

Going forward, we want to make sure we're putting available skills, expertise and enthusiasm to best use and have committed to:

- exploring with our business development team how members of PPEN can be involved in directly supporting the business case cycle, thus involving our patients and public in the decisions around service delivery.
- reviewing the role of the shadow board of governors to ensure the skills and experience of our shadow governors is used most effectively. Our shadow governors have a unique perspective and are hugely valued for the important role they perform in patient advocacy and experience in addition to their critical friend function.
- expanding the Patient & Public Engagement Network (PPEN) to involve further members of the public in hospital-wide activities.

Partnership Working

We have committed to developing strong strategic partnerships with the following organisations:

- Northamptonshire Healthcare NHS Foundation Trust
- University Hospitals of Leicester NHS Trust
- Northampton and Daventry and South Northamptonshire GP Provider Organisations
- Kettering General Hospital NHS Foundation Trust
- Northamptonshire County Council
- Northamptonshire Voluntary Impact

These partnerships are critical to the process of clinical service redesign and by working together, we will facilitate the provision of care outside of the traditional boundaries of the hospital.

We are a committed partner in the Healthier Northamptonshire programme which aims to provide better care, better health, better value to the people of Northamptonshire. We have committed to working in partnership with Kettering General Hospital NHS Foundation Trust on a clinical collaboration that will ensure we deliver efficiencies through improved quality, standardisation of pathways, alignment of teams and rotas and improved procurement.

Plans for the future

It is clear that in order to remain as a viable organisation we will need to consider new approaches to the way in which some services are managed and run. We are committed to implementing new models of care and we will take every opportunity to be at the forefront of their development .

To respond to the challenges posed by the “Five Year Forward View” (NHS England, 2014) we have to consider which model of delivery is appropriate for each of our services to ensure future sustainability is delivered.

We will continue to play a key role in the Healthier Northamptonshire Programme and ensure that optimum patient care remains the key determinant in future service provision. Forging partnerships with other providers will ensure services continue to be delivered in the most appropriate manner.

We will further develop our external partnerships by:

- Working with colleagues at Kettering General Hospital to design a collaborative approach to the delivery of a range of acute services
- Working with local primary care leaders to design a primary and acute care system with a view to integrating urgent and acute care in the first instance
- Commence the work needed to establish a health and wellbeing campus through a focus on staff wellbeing
- Explore further options for collaboration with University Hospitals of Leicester NHS Trust for the delivery of specialist services
- Work with Voluntary Impact Northamptonshire to integrate voluntary services that deliver benefits to patient care and the lives of their loved ones

Our Staff

Equality

During 2014/15, we upgraded our Equality Delivery System (EDS) to incorporate nationally-revised EDS2 principles. EDS2 is about making positive differences to healthy living and working lives so that everyone counts.

We carried out a full assessment of the 18 outcomes grouped into four goals. The outcomes focus on the issues of most concern to patients, carers, communities, NHS staff and Boards. It is against these outcomes that performance is analysed, graded and action determined. The goals are:

- better health outcomes
- improved patient access and experience
- a representative and supported workforce
- inclusive leadership.

The EDS2 assessment led to a review of the objectives of our four year plan, an outcome-focussed approach to setting challenging but measurable targets to improve service outcomes and the way we employ our staff.

The four year plan's objectives are:

Goals	Objective
1. Better Health outcomes	We will be able to demonstrate 'due regard' by providing evidence that patients from all protected groups receive a quality service and are not unlawfully discriminated against. This will be completed in line with our patient experience programme
2. Improved patient access and experience	We will increase engagement and involvement with representatives from protected groups
3. A representative and supported workforce	We will aim to improve our staff satisfaction rates as reported in the annual staff survey and the staff family and friends test, particularly regarding whether staff would recommend the Trust as place to work.
4. Inclusive leadership	To develop improved leadership and management capability.

The detailed action plan of our equality objectives can be access via our internet. The link to this is: www.northamptongeneral.nhs.uk/WorkforUs/Downloads/Equality-Objectives-2012-to-2016.pdf

Gender distribution of staff

Director & Non-Execs

	Count	Percentage
Female	6	40.00
Male	9	60.00
Grand Total:	**15**	**100**

Senior Managers (Band 8-A and above)

	Count	Percentage
Female	116	71.17
Male	47	28.83
Grand Total:	**163**	**100**

All Employees

	Count	Percentage
Female	3823	79.28
Male	999	20.72
Grand Total:	**4822**	**100**

Staff Survey

Capita were commissioned to undertake the 2014 NHS National Staff Survey on our behalf. A total of 394 members of staff returned the survey constituting a 47 per cent response rate. Of the 29 key findings (relevant to acute sector) there was improvement in 17 areas, six deteriorated, four were unchanged and two could not be compared.

There were two significant improvements reported in the numbers of staff appraised and staff having received health and safety training. The survey highlighted a number of positive staff perceptions including improved communication between managers and staff and feeling motivated to come to work.

The key areas for improvement are:

- Staff engagement
- Quality of appraisals
- Staff receiving job relevant training, learning and development,
- Feeling pressure to attend work when feeling unwell
- Equal opportunities for career progression or promotion.

We recognise that the survey highlights areas of concern and we have already taken steps to address many of the issues raised in implementing our organisational effectiveness strategy. The strategy was designed to address the underlying cultural and organisational issues that influence staff perceptions about the organisation, their work environment and their role.

During the year we established an organisational development team, began delivering the Francis Crick Development Programme and introduced the staff, friends and family test. We also adopted two new strategies to improve engagement with employees and stakeholders.

Sickness absence

We recognise the importance of health and wellbeing of our staff and aim to ensure the attendance of all employees throughout the working week to maintain high standards of care, safety, security and service.

The management of sickness absence remains a high priority and much work has already been done to ensure that managers have the capability to manage sickness absence effectively.

Key initiatives that have taken place in the year include:

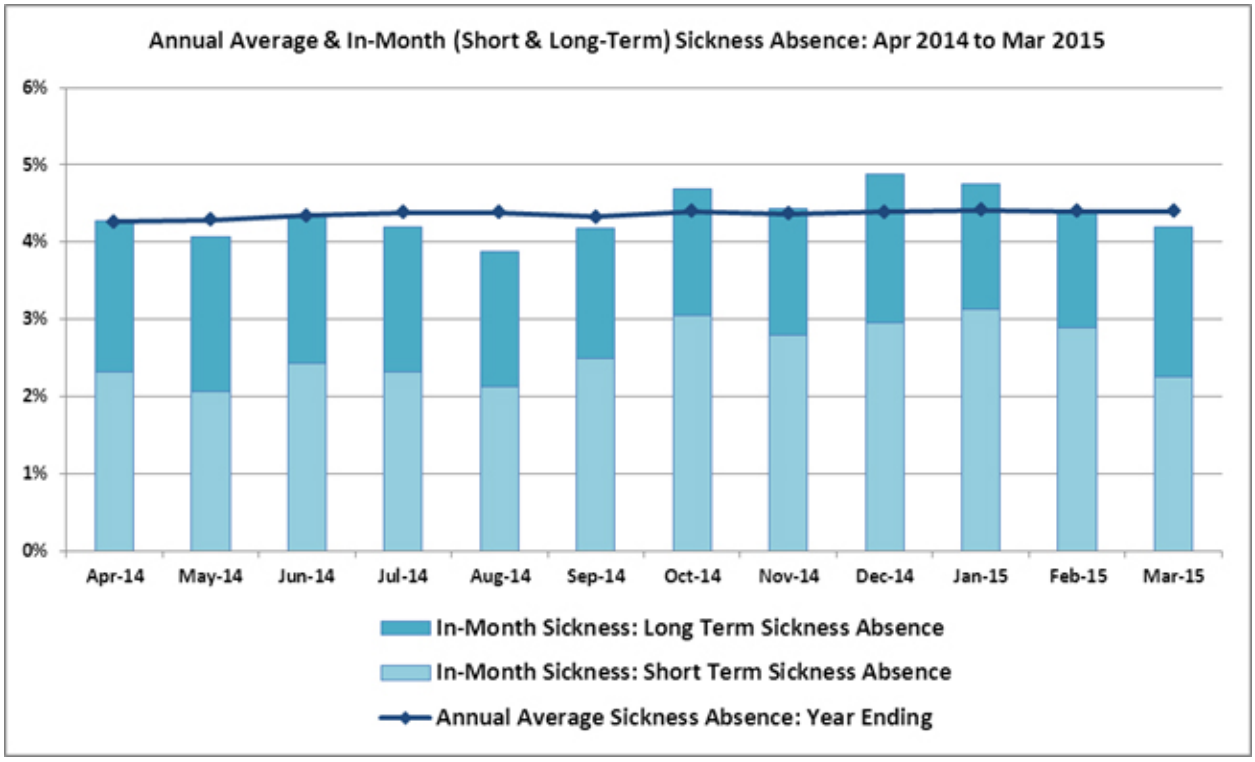
- Raising staff awareness of the sickness absence notification procedure
- Monitoring the number of return-to-work interviews
- Tackling high levels of short term sickness in the formal stages of the policy
- Providing reasonable adjustments to staff where applicable

- Monitoring the reasons for sickness within divisions

Our occupational health team is actively involved with the management of sickness absence and works closely with HR and managers to ensure timely and effective referral management.

In the year 2014/2015 sickness absence rates continued to remain above our target of 3.8 per cent with our total sickness absence average for the financial year at **4.40 per cent**.

		Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15
In-Month Sickness	Short Term Sickness Absence	2.31%	2.06%	2.43%	2.31%	2.12%	2.50%	3.05%	2.80%	2.96%	3.13%	2.89%	2.25%
	Long Term Sickness Absence	1.97%	2.00%	1.89%	1.89%	1.75%	1.68%	1.64%	1.63%	1.92%	1.62%	1.48%	1.95%
	Total In-Month Absence	4.27%	4.06%	4.32%	4.21%	3.86%	4.17%	4.69%	4.43%	4.88%	4.75%	4.37%	4.20%
Annual Average Sickness Absence	Year Ending	4.26%	4.29%	4.34%	4.38%	4.38%	4.33%	4.40%	4.37%	4.39%	4.41%	4.40%	4.40%



Learning and development

Our learning and development team supports all staff in their mandatory and role-specific training as well as the development of Bands 1-4. The main areas of activity are mandatory training, in compliance with Care Quality Commission requirements; apprenticeship frameworks and work experience.

Skills and learning for registered staff is delivered in-house by the practice development team. Registered staff are also able to access modules from Universities across the East Midlands region at Postgraduate Degree and Masters Level thus supporting service developments and providing continuing professional development.

All new staff attend a trust induction programme which delivers mandatory training subjects; patient-facing staff are then expected to attend additional training. We subscribes to the East Midlands Leadership Academy, enabling staff to access leadership and management programmes, some of which are nationally led and delivered.

We have a successful in-house assessment and recruitment process for apprentices which have been expanded resulting in apprentices being employed across most directorates in a variety of roles. Scoping of new areas is ongoing to identify new opportunities. Many apprentices have gained successful employment with us on completing their framework qualification.

During the year, we achieved the highest possible level of assurance for our systems and processes in an audit of our learning and development functions.

Organisational development

The focus of the organisational development team is to build our to achieve our goals through planned development, improvement and reinforcement of strategies, structures and processes that lead to organisational effectiveness.

The Best Possible Leaders

Fifty of our leaders are taking part in the Francis Crick Programme, a 15-month bespoke development programme which has been co-designed to develop highly effective leaders who are able to lead and transform services based on our leadership model.

Living and breathing our values

In 2014 we introduced

- Values-based recruitment.

  We have added our values to our adverts and we are asking questions about people's values at interview
- Learning from experience

  We began working with our complaints team to identify what has got in the way of us delivering the best possible care under the themes of our values and developing case studies to support team development
- Patients experience of our values

  We started a project with our patient experience team to include questions in our patient survey to identify where our values are experienced on a patient journey.

The NGH way

We launched our employee engagement strategy (The NGH Way) and introduced our three-part model that will help us improve communication, enable creativity and lead to supportive and respectful relationships at work.

1. Communication

   We introduced a workshop which helps people to understand the way they communicate and how this impacts on others. It lets us understand how people around us are different and that to consider how each might prefer to be communicated with, builds stronger relationships between individuals and amongst teams.

2. Culture

   To help us look at how our culture (the way we do things) evolves we have introduced an interactive workshop called ‘Back in the Box.’ This helps us consider how everything we say or don’t say, do or don’t do, actually contributes to the culture around us.

3. Improving services

   Our front line staff are often the best people to understand what needs to be done to improve our services to patients. Using our ‘street talk’ brand, we are working with individuals and groups to help identify the improvements that matter to them, their patients and areas of work. Together we look at what is getting in the way and how to take responsibility and ownership to continuously improve our services.

Since launching the employee engagement strategy in 2014, over 650 employees have taken part in joining the journey making NGH a great place to work, for everyone.

Report from the Director of Finance

Economic Outlook and Impact on the Trust

The UK economy may be recovering but there is still intense pressure on public sector finances due to the immense challenge of closing the deficit between tax revenues and public expenditure. The Five Year Forward View for the NHS highlights a potential £30 billion funding shortfall in the NHS within five years which could reduce to £8 billion but only if the NHS delivers unprecedented levels of efficiency improvement. The financial challenge is felt most by acute hospital providers. In response to this challenge we are improving our quality and efficiency through our Changing Care @ NGH programme. We are also working closely with NHS and local authority partners to plan for future provision of effective and efficient high quality services.

Financial Performance

We faced unprecedented pressures in 2014/15 due to increased demand for service both in terms of patient attendance and admission numbers and patient acuity. We also faced the issue of a national shortage of trained nurses, shortages in some areas of medical staffing and other clinical support staff. In response we had no alternative but to deploy large numbers of agency doctors and nurses to ensure adequate staffing for service provision was maintained. This resulted in higher than planned pay expenditure despite every effort being made to recruit and retain permanent staff.

We were also exposed to the marginal rate emergency tariff which meant that all urgent care activity above that provided in 2008/9 was only funded at 30 per cent of cost. We also experienced high levels of delayed discharges which compromised some attempts to improve patient flow through the hospital.

The above factors contributed to disappointing in-year financial performance. We, like many other similar hospitals, went into deficit in 2014/15. The deficit for 2014/15 was £16.5 million. This was £8.7 million more than the deficit planned at the outset of the financial year of £7.8 million but £0.2m better than the financial recovery plan target identified mid financial year of £16.7 million.

We met all other financial duties including managing capital expenditure within the agreed capital resource limit, managing cash flow within the agreed external finance limit and paying suppliers within 30 days for 95 per cent of invoices paid.

We are improving our efficiency through the Changing Care@ NGH programme as part of measures we are taking, in conjunction with health economy partners, to meet our financial challenges and secure our financial sustainability. The changes are being clinically led and are linked to quality improvement.

Capital Expenditure

We invested £14.131 million in 2014/15 improving our estate, medical equipment and information technology (IT) assets. In doing so we met our duty not to exceed our Capital Resource Limit. In 2015/16 we will continue to invest in estate, equipment and IT to ensure our assets are in good condition to deliver quality patient care.

Charitable Funds

The charitable fund continued to make valued contributions during 2014- 15, including £0.2m for staff and patient benefit and £0.2m for building projects and medical equipment. Of specific note during the year has been the active involvement from many staff in supporting the Chemotherapy suite refurbishment appeal, work scheduled to be undertaken later in 2015, which had raised more than £0.2m by the end of March. At the end of the financial year notification was also received of a legacy to fund diabetic research of nearly £0.5m from the late Mrs Lorna Smart.

Northampton General Hospital NHS
NHS Trust

Section 2

Quality Account

A Quality Account is a report produced annually by providers of healthcare in the NHS.

It reflects the quality of the services they deliver when compared to national and local targets across a range of scoring systems. The process of producing a QA brings together a wide range of information that enables a broad assessment of quality standards and allows us to demonstrate our commitment to continuous quality improvement in order to provide optimum care.

This report highlights the key developments during 2014/15. A separate statutory report in more detail is available via NHS Choices or our website.

Our quality strategy

The purpose of our quality strategy is to ensure we provide the best possible care for all of our patients. We define quality as embracing three key components:

1. Patient safety
    - There will be no avoidable harm to patients from the healthcare they receive.
    - This means ensuring the environment is clean and safe at all times and that harmful events never happen.

2. Effectiveness of care
    - The most appropriate treatments, interventions, support and services will be provided at the right time and in the right place to those patients who will benefit.
    - Our patients will have healthcare outcomes which achieve those described in the NHS Outcomes Framework and NICE quality standards

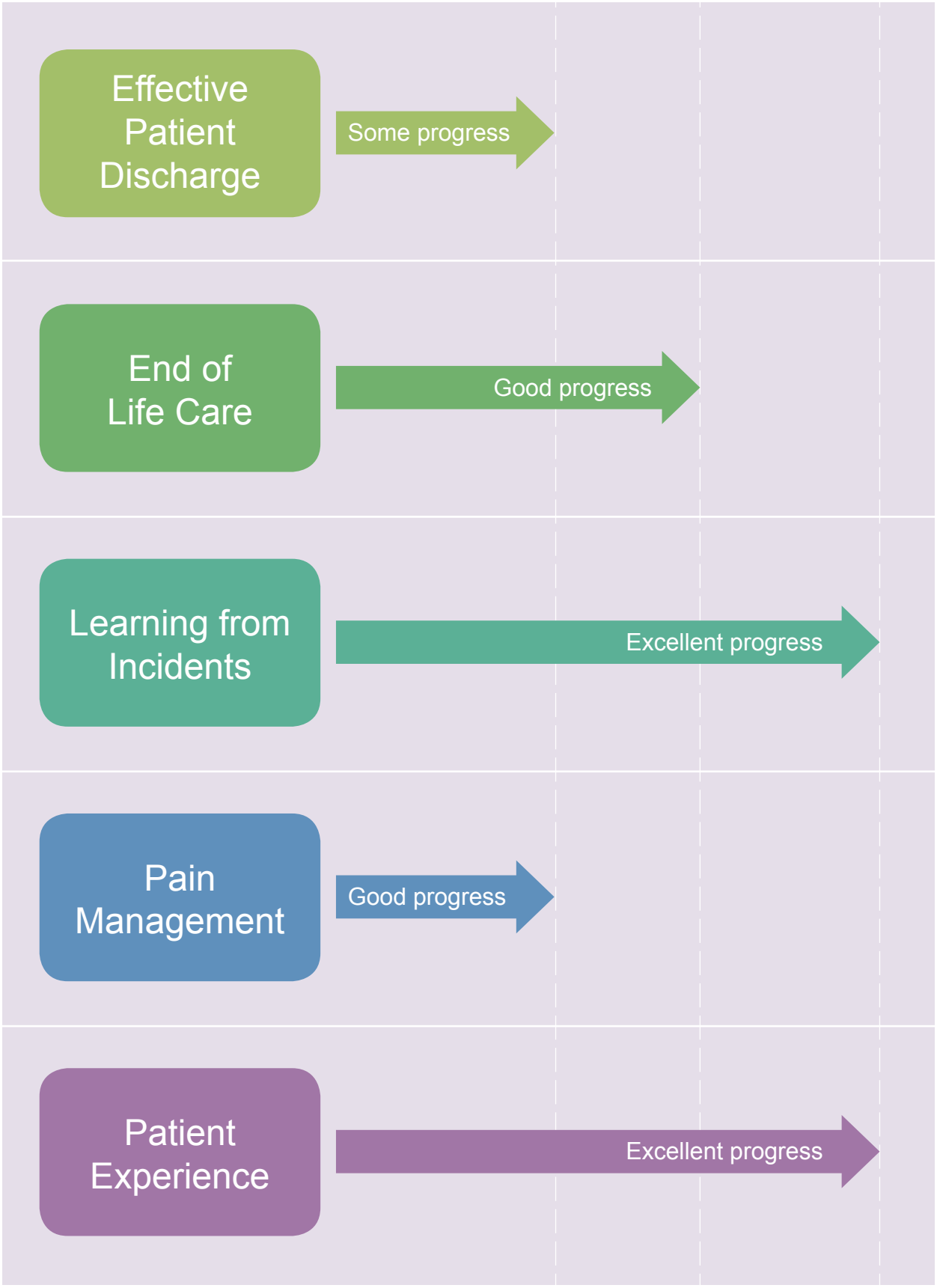
3. Patient experience
    - Patients will experience compassionate, caring and communicative staff who work in partnership with patients, relatives and carers to achieve the best possible health outcomes.

Quality priorities – actions and progress in 2014/15

A number of potential priorities were agreed by the trust board, following which they were subject to wide consultation and prioritisation with staff, patients, the public, our shadow governors, members and external stakeholders. Following review of the feedback received, the five work streams below were selected to demonstrate our commitment to quality in 2014/15:

- Effective patient discharge – improving the process
- End of life care – using alternative care planning methods
- Learning from incidents – making better use of the information we collect to improve patient care and safety
- Pain management – focussing on the acute phase of care
- Patient experience – increase patient involvement in reviewing and planning services

The diagram below summaries progress towards achieving the priorities



Effective Patient Discharge

Background

This was chosen as a priority last year as we had received feedback from our patients that there were areas of discharge processes that were not working well. Patient discharge is dependent on many factors to make it work well so many teams were involved in looking at how we could make improvements.

Overall aim

We will improve our information and implement robust planning and monitoring processes to achieve a reduction in complaints related to discharge and improve patient satisfaction. To achieve this we set ourselves the following targets

- Overall 25% increase from the baseline in the number of patients who have planned early discharge from the wards
- Utilise our shared tracking list to promote ownership of discharges by our community partners and demonstrate a reduction in delayed transfers of care against the agreed baseline (25%).
- Improve patient experience by timely delivery of TTO (to take out) medication to enable patients to be discharged with their medication and enable staff to educate patients in regards to their TTO (to take out) medications before discharge

AIM	TARGET	ACHIEVEMENT
Promote planned early discharge on all wards.	Overall 25% increase from the baseline in the number of patients who have planned early discharge from the wards.	Discharge training has taken place at grand round Imaging waits discussed at all huddles with plans to expedite discharge. Ticket Home initiative commenced in October 2014 A consistent approach has been implemented across the surgical division ensuring all potential discharges are reviewed early in the day. Discharge traffic light system across medicine, in order to improve discharge. Development of discharge suite standard operating procedure in preparation for new discharge suite Discharge passport launched in October 2014

AIM	TARGET	ACHIEVEMENT
		Implemented Discharge Before !0 initiative to see and discharge patients from the wards before 10am
Ensure accurate recording of delayed discharges	Utilise the shared tracking list to promote ownership of discharges by our community partners and demonstrate a reduction in delayed transfers of care against the agreed baseline (25%).	Shared tracking being utlised
Improve the patient experience by timely delivery of To Take Out (TTO) prescriptions to enable patients to be discharged with their medication and enable staff to educate patients in regards to their TTO medications before discharge.	Pilots undertaken in the following areas prior to implementation: ● TTO streaming in dispensary - Collingtree Pharmacist/prescriber early ward round (protected time) ● Pre-pack medication introduced to Dryden and Eleanor wards ● Pre-pack policy developed to make better use of existing pre-packs during working hours and speed up discharge ● Streamline Sunday working hours to align with patients' needs. Review data to determine if actions have supported a reduction in the number of patients who are discharged home without their medication and increased patient experience/ satisfaction with our services	TTO streaming in dispensary achieved an improvement on the average time to dispense a TTO from 106min in 2013/14 to 61minutes in 2014/15, a 2% improvement on performance. Time taken for a pharmacist to begin the process of clinically screening a TTO after it has been prescribed by a doctor decreased from an average time of 70min in 2013/14 to 64 minutes in 2014/15, an 8% improvement on performance Average number of pre-packs issued to wards and departments: ● 2013/14= 3,377 per month ● 2014/15= 2,950 per month ● 13% reduction in the use of pre-packs at discharge Average number of TTOs dispensed on all of the Sundays each month has increased from 29 in 2013/14 to 32 in 2014/15. Sunday working hours remain at 1pm-3pm 79% of all TTOs are ready at least 30mins before planned discharge time 44% of all TTOs are sent to pharmacy with less than 90mins notice of discharge time: this is a 2% increase on 2013/14

End of Life Care

Background
An average of 50% of all deaths in Northamptonshire occurred in one of the two acute hospitals between 2010 and 2012. In 2013 we participated in a national project, Transforming End of Life Care in the Acute Hospital – The Route to Success. This programme highlighted best practice in care and provided practical support to enable us to work towards improvements.

The AMBER care bundle (AMBER = Assessment, Management, Best practice, Engagement, Recovery) is a national-recognised tool to improve the quality of care for people whose recovery is uncertain. It encourages clinical teams to work with the patient and family and discuss options of care, wishes and preferences if they are thought to be in the last eight weeks of life.

A heat map of all wards highlighted areas where the AMBER care bundle would be suitably implemented and an elderly medical ward was identified. The suitability was supported by a baseline audit of current practice on that ward. A clinical lead was identified and after a period training on the ward, AMBER Care was implemented. A comparative audit is in the process of completion to assess whether AMBER Care is effective in improving patient experience.

Five Band 6 and 7 nurses took part in a Quality End of Life Care for All programme facilitated by Cynthia Spencer Hospice. The programme consists of clinical experience in a hospice setting for two days with an additional three days of theory. At the end of the programme, the ward sisters were asked to set SMART objectives to improve End of Life Care on their ward

Overall Aim
To improve end of life care and care of the dying

AIM	TARGET	ACHIEVEMENT
Implementation of AMBER Care Bundle (Assessment, Management, Best practice, Engagement, Recovery) on an identified ward with a named consultant lead.	Project launched based on the AMBER Care Bundle outcomes for patients who died on the identified wad and those who died within 100 days of discharge from the identified ward. Action plan developed to roll our AMBER across the Trust	AMBER Care was fully implemented on one ward and due to its success it was implemented on a further two wards before April 2015. A full report on the comparative audit will be available in July when data is collected for patients discharged and who died within 100 days.
Develop leadership in End of Life Care across the hospital through the Quality End of Life Care training programme	Present course content and design to be reviewed following the feedback. NGH to liaise with Cynthia Spencer Hospice and identify a training course for 2014/15 using existing NMET finds. Five participants identified and training undertaken	Five Band 6 and 7s completed the programme. A new programme developed based on the principles of QELCA began in April 2015

Learning from Incidents

Background
When things go wrong it is important we find out why they happened so we can take the necessary steps to avoid the same thing happening again. To do this we needed to ensure our staff knew and were encouraged to report all incidents or mistakes which may have a negative impact on safety or quality of care. We recognised that our processes for supporting this needed improvement and therefore we chose to make this a priority to improve our safety culture

Overall aim
Improve learning from patient safety incidents and ensure that lessons learnt are used to improve patient safety and quality of care

AIM	TARGET	ACHIEVEMENT
Ensure that patient safety incidents where harm has occurred are robustly investigated, root causes are identified and appropriate actions are put in place to reduce the likelihood of reoccurrence.	Develop and implement training for staff on root cause analysis. Agreement and roll out of action plan assurance pathway. All action plans from incidents where harm has occurred will be uploaded to HealthAssure. Deliver root causes analysis training. Monitoring of action plan progress on HealthAssure and overseen by the Serious Incident Group. Evidence of completion presented to the Serious Incident Group. We aim to be able to demonstrate that similar root causes are not being identified when harm occurs	Root cause analysis training was implemented in October 2014 with monthly workshops continuing throughout 2015/16. Following completion of the investigation report the recommendations and action plans are monitored within directorates/ divisions. Assurance that actions have been completed and practice changed is gained from evidence collection, audit findings and further monitoring of reported incidents. Evidence is linked to HealthAssure and overseen by the Serious Incident Group. Monthly reports on action plan compliance are submitted to the Serious Incident Group; Quality Governance Committee and Trust Board. A month-on-month improvement in compliance has been demonstrated throughout the year.
Ensure that lessons learnt from incidents where harm has occurred are shared across the organisation and the wider health economy as appropriate	We aim to demonstrate that by sharing lessons learnt there will be a reduction in the number of similar incidents occurring.	During 2014/15 we achieved a 2.3% increase in the number of patient safety incidents reported with a 37.2% decrease in the number of serious harm incidents.

AIM	TARGET	ACHIEVEMENT
	By the end of March 2015 there will be an increase in the number of positive responses in relation to lessons learnt from incidents where harm has occurred in the QuEST (Quality Effectiveness Safety Team) audits	We introduced a quarterly staff newsletter in April 2014 called 'Quality Street'. The newsletter contains information on incidents, trends and lessons learnt following investigation. All staff interviewed during the January 2015 QuEST (Quality Effectiveness Safety Team) were able to give examples of lessons learnt and changes implemented following serious incidents.

Pain Management

Background
We had received complaints related to poor pain control for our patients. We chose this as a priority to improve patient and carer experience as evidenced by a reduction in complaints.

Overall aim
To improve the overall management of acute pain control across the trust and reduce incidents, poor patient and family feedback and complaints

AIM	TARGET	ACHIEVEMENT
Gain an understanding of the factors affecting acute pain management in NGH and reduce the number of incidents. To monitor improvements and compliance with KPIs	Benchmark position in respect of complaints and incidents relating to pain management including complaints/FFT/ Datix. All relevant complaints and incidents to be forwarded to the pain team. Ensure pain remains on the NEWS (National Early Warning Score) chart and is completed by all staff (training) in all departments. Pain management added to the monthly patient safety dashboard. Incidents reduced each quarter by an agreed percentage	Monitoring of FFT, DATIX and complaints Pain included within VitalPac system. Inclusion of pain assessment on VitalPac with monitoring to understand how information is being used

AIM	TARGET	ACHIEVEMENT
To ensure that relevant materials are achievable to support staff	Review and revise pain assessment tools trust-wide, focussing on A&E, medicine and maternity, including patient-controlled oral analgesia (PCOA) in maternity. Revised documentation to be consulted upon, approved and disseminated	Pain included within A&E's electronic patient record system Symphony Guidelines produced
To raise awareness of available material. Increase use of link nurse network to raise awareness and ensure that all areas access available training	Website use to be promoted for acute pain support documents. Education leaflets to be developed for staff and patients. Group clinical supervision to be developed, training level set and delivered Improvement in training levels to be evaluated	Documents and assessment info available on pain website. At time of printing, awaiting final ratification of doctor and nurse handbook. Individual supervision, accessible if needed, for staff carried out.
Increase resources available to the acute pain management team	Increase physical staff resources within the team by developing and submitting revised business case and recruiting relevant staff following approval. Prioritise service delivery within available resources	Business case developed and submitted for approval. Priority is given to face-to-face review of patients /safety related issues
To improve pain management resources available for patients To be able to provide/offer more comprehensive psychological assessment and treatment	Offer a more comprehensive psychological assessment and treatment to prevent recurring admissions with pain control issues, including patients with substance misuse issues. Identify alternative treatment and support options where appropriate. Consider the possibilities of referral to clinical psychology and substance misuse specialists where this is identified as being in the patients best interests	Service is being reviewed to better understand requirements. Requested input from psychologist submitted in business case. Ongoing work with mental health liaison team to clarify provision / support for patients in this client group.

Patient experience

Background
We are committed to the involvement of patients and the public and this priority was chosen to reflect our corporate objective to exceed our patients' expectations. We strive to listen to, understand and respond to patient and public opinion and expectations and to ensure their views continue to inform ongoing improvement work.

Overall aim
To co-ordinate, monitor, feedback, and engage with our patients on their experiences, and work collaboratively to improve in areas where patients are voicing dissatisfaction.

AIM	TARGET	ACHIEVEMENT
Integrate current patient and public involvement with patient experience	Review patient and public involvement activity and strategy Develop patient engagement network (PEN) Clarify roles and responsibilities for members of PEN	A new patient experience and engagement strategy was developed The patient & public engagement network (PPEN) was formed. A patient & carer experience & engagement group (PCEEG) was formed. For 2015/2016, systems for managing engagement in the hospital are being explored.
Ensure the patient experience strategy reflects partnerships with patient and public involvement	Review and revise patient experience strategy and develop patient experience and engagement strategy. Ratify new strategy through Patient Experience Board.	The patient & carer experience and engagement group (PCEEG) includes representation from Healthwatch Northamptonshire, carers' representatives as well as a number of focus groups: ● End of life ● Dementia action committee ● Black and Ethnic Minority forum ● Dignity forum ● Disability partnership forum

AIM	TARGET	ACHIEVEMENT
Improve the patient experience at ward level	Ward sisters to be responsible for co-ordinating patient feedback and sharing with their staff. This will include: • Patient story at the beginning of each ward meeting • Share FFT, complaints and compliments with their ward team through ward meetings, huddles and 1:1 • Review FFT scores and comments, and co-ordinate improvement plans to address areas of dissatisfaction • Feedback to patient experience lead work undertaken and outcomes.	● Ward sisters receive their FFT (Friends & Families Test) data from the patient experience lead monthly which includes: ● • A poster to be displayed in the department for staff and patients ● • A monthly breakdown of each ward's individual performance ● • A graph showing month-on-month tracked trends from the satisfaction scores received. This information is shared by all ward sisters within their huddles alongside patient stories and any complaints that they have received. The information gained through the FFT is consistently reviewed for themes and trends and was part of the catalyst for the Sleep Well campaign targeted at helping patients to rest and sleep while in hospital. Where reduction in satisfaction levels has been observed, or an area receives consistently poor results, the ward sister and matron are invited to attend the patient & carer experience and engagement group to report on any issues identified and progress made to address them An example of progress can be seen from a particular ward highlighted as an area of concern in February due to their depreciating FFT results. The sister and matron were contacted and discussions took place around their feedback data including the comments and common themes. Following these discussions and action taken, the ward saw their satisfaction levels rise from 73% of patients recommending the ward in January to 95% in February. This ward will continue to be reviewed to ensure the achievement is sustained

AIM	TARGET	ACHIEVEMENT
Improve the patient experience at directorate level.	Improve the patient experience at directorate level.	Meetings have been held with our business development team to explore how members of PPEN can be involved in directly supporting the business case cycle. This will be reviewed alongside the cycle for 2015/2016.
Improve the patient experience at a trust-wide level	Trust Board and senior forums to begin with patient story. Corporate projects / workstreams to include PEN representative. Patient experience projects to be fully supported by PEN. Feedback and outcomes from patient experience activities co-ordinated and shared through patient experience lead	Each Trust Board meeting begins with a patient story. All projects which have been initiated via patient experience have had representation from members of PPEN. For example, a group of PPEN members were involved in the Sleep Well Campaign conducting audits on the wards and attending meetings as members of the steering group. The wider PPEN was also involved in the production of supporting leaflets and posters to ensure they were user friendly. The hotel service focus group conduct monthly food tasting audits and visit the wards to assess the overall experience for patients during mealtimes. These are just two examples of the invaluable work members of our public have been able support throughout 2014/2015 All work related to engagement is fed through the patient & carer experience and engagement group and shared in reports to the Quality Committee.

AIM	TARGET	ACHIEVEMENT
Achieve National CQUIN	Work with Healthwatch Northamptonshire, Age UK and other external agents to support the patient experience strategy. Develop structured feedback from Task & Finish groups, audit engagement and project leads	Healthwatch Northamptonshire are represented on the patient & carer experience and engagement group and present any findings related to. They're also involved in key discussions regarding experience and engagement as part of the group. The carers' organisation are also represented at these meeting s. Under its new structure, a number of focus groups now directly feed into the group: ● End of life ● Dementia action committee ● Black and ethnic minority ● Dignity forum ● Disability partnership forum (including deaf connect and Northamptonshire Association for the Blind (NAB).
Continue to roll out the Friends and Family Test to outpatients and day case areas.	Identify an external technology solution for capturing FFT data throughout the organisation. Roll out FFT in outpatients in line with CQUIN requirements.	Healthcare Communications were procured in September 2014 following a review of a number of different providers of electronic solutions for the Friends & Family Test. Given the growing size of the FFT and the requirement to roll out to outpatients by October 2014 to meet the CQUIN it was determined that a method which did not require data collection/entry, or the purchasing/maintenance of expensive IT equipment was the best method for the organisation. For this reason, Healthcare Communications were chosen as the most proficient and competitive with SMS text messaging and Interactive Voice Messaging. In addition to this, they provide an exemplary dashboard system and online monitoring.

AIM	TARGET	ACHIEVEMENT
		With the support of Healthcare Communications the organisation was able to meet the CQUIN deadline of the 1st October 2014 and roll out to all outpatient and day case areas. For Q3, this saw the organisation collect 16,285 responses to the FFT from outpatient services and 2532 for day case services across NGH and Danetre, providing a wealth of data related to how our patients are experiencing our services

Quality Priorities 2015/16

Following consultation with staff, patients, the public, our members and external stakeholders, we agreed the following Quality Priorities for 2015/16:

1. **Support patients in getting home**
   (Improving discharge process)
2. **Listen to our patients**
   (Learning from complaints)
3. **Invest in our staff**
   (Staff engagement and leadership)
4. **Sign up to safety**
   (Harm free care)
5. **Improve end of life care**

Numbers and themes of serious incidents over the last year

The Trust Board receives monthly reports on serious incidents and there are quarterly reports internally through the governance structure including monthly reports to Quality Governance Committee (QGC) and Clinical Quality & Effectiveness group (CQEG).

During 2014-15 we declared 93 serious incidents (SIs); this is fewer than the 112 SIs declared during 2013-14. More than 70 per cent of SIs relate to pressure ulcers and falls which result in harm.

Leadership of the serious incident management process is provided by the medical director and is overseen by the serious incident group. Every serious incident is reviewed in detail to ensure that all service/care delivery problems are identified and actions are agreed to prevent reoccurrence. Serious incidents are reported to our commissioners via the Strategic Executive Information System (StEIS) and the National Reporting and Learning System (NRLS).

The culture of incident reporting is continuing to mature, with the total number of incidents reported increasing annually to ensure that lessons are learnt if something goes wrong.

Number and themes of serious incidents during 2014-5:

Category	Number
Grade 3 Pressure Ulcers	53
Slips/Trips/Falls	14
Delayed Diagnosis	6
Sub-optimal care	2
MRSA Bacteraemia	2
Child death	2
Maternity - Stillbirth	2
Infected Healthcare Worker	1
Maternity – Unplanned admission ITU	1
Safeguarding Vulnerable Children	1
Wrong Site Surgery	1
Surgical Error	1
Screening Issues	1
Maternity – Retained Swab	1
Other	1
Unexpected death	1
Failure to act on test results	1
Communicable disease and infection issues	1
Drug Error	1
Total	93

The systematic investigation of serious incidents results in clinical improvements being identified and implemented. These improvements support the embedding of a positive safety culture which allows high quality, safe patient care. Examples include:

- Introduction of a Red Flag electronic system in the Accident & Emergency department to highlight patients who have additional risk factors requiring a more urgent review
- Introduction of a wider range of pressure-relieving equipment to prevent device-related skin pressure damage
- Triage category for needlestick injuries reviewed to high risk to ensure timely administration of post- exposure prophylaxis
- Review of guidance on central venous cannulation and development of simulation scenario training sessions which includes managing complications
- Introduction of hourly safety rounds in the Accident & Emergency department which includes assessment of pain

- Increased availability of CT pulmonary angiogram out of hours
- Joint working with commissioners to review the pathways for recurrent frequent attenders to the Accident & Emergency department in order to ensure they receive the correct support for their needs
- Guideline for the reversal of warfarin in patients with intracranial haemorrhage reviewed and re-launched
- Review of failed day case policy to include review by a consultant on a daily basis

Numbers and themes of Never Events over the last year

Never events, first introduced in 2010, are a list of events described as "serious, largely preventable patient safety incidents that should not occur if the available preventative measures have been implemented by healthcare providers" (National Patient Safety Authority 2010). These can be used as an indicator of how safe an organisation is and the patient safety culture within that setting.

During the 2014-15 reporting period, we investigated one 'never event' which related to wrong site surgery. Following this event, a number of actions have been implemented to reduce the risk of recurrence including:

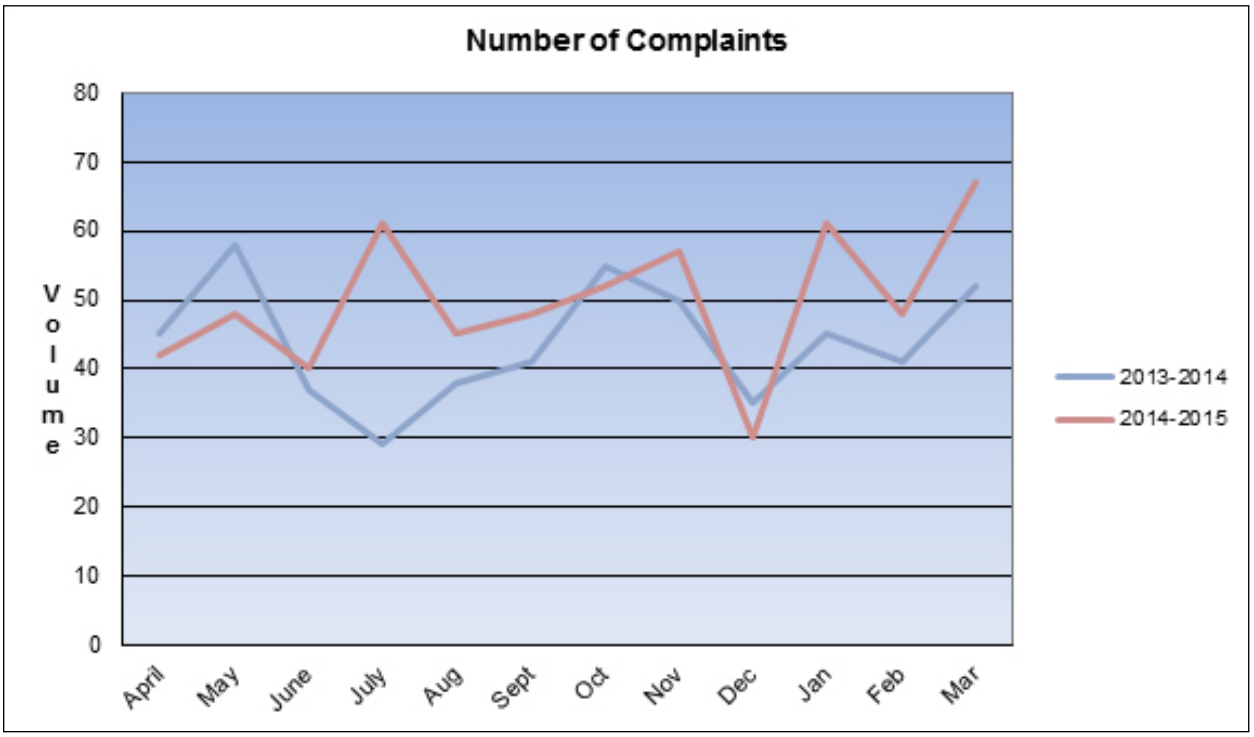
- Introduction of a rolling training programme in the WHO checklist for all members of the peri-operative team; to include all surgical and anaesthetic junior doctors
- Surgical side marking implemented for all unilateral procedures in ENT to ensure there is a visual cue for the surgeon when it is not possible to mark the surgical site

COMPLAINTS

We received 599 written complaints that were investigated through the NHS complaints procedure from 1st April 2014 to 31st March 2015, compared to 526 complaints received the previous financial year. This represents 0.10 per cent of the number of patients seen or treated by us.

Total no of complaints for the year	599
Average response rate (including 307 renegotiated timescales)	*78%
Total no of complaints that exceeded the renegotiated timescale	*103
Complaints that were still open at the time that the information was prepared (14th April 2015)	*67
Total patient contacts/episodes (Versus 2013/2014)	607,659 (571,868)
Percentage of complaints versus number of patient contacts/episodes (Versus 2013/2014)	0.10% (0.11%)

**Figures correct at the time of going to print*



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Total
2013 - 2014	45	58	37	29	38	41	55	50	35	45	41	52	526
2014 - 2015	42	48	40	61	45	48	52	57	30	61	48	67	599

Trend Analysis

The following table provides the top 5 themes emerging from complaints.

	2014-2015	% of Total Complaints Received
Clinical Care	64	11%
Delays/Cancellations	26	4%
Communication	20	3%
Attitude	16	2.6%
Discharge	12	2%

Clwyd/Hart report

The publication in 2013 of the Francis Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry prompted the Prime Minister and the Secretary of State for Health to commission a review into NHS hospitals complaint handling arrangements. The review was co-chaired by the Right Honourable Ann Clwyd, MP for the Cynon Valley and Professor Tricia Hart, chief executive of South Tees Hospitals NHS Foundation Trust. The aim of the review was to consider the way concerns and complaints are handled across NHS hospitals in England. The focus was on acute hospitals, although evidence was also taken from other care providers. Subsequently the Clwyd /Hart report 'A review of the NHS hospitals Complaints System – Putting Patients Back in the Picture' - was published.

Following the release of the report our head of complaints prepared a detailed gap analysis early in 2014 incorporating the recommendations made within the report. We previously received an 'excellent' rating from the most recent full audit of complaints handling incorporating CQC outcome 17, and the NHS Statutory Complaints Regulations.

However, on the back of the Clwyd/Hart report we identified that some improvements could be made to the way in which complaints are handled at directorate, divisional and corporate levels. A development plan was subsequently prepared which is ongoing at present.

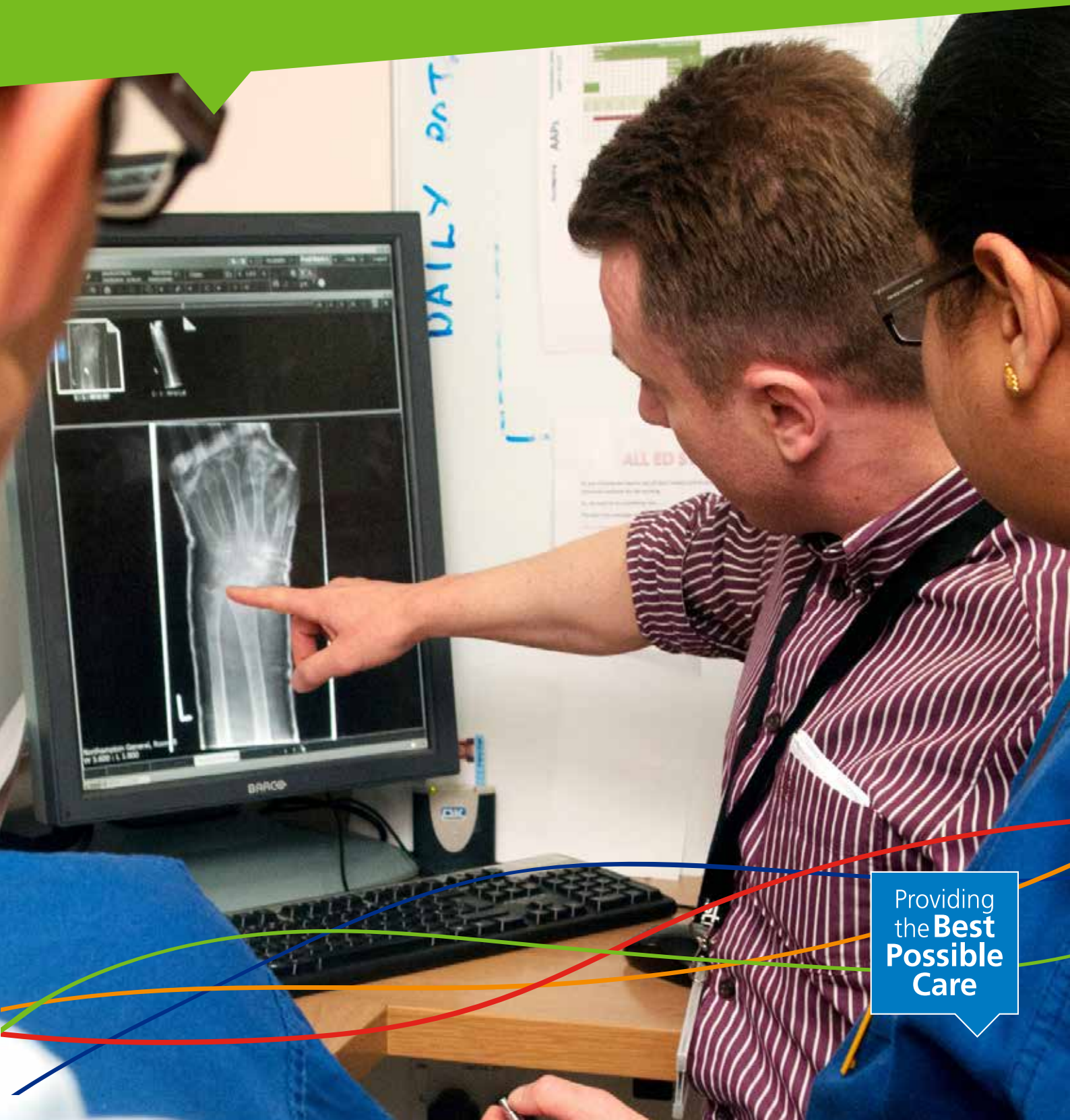
In December 2014 the Parliamentary & Health Service Ombudsman published a report My expectations for raising concerns and complaints. This report was has been combined with our development plan as it all relates to improving complaints handling within the NHS.

We take pride in the way in which complaints are managed as it is important to us that the process, the decision making and the way in which we communicate, are as straight forward and effective as possible. We aim to provide various remedies through the issuing of an appropriate apology and a variety of actions which aim to redress the issues identified, where appropriate. We work in accordance with the Parliamentary & Health Service Ombudsman's principles for remedy.

Northampton General Hospital NHS
NHS Trust

Section 3

Statutory Information



Embedding Sustainability

Great Green Star Award 2015

Setting the standard for the environment

In 2014 we achieved the Investors in the Environment Green Accreditation. This demonstrated that we had achieved a reduction in resource consumption, had a green travel plan, active waste minimisation and recycling and that we had carried out at least three additional green actions. We were also awarded the status of overall achiever, only one of which is given each year amongst the organisations taking part in the region. This was in recognition of our additional effort made.

Carbon Management Plan

The interim carbon emissions target was missed by approximately 3.8 per cent. This is due to the high percentage of coal used for power generation for the national grid which has increased carbon emissions for electricity. Had the emissions factors remained the same as previous years we would have hit our carbon target for the year. Despite increasing patient numbers, our carbon emissions have remained static. We are looking forward to a full year's operation of the new CHP engine and biomass boiler which will enable us to achieve the full 25 per cent reduction (compared to 2010) by the end of the next financial year.

	2012/2013	2013/2014	2014/2015
***GHG Emissions tCO2e**			
Gas	6306	6172	5411
Fuel Oil	0	9	44
Purchased Electricity	7147	6913	7652
Business Travel	345	320	298
Water	145	144	135
Total tCO2e	13943	13550	13539
Target tCO2e	15075	13396	13045
Consumption Data			
Gas kWh	35,350,409	33,538,628	29,250,909
Electricity kWh	14,435,769	14,315,605	14,649,097
Water m3	137,355	136,369	127,781
Business Travel miles	1,140,495	1,079,683	977,976
Financial Data £			
Gas	1,204,028	1,140,618	1,155,563
Electricity	1,317,918	1,465,853	1,063,462
**Water	271,875	278,441	268,190**
Business Mileage	406,762	449,155	431,790

** calculated using revised Defra Conversion factors as advised by Defra.*

*** Final month's figures not available at time of going to press, interpolated figures used*

**** All figures remove gas used for CHP and include electricity generated by CHP*

Investment

In addition to the new energy centre, an additional £120,000 was invested in new lighting and building controls through the Salix scheme which will save an additional 100 tonnes of CO2e next year.

Water use

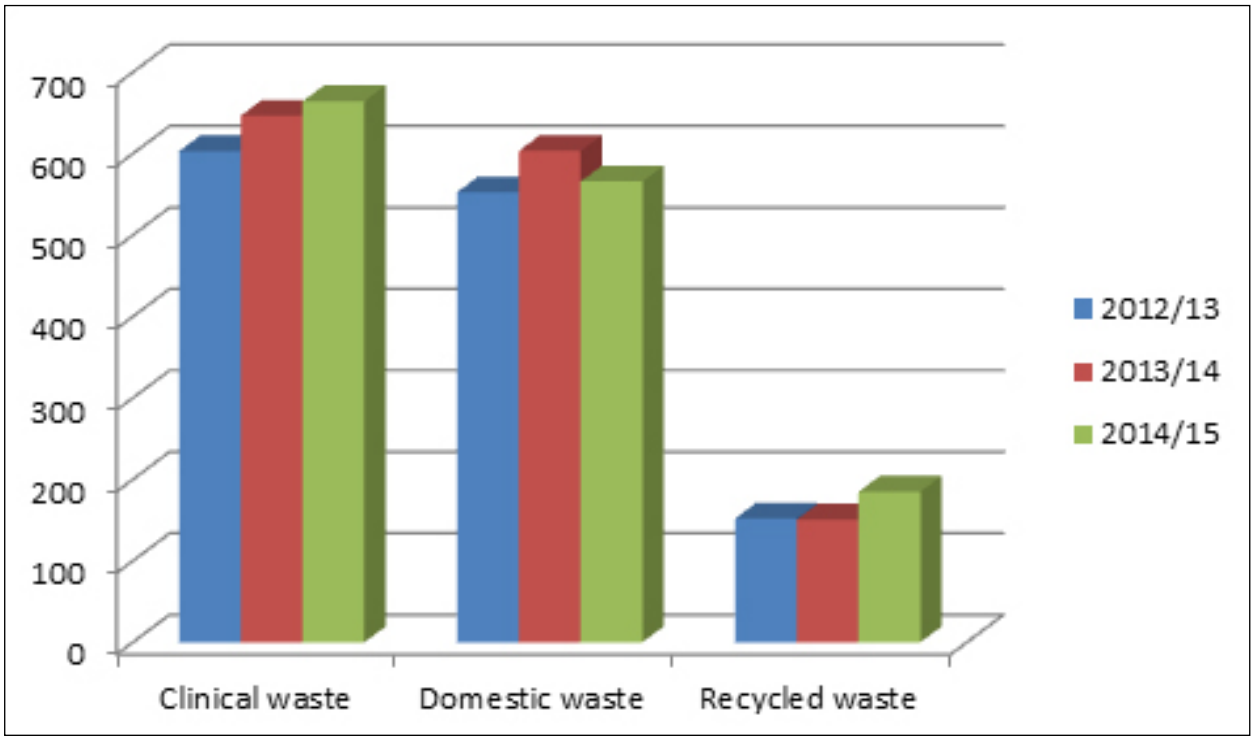
Water consumption decreased over the last 12 months by 6.3 per cent. This is as a result of better housekeeping and installation of more water efficient technologies. We are partway through a program of work with Anglian Water to map our water use and identify areas for improvement and improve our resilience. This should lead to improved water efficiency over the next 12 months.

Waste and Recycling

2014 saw major changes in the way that waste is handled at the hospital. Our clinical waste segregation has improved, removing more waste from incineration to alternative treatments and reducing costs.

The new domestic waste and recycling contract started in October following a tender process that put the emphasis on innovation rather than short term costs. We are confident that this approach will bring down the costs through the length of the contract as well as improving our environmental impact.

Recycling rates have improved slightly from 22 per cent to 25 per cent, and overall domestic waste and recycling levels have reduced by 0.5% despite increased patient activity. Recycling rates are expected to increase in the coming year with the provision of more recycling stations and closer working with our new contractor and with more engagement and education of our staff on this important topic. This follows on from our participation in Zero Waste Week where we had a different event every day; from a very successful stationery amnesty to a day of recipes from the Love Food Hate Waste campaign served in the restaurant and a display and recycling quiz by our new waste management contractor.



** Full year figures are estimated from those of the second half of the year due to lack of reliable data from one of the contractors for the first half of the year.*

Carbon Footprint and Procurement

The NHS has calculated its approximate carbon footprint of which over 60 per cent has been attributed to procurement activities. The procurement team is now working through the Defra Procuring for Carbon Reduction Framework and has calculated an approximate carbon footprint from purchased goods and services. It has also started to engage suppliers on the sustainability agenda and all tenders now include sustainability sections.

As more detailed data is made available further additions to the reported carbon footprint will be made. Using the data from the sustainable development unit, an approximate footprint of

63,685 tonnes of CO2e has been calculated for NGH activities.

Emissions from the anaesthetic gases (including entonox and nitrous oxide) are reported for the first time; they have been calculated at 2,538 tonnes CO2e, a 10 percent reduction on the previous year.

Travel

We completed the first staff commute survey to determine usual modes of transport to the hospital and calculated the approximate carbon footprint for journeys. We have agreed with Stagecoach to fund a month's free travel for anyone giving up their parking permit for the month, scheduled for launch in May 2015.

To encourage more active travel we held a number of Dr Bike Fixit sessions and started a weekly lunchtime walk for staff.

NHS Sustainability Day

We took part in national Sustainability Day for the third year. This year we put the emphasis on active travel and worked with SusTrans to put on a Dr Bike session and a smoothie bike in the south entrance so staff and visitors could make their own healthy drink and learn more about cycling and walking in Northamptonshire.

Plans for Next Year

The new year will see a new sustainability strategy aligned with the national NHS sustainable development unit's sustainability strategy. We will also be hoping to gain our green accreditation with the Investors in the Environment scheme for the second year.

In addition to talking to all new starters about sustainability and, in particular climate change and energy consumption, it is planned to use the electricity submeters in a wider switch off campaign targeted at different staff groups.

NGH recognises that sustainability is about much more than just energy and waste and will be applying for the Bronze Accreditation in the Food for Life scheme for its patient meals. This will ensure that the menu will change seasonally and that meat, fish and eggs are sustainably produced.

Risk management

We review risks against our principal objectives on a regular basis and an agreed system of internal control is in place. This is described in more detail in the Annual Governance Statement, which can be found on page xxx

Counter-fraud policies

We take all reasonable steps to comply with the requirements set out in the code of conduct for NHS managers, and has appointed CEAC (Central England Audit Consortium) to provide an accredited counter-fraud specialist service. Their remit also includes compliance with the Bribery Act.

Information technology

2014/15 was another busy year for ICT and once again our capital programme was delivered as planned.

Data centre award:

Our supplier/partner in the build of our secondary data centre to provide failover and disaster recovery for our systems was shortlisted for a Business Green Leader Award in the category of 'Green IT Project of the Year' for our data centre project. The awards celebrate the best in the world of green business, bringing together exciting, inspiring projects and teams working to advance the green economy.

PACS imaging:

We are part of a consortium of seven NHS Trusts across the East Midlands (EMRAD) who have worked together to purchase a new radiology system. The proposed system will store and transmit images and reports seamlessly around the region, supporting timely and high quality clinical care regardless of geographical location. The systems will support 24/7 services and provide a sustainable long-term model for radiology services in the region.

Through EMRAD, we used our buying power as well as our clinical, technical and management know-how to get the best possible system for our patients.
Staff at all seven Trusts were given the chance to see shortlisted companies demonstrate their systems and GE were awarded the contract to provide the service.

The sort of technology we're investing in opens up all sorts of options for the way the whole care pathway can be delivered. Radiology systems have developed hugely in the years since PACS was first installed. The ability to review radiology images and reports is now a crucial part of many clinical pathways, and increasingly these pathways involve multiple hospital locations, 24/7.

Tech funds:

We progressed three projects with funding from the Safer Hospitals Safer Wards fund and the Nurse Technology fund:

- roll out of the VitalPac system, which records patients' observations and vital signs on handheld devices, enabling escalation of the sickest patients at a glance.
- Go live on pilot wards with electronic prescribing including electronic cabinets bringing many safety improvements in the issuing of medicines. The roll out to the rest of the hospital is now underway.
- Embedding of our Mobility in the Community project enabling our community midwives and community stroke team to access essential IT systems at the point of caring for their patients.

VOIP:

We completed a pilot of a VOIP telecommunications system and the roll out throughout the hospital over the coming period will bring with it many benefits to our busy clinicians as we enter into the world of unified communications.

National Programme for IT:

We now have another exceptionally busy year ahead of us with the conclusion of the National Programme for IT. We have to replace our main hospital patient administration (PAS) system and our laboratory information system over the next couple of years. Both of these systems are core to the running of the hospital and of course to our electronic patient record strategy.

Electronic patient record:

Everything we do in IT is working towards the provision of a joined up patient centric view of clinical information – the fully electronic patient record - fom the underpinning infrastructure to the new interfaced or integrated systems we introduce. Consideration going forward must be given to how this will work alongside new methods of delivering care in different settings across the health and social care economy, to ensure all of our patients' records are available at the point of care. Mobile working for our clinicians will be key.

Emergency preparedness

We are a Category 1 responder as defined by the Civil Contingencies Act (CCA) and therefore emergency preparedness, resilience and response (EPRR) is a very important element of our activity.

The CCA requires NHS organisations to continue to operate safe patient care during emergency situations, while maintaining essential services. We therefore need to plan for, and respond to, a wide range of incidents and emergencies. These could be anything from extreme weather conditions to an outbreak of an infectious disease or a major transport accident.

We have a major incident plan that is tested on a regular basis. Our suite of emergency response plans are developed in collaboration with other agencies involved in emergency planning, including Northamptonshire Police, Northamptonshire Fire and Rescue Service, East Midlands Ambulance service, local clinical commissioning groups, local area teams and Northamptonshire County Council's emergency planning team to ensure we provide a cohesive response.

In the last 12 months we:

- Delivered major incident training at all levels of the organisation.
- Undertaken a 'live' exercise.
- Prepared for potential cases of Ebola.
- Managed the preparation and response to industrial action.
- Engaged in multi-agency exercises to test and develop the capability of the local health economy.

In the next 12 months we will be working to:

- Support local teams to review and update business continuity management (BCM) and major incident plans for all areas of the hospital.
- Engage in training and exercising of all local plans.
- Expand the major incident alerting system across the hospital.
- Continue to engage with health and other response partners to deliver the best possible response to incidents in the county.

Charges for information

We have complied with HM Treasury's guidance on setting charges for information, as outlined in Appendix 6.3 HM Treasury's guidance 'Managing Public Money'. This includes the use of charges in relation to requests for information as in accordance with relevant legislation, including the Freedom of information Act 2000; Environmental Information Regulations 2004; Data Protection Act 1998; and the Access to Health Records Act 1990. Standard charges are published on the NGH website together with contact information if a special request is to be made.

Compliance with the NHS Constitution

Based on the reports it receives, the Board is able to provide reasonable assurance that it is compliant with the rights and pledges within the NHS Constitution and has had regard to the NHS Constitution in carrying out its function.

Better Payment Practice Code

The Confederation of British Industry (CBI) outlines the process in relation to:

Paying suppliers on time

- Within the terms agreed at the outset of the contract
- Without attempting to change payment terms retrospectively
- Without changing practice on length of payment for smaller companies on unreasonable grounds

Giving clear guidance to suppliers

- Providing suppliers with clear and easily accessible guidance on payment procedures
- Ensuring there is a system for dealing with complaints and disputes which is communicated to suppliers
- Advising them promptly if there is any reason why an invoice will not be paid to the agreed terms

Encouraging good practice

By requesting that lead suppliers encourage adoption of the code throughout their own supply chains.

The normal payment terms for an approved invoice are 30 days from invoice date. Exceptions to this may arise where there is disagreement over the invoice or it is received with insufficient time for processing. In the exception cases payment is made as soon as possible after agreement or receipt of the invoice as relevant. Where there is a dispute over an invoice our policy is to communicate this to the supplier as soon as the difference of view is apparent and agree how to proceed towards resolution.

We are signed up to the Better Payment Practice Code

The Trust Board

Led by the chairman, Paul Farenden, the trust board comprises executive and non-executive directors who are responsible for determining our strategic direction, agreeing policy framework and monitoring performance. Its statutory obligations are set out in the codes of conduct and accountability, published by the Department of Health.

The trust board discharges its responsibilities through bi-monthly public meetings and bi monthly Board of Director meetings, an annual public meeting and a framework of formal subcommittees. The supporting committee structure is designed to:

- Deliver the Board's collective responsibility for the exercise of the powers and performance of the Trust
- Assess and manage financial and quality risk
- Ensure compliance with Department of Health guidance, relevant statutory requirements such as the Care Quality Commission requirements and contractual obligations.

The current composition of the Board is:

- Chairman
- Five non-executive directors (one of whom is vice-chairman)
- Five executive directors with voting rights
- Four executive directors

The directors do not have material interests in organisations where those organisations or related parties are likely to do business, or are possibly seeking to do business with Northampton General Hospital NHS Trust.

The directors are not aware of any relevant audit information of which the trust's auditors are unaware and they have taken all the steps that they ought to have taken as directors in order to make themselves aware of any relevant audit information and to establish that the trust's auditors are aware of that information.

Directors during 2014-15

Job title	Name	Comments
Chairman*	Paul Farenden	
Chief Executive*	Dr Sonia Swart	
Non-Executive Directors*	Phil Zeidler (vice Chair) Graham Kershaw Elizabeth Searle Nicholas Robertson David Noble	
Chief Operating Officer*	Debbie Needham	
Medical Director*	Dr Mike Wilkinson (interim) Michael Cusack	To Sept 2014 From Sept 2014
Director of Nursing*	Jane Bradley (interim) Rachel Corser (interim)	To January 2015 From January 2015
Director of Finance*	Simon Lazarus	
Director of Facilities and Capital Development	Charles Abolins	
Director of Workforce and Transformation	Janine Brennan	
Director of Strategy and Partnerships	Chris Pallot	
Director of Corporate Development, Governance and Assurance	Catherine Thorne	From January 2015

* denotes voting members of the Trust Board.

Board Members

Paul Farenden, CIPFA, MBA
Chairman

Paul was appointed as Chairman on 1st March 2012. A local man, who was previously chief executive at the Dudley Group of Hospitals NHS Foundation Trust, Paul has some 40 years' experience in healthcare finance, management and leadership. A qualified accountant, Paul has been chief executive in three NHS Trusts over the last 20 years, where he has led large-scale organisational change. Paul's experience has provided him with an in-depth understanding of both the NHS and the wider healthcare system.

Phil Zeidler
Vice Chairman

Phil had a successful career as an entrepreneur in financial services, building a number of businesses, including the largest independent outsourced distributor of general insurance in the UK. Currently Chairman of two insurance businesses, a music fund and two strategy of change consultancies, his core skills lie in strategic planning, innovation and developing strategic relationships. He is married to a consultant paediatrician.

Graham Kershaw
Non-executive director

Graham holds a first class honours degree in business from Leeds Metropolitan University and an MBA. He is a fellow of both the Chartered Institute of Secretaries and Administrators and the Chartered Institute of Personnel and Development. Graham also holds a professional marketing qualification. Graham has been a main board director of a number of major UK retail companies including Lloyds Pharmacy, Capio UK and Joshua Tetley's. He is currently managing director of Cogniscence Ltd a business providing change management and business turnaround input mainly to the public sector.

David Noble
Non-executive director

David Noble's career has been in finance covering both the public and private sectors. Most recently David has spent nine years as Finance Director of the Equipment Procurement and Support sector of the Ministry of Defence, leading change programmes to improve the performance of the organisation. He chairs the audit committee.

Nicholas Robertson, MA, FCA
Non-executive director

Nick worked for Royal Dutch Shell for 32 years in many countries; mainly in finance, including periods as CFO of major businesses, but also in general management and HR. For his last eight years with Shell he was Vice President, Group Risk Management and Insurance. He is now acting as a consultant on risk management for industrial companies. He is a trustee director of Mental Health Matters, a charity, and a governor of the University of Northampton. Nick has a degree in engineering and economics and is a chartered accountant.

Elizabeth Searle
Non-executive director

After qualifying as a nurse and working in cancer and palliative care, Liz Searle held posts in higher education developing palliative care courses, with Macmillan as Director of Education Development and Support, and at Sue Ryder Care as Head of Palliative Care working with their hospices.

Dr Sonia Swart, MA, MB, BCh, MD, FRCP, FRCPath
Chief Executive

Sonia was appointed as Chief Executive in September 2013, having been the Trust's Medical Director since September 2007 and acting Chief Executive since July 2013. Sonia qualified from the University of Cambridge and went on to train in general medicine and clinical haematology. She worked as a consultant haematologist in North Warwickshire before joining Northampton General Hospital in 1994. Prior to becoming Medical Director, Sonia combined an active clinical role with a number of managerial activities, including head of pathology, clinical director for diagnostics and clinical lead for the foundation trust application. Sonia has made a commitment to align the trust's aims, values, objectives and corporate governance to support a clinically-led quality agenda.

Deborah Needham,
Chief Operating Officer

Deborah trained as a Registered General Nurse in Lancashire, where she held positions in both respiratory and emergency medicine units before moving to London in 1998 as a ward sister. After graduating as a nurse, Deborah gained a diploma in respiratory medicine and nursing care and a BA (Hons) in healthcare management.

Simon Lazarus
Director of Finance

Simon joined NGH in March 2014 from the Oxford University Hospitals NHS Trust where he was the Deputy Director of Finance. Simon has held a number of senior roles in NHS hospital finance since joining the NHS in 1993. He has a special interest in improving hospital finances, financial planning and major capital projects. Simon is a chartered accountant and has a degree in natural sciences from Cambridge University. Simon started his career in the private sector working in London before joining the NHS.

Dr Michael Cusack
Medical Director

Dr Michael Cusack, a consultant cardiologist, joined our executive team in September 2014. Mike was closely involved with reconfiguration of cardiac services across sites, led the Black Country Cardiovascular Network from 2008-2012 and has been involved in various aspects of pathway redesign. He has a longstanding interest in medical management and has been a clinical director and more recently a divisional medical director of a large surgical division at Royal Wolverhampton Hospital. His responsibility there included all surgical specialties, anaesthetics, theatres, support and maternity services in a medically led management model.

Rachel Corser
Director of Nursing (Interim)

Rachael joined the Trust in January 2015 from CareUK, the largest independent provider of NHS healthcare, where she was in a national role as the Director of Nursing. Prior to this Rachael held a number of senior nursing positions across acute and community NHS healthcare, more latterly in Buckinghamshire NHS Healthcare Trust, where she was pivotal to the successful vertical integration of acute and community services and the major reconfiguration of acute and emergency services.

Charles Abolins, FBIFM, MHCIMA
Director of Facilities and Capital Development (non-voting)

Responsible for our estates and facilities, procurement and capital development, purchasing and supply. After graduating in hospitality management from Birmingham College of Food and Tourism, Charles held a number of facilities management posts in the NHS. Since joining NGH, Charles has been responsible for leading and implementing complex, major capital building programmes and managing a wide range of facilities support services. He is our lead for sustainability.

Janine Brennan
Director of Workforce and Transformation (non-voting)

Janine was appointed as Director of Workforce & Transformation on 2nd April 2013, having worked previously as Director of Workforce and Organisational Development at Royal Berkshire NHS Foundation Trust. She qualified in law and human resources management and has worked in a number of acute Trusts, as well as the public sector and not for profit organisations. Janine's special interest is in developing staff commitment and engagement in ways that lead to improvements in the care we give to patients.

Chris Pallot MSc, BA (Hons), DipHSM, DipM
Director of Strategy and Partnerships (non-voting)

Chris has worked at NGH since January 2010. He joined the NHS Management Training Scheme in 1995 after graduating from university and since then has gained a postgraduate Diploma in Marketing and an MSc in Management. During his career, Chris has held previous positions at Kettering General Hospital, the NHS Modernisation Agency, Northamptonshire Heartlands PCT and NHS Northamptonshire. In previous roles he has been responsible for operational management, service improvement and commissioning & contracting. As Director of Strategy and Partnerships, he has responsibility for strategy development, contracting, market development, clinical coding, medical records, information management, and information technology services.

Catherine Thorne,
Director of Corporate Development, Governance and Assurance (non-voting)

Catherine was appointed as Director of Corporate Development, Governance and Assurance in January 2015 having previously held the post of Director of Governance for London North West Healthcare NHS Trust. She started her career clinically within radiotherapy and oncology services, transitioning into a variety of senior NHS roles in quality assurance, service improvement and governance. Catherine acts as the Board Secretary in addition to responsibility for clinical governance, health and safety and legal services.

Table of Attendance 2013-2014

A = Maximum number of meetings the director could have attended
B = Number of meetings the director actually attended

Name	Trust Board / Board of Director Meetings		Audit Committee		Healthcare*/ Quality Governance Committee		Finance, Investment and Performance Committee		Workforce committee		Remuneration Committee	
Chairman	**A**	**B**	**A**	**B**	**A**	**B**	**A**	**B**	**A**	**B**	**A**	**B**
Paul Farenden	11	10			12	4	12	10	4	4	4	4
Chief Executive	**A**	**B**	**A**	**B**	**A**	**B**	**A**	**B**	**A**	**B**	**A**	**B**
Dr Sonia Swart	11	10			12	4	12	10	4	4	4	4
Non-Executive Directors	**A**	**B**	**A**	**B**	**A**	**B**	**A**	**B**	**A**	**B**	**A**	**B**
Graham Kershaw	11	9	4	4	12	9	1	1	4	4	4	4
David Noble	11	9	4	4	12	8	12	11			4	3
Nicholas Robertson	11	8	4	4	1	1	1	1	4	3	4	2
Elizabeth Searle	11	8			12	9					4	0
Phil Zeidler	11	8					12	9	1	1	4	4
Executive Directors	**A**	**B**	**A**	**B**	**A**	**B**	**A**	**B**	**A**	**B**	**A**	**B**
Deborah Needham	11	10			12	10	12	9	4	3		
Simon Lazarus	11	11	4	4	6	5	12	10	4	3		
Rachael Corser	3	3	1	1	3	3	3	3	3	2		
Dr Michael Cusack	6	5			6	5	4	1	4	1		
Chris Pallot	11	10			6	5	12	10				
Janine Brennan	11	10	1	1	12	9	12	9	4	4	4	4
Charles Abolins	11	9	3	3	12	7	12	10	4	3		
Catherine Thorne	3	3	1	1	3	2	3	2	3	2		
Jane Bradley	7	7			9	7						
Dr Mike Wilkinson	5	5			6	4						

- *During 2014/15 the Trust altered its governance structure with revised committee structures effective from December 2014. This change also included a revision of membership.*
- *The Healthcare Governance committee became the Quality Governance committee and the Trust instated a Workforce subcommittee of the Trust Board*
- *From January 2015 the organisation implemented a monthly alternating Trust Board / Board of Directors meeting schedule*

Board Meetings

The Board meets in public session every other month with a Board of Directors meeting in the intervening months. Where the Board meets in public this is also followed by a second session held in private. Information regarding Board meetings, including agenda and papers, is posted on our website – www.ngh.nhs.uk.

Audit committee

The Audit Committee meets around six times per year. Its purpose is to review the systems of integrated governance, risk management and internal control, to ensure that there is an effective internal audit function, to review the findings of the external auditor, to review the findings of other significant assurance functions and considers the draft annual report and financial statements before submission to the Board.

Finance Investment and Performance Committee

The Finance Investment and Performance Committee meets monthly. The committee's purpose is to maintain a detailed overview of the Trust's assets and resources in relation to the achievement of financial targets and business objectives and the financial stability of the Trust on behalf of the Board. In addition, this committee is responsible for ensuring the delivery of all key performance metrics.

Quality Governance Committee

The Quality Governance committee meets monthly. The purpose of the Committee is to ensure there is an effective system of integrated governance, risk management, and internal control across the clinical activities of the organisation that support the organisation's objectives of delivering the best possible outcomes of care to patients.

Workforce Committee

The workforce committee meets monthly. The purpose of the committee is to provide assurance to the Trust Board on organisational development and workforce performance and on the achievement of associated key performance indicators and to make recommendations to the Trust board on key strategic organisational development and workforce initiatives.

External Auditors

KPMG are the Trust's external auditors and associated costs are disclosed in note 8 to the accounts.

Remuneration Report

Salary and Pension entitlements of senior managers

2014-15						
Name and title	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 £2,000) £000	Total - Salary & Benefits (bands of 5,000) £000
Paul Farenden - Chairman	20-25	1,900				20 - 25
Dr Sonia Swart - Chief Executive Officer	225-230					225-230
Deborah Needham - Chief Operating Officer (10 April 2014 onwards) Deputy Chief Excutive Officer (2 February 2015 onwards) / Joint Acting Chief Operating Officer (1 -9 April 2014)	125-130				227.5-230	355-340
Rebecca Brown - Joint Acting Chief Operating Officer (1-9 April 2014)	0-5					0-5
Michael Cusack - Medical Director(29 September 2014 onwards)	90-95				240-242.5	330-335
Dr Mike Wilkinson - Acting Medical Director (April 2014 - 26 September 2014)	65-70			10-15		75-80
Rachael Corser - Interim Director of Nursing, Midwifey & Patient Services (5 January 2015 onwards)	25-30				27.5-30	55-60
Jane Bradley - Acting Director of Nursing, Midwifey & Patient Services (14 April 2014 - 2 Jan 2015)	70-75				222.5-225	290-295
Suzie Loader - Director of Nursing, Midwifey & Patient Services (1 - 11 April 2014)	55-60				32.5-35	85-90
Simon Lazarus - Director of Finance	120-125				115-117.5	235-240
Charles Abolins - Director of Facilities & Capital Development	95-100				85-87.5	180-185
Janine Brennan - Director of Workforce and Transformation	110-115					110-115
Chris Pallot - Director of Strategy & Partnerships	95-100				5-7.5	105-110
Catherine Thorne - director of Corporate Developement, Governance & Assurance (19 January 2015 onwards)	20-25					20-25
Phil Zeidler - Non-Executive Director (Vice Chairman)	5-10	900				5 - 10
Nicholas Robertson - Non-Executive Director	5-10	500				5 - 10
Graham Kershaw - Non-Executive Director	5-10	600				5 - 10
David Noble - Non-Executive Director	5-10					5 - 10
Elizabeth Searle - Non-Executive Director	5-10					5 - 10

2013-14						
Name and title	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 £2,000) £000	Total - Salary & Benefits (bands of 5,000) £000
Paul Farenden - Chairman	20-25	2,500				20 - 25
Dr Sonia Swart - Chief Executive Officer	215-220				0	225-230
Deborah Needham - Chief Operating Officer (10 April 2014 onwards) Deputy Chief Excutive Officer (2 February 2015 onwards) / Joint Acting Chief Operating Officer (1 -9 April 2014)	40-45				42.5-45	80-85
Rebecca Brown - Joint Acting Chief Operating Officer (1-9 April 2014)	40-45				42.5-45	80-85
Michael Cusack - Medical Director(29 September 2014 onwards)						
Dr Mike Wilkinson - Acting Medical Director (April 2014 - 26 September 2014)	70-75			10-15	0	80-85
Rachael Corser - Interim Director of Nursing, Midwifey & Patient Services (5 January 2015 onwards)						
Jane Bradley - Acting Director of Nursing, Midwifey & Patient Services (14 April 2014 - 2 Jan 2015)						
Suzie Loader - Director of Nursing, Midwifey & Patient Services (1 - 11 April 2014)	110-115				5-7.5	115-120
Simon Lazarus - Director of Finance	5-10				22.5-25	30-35
Charles Abolins - Director of Facilities & Capital Development	85-90				0	85-90
Janine Brennan - Director of Workforce and Transformation	110-115				15-17.5	125-130
Chris Pallot - Director of Strategy & Partnerships	95-100				30-32.5	125-130
Catherine Thorne - director of Corporate Developement, Governance & Assurance (19 January 2015 onwards)						
Phil Zeidler - Non-Executive Director (Vice Chairman)	5-10					5 - 10
Nicholas Robertson - Non-Executive Director	5-10	900				5 - 10
Graham Kershaw - Non-Executive Director	5-10	1,300				5 - 10
David Noble - Non-Executive Director	5-10					5 - 10
Elizabeth Searle - Non-Executive Director	5-10					5 - 10

Salary Notes

Sonia Swart's 2013-14 Salary includes Clinical Work undertaken whilst Medical Director from April - June 2013
Deborah Needham & Rebecca Brown's 2013/14 Salary includes the salary paid as Care Group Manager whilst Joint Acting Chief Operating Officer. 2013/14 represent part year from October 2013 - March 2014
Michael Cusack received a relocation package of £5k. This was paid exempt of Tax & NICs in accordance with HMRC guidelines
Mike Wilkinson's Salary includes salary paid for Clinical Work undertaken, 'Long term Performance Pay & Bonuses' represents Clinical Excellence Award. 2013/14 represents part year from October 2013 - March 2014
Suzie Loader's 2014/15 salary represents April - October 2014 and includes salary paid whilst on secondment as Nurse Advisor for the 'The Shape of Caring' Project. This was a national project chaired by Lord Willis. 2013/14 represents a full year
Simon Lazarus' 2013/14 salary represents March 2014 only
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.

Pension Benefits

Name and title	Real increase in pension at age 60 (bands of £2,500)	Real increase in pension lump sum at age 60 (bands of £2,500)	Total acrued pension at age 60 at 31 March 2015 (bands of £5,000)	Lump sum at age 60 related to accured pension at 31 March 2015 (bands of £5,000)	Cash Equivalent Transfer Value at 1 April 2014	Real increase in Cash Equivalent Transfer Value	Cash Equivent Transfer Value at 31 March 2015	Employer's contibution to stakeholder pension
	£000	£000	£000	£000	£000	£000	£000	£000
Dr Sonia Swart - Chief Executive Officer	N/A	N/A	N/A	N/A	N/A	N/A	N/A	0
Deborah Needham - Chief Operating Officer (10 April 2014 onwards) Deputy Chief Excutive Officer (2 February 2015 onwards) / Joint Acting Chief Operating Officer (1 -9 April 2014)	10-12.5	30-32.5	35-40	105-110	342	160	511	0
Rebecca Brown - Joint Acting Chief Operating Officer (1-9 April 2014)	0	0	20-25	65-70	392	0	384	0
Michael Cusack - Medical Director(29 September 2014 onwards)	5-7.5	15-17.5	40-45	120-125	472	101	681	0
Dr Mike Wilkinson - Acting Medical Director (April 2014 - 26 September 2014)	0-2.5	0-2.5	40-45	125-130	805	15	857	0
Rachael Corser - Interim Director of Nursing, Midwifey & Patient Services (5 January 2015 onwards)	0-2.5	0-2.5	10-15	35-40	146	6	173	0
Jane Bradley - Acting Director of Nursing, Midwifey & Patient Services (14 April 2014 - 2 Jan 2015)	7.5-10	22.5-25	30-35	95-100	387	146	599	0
Suzie Loader - Director of Nursing, Midwifey & Patient Services (1 - 11 April 2014)	0-2.5	0-2.5	35-40	115-120	644	2	712	0
Simon Lazarus - Director of Finance	5-7.5	17.5-20	30-35	90-95	398	111	520	0
Charles Abolins - Director of Facilities & Capital Development	2.5-5	12.5-15	50-55	155-160	N/A	N/A	N/A	0
Janine Brennan - Director of Workforce and Transformation	0	0	40-45	130-135	784	17	822	0
Chris Pallot - Director of Strategy & Partnerships	0-2.5	2.5-5	20-25	70-75	327	24	360	0
Catherine Thorne - director of Corporate Developement, Governance & Assurance (19 January 2015 onwards)	0	0-2.5	30-35	105-110	588	5	629	0

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

A Cash Equivalent Transfer Value (CETV) is the actuarially assessed capital value of the pension scheme benefits accrued by a member at a particular point in time. The benefits valued are the member's accrued benefits and any contingent spouse's (or other allowable beneficiary's) pension payable from the scheme. A CETV is a payment made by a pension scheme, or arrangement to secure pension benefits in another pension scheme or arrangement when the member leaves a scheme and chooses to transfer the benefits accrued in their former scheme. The pension figures shown relate to the benefits that the individual has accrued as a consequence of their total membership of the pension scheme, not just their service in a senior capacity to which the disclosure applies. The CETV figures and the other pension details include the value of any pension benefits in another scheme or arrangement which the individual has transferred to the NHS pension scheme. They also include any additional pension benefit accrued to the member as a result of their purchasing additional years of pension service in the scheme at their own cost.

CETVs are calculated in accordance with the Occupational Pensions Schemes (Transfer Values) Regulations 2008.

The NHS Pensions Agency has used the most recent set of actuarial factors produced by the Government Actuary's Department (GAD) with effect from 8 December 2011. Therefore, the GAD factors used for calculation of CETV as at 31 March 2012 are different from those used as at 31 March 2011. This is not in strict compliance with the Manual for Accounts for NHS bodies which requires the real increase in the CETV to be calculated using common market valuation factors for the start and end of the period.
Real Increase in CETV - This reflects the increase in CETV effectively funded by the employer. It takes account of the increase in accrued pension due to inflation, contributions paid by the employee (including the value of any benefits transferred from another pension scheme or arrangement) and uses common market valuation factors for the start and end of the period.
A rate of 2.70% Consumer Price Index (CPI) annual inflation has been used to calculate the real increases/ decreases. This is the current CPI applied to pensions from 7th April 2014

No lump sum is shown for employees who only have membership in the 2008 Section of the NHS Pension Scheme.
No CETV is shown for pensioners, members over 60 (1995 Section) or members over 65 (2008 Section)

Off-Payroll Engagements Table 1

For all off-payroll engagements as of 31 March 2015, for more than £220 per day and that last longer than six months

Narrative	Number
Number of existing engagements as of 31 March 2015	**6**
Of which, the number that have existed:	
for less than one year at the time of reporting	**2**
for between 1 and 2 years at the time of reporting	**0**
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	**4**

Confirmation that all existing off-payroll engagements have at some point been subject to a risk based assessment as to whether assurance is required that the individual is paying the right amount of tax and, where necessary, that assurance has been sought.

Off-Payroll Engagements Table 2

For all new off-payroll engagements between 1 April 2014 and 31 March 2015, for more than £220 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 2014 and 31 March 2015	**2**
Number of new angagements which include contractual clauses giving the Trust the right to request assurance in relation to income tax and National Insurance obligations	**0**
Number for whom assurance has been requested	**2**
Of Which	**0**
assurance has been received	**2**
assurance has not been received	**0**
engagement terminated as a result of assurance not being received	**0**

number of off-payroll engagements of board members, and/or senior officers with significant financial responsibility, during the year	**0**

Number of individuals that have been deemed “board members, and/or senior officers with significant finanical responsibility” during the financial year. This figure includes both off-payroll and on-payroll engagements	**10**

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 2014-15 was £225-230k (2013-14, £215-220k). This was 10.07 times (2013-14, 9.41 times) the median remuneration of the workforce, which was £23k (2013-14, £23k).

In 2014-15 and 2013-14 no employees received remuneration in excess of the highest-paid director.

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 increased in 2014/15 by 0.66. The highest-paid director’s salary has increased due to the full year effect of the position held. Healthcare assistants and other support staff represent the largest increase in Total Average Staff Numbers. This has contributed to the reduction in the overall median remuneration of the workforce.

Northampton General Hospital NHS
NHS Trust

Section 4

Annual Accounts

Annual Accounts

STATEMENT OF THE CHIEF EXECUTIVE'S RESPONSIBILITIES AS THE ACCOUNTABLE OFFICER OF THE TRUST

The Chief Executive of the NHS Trust Development Authority has designated that the Chief Executive should be the Accountable Officer to the trust. The relevant responsibilities of Accountable Officers are set out in the Accountable Officers Memorandum issued by the Chief Executive of the NHS Trust Development Authority. 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 with the approval of the Treasury 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 **28 May 2015**

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 the 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, 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.

By order of the Board

Dr Sonia Swart
Date **28 May 2015** Chief Executive

Simon Lazarus
Date **28 May 2015** Finance Director

Annual Governance Statement

1. Scope of Responsibility

As Accountable Officer, I am responsible for maintaining a sound system of internal control that supports the achievement of the 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 Trust is administered prudently and economically and that resources are applied efficiently and effectively.

I acknowledge my responsibilities as set out in the Accountable Officer Memorandum, including in relation to the production of statutory accounts, effective management systems and regularity and propriety of expenditure.

As Chief Executive I am accountable to the Trust Board. I am also responsible, via the NHS Accounting Officer, to Parliament for the stewardship of resources within the Trust

2. Governance Framework of the Organisation

The Trust's governance framework and system of internal control is designed to manage risk to a reasonable level rather than 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 organisation's policies, aims and objectives and
- Evaluate the likelihood of those risks being realised and the impact should they be realised, and to manage them efficiently, effectively and economically

During 2015 the system of control and risk management process was modified to support a new organisational operational structure and improve risk management and assurance mechanisms. This provides important context for the commentary and associated assessment which follows.

Trust Board and Committee Structure

Northampton General Hospital NHS Trust has a Board of Directors (the Board) which compromises both Executive and Non-Executive Directors and has met monthly throughout the year.
Voting members comprise the Chair and five non-Executive Directors and five Executive Directors, including the Chief Executive.

The role of the Board is to govern the organisation effectively and in doing so to build public and stakeholder confidence that their health and healthcare is in safe hands and ensure the Trust is providing safe, high quality patient – centred care.

The Board holds its meetings in public bi monthly and papers are available on the Trust website. The Board regularly reviews performance against national standards and regulatory requirements and a summary of performance against these priorities is available through the Trust's Annual report. The Board places a strong emphasis on quality and safety of patient

care and in addition to performance reports, regularly hears directly from patients and carers, including patient stories and ward visits.

The Trust Board approved the organisation's Quality Account in June 2014, further to review by the Quality Governance Committee. The accuracy of the Quality Account is assured through internal review and data checking processes as part of the Trust's data quality arrangements. The Trust's External Auditors also undertook an audit of the Quality Account and the findings are being taken into account for the production of this year's Quality Account which is due to be agreed by the Board in June 2015.

The Board has reviewed its effectiveness against the Board Governance Framework and will repeat this exercise in quarter 1 of next year to ascertain progress and further areas for development. An output of recent Board governance reviews has been a re-casting of the Trust Board subcommittee structure with revised terms of reference to strengthen assurance functions across committees.

In January 2015 the Board commenced a development programme which will be ongoing throughout 2015. An early diagnostic phase has included a review of both Board and committee effectiveness using one to one interviews with Board members, observation of meetings and a review of the Trust's Quality Governance and assurance arrangements.

The finding have informed the full development programme which started in February 2015.

The principle committees of the Trust Board which support it in undertaking its responsibilities are:

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 the Quality Governance committee.

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.

Finance Investment and Performance Committee

The Finance Investment and Performance committee undertakes on behalf of the Trust Board objective scrutiny of the Trust's financial plans, investment policy and major investment decisions.
Additionally it is responsible for overseeing the delivery of all key performance metrics for finance and operational delivery. The committee reviews the Trust's monthly financial and operational performance and identifies key issues and risks requiring discussion or decision by the Trust Board.

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.

Remuneration and Appointments Committee

The Remuneration and Appointments committee has delegated authority from the Board to appoint and remove the Chief Executive and together with the Chief Executive to appoint and remove other Directors. In addition, it sets the remuneration, allowances and other terms and conditions of office for the Trust's Executive Directors.

Charitable Funds Committee

The Charitable Funds Committee acts on behalf of the Corporate Trustee, in accordance with the Northampton General Hospital NHS Trust Standing Orders to oversee the charity's operation and to ensure that the administration of charitable funds is distinct from its exchequer funds.

Name	Position	Date of Commencing Appointment	Board Record of Attendance	Membership of Board Committees					
				Audit Committee	Quality Governance Committee	Finance Investment & Performance Committee	Workforce Committee	Remuneration and Appointments Committee	Charitable Funds Committee
Paul Farenden	Non- Executive Director, Chair	1.3.12	90%		x	x	x	x	
Phil Zeidler	Non- Executive Director, Vice Chair	1.12.08	70%			x		x	x
David Noble	Non- Executive Director	1.1.13	90%	x	x	x		x	x
Liz Searle	Non- Executive Director	1.1.13	80%		x			x	
Graham Kershaw	Non- Executive Director	1.3.13	80%	x	x		x	x	
Nick Robertson	Non- Executive Director	1.2.09	70%	x			x	x	x
Sonia Swart	CEO	23.9.13	90%		x	x	x		
Debbie Needham	Chief Operating Officer	10.4.14	90%		x	x	x		
Catherine Thorne	Director Corporate Development Governance and Assurance	19.1.15	100%	Attend	x		x		
Simon Lazarus	Director of Finance	11.3.14	100%	Attend	x	x			
Janine Brennan	Director of Workforce and Transformation	2.4.13	90%		x	x	x		
Charles Abolins	Director of Facilities	29.11.10	80%		x	x	x		
Chris Pallot	Director of Strategy and Partnerships	11.10.10	90%		x	x			
Jane Bradley*	Interim Director of Nursing	14.4.14	90%						
Rachael Corser	Interim Director of Nursing	5.1.15	100%		x	x	x		
Mike Wilkinson**	Interim MD	23.10.13	100%						
Mike Cusack	Medical Director	26.9.14	90%		x		x		

**Stepped down 2.1.2015*

***Stepped down 26.9.2014*

Annual Governance Statement

Organisational Principal risks

1. Risk of suboptimal standards of care and patient experience related to difficulties in recruiting to substantive nursing posts across the organisation.

2. Risk of suboptimal standards of care and patient experience, in addition to a failure to meet national performance targets, due to high demand on emergency and urgent care services.

3. Risk of failing to meet emergency and urgent care demand and failing to meet national performance targets due to large numbers of delayed transfers of care leading to shortages in bed capacity.

4. Risk of systems failures related in relation to the Trusts' estate due to aging infrastructure

5. Risk of suboptimal standards of care and patient experience related to difficulties in recruiting to the medical workforce posts across the organisation.

6. Risk that Trust may not meet its statutory duties in relation to financial controls due to increased demand and activity, particularly related to emergency pathway pressures.

7. Risk of suboptimal standards of care and patient experience due to increased demand on cancer pathways together with late referrals

8. Risk of not meeting cost improvement targets due to organisational pressure, poor organisational and stakeholder engagement causing slippage in programme schemes.

9. Risk of action by the ICO for failure of staff to comply with Trust systems and processes which ensure compliance with confidentiality of person identifiable information.

3. The risk and control framework and risk assessment

As designated accountable Officer I have overall responsibility for risk management with specific responsibilities delegated to other Executive Directors and senior managers within the organisation.

Risk Management Framework

The trust has a comprehensive Risk Management Strategy and Policy which has Board approval and is available to staff via the Trust's intranet pages.

These documents describe the Trust's overall risk management strategy, responsibilities for risk at each level of the organisation, the risk management process and the Trust's risk identification, evaluation and control system.

The leadership and governance framework for risk management is as follows:

- The Audit Committee meets 4-5 times annually and oversees the overall performance of the risk management system. Additionally the Trust's Board-level Quality Governance committee on a monthly basis and monitors reviews and reports on the quality of services provided by the Trust. It provides assurance to the Audit Committee and the Trust Board that effective governance, risk management and internal control systems are in place to ensure that the Trust's services deliver safe, high quality, patient-centred care. Key risks are highlighted to and reviewed by the Trust Board both as part of its regular monitoring of performance and in the context of specific issues that may arise.

  In addition there is a bi annual meeting of the Quality Governance, Finance and Investment and Audit committee to cross reference risk and assurance from respective areas across the Trust

- The Trust has a Risk Group which was chaired during 2013/14 by the Medical Director and provides executive oversight of risk management issues. The Risk Group is responsible for ensuring the development and implementation of effective systems and processes for risk management at each level of the Trust.
  The Risk Group reviews the Trust's corporate risk register on an ongoing basis. All new risks with a proposed score of 15 and above ('Significant') are reviewed by the Risk Group who also undertakes a monthly review of corporate directorate and Divisional / Directorate risks with a score of 12 ('High') and above and those risks with high consequence but low likelihood.

- 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 ever at every level in the organisation and the aggregation of results at a corporate level.

- The Director of Strategy and Partnerships 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.

- For 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 within the Divisions, including management of the Divisional risk register supported the Divisional manager. The Divisional management groups have responsibility for monitoring, managing and where necessary escalating risks on their risk registers.

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 feedback to Divisions and corporate directorates via a central monitoring database with Human Resources which allows corrective action to be taken by management teams as required and throughout the year we have aimed to improve attendance rates.

Board Assurance Framework (BAF)

Throughout 2014/15 and continuing into 2015/16 the organisation is reviewing processes for developing the BAF and risk management processes and has recruited a Director of Corporate Development, Governance and Assurance to continue this work. The internal Audit opinion in 2014/15 provided substantial assurance to the Board on processes related to the use of the BAF.

The BAF based around the Trust's strategic objectives and is mapped to the Care Quality Commission Essential Standards of Quality and Safety. 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.

It also details some gaps in control and assurance in relation to the risks, including strategic objectives related to service delivery, workforce, finance, service transformation, 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 reviewed and updated monthly by the Executive Director leads and in addition each risk is allocated to a Trust Board assurance committee for monitoring and oversight. It is presented to the Board quarterly. It is also crossed referenced to the Corporate Risk Register The Trust's principal risks can be found listed in Appendix 1.

Internal Audit

During the year the Trust engaged TiAA Ltd as its Internal Auditors, taking over from the Central England Audit Consortium which was dis-banded in September 2014.
TiAA have integrated successfully with the Trust and have made progress in completing the original internal audit programme as agreed at the start of the financial year.

Counter Fraud

Northampton General Hospital NHS Trust Local Counter Fraud service ensures an annual plan of proactive work to minimise the risk of fraud within the Trust and is fully compliant with NHS Protect Counter Fraud Standards for providers. Preventative measures include reviewing Trust policies to ensure they are fraud-proof utilising intelligence, best practice and guidance from NHS Protect.

The Trust is committed to promoting and maintaining an absolute standard of honesty and integrity, and to eliminating fraud and illegal acts committed within the Trust and detection exercises are undertaken where a known area is at high risk of fraud.

Fraud is deterred by publicising proven cases of NHS fraud and staff are encouraged to report suspicions of fraud through utilising communications, presentations and fraud awareness literature throughout the Trust's sites. The Local Counter Fraud Specialist liaises with Internal Audit in order to capture any fraud risks from internal audits undertaken within the Trust. Counter Fraud reports are presented to the Audit and Risk Committee and include details of reported suspicions of fraud in addition to actual fraud.

Stakeholder involvement in risk

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 Trust's Patient Forum, 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 Boards.
  - Meetings of the Trust Board held in public which include monthly Patient Stories.
  - A Shadow Council of Governors
  - An extensive volunteering programme across hospital sites
  - A Patient & Public Engagement Network to ensure engagement is managed effectively with people that wish to be involved given opportunities throughout the organisation.
  - A dedicated and committed group of ward audit volunteers who conduct surveys and audits on behalf of the Trust
  - The National Patient Survey Programme and the results of Real Time Feedback through the Friends and Family Test available on wards, and through the NGH external website.
  - Representation on the Patient & Carer Experience and Engagement Group (PCEEG) from Health Watch and internal focus groups (such as BME, Dignity, end of life)

- **Staff**
  - Staff workshop to inform Board on visions and values
  - Strong focus on encouraging staff to raise concerns
  - Board to Ward visits by Executive and non-Executive Directors
  - Monthly Core Brief to staff by Executive team
  - Partnership forum with staff-side representation
  - Staff Engagement Strategy that includes specific vehicle through which staff views are sought on key matters

- **Partners**
  - Regular performance discussions with commissioners and the TDA
  - Shadow Council of Governors
  - Weekly Operations Executive Meeting comprising the Chief Executive Officers of Health and Social Care partners across the Northamptonshire County.
  - Healthier Northamptonshire - a countywide, multi partner forum for transformation delivery

Compliance matters

The trust has a Equality and Human Rights Strategy, that was adopted in 2013 and is due for review in April 2016, together with a
4 year Equality and Diversity Plan. We also produce an Annual report and an Annual Equality and Human Rights Monitoring report.

There is a Staff Equality and Diversity group that reports into the workforce committee and a patient group

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 in to 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.

Northampton General Hospital NHS Trust has undertaken risk assessments and Carbon Reduction Delivery Plans are in place in accordance with emergency preparedness and civil contingency requirements, as based on UKCIP 2009 weather projects, to ensure that this organisation's obligations under the Climate Change Act and the Adaptation Reporting requirements are complied with. Adaptation reporting uses a risk assessment approach in conjunction with resilience planning founded on weather-based risks e.g. heat wave, extreme cold, drought, flood.

Details of noncompliance with the Care Quality Commission's Essential Standards of Quality and Safety can be found in Section 4 below.

Information Governance (IG)

Northampton General Hospital NHS Trust is committed to ensuring it manages all the information it holds and processes in an efficient, effective and secure manner through the application of robust IG policies and procedures to support the delivery of high quality patient care. The IG team also run a series of audits and checks across the organisation to ensure compliance.

The Trust has had three data security breaches during the year which have been reported to the Information Commissioners Office and details are included within section 4.

Quality Account

The Trust produces an annual Quality Account which outlines its main Quality Priorities for the year and includes specific statements related Assurance and the Trust's performance against national standards.

The indicators within this document are subject to external audit scrutiny and they are required to provide a limited assurance opinion to the organisation.

The Trust received a qualified Limited assurance opinion in respect to its last Quality Account. Data quality assurance around the Friends and Family Test (FFT) had been the trigger for this qualified Limited Assurance by external audit in 2013-14. The area was therefore re-audited by internal audit during 2014-15; the review noted that Trust systems had improved and provided an overall opinion of substantial assurance for the area.

4. Review of the effectiveness of risk management and internal control

As Accountable Officer, I have responsibility for reviewing the effectiveness of the system of internal control. My review is informed in a number of ways.

The Head of Internal Audit provides me with an opinion on the overall arrangements for gaining assurance through the Assurance Framework and on the controls reviewed as part of Internal Audit's work.
The Head of Internal Audit Opinion for 2014/15 concludes in summary that:

"I am satisfied that sufficient internal audit work has been undertaken to allow me to draw a reasonable conclusion as to the adequacy and effectiveness of Northampton General Hospital NHS Trust's internal control processes. In my opinion, ***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."*

However, the full opinion does note that there are some areas where improvements can be made in design or consistency of application which may increase the effectiveness of some controls to eliminate or mitigate risks to the achievement of some of the objectives. These include the audits where Limited assurance was given in:

- Procurement
- Information Governance Toolkit
- E- rostering

My review has been informed by

- Executives and managers within the organisation, who have responsibility for the development and maintenance of the system of risk management and internal control.
- Performance against national and local standards.
- The Trust's ongoing assessment of compliance with the CQC's Essential Standards of Quality and Safety.
- The findings of the comprehensive inspection of Northampton General Hospital NHS Trust by the Chief Inspector of Hospitals.
- The work of internal audit through the year. Details of the internal audit reports completed during 2014/15 and the level of assurance provided are set out in the head of internal audit opinion.
- Outcomes of the Trust's clinical audit programme.
- The results of external audits work on the Trust's annual accounts and local tailored performance management reviews.
- Patient and staff surveys and feedback and other sources of external scrutiny and accreditation including clinical peer review arrangements.

I have been advised on the implications of the result of my review of the effectiveness of the system of internal control by the Quality Governance Committee, Risk Management Group and the Audit Committee and a plan to address weaknesses and ensure continuous improvement of the system is in place. Key roles have been as follows:

- The Board has played a key role in reviewing risks to the delivery of the Trust's performance objectives through monthly monitoring and discussion of the Corporate Performance Report and detailed financial and quality and safety reports, and through

Board and committee reporting on progress against other strategic objectives.

- The Audit and Risk Committee has overseen the effectiveness of the risk management arrangements.
- The Risk Management Group has reviewed the Trust's risk register and the Board Assurance Framework and monitored key clinical and non-clinical risks highlighted by Trust committees and individual managers.
- Executive Directors have ensured that key risks have been highlighted and monitored within their functional areas and the necessary action taken to address them.
- Both Internal and External Audit have provided scrutiny and assurance in relation to governance and control arrangements across a wide range of the Trust's activities.

The Trust has identified the following significant control issues and the actions which have been or are being taken to address them.

Compliance with Care Quality Commission (CQC) Essential Standards of Quality and safety

Northampton General Hospital NHS Trust is registered with the Care Quality Commission and following the CQC Chief Inspector of Hospital's Inspection in January 2014 received an overall rating of 'Requires Improvement' and a Warning Notice for failure to comply with the relevant requirements of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 (the Regulated Activities Regulations 2010).

Immediate actions in response to the Warning Notice were taken and an action plan of improvements against the overall findings was developed and implemented during 2014/15.

The Trust was re-inspected on 23 September 2014 and the warning notice has subsequently been lifted.

Data Security

During the year there were three serious incidents involving personal data which were reported to the Information Commissioners Office (ICO).

All three incidents involved patient level information being sent to the CCG in an unsecure manner. As the CCG do not have the legal rights to patient level information from the Trust, this led to disclosure of patient confidential data to an unauthorised individual/Organisation. All incidents were graded as Level 2 on the Information Governance (IG) Toolkit Incident reporting tool.

The IG Team put together an action plan, working closely with the ICO caseworker in order to provide significant assurance of the Trust's IG agenda. Reminders and newly developed guidance were provided to staff and uploaded to the Trust's staff intranet. In addition the IG team ran an IG awareness week during October 2014; visiting wards, administrative areas, carrying out confidentiality spot checks and providing bespoke training sessions to departments. This is intended to now run as an annual event on the IG calendar.

The ICO concluded their investigations, deciding that the incidents were rapidly escalated and contained with the Trust taking appropriate remedial actions to learn lessons and minimise the risk of similar incidents in the future.

National Performance Standards

The Trust met the majority of national performance standards in 2014/15. However it underachieved on the standards for:

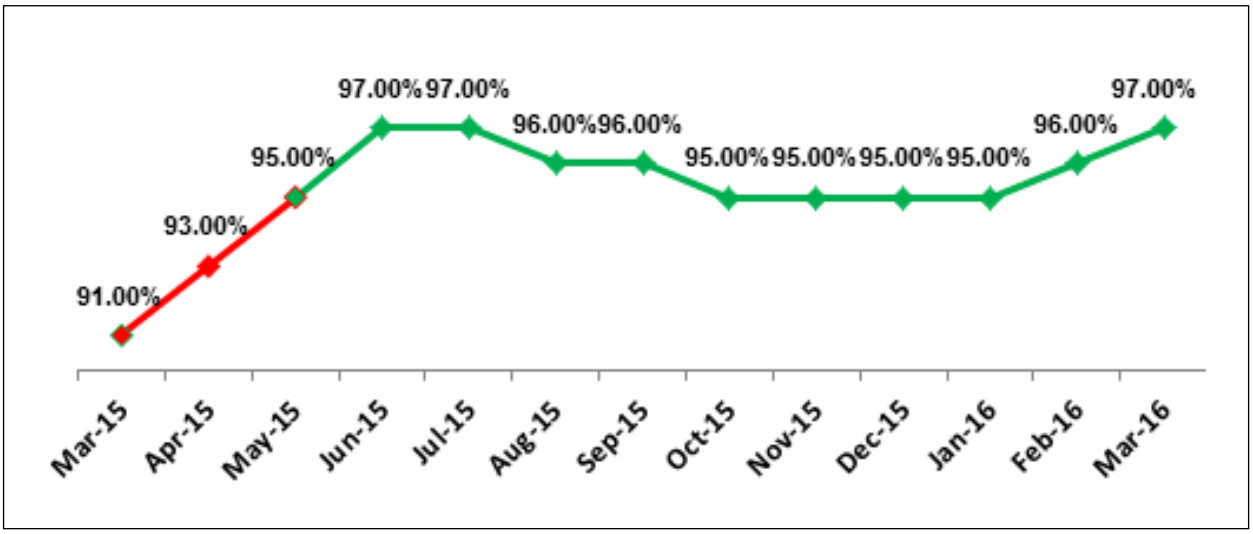
- **4Hr A&E standard**

This was another challenging year for the urgent and emergency care pathways for the Trust. The emergency department saw an additional 1519 patients, with 2235 more admissions than the previous year.

In addition to a high occupancy rate the Trust has struggled with regularly high numbers of delayed discharges, however whilst failing to meet the standard the Trust's performance for the 95% target has improved by 0.5% during 2014/15.

In March 2014 McKinsey were brought in to undertake a diagnostic piece of work to support improvements and this, together with organisational change to a more clinically led and accountable structure is expected to bring about further benefits

During 2015/16 the Trust is implementing a 'Changing Care @ NGH' Programme which will tackle multiple themes, again it is hoped this will support emergency care pathways and the proposed revised trajectory against the 95% target is displayed below



- **Cancer waiting times**
  - 31 day wait standard
  - 62 day wait standard

The Trust underwent a review by the Intensive Support Team who identified a range of measures to improve performance impacting on Cancer Waiting Time Standards.

A failure to recruit to consultant posts impacted on the capacity to meet demand for two week wait appointments and the Trust's ability to provide oncological treatment within the national cancer standards.

In addition theatre cancellations due to our HDU and diagnostic capacity and administration difficulties including late referrals from other Trusts also impacted on the 62 day and 31 day pathways.

The Trust has taken steps to recruit to permanent consultant positions, strengthened its Cancer Board and developed improved partnerships with neighbouring centres together with a broader Cancer Action Plan has assisted in improvements in achieving the national standards with a forecast trajectory predicting achievement by June 2015.

Never events

During the year Northampton General Hospital reported one incident that fell under the reporting category of Never Events.

This was as follows:

- Incorrect site surgery – Tonsillar Cyst removed from left tonsil rather than the right.

Financial Improvement Plan

Northampton General Hospital incurred a deficit position of £16.53 million during 2014/15.

There was an emergent risk within the year with a projected deficit position of approximately £20 million; however, on becoming aware of the position the Trust deployed a range of non-recurrent financial measures to mitigate the risk. The Trust applied to the Independent Financing Facility (ITFF) and was successful in securing £15.1m of PDC funding to meet the cash flow implications of the in-year deficit position

Throughout the year the organisation has also introduced revised arrangements to strengthen the delivery of quality and efficiency programmes for 2015/16 with a new Programme Management Office headed by the Director of Finance which will support delivery of work-streams through the new clinically led organisational structure.

The Trust is continuing to work to identify a medium term financial strategy aimed at returning the Trust to financial balance within five years.

Mandatory Training and Appraisal

The Trust has had a risk related to compliance with statutory and mandatory training and organisational appraisal compliance rates.

Following a comprehensive review a revised approach to Mandatory and Role specific training has been adopted was adopted.
Mandatory and role specific training compliance rates are now monitored via the Trust Board Workforce sub Committee and this has seen an improvement in compliance during the year from 65.14% to 79.92%.

In respect to staff appraisal a targeted approach has been adopted with an improved monitoring process this has seen an increase in compliance rates throughout the year from approximately 34% to 79%.

Nurse Recruitment

The national shortage of trained nurses poses a significant risk to the organisation. To mitigate this risk the Trust has implemented an “Overseas Nurses” recruitment programme.

In addition a revised staff retention strategy is being implemented in order to support our existing staff and reduce turnover rates.

Conclusion

With the exception of the internal control issues that I have outlined in this statement, my review confirms that Northampton General Hospital NHS Trust has a generally sound system of internal controls that supports the achievement of its policies, aims and objectives and that those control issues have been or are being addressed.

Dr Sonia Swart
Chief Executive

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

We have audited the financial statements of Northampton General Hospital NHS Trust for the year ended 31 March 2015 on pages 90 to 131. These financial statements have been prepared under applicable law and the accounting policies directed by the Secretary of State with the consent of the Treasury as relevant to NHS Trusts in England. We have also audited the information in the Remuneration Report that is subject to audit.

This report is made solely to the Board of Directors of Northampton General Hospital NHS Trust, as a body, in accordance with Part II of the Audit Commission Act 1998. 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.

Respective responsibilities of Directors and auditor

As explained more fully in the Statement of Directors' Responsibilities set out on page 70, the Directors are responsible for the preparation of financial statements which give a true and fair view. Our responsibility is to audit, and express an opinion on, the financial statements in accordance with applicable law and International Standards on Auditing (UK and Ireland). Those standards require us to comply with the Auditing Practices Board's Ethical Standards for Auditors.

Scope of the audit of the financial statements

An audit involves obtaining evidence about the amounts and disclosures in the financial statements sufficient to give reasonable assurance that the financial statements are free from material misstatement, whether caused by fraud or error. This includes an assessment of: whether the accounting policies are appropriate to the Trust's circumstances and have been consistently applied and adequately disclosed; the reasonableness of significant accounting estimates made by the Directors; and the overall presentation of the financial statements.

In addition we read all the financial and non-financial information in the annual report to identify material inconsistencies with the audited financial statements and to identify any information that is apparently materially incorrect based on, or materially inconsistent with, the knowledge acquired by us in the course of performing the audit. If we become aware of any apparent material misstatements or inconsistencies we consider the implications for our report.

Opinion on financial statements

In our opinion the financial statements:

- give a true and fair view of the financial position of the Trust as at 31 March 2015 and of the Trust's expenditure and income 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 relevant to NHS Trusts in England.

Opinion on other matters prescribed by the Code of Audit Practice 2010 for local NHS bodies

In our opinion:

- the part of the Remuneration Report subject to audit has been properly prepared in accordance with the accounting policies directed by the Secretary of State with the consent of the Treasury as relevant to NHS Trusts in England; and

- the information given in the Strategic Report and Director's Report for the financial year for which the financial statements are prepared is consistent with the financial statements.

Matters on which we are required to report by exception

We have nothing to report in respect of the following matters where the Code of Audit Practice 2010 for local NHS bodies requires us to report to you if:

- in our opinion, the Governance Statement does not reflect compliance with the NHS Trust Development Authority guidance;

- any referrals to the Secretary of State have been made under section 19 of the Audit Commission Act 1998; or

- any matters have been reported in the public interest under the Audit Commission Act 1998 in the course of, or at the end of the audit.

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

Respective responsibilities of the Trust and auditor

The Trust is responsible for putting in place proper arrangements to secure economy, efficiency and effectiveness in its use of resources, to ensure proper

stewardship and governance, and to review regularly the adequacy and effectiveness of these arrangements.

We are required under Section 5 of the Audit Commission Act 1998 to satisfy ourselves that the Trust has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources. The Code of Audit Practice 2010 for local NHS bodies issued by the Audit Commission requires us to report to you our conclusion relating to proper arrangements, having regard to relevant criteria specified by the Audit Commission.

We report if significant matters have come to our attention which prevent us from concluding that the Trust has put in place proper arrangements for securing economy, efficiency and effectiveness in its use of resources. We are not required to consider, nor have we considered, whether all aspects of the Trust's arrangements for securing economy, efficiency and effectiveness in its use of resources are operating effectively.

Scope of the review of arrangements for securing economy, efficiency and effectiveness in the use of resources

We have undertaken our work in accordance with the Code of Audit Practice 2010 for local NHS bodies, having regard to the guidance on the specified criteria, published by the Audit Commission in October 2014, as to whether the Trust has proper arrangements for:

- securing financial resilience; and
- challenging how it secures economy, efficiency and effectiveness.

The Audit Commission has determined these two criteria as those necessary for us to consider under the Code of Audit Practice 2010 for local NHS bodies in satisfying ourselves whether the Trust put in place proper arrangements for securing economy, efficiency and effectiveness in its use of resources for the year ended 31 March 2015.

We planned and performed our work in accordance with the Code of Audit Practice 2010 for local NHS bodies. Based on our risk assessment, we undertook such work as we considered necessary to form a view on whether, in all material respects, the Trust had put in place proper arrangements to secure economy, efficiency and effectiveness in its use of resources.

Basis for qualified conclusion

In considering the Trust's arrangements for challenging how it secures financial resilience through financial planning, we identified that the Trust has delivered a deficit of £16.5m in 2014/15 and it has failed to deliver a number of operational targets for the year particularly the Accident and Emergency wait target. In addition, the Trust is budgeting for a £21.2m deficit in 2015/16.

Conclusion

On the basis of our work, having regard to the guidance on the specified criteria published by the Audit Commission in October 2014, with the exception of the matters reported in the basis for qualified conclusion paragraph above we are satisfied that, in all material respects, Northampton General Hospital NHS Trust put in place proper arrangements to secure economy, efficiency and effectiveness in its use of resources for the year ending 31 March 2015.

Certificate

We certify that we have completed the audit of the accounts of Northampton General Hospital NHS Trust in accordance with the requirements of the Audit Commission Act 1998 and the Code of Audit Practice 2010 for local NHS bodies issued by the Audit Commission.

Tony Crawley for and on behalf of KPMG LLP, Statutory Auditor

Chartered Accountants
1 Waterloo Way
Leicester
LE1 6LP

3 June 2015

Statement of Comprehensive Income for year ended 31 March 2015

	NOTE	2014-15 £000s	2013-14 £000s
Gross employee benefits	10.1	**(184,523)**	(179,692)
Other operating costs	8	**(101,621)**	(90,924)
Revenue from patient care activities	5	**242,451**	247,359
Other Operating revenue	6	**27,907**	29,535
Operating surplus/(deficit)		**(15,786)**	6,278
Investment revenue	12	**27**	33
Other gains and (losses)	13	**2**	6
Finance costs	14	**(22)**	(26)
Surplus/(deficit) for the financial year		**(15,779)**	6,291
Public dividend capital dividends payable		**(4,332)**	(4,188)
Transfers by absorption - gains		**0**	0
Transfers by absorption - (losses)		**0**	0
Net Gain/(loss) on transfers by absorption		**0**	0
Retained surplus/(deficit) for the year		**(20,111)**	2,103

Other Comprehensive Income	2014-15 £000s	2013-14 £000s
Impairments and reversals taken to the Revaluation Reserve	**0**	0
Net gain/(loss) on revaluation of property, plant & equipment	**701**	3,712
Net gain/(loss) on revaluation of intangibles	**0**	0
Net gain/(loss) on revaluation of financial assets	**0**	0
Other gain /(loss) (explain in footnote below)	**0**	0
Net gain/(loss) on revaluation of available for sale financial assets	**0**	0
Net actuarial gain/(loss) on pension schemes	**0**	0
Other Pension Remeasurements	**0**	0
Reclassification Adjustments		
On disposal of available for sale financial assets	**0**	0
Total Comprehensive Income for the year	**(19,410)**	5,815

Financial performance for the year		
Retained surplus/(deficit) for the year	**(20,111)**	2,103
Prior period adjustment to correct errors and other performance adjustments	0	0
IFRIC 12 adjustment (including IFRIC 12 impairments)	0	0
Impairments (excluding IFRIC 12 impairments)	**3,338**	(2,257)
Adjustments in respect of donated gov't grant asset reserve elimination	**248**	351
Adjustment re Absorption accounting	**0**	0
Adjusted retained surplus/(deficit)	**(16,525)**	197

IThe impairment cost of £3,338k relates to the in year revaluation of the new IT data centre (£344k) and the balance relates to the full site revaluation exercise undertaken as at April 2015 and is excluded from retained deficit and statutory breakeven in accordance with the DH Manual for Accounts, note 17 refers.

Donated asset net benefit of £248k (consisting of £542k donated depreciation less £294k donated additions) is excluded from retained surplus and statutory breakeven duty in accordance with the DH Manual for Accounts.

A transfer of community beds to Northamptonshire Healthcare Foundation Trust took place in April 2015, however there were no asset / liabilities transferred as part of this service.

Statement of Financial Position as at 31 March 2015

	NOTE	31 March 2014 £000s	31 March 2013 £000s
Non-current assets:			
Property, plant and equipment	15	**141,422**	141,113
Intangible assets	16	**1,828**	2,346
Investment property	18	**0**	0
Other financial assets		**0**	0
Trade and other receivables	22.1	**215**	236
Total non-current assets		**143,465**	143,695
Current assets:			
Inventories	21	**5,961**	5,136
Trade and other receivables	22.1	**11,126**	12,501
Other financial assets	23	**0**	0
Other current assets	24	**0**	0
Cash and cash equivalents	25	**1,114**	4,445
Total current assets		**18,201**	22,082
Non-current assets held for sale	26	**0**	0
Total current assets		**18,201**	22,082
Total assets		**161,666**	165,777
Current liabilities			
Trade and other payables	27	**(17,996)**	(18,402)
Other liabilities	28	**(721)**	(811)
Provisions	34	**(1,396)**	(2,338)
Borrowings	29	**(208)**	(285)
Other financial liabilities	30	**0**	0
DH revenue support loan	29	**0**	0
DH capital loan	29	**(159)**	0
Total current liabilities		**(20,480)**	(21,836)
Net current assets/(liabilities)		**(2,279)**	246
Non-current assets plus/less net current assets/liabilities		**141,186**	143,941
Non-current liabilities			
Trade and other payables	27	**0**	0
Other liabilities	28	**0**	0
Provisions	34	**(1,072)**	(1,384)
Borrowings	29	**(248)**	(341)
Other financial liabilities	30	**0**	0
DH revenue support loan	29	**0**	0
DH capital loan	29	**(1,431)**	0
Total non-current liabilities		**(2,751)**	(1,725)
Total Assets Employed:		**138,435**	142,216
FINANCED BY:			
Public Dividend Capital		**119,240**	103,611
Retained earnings		**(16,684)**	2,878
Revaluation reserve		**35,879**	35,727
Other reserves		**0**	0
Total Taxpayers' Equity:		**138,435**	142,216

Notes 1 to 41 which commence on page 88 form part of these accounts

The financial statements on pages 84 to 87 were approved by the Board on 28 May 2015 and signed on its behalf by

Dr Sonia Swart Date: 28 May 2015
Chief Executive

Statement of Changes in Taxpayers' Equity
For the year ending 31 March 2015

	Public Dividend capital	Retained earnings	Reval-uation reserve	Other reserves	Total reserves
	£000s	£000s	£000s	£000s	£000s
Balance at 1 April 2014	**103,611**	**2,878**	**35,727**	**0**	**142,216**
Changes in taxpayers' equity for 2014-15					
Retained surplus/(deficit) for the year	0	(20,111)	0	0	**(20,111)**
Net gain / (loss) on revaluation of property, plant, equipment	0	0	701	0	**701**
Net gain / (loss) on revaluation of intangible assets	0	0	0	0	**0**
Net gain / (loss) on revaluation of financial assets	0	0	0	0	**0**
Net gain / (loss) on revaluation of available for sale financial assets	0	0	0	0	**0**
Impairments and reversals	0	0	0	0	**0**
Other gains/(loss) (provide details below)	0	0	0	0	**0**
Transfers between reserves	0	549	(549)	0	**0**
Reclassification Adjustments					
Transfers to/(from) other bodies within the resource account boundary	0	0	0	0	**0**
Transfers between revaluation reserve & retained rarnings in respect of assets transferred under absorption	0	0	0	0	**0**
On disposal of available for sale financial assets	0	0	0	0	**0**
Reserves eliminated on dissolution	0	0	0	0	**0**
Originating capital for Trust established in year	0	0	0	0	**0**
New temporary and permanent PDC received - cash	26,129	0	0	0	**26,129**
New temporary and termanent PDC repaid in year	(10,500)	0	0	0	**(10,500)**
PDC written off	0	0	0	0	**0**
Transferred to NHS Foundation Trust	0	0	0	0	**0**
Other movements	0	0	0	0	**0**
Net actuarial gain/(loss) on pension	0	0	0	0	**0**
Other pensions remeasurement	0	0	0	0	**0**
Net recognised revenue/(expense) for the year	**15,629**	**(19,562)**	**152**	**0**	**(3,781)**
Balance at 31 March 2015	**119,240**	**(16,684)**	**35,879**	**0**	**138,435**
Balance at 1 April 2013	**100,115**	**(306)**	**32,487**	**609**	**132,905**
Changes in taxpayers' equity for the year ended 31 March 2014					
Retained surplus/(deficit) for the year	0	2,103	0	0	**2,103**
Net gain / (loss) on revaluation of property, plant, equipment	0	0	3,712	0	**3,712**
Net gain / (loss) on revaluation of intangible assets	0	0	0	0	**0**
Net gain / (loss) on revaluation of financial assets	0	0	0	0	**0**
Net gain / (loss) on revaluation of assets held for sale	0	0	0	0	**0**
Impairments and reversals	0	0	0	0	**0**
Other gains / (loss)	0	0	0	0	**0**
Transfers between reserves	0	1,081	(472)	(609)	**0**
Transfers under Modified Absorption Accounting - PCTs & SHAs	0	0	0	0	**0**
Transfers under Modified Absorption Accounting - Other Bodies	0	0	0	0	**0**
Reclassification Adjustments					
Transfers to/(from) Other Bodies within the Resource Account Boundary	0	0	0	0	**0**
Transfers between revaluation reserve & retained earnings reserve in respect of assets transferred under absorption	0	0	0	0	**0**
On disposal of available for sale financial assets	0	0	0	0	**0**
Reserves eliminated on dissolution	0	0	0	0	**0**
Originating capital for Trust established in year	0	0	0	0	**0**
New temporary and permanent PDC received - cash	3,496	0	0	0	**3,496**
	0	0	0	0	**0**
New PDC received/(repaid) - PCTs and SHAs legacy items paid for by DH					
New temporary and permanent PDC repaid in year	0	0	0	0	**0**
PDC written off	0	0	0	0	**0**
Transferred to NHS Foundation Trust	0	0	0	0	**0**
Other movements	0	**0**	**0**	**0**	**0**
Net actuarial gain/(loss) on pension	**0**	**0**	**0**	**0**	**0**
Other pension remeasurement	**0**	**0**	**0**	**0**	**0**
Net recognised revenue/(expense) for the year	**3,496**	**3,184**	**3,240**	**(609)**	**9,311**
Transfers between reserves in respect of modified absorption - PCTs & SHAs	**0**	**0**	**0**	**0**	**0**
Transfers between reserves in respect of modified absorption - Other Bodies	**0**	**0**	**0**	**0**	**0**
Balance at 31 March 2014	**103,611**	**2,878**	**35,727**	**0**	**142,216**

Statement of Cash Flows for the Year ended 31 March 2015
31 March 2014

	NOTE	**2014-15 £000s**	2013-14 £000s
Cash Flows from Operating Activities			
Operating Surplus/(Deficit)		**(15,786)**	6,278
Depreciation and Amortisation		**11,407**	10,425
Impairments and Reversals		**3,338**	(2,257)
Other Gains/(Losses) on foreign exchange		**0**	0
Donated Assets received credited to revenue but non-cash		**(149)**	(203)
Government Granted Assets received credited to revenue but non-cash		**0**	0
Interest Paid		**0**	0
Dividend (Paid)/Refunded		**(4,480)**	(4,246)
Release of PFI/deferred credit		**0**	0
(Increase)/Decrease in Inventories		**(825)**	(202)
(Increase)/Decrease in Trade and Other Receivables		**1,396**	(2,342)
(Increase)/Decrease in Other Current Assets		**0**	0
Increase/(Decrease) in Trade and Other Payables		**690**	2,869
(Increase)/Decrease in Other Current Liabilities		**(90)**	25
Provisions Utilised		**(835)**	(2,599)
Increase/(Decrease) in Provisions		**(430)**	1,516
Net Cash Inflow/(Outflow) from Operating Activities		**(5,764)**	9,264
Cash Flows from Investing Activities			
Interest Received		**27**	33
(Payments) for Property, Plant and Equipment		**(14,290)**	(11,794)
(Payments) for Intangible Assets		**(650)**	(858)
(Payments) for Investments with DH		**0**	0
(Payments) for Other Financial Assets		**0**	0
(Payments) for Financial Assets (LIFT)		**0**	0
Proceeds of disposal of assets held for sale (PPE)		**297**	6
Proceeds of disposal of assets held for sale (Intangible)		**0**	0
Proceeds from Disposal of Investment with DH		**0**	0
Proceeds from Disposal of Other Financial Assets		**0**	0
Proceeds from the disposal of Financial Assets (LIFT)		**0**	0
Loans Made in Respect of LIFT		**0**	0
Loans Repaid in Respect of LIFT		**0**	0
Rental Revenue		**0**	0
Net Cash Inflow/(Outflow) from Investing Activities		**(14,616)**	(12,613)
Net Cash Inform / (outflow) before Financing		**(20,380)**	(3,349)
Cash Flows from Financing Activities			
Public Dividend Capital Received		**26,129**	3,496
Public Dividend Capital Repaid		**(10,500)**	0
Loans received from DH - New Capital Investment Loans		**1,590**	0
Loans received from DH - New Revenue Support Loans		**0**	0
Other Loans Received		**118**	277
Loans repaid to DH - Capital Investment Loans Repayment of Principal		**0**	0
Loans repaid to DH - Revenue Support Loans		**0**	0
Other Loans Repaid		**(288)**	(320)
Cash transferred to NHS Foundation Trusts		**0**	0
Capital Element of Payments in Respect of Finance Leases and On-SoFP PFI and LIFT		**0**	0
Capital grants and other capital receipts (excluding donated / government granted cash receipts)		**0**	0
Net Cash Inflow/(Outflow) from Financing Activities		**17,049**	3,453
NET INCREASE/(DECREASE) IN CASH AND CASH EQUIVALENTS		**(3,331)**	104
Cash and Cash Equivalents (and Bank Overdraft) at Beginning of the Period		**4,445**	4,341
Effect of Exchange Rate Changes in the Balance of Cash Held in Foreign Currencies		**0**	0
Cash and Cash Equivalents (and Bank Overdraft) at year end		**1,114**	4,445

NOTES TO THE ACCOUNTS

1. Accounting Policies

The Secretary of State for Health has directed that the financial statements of NHS trusts shall meet the accounting requirements of the Department of Health Group Manual for Accounts, which shall be agreed with HM Treasury. Consequently, the following financial statements have been prepared in accordance with the DH Group Manual for Accounts 2014-15 issued by the Department of Health. The accounting policies contained in that manual 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 Manual for Accounts permits a choice of accounting policy, the accounting policy which 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 by the trust are described below. They have been applied consistently in dealing with items considered material in relation to the accounts.

1.1 Accounting convention

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

1.1.1 Basis of accounting – going concern

As described in the Directors' Report of the Annual Report, the current financial environment for many NHS Trusts is unprecedented. The Trust has incurred a deficit of £16.5m in 2014-15 with the recurrent nature of the financial position has led the Board to agree a deficit plan of £21.2m for the 2015/16 financial year. In so doing, the Directors have considered the impact of incurring a deficit in terms of cash flow and have included a requirement for additional cash borrowing of £21.4m in the annual NHS Trust Development Agency (NTDA) plan submission.

The Board of Directors has concluded that the Trust is able to demonstrate that it is a going concern on the following basis;

- Agreement of the 2015/16 annual plan and key assumptions with the NHS Trust Development Authority.
- The Trust has signed service contracts with CCGs and Specialised Commissioners for 2015/16 which demonstrate the continuation of the provision of a service in the future. Importantly the Trust has agreed a PBR compliant contract under the Enhanced Tariff Option with its lead Clinical Commissioning Group reducing significantly reducing exposure to the marginal rate emergency tariff in 2015/16.
- The Department of Health and NHS Trust Development Agency have confirmed arrangements for accessing cash financing for organisations that have submitted a deficit plan for 2015/16. The NTDA's Accountability Framework sets out the process where an NHS Trust will be assisted to develop and agreement of a formal recovery plan to address deficit positions.
- The NTDA have issued guidance to the NHS Trusts stating that the reporting of an actual or planned deficit should not; in themselves trigger difficulties in respect of the concept of going concern. The NTDA has put in place arrangements to ensure that organisations can demonstrate continuity of service through the contract agreement process with NHS England. Where organisations have reported a deficit, an escalation process is in place. Access to cash financing will also be available in certain circumstances, this will also, provide further assurance of the continuing nature of funding available to the organisation.
- Robust arrangements are in place for the delivery of cost improvement plans supported by a revised governance and accountability framework to ensure delivery.
- For the period ended 31st March 2015, the Trust has a cumulative deficit of £9.3m (3.5%) for the purposes of calculating the statutory NHS breakeven duty. The Trust must therefore recover this deficit over the next two financial years (or a longer period where agreed by the TDA) to avoid breaching the Statutory Breakeven duty in 2017/18.

In preparing the annual plan for 2015/16 the Directors have considered a range of risks to the financial position, notably the identification of a robust CIP programme in and a medium term financial recovery plan. The Board remains reasonably confident that the plan will be delivered, enabling on-going operations to continue. After making enquiries, and considering the uncertainties described above, the Directors have a reasonable expectation that the Trust will have access to adequate cash resources through the TDA to continue in operational existence for the foreseeable future.

1.2 Acquisitions and discontinued operations

Activities are considered to be 'acquired' only if they are taken on from outside the public sector. Activities are considered to be 'discontinued' only if they cease entirely. They are not considered to be 'discontinued' if they transfer from one public sector body to another.

1.3 Movement of assets within the DH Group

"Transfers as part of reorganisation fall to be accounted for by use of absorption accounting in line with the Treasury FReM. The FReM does not require retrospective adoption, so prior year transactions (which have been accounted for under merger accounting) have not been restated. Absorption accounting requires that entities account for their transactions in the period in which they took place, with no restatement of performance required when functions transfer within the public sector. Where assets and liabilities transfer, the gain or loss resulting is recognised in the SOCNE/ SOCNI, and is disclosed separately from operating costs.

Other transfers of assets and liabilities within the Group are accounted for in line with IAS20 and similarly give rise to income and expenditure entries.

For transfers of assets and liabilities from those NHS bodies that closed on 1 April 2013, Treasury agreed that a modified absorption approach should be applied. For these transactions and only in the prior-period, gains and losses are recognised in reserves rather than the SOCNE/SOCNI."

1.4 Charitable Funds

Under the provisions of IFRS10 Consolidated and Separate Financial Statements, those Charitable Funds that fall under common control with NHS bodies are consolidated within the entity's financial statements. In accordance with IAS 1 Presentation of Financial Statements, restated prior period accounts are presented where the adoption of the new policy has a material impact.

The Trust has decided not to consiloidate the charity on the basis of materiality.

1.5 Critical accounting judgements and key sources of estimation uncertainty

In the application of the NHS trust's accounting policies, management is required to make judgements, estimates and assumptions about the carrying amounts of assets and liabilities that are not readily apparent from other sources. The estimates and associated assumptions are based on historical experience and other factors that are considered to be relevant. Actual results may differ from those estimates and the estimates and underlying assumptions are continually reviewed. Revisions to accounting estimates are recognised in the period in which the estimate is revised if the revision affects only that period or in the period of the revision and future periods if the revision affects both current and future periods.

1.5.1 Critical judgements in applying accounting policies

The following are the critical judgements, apart from those involving estimations (see below) that management has made in the process of applying the NHS trust's 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;
Selection of indices for land and building valuations;
All lease liabilities have been identified through a review of contract documentation.

1.5.2 Key sources of estimation uncertainty

The following are the key assumptions concerning the future, and other key sources of estimation uncertainty at the end of the reporting period, that have a significant risk of causing 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

Further details of these estimations are given with each related note to the Accounts.

1.6 Revenue

Revenue in respect of services provided is recognised when, and to the extent that, performance occurs, and is measured at the fair value of the consideration receivable. The main source of revenue for the trust is from commissioners for healthcare services. Revenue relating to patient care spells that are part-completed at the year end are apportioned across the financial years on the basis of length of stay at the end of the reporting period compared to expected total length of stay using the financial year's case-mix and tariff rules.

Where income is received for a specific activity that is to be delivered in the following year, that income is deferred.

The NHS 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 e.g. by an insurer. The NHS trust recognises the income when it receives notification from the Department of Work and Pension's Compensation Recovery Unit that the individual has lodged a compensation claim. The income is measured at the agreed tariff for the treatments provided to the injured individual, less a provision for unsuccessful compensation claims and doubtful debts.

The majority of income from sale of goods relates to the resale of pharmaceuticals. These are sold in accordance with individual service level agreements or other specific arrangements.

1.7 Employee Benefits

Short-term employee benefits

Salaries, wages and employment-related payments are recognised in the period in which the service is received from employees. The cost of leave earned but not taken by employees at the end of the period is recognised in the financial statements. This is calculated on a sample based estimation of accrued leave not taken and permitted to be carried forward into the following financial year.

Retirement benefit costs

Past and present employees are covered by the provisions of the NHS Pensions Scheme. The scheme is an unfunded, defined benefit scheme that covers NHS employers, General Practices and other bodies, allowed under the direction of the Secretary of State, in England and Wales. The scheme is not designed to be run in a way that would enable NHS bodies to identify their share of the underlying scheme assets and liabilities. Therefore, the scheme is accounted for as if it were a defined contribution scheme: the cost to the NHS body of participating in the scheme is taken as equal to the contributions payable to the scheme for the accounting period.

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

1.8 Other expenses

Other operating expenses are recognised when, and to the extent that, the goods or services have been received. They are measured at the fair value of the consideration payable.

1.9 Property, plant and equipment

Recognition

Property, plant and equipment is capitalised if:

- 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 will be supplied to the NHS Trust;
- it is expected to be used for more than one financial year;
- the cost of the item can be measured reliably; and
- 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 a cost of more than £250, where the assets are functionally interdependent, they had broadly simultaneous purchase dates, are anticipated to have simultaneous disposal dates and are under single managerial control; or
- 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 own useful economic lives.

Valuation

All property, plant and equipment are measured initially at cost, representing the cost 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 fair value.

Land and buildings used for the Trust's services or for administrative purposes are stated in the statement of financial position at their revalued amounts, being the fair value at the date of revaluation less any subsequent accumulated depreciation and impairment losses.

Revaluations are performed with sufficient regularity to ensure that carrying amounts are not materially different from those that would be determined at the end of the reporting period. Fair values are determined as follows:

- Land and non-specialised buildings – market value for existing use
- Specialised buildings – depreciated replacement cost

HM Treasury has adopted a standard approach to depreciated replacement cost valuations based on modern equivalent assets and, where it would meet the location requirements of the service being provided, an alternative site can be valued.

Properties in the course of construction for service or administration purposes are carried at cost, less any impairment loss. Cost includes professional fees but not borrowing costs, which are recognised as expenses immediately, as allowed by IAS 23 for assets held at fair value. Assets are revalued and depreciation commences when they are brought into use.

Fixtures and equipment are carried at fair value, with the carrying value of existing assets written off over their remaining useful lives. The Trust only indexes equipment where the asset life is greater than 5 years, using the CHAZ index, which is RPI less housing costs.

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. Impairment losses that arise from a clear consumption of economic benefit should be taken to expenditure. Gains and losses recognised in the revaluation reserve are reported as other comprehensive income in the Statement of Comprehensive Income.

Subsequent expenditure

Where subsequent expenditure enhances an asset beyond its original specification, the directly attributable cost is capitalised. Where subsequent expenditure restores the asset to its original specification, the expenditure is capitalised and any existing carrying value of the item replaced is written-out and charged to operating expenses.
bodies to identify their share of the underlying scheme assets and liabilities. Therefore, the scheme is accounted for as if it were a defined contribution scheme: the cost to the NHS body of participating in the scheme is taken as equal to the contributions payable to the scheme for the accounting period.

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

1.10 Intangible assets

Recognition

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

Intangible assets acquired separately are initially recognised at fair value. Software that is integral to the operating of hardware, for example an operating system, is capitalised as part of the relevant item of property, plant and equipment. Software that is not integral to the operation of hardware, for example application software, is capitalised as an intangible asset. Expenditure on research is not capitalised: it is recognised as an operating expense in the period in which it is incurred. Internally-generated assets are recognised if, and only if, all of the following have been demonstrated:

- the technical feasibility of completing the intangible asset so that it will be available for use
- the intention to complete the intangible asset and use it
- the ability to sell or use the intangible asset
- how the intangible asset will generate probable future economic benefits or service potential
- the availability of adequate technical, financial and other resources to complete the intangible asset and sell or use it
- the ability to measure reliably the expenditure attributable to the intangible asset during its development

Measurement

The amount initially recognised for internally-generated intangible assets is the sum of the expenditure incurred from the date when the criteria above are initially met. Where no internally-generated intangible asset can be recognised, the expenditure is recognised in the period in which it is incurred.

Following initial recognition, intangible assets are carried at fair value by reference to an active market, or, where no active market exists, at amortised replacement cost (modern equivalent assets basis), indexed for relevant price increases, as a proxy for fair value. Internally-developed software is held at historic cost to reflect the opposing effects of increases in development costs and technological advances.

1.11 Depreciation, amortisation and impairments

Freehold land, properties under construction, and assets held for sale are not depreciated.

Otherwise, depreciation and amortisation are charged to write off the costs or valuation of property, plant and equipment and intangible non-current assets, less any residual value, over their estimated useful lives, in a manner that reflects the consumption of economic benefits or service potential of the assets. The estimated useful life of an asset is the period over which the NHS trust expects to obtain economic benefits or service potential from the asset. This is specific to the NHS trust and may be shorter than the physical life of the asset itself. Estimated useful lives and residual values are reviewed each year end, with the effect of any changes recognised on a prospective basis. Assets held under finance leases are depreciated over their estimated useful lives

At each reporting period end, the NHS trust checks whether there is any indication that any of its tangible or intangible non-current assets have suffered an impairment loss. If there is indication of an impairment loss, the recoverable amount of the asset is estimated to determine whether there has been a loss and, if so, its amount. Intangible assets not yet available for use are tested for impairment annually.

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. Impairment losses that arise from a clear consumption of economic benefit should be taken to expenditure. Where an impairment loss subsequently reverses, the carrying amount of the asset is increased to the revised estimate of the recoverable amount but capped at the amount that would have been determined had there been no initial impairment loss. The reversal of the impairment loss is credited to expenditure to the extent of the decrease previously charged there and thereafter to the revaluation reserve.

Impairments are analysed between Departmental Expenditure Limits (DEL) and Annually Managed Expenditure (AME). This is necessary to comply with Treasury's budgeting guidance. DEL limits are set in the Spending Review and Departments may not exceed the limits that they have been set. AME budgets are set by the Treasury and may be reviewed with departments in the run-up to the Budget. Departments need to monitor AME closely and inform Treasury if they expect AME spending to rise above forecast. Whilst Treasury accepts that in some areas of AME inherent volatility may mean departments do not have the ability to manage the spending within budgets in that financial year, any expected increases in AME require Treasury approval.

1.12 Donated assets

Donated non-current assets are capitalised at their fair value on receipt, with a matching credit to Income. They are valued, depreciated and impaired as described above for purchased assets. Gains and losses on revaluations, impairments and sales are as described above for purchased assets. Deferred income is recognised only where conditions attached to the donation preclude immediate recognition of the gain.

1.13 Government grants

The value of assets received by means of a government grant are credited directly to income. Deferred income is recognised only where conditions attached to the grant preclude immediate recognition of the gain.

1.14 Non-current assets held for sale

Non-current assets are classified as held for sale if their carrying amount will be recovered principally through a sale transaction rather than through continuing use. This condition is regarded as met when the sale is highly probable, the asset is available for immediate sale in its present condition and management is committed to the sale, which is expected to qualify for recognition as a completed sale within one year from the date of classification. Non-current assets held for sale are measured at the lower of their previous carrying amount and fair value less costs to sell. Fair value is open market value including alternative uses.

The profit or loss arising on disposal of an asset is the difference between the sale proceeds and the carrying amount and is recognised in the Statement of Comprehensive Income. On disposal, the balance for the asset on the revaluation reserve is transferred to retained earnings. For donated and government-granted assets, a transfer is made to or from the relevant reserve to the profit/loss on disposal account so that no profit or loss is recognised in income or expenses. The remaining surplus or deficit in the donated asset or government grant reserve is then transferred to retained earnings.

Property, plant and equipment that is to be scrapped or demolished does not qualify for recognition as held for sale. Instead, it is retained as an operational asset and its economic life is adjusted. The asset is de-recognised when it is scrapped or demolished.

1.15 Leases

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

The trust as lessee

Property, plant and equipment held under finance leases are initially recognised, at the inception of the lease, at fair value or, if lower, at the present value of the minimum lease payments, with a matching liability for the lease obligation to the lessor. Lease payments are apportioned between finance charges and reduction of the lease obligation so as to achieve a constant rate on interest on the remaining balance of the liability. Finance charges are recognised in calculating the trust's surplus/deficit.

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.

Where a lease is for land and buildings, the land and building components are separated and individually assessed as to whether they are operating or finance leases.

The NHS trust as lessor

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

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 on a straight-line basis over the lease term.

1.16 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.

1.17 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 NHS trust's cash management.

1.18 Provisions

Provisions are recognised when the Trust has a present legal or constructive obligation as a result of a past event, it is probable that the Trust will be required to settle the obligation, and a reliable estimate can be made of the amount of the obligation. The amount recognised as a provision is the best estimate of the expenditure required to settle the obligation at the end of the reporting period, taking into account the risks and uncertainties. Where a provision is measured using the cash flows estimated to settle the obligation, its carrying amount is the present value of those cash flows using HM Treasury's applicable discount rate in real terms (1.8% for employee early departure obligations).

When some or all of the economic benefits required to settle a provision are expected to be recovered from a third party, the receivable is recognised as an asset if it is virtually certain that reimbursements will be received and the amount of the receivable can be measured reliably.

A restructuring provision is recognised when the Trust has developed a detailed formal plan for the restructuring and has raised a valid expectation in those affected that it will carry out the restructuring by starting to implement the plan or announcing its main features to those affected by it. The measurement of a restructuring provision includes only the direct expenditures arising from the restructuring, which are those amounts that are both necessarily entailed by the restructuring and not associated with ongoing activities of the entity.

1.19 Clinical negligence costs

The NHS Litigation Authority (NHSLA) operates a risk pooling scheme under which the trust pays an annual contribution to the NHSLA which in return settles all clinical negligence claims. The contribution is charged to expenditure. Although the NHSLA is administratively responsible for all clinical negligence cases the legal liability remains with the NHS trust'. The total value of clinical negligence provisions carried by the NHSLA on behalf of the trust is disclosed at note 34.

1.20 Non-clinical risk pooling

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

1.21 Carbon Reduction Commitment Scheme (CRC)

CRC and similar allowances are accounted for as government grant funded intangible assets if they are not expected to be realised within twelve months, and otherwise as other current assets. They are valued at open market value. As the NHS body makes emissions, a provision is recognised with an offsetting transfer from deferred income. The provision is settled on surrender of the allowances. The asset, provision and deferred income amounts are valued at fair value at the end of the reporting period.

1.22 Contingencies

A contingent liability is a possible obligation that arises from past events and whose existence will be confirmed only by the occurrence or non-occurrence of one or more uncertain future events not wholly within the control of the NHS trust, or a present obligation that is not recognised because it is not probable that a payment will be required to settle the obligation or the amount of the obligation cannot be measured sufficiently reliably. A contingent liability is disclosed unless the possibility of a payment is remote.

A contingent asset is a possible asset that arises from past events and whose existence will be confirmed by the occurrence or non-occurrence of one or more uncertain future events not wholly within the control of the Trust. A contingent asset is disclosed where an inflow of economic benefits is probable.

Where the time value of money is material, contingencies are disclosed at their present value.

1.23 Financial assets

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

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

Financial assets at fair value through profit and loss
The Trust has not identified any Financial Assets at fair value through profit and loss. Should any of these be identified in the future, further disclosures will be given.

Held to maturity investments

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

Available for sale financial assets

The Trust has not identified any Available for sale financial assets. Should any of these be identified in the future, further disclosures will be given.

1.24 Financial liabilities

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

Loans from the Department of Health are recognised at historical cost. Otherwise, financial liabilities are initially recognised at fair value.

1.25 Value Added Tax

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

1.26 Foreign currencies

The Trust's functional currency and presentational currency is sterling. Transactions denominated in a foreign currency are translated into sterling at the exchange rate ruling on the dates of the transactions. At the end of the reporting period, monetary items denominated in foreign currencies are retranslated at the spot exchange rate on 31 March. Resulting exchange gains and losses for either of these are recognised in the trust's surplus/deficit in the period in which they arise.

1.27 Third party assets

Assets belonging to third parties (such as money held on behalf of patients) are not recognised in the accounts since the trust has no beneficial interest in them. Details of third party assets are given in Note 41 to the accounts.

1.28 Public Dividend Capital (PDC) and PDC dividend

Public dividend capital represents taxpayers' equity in the NHS trust. 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. As PDC is issued under legislation rather than under contract, it is not treated as an equity financial instrument.

An annual charge, reflecting the cost of capital utilised by the trust, is payable to the Department of Health as public dividend capital dividend. The charge is calculated at the real rate set by HM Treasury (currently 3.5%) on the average carrying amount of all assets less liabilities (except for donated assets and cash balances with the Government Banking Service). The average carrying amount of assets is calculated as a simple average of opening and closing relevant net assets.

1.29 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 NHS Trusts not been bearing their own risks (with insurance premiums then being included as normal revenue expenditure). However, the note on losses and special payments is compiled directly from the losses and compensations register which reports amounts on an accruals basis with the exception of provisions for future losses.

1.30 Subsidiaries

Material entities over which the NHS trust has the power to exercise control are classified as subsidiaries and are consolidated. The NHS trust has control when it is exposed to or has rights to variable returns through its power over another entity. The income and expenses; gains and losses; assets, liabilities and reserves; and cash flows of the subsidiary are consolidated in full into the appropriate financial statement lines. Appropriate adjustments are made on consolidation where the subsidiary's accounting policies are not aligned with the NHS trust or where the subsidiary's accounting date is not co-terminus.

Subsidiaries that are classified as 'held for sale' are measured at the lower of their carrying amount or 'fair value less costs to sell'.

From 2013-14, there is a requirement for Trust's to consolidate the results of Charitable Funds over which it is deemed to exercise control, under IAS27 requirements, however the Trust has decided not to consolidate on the basis of materiality.

1.31 Associates

Material entities over which the NHS trust has the power to exercise significant influence so as to obtain economic or other benefits are classified as associates and are recognised in the NHS trust's accounts using the equity method. The investment is recognised initially at cost and is adjusted subsequently to reflect the NHS trust share of the entity's profit/loss and other gains/losses. It is also reduced when any distribution is received by the NHS trust from the entity.

Associates that are classified as 'held for sale' are measured at the lower of their carrying amount or 'fair value less costs to sell'. The Trust has not identified any Associates. Should any of these be identified in the future, further disclosures will be given.

1.32 Joint arrangements

Material entities over which the NHS trust has joint control with one or more other entities are classified as joint arrangements. Joint control is the contractually agreed sharing of control of an arrangement. A joint arrangement is either a joint operation or a joint venture.

A joint operation exists where the parties that have joint control have rights to the assets and obligations for the liabilities relating to the arrangement. Where the NHS body is a joint operator it recognises its share of, assets, liabilities, income and expenses in its own accounts. The Trust has not identified any joint operations. Should any of these be identified in the future, further disclosures will be given.

A joint venture is a joint arrangement whereby the parties that have joint control of the arrangement have rights to the net assets of the arrangement. Joint ventures are recognised as an investment and accounted for using the equity method. The Trust has not identified any joint ventures. Should any of these be identified in the future, further disclosures will be given. The Trust has not identified any Joint Arrangements. Should any of these be identified in the future, further disclosures will be given.

1.33 Accounting Standards that have been issued but have not yet been adopted

The Treasury FReM does not require the following Standards and Interpretations to be applied in 2014-15. The application of the Standards as revised would not have a material impact on the accounts for 2014-15, were they applied in that year :
IFRS 9 Financial Instruments - subject to consultation
IFRS 13 Fair Value Measurement - subject to consultation
IFRS 15 Revenue from Contracts with Customers

2. Pooled budgets

Northampton General Hospital NHS Trust does not have any pooled budget arrangements.

3. Operating segments

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

4. Income generation activities

The Trust has no formal registered income generation schemes.

For the purpose of reporting Catering and Non-staff car parking are treated as income generation activities. The combined income and costs of these schemes are shown below.

Summary Table - aggregate of all schemes	**2014-15 £000s**	2013-14 £000s
Income	**2,427**	2,273
Full cost	**1,129**	1,085
Surplus/(deficit)	**1,298**	1,188

5. Revenue from patient care activities

	2014-15 £000s	2013-14 £000s
NHS Trusts	**0**	0
NHS England	**40,637**	46,717
Clinical Commissioning Groups	**199,139**	197,455
Foundation Trusts	**253**	276
Department of Health	**0**	0
NHS Other (including Public Health England and Prop Co)	**0**	107
Additional income for delivery of healthcare services	**0**	0
Non-NHS:		
Local Authorities	**0**	0
Private patients	**901**	1,097
Overseas patients (non-reciprocal)	**203**	280
Injury costs recovery	**1,318**	1,427
Other	**0**	0
Total Revenue from patient care activities	**242,451**	247,359

In 2013/14 Revenue from patient care activities included £4,500k funding from NHS England relating to specific non-recurrent items.

6. Other operating revenue

	2014-15 £000s	2013-14 £000s
Recoveries in respect of employee benefits	**3,230**	3,661
Patient transport services	**0**	0
Education, training and research	**10,278**	10,370
Charitable and other contributions to revenue expenditure - NHS	**0**	166
Charitable and other contributions to revenue expenditure -non- NHS	**232**	0
Receipt of donations for capital acquisitions - Charity	**294**	203
Support from DH for mergers	**0**	0
Receipt of Government grants for capital acquisitions	**0**	0
Non-patient care services to other bodies	**2,077**	2,126
Income generation	**2,427**	2,273
Rental revenue from finance leases	**0**	18
Rental revenue from operating leases	**28**	34
Other revenue	**9,341**	10,684
Total Other Operating Revenue	**27,907**	29,535
Total operating revenue	**270,358**	276,894

Other revenue includes :
Pharmacy Sales £5,828k (£7,081k)
Accommodation Charges £477k (£427k)
Provision of Services to private hospitals £402k (£395k)

7. Revenue

	2013-14 £000	2012-13 £000
Income recognised during 2014-15 (invoiced amounts and accruals)	**203**	280
Cash payments received in-year (re receivables at 31 March 2014)	**45**	7
Cash payments received in-year (iro invoices issued 2014-15)	**46**	51
Amounts added to provision for impairment of receivables (re receivables at 31 March 2014)	**42**	133
Amounts added to provision for impairment of receivables (iro invoices issued 2014-15)	**148**	0
Amounts written off in-year (irrespective of year of recognition)	**146**	77

8. Operating expenses	2013-14 £000s	2012-13 £000s
Services from other NHS Trusts	**8**	61
Services from CCGs/NHS England	**0**	0
Services from other NHS bodies	**0**	0
Services from NHS Foundation Trusts	**1,224**	956
Total Services from NHS bodies*	**1,232**	1,017
Purchase of healthcare from non-NHS bodies	**2,842**	2,026
Trust Chair and Non-executive Directors	**55**	55
Supplies and services - clinical	**57,801**	55,512
Supplies and services - general	**3,258**	3,269
Consultancy services	**1,527**	548
Establishment	**2,936**	2,941
Transport	**218**	179
Service charges - ON-SOFP PFIs and other service concession arrangements	**0**	0
Service charges - On-SOFP LIFT contracts	**0**	0
Total charges - Off-SOFP PFIs and other service concession arrangements	**0**	0
Total charges - Off-SOFP LIFT contracts	**0**	0
Business rates paid to local authorities	**746**	726
Premises	**7,319**	7,535
Hospitality	**5**	15
Insurance	**220**	227
Legal Fees	**320**	306
Impairments and Reversals of Receivables	**618**	845
Inventories write down	**100**	73
Depreciation	**10,358**	9,459
Amortisation	**1,049**	966
Impairments and reversals of property, plant and equipment	**3,338**	(2,257)
Impairments and reversals of intangible assets	**0**	0
Impairments and reversals of financial assets [by class]	**0**	0
Impairments and reversals of non current assets held for sale	**0**	0
Audit fees	**72**	93
Other auditor's remuneration [detail]	**36**	51
Clinical negligence	**5,895**	5,913
Research and development (excluding staff costs)	**0**	0
Education and Training	**639**	647
Change in Discount Rate	**0**	8
Other	**1,037**	770
Total Operating expenses (excluding employee benefits)	**101,621**	90,924

Supplies & services clinical includes value of drugs including gases of £29,275k (£26,905k)

Other auditors remuneration includes :
KPMG £36k (£51k)
- Consultancy in relation to Salary Sacrifice Schemes £24k (£51k)
- Quality Accounts Audit Fee £12k (£0k)

Other expenditure includes :
Translation Services £76k (£89k)
Internal Audit Fees £287k (£188k)
Home Oxygen Service £132k (£129k)
Professional Subscriptions £139k (£170k)

Employee Benefits		
Employee benefits excluding Board members	**183,237**	178,504
Board members	**1,286**	1,188
Total Employee Benefits	**184,523**	179,692
Total Operating Expenses	**286,144**	270,616

*Services from NHS bodies does not include expenditure which falls into a category below

9 Operating Leases

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 and pathology systems.

9.1 Trust as lessee	Land £000s	Buildings £000s	Other £000s	2014-15 Total £000s	2013-14 £000s
Payments recognised as an expense					
Minimum lease payments				**549**	511
Contingent rents				**0**	0
Sub-lease payments				**0**	0
Total				**549**	511
Payable:					
No later than one year	0	0	514	**514**	456
Between one and five years	0	0	658	**658**	1,243
After five years	0	0	0	**0**	0
Total	0	0	1,172	**1,172**	1,699
Total future sublease payments expected to be received:				0	0

9.2 Trust as lessor

An optician's shop operates on the Trust's site under an operating lease.

	2014-15 £000	2013-14 £000s
Recognised as revenue		
Rental revenue	28	34
Contingent rents	0	0
Total	**28**	34
Receivable:		
No later than one year	28	34
Between one and five years	0	0
After five years	0	0
Total	**28**	34

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.

The Trust is considering letting a concession to Northants Leisure Trust to run the leisure facilities situated at the CRIPPS centre from 1 May 2015.

10 Employee benefits and staff numbers

10.1 Employee benefits

	Total £000s	2014-15 Permanently employed £000s	Other £000s
Employee Benefits - Gross Expenditure			
Salaries and wages	**157,138**	141,107	16,031
Social security costs	**11,567**	11,567	0
Employer Contributions to NHS BSA - Pensions Division	**15,812**	15,812	0
Other pension costs	**6**	6	0
Termination benefits	**0**	0	0
Total employee benefits	**184,523**	**168,492**	**16,031**
Employee costs capitalised	**0**	0	0
Gross Employee Benefits excluding capitalised costs	**184,523**	**168,492**	**16,031**

Employee Benefits - Gross Expenditure 2012-13	Total £000s	Permanently employed £000s	Other £000s
Salaries and wages	152,258	141,119	11,139
Social security costs	11,586	11,586	0
Employer Contributions to NHS BSA - Pensions Division	15,758	15,758	0
Other pension costs	0	0	0
Termination benefits	90	90	0
TOTAL - including capitalised costs	179,692	168,553	11,139
Employee costs capitalised	0	0	0
Gross Employee Benefits excluding capitalised costs	179,692	168,553	11,139

In 2012-13 there were rows for 'other post-employment benefits' and 'other employment benefits'. These are now included within the 'Salaries and wages' row.

10.2 Staff Numbers

	2014-15			2013-14
	Total Number	**Permanently employed Number**	**Other Number**	Total Number
Average Staff Numbers				
Medical and dental	**509**	478	31	485
Ambulance staff	**0**	0	0	0
Administration and estates	**972**	939	33	938
Healthcare assistants and other support staff	**872**	872	0	883
Nursing, midwifery and health visiting staff	**1,415**	1,317	98	1,400
Nursing, midwifery and health visiting learners	**0**	0	0	0
Scientific, therapeutic and technical staff	**641**	616	25	654
Social Care Staff	**0**	0	0	0
Other	**0**	0	0	0
TOTAL	**4,409**	**4,222**	**187**	4,360
Of the above - staff engaged on capital projects	**0**	0	0	0

10.3 Staff Sickness absence and ill health retirements

	2014-15 Number	2013-14 Number
Total Days Lost	40,921	37,517
Total Staff Years	4,111	4,005
Average working Days Lost	9.95	9.37

	2014-15 Number	2013-14 Number
Number of persons retired early on ill health grounds	**2**	6
	£000s	£000s
Total additional pensions liabilities accrued in the year	**82**	153

10.4 Exit Packages agreed

Exit package cost band (including any special payment element)	2014-15 *Number of compulsory redundancies	2014-15 *Number of other departures agreed	2014-15 Total number of exit packages by cost band	2013-14 *Number of compulsory redundancies	2013-14 *Number of other departures agreed	2013-14 Total number of exit packages by cost band
	Number	**Number**	**Number**	Number	Number	Number
Less than £10,000	0	0	0	0	0	0
£10,000-£25,000	1	0	1	1	0	1
£25,001-£50,000	0	0	0	0	0	0
£50,001-£100,000	1	0	1	1	0	1
£100,001 - £150,000	0	0	0	0	0	0
£150,001 - £200,000	0	0	0	0	0	0
>£200,000	0	0	0	0	0	0
Total number of exit packages by type (total cost	**0**	**0**	**0**	2	0	2
Total resource cost (£s)	0	0	0	108,866	0	108,866

Redundancy and other departure costs have been paid in accordance with the provisions of the NHS Scheme. Exit costs in this note are accounted for in full in the year of departure. Where the Trust has agreed early retirements, the additional costs are met by the Trust and not by the NHS pensions scheme. Ill-health retirement costs are met by the NHS pensions scheme and are not included in the table.

This disclosure reports the number and value of exit packages agreed in the year. Note: The expense associated with these departures may have been recognised in part or in full in a previous period.

The Trust has no exit package costs in 2014/15.

10.5 Exit packages - Other Departures analysis

	2014-15 Agreements Number	2014-15 Total value of agreements £000s	2013-14 Agreements Number	2013-14 Total value of agreements £000s
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	0	0
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	0	0
Non-contractual payments made to individuals where the payment value was more than 12 months of their annual salary	0	0	0	0

This disclosure reports the number and value of exit packages agreed in the year. Note: the expense associated with these departures may have been recognised in part or in full in a previous period

As a single exit packages can be made up of several components each of which will be counted separately in this Note, the total number above will not necessarily match the total numbers in Note 10.4 which will be the number of individuals.

*includes any non-contractual severance payment made following judicial mediation, and relating to non-contractual payments in lieu of notice.

The Remuneration Report includes disclosure of exit payments payable to individuals named in that Report.

The Trust has no exit package costs in 2014/15.

10.6 Pension costs

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

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) Full actuarial (funding) valuation

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

The last published actuarial valuation undertaken for the NHS Pension Scheme was completed for the year ending 31 March 2012.

The Scheme Regulations allow contribution rates to be set by the Secretary of State for Health, with the consent of HM Treasury, and consideration of the advice of the Scheme Actuary and appropriate employee and employer representatives as deemed appropriate.

b) Accounting valuation

A valuation of the scheme liability is carried out annually by the scheme actuary 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 are accepted as providing suitably robust figures for financial reporting purposes. The valuation of the scheme liability as at 31 March 2015, is based on valuation data as 31 March 2014, updated to 31 March 2015 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 scheme actuary report, which forms part of the annual NHS Pension Scheme (England and Wales) Pension Accounts, published annually. These accounts can be viewed on the NHS Pensions website. Copies can also be obtained from The Stationery Office.

c) Scheme provisions

The NHS Pension Scheme provided defined benefits, which are summarised below. This list is an illustrative guide only, and is not intended to detail all the benefits provided by the Scheme or the specific conditions that must be met before these benefits can be obtained:

The Scheme is a "final salary" scheme. Annual pensions are normally based on 1/80th for the 1995 section and of the best of the last three years pensionable pay for each year of service, and 1/60th for the 2008 section of reckonable pay per year of membership. Members who are practitioners as defined by the Scheme Regulations have their annual pensions based upon total pensionable earnings over the relevant pensionable service.

With effect from 1 April 2008 members can choose to give up some of their annual pension for an additional tax free lump sum, up to a maximum amount permitted under HMRC rules. This new provision is known as "pension commutation".

Annual increases are applied to pension payments at rates defined by the Pensions (Increase) Act 1971, and are based on changes in retail prices in the twelve months ending 30 September in the previous calendar year. From 2011-12 the Consumer Price Index (CPI) has been used and replaced the Retail Prices Index (RPI).

Early payment of a pension, with enhancement, is available to members of the scheme who are permanently incapable of fulfilling their duties effectively through illness or infirmity. A death gratuity of twice final year's pensionable pay for death in service, and five times their annual pension for death after retirement is payable.

For early retirements other than those due to ill health the additional pension liabilities are not funded by the scheme. The full amount of the liability for the additional costs is charged to the employer.
Members can purchase additional service in the NHS Scheme and contribute to money purchase AVC's run by the Scheme's approved providers or by other Free Standing Additional Voluntary Contributions (FSAVC) providers.

11 Better Payment Practice Code

11.1 Measure of compliance	2014-15 Number	2014-15 £000s	2013-14 Number	2013-14 £000s
Non-NHS Payables				
Total Non-NHS Trade Invoices Paid in the Year	**91,221**	**107,061**	81,899	92,882
Total Non-NHS Trade Invoices Paid Within Target	**87,753**	**104,787**	74,920	87,974
Percentage of NHS Trade Invoices Paid Within Target	**96.20%**	**97.88%**	91.48%	94.72%
NHS Payables				
Total NHS Trade Invoices Paid in the Year	**2,214**	**18,835**	2,341	**20,478**
Total NHS Trade Invoices Paid Within Target	**2,085**	**18,234**	1,680	**18,359**
Percentage of NHS Trade Invoices Paid Within Target	**94.17%**	**96.81%**	71.76%	89.65%

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 a valid invoice, whichever is later.

11.2 The Late Payment of Commercial Debts (Interest) Act 1998	2013-14 £000s	2012-13 £000s
Amounts included in finance costs from claims made under this legislation	**0**	0
Compensation paid to cover debt recovery costs under this legislation	**0**	0
Total	**0**	0

12 Investment Revenue

	2014-15 £000s	2013-14 £000s
Rental revenue		
PFI finance lease revenue (planned)	**0**	0
PFI finance lease revenue (contingent)	**0**	0
Other finance lease revenue	**0**	0
Subtotal	**0**	0
Interest revenue		
LIFT: equity dividends receivable	**0**	0
LIFT: loan interest receivable	**0**	0
Bank interest	**15**	33
Other loans and receivables	**12**	0
Impaired financial assets	**0**	0
Other financial assets	**0**	0
Subtotal	**27**	33
Total investment revenue	**27**	33

13 Other Gains and Losses

	2014-15 £000s	2013-14 £000s
Gain/(Loss) on disposal of assets other than by sale (PPE)	**2**	6
Gain/(Loss) on disposal of assets other than by sale (intangibles)	**0**	0
Gain/(Loss) on disposal of Financial Assets other then held for sale	**0**	0
Gain (Loss) on disposal of assets held for sale	**0**	0
Gain/(loss) on foreign exchange	**0**	0
Change in fair value of financial assets carried at fair value through the SoCI	**0**	0
Change in fair value of financial liabilities carried at fair value through the SoCI	**0**	0
Change in fair value of investment property	**0**	0
Recycling of gain/(loss) from equity on disposal of financial assets held for sale	**0**	0
Total	**2**	6

14 Finance Costs

	2014-15 £000s	2013-14 £000s
Interest		
Interest on loans and overdrafts	**0**	0
Interest on obligations under finance leases	**0**	0
Interest on obligations under PFI contracts:		
- main finance cost	**0**	0
- contingent finance cost	**0**	0
Interest on obligations under LIFT contracts:		
- main finance cost	**0**	0
- contingent finance cost	**0**	0
Interest on late payment of commercial debt	**0**	0
Total interest expense	**0**	0
Other finance costs	**11**	11
Provisions - unwinding of discount	**11**	15
Total	**22**	26

15.1 Property, plant and equipment	Land	Buildings excluding dwellings	Dwellings	Assets under construction & payments on account	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
2013-14	**£000's**	**£000's**	**£000's**	**£000's**	**£000's**	**£000's**	**£000's**	**£000's**	**£000's**
Cost or valuation:									
At 1 April 2014	**20,100**	**106,288**	**586**	**5,174**	**39,745**	**56**	**14,325**	**391**	**186,665**
Additions of Assets Under Construction	0	0	0	5,684	0	0	0	0	**5,684**
Additions Purchased	0	3,439	0	0	2,521	6	1,680	0	**7,646**
Additions - Non Cash Donations (i.e. physical assets)	0	0	0	0	149	0	0	0	**149**
Additions - Purchases from Cash Donations & Government Grants	0	(9)	0	79	45	0	30	0	**145**
Additions Leased	0	0	0	0	0	0	0	0	**0**
Reclassifications	0	4,404	0	(6,012)	0	0	1,583	0	**(25)**
Reclassifications as Held for Sale and reversals	0	(308)	0	0	0	0	0	0	**(308)**
Disposals other than for sale	0	(432)	0	0	(4,200)	0	(751)	(216)	**(5,599)**
Revaluation	(170)	(12,177)	(10)	(1,222)	823	1	0	0	**(12,755)**
Impairments/negative indexation	0	0	0	0	0	0	0	0	**0**
Reversal of Impairments	0	0	0	0	0	0	0	0	**0**
Transfers to NHS Foundation Trust	0	0	0	0	0	0	0	0	**0**
Transfers (to)/from Other Public Sector Bodies under Absorption Accounting	0	0	0	0	0	0	0	0	**0**
At 31 March 2015	**19,930**	**101,205**	**576**	**3,703**	**39,083**	**63**	**16,867**	**175**	**181,602**
Depreciation									
At 1 April 2014	0	7,204	79	0	28,675	41	9,255	298	**45,552**
Reclassifications	0	0	0	0	0	0	0	0	**0**
Reclassifications as Held for Sale and reversals	0	(40)	0	0	0	0	0	0	**(40)**
Disposals other than for sale	0	(425)	0	0	(4,180)	0	(751)	(216)	**(5,572)**
Upward revaluation/positive indexation	(1)	(14,018)	(10)	0	572	1	0	0	**(13,456)**
Impairments	1	4,786	0	917	1	0	0	0	**5,705**
Reversal of Impairments	0	(2,268)	(99)	0	0	0	0	0	**(2,367)**
Charged During the Year	0	4,761	30	0	3,598	5	1,931	33	**10,358**
Transfers to NHS Foundation Trust	0	0	0	0	0	0	0	0	**0**
Transfers (to)/from Other Public Sector Bodies under Absorption Accounting	0	0	0	0	0	0	0	0	**0**
At 31 March 2015	**0**	**0**	**0**	**917**	**28,666**	**47**	**10,435**	**115**	**40,180**
Net Book Value at 31 March 2015	**19,930**	**101,205**	**576**	**2,786**	**10,417**	**16**	**6,432**	**60**	**141,422**

	Land	Buildings excluding dwellings	Dwellings	Assets under construction & payments on account	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
Asset financing:									
Owned - Purchased	19,930	94,469	576	2,786	9,889	16	6,400	12	**134,078**
Owned - Donated	0	6,736	0	0	528	0	32	48	**7,344**
Owned - Government Granted	0	0	0	0	0	0	0	0	**0**
Held on finance lease	0	0	0	0	0	0	0	0	**0**
On-SOFP PFI contracts	0	0	0	0	0	0	0	0	**0**
PFI residual: interests	0	0	0	0	0	0	0	0	**0**
Total at 31 March 2015	**19,930**	**101,205**	**576**	**2,786**	**10,417**	**16**	**6,432**	**60**	**141,422**

Revaluation Reserve Balance for Property, Plant & Equipment	Land	Buildings	Dwellings	Assets under construction & payments on account	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000's	**£000's**	**£000's**	**£000's**	**£000's**	**£000's**	**£000's**	**£000's**	**£000's**
At 1 April 2014									
Movements (specify)	11,241	23,388	0	0	1,093	2	0	3	**35,727**
At 31 March 2015	(169)	621	0	0	(296)	(1)	0	(3)	**152**
	11,072	**24,009**	**0**	**0**	**797**	**1**	**0**	**0**	**35,879**

Additions to Assets Under Construction in 2014/15

	£000's
Land	0
Buildings excl Dwellings	3,487
Dwellings	0
Plant & Machinery	2,197
Balance as at YTD	**5,684**

15.2 Property, plant and equipment prior-year	Land	Buildings excluding dwellings	Dwellings	Assets under construction & payments on account	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
2013-14	**£000's**	**£000's**	**£000's**	**£000's**	**£000's**	**£000's**	**£000's**	**£000's**	**£000's**
Cost or valuation:									
At 1 April 2013	20,100	97,950	553	546	38,217	87	13,727	509	**171,689**
Transfers under Modified Absorption Accounting - PCTs & SHAs	0	0	0	0	0	0	0	0	**0**
Transfers under Modified Absorption Accounting - Other Bodies	0	0	0	0	0	0	0	0	**0**
Additions of Assets Under Construction	0	0	0	6,243	0	0	0	0	**6,243**
Additions Purchased	0	4,098	0	0	2,028	0	1,270	12	**7,408**
Additions Donated	0	159	0	2	42	0	0	0	**203**
Additions Government Granted	0	0	0	0	0	0	0	0	**0**
Additions Leased	0	0	0	0	0	0	0	0	**0**
Reclassifications	0	333	0	(1,617)	187	0	1,097	0	**0**
Reclassifications as Held for Sale and reversals	0	0	0	0	0	0	0	0	**0**
Disposals other than for sale	0	0	0	0	(1,764)	(34)	(1,769)	(130)	**(3,697)**
Upward revaluation/positive indexation	0	3,748	33	0	1,035	3	0	0	**4,819**
Impairments/negative indexation	0	0	0	0	0	0	0	0	**0**
Reversal of Impairments	0	0	0	0	0	0	0	0	**0**
Transfers to NHS Foundation Trust	0	0	0	0	0	0	0	0	**0**
Transfers (to)/from Other Public Sector Bodies under Absorption Accounting	0	0	0	0	0	0	0	0	**0**
At 31 March 2014	**20,100**	**106,288**	**586**	**5,174**	**39,745**	**56**	**14,325**	**391**	**186,665**
Depreciation									
At 1 April 2013	0	4,708	40	0	26,453	56	9,286	397	**40,940**
Reclassifications	0	0	0	0	0	0	0	0	**0**
Reclassifications as Held for Sale and reversals	0	0	0	0	0	0	0	0	**0**
Disposals other than for sale	0	0	0	0	(1,764)	(34)	(1,769)	(130)	**(3,697)**
Upward revaluation/positive indexation	0	408	3	0	694	2	0	0	**1,107**
Impairments	0	0	0	0	0	0	0	0	**0**
Reversal of Impairments	0	(2,257)	0	0	0	0	0	0	**(2,257)**
Charged During the Year	0	4,345	36	0	3,292	17	1,738	31	**9,459**
Transfers to NHS Foundation Trust	0	0	0	0	0	0	0	0	**0**
Transfers (to)/from Other Public Sector Bodies under Absorption Accounting	0	0	0	0	0	0	0	0	**0**
At 31 March 2014	**0**	**7,204**	**79**	**0**	**28,675**	**41**	**9,255**	**298**	**45,552**
Net Book Value at 31 March 2014	20,100	99,084	507	5,174	11,070	15	5,070	93	**141,113**

	Land	Buildings excluding dwellings	Dwellings	Assets under construction & payments on account	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
Asset financing:									
Owned - Purchased	20,100	92,040	507	5,172	10,532	13	5,058	20	**133,442**
Owned - Donated	0	7,044	0	2	538	2	12	73	**7,671**
Owned - Government Granted	0	0	0	0	0	0	0	0	**0**
Held on finance lease	0	0	0	0	0	0	0	0	**0**
On-SOFP PFI contracts	0	0	0	0	0	0	0	0	**0**
PFI residual: interests	0	0	0	0	0	0	0	0	**0**
Total at 31 March 2014	**20,100**	**99,084**	**507**	**5,174**	**11,070**	**15**	**5,070**	**93**	**141,113**

15.3 (cont). Property, plant and equipment

Donated equipment to the value of £76k & other minor building work to the value of £70k were funded by NGH Charitable Fund and £149k of Clinical Simulation kit was funded by Health Education England.

Professional valuations are carried out by the District Valuers of the Revenue and Customs Government Dept.

The valuations are carried out in accordance with the Royal Institute of Chartered Surveyors (RICS) Appraisal and Valuation Manual, in so far as these terms are consistent with the agreed requirements of the Department of Health and HM Treasury.

A site revaluation exercise was undertaken in the current financial year with an effective date of 1 April 2015 for land and buildings and this valuation has been incorporated into these accounts, the next revaluation exercise is due in April 2018.

Equipment is depreciated on current cost evenly over the estimated life of the asset.

Plant & Machinery	5 - 15 years
Transport	7 years
I.T.	5 years
Furniture & Fittings	5 years

Where the useful economic life of an asset is reduced from that initially estimated due to the revaluation of an asset for sale, depreciation is charged to bring the value of the asset to its value at the point of sale.

The gross carrying amount of fully depreciated assets still in use is £21,045k (£21,547k)

16.1 Intangible non-current assets

2014-15	IT - in-house & 3rd party software	Computer Licenses	Licenses and Trademarks	Patents	Development Expenditure - Internally Generated	Total
	£000's	£000's	£000's	£000's	£000's	£000's
At 1 April 2014	**374**	**7,734**	**0**	**0**	**0**	**8,108**
Additions Purchased	0	506	0	0	0	**506**
Additions Internally Generated	0	0	0	0	0	**0**
Additions - Non Cash Donations (i.e. physical assets)	0	0	0	0	0	**0**
Additions - Purchases from Cash Donations and Government Grants	0	0	0	0	0	**0**
Additions Leased	0	0	0	0	0	**0**
Reclassifications	25	0	0	0	0	**25**
Reclassified as Held for Sale and Reversals	0	0	0	0	0	**0**
Disposals other than by sale	0	(274)	0	0	0	**(274)**
Revaluation & indexation gains	0	0	0	0	0	**0**
Impairments charged to reserves	0	0	0	0	0	**0**
Reversal of impairments charged to reserves	0	0	0	0	0	**0**
Transfer to NHS Foundation Trust	0	0	0	0	0	**0**
Transfer (to)/from Other Public Sector bodies under Absorption Accounting	0	0	0	0	0	**0**
At 31 March 2014	**399**	**7,966**	**0**	**0**	**0**	**8,365**
Amortisation						
At 1 April 2014	**181**	**5,581**	**0**	**0**	**0**	**5,762**
Reclassifications	0	0	0	0	0	**0**
Reclassified as Held for Sale and Reversals	0	0	0	0	0	**0**
Disposals other than by sale	0	(274)	0	0	0	**(274)**
Revaluation or indexation gains	0	0	0	0	0	**0**
Impairments charged to operating expenses	0	0	0	0	0	**0**
Reversal of impairments charged to operating expenses	0	0	0	0	0	**0**
Charged during the year	81	968	0	0	0	**1,049**
Transfer to NHS Foundation Trust	0	0	0	0	0	**0**
Transfer (to)/from Other Public Sector bodies under Absorption Accounting	0	0	0	0	0	**0**
At 31 March 2015	**262**	**6,275**	**0**	**0**	**0**	**6,537**
Net Book Value at 31 March 2015	**137**	**1,691**	**0**	**0**	**0**	**1,828**
Asset Financing: Net book value at 31 March 2015 comprises:						
Purchased	137	1,691	0	0	0	**1,828**
Donated	0	0	0	0	0	**0**
Government Granted	0	0	0	0	0	**0**
Finance Leased	0	0	0	0	0	**0**
On-balance Sheet PFIs	0	0	0	0	0	**0**
Total at 31 March 2015	**137**	**1,691**	**0**	**0**	**0**	**1,828**

Revaluation reserve balance for intangible non-current assets

	£000's	£000's	£000's	£000's	£000's	£000's
At 1 April 2014	0	0	0	0	0	**0**
Movements (specify)	0	0	0	0	0	**0**
At 31 March 2015	**0**	**0**	**0**	**0**	**0**	**0**

16.2 Intangible non-current assets prior year

2013-14	IT - in-house & 3rd party software	Computer Licenses	Licenses and Trademarks	Patents	Development Expenditure - Internally Generated	Total
	£000's	£000's	£000's	£000's	£000's	£000's
Cost or valuation:						
At 1 April 2013	395	7,290	0	0	0	7,685
Transfers under Modified Absorption Accounting - PCTs & SHAs	0	0	0	0	0	0
Transfers under Modified Absorption Accounting - Other Bodies	0	0	0	0	0	0
Additions - purchased	0	518	0	0	0	518
Additions - internally generated	0	0	0	0	0	0
Additions - donated	0	0	0	0	0	0
Additions - government granted	0	0	0	0	0	0
Additions Leased	0	0	0	0	0	0
Reclassifications	0	0	0	0	0	0
Reclassified as held for sale	0	0	0	0	0	0
Disposals other than by sale	(21)	(74)	0	0	0	(95)
Revaluation & indexation gains	0	0	0	0	0	0
Impairments	0	0	0	0	0	0
Reversal of impairments	0	0	0	0	0	0
Transfer to NHS Foundation Trust	0	0	0	0	0	0
Transfer (to)/from Other Public Sector bodies under Absorption Accounting	0	0	0	0	0	0
At 31 March 2014	374	7,734	0	0	0	8,108
Amortisation						
At 1 April 2013	124	4,767	0	0	0	**4,891**
Reclassifications	0	0	0	0	0	**0**
Reclassified as held for sale	0	0	0	0	0	**0**
Disposals other than by sale	(21)	(74)	0	0	0	**(95)**
Revaluation or indexation gains	0	0	0	0	0	**0**
Impairments charged to operating expenses	0	0	0	0	0	**0**
Reversal of impairments charged to operating expenses	0	0	0	0	0	**0**
Charged during the year	78	888	0	0	0	**966**
Transfer to NHS Foundation Trust	0	0	0	0	0	**0**
Transfer (to)/from Other Public Sector bodies under Absorption Accounting	0	0	0	0	0	**0**
At 31 March 2014	181	5,581	0	0	0	**5,762**
Net book value at 31 March 2014	**193**	**2,153**	**0**	**0**	**0**	**2,346**
Net book value at 31 March 2014 comprises:						
Purchased	193	2,153	0	0	0	**2,346**
Donated	0	0	0	0	0	**0**
Government Granted	0	0	0	0	0	**0**
Total at 31 March 2014	**193**	**2,153**	**0**	**0**	**0**	**2,346**

16.3 Intangible non-current assets

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

Intangible assets held for operational use are valued at historical cost and are depreciated over the estimated life of the asset on a straight line basis. The carrying value of intangible assets is reviewed for impairment at the end of the first full year following acquisition and in other periods if events or changes in circumstances indicate the carrying value may not be recoverable.

For the purpose of determining fair value historical cost is considered to be the most accurate basis considering the nature of software evolution and development.

Intangible Assets are depreciated on current cost evenly over the estimated life of the asset, which is determined on a case by case basis between 3 and 5 years.

The gross carrying amount of fully depreciated assets still in use is £3,684k (£3,412k)

17 Analysis of impairments and reversals recognised in 2014-15	2014-15 Total £000s
Property, Plant and Equipment impairments and reversals taken to SoCI	3,338
Loss or damage resulting from normal operations	0
Over-specification of assets	0
Abandonment of assets in the course of construction	0
Total charged to Departmental Expenditure Limit	**0**
Unforeseen obsolescence	0
Loss as a result of catastrophe	0
Other	0
Changes in market price	3,338
Total charged to Annually Managed Expenditure	**3,338**
Total Impairments of Property, Plant and Equipment changed to SoCI	**3,338**
Intangible assets impairments and reversals charged to SoCI	
Loss or damage resulting from normal operations	0
Over-specification of assets	0
Abandonment of assets in the course of construction	0
Total charged to Departmental Expenditure Limit	**0**
Unforeseen obsolescence	0
Loss as a result of catastrophe	0
Other	0
Changes in market price	0
Total charged to Annually Managed Expenditure	**0**
Total Impairments of Intangibles charged to SoCI	**0**
Financial Assets charged to SoCI	
Loss or damage resulting from normal operations	0
Total charged to Departmental Expenditure Limit	**0**
Loss as a result of catastrophe	0
Other	0
Total charged to Annually Managed Expenditure	**0**
Total Impairments of Financial Assets charged to SoCI	**0**
Non-current assets held for sale - impairments and reversals charged to SoCI.	
Loss or damage resulting from normal operations	0
Abandonment of assets in the course of construction	0
Total charged to Departmental Expenditure Limit	**0**
Unforeseen obsolescence	0
Loss as a result of catastrophe	0
Other	0
Changes in market price	0
Total charged to Annually Managed Expenditure	**0**
Total impairments of non-current assets held for sale charged to SoCI	**0**
Total Impairments charged to SoCI - DEL	**0**
Total Impairments charged to SoCI - AME	**3,338**
Overall Total Impairments	**3,338**
Donated and Gov Granted Assets, included above	
PPE - Donated and Government Granted Asset Impairments: amount charged to SOCI - DEL	(126)
Intangibles - Donated and Government Granted Asset Impairments: amount charged to SOCI - DEL	0

17 Analysis of impairments and reversals recognised in 2014-15

	Total	Property Plant and Equipment	Intangible Assets	Financial Assets	Non-Current Assets Held for Sale
	£000s	£000s	£000s	£000s	£000s
Impairments and reversals taken to SoCI					
Loss or damage resulting from normal operations	**0**	0	0	0	0
Over-specification of assets	**0**	0	0	0	0
Abandonment of assets in the course of construction	**0**	0	0	0	0
Total charged to Departmental Expenditure Limit	**0**	**0**	**0**	**0**	**0**
Unforeseen obsolescence	**0**	0	0	0	0
Loss as a result of catastrophe	**0**	0	0	0	0
Other	**0**	0	0	0	0
Changes in market price	**3,338**	3,338	0	0	0
Total charged to Annually Managed Expenditure	**3,338**	**3,338**	**0**	**0**	**0**
Total Impairments of Property, Plant and Equipment changed to SoCI	**3,338**	**3,338**	**0**	**0**	**0**

Donated and Gov Granted Assets, included above	**£000s**
PPE - Donated and Government Granted Asset Impairments: amount charged to SOCI - DEL	**(126)**
Intangibles - Donated and Government Granted Asset Impairments: amount charged to SOCI - DEL	**0**

18 Investment property

	31 March 2015 £000s	31 March 2014 £000s
At fair value		
Balance at 1 April 2014	**0**	0
Transfers under Modified Absorption Accounting - PCTs & SHAs	**0**	0
Transfers under Modified Absorption Accounting - Other Bodies	**0**	0
Additions Through Subsequent Expenditure	**0**	0
Other Acquisitions	**0**	0
Disposals	**0**	0
Property Reclassified as Held for Sale	**0**	0
Loss from Fair Value Adjustments - Impairments	**0**	0
Loss from Fair Value Adjustments - Reversal of Impairments	**0**	0
Gain from Fair Value Adjustments	**0**	0
Transfer to other NHS Foundation Trust	**0**	0
Transfers (to) / from Other Public Sector Bodies under absorption accounting	**0**	0
Other Changes	**0**	0
Balance at 31 March 2015	**0**	0

19 Commitments

19.1 Capital commitments

Contracted capital commitments at 31 March not otherwise included in these financial statements:

	31 March 2015 £000s	31 March 2014 £000s
Property, plant and equipment	**2,818**	1,450
Intangible assets	**19**	87
Total	**2,837**	1,537

19.2 Other financial commitments

The trust has entered into non-cancellable contracts (which are not leases or PFI contracts or other service concession arrangements), for ……... The payments to which the trust is committed are as follows

	31 March 2015 £000s	31 March 2014 £000s
Not later than one year	**0**	0
Later than one year and not later than five year	**0**	0
Later than five years	**0**	0
Total	**0**	0

20 Intra-Government and other balances

	Current receivables £000s	Non-current receivables £000s	Current payables £000s	Non-current payables £000s
Balances with other Central Government Bodies	538	0	5,482	0
Balances with Local Authorities	0	0	0	0
Balances with NHS bodies outside the Departmental Group	0	0	9	0
Balances with NHS Trusts and Foundation Trusts	5,206	0	1,592	1,431
Balances with Public Corporations and Trading Funds	0	0	1	0
Balances with bodies external to government	5,382	215	12,000	248
At 31 March 2015	**11,126**	**215**	**19,084**	**1,679**
prior period:				
Balances with other Central Government Bodies	5,838	0	5,738	0
Balances with Local Authorities	0	0	0	0
Balances with NHS bodies outside the Departmental Group	24	0	0	0
Balances with NHS Trusts and Foundation Trusts	1,494	0	535	0
Balances with Public Corporations and Trading Funds	0	0	0	0
Balances with bodies external to government	5,145	236	12,129	0
At 31 March 2014	**12,501**	**236**	**18,402**	**0**

A reclassification of the analysis has been undertaken for 2014/15

21 Inventories	Drugs	Consumables	Work in Progress	Energy	Total	Of which held at NRV
	£000s	£000s	£000s	£000s	£000s	£000s
Balance at 1 April 2014	**2,179**	**2,887**	**0**	**70**	**5,136**	**5,066**
Additions	29,617	24,361	0	0	**53,978**	53,978
Inventories recognised as an expense in the period	(29,274)	(23,765)	0	(14)	**(53,053)**	(53,039)
Write-down of inventories (including losses)	(100)	0	0	0	**(100)**	(100)
Reversal of write-down previously taken to SOCI	0	0	0	0	**0**	0
Transfers (to) Foundation Trusts	0	0	0	0	**0**	0
Transfers (to)/from Other Public Sector Bodies under Absorption Accounting	0	0	0	0	**0**	0
Balance at 31 March 2015	**2,422**	**3,483**	**0**	**56**	**5,961**	**5,905**

22.1 Trade and other receivables	Current		Non-current	
	31 March 2015	31 March 2014	**31 March 2015**	31 March 2014
	£000s	£000s	£000s	£000s
NHS receivables - revenue	**5,036**	6,902	**0**	0
NHS receivables - capital	**0**	0	**0**	0
NHS prepayments and accrued income	**0**	0	**0**	0
Non-NHS receivables - revenue	**1,426**	1,710	**0**	0
Non-NHS receivables - capital	**0**	0	**0**	0
Non-NHS prepayments	**1,666**	1,102	**0**	0
PDC Dividend prepaid to DH	**170**	22	**0**	0
Provision for the impairment of receivables	**(1,306)**	(1,223)	**0**	0
VAT	**456**	454	**0**	0
Current/non-current part of PFI and other PPP arrangements prepayments and accrued income	**0**	0	**0**	0
Interest receivables	**0**	0	**0**	0
Finance lease receivables	**11**	0	**215**	236
Operating lease receivables	**0**	0	**0**	0
Other receivables	**3,667**	3,534	**0**	0
Total	**11,126**	12,501	215	236
Total current and non current	**11,341**	12,737		
Included in NHS receivables are prepaid pension contributions:	**0**			

NHS receivables - revenue
- Estimated value of partially completed spells £1,604k (£1,569k)

Other receivables include:
- Injury Cost Recovery claims (ICR) £2,677k (£2,694k)
- Salary overpayments/other recoverable pay £499k (£275k)

The great majority of trade is with Clinical Commissioning Groups, as commissioners for NHS patient care services. As Clinical Commissioning Groups are funded by Government to buy NHS patient care services, no credit scoring of them is considered necessary.

22.2 Receivables past their due date but not impaired	**31 March 2015 £000s**	31 March 2014 £000s
By up to three months	**1,163**	914
By three to six months	**352**	591
By more than six months	**39**	145
Total	**1,554**	1,650

This includes £562k (£690k) relating to invoices raised to Clinical Commissioning Groups for Non Contracted Activity for which there were issues in confirmation of activity data

22.3 Provision for impairment of receivables	2014-15 £000s	2013-14 £000s
Balance at 1 April 2014	(1,223)	(958)
Transfers under Modified Absorption Accounting - PCTs & SHAs	0	0
Transfers under Modified Absorption Accounting - Other Bodies	0	0
Amount written off during the year	535	580
Amount recovered during the year	0	0
(Increase)/decrease in receivables impaired	(618)	(845)
Transfer to NHS Foundation Trust	0	0
Transfers (to)/from Other Public Sector Bodies under Absorption Accounting	0	0
Balance at 31 March 2015	(1,306)	(1,223)

The Trust provides for non recovery of receivables as follows:
All Non-NHS Trade receivables over 3 months old from date of invoice unless known reason for payment delay.
18.9% of recognised Injury Cost Recovery claims are provided for as per DH guidance.
All salary overpayments that occurred prior to 31 March 2014, for which no recovery plan is in place, are provided for in full.

23 Other Financial Assets - Current

	31 March 2015 £000s	31 March 2014 £000s
Current part of loans repayable transferred from non-current assets	0	0
NLF deposits over 3 months	0	0
Closing balance 31 March	**0**	0

(note line descriptions different in prior year)

24 Other current assets

	31 March 2015 £000s	31 March 2014 £000s
EU Emissions Trading Scheme Allowance	**0**	0
Other Assets	**0**	0
Total	**0**	0

25 Cash and Cash Equivalents

	31 March 2015 £000s	31 March 2014 £000s
Opening balance	**4,445**	4,341
Net change in year	**(3,331)**	104
Closing balance	**1,114**	4,445
Made up of		
Cash with Government Banking Service	**1,039**	4,333
Commercial banks	**66**	104
Cash in hand	**9**	8
Liquid deposits with NLF	**0**	0
Current investments	**0**	0
Cash and cash equivalents as in statement of financial position	**1,114**	4,445
Bank overdraft - Government Banking Service	**0**	0
Bank overdraft - Commercial banks	**0**	0
Cash and cash equivalents as in statement of cash flows	**1,114**	4,445
Patients' money held by the Trust, not included above	**0**	0

The reduction in cash holding in year was a key requirement of conditions in requesting temporary borrowing support from the Department of Health.

26 Non-current assets held for sale	Land	Buildings, excl. dwellings	Dwellings	Asset Under Construction and Payments on Account	Plant and Machinery	Transport and Equipment	Information Technology	Furniture and Fittings	Intangible Assets	Financial Assets	Total
	£000s	£000s	£000s	£000s	£000s	£000s	£000s	£000s	£000s	£000s	£000s
Balance at 1 April 2014	0	0	0	0	0	0	0	0	0	0	**0**
Plus assets classified as held for sale in the year	0	268			0	0	0	0	0	0	**268**
Less assets sold in the year	0	(268)	0	0	0	0	0	0	0	0	**(268)**
Less impairment of assets held for sale	0	(15)	0	0	0	0	0	0	0	0	**(15)**
Plus reversal of impairment of assets held for sale	0	15	0	0	0	0	0	0	0	0	**15**
Less assets no longer classified as held for sale, for reasons other than disposal by sale	0	0	0	0	0	0	0	0	0	0	**0**
Transfers to Foundation Trust	0	0	0	0	0	0	0	0	0	0	**0**
Transfers (to)/from Other Public Sector Bodies under Absorption Accounting	0	0	0	0	0	0	0	0	0	0	**0**
Balance at 31 March 2015	0	0	0	0	0	0	0	0	0	0	**0**
Liabilities associated with assets held for sale at 31 March 2015	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
Balance at 1 April 2012	0	0	0	0	0	0	0	0	0	0	**0**
Transfers under Modified Absorption Accounting - PCTs & SHAs	0	0	0	0	0	0	0	0	0	0	**0**
Transfers under Modified Absorption Accounting - Other Bodies	0	0	0	0	0	0	0	0	0	0	**0**
Plus assets classified as held for sale in the year	0	0	0	0	0	0	0	0	0	0	**0**
Less assets sold in the year	0	0	0	0	0	0	0	0	0	0	**0**
Less impairment of assets held for sale	0	0	0	0	0	0	0	0	0	0	**0**
Plus reversal of impairment of assets held for sale	0	0	0	0	0	0	0	0	0	0	**0**
Less assets no longer classified as held for sale, for reasons other than disposal by sale	0	0	0	0	0	0	0	0	0	0	**0**
Transfers to Foundation Trust	0	0	0	0	0	0	0	0	0	0	**0**
Transfers (to)/from other public sector bodies	0	0	0	0	0	0	0	0	0	0	0
Balance at 31 March 2014	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
Liabilities associated with assets held for sale at 31 March 2014	0	0	0	0	0	0	0	0	0	0	0

The above relates to the sale of Camelot Way, which was a bungalow located in Duston within Northampton, which has ceased to be used since the transfer of the CAMH service to Northamptonshire Healthcare NHS Foundation Trust. The property was sold for £268k following revaluation to open market value on 22nd January 2015 to an unrelated third party.

27 Trade and other payables	Current		Non-current	
	31 March 2014 £000s	31 March 2013 £000s	**31 March 2014 £000s**	31 March 2013 £000s
NHS payables - revenue	**442**	637	**0**	0
NHS payables - capital	**0**	0	**0**	0
NHS accruals and deferred income	**1,000**	0	**0**	0
Non-NHS payables - revenue	**1,288**	1,301	**0**	0
Non-NHS payables - capital	**2,157**	3,261	**0**	0
Non-NHS accruals and deferred income	**7,218**	7,192	**0**	0
Social security costs	**3,300**	3,435	**0**	0
PDC Dividend payable to DH	**0**	0	**0**	0
VAT	**0**	0	**0**	0
Tax	**0**	0	**0**	0
Payments received on account	**0**	0	**0**	0
Other	**2,591**	2,576	**0**	0
Total	**17,996**	18,402	**0**	0
Total payables (current and non-current)	**17,996**	**18,402**		
Included above:				
to Buy Out the Liability for Early Retirements Over 5 Years	**0**	0		
number of Cases Involved (number)	**0**	0		
outstanding Pension Contributions at the year end	**(2,182)**	(2,201)		

28 Other liabilities	Current		Non-current	
	31 March 2015 £000s	31 March 2014 £000s	**31 March 2015 £000s**	31 March 2014 £000s
PFI/LIFT deferred credit	**0**	0	**0**	0
Lease incentives	**0**	0	**0**	0
Other - Employee Benefits	**721**	811	**0**	0
Total	**721**	811	**0**	0
Total other liabilities (current and non-current)	**721**	**811**		

28 Other liabilities	Current		Non-current	
	31 March 2015 £000s	31 March 2014 £000s	**31 March 2015 £000s**	31 March 2014 £000s
Bank overdraft - Government Banking Service	**0**	0	**0**	0
Bank overdraft - commercial banks	**0**	0	**0**	0
Loans from Department of Health	**159**	0	**1,431**	0
Loans from other entities	**208**	285	**248**	341
PFI liabilities:				
Main liability	**0**	0	**0**	0
Lifecycle replacement received in advance	**0**	0	**0**	0
LIFT liabilities:				
Main liability	**0**	0	**0**	0
Lifecycle replacement received in advance	**0**	0	**0**	0
Finance lease liabilities	**0**	0	**0**	0
Other (describe)	**0**	0	**0**	0
Total	**367**	**285**	**1,679**	**341**
Total other liabilities (current and non-current)	**2,046**	**626**		

Loans - repayment of principal falling due in:

	31 March 2015 DH £000s	**Other £000s**	**Total £000s**
0-1 Years	**159**	208	**367**
1 - 2 Years	**318**	146	**464**
2 - 5 Years	**477**	102	**579**
Over 5 Years	**636**	0	**636**
TOTAL	**1,590**	**456**	**2,046**

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

The loan is subject to zero interest and is repayable over 4 years in equal instalments.

The Trust has taken a DH capital loan to replace imaging equipment in radiology and radiotherapy.

The total loan approved is £7.207 million and £1.590 million has been drawn down in 2014/15, repayments identified above relate to the initial £1,590k and not the full loan approval.

The loan is subject to an interest rate of 1.6% and is repayable over 10 years in equal instalments.

30 Other financial liabilities

	Current		Non-current	
	31 March 2015 £000s	31 March 2014 £000s	**31 March 2015 £000s**	31 March 2014 £000s
Embedded Derivatives at Fair Value through SoCI	**0**	0	**0**	0
Financial liabilities carried at fair value through profit and loss	**0**	0	**0**	0
Amortised Cost	**0**	0	**0**	0
Total	**0**	0	**0**	0
Total other financial liabilities (current and non-current)	**0**	0		

31 Deferred revenue

	Current		Non-current	
	31 March 2015 £000s	31 March 2014 £000s	**31 March 2015 £000s**	31 March 2014 £000s
Opening balance at 1 April 2014	**535**	51	**0**	0
Deferred revenue addition	**1,784**	591	**0**	0
Transfer of deferred revenue	**(542)**	(107)	**0**	0
Current deferred Income at 31 March 2015	**1,777**	535	**0**	0
Total deferred income (current and non-current)	**1,777**	535		

32 Finance lease obligations as lessee

The Trust has no finance lease obligations as a lessee.

33 Finance lease receivables as lessor

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

Amounts receivable under finance leases (buildings)	**Gross investments in leases**		**Present value of minimum lease payments**	
Of minimum lease payments	**31 March 2015 £000s**	31 March 2014 £000s	**31 March 2015 £000s**	31 March 2014 £000s
Within one year	**11**	10	**11**	10
Between one and five years	**44**	40	**44**	40
After five years	**171**	186	**171**	186
Less future finance charges	**0**	0	**0**	0
Gross Investment in Leases / Present Value of Minimum Lease Payments	**226**	236	**226**	236
Less allowance for uncollectible lease payments:	**0**	0	**0**	0
Total finance lease receivable recognised in the statement of financial position	226	236	**236**	236
Included in:				
Current finance lease receivables			**11**	0
Non-current finance lease receivables			**215**	236
			226	236

Rental revenue	**31 March 2015**	31 March 2014
Contingent rent	**0**	0
Other	**0**	0
Total rental revenue	**0**	0

34 Provisions

		Comprising:						
	Total	Early Departure Costs	Legal Claims	Restructuring	Continuing Care	Equal Pay (incl. Agenda for Change	Other	Redundancy
	£000s	£000s	£000s	£000s	£000s	£000s	£000s	£000s
Balance at 1 April 2014	**3,722**	0	0	0	0	0	3,722	0
Arising during the year	**1,239**	0	0	0	0	0	1,239	0
Utilised during the year	**(835)**	0	0	0	0	0	(835)	0
Reversed unused	**(1,669)**	0	0	0	0	0	(1,669)	0
Unwinding of discount	**11**	0	0	0	0	0	11	0
Change in discount rate	**0**	0	0	0	0	0	0	0
Transfers to NHS Foundation Trusts (for Trusts becoming FTs only)	**0**	0	0	0	0	0	0	0
Transfers (to)/from other public sector bodies under absorption accounting	**0**	0	0	0	0	0	0	0
Balance at 31 March 2015	**2,468**	0	0	0	0	0	2,468	0
Expected Timing of Cash Flows:								
No Later than One Year	**1,396**	0	0	0	0	0	1,396	0
Later than One Year and not later than Five Years	**968**	0	0	0	0	0	968	0
Later than Five Years	**104**	0	0	0	0	0	104	0

Amount Included in the Provisions of the NHS Litigation Authority in Respect of Clinical Negligence Liabilities:	
As at 31 March 2015	51,582
As at 31 March 2014	45,653

Pension provisions are based on expected lives and current levels of payment.
Provisions arising in year relate to service level agreements, payments in respect of notice period on protected earnings, injury retirement, legal and associated employment claims.

35 Contingencies

	31 March 2015 £000s	31 March 2014 £000s
Contingent liabilities		
NHS Litigation Authority legal claims	**0**	0
Employment Tribunal and other employee related litigation	**0**	0
Redundancy	**0**	0
Other [give details]	**0**	(203)
Amounts recoverable against contingent liabilities	**0**	0
Net value of contingent liabilities	**0**	(203)
Contingent assets		
Contingent assets [give details]	0	0
Net value of contingent liabilities	0	0

The Trust is aware of recent legal rulings in relation to the calculation of overtime and holiday pay. At this stage it is not clear how this ruling may relate to the NHS and if so which staff groups may be affected. As such no financial value has been included in these accounts in relation to the rulings and the Trust will continue to monitor the situation pending legal advice and / or specific advice from NHS employers.

36 Financial Instruments

36.1 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 Groups 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 the strategic health authority. 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.

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 2015 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 Care Group's, 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.

36.2 Financial Assets	At 'fair value through profit and loss'	loans and receivables	Available for sale	Total
	£000s	£000s	£000s	£000s
Embedded derivatives	**0**	0	**0**	0
Receivables - NHS	**0**	5,036	**0**	5,036
Receivables - non-NHS	**0**	5,634	**0**	5,634
Cash at bank and in hand	**0**	1,114	**0**	1,114
Other financial assets	**0**	226	**0**	226
Total at 31 March 2015	**0**	12,010	**0**	12,010
Embedded derivatives	**0**	0	**0**	0
Receivables - NHS	**0**	6,902	**0**	6,902
Receivables - non-NHS	0	5,145	**0**	**5,145**
Cash at bank and in hand	**0**	4,445	**0**	4,445
Other financial assets	**0**	236	**0**	236
Total at 31 March 2014	**0**	16,728	**0**	16,728

36.3 Financial Liabilities	At 'fair value through profit and loss'	Other	Total
	£000s	£000s	£000s
Embedded derivatives	0	0	**0**
NHS payables	0	442	**442**
Non-NHS payables	0	14,254	**14,254**
Other borrowings	0	2,046	**2,046**
PFI & finance lease obligations	0	0	**0**
Other financial liabilities	0	721	**721**
Total at 31 March 2015	**0**	**17,463**	**17,463**
Embedded derivatives	0	0	0
NHS payables	0	637	637
Non-NHS payables	0	14,330	14,330
Other borrowings	0	626	626
PFI & finance lease obligations	0	0	0
Other financial liabilities	0	811	811
Total at 31 March 2013	**0**	16,404	16,404

37 Events after the end of the reporting period

There are no material events after the reporting date of 31 March 2015 which effect the financial position.

38 Related party transactions

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 £9.9m (£9.8m)
Nene Clinical Commissioning Group £189.6m (£188.1m)
Corby Clinical Commissioning Group £2.9m (£4.0m)
Milton Keynes Clinical Commissioning Group £2.8m (£3.3m)
Leicestershire & Lincolnshire Area Team £33.1m (£37.3m)
Hertfordshire & South Midlands Area Team £7.4m (£8.8m)
Northamptonshire Healthcare NHS Foundation Trust £7.4m (£7.3m)

Expenditure Transactions

NHS Litigation Authority £6.1m (£6.1m)
Northamptonshire Healthcare NHS Foundation Trust £1.2m (£1.9m)
NHS Blood and Transplant £1.4m (£1.7m)

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 £746k (£726k)), Northamptonshire County Council (Pathology Services £150k (£151k)) and HM Revenue & Customs (Employers National Insurance contribution £11.6m (£11.6m)), National Health Service Pension Fund Scheme £15.8m (£15.8m) and NHS Business Services Authority £7.6m (£7.1m).

The Trust has also received revenue and capital payments from Northamptonshire Health Charitable fund. The corporate trustee of the Northamptonshire Health Charitable fund is the Trust Board.

Grants totalling £176k (£166k), 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 £211k (£203k) of Building Works & Medical Equipment.

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.nghgreenheart.co.uk or contact the Fundraising Team on 01604 545857 or E-mail greenheart@ngh.nhs.uk

39 Losses and special payments

The total number of losses cases in 2014-15 and their total value was as follows:

	Total Value of Cases £s	Total Number of Cases
Losses	**162,648**	261
Special payments	**115,729**	53
Total losses and special payments	**278,377**	314

The total number of losses cases in 2013-14 and their total value was as follows:

	Total Value of Cases £s	Total Number of Cases
Losses	285,058	330
Special payments	99,103	67
Total losses and special payments	384,161	397

40. Financial performance targets

The figures given for periods prior to 2009-10 are on a UK GAAP basis as that is the basis on which the targets were set for those years.

40.1 Breakeven performance	2005-06 £000s	2006-07 £000s	2007-08 £000s	2008-09 £000s	2009-10 £000s	2010-11 £000s	2011-12 £000s	2012-13 £000s	2013-14 £000s	2014-15 £000s
Turnover										
Retained surplus/(deficit) for the year	164,673	174,041	187,379	206,926	227,805	236,260	255,481	271,295	276,894	270,358
Adjustment for:	(2,907)	156	1,834	2,100	(4,958)	1,109	(1,917)	(764)	2,103	(20,111)
Timing/non-cash impacting distortions:										
Pre FDL(97)24 Agreements	0	0	0	0	0	0	0	0	0	0
2006/07 PPA (relating to 1997/98 to 2005/06)	0	0	0	0	0	0	0	0	0	0
2007/08 PPA (relating to 1997/98 to 2006/07)	0	0	0	0	0	0	0	0	0	0
2008/09 PPA (relating to 1997/98 to 2007/08)	0	0	0	0	0	0	0	0	0	0
Adjustments for Impairments	0	0	0	729	7,039	0	3,453	899	(2,257)	**3,338**
Adjustments for impact of policy change re donated/government grants assets	0	0	0	0	0	0	(1,032)	264	351	**248**
Consolidated Budgetary Guidance - Adjustment for Dual Accounting under IFRIC12*	0	0	0	0	0	0	0	0	0	**0**
Adsorption Accounting Adjustment	0	0	0	0	0	0	0	0	0	**0**
Other agreed adjustments	0	0	0	0	0	0	0	0	0	**0**
Break-even in-year position	**(2,907)**	**156**	**1,834**	**2,829**	**2,081**	**1,109**	**504**	**399**	**197**	**(16,525)**
Break-even cumulative position	**(1,927)**	**(1,771)**	**63**	**2,892**	**4,973**	**6,082**	**6,586**	**6,985**	**7,182**	**(9,343)**

*Due to the introduction of International Financial Reporting Standards (IFRS) accounting in 2009-10, NHS [organisation]'s financial performance measurement needs to be aligned with the guidance issued by HM Treasury measuring Departmental expenditure. Therefore, the incremental revenue expenditure resulting from the application of IFRS to IFRIC 12 schemes (which would include PFI schemes), which has no cash impact and is not chargeable for overall budgeting purposes, is excluded when measuring Breakeven performance. Other adjustments are made in respect of accounting policy changes (impairments and the removal of the donated asset and government grant reserves) to maintain comparability year to year.

	2005-06 %	2006-07 %	2007-08 %	2008-09 %	2009-10 %	2010-11 %	2011-12 %	2012-13 %	2013-14 %	2914-15 %
Materiality test (I.e. is it equal to or less than 0.5%):										
Break-even in-year position as a percentage of turnover	-1.77	0.09	0.98	1.37	0.91	0.47	0.20	0.15	0.07	-6.11
Break-even cumulative position as a percentage of turnover	-1.77	-1.02	0.03	1.40	2.18	2.57	2.58	2.57	2.59	-3.46

The amounts in the above tables in respect of financial years 2005/06 to 2008/09 inclusive have not been restated to IFRS and remain on a UK GAAP basis.

40.2 Capital cost absorption rate
The dividend payable on public dividend capital is based on the actual (rather than forecast) average relevant net assets and therefore the actual capital cost absorption rate is automatically 3.5%.

40.3 External financing
The Trust is given an external financing limit which it is permitted to undershoot.

	2014-15 £000s	2013-14 £000s
External financing limit (EFL)	**20,413**	3,413
Cash flow financing	**20,380**	3,349
Unwinding of Discount Adjustment	**0**	15
Finance leases taken out in the year	**0**	0
Other capital receipts	**0**	0
External financing requirement	**20,380**	3,364
Under/(Over) Spend against EFL	**33**	49

40.4 Capital resource limit
The Trust is given a capital resource limit which it is not permitted to exceed.

	2014-15 £000s	2013-14 £000s
Gross capital expenditure	**14,131**	14,371
Less: book value of assets disposed of	**(280)**	0
Less: capital grants	**0**	0
Less: donations towards the acquisition of non-current assets	**(295)**	(203)
Charge against the capital resource limit	**13,556**	14,168
Capital resource limit	**13,572**	14,221
(Over)/underspend against the capital resource limit	**16**	53

41 Third party assets
The Trust held cash and cash equivalents which relate to monies held by the NHS Trust on behalf of patients or other parties. This has been excluded from the cash and cash equivalents figure reported in the accounts.

	31 March 2015 £000s	31 March 2014 £000s
Third party assets held by the Trust	**0**	0

Northampton General Hospital NHS
NHS Trust

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Providing the Best Possible Care